



DRAFT National Guidance for Child Protection in Scotland 2020



Scottish Government
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Introduction

Purpose

1. This non-statutory national guidance describes responsibilities and expectations for all involved in protecting children in Scotland. The guidance outlines how agencies should work together with parents, families and communities to prevent harm and to protect children from abuse and neglect.
2. The revision forms part of the Scottish Government's [Child Protection Improvement Programme](#). This version reflects six years of changes in legislation, as well as standards and policy, developments in practice, findings from research, Significant Case Reviews and Inspections. Review and improvement is an inevitable and continual process within a complex and contentious practice landscape.
3. Revisions have been informed by a co-productive process. The views of children, families, professionals in the public and Third Sectors, practice educators and community groups have been taken into account.
4. This guidance document recognises that physical and emotional safety provides a foundation for wellbeing and healthy development. There are collective responsibilities to work together to prevent harm from abuse or neglect from pre-birth onwards, including safe transitions of vulnerable young people towards adult life and services.

Principles underpinning this guidance

5. The most effective protection of children involves early support within the family, before urgent action is needed and purposeful use of compulsory measures are necessary. If children do require placement away from home, real protection involves attuned, trauma-informed and sufficiently sustained support towards re-unification, or towards an alternative secure home base when this is not possible.
6. The Scottish approach to child protection is based upon the protection of children's rights. The Getting it right for every child (GIRFEC) policy and practice model is a practical expression of the Scottish Government's commitment to implementation of the United Nations Convention on Rights of the Child (UNCRC). This requires a continuum of preventative and protective work.
7. There are consistent threads running between enabling, preventative and protective work applying the GIRFEC approach. They may be distilled in this way:
 - The timing, process and content of all assessment, planning and action will apply to the individual child, and to their present and future safety and wellbeing. Their views will be heard and given due consideration in decisions, in accordance with their age, level of maturity, and understanding.
 - Services will seek to build on strengths and resilience as well as address risks and vulnerabilities within the child's world.
 - Partnership is promoted between those who care about and those who have responsibilities for the child – a collaborative approach between professionals, carers and family members.

8. 'Partnership' may not be attainable in a timescale that protects the child. However, even when urgent action is needed, this guidance stresses the need for proactive and persistent effort to understand and achieve a shared understanding of concerns, and a shared approach to addressing them. The guidance references collaborative, strength-based approaches to assessment and engagement in protective action.
9. Recognising the context of risk and need entails recognition of the influence of structural inequalities, such as poverty. Effective protection addresses the interaction between early adverse experiences, poverty, ill health and neglect. A disproportionate intensity of child protection interventions in the most materially deprived neighbourhoods indicates a need, not only to 'think family' but to think beyond the family, addressing patterns of concern and supporting positive opportunities in communities.
10. In rural and island areas, access to assessment and support services may be reduced. Child protection structures may require tailored adaptation in every area. This guidance clarifies shared responsibilities and standards across diverse structures.
11. The interaction of risks and needs for each child in the context of their family and their community increasingly involves appreciation of the role of media and internet in each situation, especially in teenage years. Every child has rights to safety and support online.
12. Guidance, procedures and assessment frameworks may promote broad consistency. However, effective communication and partnership is a matter of relationship. This begins with listening and seeking shared understanding. Intuition, analysis, consultation and professional judgement all play a part in deciding when and how to intervene in each situation. Inter-agency training and predictable supervision are key to safe, principled and competent practice.
13. Child protection provokes constant developmental challenges for every individual and for every team. Safe practice is more likely to arise from a culture of leadership that has an evaluative focus on outcomes and promotes systematic learning from mistakes.

Engagement with children in child protection

14. Voices of children and young people shaped the Children's Charter in 2004. Expectations of children and young people are represented in the wheel diagram (Figure 1). Those voices are echoed and strengthened by the voices of those who, 15 years later, contributed to consultation on the [National Practice Model for Advocacy in the Children's Hearings System](#) (Revised 2020).
15. The [Independent Care Review \(2020\)](#) listened to over 5,500 experiences. Over half of these were from children and young people with experience of the 'care system' and of adults who had lived in care. Their voices will be formative in child protection planning.
16. The Review found that "... when children talk about wanting to be safe, they talk about having relationships that are real, loving and consistent" and underlines the need for recognition of the significance of sibling relationships in assessment and decision-making.

Engagement with families in child protection

17. Families have a range of distinct yet connected expectations. Strong themes arose from parents, support groups, advocacy and support services during the revision of this Guidance. These are reflected in Figure 2. ‘Parents’ here refers to parents and any other carers with parental responsibility for the child.

Figure 1: Expectations of children who may be involved in child protection processes.



Figure 2: Expectations of parents who may be involved in child protection processes.



Structure and content: what has changed?

18. Although all sections are revised and supplemented, the 2020 Guidance builds on the four part structure of the 2014 Guidance, with the exception of Part 2b, which is new.

[Part 1: Principles, definitions and overarching legal framework.](#)

[Part 2: Roles and responsibilities in child protection.](#)

[Part 2b: Approach to assessment.](#)

[Part 3: Identifying and responding to child protection concerns.](#)

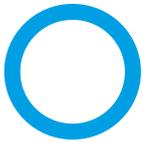
[Part 4: Specific areas of concern.](#)

[Appendices, including references and sources, and a list of legislation.](#)

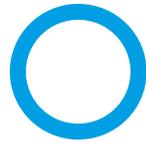
The table below is not comprehensive but does indicate areas and types of change since 2014.

Core requirements	Tonal shift	Standards and principles	Revisions and supplement	Practice notes, research links
Rights	Relationships	Assessment components	Domestic abuse Substance use Neglect Self-harm and mental health	Pre-birth support Parent with learning disabilities
Information sharing	Resilience Strength-based approach	Investigative interviews Investigating principles Trauma informed	Trafficking separated children criminalisation Hate crime Bullying Physical abuse	Neglect and emotional abuse Disabled children
Integrated health professional guidance	Engagement Communication Collaboration	Planning Timescales Chronologies Looked after Complex investigations	Sexual abuse Child abuse Exploitation Online safety Internet enabled abuse Under-age sex	Family decision making Return home/unification Repeat removal
Child protection committees and chief officers Inter-agency co-operation Inter-agency referral discussion	Advocacy Language Learning culture Supervision Inter-agency training Significant case reviews; dataset	Harmful behaviour by children Child protection FGM, honour-based abuse, forced marriage	16-17 and adult protection Children missing Transitional phases intersections: poverty, ill-health, ethnicity, disabilities, isolation	Culture, faith, rurality, community Public emergencies Contextual safeguarding
Legal and policy updates	Self-evaluation, inspection	Obesity and child protection	Non recent abuse	Capacity to change

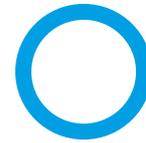
Part 1



Definitions and concepts



What is child protection?



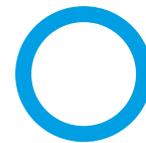
Named person, lead professional,
child's plan



What is the child
protection register?



Principles and standards



Information sharing



Key legislation



PART 1

THE CONTEXT FOR CHILD PROTECTION

KEY DEFINITIONS AND CONCEPTS

1. This chapter aims to collate and summarise definitions and explanations of key terms applicable to child protection processes. Relevant legislative provisions provide full and accurate legal definitions.
2. In general terms, the protection of children and young people includes unborn babies, and children and young people under the age of 18 years. It is essential that Child Protection Committees and Adult Protection Committees work together to best protect children and young people at key transition points, for example transition from children's to adult services.
3. The needs, rights, and mutual significance of siblings will be considered in any process that has a focus on a single child.

Definitions of 'child'

4. While child protection procedures may be considered for a person up to the age of 18, the legal boundaries of childhood and adulthood are variously defined. There are overlaps.
5. In Part 1 of the [Children \(Scotland\) Act 1995](#), which deals with matters including parental rights and responsibilities, a child is generally defined as someone under the age of 18, but most of the provisions apply only to children under the age of 16.
6. Chapter 1 of Part 2 deals with support for children and families and includes local authorities' duties in respect of looked-after children and children "in need". For these purposes a child is also defined as someone under the age of 18.
7. Section 67 of [The Children and Young People \(Scotland\) Act 2014](#) inserted a new section, 26A, into the Children (Scotland) Act 1995. The current law provides that a young person born on or after 1 April 1999 who is looked after in foster, kinship or residential care is eligible to remain in their current care placement until they turn 21. This is called Continuing Care.
8. The [Children's Hearings \(Scotland\) Act 2011](#) contains provisions about the Children's Hearings system and child protection orders. Section 199 states that, for the purposes of this Act, a child means a person under 16 years of age. However, section 199 of this Act provides qualifications, which this guidance has sought to summarise below:
 - In the ground for referral to a hearing under section 67(2)(o) (failure to attend school), "child" means a person who is of school age, and school age has the definition in section 31 of the Education (Scotland) Act 1980.
 - "Child" includes any child who has turned 16 after being referred to the Principal Reporter, until the Principal Reporter makes a decision not to arrange a hearing, or a hearing makes a decision to discharge a referral, or until a compulsory supervision order is made.
 - Children who are subject to compulsory measures of supervision under the Act on or after their 16th birthday are also treated as children until they reach the age of 18, or until order is terminated if this occurs first.

- Where a sheriff remits a case to the Principal Reporter under section 49(7)(b) of the Criminal Procedure (Scotland) Act 1995, then the person is treated as a child until the referral is discharged, any compulsory supervision order in place is terminated, or the child turns 18.
9. UNCRC rights apply to anyone under the age of 18. Article 1 states that this is the case unless majority is attained earlier under the law applicable to the child. Scottish Government intends to incorporate UNCRC within domestic law.
 10. [The Human and Exploitation \(Scotland\) Act 2015](#) defines a child as a person under 18 years in relation to the crime of trafficking. When s38 of this Act is implemented there will be a statutory duty on certain public bodies to notify Police Scotland about possible victims of human trafficking. The sexual abuse of trust offence applies to persons over 18 who are in a defined position of trust (such as teachers, care workers and health professionals) intentionally engaging in sexual activity towards a person under 18 years ([Sexual Offences \(Scotland\) Act 2009, s42](#)). The [Protection of Children and Prevention of Sexual Offences \(Scotland\) Act 2005](#) also defines a child as a person under 18 years in relation to sexual exploitation of children under the age of 18 through prostitution or pornography.
 11. Under the Children and Young People (Scotland) Act 2014, a “child” is defined, for the purposes of all Parts of that Act, as someone who has not yet attained the age of 18. The individual young person’s circumstances and age will dictate what legal measures can be applied. For example, the [Adult Support and Protection \(Scotland\) Act 2007](#) can be applied to over-16s when the criteria are met.
 12. Under the sections 32(3) and 33(2) and (4) of the [Education \(Scotland\) Act 1980](#), a person is of school age if he has attained the age of five years and has not attained the age of sixteen years.
 13. Local services must ensure sufficient continuity and co-ordination of planning and support for each vulnerable young person at risk of harm as they make their individual transitions to adult life and services. ‘Transitions’ may be considered by services to be a ‘handover’ between services, and yet for a young person they are multi-dimensional. Phases of enhanced risk may relate to emotional and relational transitions that occur some time after changes in service, worker or home base.
 14. Where a young person between the age of 16 and 18 requires support and protection, services will need to consider which legal framework best fits each persons’ needs and circumstances. Consideration must be given to the issue of consent. While it is inherently unfair to ask for consent for information sharing where you would have shared that information regardless of whether consent was given, it is always appropriate to seek the views of the person, and to take these into account.
 15. The [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#) follows the Children (Scotland) Act 1995 in considering a child to be under the age of 18. This does not affect a young person’s ability to consent to medical treatment, but this legislation ensures that additional safeguards are in place when a person aged under 18 needs compulsory care and treatment in relation to their mental health.
 16. The [Adults with Incapacity \(Scotland\) Act 2000](#) safeguards people who do not have capacity in relation to making decisions about their welfare and/or finances. This legislation defines “adults” as those who have attained the age of aged 16.

17. The Adult Support and Protection (Scotland) Act 2007 also applies to those aged 16 and over as “adult” is defined as an individual aged 16 or over. An “adult at risk” is someone who:
 - is unable to safeguard their own wellbeing, property, rights or other interests
 - is at risk of harm
 - and because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected
18. An adult is at risk of harm if another person is causing (or is likely to cause) the adult to be harmed, or the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm. The entirety of a person’s particular circumstances can combine to make them more vulnerable to harm than others. This legislation primarily places an emphasis on support but also provides a framework for intervention if someone requires protection.
19. When it comes to health procedure or treatment, the [Age of Legal Capacity \(Scotland\) Act 1991 \(section 2\(4\)\)](#) gives medical practitioners authority to make a judgement about the level of understanding of a child: “A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.”
20. Universal services should seek to identify pregnant women who will require additional support. There must be local assessment and support processes for high-risk pregnancies. ([Pre-birth safeguarding – Part 4](#)).

Definitions of parents and carers

21. A ‘parent’ is someone who is the genetic or adoptive mother or father of the child. This is subject to the [Human Fertilisation and Embryology Act 2008](#), which sets out which persons are to be treated as the parents of a child conceived through assisted reproduction.
22. All mothers automatically get parental responsibilities and rights (PRRs) for their child. A father also has PRRs automatically if he is or was married to the mother at the time of the child’s conception, or subsequently. If a father is not married to the mother, he will acquire PRRs if he is registered as the child’s father on the child’s birth certificate, which requires the mother’s agreement as this must have been registered jointly with the child’s mother. A father can also acquire PRRs by completing and registering a Parental Responsibilities and Rights agreement with the mother or obtaining a court order.
23. In relation to same sex parents, the child’s mother receives PRRs as does any second female parent if she was married or in a civil partnership with the mother at the time of the insemination/fertility treatment, or she is named as the other parent on the child’s birth certificate and the birth was registered post 4 May 2006, or she completes and registers a Parental Responsibilities and Rights agreement with the mother. ([Parental responsibilities and rights guide, 2020](#)).
24. Parental rights are necessary to allow a parent to fulfil their responsibilities, which include looking after their child’s health, development and welfare, providing guidance to their child, maintaining regular contact with their child if they do not live with them, and acting as their child’s legal representative. In order to fulfil these responsibilities, parental rights include the right to have their child live with them and to decide how their child is brought up. Parents continue to hold parental rights for a child unless and until these are removed. If this happens, it must be clear who does hold parental rights and responsibilities.

25. A “carer” is someone other than a parent who is looking after a child. A carer may be a “relevant person” within the Children’s Hearing system. “Relevant persons” have extensive rights within the Children’s Hearing system, including the right to attend Children’s Hearings, receive documents relating to Hearings and appeal decisions taken within those proceedings. Relevant persons are 1) parents, whether or not they have parental rights and responsibilities (unless their parental rights and responsibilities have all been removed), 2) other persons, not parents, who have parental rights and responsibilities for a child, and 3) any person who has been deemed to be a relevant person by a Children’s Hearing or pre-hearing panel on the basis that the person has, or has recently had, significant involvement in the upbringing of the child. (Section 200 and Section 81(3) in the Children’s Hearings (Scotland) Act 2011).
26. A ‘kinship carer’ is a carer for a child looked after by the local authority, where the child is placed with the kinship carer in accordance with Regulation 10 of the Looked After Children (Scotland) Regulations 2009 (“the 2009 Regulations”). In order to be approved as a kinship carer, the carer must be 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](#) (“the 2009 Regulations”) 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.
27. 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 2009 Regulations and, taking into account that information, carry out an assessment of that person’s suitability to care for the child. Other duties placed on local authorities by the 2009 Regulations are intended to ensure placements are safe, in the child’s best interests, and subject to regular review.
28. Kinship care placements of looked-after children made under the 2009 Regulations are often referred to as formal kinship care. Informal kinship care refers to care arrangements made by parents or those with parental responsibilities with close relatives or, in the case of orphaned or abandoned children, by those relatives providing care. A child cared for by informal kinship carers is not ‘looked after’. The carer in such circumstances is not a public foster carer. Foster carer means a person approved as a foster carer in accordance with a decision made under regulation 22(3), 23 or 26(8) of the Looked After Children (Scotland) Regulations 2009. A kinship carer or foster carer may or may not have parental rights and responsibilities.
29. Foster carers and kinship carers require support and partnership in the care and protection of the children placed with them. This may include help managing potential risks posed by parents or other family members. Kinship carers may have ambivalent feelings about the circumstances that have resulted in them having to care for a child or young person and parents may find it difficult to accept or respect the carer’s role. Working together in this context is likely to require a focus on the child’s needs and experience, sensitivity, mediation skills, and shared understanding about roles and boundaries. Part 13 of the Children and Young People (Scotland) Act 2014 describes eligibility for assistance in kinship care for children including those subject of or recently subject of a kinship care order, or at risk of being looked after, and for kinship carers, including those in whose favour a kinship care order subsists, or who may be considering application for such an order.
30. Private fostering refers to children placed by private arrangement with persons who are not close relatives. ‘Close relative’ in this context means mother, father, brother, sister, uncle, aunt, grandparent, of full blood or half blood or by marriage. Where the child’s parents have never married, the term will include the birth father and any person who would have been defined as a relative had the parents been married. (Scottish Government (2013) Be Safe, be sure. [Private fostering in Scotland: practice guidance for local authority children’s services](#).)

What is child abuse and child neglect?

31. Abuse and neglect are forms of maltreatment. Abuse or neglect may involve inflicting harm or failing to act to prevent harm. Children may be maltreated at home, within a family or peer network, in care placements, institutions or community settings. Those responsible may be previously unknown or familiar, or in positions of trust. They may be family members. Children may be harmed pre-birth, for instance by domestic abuse of a mother or through parental alcohol and drug use.

Physical abuse

32. Physical abuse is the causing of physical harm to a child or young person. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after.
33. There may be some variation in family, community or cultural attitudes to parenting, for example in relation to reasonable discipline. Cultural sensitivity must not deflect practitioners from a focus on a child's essential needs for care and protection from harm, or a focus on the need of a family for support to reduce stress and associated risk.

Emotional abuse

34. Emotional abuse is persistent emotional ill treatment that has severe and persistent adverse effects on a child's emotional development. 'Persistent' means there is a continuous or intermittent pattern which has caused, or is likely to cause, significant harm. Emotional abuse is present to some extent in all types of ill treatment of a child, but it can also occur independently of other forms of abuse. It may involve:
- conveying to a child that they are worthless or unloved, inadequate or valued only in so far as they meet the needs of another person
 - exploitation or corruption of a child, or imposition of demands inappropriate for their age or stage of development
 - repeated silencing, ridiculing or intimidation
 - demands that so exceed a child's capability that they may be harmful
 - extreme overprotection, such that a child is harmed by prevention of learning, exploration and social development
 - seeing or hearing the abuse of another (in accordance with the [Domestic Abuse \(Scotland\) Act 2018](#))

Sexual abuse

35. **Child sexual abuse (CSA)** is an act that involves a child under 16 years of age in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening.
36. For those who may be victims of sexual offences aged 16-17, child protection procedures should be considered. These procedures must be applied when there is concern about the sexual exploitation or trafficking of a child.

37. The activities 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 indecent images, in watching sexual activities, using sexual language towards a child, or encouraging children to behave in sexually inappropriate ways.
38. Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a person under 18 into sexual activity in exchange for something the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact. It can also occur through the use of technology. Children who are trafficked across borders or within the UK may be at particular risk of sexual abuse.

Criminal exploitation

39. Criminal exploitation refers to the action of an individual or group using an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity in exchange for something the victim needs or wants, or for the financial or other advantage of the perpetrator or facilitator. Violence or the threat of violence may feature. The victim may have been criminally exploited, even if the activity appears consensual. Child criminal exploitation may involve physical contact and may also occur through the use of technology. It may involve gangs and organised criminal networks. Sale of illegal drugs may be a feature. Children and vulnerable adults may be exploited to move and store drugs and money. Coercion, intimidation, violence (including sexual violence) and weapons may be involved.

Child Trafficking

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

Neglect

41. 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. 'Persistent' means there is a pattern which may be continuous or intermittent which has caused, or is likely to cause significant harm. However, single instances of neglectful behaviour by a person in a position of responsibility can be significantly harmful. Early signs of neglect indicate the need for support to prevent harm.
42. 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), to protect a child from physical and emotional harm or danger, to ensure adequate supervision (including the use of inadequate caregivers), or to seek consistent access to appropriate medical care or treatment.
43. Neglect may include unresponsiveness to a child's essential emotional needs. 'Non-organic failure to thrive' refers to an inability to reach normal weight and growth or development milestones in the absence of medically discernible physical and genetic reasons. This condition may be associated with chronic neglect.

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

Female Genital Mutilation

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

Forced marriage

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

What is child protection?

47. Child protection refers to the processes involved in consideration, assessment and planning of required action, together with the actions themselves, where there are concerns that a child may be at risk of harm. Child Protection Guidance provides overall direction for agencies and professional disciplines where there are concerns that a child may be at risk of harm. Child Protection Procedures (as described in Part 3) are initiated when Police, Social Work or Health professionals determine that a child may have been abused or may be at risk of significant harm. Child protection involves:
- immediate action, if necessary, to prevent significant harm to a child
 - inter-agency investigation about the occurrence or probability of abuse or neglect, or of a criminal offence against a child. Investigation extends to other children affected by the same apparent risks as the child who is the subject of a referral
 - assessment and action to address the interaction of behaviour, relationships and conditions that may, in combination, cause or accelerate risks
 - focus within assessment, planning and action upon each child's experience, needs and feelings
 - collaboration between agencies and persistent efforts to work in partnership with parents in planning and action to prevent harm or reduce risk of harm
 - recognition and support for the strengths, relationships and skills within the child and their world in order to form a plan that reduces risk and builds resilience
48. Child protection is part of a continuum of collaborative duties upon agencies working with children. The Getting it right for every child (GIRFEC) approach promotes and supports planning for such services to be provided in the way which best safeguards, supports and promotes the wellbeing of children, and ensures that any action to meet needs is taken at the earliest appropriate time to prevent acute needs arising. The planning of systems should ensure that action is integrated from the point of view of recipients.

49. Child protection processes fall at the urgent end of a continuum of services which include prevention and early intervention. The GIRFEC principles and approach are consistently applicable. Children who are subject to child protection processes may already be known to services. They may already have a child's plan in place. Child protection processes should build on existing knowledge, strengths in planning and partnerships to reduce the risk of harm, and to meet the child's needs.
50. Preventative and protective work may be needed at the same time. Preventative, restorative, supportive, collaborative and therapeutic approaches do not stop because compulsory measures or urgent protective legal steps are taken. A tailored blend of care and professional authority may be needed whether a child at risk is at home with family or accommodated, or when the child is to transition between placements or to be reunified with birth family after a placement away from home.
51. The level of risk a child is exposed to can shift, often rapidly, as circumstances change or information emerges. Services may be organised in response to 'thresholds' of risk. However, the way children and families act and think is not bound within such categories. Safe systems allow for a degree of flexibility as professional understanding of need and risk evolves. Safe systems ensure sufficient continuity of support when the immediate urgency to protect is alleviated. Safety may depend upon accessible support when need arises over the longer term.

What is harm and significant harm in a child protection context?

52. Protecting children involves preventing harm and/or the risk of harm from abuse or neglect. Child protection investigation is triggered when the impact of harm is deemed to be significant.
53. 'Harm' means the ill treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. 'Development' can mean physical, intellectual, emotional, social or behavioural development. 'Health' can mean physical or mental health. Forming a view on the significance of harm involves information gathering, putting a concern in context, and analysis with the assistance of appropriate information sharing.
54. For some actions and legal measures the test is 'significant harm' or risk of significant harm. There is no legal definition of significant harm or the distinction between harm and significant harm. The extent to which harm is significant will relate to the severity or anticipated severity of impact upon a child's health and development.
55. It is a matter for professional judgement as to whether the degree of harm to which the child is believed to have been subjected, is suspected of having been subjected, or is likely to be subjected is 'significant'. Judgement is based on as much information as can be lawfully and proportionately obtained about the child, his or her family and relevant context, including observation. Assessment frameworks and tools, some of which may be specialised, can assist professional judgement. The way in which information about children's developmental needs, parenting capacity, and family and community context is recorded will help professionals analyse the child's needs, and the capacity of the parents or carers. Purposeful and accurate chronologies assist in analysis and decision-making. ([Chronologies – Part 3](#)).
56. Professional judgement entails forming a view on the impact of an accumulation of acts, events and gaps or omissions, and sometimes upon on the impact of a single event. Judgement means making a decision about a child's needs, the capacity of parents or carers to meet those needs, and the likelihood of harm, significant or otherwise, arising.

57. A [National Risk Assessment Toolkit](#) is a resource which integrates the GIRFEC National Practice Model in a generic approach to assessment of risk, strength and resilience in the child's world.
58. When there are concerns that a child may have experienced or may experience significant harm, and these concerns relate to the possibility of abuse or neglect, then Police or Social Work must be notified. Along with other relevant services they will form a view as to whether the harm is or is likely to be significant. ([Inter-agency information sharing](#)) Professionals must also consider what harm might come to a child from failing to share relevant information, within the terms of their respective duties. Police and Health also have single-agency duties in relation to protection from harm.
59. In assessing whether harm is or may become 'significant', it will be relevant to consider the nature, degree and extent of physical or emotional harm apparent, the duration and frequency of abuse and neglect, overall parenting capacity, and the apparent or anticipated impact given the child's age and stage of development. The extent of any premeditation must be considered alongside the presence or degree of threat, coercion, sadism and any other factors that may accentuate risk to do with child, family or wider context.
60. Sometimes, a single traumatic event may constitute significant harm – for example a violent assault, suffocation or poisoning. More often, significant harm results from an accumulation of significant events, both acute and long-standing, that interrupt, change or damage the child's physical and psychological development.
61. The reactions, perceptions, wishes and feelings of the child must also be considered, with account taken of their age and level of understanding. This will depend on effective communication, including with those children and young people who find communication difficult because of their age, impairment or particular psychological or social situation. It is important to observe what children do as well as what they say, and to bear in mind that children may experience a strong desire to be loyal to their parents or carers (who may also hold some power over the child). Steps should be taken to ensure that any accounts of adverse experiences given by children are as accurate and complete as possible, and that they are recorded fully.
62. Where there is evidence of harm relating to parental behaviour, assessing risk of future significant harm is enhanced by assessment of parental capacity to change. This consists in analysis of what helps and hinders the parents to change their behaviour. It also involves assessment of progress within supported opportunities for parents to resolve key difficulties, within an agreed timescale that relates to the child's needs.
63. Significant harm is not the threshold for referral to the Principal Reporter. The test for referral to the Principal Reporter, in the case of those (local authority & Police) with a statutory duty to refer is, namely, that i) the child is in need of protection, guidance, treatment or control, and ii) it might be necessary for a Compulsory supervision order to be made. The determination of grounds for a hearing are set out in [s67 of the Children's Hearings \(Scotland\) Act 2011](#). They define a broad range of harms or potential harms that might individually or in combination have significant effect, including, for example, exposure to a person who may cause harm, or lack of parental care which may cause unnecessary suffering or serious impairment to health and development.
64. Risk of significant harm is not the test for the making of an order with secure accommodation authorisation. However the threshold for such an order is high and implies the need for evidence of risk of significant harm. The test is that the child has previously absconded and is likely to abscond again and, if the child were to abscond, it is likely that the child's physical, mental or moral welfare would be at risk, or that the child is likely to engage in self-harming conduct or cause injury to another person.

65. “Significant harm is the test for the making of a Child Protection Order in terms of the [Children’s Hearings \(Scotland\) Act \(2011\)](#). The criteria which must be satisfied in order for a Sheriff to grant a child protection order (following an application from the local authority or another person), is that there are reasonable grounds to suspect that the child has been or is being treated in such a way that the child is suffering or is likely to suffer significant harm, or that the child has been or is being neglected, and as a result of the neglect the child is suffering or is likely to suffer significant harm, or that the child will be treated or neglected in such a way that is likely to cause significant harm to the child if the child does not remain in the place at which the child is staying (whether or not the child is resident there). Such an order must be necessary to protect the child from that harm or from further harm ([s38 and s39 Children’s Hearings \(Scotland\) Act 2011](#)).
66. Likely significant harm is the test set out in the Children’s Hearing (Scotland) Act 2011 for decisions which can be made in some circumstances, by Children’s Hearings, Sheriffs and Reporters, not to provide information to a person who would otherwise be entitled to that information.
67. Harm is included in relation to conditions for medical examination orders in terms of risk of self-harm. ([s87 of the 2011 Act](#)).
68. The 2011 Act recognises that ‘serious harm’ may occur as a result of a child’s actions towards others. The need to safeguard and promote the welfare of the child throughout childhood is the paramount consideration for a children’s hearing, pre-hearing panel or Sheriff, unless the hearing, pre-hearing panel or Sheriff considers that a decision is necessary for the purpose of protecting members of the public from serious harm (whether physical or not). In such situations, the child’s welfare is ‘a primary’ but not ‘the paramount’ consideration.
69. Reflection and supervision play a role in supporting careful, balanced and legitimate steps. This is essential given the contested, complex and partial information that may be available, and as a result of the pressure of time when a situation is urgent. Variability in judgement can unfold from differences in presentation and source of concerns. Judgement may also be affected by differences in agency policy, leadership style, professional skills, experience, values, intuition and assumptions. There may be differences in personal or collective emotional response affecting judgement. The availability of experienced peer support is a quietly influential factor, the presence or absence of which can affect the perceptions and professional resilience of everyone involved in child protection. For these reasons, the likelihood and significance of harm will be aided by standard operating procedures, guidance and frameworks. Safe judgement also requires the development and preservation of reflective practice, supervision and teamwork under stressful conditions.
70. In summary, child protection involves activity to assess and prevent harm from abuse, neglect, maltreatment and exploitation. Inter-agency judgement about whether harm is significant will evolve from assessment activity in which the child is central. Significant harm remains the test for some legal steps and actions. However, the threshold is not precisely defined in law or in guidance. Professionals need to be open minded and clear about the evidence and analysis that informs professional judgement regarding potential harm to a child at a certain stage in time, recognising that risk factors interact and assessments must be reviewed to reflect change.

What is a named person, lead professional and child's plan?

71. The GIRFEC approach underpins both preventative and child protection processes. This includes an identified point of contact to provide early support, advice and access to services, a shared approach to assessment and consideration of wellbeing, and a shared response to identified needs, included planning for children across services where needed. ([Refreshed GIRFEC Guidance and Policy is forthcoming](#)).
72. A named person role has been promoted across Scotland in order to provide support and a clear point of contact if a child, young person or their parents want information or advice, or help. The role of a named person is to promote, support and safeguard children's wellbeing. This also means parents will have access to a named person to help them get the support they need. This support is usually provided by someone known to the child and family from universal services, including a midwife from pre-birth, usually to 10 days, a health visitor from birth to school age, a head teacher or deputy during primary school years, and a head teacher, deputy or guidance teacher during secondary school years.
73. The family may be offered direct support from their named person, or access to relevant services offered by the NHS, local authorities and Third Sector or community groups. At times during childhood and adolescence, some children and young people will need some extra help. A named person can provide or access information, advice and support to children and young people from within their own service, and when necessary request support from other services or agencies.
74. However, when the complexity or urgency of need requires co-ordinated intervention from more than one service or agency, it is crucial that a lead professional is identified to take on that coordinating role. A 'child's plan' should be developed.
75. The partners involved in supporting the child need to agree which professional takes on the lead professional role, co-ordinating a multi-agency child's plan. The lead professional can be drawn from any of the services or agencies which are partners to the child's plan.
76. Children and families may be involved in several formal processes. For example they may be looked after and have a child protection plan, and/or a co-ordinated support plan. They should experience a co-ordinated process, managed as far as possible by a single meeting structure, with due respect for principles of lawful information sharing as described in 1.6. Family understanding and positive engagement is likely to depend on the extent to which they can hear and be heard, and become partners in 'joined-up' planning.
77. Where a child is thought to be at risk of harm, their safety is the priority concern and assessment and planning processes will reflect this.
78. A 'child protection planning meeting' (CPPM) is an inter-agency meeting which is convened when there are concerns that a child is or may be at risk of significant harm. Part 3 of this guidance describes activities that precede a CPPM. The chair ensures the CPPM supports engagement of parents and all relevant agencies in assessment of risks and strengths, and in planning next steps. This includes potential referral to the Principal Reporter.

79. A lead professional will be responsible for ensuring the production and review of an agreed multi-agency child's plan as detailed in Part 3 of this Guidance. This should integrate information from previous plans by individual agencies as appropriate. Reports for a child's planning meeting or for a CPPM should be circulated to everyone involved, especially the child and family. Reports should be available and presented so that they are accessible to all. This includes, for example, children or parents or carers with learning disabilities.
80. In child protection cases, the role of a lead professional will typically be taken by the local authority Social Worker. Where a child is believed to be at risk of significant harm, a Child Protection Plan should be incorporated into the child's plan for as long as the risk of significant harm is deemed to last. The multi-agency group working with the child and their family will be known as the Core Group. For further information, see section 3 of this Guidance.
81. A lead professional will:
- work with the child and family and talk through with them how everyone thinks the plan is working
 - track and respond to changes in circumstances that may affect the plan
 - be a point of contact for all practitioners who are delivering services to the child
 - make sure that the help provided is consistent with the child's plan
 - be a bridge to engagement with and support from other agencies
 - offer to link the child and family with specialist advocacy when appropriate
 - monitor how well the child's plan is working
 - co-ordinate the provision of other help or specialist assessments as needed
82. A lead professional will make sure the child is supported through significant points of transition. They will ensure a planned transfer of responsibility when another practitioner becomes the lead professional, for example if the child's needs change or the family moves away.

What is the Child Protection Register?

83. All local authorities are responsible for maintaining a central Child Protection Register for all children who are the subject of an inter-agency Child Protection Plan. This includes unborn babies. The register has no legal status. This is an administrative system for alerting practitioners that there is sufficient professional concern about a child to warrant an inter-agency Child Protection Plan. Local authority Social Work services are responsible for maintaining a register of all children in their area who are subject to a Child Protection Plan. Some authorities may choose to maintain a joint register with other authorities. The decision to place a child's name on the register should be taken following multi-agency assessment and a [Child Protection Planning Meeting](#), as detailed in Part 3 of this Guidance.
84. A child may be placed on the register if there are reasonable grounds to believe or suspect that a 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. When placing a child on the register, it is not necessary to identify a category of registration relating to the primary type of abuse and neglect. The local authority should ensure the child's name and details are entered on the register, as well as record the areas of concern identified. The local authority should inform the child's parents or carers verbally and in writing about the information held on the register and who has access to it.

85. If a compulsory supervision order is likely to be required to meet the child's needs for protection, guidance, treatment or control, or to ensure compliance, then a referral must be made to the Principal Reporter to allow consideration as to whether a children's hearing should be arranged.
86. A National Child Protection Register is under consideration. In the interim, Police Scotland are developing a child protection flag for the interim Vulnerable Persons Database (iVPD) held by Police Scotland. This will alert Police call-handling staff and Police officers attending incidents that there has been sufficient previous professional concern about a child to warrant placing them on the child protection register. It will also provide details of the lead local authority contact. Local authorities will continue to be responsible for maintaining a child protection register for children in their areas. The national register will comply with data protection law.

Removing a child from the Child Protection Register

87. If and when the practitioners who are working with the child and family decide that the risk of significant harm to the child has been sufficiently reduced and the child or young person is no longer in need of a Child Protection Plan, the local authority should remove the child from the Child Protection Register. The decision to remove a child's name will be made through a review CPPM at which all the relevant agencies are represented, as well as the child and their family. When a child's name is removed from the register, the child and their family must be informed.
88. Removal of a child's name from the register should not necessarily lead to a reduction or withdrawal of services or support to the child and family by any of the agencies. The risk of significant harm to the child may have receded, but the child may continue to require a range of support. This will form part of the single planning process for the child. At the point of de-registration, consideration should be given to whether a different lead professional should be appointed. If so, arrangements made for the transfer will be agreed. Following de-registration, the child's plan will be amended to reflect the revised assessment of risk and need.

Making use of the register

89. The register should be maintained by Social Work services. It is a distinct record. It must be securely kept, accurate at all times, and comply with the law. Social Work services should appoint a person to ensure maintenance, management and appropriate 24-hour access for the purposes of child protection.
90. Local areas should have in place mechanisms and arrangements for practitioners making an enquiry to the register, including criteria for when this should be done and by whom. Local protocols should be in place to make sure information is shared and every relevant system and organisation is alerted when there is a child protection concern.
91. The Scottish Government maintains a list of contact points for Child Protection Registers in other parts of the UK. Local authorities should notify the Scottish Government of any changes so that the list can be kept up-to-date. All practitioners should notify the keepers of local registers of any changes to details relating to children named on the register.
92. The person accountable for the register will be responsible for attempting to trace a registered child whose whereabouts become unknown, including notifications and alerts to other areas and services.

Movement of children who are on the Child Protection Register

93. When families move between local authority areas the original local authority will notify the receiving authority immediately. A written notification must follow. The receiving local authority should immediately place the child's name on their local register. Where possible, the original local authority should advise how long the child is expected to stay in the area. The authorities should make each other aware when and why temporary registration is no longer required. Information pertinent to keeping a child safe must be shared. Where a Child Protection Plan is in place, the responsible authority for the child is, with few exceptions, the health board or local authority where the child resides.
94. If the child is temporarily residing in another local authority, preparatory communication between authorities is necessary. Arrangements must be agreed for the monitoring, supervision and implementation of the Child Protection Plan. If agreement cannot be reached about arrangements, senior managers should be involved to negotiate a resolution that prioritises the child's safety.

PRINCIPLES AND STANDARDS FOR CHILD PROTECTION

95. Agencies and professional groups may have procedures and guidelines relating to their responsibilities. However, child protection is a shared responsibility. This section of the guidance outlines inter-agency values and standards in order to promote a shared approach.

Safety and rights

96. The Scottish Government supports implementation of UNCRC Rights and intends to incorporate UNCRC in Scots law. The Convention Rights are inter-related and interdependent. For example, rights to protection from abuse, neglect and exploitation are inextricable from consideration of best interests and rights in relation to participation, non-discrimination, survival, recovery, parental support, and support for healthy development. The UNCRC informs the GIRFEC approach (Scottish Government/Aldgate 2013). An [appended table](#) signposts UNCRC Articles relevant to child protection. An introduction to the Convention and the articles in full text and in accessible form may be accessed [here](#).
97. Public authorities should promote the upbringing of children by their families, in so far as is consistent with safeguarding and promoting the child's welfare. Each child has a right to be treated as an individual. Every child who can form a view on matters affecting them has the right to express those views if they so wish. Those views should be given due weight in accordance with a child's age and maturity. Any intervention by a public authority in the life of a child must be properly justified. Connections between safety and rights are further illustrated in '[The Promise](#).' Children must be heard in decision-making that affects them. Children feel safe when the relationships which they need are recognised, supported and sustained.
98. The UNCRC (Article 23) protects the rights of disabled children and the UN Convention on the Rights of Persons with Disabilities, ratified by the UK Government in 2009, states that in order for disabled children to be able to realise the rights mentioned above, they need to be provided with disability and age-appropriate assistance. If a child has learning disabilities or needs additional support with communication, consideration must be given to the best way to involve the child.

99. For parents with learning disabilities or additional communication needs, consideration should be given to the best way to involve them, as detailed in Part 4 of this Guidance.

Child's experience

100. The child's experience, views and needs are central within child protection processes. Talking with and listening to children means attention not only to their words, but also to their experience, needs, wishes and feelings. Listening includes attention to non-verbal communication, and to physical and behavioural responses to their care and environment. Understanding communication involves consideration of the timing and context of expressed words and feelings.
101. Children should be involved in decision-making in ways that are attuned to the needs and understanding of each child.

Culture, community and family context

102. It is essential to consider the child's experience and consider the risks, stresses and protective factors in the child's world. Cultural sensitivity and competence is necessary in considering the family perspective. Religion, faith and places of community and worship may be a key reference point and a source of resilience, identity and social connection. At the same time, for some families, isolation, racism, poverty, food insecurity, poor housing and barriers to employment accentuate stresses and risks. These issues are considered further in Part 4 of this Guidance.
103. Children dislocated from family and community may be additionally vulnerable to abuse and exploitation. Children living in close knit communities, whether urban or rural, may find it more difficult to go outside for help. Family honour and reputation may in some instances provide a barrier to sharing knowledge of maltreatment and abuse. Practitioners sometimes fear asking questions and making judgements about harsh or abusive parenting that might be deemed cultural practices. However, in all circumstances, a child's right to be protected from harm is paramount. Practitioners need sensitivity and persistence in developing an understanding of what life is like, and has been like, for each child.
104. Awareness of contextual risks and strengths entails consideration of relationships within and beyond the family. This includes online relationships or risk in specific community settings.

Engagement and working together

105. The introduction to this Guidance contains a summary of what parents might expect of services during child protection processes. These expectations form a basis for positive engagement. The aim is to develop goals in collaboration on the basis of shared understanding.
106. In some situations partnership may seem unrealistic due to resistance, avoidance, or aggression. Some parents struggle to follow through on verbal agreements. Engagement therefore requires exploration of the barriers to collaboration and of the factors that encourage motivation to change. Persistent outreach or advocacy may be needed for those with whom services find it hard to engage.
107. Frontline staff who experience aggressive and threatening behaviour from service users should be provided with supervisory support.

108. Child protection procedures should promote consistency and co-ordinated action. However, families may still find it hard to understand what is happening. Partnership can only evolve if processes and choices are understood. Trust cannot develop unless professionals are reliable.
109. Investigations and formal meetings require careful preparation for child and family. This entails attention to the pace, place, planning and support for anxiety-provoking processes and transitions.
110. Preventative, protective and reparative assessment and action should all be co-ordinated and streamlined, as appropriate in each situation.

Inequalities

111. Child protection assessment, planning and intervention involves exploration of the interaction of variables that impact on risk of harm for the child.

This may include:

- dynamic factors that may be amenable to shift and change, such as poverty (or affluence), housing, employment, ill health, available support, personal attitudes and behaviours
- static factors such as early adverse experiences or intellectual disabilities, the impact of which may be affected by the understanding and pragmatic support offered
- Assessment of risk entails consideration of the interaction of relationships and factors in the child's family and wider world, including impact of past experiences. In every situation the interaction of risks and strengths may be assisted by consideration of components of the GIRFEC National Practice Model, such as the concept of resilience.

Workforce

112. Child protection is an inter-agency responsibility. Professionals should each play their part in ensuring plans are clearly understood, co-ordinated and streamlined as appropriate. The lead professional role is key. Those involved should know who is co-ordinating processes and whom to contact.
113. [Protecting children and young people: a Framework for Standards](#) was published alongside the Children's Charter (Scottish Executive 2004). The principles in this framework, applying across the workforce, are:
 - children get the help they need when they need it
 - professionals take timely and effective action to protect children
 - professionals ensure children are listened to and respected
 - agencies and professionals share information about children where this is necessary to protect them
 - agencies and professionals work together to assess needs and risks and develop effective plans
 - professionals are competent and confident
 - agencies, individually and collectively, demonstrate leadership and accountability for their work and its effectiveness
 - agencies work in partnership with members of the community to protect children
 - the individual protected characteristics, including the religious and cultural background of the child and family, are taken into consideration when any decisions are being taken

- children and their families should be involved, wherever possible, in planning to meet the child's needs, both in the short and longer term. Children and their families are often best placed to know 'what works' for them.
114. **Shared principles for staff development and training** are necessary to support competence, confidence and supervisory understanding in child protection across agencies. Supervision is a key to safe practice and a learning culture as outlined in Part 2 below.
 115. **Appropriate pre- and post-qualifying training** should provide essential preparation for lead agencies. Frameworks should be subject to review and improvement. It should be noted that revised guidance on child protection for health professionals is integrated within this guidance, rather than sitting alongside in a separate publication.
 116. **A trauma-informed approach** is necessary across the workforce involved in child protection (NES 2018). A new national training programme for Joint Investigative Interviewing developed by Police Scotland/Social Work Scotland (2019) will devote a module to the application of a knowledge of child development and the impact of trauma within investigative processes.
 117. **Transitional support:** There is a need to ensure sufficient planning, continuity and consistency of [support for good transitions](#).
 118. **Flexibility:** The GIRFEC approach promotes provision of the right help at the right time. Families benefit when there is sufficient flexibility to allow a step-up or step-down in the intensity of provision without excessive delays or fractures in support.
 119. **Connected planning:** Child protection is not just about investigative and planning stages and methods. When children are accommodated or have to move for their own safety, emotional safety and resilience is more likely if significant relationships in the child and young person's life are recognised and valued. Once accommodated, there are times when the level of professional attention may diminish. Immediate risk is alleviated. A robust approach to assessment and support of foster and kinship placements, and a step by step approach to assessment and support for re-unification, ensure that child protection investigation and planning are part of a safely connected sequence of options.
 120. **Co-ordinated planning:** More children are coming into the care and protection systems in early years and remaining longer, due to the need for permanency planning ([Complexity in the lives of looked after children and their families in Scotland; 2003 to 2016](#)). The complexity and close connections between child protection, children's hearings and permanence processes can be confusing for families unless co-ordination of planning and engagement of key professionals is reliable, accessible and purposeful. Child protection planning is the first step in enabling safety for a child, the process must be followed through to conclusion to enable future legal stability with the child staying at home; returning home; living with kinship, foster, residential or adoptive carers.

121. The interconnection of processes is graphically illustrated in this Child Protection and Permanence System Map which shows essential steps, decisions and options, including appeals.

https://www.celcis.org/files/6415/1558/3836/PACE_Systems_Map.pdf

A simplified version can be found at:

https://www.celcis.org/files/4215/1264/7053/ CPP_System_Map_Simple.pdf

INFORMATION SHARING, INTER-AGENCY PRINCIPLES

123. Sharing relevant information is an essential part of protecting children from harm. Practitioners and managers in statutory services and the voluntary sector should all understand when and how they may share information. Practitioners must be supported and guided in working within and applying the law through organisational procedures and supervisory processes. Within agencies, data controllers and information governance/data protection leads should ensure that the systems and procedures for which they share accountability provide a framework for lawful and effective information sharing.
124. Where there is a child protection concern, relevant information should be shared with Police or Social Work without delay, provided it is necessary, proportionate and lawful to do so.

Professional judgement

125. It is the role of designated Police, Social Work and Health staff to consider whether there may be a risk of significant harm, and if so, to progress necessary action through child protection procedures. This will include careful consideration and a plan for how information should be shared with the child and family, including where there is no further action required. Practitioners with child protection concerns may share information to:
- clarify if there is a risk of harm to a child
 - clarify the level of risk of harm to a child
 - safeguard a child at risk of harm
 - clarify if a child is being harmed
 - clarify the level of harm a child is experiencing
 - safeguard a child who is being harmed
126. Professional judgement must always be applied to the available evidence about each specific emerging concern, and about what is relevant, proportionate, and necessary to share. The concern must be placed in the context of available observed and recorded information about the particular child, their needs and circumstances.

Sharing without consent

127. Where there may be a child protection concern, information may be lawfully shared without the need for consent to be given by the individual(s) to whom the information relates. The following considerations will be helpful to support relevant, proportionate, timely, safe and effective information sharing:
- If there is evidence that a child is at risk of significant harm, relevant information can be shared with a statutory agency without delay. Consent is not required or appropriate because the information must be shared in order to protect the child. Consent should only be sought when the individual has a real choice over the matter. However, where appropriate, agreement and understanding about the sharing of information may be helpful in engaging individuals in the process.
 - The needs, feelings, views and wishes of the child should be taken into account and documented. They may also need additional support to understand and communicate.
 - Information sharing decisions must be based not only upon considerations about the safety and wellbeing of the individual, but also the safety of others.
 - Information can be shared without consent if, for example, a practitioner is unable to gain consent from the individual in time to prevent risk of harm, or if gaining consent could place a child at risk.
 - Relevant personal information can be shared lawfully if, for example, it is to keep a child or individual at risk safe from neglect or physical, emotional or psychological harm. This must be done in a way that complies with the relevant areas of law such as data protection, human rights and confidentiality.
 - In all circumstances, it is important to be transparent with children and families so that they know what information is to be shared or has been shared and in what circumstances. In certain exceptional circumstances, it may not be appropriate to advise the individual that information is to be shared.
 - Children and their families should also be aware that they can challenge whether sharing information is proportionate.
 - A record should be made of the reasons and considerations that informed the decision to share the information.
128. **If, where there is a possible child protection concern, a decision is made not to share information,** consider:
- what are the reasons for deciding not to share information?
 - what harm could result if this information is not shared?
 - what are the possible risks for the child or young person or for others if information is not shared, and how serious could those risks be?
129. **Seeking Advice.** If in doubt about the boundaries of information sharing, practitioners should seek advice from their line managers. Further consultation may be necessary with agency advisors for GIRFEC and/or child protection. There should also be a governance lead to consult about the sharing of information in principle, without disclosing the identity of the individual. In any circumstances, agreement or disagreement and course of action or intervention should be recorded.

130. Within Health services, Caldicott Guardians are senior persons appointed to ensure that personal information is processed legally, ethically and appropriately. Caldicott Guardians provide leadership and informed guidance on complex matters involving confidentiality and information sharing ([A Manual for Caldicott Guardians](#)). If and when there is a decision to share information in relation to a child protection concern, then consideration should be given to the necessity to consult the child or young person's named person (if they have one), and where there is one appointed, the lead professional. They may have information that is relevant to the concern.
131. Chronologies are a form of data processing. They may be shared or jointly compiled between agencies and can have a formative influence on inter-agency child protection assessment and planning. Further detail may be found in Part 3 of this Guidance

Guiding principles: Information shared must only be that which is necessary for child protection purposes.

Individuals about whom information is being shared should not be put under pressure to consent to the sharing of their information. They should be informed and involved in such a way that they understand what is happening and why. They should also be told what information about them is being shared, with whom and why this is necessary, unless to do so would be detrimental to:

- the best interests of a child
- the health or safety of a child or another person
- the prevention or detection of crime (e.g. creating a risk of harm to a child)

or

- the apprehension or prosecution of offenders

or

- it is not reasonably practical to contact the person
- it would take too long given the particular circumstances (e.g. where you have to act quickly)
- the cost would be prohibitive
- there is some other compelling reason

Information sharing must be:

- timely in relation to the child protection concern
- secure in the manner in which it is shared
- explicit in the records about any dispute in facts or opinions shared

Shared information and records held must:

- state with whom the information has been shared and why
- be accurate and up-to-date
- be explicit about reasons for sharing or not sharing information

Information sharing that may be viewed as interfering with the right to private family life can only be lawful if it is done in a way that is proportionate to the achievement of a legitimate aim.

Involvement of children

Article 12 of the UNCRC must inform the approach to participation of children in child protection processes. This makes no restrictive presumption about age.

“States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.” There is no age limit on the right of the child to express their views. Practitioners must not begin with the assumption that a child is incapable of expressing her or his own views, but rather presume that a child has the capacity to form their own views and recognise that she or he has the right to express them. Advocacy, translation or communication support may be needed.

Implementation of Article 12 requires recognition of, and respect for, non-verbal forms of communication including play, body language, facial expressions, and drawing and painting, through which very young children demonstrate understanding, choices and preferences.

Records management

132. Effective records management policies include a well-structured file plan, standard file-naming conventions for electronic documents, and a clear retention policy about when to keep and delete documents. This will assist organisations with accountability and documentation obligations, including those relating to access to records.
133. **Access to records:** The right of access (known as subject access) is a fundamental right of the General Data Protection Regulation (GDPR). It allows individuals to find out what personal data is held about them and to obtain a copy of that data. The Information Commissioner has developed Guidance (2018; 2020 forthcoming) about the rights that individuals have to access their personal data and the obligations on data controllers.

LEGISLATION RELATING TO CHILD PROTECTION

134. Legislation places a variety of duties and responsibilities on services and organisations. These include duties to investigate and respond to concerns about a child’s safety and wellbeing. Legislation defines the responsibilities of local authorities to develop community planning processes with partner agencies. This section reviews overarching legislation covering the duties placed on services, and outlines a selection of key overarching legislation. For an outline of other legislation current or impending, see [Appendix C](#).
135. Practitioners should be aware of their own legal responsibilities and duties, and understand the legal framework within which they and other organisations and agencies operate.

Duties to protect

136. The legal duty to investigate and report issues in relation to child protection is derived from two sources: the [Police and Fire Reform \(Scotland\) Act 2012](#), which provides the mandate for Police officers, and the Children's Hearings (Scotland) Act 2011, sections 60-64, which set out the duties and powers of local authorities, constables, courts and other persons to refer all children who may be in need of compulsory measures of supervision to the Scottish Children's Reporters Administration. Section 66 of the 2011 Act requires the Principal Reporter to consider whether such compulsory measures of supervision are necessary – in which case the Reporter must refer the case to the Children's Hearing under section 69.

Police and Fire Reform (Scotland) Act 2012

137. The Police and Fire Reform (Scotland) Act 2012 defines the duty of a constable, and overarching policing priorities. The main purpose of policing is to improve the safety and wellbeing of persons, localities and communities in Scotland and, as such, the duty of a Constable includes the prevention and detection of crime, maintaining order, and the protection of life and property. They may take such lawful measures and make such reports to the appropriate prosecutor as may be needed to bring offenders to justice.

Children's Hearings (Scotland) Act 2011

138. The Children's Hearings (Scotland) Act 2011 sets out the legal basis for the care and protection of children by the imposition of compulsory measure of supervision. The Act sets out the duties and powers of local authorities, Police officers and others to make a referral to the Principal Reporter in relation to a child. The Act also sets out the Principal Reporter's powers to investigate the circumstances of any referred child in order to make a decision about whether there is an evidential basis for the child to be referred to a hearing, and about whether a hearing is necessary. The Act also governs the proceedings at Children's Hearings. It sets out the circumstances in which hearings can make a compulsory supervision order, which provides the basis for compulsory intervention in the child's life, and which can include a range of different measures, depending on what is necessary in the child's circumstances. This Act also sets out the legislation governing emergency measures for the protection of children, including child protection and child assessment orders, emergency applications to justices of the peace and the powers of a constable to remove a child to a place of safety.

Children & Young People (Scotland) Act, 2014

139. Part 1 defines the duties of Ministers and of public authorities in relation to the fulfilment of rights of children, and in furthering the effect of the UNCRC in Scotland. Part 3 (Children's Services Planning) requires local authorities and health boards to take a strategic approach to the design and delivery of a wider view of services used by children and families than those previously set out in the Children (Scotland) Act 1995. Section 8 requires every local authority and its relevant health board to jointly prepare a Children's Services Plan for the area of the local authority, in respect of each three-year period.
140. A range of other relevant local and national bodies are expected to participate in the development of the plan. The Act requires the local authority and relevant health board to jointly publish an annual report outlining the ways in which provision of children's services and related services in that area have been provided in accordance with the plan.

141. The Act contains provisions about the rights of children and young people; investigations by the Commissioner for Children and Young People in Scotland; the provision of services and support for or in relation to children and young people; the extension of early learning and childcare; the role of ‘corporate parents’; the extension of aftercare support to young people leaving care (up to and including the age of 25); entitling 16 year olds in foster, kinship or residential care the right to stay in care until they are 21; support for kinship care; the creation of an adoption register; consultation on certain school closure proposals; amendments to children’s hearings legislation; appeals against detention in secure accommodation; the provision of free school lunches. Guidance has been produced to support those parts of the Act that have been implemented.
142. Where there is duty to assess the wellbeing of children and young people under the Act, there are provisions to require this to be done with reference to the 8 wellbeing indicators. There is an intention to seek to repeal Parts 4 and 5 of the 2014 Act, on named person and child’s plan (which were never implemented and are therefore not currently in force). The commitment remains to deliver these core components of GIRFEC within existing law. Policy and practice guidance is being developed to support on-going implementation of GIRFEC underpinned by necessary, relevant and proportionate information sharing.

* The Scottish Government has committed to the incorporation of the UNCRC in Scots law.

Children (Scotland) Act 1995

143. This remains one of the primary pieces of legislation providing the range and scope of local authority intervention in the lives of children and their families, and the duties and responsibilities it establishes are discussed at different points elsewhere in this Guidance. The duties of the local authority within this legislation are, in the main, discharged by statutory Social Work services.
144. This Act sets out the duties of a local authority to publish information about services provided by them for children in their area, or which are provided for these children by other local authorities (section 20).
145. The Act also permits the local authority to request help, in the exercise of their functions in children’s services, from a range of persons specified, and imposes an obligation on the person requested to provide help, unless where doing so would not be compatible with that person’s own statutory or other duties (section 21).

Community Empowerment (Scotland) Act 2015

146. Part 2 of the Act replaces community planning provisions in the Local Government in Scotland Act 2003 and provides a statutory basis for Community Planning Partnerships (CPPs). Community Planning is a process that helps public agencies and bodies to work together and with the community to plan and deliver better services that make a real difference to people’s lives. Part 2 came into force on 20 December 2016.
147. The purpose of community planning is improvement in the achievement of outcomes resulting from, or contributed to, by the provision of services delivered by or on behalf of the local authority or the persons listed in schedule 1.
148. Schedule 1 of the act lists all the bodies considered to be community planning partners of the local authority. It includes the Chief Constable of Police Scotland, NHS Boards, and any integration joint board established by the Public Bodies (Joint Working) (Scotland) Act 2014.

149. The CPP must prepare and publish a local outcomes improvement plan (LOIP) which sets out the local outcomes that the CPP will prioritise for improvement.

Local Government in Scotland Act 2003

150. Part 3 of the Act deals with the power to advance wellbeing. This sits alongside Community Planning and allows a local authority to do anything to promote or improve wellbeing within the authority's area.

Public Bodies (Joint Working) (Scotland) Act 2014

151. This Act provides a legislative framework for the integration of health and social care services in Scotland. The Act removed community health partnerships from statute and places a duty on local authorities and NHS Boards to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services, and some hospital services. A total of 32 health and social care partnerships (HSCPs) have been established, with a jointly agreed integration scheme for each setting out key arrangements for the integration of services. The Act also allows for the integration of other areas of activity, such as children's health and social care services.

Social Work (Scotland) Act 1968

152. Although amended many times over the years, this legislation provides the primary mandate for Social Work intervention in Scotland. It is the legislation that creates the duty under section 12 to promote social welfare. While this has been added to by the Children (Scotland) Act 1995 to specify children in need, the overarching mandate remains that it is the duty of the local authority to ensure that such services are made available across their jurisdiction as could be considered consistent with this duty.

Local Government in Scotland Act 2003

153. Part 3 of the Act deals with the power of local authorities to enhance wellbeing, and again this can be interpreted as being relevant to the establishment of Child Protection Committees.

The Protection of Vulnerable Groups (Scotland) Act 2007

154. This legislation introduced the Protection of Vulnerable Groups (PVG) scheme to replace the former system of Disclosure for people working with vulnerable groups. It identifies categories of employment or contact (regulated work) where there is the expectation that a PVG check will be required and also provides direction on the responsibilities of employers.

Education (Additional Support for Learning) (Scotland) 2004 as amended

155. Under section 4 of the 2004 Act, where a local authority has responsibility for the child's or young person's education, and it has been established that the child or young person has additional support needs, the authority has a duty to provide such support as is necessary to help them benefit from school education. Under section 9 of the 2004 Act, where a local education authority has responsibility for the child's or young person's education and it has been established that the child or young person requires a co-ordinated support plan, the education authority has a duty to provide this.

The Equality Act 2010

156. Child protection policy must pay due regard to equality and diversity issues. Access to and delivery of child protection services should be fair, consistent, reliable, and focused on individual outcomes and enablement. Children and families should experience listening, respectful, responsive services. There should be no discrimination on the grounds of: age, disability, gender reassignment, marriage or civil partnership status, pregnancy or maternity, race, religion or belief, sex or sexual orientation. The 2010 Act 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.
157. Public authorities also have responsibilities under equality legislation for ensuring that discrimination does not occur, and for promoting equality of opportunity regardless of race, sex and disability. From April 2011 the public sector equality duty, under the Equality Act 2010, has required public authorities to have due regard to certain matters relating to equality when exercising their functions. These matters are eliminating conduct prohibited by the Act, advancing equality of opportunity, and fostering good relations between people who share a protected characteristic and people who do not share it. Specific duties placed on Scottish public authorities are set out in the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (as amended).
158. Account must always be taken of diversity and equality issues. For example, staff will need to consider carefully the types of communication methods they use, adapting them as necessary to cultural preferences, literacy and language skills, communication skills and abilities, so as to overcome the range of communication barriers which a diverse population of children, young people and adults might face.

Child Poverty (Scotland) Act 2017

159. The Child Poverty (Scotland) Act 2017 sets in statute the ambition to eradicate child poverty through the Child Poverty (Scotland) Act 2017. Local authorities and health boards must work together to prepare joint annual Local Child Poverty Action Reports, outlining action both taken and planned, in order to tackle local child poverty.

An appendix on legislation will include more comprehensive references to the legislation and related policy and guidance in place. The appendix will cover the Domestic Abuse (Scotland) Act 2018; Data Protection Act 2018; ECHR/Human Rights Act and HR Scotland Act; Self-Directed Support (Scotland) Act 2013. It will outline legislation in consultation, going through Parliament or not yet implemented including Age of Criminal Responsibility (Scotland) Act 2019; Domestic abuse: emergency Protective Orders; Vulnerable Witnesses; Equal Protection; S12 of 1937 Act; FGM and consultation on strengthening the law; access to records; legislation in relation to trafficking; offences against children; and other matters as recommended by SOLAR and other consultees. The outcome of the consultation in relation to incorporating UNCRC in Scots law may be referenced in view of the centrality of UNCRC in child protection work.

Part 2 Roles and responsibilities



Collective responsibilities

Leadership

Inspection

Learning and support



Single agency responsibilities

Police, Health, Education,
boarding and early learning

Social Work

Third sector



Children's Hearings:
Crown & Procurator Fiscal

Housing; Carers

Community Safety,
Prisons, Fire and Rescue

Faith organisations,
Defence Community

Culture and leisure;
sports associations



Wider planning links

Community Justice;
Public Protection

Interface between
child and adult protection

(2b) Elements in
multi-agency assessment



PART 2: ROLES AND RESPONSIBILITIES FOR CHILD PROTECTION

This section outlines collective and single agency responsibilities. It highlights key roles and wider planning links, and concludes with considerations for all services and practitioners.

COLLECTIVE RESPONSIBILITIES FOR CHILD PROTECTION

1. All agencies have a responsibility to recognise and actively consider potential risks to a child, irrespective of whether the child is the main focus of their involvement. There must be consideration of the needs, rights and mutual significance of siblings in any process that has a focus on a single child.
2. Effective partnerships between organisations, professional bodies and the public are more likely if key roles and responsibilities are well defined and understood.
3. This section therefore outlines collective responsibilities for child protection. This encompasses Chief Officers, Child Protection Committees, local communities and the general public.
4. Effectiveness and continual improvement within child protection services relies upon:
 - collaborative leadership from chief officers and senior managers
 - planned workforce development
 - communication, information and partnership with communities
 - communication and commitment to partnership with families
5. Concerns about a child at risk of significant harm may come from family, friends, neighbours, carers or any other source in the community. Children may disclose abuse directly or express anxieties about their treatment indirectly.
6. Agencies working with children and families must provide clear information about how they work together with families and the community to promote the wellbeing and safety of children. This includes information about the ways in which early help can be provided to avoid escalating need and risk, and about relevant protective processes when this becomes appropriate.
7. Relevant information includes advice about:
 - what to do if a member of the public has concerns about a child
 - sharing of information between core agencies, as defined in Part 3 of this Guidance, if there is concern about risk of harm to a child (as necessary, in a manner that is proportionate, relevant, accurate, timely and secure)
 - next steps and follow-up when concerns are reported
 - the role and responsibilities of named persons

Leadership in child protection: Chief Officers Groups and Child Protection Committees

8. The roles, responsibilities and accountability of Chief Officers and Child Protection Committees have been reviewed and revised. They are outlined in the document entitled [Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities \(Scottish Government, 2019\)](#).

Chief Officers

9. Police Scotland, NHS Boards and local authorities are the key agencies that have individual and collective responsibilities for child protection. They must account for this work and its effectiveness.
10. The Chief Constable and the Chief Executives of health boards and of local authorities are referred to as Chief Officers. They are the members of 'Chief Officer's Groups', responsible for ensuring that their agency, individually and collectively, works to protect children and young people as effectively as possible.
11. The Chief Officers of Health and Social Care Partnerships (Integration Joint Boards) are accountable to the Chief Executives of the Local Authority and the health board that make up their partnership for their role in relation to child protection and other aspects of public protection. These Chief Officers must be appropriately linked to local governance arrangements for the protection of children in their area. This applies regardless of whether children's services are in the scheme of integration.
12. Local Police Commanders and Chief Executives of health boards and Local Authorities are responsible for ensuring that their agencies, individually and collectively, work to protect children and young people as effectively as possible. They also have responsibility for integrating the contribution of those agencies not under their direct control, including the Scottish Children's Reporter Administration, the Crown Office and Procurator Fiscal Service, and the Third Sector.
13. Chief Officers are individually and collectively responsible for the leadership, direction and scrutiny of their respective child protection services and their Child Protection Committees (CPCs).

Child Protection Committees

14. Child Protection Committees (CPCs) were established in each local authority in Scotland in 1991. CPCs are the key local bodies for developing, implementing and improving child protection strategy across and between agencies, bodies and the local community. [Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities \(Scottish Government 2019\)](#).
15. A CPC is expected to perform a number of crucial functions in order to jointly identify and manage the risk to children and young people, monitor and improve performance, and promote the ethos that: "It's everyone's job to make sure I'm alright" (Scottish Executive 2002; Scottish Government 2017). CPCs must ensure all of these functions are carried out to a high standard and are aligned to the local GIRFEC arrangements.

Chief Social Work Officers

16. The [Social Work \(Scotland\) Act 1968](#) requires local authorities to appoint a single Chief Social Work Officer (CSWO). The CSWO will advise and assist local authorities and their partners in relation to governance and fulfilment of statutory responsibilities. This includes corporate parenting, child protection, adult protection and the management of high-risk offenders, as well as the role of Social Work in achievement of a wide range of national and local outcomes. The CSWO also has a contribution to make in supporting overall performance improvement and management of corporate risk ([The Role of Chief Social Work Officer, 2016](#)).
17. NHS Boards must have designated professional leads for child protection. This is usually a Chief or Consultant Nurse, and Consultant Paediatrician. These officers have pivotal roles to play in building strong collaborative relationships with professional leads in Health and Social Care Partnerships, and with other key stakeholders. The health board Accountability Framework for child protection is referenced in [Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities \(2019\)](#).

Self-Evaluation and Inspection

18. Self-evaluation is central to continuous improvement. It is a continuous, dynamic process which establishes a baseline from which to plan and set priorities for improvement. Used effectively, continuous self-evaluation helps to monitor progress and impact. Self-evaluation is therefore integral to the work of the child protection committee and children's planning processes. It should not just be an episode in preparation for inspection.
19. The Care Inspectorate has published a [Quality Framework for children and young people in need of care and protection](#).
20. This supports both self-evaluation and inspection, through identification and analysis of:
 - strengths to be maintained and areas for improvement in systems and practice
 - positive impact on and gaps within service provision for children, young people and their families
21. Child Protection committees should use the quality framework to evaluate the efficacy and impact of child protection practice in their area. Through its programme of joint inspection of services for children in need of protection, the Care Inspectorate identifies key local and national messages to promote good practice and learning.

Inspection

22. Scottish Ministers have requested the Care Inspectorate to lead a programme of joint inspections that focus on the care and protection of children and young people, and on their experience of services. These inspections are undertaken in collaboration with Education Scotland, Healthcare Improvement Scotland (HIS), and Her Majesty's Inspectorate of Constabulary in Scotland (HMICS).
23. Inspection reports consider key questions and indicators which go beyond child protection along the continuum of prevention, protection and care, as summarised below. All the questions and elements within this self-evaluation and inspection Framework have a bearing upon the effective and sustained prevention of harm to children.

Learning and development

24. Single and multi-agency agency training should be available to promote the knowledge, skills and values needed to support effective inter-disciplinary work. Child Protection Committees will ensure mechanisms are in place for the delivery and evaluation of local training. They will publish, implement, review and evaluate an inter-agency child protection training strategy.
25. Recognising that there are different levels of awareness and specificity in training needs within the workforce, the Scottish Government first published a [National Framework for Child Protection Learning and Development](#) in 2012.
26. Individual agencies are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting children's wellbeing.
27. Child Protection Committees should have an overview of the training needs of all practitioners involved in child protection activity. This includes practitioners with a particular responsibility for protecting children, such as Lead Professionals, named persons or other designated health and education practitioners, Police, Social Workers and other practitioners undertaking child protection investigations or working with complex cases. Others who work directly with children, young people and parents/carers and who may be asked to contribute to assessments, will need a fuller understanding of how to work together to identify and assess concerns, and how to plan, undertake and review interventions. Practitioners who have regular contact with children as part of their role, (such as housing officers and school bus drivers), may recognise signs of abuse or neglect and should understand how they may share such concerns appropriately.
28. Training and development for managers is also essential, at both operational and strategic levels. As well as 'foundation level' training, this may include training on joint planning and investigations, chairing multi-disciplinary meetings, supervision and support of practitioners, and decision-making. Specific training will be necessary for those conducting Inter-agency Referral Discussions (IRD) and Joint Investigative Interviews (JII). Some managers will also need training on undertaking significant case reviews.
29. Training may be delivered in collaboration across local areas, especially where local policing divisions or health boards span more than one local authority area. The content of training must reflect core components, values and principles of the GIRFEC approach (Scottish Government 2019). The content of training must reflect the principles and core components of the GIRFEC approach. They should contribute to planned and co-ordinated transitions between services and at key points in health care provision, including from midwifery to a named person in health visiting, and then to a named person in education, where there is agreement with children, young people and their parents to do so. Other key points of transition that require collaborative planning include children to adult health services, and geographical transitions within and across board areas.
30. Training should be relevant to different groups from statutory, third and other sectors, including volunteers. Training must be regularly reviewed and updated to reflect research, learning from Significant Case Reviews, and practice experience.

31. [A Scottish Knowledge and Skills Framework for Psychological Trauma and accompanying Trauma Training Plan](#), commissioned by Scottish Government and developed by NHS Education for Scotland is now accessible to the broader workforce, with a range of accompanying training resources. This is particularly relevant to child protection work and will help workers to understand the impact of trauma on children's lives. It will also support in successfully delivering quality, evidence-based trauma-informed and trauma-responsive services to people affected by adverse experience. The Trauma Training Plan will also help managers and supervisors to identify and explore practitioners' strengths, and address any gaps in their knowledge and skills.
32. A contextual understanding of child protection can be encouraged by clear leadership, training and supervision. Although every situation is unique, there may also be similar factors and experiences – such as poverty, exclusion, isolation, gender-based violence and racial discrimination – which could interact and accelerate the chemistry of some risks and harms.

Selected resources available to assist practitioners development and training can be found in [Appendix](#).

Support for practitioners: supervision

33. Support and supervision for practitioners involved in child protection work, regardless of professional role, is critical to ensure:
 - support for those who are directly involved in child protection work, which may be distressing
 - critical reflection and two-way accountability, which enables a focus on outcomes, the development of good practice for individual practitioners, and improvement in the quality of the service provided by the agency
34. Support and supervision can be both distinctly separate and joined-up activities, depending on the situation. For some professionals, such as Social Workers, supervision is a formal professional requirement whereas for others, including education practitioners, it is not. Regardless of requirement for supervision, the purpose of support and supervision in ensuring accountability for practice is relevant for anyone in a professional role with specific responsibilities for child protection. Support can also help to review the understanding of a child's situation in the light of new information, shifting circumstances or challenges to the current assessment.
35. Support and supervision should be relevant to a practitioner's professional role and scope of practice, their responsibilities, and the intensity of their involvement in child protection. Single agencies have robust standards and procedures underpinning support and/or supervision. Established standards and models of practice provide key points of reference. Examples include:
 - The [Police National Decision Model](#)
 - The [Scottish Social Service Council Supervision & Learning Resource](#)
36. Specific training and supervision may be required in relation to the knowledge and skills required in the conduct of, for example, Inter-Agency Referral Discussions or Joint Investigative Interviews, or in the development of specific assessment, therapeutic or management skills.
37. Support and supervision should provide a safe and confidential environment for discussion and reflection on the knowledge and skills informing the task, the teamwork required, and the impact of the work and engagement of each practitioner with their role. In all forms of support, the safety, experience and voice of the child should have a central focus.

38. Support and supervision should include conversations about how to continually seek the child's view, and how to ensure that, having listened to these views, practitioners keep doing what is working, or do something different where it isn't.
39. Support and supervision for practitioners may be provided within a group or team environment or in an individual setting. Some areas value inter-agency support and review in complex protection work. Informal peer supervision and support can complement formal support structures.
40. Whatever the model, practitioners need support to develop knowledge and skills to think analytically, critically and reflectively. They also need to be able to inform their judgement through inter-agency collaboration, and through sufficient knowledge of current research and evidence.
41. Support should help to ensure that:
 - practice is consistent with legal requirements, organisational policies and procedures
 - practice is underpinned by the values and core principles of GIRFEC
 - practitioners understand their roles and responsibilities, and the boundaries of their authority
 - practice is evidence-informed
 - practitioners develop skills in critical reflection about their own assumptions and values
 - the training and development needs of practitioners and supervisors are identified
 - there is structured discussion of child protection concerns, assessment and action
 - information sharing and recording is reviewed
 - there is reflection on the skills required for practitioners to engage effectively with children and their families
 - there is reasoned consideration of counter views, options and probable outcomes
 - there is reflection on teamwork and individual work impact
42. The following section outlines the roles and responsibilities of public services and other community services.

SINGLE AGENCY RESPONSIBILITIES FOR CHILD PROTECTION

43. All services and professional bodies should have clear policies in place for identifying, sharing and acting upon concerns about risk of harm to a child or children.
44. Each practitioner remains accountable for their own practice and must adhere to their own professional guidelines, standards and codes of professional conduct. Practitioners at all levels in all services, including third and private sector services, should have information, advice and training to make them aware of potential risks to children. Practitioners should have an understanding of steps they might take to keep children safe.

Police Service of Scotland ('Police Scotland')

45. The [Police and Fire Reform \(Scotland\) Act 2012](#) places a statutory duty on Police Officers to detect and prevent crime. Therefore child protection is a fundamental part of the duties of all Police Officers. 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.

46. The local delivery of public protection arrangements remains the responsibility of Local Police Commanders. Community policing teams contribute to prevention and personal safety programmes for children and young people. Every local policing division across Scotland has a dedicated Public Protection Unit staffed by specialist officers, with Investigation teams and a Divisional Concern Hub. The Divisional Concern Hub functionality includes responsibility of triage, research, assessment and consideration, if appropriate, of information sharing of all identified concerns.
47. Police Scotland records information about individuals who are, or are perceived to be, experiencing some form of adversity and/or situational vulnerability which may impact on their current or future wellbeing. Police Scotland also records reports and action taken where an immediate crisis response has been required. This might include adult or child protection, domestic abuse, hate crime or youth offending. Details of victim's rights under Section 8 (and 9 when implemented) of the [Victims and Witnesses \(Scotland\) Act 2014](#) would be noted. Information is recorded, assessed and shared, where appropriate, with relevant statutory agencies and/or Third Sector organisations/ advocacy.
48. Introduction and development of Divisional Concern Hubs has further strengthened Police Scotland's ability to apply clear assessment, rationale and audit information sharing pathways.
49. The identification of concerns at an early stage better enables Police Scotland and partners to promote, support and safeguard the wellbeing of individuals and communities, which helps keep people safe. It provides an opportunity to provide support at an earlier stage, where appropriate to do so, and to take preventative action to stop low-level concerns developing into crisis situations.
50. Where it is considered necessary to remove a child from harm or risk of harm, consideration may be given by Police to invoke statutory powers under the [Children's Hearing \(Scotland\) Act 2011](#), to apply for a Child Protection Order (CPO) or, in an emergency situation, to remove a child to a place of safety.
51. Where the conditions for applying for a CPO are met, but it is not practicable to apply to a Sheriff for such an order, a Constable may remove a child to a place of safety under section 56 of the Children's Hearing (Scotland) Act 2011. Before invoking their emergency powers, officers should carefully consider the justification for their actions, and whether the provisions of the legislation are met.
52. It should be borne in mind that these measures are used in emergency situations and only last for 24 hours. When a child is removed to a place of safety the Constable must inform the Principal Reporter as soon as is practical thereafter. Where a child is removed to a place of safety, the local authority may seek a Child Protection Order to ensure the on-going protection and safety of that child.
53. 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 Principal Reporter whether or not there are grounds for criminal prosecution. Section 61 of the Children's Hearing (Scotland) Act 2011 provides a statutory duty on a constable to provide information to the Principal Reporter, Scottish Children's Reporter Administration (SCRA), where the constable considers: a) that a child is in need of protection, guidance, treatment or control, and b) that it may be necessary for a compulsory supervision order to be made in relation to the child.

54. The Police will share proportionate information and consult as part of an inter-agency discussion (IRD) to determine whether the matter is a child protection concern. If so, the Police will share information with other core agencies, Health and Social Work, as part of the IRD, and will attend Child Protection Planning Meetings (CPPM). ([see Part 3](#)).
55. Where appropriate, the Police should attend and contribute to Child Protection Planning Meetings. Police are unlikely to play an active role in the core group responsible for developing the “Child Protection Plan”, unless their involvement is crucial to the successful implementation of the plan.
56. The Police are responsible for investigation and evidence gathering in criminal enquiries. This task may be carried out in conjunction with other agencies, including Social Work services and medical practitioners, but the Police are ultimately accountable for conducting criminal enquiries. In cases of child abuse and neglect, 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. All child protection investigations will be dealt with in a child-focused manner, taking into account the views of the child when decisions are made, unless this places them at further risk.
57. Information about suspected or actual child abuse or neglect can come to Police attention from a number of sources, both internally and externally. All concerns must be dealt with comprehensively and impartially. Sources can include victims, witnesses, health services, Social Work or education professionals, housing providers, Third Sector organisations, anonymous reporters or Police officers through routine contact with the public.
58. Officers should be sensitive to the impact of adults’ behaviour on any child normally resident within the household when attending incidents or conducting investigations, for example domestic abuse, or problematic alcohol or drug use. Officers may gain access to homes where living conditions are poor. When conducting investigations, they may become aware of children who are at home when they should be at school, or they may be suspicious about a child’s status within the household. A child’s appearance or demeanour may give rise to concern.
59. Police Officers will be mindful that there may be occasions when concerns and/or risks to children are not easily identifiable while maintaining an awareness of the communities they serve, and also of the indicators of different types of child abuse such as Female Genital Mutilation (FGM) and Child Sexual or Criminal Exploitation (CSE/CCE). Other complex forms of abuse such as Honour Based Abuse, Forced Marriage (FM), and Human Trafficking (HT), are not specific to children but should be considered when attending any incident.
60. Police will also liaise with a number of adult services, where investigations dealing with adults may impact on children. For example, they may liaise with social services on issues such as youth justice, adult protection, children affected by parental problematic alcohol and/or drug use, anti-social behaviour, domestic abuse and offender management.
61. Officers will also be mindful of the need to ensure adequate care arrangements when parents are detained, or cannot care for their children for other reasons.

British Transport Police (BTP)

62. BTP, like other statutory agencies, has a responsibility for promoting the safety, welfare and well-being of children, and for taking positive interventions to protect them from harm. BTP applies a child protection and safeguarding policy and associated Standard Operating Procedure which applies in Scotland (as well as England and Wales) for all Police Officers, Police Community Support Officers, Police Staff and Special Constables (collectively termed 'employees').

Health services

63. NHS Boards will have designated lead roles for child protection, though titles may vary. This section describes overarching responsibilities for all health practitioners and describes some of the essential roles within a wide spectrum of services.
64. NHS Boards will support all health practitioners in upholding professional standards and regulations as outlined by their governing bodies. They will ensure that child protection processes and systems are embedded throughout the Board area and across acute and community services. This entails implementing a framework for governance, quality assurance and improvement of systems, and providing defined roles for clinical and strategic leadership of child protection services.
65. Boards will provide robust child protection services by ensuring:
- there are clear clinical and care governance processes and systems in place. These will enable continuous improvement in practice, as well as learning from child protection reviews, including both significant and adverse case reviews.
 - their NHS Board is represented by health professionals in designated child protection roles within Inter-agency Referral Discussions ([IRD Guidance – Part 3](#)).
 - health staff have access to child protection advice and support from designated health professionals.
 - there is a contemporary learning and educational framework that supports practitioners to build confidence and competence in discharging their duty to safeguard and protect children.
 - there are mechanisms in place that enable organisational assurance that all health staff are supported in accessing learning and education appropriate for their role and scope of professional practice.
 - designated health staff are available to contribute where appropriate to multi-agency learning.
 - that arrangements are in place for the support of those who have suffered abuse and neglect, from the point this is known by agencies. ([The knowledge and skills framework \(2017\)](#)).
66. All NHS practitioners have a role in protecting the public, and all regulated staff in NHS Boards and services have legal duties to protect the public. This section describes some key roles and responsibilities within a wide spectrum of NHS services. All health staff, practitioners and services will:
- be aware of their responsibilities to identify and promptly share concerns about actual or potential risk of harm to a child from abuse or neglect, in line with national guidance and local policy.
 - be aware of the early signs or indicators of neglect, and engage promptly and proportionately in co-ordinated multi-disciplinary or agency assessments.
 - work collaboratively with agencies who have statutory functions for specific aspects of child protection; namely Social Work Services and Police Scotland.

- be alert and responsive when children are not brought to health appointments, and consider what, if any action they are required to take (as opposed to applying a 'did not attend' policy without question).
- prioritise the needs of the child and ensure practice is underpinned by the principles and values of the [GIRFEC National Practice Model](#).
- be alert to other factors which may contribute to risk of harm, and which may be a barrier to receiving preventative health care. This could include poverty, disability, culture, lack of understanding or fear of public and formal systems.
- consider the potential impact of adult alcohol and drug use, domestic abuse and mental ill health on children, regardless of care setting or service being accessed by adults.
- when engaged, work collaboratively with the Lead Professional (usually a Social Worker) who is responsible for co-ordinating and overseeing a multi-agency child's plan.
- consider the need for a Lead Health Professional when multiple health services are involved within a child's plan, particularly when a child has multiple and/or complex health needs.
- seek to ensure and contribute to planned and co-ordinated transitions between services and at key points in health care provision, including from midwifery to a named person in health visiting onwards to school services, and a named person in education. Other key points of transition that require collaborative planning include children-to-adult health services and geographical transitions within and across board areas.

Chief/Lead Nurse for child protection

67. The most senior nurse responsible for Child Protection holds a strategic role. They must support the Board in delivering high quality, safe and effective services that promote wellbeing, early intervention and support for children and their families. The Chief Nurse for child protection must be a registered nurse, and could be a midwife educated to Masters level. They should have expertise and experience in child protection and professional leadership.
68. The Chief Nurse should take a professional lead on all aspects of the health service contribution to safeguarding. They are responsible for ensuring that child protection procedures and workforce development policies are in place. The Chief Nurse has a key role in the NHS Board's clinical and care governance processes for child protection. The Chief Nurse may represent the Board within National and local and professional fora, including Child Protection Committees.

Lead Doctor for Child Protection

69. This senior clinician is usually a paediatrician who must have child protection expertise and experience in order to:
- advise the health board on strategic child protection matters.
 - contribute to the development of child protection strategic planning arrangements, standards and guidelines with the Chief/Lead Nurse both on an intra and inter-agency basis.
 - advise and support providers, child protection health professionals, local authority children's services, local public protection partnerships, and local integrated health and Social Care Partnerships.
 - contribute to the work of the Child Protection Committee and subgroups.
 - provide clinical leadership to medical staff, and other clinicians delivering child protection services.

Child Protection Nurse Adviser (CPNA)

70. Child Protection Nurse Advisers are registered nurses or midwives who have undertaken specialist further education in child protection, usually at Masters level.
71. CPNA's will:
- support the Chief Nurse/Nurse Consultant in delivering the child protection service across the Board area, both in an intra and inter-agency basis.
 - provide advice and support on child protection to all health employees, clinicians and practitioners from partner agencies.
 - assist in the design, planning and implementation of child protection policies and protocols for their Board. They may also represent the Board at Child Protection Committee and relevant subgroups.

In addition, they may:

- take a lead role in the planning and delivery of child protection training to all Healthcare practitioners, both single and multi-agency.
- participate in inter-agency meetings where appropriate, for example in the development of Child Protection Plans.

Paediatricians with a Special Interest in child protection (PwSICP)

72. These are Paediatricians who support the clinical child protection service and the Lead Doctor for child protection. They provide:
- operational child protection services, including management of the child protection rota. They can undertake child protection related medical examinations.
 - support for peer review and advice for colleagues in the clinical assessment and care of children and young people where there are child protection concerns.
 - liaison between hospital and community staff for Child Protection.

Paediatricians

73. Paediatricians have a duty to identify child abuse, neglect and risk to wellbeing. They must therefore maintain their skills in this area and make sure they are familiar with the procedures to be followed where abuse or neglect is suspected. Clinical services must ensure that all paediatricians are trained to assess children for signs of abuse and neglect and are supported to make decisions on the timing of any further assessment or forensic assessment.
74. Paediatricians must be able to write a report for court as to their findings and conclusions. Paediatricians will be involved in difficult diagnostic situations, where they must differentiate abnormalities resulting from abuse from those with a medical cause. Along with forensic medical examiners, paediatricians with further training will be involved in specialist examinations of children and young people suspected of being abused and neglected, or who have reported abuse or neglect. Paediatricians have expertise in examining children who report sexual abuse, the interpretation of injuries, report writing, and appearing as expert witnesses.

Antenatal and maternity care

75. Midwives and obstetric services have a duty to identify potential child abuse, neglect and risk to the wellbeing of an unborn baby, or another child in the same environment. They must therefore maintain their skills in this area and make sure they are familiar with the procedures to be followed where possible abuse or neglect is suspected. Midwives are usually in the best position to provide a named-person role. The health visitor will normally take on the role 10 days after birth, unless otherwise agreed in advance. In any circumstances parent(s) should understand whom they can contact for support.
76. All Healthcare staff must be alert to the support and preparation needs of parents of unborn babies. Midwives and obstetric services have a duty in prevention and early intervention and detection. They are well placed to identify potential child abuse and risk when providing care to the mother and working with families to support the development of parenting potential. Midwives who provide maternity care at home will engage and work collaboratively across health and social care teams as required.

Health Visitor

77. Health visitors have a pivotal role to play in supporting children and families in the first five years of a child's life. Health visitors are registered nurses or midwives who have undertaken additional education at MSc level to be eligible to register and practice as health visitors.
78. [The Universal Health Visiting Pathway](#), published in October 2015, presents a core home visiting programme to be offered to all families with children under five years of age. It consists of 11 home visits, three of which include a formal review of the family and child's health by the health visitor (13-15 months, 27-30 months, and prior to starting school). Health visitors support parents by providing information, advice, and help to access other services. Health visitors have a professional duty to raise concerns when they consider a child is at risk or experiencing significant harm.

Family Nurse

79. [The Family Nurse Partnership \(FNP\) programme](#) is being delivered across 11 Health board areas in Scotland. The family nurse works with young first-time mothers and their families, from pregnancy until their child is two years old. The family nurse aims to guide the mother to achieve the three programme goals, which are to improve antenatal health and birth outcomes, child health and development, and parental economic self-sufficiency.
80. The licensed, socio-educative programme is delivered by specially trained family nurses to enhance parenting capacity, and seeks to support parents to achieve their aspirations. In addition to the schedule of home visits, the family nurse fulfils the requirements of the Universal Health Visiting Pathway.
81. When a child reaches their second birthday, both they and their mother graduate from the FNP programme, and their on-going care is transferred to the Health visiting service.

School Nurse

82. The role of the school nurse (SN) has been redefined ([Transforming nursing, midwifery and health professions roles: the school nursing role in integrated community nursing teams](#)). SNs are registered nurses or midwives who have undertaken additional education, usually at Masters level, in order to support school-aged children in attaining their health potential. SNs deliver proportionate universal services to school age children, based on their professional assessment of need. SNs aim to work in collaboration with named persons and health and social care teams to provide early support, and prevent escalation of need. School Nurses will be alert to children who may be at risk or experiencing significant harm, and must raise their concerns in line with local policy.

Emergency care health services

83. This includes out of hours Primary Care and GP Medical Services, NHS 24 and the Scottish Ambulance Service, as described separately below.

Emergency Departments

84. Children or young people may be taken or present themselves at Accident and Emergency departments. In some instances, abuse or neglect may be suspected, so in addition to care and treatment, local procedures for raising child protection concerns must be followed. Local guidance must be in place to respond to refusal of treatment, or premature removal of a child from the emergency department. If health staff suspect that a child or young person has experienced or is at risk of abuse or neglect, they must provide any immediate medical care required, gather information from the child or young person's medical records, and contact Social Work standby services. They must examine the child for evidence of injuries (remembering that these may be concealed under clothing), document carefully all clinical findings including skin condition, bruising, scars, weight and height, and ensure that senior practitioners are involved in any decision-making process. They must follow local child protection procedures, including ensuring concerns are raised immediately with Social Work services.

General Practitioners

85. General Practitioners (GP) and practice staff are well placed to detect early or developing concerns about children and families. Their roles encompass prevention, recognition and early response, and out of hours GP services. GPs provide on-going therapeutic support to children and families who have experienced harm, often into adulthood. In addition, GPs and their teams may be working directly with adults who pose a risk to children and young people, including those experiencing problematic alcohol and drug use or living with domestic abuse, and those who have mental health difficulties.
86. GPs will alert a statutory agency without delay if they are concerned that a child or young person has experienced or is at risk of harm from abuse or neglect. GPs are also key in the identification and support for adults with significant risk factors, such as alcohol and drug use and mental health difficulties, which may impact on their ability to care.

GP Out of Hours Services.

87. Children may attend a Primary Care or General Practice unscheduled care service for medical care. In some instances, abuse or neglect may be suspected. In addition to care and treatment, local procedures for raising child protection concerns will be followed. Local guidance should be in place to support response to refusal of treatment, or premature termination of the appointment. If health staff suspect that a child or young person attending an unscheduled care service has experienced or is at risk of abuse or neglect, practitioners should provide any immediate medical care required. They will examine the child for evidence of injuries, remembering that these may be concealed under clothing, document carefully all clinical findings including skin condition, bruising, scars, weight and height, and follow local child protection procedures. They must share concerns about risk of abuse or neglect without delay with Social Work out of hours services. This will ensure the local Child Protection Register is checked. If there is immediate risk of harm Police should be contacted.

Scottish Ambulance Service

88. The Scottish Ambulance Service covers the whole of Scotland and has a duty of care to protect the public, including the care and protection of children. Ambulance crews attend emergency and urgent calls across the whole of the country and may be the first to identify that a child is at risk or may have been harmed, at which point local policy for raising their concerns will be followed.

NHS 24

89. NHS 24 delivers a range of urgent and unscheduled care services connecting people to the care they need, and is Scotland's National TeleHealth and Telecare Service. It provides access to clinical assessment, Healthcare advice and information 24 hours per day. The aim is to provide service users with a timely response in relation to any assistance or advice required to meet their health needs, including additional support that requires onward referral to alternative professional services. Most calls are received via the 111 service when GP Surgeries and other services are closed.
90. NHS 24 plays a crucial role in the recognition and timely response to Public Protection concerns, which include the unborn baby, children and young people. This is to ensure relevant and proportionate information regarding protection needs is shared with appropriate professionals, including Social Work and/or Police Scotland.
91. If Social Work services contact emergency medical services or NHS 24 due to concerns about a child or young person's injuries or illness, the health staff professional should:
- arrange appropriate clinical care.
 - establish whether Social Work and Police have discussed the case with the local NHS child protection service, confirming that Social Work are in contact with the on-call child protection paediatrician.
 - establish whether a joint investigation has been undertaken or planned.
 - consult previous medical records (including IT systems) to check any previous attendance for analysis of the information to be shared.
 - share any relevant and proportionate information with health staff involved in the child or young person's care.

Child Protection Medical Examinations

92. There are three main types of medicals that may be undertaken within the Child Protection process: Joint Paediatric Forensic Examination (JPFE), Specialist Child Protection Paediatric/Single Doctor, and Comprehensive Medical Assessments. Part 3 of this Guidance provides further detail on Inter-agency referral discussions, and on the form and purpose of health assessments.
93. In some parts of Scotland, where victims of rape or sexual assault are over 16 years of age, they are able to self-refer for a forensic medical examination without first making a report to police. [The Scottish Government Forensic Medical Services \(Victims of Sexual Offences\) \(Scotland\) Bill](#) proposes to extend this provision across Scotland.
94. Professional judgement is required as to whether following self-referral, a forensic medical examination is in person's best interests. This includes clinical and non-clinical considerations. Even when an FME is not provided, the need for care and treatment must be considered.
95. A Clinical Pathway for Children and Young People and a Self-Referral Protocol will provide further guidance. A Memorandum of Understanding between Police Scotland and all health boards in Scotland will remain in place for forms of examination that fall outside the Bill.
96. Comprehensive medicals for chronic neglect can be arranged and planned within localities when all relevant information has been collated. However there may be extreme cases of neglect that require urgent discussion with the Child Protection Paediatrician.

Community pharmacy services

97. Community pharmacists, pharmacy technicians and pharmacy support staff regularly support the Healthcare needs of children and parents or carers, including those in 'at risk' groups, such as children of parents with drug problems. As such, they have an important role to play in identifying and raising concerns when a child is thought to be at risk of or experiencing significant harm or abuse.

Dental care practitioners

98. Dental care practitioners will often come into contact with vulnerable children and are in a position to identify possible child abuse or neglect from routine examinations, or presentation of injuries or poor oral hygiene. The dental team must have knowledge and skills to identify these concerns and raise concerns in line with local policy.

Mental Health services

99. All mental health staff in child and adolescent services and within adult services must be competent to identify concerns about children and young people. Mental health services are largely community based, with some inpatient facilities, and delivered by multi-disciplinary teams including Social Workers. They may become aware of children and young people who have experienced, or are at risk of, abuse and/or neglect, and would raise concerns in line with local policy. Within adult service, consideration should then be given to the impact of the mental ill health of a significant person in the child's world. If they are concerned that a person's mental health could put children at risk of immediate or significant harm, they must take action in line with local child protection procedures.
100. Mental health practitioners should take account of any wider factors that may affect the family's ability to manage and parent effectively, including strengths within the family in relation to the child's needs. For further information, see the section on parental mental health problems. Mental health practitioners have a potential key role in both adult and child support and protection, because they engage with vulnerable people. They play an important role in reducing any risks arising from adult mental health difficulties identified within the child's plan.
101. In some cases, adults and older young people may disclose abuse experienced some time ago. Even if they are no longer in the abusive situation, a crime may still have been committed and other children may still be at risk. Advice should be sought from professional advisors within their health boards.

Addiction services

102. Addiction services, whether based within Health or Social Work or delivered by a community-based joint addiction team, have an important role to play in the protection of children. Practitioners from addiction services have a critical role in the on-going assessment of adult service users who have caring responsibilities for children. Where risks are identified, practitioners must share information and participate in relevant core groups and planning meetings. All addiction practitioners should identify where children are living in the same household as, and/or are being cared for, by adults with alcohol and/or drug use problems. Consideration should then be given to how the problematic alcohol and/or drug use of the parent or carer impacts on the child, in conjunction with children and family services. (For further information, see Part 4 of this Guidance on [Parental alcohol and substance use](#)).

Adult Healthcare providers

103. All health staff providing services to adults have a duty of care to children and young people, and must work to consider and identify their needs. Providers of adult health services must be able to identify when a child is or at risk of significant harm, and must raise their concerns in line with local policy.

Other Health services

104. All staff working in the NHS may identify child protection concerns. Child protection concerns must be raised in line with local policy. All NHS Boards have specialist staff who can advise and support staff in relation to child protection.

References

- GMC guidance (2018) Protecting children and young people: The responsibilities of all doctors
- GMC Ethical Guidance (2018) <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people>), when child protection concerns arise
- NMC The Code (2015)
- Nice Clinical Guidance (2017) Child maltreatment: when to suspect maltreatment in under 18s <https://www.nice.org.uk/guidance/cg89>
- RCGP Safeguarding toolkit (2018) <https://www.rcgp.org.uk/clinical-and-research/safeguarding/child-safeguarding-toolkit.aspx>
- RCPCH Child Protection Companion 2nd Edition <https://www.rcpch.ac.uk/resources/child-protection-companion-about>
- Scottish Government (2017) The Best Start: A Five Year Year Forward Plan for Maternity and Neonatal care in Scotland. <https://www.gov.scot/publications/best-start-five-year-forward-plan-maternity-neonatal-care-scotland-9781786527646/>
- *Scottish Government/Scottish Executive Nurse Directors (2018) Transforming Nursing, Midwifery and Health Professions' (NMaHP) Roles: pushing the boundaries to meet health and social care needs in Scotland. Paper 4: The school nursing role in integrated community nursing teams. <https://www.gov.scot/publications/school-nursing-role-integrated-community-nursing-teams/>

Local Authority Education Services

106. All staff working in education establishments, including early learning and childcare settings, have a key role in the support and protection of children and young people. Day-to-day professional experience of, and relationship with children is a fundamental protective factor. All staff must be aware of, and must follow, child protection procedures.
107. Every school should have a child protection co-ordinator taking lead responsibility for child protection in the school, in liaison with the head and governors, to whom he/she will report. The child protection lead should also engage with appropriate training and development in order to be able to respond effectively to child protection concerns, to support staff and to share learning. Education Scotland has a strategic Safeguarding Lead.
108. [The Health & Wellbeing: Responsibility of All Experiences and Outcomes within Curriculum for Excellence](#) summarises how practitioners, pupils, parents and communities must work together in protecting and promoting children's rights, wellbeing and safety. This includes helping children develop in their ability to keep themselves and others safe, and helping them learn how to get help and support if they need it.
109. Some protective work is preventative and developmental. For example, 'Personal & Social Education' aims to provide children with the knowledge, skills and values associated with Healthy choices and relationships, and preparation for adult life.

110. When concerns about risk of harm arise, education services are well placed to notice and respond to:
- additional needs or factors that may impact on a child's ability to voice concern
 - physical and emotional changes in a child that could indicate abuse or neglect
 - family, school, cultural and community context of concerns about a child or children
 - escalating support needs of child and family
 - risks and stresses for some children in transitional stages as they move into a new school or on to adult life and services
111. Children often see education staff as a trusted source of help and support in confidence. However, when there are concerns about harm to a child emerging from their presentation, or from what they have said or done, then the nominated child protection officer will be consulted immediately. All steps and actions will be recorded.
112. While all staff in schools have responsibilities in relation to child protection, the [named person](#) within the GIRFEC approach has a focal role in the recognition of concerns and the co-ordination of help and response from the service, as appropriate. Education services will share information and contribute to investigation and assessment, according to inter-agency child protection protocols, and as far as may be proportionate, relevant and lawful. A child may be referred to the Principal Reporter if there is cause to believe they may be in need of compulsory measures.
113. Education services are an essential part of inter-agency planning and support with children and their parents, whether this is within child protection processes or as part of the co-ordinated planning within a GIRFEC approach. Community learning and development and youth work may provide significant support in planning around each child's needs.
114. Where a child goes missing from education, services within local authorities will conduct investigations in line with their local policy. This will be a collaborative approach, sharing information across services and agencies to re-establish contact with the missing child. Each local authority has a co-ordinator for children missing from education who can provide further guidance. ([Children missing from education in Scotland](#))
115. Education services have responsibilities towards children educated at home. Home educators and local authorities are encouraged to work together to develop trust, mutual respect and a positive relationship in the best educational interests of the child. The welfare and protection of all children, both those who attend school and those who are educated by other means, is paramount. Whilst a child educated at home may have limited engagement with services which could otherwise help ensure their safety and wellbeing, home education is not in itself a child protection issue. Further [guidance](#) to parents and local authorities on home education has been published by the Scottish Government.
116. Specific forms of concern require appropriate levels of awareness, knowledge and skills within an establishment. These include recognition of neglect, mental health problems, parental alcohol and drug use, under-age sexual activity, child sexual abuse and exploitation, honour-based abuse, forced marriage, female genital mutilation and bullying. Education establishments and early learning and childcare settings have a responsibility, in co-operation with Child Protection Committees, to ensure that there are appropriate and regularly reviewed procedures and guidance in place.

Grant Aided Special Schools (GASS)

117. GASS offer specialist support services for children and young people with complex additional support needs. They are all registered charities, charge fees for their services and receive direct funding from Scottish Government. Staff working in these schools share the same responsibilities in protecting children as all staff working in local authority education services.

Independent schools

118. As for all staff in local authority establishments, all staff in independent schools, whether or not grant-aided, have a responsibility to ensure that the children in their care are not harmed. This applies to teachers and all other practitioners, but has added force in schools with a boarding facility. The Education (Scotland) Act 1980 places a statutory duty upon the managers of independent boarding schools to safeguard and promote the welfare of children resident in their schools, or another place under arrangements made by their schools
119. The [Public Services Reform \(General Teaching Council for Scotland\) Order 2011](#) and the [Protection of Vulnerable Groups \(Scotland\) Act 2007](#) strengthened the provisions which ensure that teachers in independent schools (as well as other persons in child care positions) meet the necessary standards to enable them to work with children. From 1 October 2020 all teachers in independent schools must be GTCS-registered. Anyone who has cause for concern about a child or young person should share information according to their organisation's local protocol.
120. All agencies and organisations working with children and young people are expected to have child protection procedures in line with local procedures. The Scottish Council for Independent Schools provides the sector support and professional learning on child protection. SCIS works closely with the Boarding Schools Association (BSA), which upholds a Commitment to Care Charter (2017) encompassing child protection. BSA provides Safeguarding training, advice and resources for more than 500 boarding schools in the UK, including more than 20 in Scotland.

Early Learning and Childcare

121. Early learning and childcare (ELC) is a service consisting of education and care for children who are under school age. All three – and four-year-olds, and certain two-year-olds, are entitled to funded ELC. Local authorities also have discretionary powers to provide ELC in addition to the funded early learning and childcare entitlement to children deemed to be “in need”. ELC is delivered by local authority, private and Third Sector providers, including self-employed childminders. As with any service that works directly with children and their families, ELC providers are well placed to identify concerns, offer support, and participate in plans to reduce risk as appropriate. They are also expected to have effective child protection procedures in place to ensure staff have a clear understanding of their responsibilities, and to respond appropriately.

Local authority children and families Social Work

122. Local authorities have a duty to promote, support and safeguard the wellbeing of all children in need in their area, and, insofar as is consistent with that duty, to promote the upbringing of children by their families by providing a range and level of services appropriate to children's welfare and wellbeing needs. Each child has the right to protection from all forms of abuse, neglect or exploitation. In child protection processes local authorities will ensure that each child's views are taken into account in decisions that affect their lives. The welfare of the child is the paramount consideration. An early intervention approach is supported in the Children (Scotland) Act 1995 in relation to provision of support for children in need.

123. The local authority must make all necessary inquiries into the child's circumstances if it appears that the child is in need of protection, guidance, treatment or control, and if it might be necessary for a compulsory supervision order to be made in relation to the child. The local authority must give the Principal Reporter any information they have about the child.
124. Guidance for Local Authorities stipulates that, where children are in need of protection and/or in danger of serious exploitation or significant harm, a registered Social Worker will be accountable for carrying out enquiries and making recommendations, where necessary, as to whether or not the child or young person should be the subject of compulsory protection measures ([Role of the registered social worker in statutory interventions: guidance for local authorities](#)).
125. Children and family Social Workers also either directly provide or facilitate access to services to support vulnerable children and families. Social Workers are involved in work to support parenting capacity and confidence by working in partnership with sources of support within the family, and in arranging services to help children recover from the impact of abuse and neglect.
126. For children in need of care and protection, Social Workers usually act as Lead Professional, co-ordinating services and support as agreed in the 'Child Protection Plan'.
127. Social Workers play a key role in helping to ensure that suitable care arrangements are put in place by identifying appropriate placements, assessing and supporting kinship carers and foster carers, and supporting children within these placements.
128. In fulfilling the local authorities' responsibilities to children in need of protection, Social Work services have a number of key roles. These include:
 - co-ordinating multi-agency risk assessments as defined in [Part 3](#)
 - arranging Child Protection Planning Meetings
 - maintaining the Child Protection Register
 - discharging the local authority's duty to refer to the Principal Reporter children who may be in need of a compulsory supervision order
 - supervising the child on behalf of the local authority as implementation authority, giving effect to the decisions of children's hearings
129. Social Workers work with children and young people involved in offending behaviour, and play an important role in assessing and intervening with children and young people who may present risks to others. Such young people may need support in relation to experiences of neglect, trauma and abuse, as well as help to manage their offending behaviour. In those areas with specialist youth justice services, practitioners may be asked to contribute to risk assessments, as well as to support child's plans including those where protection is the primary issue.
130. Local authority Social Work services also have a responsibility to children from their own area who are placed outside the authority's geographical boundaries, or with kinship or foster carers or in establishments managed by providers other than the local authority. The definition and negotiation of the parameters of these responsibilities are to be outlined in guidance forthcoming.
131. From a safeguarding perspective, local authorities have duties to support migrant families with No Recourse to Public Funds. These families face a high risk of poverty and destitution. Guidance for local authorities on migrant rights and entitlements is linked [here](#).

Social Work justice services

132. Local authorities' Social Work justice services have a critical role in protecting children from harm, both directly and indirectly. Overarching aims are to maintain community safety through protecting the public from serious harm, to hold individuals accountable for their actions in order to reduce their risk of re-offending, and to support individuals' efforts to desist from offending by promoting Health, wellbeing and social inclusion. Social Work justice services have responsibilities for the supervision and management of risk relating to adults who have committed high-risk offences, including those against children. They must be aware of risks to children in cases of domestic abuse and parental alcohol and drug use, and must respond proportionately.
133. Some parents live with and multiple disadvantages, including homelessness, alcohol and drug use, mental ill Health, poverty, and involvement with offending. The intersection of risks for some family members can have a direct impact on the children within that family. ([Hard Edges Scotland, 2019](#)). It is also estimated that around 20-27,000 children experience the imprisonment of a parent each year in Scotland. No official data is collected on this group. This can result in them being overlooked in policy and practice. (Deacon 2019)

Adult Health & Social Care Services

134. Adult support services include a wide range of specialist provisions for different care groups. Some of these are described below, however, the same duties and responsibilities apply to all. Adult services are now largely delivered through multi-disciplinary services, and include a variety of commissioned and non-commissioned services which are delivered in partnership with the third and independent sectors. Staff in adult health and social care services must be aware of the circumstances in which an adult's additional needs impinge on children's needs and safety. They may play a role in a child's plan to reduce identified risks. Adult services, along with colleagues in children and families services, should ensure that there is strong transitional planning for young people accessing their services (see section on transition planning). This should form part of the single planning process for that young person.

Learning Disability Services

135. Learning disability services are largely community based and delivered by multi-disciplinary teams including Social Workers. Learning disability practitioners working with adults with learning disabilities should always be aware of how this might impact on any children in the family, and should give early consideration to the support that parents may need. Where they have any concerns that a child may be at risk of significant harm, they should liaise with colleagues in children's services in line with local child protection procedures. Learning disability practitioners should take account of any wider factors that may affect the family's ability to manage and parent effectively, including strengths within the family in relation to the child's needs. By engaging with vulnerable people, learning disability practitioners have a potential key role in both adult and child support and protection.

Young Carers Services

136. Young carers are often identified by adult support services working with an adult in the family. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical wellbeing, and their prospects in education and life. The [Children and Young People \(Scotland\) Act 2014](#) states that young carers, along with any other child with additional needs, should have any needs concerning their wellbeing assessed with reference to the eight wellbeing indicators. The [Carers \(Scotland\) Act 2016](#) states that young carers have a right to a young carer's statement and support. Where a child has a plan, it is good practice to integrate the statement within the plan.
137. Practitioners in other local authority services may encounter situations where a child may be at risk of harm. The local authority should ensure that practitioners are aware of child protection procedures, and are confident about how to respond to child protection concerns.

Third Sector

138. The Third Sector is made up of various types of organisation with certain characteristics in common. They are non-governmental, value-driven and typically reinvest any profits in furthering their social, environmental or cultural objectives. The term encompasses voluntary and community organisations, charities, social enterprises, co-operatives and mutual societies, both large and small. This is distinct from the responsibility that the Third Sector has when providing services on commission for and/or in lieu of services provided by and for local authorities under their statutory obligations. They must all have their own child protection policies and procedures, linked and congruent with local child protection procedures approved by Child Protection Committees.
139. The Third Sector provides a wide spectrum of services for children and young people, including nurseries, residential care, pre-school play groups, parenting and family support, youth work and other youth services, befriending, counselling, respite care, foster care, adoption, through-care and after-care, advocacy, helplines and education. The Third Sector also provides crucial recovery services, for example, in relation to experiences of abuse, addiction and mental ill Health. Some services are provided substantially by volunteers, particularly in relation to youth work (e.g. Scouts Scotland and Guiding Scotland) and helplines (e.g. ChildLine). The Third Sector includes charities providing a range of specialised services. These often deploy both professional staff and volunteers.
140. The Third Sector plays an essential 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. These organisations may be (but are not always) commissioned to provide direct services, such as family support, residential and fostering services. In addition, voluntary organisations are often in an ideal position to engage with those children and families who are suspicious of statutory interventions.
141. Many voluntary 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 – for example in relation to housing and tenancy support, mental health, disability, and drug and alcohol problems – may become concerned about children or adults within a family, without necessarily having seen the children. Commissioned and non-commissioned services should have organisational policies and protocols in relation to child protection. Anyone who has cause for concern about a child or adult at risk of harm should share information according to their organisation's local protocol. Within adult services, consideration should be given to the impact of the additional needs or potential risks relating to a significant person in the child's world.

142. All agencies and organisations working with children and young people are expected to have safe recruitment practices, and child and adult protection procedures, in line with the national guidance. They should provide training relevant to information sharing and potential child or vulnerable adult protection for staff, volunteers and board or committee members.
143. Safety is promoted by a clear reporting framework which includes learning from past mistakes, and by an open communication culture in which the views and concerns of those receiving and providing services are heard.
144. Local authorities may commission Third Sector agencies to provide services on their behalf, and in so doing should ensure such services have adequate child protection policies, procedures and guidance for staff. In fulfilling the local authorities' responsibilities to children in need of protection, the Third Sector has a number of key roles. These include delivery of services that meet the obligations of the commissioning bodies, having clear organisational policies and protocols in line with this guidance, and robust reporting procedures to ensure all concerns about wellbeing or protection are referred back to the statutory services so that appropriate action can be undertaken.

Children's Hearings System

145. The Children's Hearings System is the system of statutory intervention in the life of a child and their family. The statutory intervention takes the form of a Compulsory supervision order (CSO), and a CSO is issued by a Children's Hearing or by a Sheriff in associated Children's Hearing Court proceedings. The Children's Hearings system deals in the same way with children referred for care and protection concerns, and children who are referred as a result of their own behaviour, which can include offending.
146. Children's Reporters are employed by [The Scottish Children's Reporter Administration](#) (SCRA), a public body set up to administer the statutory function of the Principal Reporter. Any person or agency can refer a child to the Principal Reporter. The Principal Reporter's role is to decide if a child requires a Children's Hearing when the child may be in need of a CSO, and a Hearing will decide whether a CSO is necessary. The Police and Social Work have a duty to refer a child when they consider that a child is in need of protection, guidance, treatment or control and that a CSO might be necessary.
147. On receipt of the referral, the Principal Reporter will conduct an investigation by requesting reports from professionals who may or may not already be involved with a child. Once this information has been received, the Principal Reporter will consider whether there is evidence to establish one of the grounds for referral to the Children's Hearing, as specified in section 67 (2) of the Children's Hearings (Scotland) Act 2011, the extent of concerns about the child's wellbeing and behaviour, and the level of cooperation of the child and family with agencies. The Principal Reporter then makes a decision about whether to arrange a Children's Hearing, to refer a child to a local authority for voluntary measures of supervision, or to take no further action in the case. The Principal Reporter's investigation can take place at the same time as any on-going criminal investigation or criminal court case, but the focus for the Reporter and the Children's Hearing is firmly on the needs and wellbeing of the referred child or young person.

148. [Children's Hearings Scotland](#) (CHS) is the public body which is responsible for recruiting, training and supporting the volunteer children's panel members who make decisions in Children's Hearings. A Children's Hearing is a lay tribunal made up of a panel of three specially trained volunteers from the local community. The Hearing decides on a course of action that it believes is in the child's best interests, based on the child's plan with input from professionals. Medical, psychological and psychiatric reports may also be requested. The Hearing discusses the child's circumstances fully with the child or young person themselves, parents, carers and other relevant representatives and professionals (most commonly the Social Worker) before reaching a decision. (Children's Hearings Practice and Procedure Manual 2019; <https://www.scra.gov.uk/resources/>)
149. Without a CSO or interim CSO, all supports are reliant on the voluntary cooperation of families, even for children on the Child Protection Register. However, all those involved work to achieve partnership even when compulsory measures of care appear to be necessary. Early intervention and a CSO are also not mutually exclusive.
150. The principle is to apply the right intervention at the right time. Where there is no requirement for a CSO or interim CSO, children and young people can be dealt with in a number of ways, including early and effective intervention (EEI), restorative justice, voluntary measures or tailored programmes to tackle their behaviour.
151. Even where the Principal Reporter has concluded that there is sufficient evidence of a section 67 ground, there may not be a requirement for compulsory intervention, for example because the incident is entirely out of character, or because there are no other significant concerns about the child and the parental response has been both appropriate and proportionate to the incident. In other circumstances, compulsion may not be needed because the child and family have accepted that there is a problem and are already working with agencies such as social services or restorative justice.
152. Children's Hearings proceed on the basis of a shared agreement about the acceptance of the grounds for referral. If there is no shared agreement then the Children's Hearings (Scotland) Act 2011 allows an application for proof to be made to the Sheriff Court. An application to the Sheriff Court can also be made where the child, or indeed the relevant person, is considered not to have understood the grounds. It is the Reporter's responsibility to lead the evidence in court and seek to have the grounds established. If the Hearing's decision is appealed, the Reporter will go to court to conduct the appeal on the Hearing's behalf.
153. Hearings make significant decisions about complex matters. Vital work before the hearing is required to ensure that the Hearing has the evidence and the options available to enable it to make the right decision for a child. Children and families have to be prepared, and their participation and engagement in the Hearing process must be meaningfully supported. Panel members should receive reports from Social Workers which present a well-argued rationale for a recommended decision in a child's best interests, as well as reasons why alternatives are not recommended.
154. Local authority staff and Reporters will consider how best to plan and prepare all families for optimal support, understanding and participation in the Children's Hearing. To promote equality of participation, some groups and individuals will require extra consideration. A [SCRA research report](#) (Henderson et al 2018) describes the challenges and barriers to positive engagement for all families in contact with child protection and children's hearings systems. These include isolation, language difference, poor translation, concerns about confidentiality, family reluctance to raise concerns and accept support, lack of awareness of services and how the law operates in Scotland, and fear of service intervention. Families with other protected characteristics, or who have experienced adversity, may also require careful preparation for their involvement within the Children's Hearing.

155. Section 122 of the Children's Hearings (Scotland) Act 2011 provides that the chairing member of the children's hearing must inform the child of the availability of children's advocacy services unless he or she considers that it would not be appropriate to do so, taking into account the child's age and maturity. This section of the 2011 Act gives children the support of an independent advocacy worker as and when they need one, in order for them to give their views clearly and definitively, and to have their voice magnified within the Children's Hearing.
156. Section 78 of the Children (Scotland) Act 2011 sets out the persons who have a right to attend a Children's Hearing. These are the child, relevant persons, representatives, Reporter, safeguarder, member of an area support team, and a representative of a newspaper or news agency. Section 78(4) requires the chairing member to take all reasonable steps to ensure that the number of persons present at a Children's Hearing at the same time is kept to a minimum. Research has consistently made clear that children want the number of people in their hearing to be limited to those who are strictly necessary. Research also indicates that having a high number of people present in a hearing can impede participation by children and relevant persons. Each hearing will be conducted to ensure that process and participation is as child-centred and effective as may be planned in the circumstances. ([Better Hearings research report](#) Potential Link Better Hearings Guidance 2019 forthcoming)

Procurator Fiscal Services

157. The Crown Office and Procurator Fiscal Services (COPFS) is Scotland's sole prosecuting service, independent of the Police and the courts. Procurators Fiscal are based throughout Scotland. They are legally qualified civil servants who receive reports about crimes from the Police and others, and then decide what action to take in the public interest, including whether to prosecute someone. COPFS is also responsible for the investigation into sudden or suspicious deaths, and for investigating allegations of criminal conduct against Police officers. (Police Investigations and Review Commissioner (PIRC) may investigate where directed to do so by COPFS). In considering the public interest, Procurators Fiscal take a number of factors into account, including the interests of the victim, the accused and the wider community. This can involve competing interests and will vary with every case.
158. If there is enough evidence, the Procurator Fiscal will then decide what action is appropriate: whether to prosecute, offer an alternative to prosecution or to take no action in the case. In cases that will be considered by a jury, the Procurator Fiscal will gather and review all evidence before Crown Counsel makes the final decision on whether to prosecute.
159. Prosecutors will act fairly and without bias towards all victims, witnesses and accused persons, and be sensitive to individual needs, to ensure that the prosecution service delivers an equal opportunity to everyone in their access to justice.
160. All prosecutors and case preparers, including Advocates Depute prosecuting in the High Court, complete training in relation to the Domestic Abuse (Scotland) Act 2018, and in the nature, dynamics and impact of domestic abuse.

Carers looking after children away from home

161. A carer looking after children away from home might be a foster carer (including local authority carers), a kinship carer, a residential worker within a local authority residential unit, or a residential school practitioner. These carers can provide significant emotional and practical support to children who have experienced abuse, creating and maintaining a safe environment where the child feels valued and listened to. Carers looking after children away from home can provide pivotal support to the child via the Child Protection Plan, as well as particular insight into the child or young person's needs through day-to-day care and interaction. All carers should apply safe caring policies and practices that minimise situations where abuse could occur. They must be advised about how to respond to any reports of abuse, and about how to work within the agreed local reporting arrangements within their area. For further information, see the section on children who are looked after away from home.

Social Housing

162. Housing and homelessness services (local authority and Registered Social Landlords) are important contributors to intervening early and positively in the lives of children, young people and families who need support and assistance. Staff in these services can identify and coordinate a response to vulnerable families and young people, and may prevent their circumstances from deteriorating further.
163. When housing or homelessness staff sign up a family to a tenancy or visit a property for any reason they may identify early indications of family support needs, or evidence that actions are needed to protect children. Poor housing, homelessness and high mobility feature in a significant number of Case Reviews. To promote early support for vulnerable families, housing staff should have a good working knowledge of local services for children and families, and a thorough knowledge of child and adult protection procedures.
164. Social housing landlords should have policies, procedures and training in place to ensure they meet their responsibilities in relation to child and adult protection arrangements, working with local authority and NHS partners.
165. Social housing landlords also have a key role in the reintegration of people from prison into the community where they live in their tenancies, and the management of risk posed by individuals to others, for example through MAPP (Multi-Agency Public Protection Arrangements). There is a key role for social housing landlords to be represented at Child Protection Committees where appropriate.

Private landlords

166. Like social landlords, private landlords and letting agents may through their tenant engagement identify early indications of family support needs or evidence that actions are needed to protect children. It is therefore important that private landlords and letting agents have access to the right information and advice about reporting their concerns to appropriate authorities.

Community safety services

167. A safe community is a community where people can live without fear, risk, harm or injury. Community safety is about building resilient, participatory communities where homes, roads, public spaces and the workplace are safe, and feel safe. Community safety encompasses home safety, road safety and water safety (together known as injury prevention), as well as community justice, counter-terrorism, child sexual exploitation, criminal exploitation, online safety, and substance use.
168. Local partnerships have a key role in the development of preventative strategies and public communications to help families, schools and communities to be safe places, in tackling exploitation, and in promoting safety and wellbeing at individual, family and community levels.

Scottish Prison Service

169. The Scottish Prison Service (SPS) is an Agency of the Scottish Government and was established in 1993. The purpose of the SPS is to maintain secure custody and good order within prisons, whilst caring for prisoners with humanity and delivering opportunities which give the best chance to reduce reoffending once a prisoner returns to the community. The key issues in relation to children with parent(s) in the criminal justice system is to provide support to children at every stage of the criminal justice system, ensuring that parent-child relationships are maintained even when the parent is in long-term custody or prison. Where a child is considered at risk, the response should be timely, appropriate and proportionate in line with the approach set out in GIRFEC. SPS has a child protection policy which sits within a Families Strategy. Every establishment has a Designated Child Protection Co-ordinator.

Scottish Fire and Rescue Service

170. It is not the Scottish Fire and Rescue Service's (SFRS) responsibility to investigate concerns regarding child protection, but to ensure that information is passed to the relevant services. If a child is in imminent risk, for example in the case of a threat to life or where there may have been criminality, the Police will be informed without delay. Through community safety work SFRS engages with individuals and groups to address wider inequalities by helping to tackle antisocial behaviour, reduce reoffending, and by working in partnership to tackle domestic violence.

Faith organisations

171. Religious leaders, practitioners and volunteers within faith organisations have a unifying priority in relation to the protection of children. They may provide regulated care as well as a wide range of voluntary support services. Faith organisations including churches provide carefully planned activities for children, supporting families under stress and caring for those hurt by abuse in the past, as well as ministering to and managing those who have caused harm.
172. Within these varied roles, all reasonable steps must be taken to provide a safe environment that promotes and supports the wellbeing of children and young people. This includes careful selection and appointment of those who work with children. It also means ensuring practitioners and volunteers are confident about how to respond promptly, in line with agreed protocols, when concerns arise about risk of harm to a child from abuse or neglect. Child protection co-ordinators and safeguarding advisers should be available for consultation within faith organisations. They will work with Social Workers and Police officers as and when required. Practitioners and volunteers with church and faith organisations must report concerns about harm to a child to their line manager or safeguarding/child protection co-ordinator. The safety of the child or adult at risk is the priority. Further considerations on faith and cultural communities may be found in [Part 4](#) of this Guidance.

The Defence Community

173. The Defence community includes serving members of the Armed Forces, cadets, reservists, veterans and their families. It also includes civilian employees, volunteers and their families. When children and families of Defence personnel have need for child protection services standard processes apply, as outlined in [Part 3](#) of this Guidance. In view of distinctive military structures and supports, there is a need for close communication and teamwork between the relevant welfare structure within the base or unit and local statutory services. Defence protocols should link to national child protection guidance. Key points of contact for Defence are listed in [Appendix](#). Those in dedicated liaison roles within Defence will be aware of the Child Protection Committee role and function, and CPCs will be in communication with liaison officers in relation to developments in training, procedure and practice. Additional notes may be found in [Part 4](#).

Culture and leisure services

174. Culture and leisure services encompass a number of services specifically designed for, or including, children and young people. Services such as libraries, play schemes and play facilities, parks and gardens, sport and leisure centres, events and attractions, museums and arts centres all have a responsibility to ensure the safety of children and young people. Such services may be directly provided, purchased or grant-aided by local authorities from voluntary and other organisations and, as such, represent an opportunity to promote, support and safeguard children's wellbeing across sectors. Those working in sport-related services should be familiar with the National Strategy for Child Protection in Sport and relevant research.

([Help for families: safeguarding in sport \(Children 1st\)](#), [Standards for child wellbeing and protection in sport \(Sport Scotland\)](#) [Police Scotland](#), [Safeguarding in sport](#))

Sport organisations and clubs

175. Sports organisations work with a diverse range of children and young people in their communities. Some young people may only attend a holiday sport activity, while others may regularly attend and participate in a specific sport at a local sports club, while a small number are involved in elite sports. All of these activities are run by committed, paid and unpaid coaches, officials, volunteers and workers who have various degrees of contact with children and young people. This workforce will often become significant role models and trusted people in a child's life.

176. The Safeguarding in Sport service is a partnership between Children 1st and SportScotland. It supports sports organisations and individuals across Scotland (including sports governing bodies, sports clubs, Leisure Trusts, local authorities and parents and carers) in keeping children safe in and through sport by providing advice, consultancy, training and support. Organisations and community groups involved in sport activities should familiarise themselves with the National Strategy for Child Protection in Sport, and in particular the ten steps to safeguard children in sport. They should adopt an open culture of encouraging parents and carers to ask questions about safeguarding procedures. ([National Strategy for Child Protection in Sport 10 steps to safeguard children in sport](#))

WIDER PLANNING LINKS

177. Child protection planning must fit within the wider planning processes in a local area, showing how child protection is integral to wider economic and social objectives. This must be evident through community and integrated children's services planning, the national outcomes shared by national and local government, and the key national policy frameworks. The aim of community planning is to make sure people and communities are engaged in the decisions made about public services which affect them.
178. Scottish Government's overarching objectives are set out in a National Performance Framework. Most of these objectives have direct and immediate relevance to the safety, security and life chances of children in Scotland. Public Health Priorities for Scotland (Scottish Government/COSLA, 2018) provides the focus for national improvements in Healthy life expectancy, reduction of inequalities, and support for sustainable economic growth over the next ten years.
179. The specifics of local child protection planning and the responsibilities of Chief Officers and Child Protection Committees have been outlined above. Delivery of child protection is part of a continuum of inter-agency services for children and families informed by the GIRFEC policy and practice model.
180. Services protecting children and supporting their families are defined and influenced by a range of inter-related strategic plans. The Children and Young People (Scotland) Act 2014 set out reforms to the way services for children and young people are designed, delivered and reviewed. As part of the Act, the Scottish Government provided statutory guidance (in Part 3), on [Children's Services Planning](#). The duties placed on Local Authorities and Health boards under this part of the Act included provision of a Children's Services Plan for which they have joint responsibility. For the purpose of Children's Services Plans, a 'child' is a person under 18-years-old or a care leaver aged 18-25 years old eligible to receive 'children's services'.
181. There are overlaps between the requirement to plan for children's services and other related services, including duties included in Part 1 (**Children's Rights**), Part 6 (**Early Learning and Childcare**) and Part 9 (**Corporate Parenting**) of the 2014 Act, as well as the Public Bodies (Joint Working) (Scotland Act) 2014, the Community Empowerment (Scotland) Act 2015, the Carers (Scotland) Act 2016 (including young carers), and the Requirements for Community Learning and Development (Scotland) Regulations 2013. There are duties to report under the Education (Scotland) Act 2016, which establishes a statutory National Improvement Framework. Local authorities and health boards must also jointly publish annual reports on what they have done and will do in order to reduce child poverty in the local area.
182. Each integration authority is also required to prepare an annual performance report on how the arrangements in the strategic plan are contributing to achieving the National Health and Wellbeing Outcomes. These reports are required to cover all services provided in the exercise of functions delegated to the integration authority, including, where applicable, children's services. From the perspective of children's services planning, the adult health and social care context is important because most children live in families with adults, and because the complex question of supporting good transitions to adult life and services needs shared perspective, resourcing, management and reporting.
183. While community justice services are mainly focused on adults, there is an impact on children too, particularly where the recipient of a community justice service is a parent or sibling. The Community Justice (Scotland) Act 2016, implemented from 1 April 2017, established a new local partnership model for required community justice planning and delivery of services.

184. Services to protect children should take account of national policies to promote the wellbeing of all children, including disabled children and those most at risk, such as children affected by problematic parental alcohol and/or drug use, children affected by domestic abuse (such as Equally Safe – see below), and children at risk of being trafficked.
185. Within this complex wider planning landscape, there is a need to co-ordinate purpose, monitoring, data gathering, analysis, format and timing of reporting and review. Children’s services should be ‘integrated’ not just in organisation, but also from the perspective of children, young people, carers and families. In general terms there is a national policy emphasis on provision of early help to prevent escalating need and risk.

Public protection

186. The aim of public protection is to reduce risk of harm to both children and adults.
187. These issues overlap. For example when a child has a Child Protection Plan, where relevant, this should clearly define how the child will be protected from the risks posed by known perpetrators, together with contingency plans as appropriate in each case.
188. Public protection involves collaborative inter-agency work at strategic and operational levels. In some areas this work is overseen by a dedicated public protection forum. In others, individual fora have a specific responsibility and focus.
189. Whatever the local arrangements, steps need to be taken locally to ensure an integrated and consistent approach to planning and service delivery. Child Protection and Adult Protection Committees (sometimes combined) have a key role in this respect.
190. Public protection involves a focus on work with both victims and perpetrators. With perpetrators, the aim must be to reduce future risk. At a minimum this may involve ensuring that the right monitoring arrangements are in place to track an individual’s behaviour, but it may also mean working with that individual to help them understand their behaviour and how it impacts on others.
191. Public protection encompasses the needs of former victims, and of immediate family members at risk of harm.

Interface between child and adult protection

192. Adult and child protection may overlap and interact. The Child Protection Guidance applies to children and young people up to the age of 18. There is a potential overlap of powers and duties in relation to The Adult Support and Protection (Scotland) Act 2007 and [Code of Practice](#).
193. An adult at risk is a person aged 16 or over who:
 - is unable to safeguard their own wellbeing, property, rights or other interests
 - is at risk of harm
 - and because he or she is affected by disability, mental disorder, illness or physical or mental infirmity, is more vulnerable to being harmed than adults who are not so affected

194. To ensure that individuals do not fall between eligibility and service criteria, co-ordination and collaboration is necessary between child and adult services at both operational and strategic levels. Arrangements for linking up child and adult services in relation to support and protection must be agreed through Chief Officers Groups and Child and Adult Protection Committees as described above.
195. Adult services should be aware of the need to share concerns and work with the appropriate children's services. Similarly, there may also be situations where an adult at risk of harm is assessed as being a risk to children. Local arrangements should ensure that appropriate assessments and plans are put in place in such situations.
196. In respect of adult support and protection, the [statutory framework](#) governing adult protection establishes specific criteria for identifying an adult at risk. Young people identified as in need of protection will not automatically fit these criteria when they reach the age of 16, and services should ensure there is routine consideration of their 'risk' status.
197. Child and Adult Protection Committees should jointly develop robust procedures to ensure on-going support for any child about whom there are child protection concerns at the point where they move from children's into adult services. The GIRFEC National Practice Model supports a single planning system for all children and young people up to 18 years. A child's plan should state whether he or she is potentially an adult at risk of harm who will require on-going support, services or statutory measures.
198. In such circumstances there should be local processes in place for assessment and transition planning, starting no later than 12 months before school leaving age. These processes should include provision for the resolution of any disputes about the proposed support plan. These processes should also be separate from any arrangements for case transfer, which will be a matter for each agency's respective protocols. Instead, they will underpin the transition from child protection registration into adult services and any adult support and protection arrangements. It is important that the transition processes are clearly communicated to staff in both children's and adult services. Issues of consent are of particular significance here, as the young person may choose not to accept the services offered.
199. Staff working in children's services will need training to help them identify and act on adult support and protection issues, and vice versa. Child and Adult Protection Committees will be responsible for developing joint training to meet these needs.
200. [Some young people behave harmfully to others](#). Social Workers should pursue a holistic consideration of wellbeing, needs and the context of the behaviours. Some of these young people may themselves be in need of care and protection.

MAPPA

201. Multi-Agency Public Protection Arrangements (MAPPA), are the statutory partnership working arrangements introduced in 2007 under Section 10 of the [Management of Offenders etc. \(Scotland\) Act 2005](#). The purpose of MAPPA is public protection and the reduction of serious harm. In Scotland, the MAPPA brings together the Police, Scottish Prison Service (SPS), Health and the Local Authorities, in partnership as the Responsible Authorities, to assess and manage the risk posed for certain categories of offender. A duty to co-operate extends to other services including the Third Sector (such as those providing housing services). Multi-agency consideration must be given to managing high-risk individuals. For those who have committed sexual offences, multi-agency consideration will include their levels of contact with children, both within the family and within the community in general. These considerations will also be taken into account, where appropriate, for individuals convicted of certain violent offences (those assessed under MAPPA as “Other Risk of Serious Harm” individuals).
202. The Violent and Sex Offender Register (ViSOR) is the agreed system used by MAPPA. This is a UK-wide IT system which facilitates inter-agency communication and ensures that the Responsible Authorities contribute, share and securely store critical information about MAPPA offenders. It improves the capacity to share intelligence, and supports the immediate transfer of key information when offenders move between areas.
203. The Scottish Government has published guidance on the review of Multi-Agency Public Protection Arrangements when offenders managed under these arrangements commit, or attempt to commit, further serious crimes. The guidance sets out the steps for conducting a Significant Case Review to examine whether agencies effectively applied MAPPA arrangements and worked together effectively. Further information may be found [here](#).

Community Justice Partnerships

204. A new model for community justice came into effect on 1 April 2017. As part of this, a new national agency, Community Justice Scotland, was established to provide assurance to Scottish Ministers on the collective achievement of community justice outcomes across Scotland. At a local level, strategic planning and service delivery became the responsibility of local community justice partners. They are required to produce a local plan for community justice, known as a Community Justice Outcomes and Improvement Plan (CJOIP). Statutory partners, defined in the [Community Justice \(Scotland\) Act 2016 \(s13\)](#) are the Chief Constable of Police Scotland, health boards, Integration Joint Boards for Health and Social Care, local authorities, Scottish Courts and Tribunals Service, Scottish Fire and Rescue Service, Scottish Ministers (i.e. Scottish Prison Service, Crown Office and Procurator Fiscal Service), and Skills Development Scotland. The statutory partners are required to engage and involve the Third Sector in the planning, delivery and reporting of services and improved outcomes, and to report on progress against the CJOIP annually.

Violence Against Women Partnerships

205. Equally Safe, the Scottish Government and COSLA’s joint strategy for preventing and eradicating violence against women and girls (VaWG), was launched in 2014 and revised in 2016, with a [delivery plan](#) published in 2017. Equally Safe sets out a shared understanding of the causes, risk factors and scale of the problem, and highlights that violence against women and girls is underpinned by gender inequality. Prevention necessitates tackling perpetrators and intervening early. The strategy reflects the particular experiences of children and young people who may be subject to gendered violence, and recognises children as victims of domestic abuse and coercive control, irrespective of their gender.

206. Violence Against Women Partnerships (VAW Partnerships) are the multi-agency mechanism delivering on the strategy at a local level. The Scottish Government and COSLA's expectation is that every local authority should have a VAW Partnership with a strategic plan and designated co-ordinator for collaboration between public sector and Third Sector organisations ([Violence Against Women Partnership Guidance](#)).

Alcohol and Drug Partnerships

207. Problematic alcohol and/or drug use is often a long-term, hidden problem, and can lead to sustained issues of child neglect or abuse. Collaborative practice across child and adult services should encompass planning with services, such as adult social care and housing. This will increase the ability of services to identify children at risk from parental alcohol and drug use, and ensure that adequate and early plans are in place to support them. In early 2009, the Scottish Government, in partnership with COSLA, published A New Framework for Local Partnerships on Alcohol and Drugs. This was updated in 2019. '[Rights, respect and recovery](#)' (Scottish Government 2018) is the national strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths.
208. Alcohol and Drug Partnerships and Child Protection Committees should develop local protocols to support relevant, proportionate and necessary information sharing between drug and alcohol services and children and families services. Protocols should define standard terms and processes within assessment, co-ordinated planning, and response to risk of harm to a child, including response to concerns during pregnancy. Specialist, Third Sector and adult support services must all be aware of the potential risks and needs of children affected. Accountability for implementation, monitoring and progression of partnership protocols should be clear.
209. Multi-agency child protection training should be a standard part of the planning, commissioning and delivery of adult drug and alcohol services.

For all services and practitioners

210. This section of the Guidance has described some of the structures and responsibilities within the landscape of child protection. Inevitably, services have a focus upon risk of harm. The drive to achieve consistent operating procedures may imply linear steps in child protection. However, there are usually uncertainties and options, requiring partnership, teamwork and professional judgement at every stage. A shared ethos for all practitioners will acknowledge that child protection involves listening and consideration of:
- the child's experience and needs, in context
 - the wellbeing of the family as a whole
 - additional risks and barriers for some individuals and groups
 - the need for co-ordination in assessment and practical action
 - the opportunities to build on strengths in children, families and communities
211. The next section considers common elements in multi-agency child protection processes assessment.

PART 2(B): APPROACH TO MULTI-AGENCY ASSESSMENT IN CHILD PROTECTION

1. **Introduction:** Part 2(b) provides a bridge and preface to following sections by outlining common elements in multi-agency assessment of children and families. Cross-cutting expectations and themes are identified. The section concludes with signposts to improvement that are relevant to all services. Part 3 then describes in detail steps in child protection processes. Part 4 provides guidance in relation to specific concerns.
2. **Purpose of multi-agency assessments:** Assessments may have a specific **focus** and **legal basis**. The general purposes of a child protection assessment are (a) to gather, share and analyse such information about a child, family and relevant context as may be necessary for the purpose of determining harm, or risk of harm, and (b) to inform planning of action and support necessary to ensure a child's safety and wellbeing.
3. **Local assessment protocols** should define how assessment and planning operates within local structures. It is beyond the scope of this Guidance to provide a comprehensive manual for all relevant forms of assessment. Whatever the specific focus, stage and format, there should be a focus on the journey for the child, and a shared understanding with those people the child needs alongside them.
4. **Guiding considerations:** Whatever the nature of concerns, all practitioners will ensure that child protection processes are underpinned by consideration of rights, relationships and resilience, as indicated below.

Rights: Child protection is integral to protection of human rights.

[UNCRC](#) underpins the Getting it right for every child approach. The child's best interests, right to non-discrimination, and appropriate involvement in decision-making are key requirements. The [Children and Young People \(Scotland\) Act 2014](#) supports implementation of key aspects of UNCRC. The findings of the Independent Care Review further strengthen these expectations.

The European Convention on Human Rights (ECHR) provides a framework for human rights within which the Scottish Government and all other public bodies must act. It was given legal force in Scotland through the [Human Rights Act 1998](#) and the [Scotland Act 1998](#). The duties created under the Equality Act 2010 require public sector agencies to remove or minimise disadvantages suffered by people with protected characteristics.

Relationships: Protecting children involves listening to families, being clear and honest about concerns, giving choices and seeking co-operation, especially when compulsory measures are needed. ("All children must be supported to continue relationships that are important to them, where it is safe to do so." Independent Care Review (2020))

Resilience: Practitioners protect children by considering the holistic wellbeing needs of each child, and by building on those strengths and potentials in the child and in their world that will help them move through phases of stress and adversity.

5. **The [GIRFEC National Practice Model](#)** provides shared practical concepts within assessment and planning. Practitioners should be familiar with the core elements such as the 'SHANARRI' wellbeing indicators, the My World Triangle, and the Resilience matrix as summarised below. Together they support holistic analysis of safety and wellbeing, dimensions of need, and the interaction of strengths and concerns.

Using GIRFEC components in assessment

The wellbeing indicators provide a holistic representation of children's wellbeing needs and outcomes. Safety is paramount. The 8 indicators are inter-connected. They encapsulate children's rights to be: safe; healthy; achieving; nurtured; active; respected; responsible; and included.

The My World Triangle is a starting point for considering what risks might be present in a child's life. The Triangle focuses attention on the three dimensions of a child's world: the child; their family; and their wider environment. When a concern has arisen, the Triangle is a useful tool for gathering information about strengths and concerns within an investigation. Practitioners using the My World Triangle will need to consider who is best placed within the family and professional network to provide information in relation to specific areas within a child's life.

The resilience matrix may be used in consideration of the dynamic interaction of stresses and protective factors in the child's world. 'Resilience' refers to positive adaptation despite serious adversities and threats to a child's development.

The concept of resilience promotes analysis. The matrix is a tool which may help practitioners and key family members share understanding about concerns, and think about how to target support. The matrix is not an exact formula or map. However, it may assist focus and review of progress in relation to:

- dominant risks/concerns
- protective factors and what is working well
- what needs to change to ensure the child's safety and wellbeing.

When reflecting on the current vulnerability of the child, it may be useful to consider the following factors:

- Are there any qualities or characteristics of the child which might render them more vulnerable?
- Does the child have disabilities or communication support needs?
- How does parental understanding and expectation influence the child's safety and wellbeing? Are the expectations reasonable for the child's age and stage of development? How do services understand the family's cultural beliefs and expectations as far as this is relevant to safety?
- Are there issues from the parents' own history which shape their expectations, beliefs and behaviour?
- How have the child's past experiences affected their vulnerability?

When considering adversity, recognise current factors which threaten wellbeing. These may include material challenges such as the effects of isolation, rural or otherwise; poor housing conditions; ill Health; poverty or long-term unemployment.

When considering protective factors, consider who has reliably demonstrated support and commitment for the child's safety and wellbeing. Significant offers that come from untested supports will usually require careful, step by step evaluation. Protective factors are accessible from education, Health, faith, therapeutic and community sources.

Resilience is not a standard formula. It will have distinctive features for each child in context. Child protection assessment and planning should seek to identify and build on strengths. What helps this child survive and grow through periods of risk and stress?

Resilience is a concept which supports consideration of the chemistry of risk and strength in a child's day to day world. Resilience is likely to consist in the interactions between: significant close relationships; developing skills; and a child's growing sense of identity and confidence. A child's resilience and experience of safety is likely to be strongly related to development of a secure base in dependent relationships; and of a growing, yet realistic confidence in themselves and their abilities to reach out, explore, learn things and get help when needed. The extent to which this capacity for resilience is realised by a child will also be influenced by their age, stage, understanding and culture.

In exploring concerns and strengths, practitioners should listen, take time and keep an open mind.

- Some children/young people may give an impression of resilience, when they appear to be 'fine' when under significant stress. It may take time to understand when if needs are hidden beneath an independent, self-sufficient front.
- Others may be perceived as having 'strong' and protective attachments to significant adults; and it may take time to understand if anxiety is leading a child to cling to a source of security, avoiding Healthy exploration and learning.
- "Children who have been harmed through relationships, must have supportive relationships in order to heal." (Independent Care Review: 2020)

6. **Ecological:** Whatever the specific concern, effective multi-agency assessment, planning and support is ecological. This includes analysis of the interaction of relationships between a child, their family and their wider world. An ecological perspective includes consideration of the present and historical context of harm. Other factors may be relevant. These include culture, use of technology, the physical location of risks, barriers to understanding or accessing services, and the intersection of adversities including key variables like housing, health and income.
7. **Developmental:** Effective multi-agency assessment must be developmental, meaning that it should consider a child's age, stage and transitional needs moving on to another stage, even if the preoccupation of a child protection assessment is prevention of significant harm. A developmental perspective encompasses attention to the impact of a child's experience of attachment and of trauma, and the relevance of relationships with significant others such as siblings and non-resident parents upon assessment of risk, strength and need.
8. **Dynamic:** 'Assessment', however structured, evolves with new information and understanding. Any assessment is at a point in time. Immediate safety is a priority. Best interests throughout childhood will be a constant and overarching consideration. There are likely to be distinctive stages, moving from initial assessment and prevention of significant harm to comprehensive inter-agency assessment of risk and need in context. Professional judgement and reflection on evidence and analysis is necessary at every stage. Even in urgent circumstances there should be a moment to pause and consider safety and best interests within the available options. Each situation is distinctive. Standard solutions cannot be derived from procedures. Attention should be paid to professional intuition. However this must be brought back and located firmly within an agreed and approved framework and approach. Professional curiosity about how children and families are experiencing their situation from the inside out is critical to effective engagement and formation of an understanding of risk and strengths in the child's world.
9. **Structured assessment frameworks** can bring depth and analysis to assessment of children, adults and families. They must be endorsed locally for use by the agency, and practitioners should be trained and confident in their application. An example of a well evaluated framework with clear purpose and method is referenced below.

Example of structured assessment

The Graded Care Profile (v2) may be useful as a tool for aiding practitioners in the assessment of child neglect and care. Research suggests that, well implemented, it helps in the identification of parenting strengths as well as weaknesses, helps create a collaborative process, and helps parents understand professionals' concerns. The process should lead to a clear picture of what it is like to be a child in this family, and what needs to happen for the harm to stop.

10. **Collaboration in assessment and planning:** In forming a shared view of risks and strengths and options for supported change, strength-based approaches may provide a vehicle for partnership in critical situations. They may ensure that the expertise and resource available are brought to bear in the formation of plans focused on the child's needs. Signs of Safety and Family Group Decision Making (FGDM) are examples of approaches which are congruent with the rights-based GIRFEC National Practice Model, and with statutory guidance on Part 12 of the [Children and Young People \(Scotland\) act 2014](#).

Strength-based approaches

Effective engagement to reduce risk is more likely within approaches which stress respectful and rights-based communication with children and families, build upon strengths that have been evidenced, address need and risk, and work with the interaction of relationships and factors in the child's world.

Signs of Safety (SoS) is a model of child protection and family support which is based on structured development of partnership between professionals and family members, and between professionals themselves. The model works by encouraging shared understanding and ideas about what needs to change, and by defining shared responsibilities in steps towards achieving these changes. This contrasts with approaches which depend on externally imposed solutions.

A Signs of Safety assessment is defined as a 'mapping'. This is organised under three, or sometimes four, headings, defining 'what we are worried about' (the harm, danger statements and complicating factors); 'what is working well' (including elements contributing to existing strength and safety); and 'what needs to happen' (the safety plan). An SoS assessment records harm that has occurred, future danger and complicating factors, which include interacting risks due to factors like poor mental Health, drug and alcohol abuse, and domestic violence.

The model integrates respectful, open minded and detailed exploration of risks and strengths with step-by-step action to achieve and sustain change in order to increase safety. It is recognised that coercion and co-operation can be compatible, and offering choice is significant in forming plans that will hold firm. Plain language is fundamental to forming shared agreements in stressful and urgent circumstances.

Family group decision making (FGDM)/family group conferencing

FGDM is an independently co-ordinated process which empowers family members to shape plans for children. The process is applicable in a wide range of urgent circumstances when partnership with families is essential – for example, to develop participation in an agreed safety plan for a child at risk of significant harm.

Children and young people are normally involved in their own FGDM, although often with support from an advocate. This is a voluntary process and families cannot be forced to have a FGDM.

Families, including extended family members, are assisted by an independent co-ordinator in the crucial preparation phase before a family meeting. In the first part of the family meeting, shared purpose and parameters of decisions that can be made should be confirmed. Social Workers and other professionals must be clear about concerns; available supports; and how the meeting outcome can inform other processes. The second part of the meeting is private to the family, who work through recommended elements of a plan for the child. In the final stage of the meeting all participants work together to crystallise practical steps in partnership. The principle of the model is that the family plan should be supported, unless, in the assessment of those with statutory responsibilities, it would not be safe. Review meetings are often a helpful part of the process.

FGDM is not a form of assessment and does not absolve statutory agencies from their responsibilities in this respect. However it is a way to explore known strengths and potential supports in partnership, keeping the child's needs and voice central.

The approach only works well if there is careful preparation; skilled independent co-ordination; adherence to the principle of private family time; and commitment by services involved to support and follow up in partnership. The approach does not work well if the interface with other statutory and decision-making processes is not carefully considered and explained.

Leadership, training, supervision and resource are needed to ensure that the skills, values and distinctively effective elements within such approaches are understood and applied by the relevant workforce.

11. **Context of harm.** Child protection includes recognition, assessment and reduction of risk of harm from outside the family home where this is relevant.

Understanding contextual harm or protective factors involves considering the risks and stresses within or faced by a family, especially from the child's perspective.

Contextual safeguarding

'Contextual Safeguarding' is an ecological approach which complements the use of the My World Triangle and the concept of resilience. There are principles and tools within this evolving approach which may add depth to understanding of and response, particularly in relation to risks to teenagers, without deflecting from core child protection steps described in Part 3 of this Guidance. Contextual safeguarding emphasises:

- exploration of the dynamic between the young person, family, peers, school, and neighbourhood
- recognition of the 'weight of influence' presented by the attitude of peers, where this is relevant to risk of harm
- a shift in emphasis away from the narrative of young people 'putting themselves at risk', being 'promiscuous', or 'aggressive', a 'liar' or 'absconder', towards an understanding of the chemistry of risk and the reasons why some choices are taken. The child's perspective on risk is critical to this understanding.
- a shift away from intervention focused almost exclusively on the individual child or young person and family relationships, towards consideration and intervention with the social conditions of abuse, including known exploitation and abuse in particular locations.

Partnerships and appropriate, necessary and lawful sharing of information across sectors are important in the interruption of patterns of harm, such as sexual exploitation for example, in relation to known places of concern.

Complicating factors such as poverty should be considered as part of the context of risk.

12. **Analysis:** Child protection assessment informs planning and action. This requires analysis of the probability of risk of significant harm, and the nature and immediacy of the impact of these risks upon the child. Analysis of immediate risks may inform immediate options. Protective episodes may be part of a pattern. Analysis must include consideration of patterns and an overall consideration of best interests. Steps and analysis in child protection processes are outlined in Part 3 of this Guidance.
13. Where risk of significant harm is persistent, decisions beyond immediate child protection should go beyond the current balance of strengths and concerns, and take into account 'capacity to change'. This includes identification and analysis of factors that are likely to promote, complicate or prevent those changes which are needed to ensure safety and stability for the child. Assessment of capacity to change is an essential component of robust re-unification assessment and planning in those situations where a child has been removed from parental care. Further definition of this dimension in assessment is provided below.

Capacity to change

When child protection planning is needed to address complex and persistent risk of harm within the family, a central component of planning should be an appraisal of parents 'capacity for change'. This refers to their abilities and motivation to change, given sufficient support, in a timescale that meets a child's needs.

Capacity to change is associated with parents and practitioners forming a shared understanding of concerns, parents accepting responsibility for their own actions, sustaining changes over time and taking up offers of (reasonable, sufficient and accessible) support from services. Successful behaviour change is likely to depend upon motivation to change, the relative significance of goals to the person, and the person's self-perception in terms of confidence and competence.

Constructive collaboration with families is associated with parental change and reduction in repeat reports of abuse and neglect. Lack of parental engagement is strongly associated with recurring abuse.

Key elements of the process are that:

- particular behaviours that need to shift are defined
- capacity to change is integrated within overall holistic assessment
- parents or carers are assessed separately, but with attention to the dynamic between joint carers
- barriers and facilitators affecting capacity to change and observable changes in behaviour are key sources of information
- the assessment considers whether parents can achieve change within the child's timescale

Guidance on capacity to change assessment may provide purposeful structure in work following a Child Protection Planning Meeting (CPPM, as described in Part 3), by informing the choice of intervention, informing analysis of contact plans and assessing and planning protective placement, or re-unification. Capacity to change is likely to be an essential component of assessment when the complexity and persistence of child protection concerns prompt consideration of parallel or concurrent planning alongside intensive time-limited efforts at re-unification.

14. **Specialist assessment:** Where risk of harm relates to behaviours or needs that require specialist assessment and support, early consideration should be given to inviting these professional perspectives to assist inter-agency planning around the child. Specialist assessments and assessments commissioned of specialists, if required, should form a considered element of multi-agency assessment.

A learning culture in child protection

Effective multi-agency assessment and planning is promoted by a learning culture which constantly improves practice within professional systems.

Lived experience must be integral to learning. The table below was derived from the words of parents with learning disabilities who have had experience of child protection in Scotland. Advocacy services helped in distilling their messages about effective child protection assessment and action.

BRIDGES (“what supports us”)	CLIFFS and WALLS (“barriers to support”)
when you take time to get to know us	when we are afraid to ask for help because we fear you will say we cannot cope...
when you give help when we look for it	when workers prejudge us
when you try to understand why we feel as we do, what we are struggling with, and what help we need	when home visits are scary rather than helpful
when you work in relationship with us	when workers seem distant, cold and uncaring ... we react to this...
when advocacy helps us understand processes and concerns	when it takes a crisis to get a response
when different agencies work together to provide help	when agencies involved in child protection are not communicating with each other
when you are honest about concerns and actions	when we do not understand concerns or what is happening
when information is accessible , and given in a way each parent can understand	when you do not share concerns clearly
when you listen and realise that every family is different, every parent is different, every child is different	when ‘easy read’ is not honest about what could happen
when the reasons for meetings are shared and agreed, plans for meetings are made in plenty of time, and meetings are structured so that we are supported, heard and respected	when Social Workers writing assessments do not know the child, the parents or the wider family
when you think about the whole family .	when you fail to build on our strengths and strengths in the family

when support is provided early (for example, early in pregnancy) and lasts for as long as needed	when your training or supervision or experience has not given you enough knowledge and awareness of learning disabilities
when workers use consistent standards of good practice with parents with learning disabilities	when advocacy for parents or children is not available when we need it, or when our children need it
when plans are clear and step by step	when support is short term or only in crisis
real child protection is making sure we are supported so that our children can be supported	when you do not recognise what we want to give our children

- Assessment can also be enhanced by learning from research, inspection findings and case reviews. Cumulative lessons from research distilled by Broadhurst, Munro et al (2010) are relevant to 'avoiding common pitfalls' in multi-agency child protection. These have been re-framed below as reflective questions crucial to all practitioners in child protection.

‘Avoiding common pitfalls’

- What are children saying? How do they look? How do they behave? What is the apparent or potential impact of risks upon the child?
- How are we engaging with parents (mothers/fathers/other family carers) to assess and reduce risk?
- Has due consideration been given to information from family and others significant to this child’s safety and needs?
- How have we formed a shared understanding of concerns, plans and expectations?
- Are records about response to concerns thorough and accurate? Do referrers need to know about response?
- There may be obvious and urgent risks. What significant but less visible aspects of case history and circumstance may have been obscured by the headline concerns?
- If the focus has been on one child because of age or known harm, what are the implications for other children who may be affected?
- If a conclusion has been reached early, is assessment and decision-making based on information that is sufficiently tested and corroborated from the perspectives of those who know the situation?
- How are practitioners supported to engage with individuals and families with whom they experience aggression or avoidance?
- Are the child and family involved experiencing a ‘joined up’, co-ordinated assessment and planning processes?

16. Research, evaluation, training and supervision all play an essential part in the protective steps outlined in Part 3, and response to specific concerns in Part 4 of this Guidance. Improvements in child protection depend upon a learning culture which promotes understanding of lived experience and sustains a reflective, analytical and evaluative approach. Recent developments (2019-20) relevant to improvement in multi-agency child protection are highlighted below.

Developments

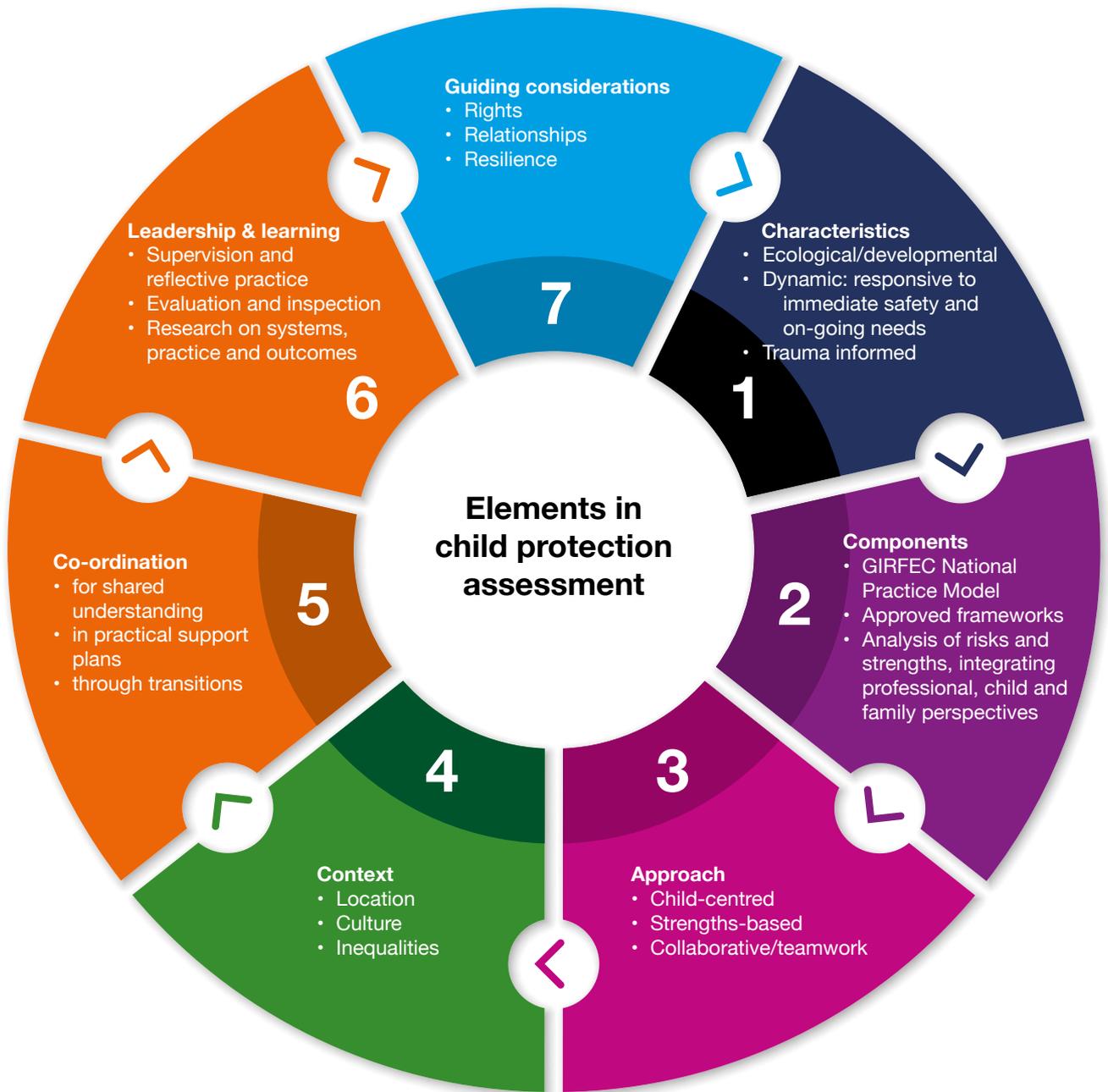
Strategic improvements are informed by data analysis. **A Minimum Dataset for Child Protection Committees** has been developed as part of the Child Protection Improvement Programme. The aims are to deliver robust data sets to support child protection improvement, to develop a national resource for advice on using child protection data for local planning and service development, and expanded analytical capacity. Child Protection Committees' responsibilities involve collation and analysis of data and evidence to inform improvement planning. The Minimum Dataset for Child Protection Committees is a 'package' of data collation, presentation, analysis, reporting and scrutiny supports.

Joint Investigative Interviewing (JII) Guidance and Training: Police Scotland and Social Work Scotland have worked with the Scottish Government to respond to the recommendations of the [Evidence and Procedure Review](#) to improve the quality and consistency of Joint Investigative Interviews (JIIs) of children. Revised guidance (which will become statutory on publication) and the development of the new Scottish Child Interview model have been informed by international research. The Model encapsulates an approach to investigative interviewing of children which is both trauma informed and achieves best evidence through more robust planning and interview techniques. The aim is that JII statements can be used as Evidence in Chief, removing the need for children to give evidence in court and reducing trauma for child victims and witnesses. Evaluation and learning from pilots of the new Scottish Model will inform national implementation beyond 2020.

Significant Case Reviews/Learning Reviews: As part of the Child Protection Improvement Plan, the approach to Significant Case Reviews has been revised, taking account of Care Inspectorate analysis, UK and international findings. There is a new focus on accessibility and applicability. Key objectives are to ensure that essential recommendations translate into effective learning to prevent recurrence of the most serious child protection events. To this end these reports will now be called Learning Reviews. (Revised Learning Review Guidance forthcoming)

Child Participation in Child Protection Processes: A Child Protection Committees Self-Evaluation is an example of analysis which is comparative and practical, describing progress and challenges in the way practitioners and managers have worked to ensure children's rights and GIRFEC principles have been applied in child protection processes.

17. **Summary.** Elements within multi-agency child protection assessment outlined in this section are reduced to a 7 point summary.



PART 3: IDENTIFYING AND RESPONDING TO CONCERNS ABOUT CHILDREN



Investigative principles



Risk; harm; significant
harm; professional judgement;
notification of concern



IRD
Investigative options
JII
Health assessment



Involving children and families



Child protection
assessment
and planning process;
pre-birth;
chairing; core groups



Harm by children
Child witnesses
Criminal injuries



Prompts to reflection on
assessment and planning
Process flow chart





Relationship with previous sections

- The GIRFEC National Practice Model underpins the inter-agency approach to child protection, as described in the Introduction.
- Part 1 includes definitions of forms of abuse and neglect, reviews the meaning of harm and significant harm in the child protection context and summarises considerations in relation to information sharing.
- Part 2 outlines, (a) inter-agency and single agency roles and responsibilities in child protection, and (b) components of multi-agency assessments.
- **Part 3** is about child protection processes, including consideration, assessment, planning and action required.

Boxes are colour shaded to assist in location of associated guidance

Blue denotes guidance on specific child protection stages and processes.

Steps within the child protection process are also summarised in a [flow chart](#).

Amber denotes guidance associated with legal options.

Green boxes denotes themes or principles.

Initiating child protection procedures

1. Concerns about possible harm to a child from abuse, neglect or exploitation should always be shared with Police or Social Work.
2. Child Protection Procedures are initiated when Police, Social Work or Health determine that a child may have been significantly harmed or may be at risk of significant harm.
3. Concerns about a risk of harm from abuse, neglect or exploitation may arise in a number of ways including:
 - because of what a child has said
 - over a period of time
 - in response to a particular incident
 - as a result of direct observations
 - through reports from family, from a third party, or from an anonymous source
 - if children are known to Social Work or have an existing child's plan
 - through notification that a child may become a member of the same household as a child in respect of whom any of the offences mentioned in Schedule 1 of the Criminal Procedure (Scotland) Act 1995 has been committed, or as a person who has committed any of the offences mentioned in Schedule 1.
4. All concerns which indicate risk of significant harm must lead to an Inter-Agency Referral Discussion (IRD) as described below.
5. Where there is a named person, they should be notified. A named person is a professional point of contact in universal services, both to support children and their parents/carers when there is a need, and to act as a point of contact for other practitioners who may have a concern about the child's safety and wellbeing. In areas where there is no named person it may be necessary to identify someone known or trusted to the child or family, or someone who can be a point of contact for other practitioners. Agency records will be checked for relevant information that may assist in placing a concern in context, and that may inform next steps.

Professional judgement about risk of significant harm

6. Professional judgement is needed about the severity and immediacy of the risk of harm. This will be reviewed as relevant information is shared. There is no statutory definition or uniform defining criteria for significant harm. Significant harm refers to serious interruption, change or damage to a child's physical, emotional, intellectual or behavioural health and development.
7. To understand and identify significant harm, it is necessary to consider:
 - the child's experience, needs and feelings as far as they are known. When a child talks about maltreatment, this may prompt a request for IRD. The child's disclosure is not a pre-requisite.
 - the child's development in context, including additional needs such as a medical condition, communication impairment or disability, that may affect the child's Health, wellbeing, vulnerability and care needs.
 - what has happened, meaning the nature of the actual or likely harm, in terms of abuse or failures to provide care and protection.
 - parental or carer responses to concern as far as they are known.
 - past occurrence, frequency or patterns in the occurrence of harm.
 - immediate risk of harm and cause of this risk.
 - impact/potential impact on the child's health and development.
 - degree of professional confidence in the information that either the abuse has occurred and is likely to be repeated, or that the child is at risk of harm.
 - capacity of the parents or carers to protect and care for the child.
 - the context of risk within the child's culture, family network and wider world.
 - interaction between known risks and known strengths, complicating or protective factors in the child's world.
 - probability of recurrence or persistence of harm or risk of harm.

Practice points relevant at any time

8. **Where a child is felt to be in immediate danger**, any practitioner should report, without delay, directly to the Police. Similarly, where a child is thought to require immediate medical assistance, this should be sought as a matter of urgency from the relevant health services.
9. **Where the risk is of harm is significant and immediate**, the focus of risk assessment is about what needs to happen to keep the child safe right now. The need to gather information must always be balanced against the need to take any immediate protective action. Social Work services and Police must decide whether any immediate action should be taken to protect the child and any others in the family or the wider community.
10. **Other children affected.** Where a child is at risk of harm from neglect, abuse or exploitation, consideration should always be given to the needs and potential risks to other children in the same household or family network, and to children who are likely to become members of the same household or family network.
11. **Risk assessment is not static.** The interaction of factors can shift, and risk of harm can become more or less severe. The risk of harm from on-going concerns may become increasingly apparent. Similarly, protective factors in the family and the child's wider world may change or could be brought to bear on the situation in a way that reduces risk of harm. The process of identifying and managing risk must therefore also be dynamic and responsive, taking account of both current circumstances and previous experiences. Immediate and long-term needs and risks should both be considered.
12. **Referral to the Principal Reporter** is an option at any stage if it is likely that the child is in need of protection, guidance, treatment or control, and that a compulsory supervision order might be necessary. The grounds for a Hearing are that the Principal Reporter, following investigation, is satisfied that one of the conditions in [s67\(2\) of the 2011 Act](#) exists and that it is necessary for a compulsory supervision order be made for the child (or an existing order be reviewed). Guidance for Children's Panel Members may be found [here](#).
13. **Proportionate response:** many concerns raised over a child's wellbeing will not need a response under local child protection procedures, but a co-ordinated response may still be necessary. The GIRFEC principles and practice model apply.
14. When short term decisions are needed, practitioners should always keep in mind the long-term emotional security of each child in support and planning with children and their families.

Inter-Agency Referral Discussions (IRD)

(Guidance on the decision to hold an IRD; and on IRD purposes, components and process)

15. **Consideration of the need for an Inter-agency referral discussion.**

This next critical phase in risk assessment and response follows notification of a child protection concern. Where information is received by Police, Health or Social Work that a child may have been abused or neglected and/or is suffering or is likely to suffer significant harm, an IRD must be convened as soon as reasonably practicable. An IRD will co-ordinate decision-making about such investigation and action as may be needed to ensure the safety of children involved as outlined below.
16. **Definition**

An Inter-agency Referral Discussion (IRD) is the start of the formal process of information sharing, assessment, analysis and decision-making following reported concern about abuse or neglect of a child or young person up to the age of 18 years, in relation to familial and non-familial concerns, and of siblings or other children within the same context. This includes an unborn baby that may be exposed to current or future risk.
17. **Purpose**

IRDs are required to ensure a co-ordinated inter-agency child protection process up until the point a Child Protection Planning Meeting (CPPM) is held, or until a decision is made that a CPPM is not required.
18. **Instigation**

The decision to convene an IRD can be made by Police, Health or Social Work, but an IRD may be requested by any agency
19. **IRD Record**

All aspects of the IRD must be recorded, including the time and reason for starting an IRD, the information shared, discussions held, reasoned decisions (including consideration of options), any lack of consensus, and the manner in which lack of consensus has been escalated and resolved, without delay. This will form a single core IRD record.
20. **Capacity**

As far as can be ascertained from earliest inquiries, consideration is given not only to the child's age but to the child's development, including:

 - linguistic abilities
 - memory retrieval capacities
 - suggestibility
 - effects of stress and trauma

21. In all investigations, decisions and plans, the additional support needs for each child must be taken into account, including:
- health concerns
 - emotional distress
 - speech and language
 - translation requirements
 - risk of self-harm
 - additional supports relating to disabilities and all protected characteristics

The racial and cultural context in which the harm has arisen must be considered in IRD, preparatory to investigation and next steps in engagement or support.

Core Professionals

22. Practitioners in Police, Social Work and Health must participate in the IRD. Notwithstanding, information gathering should involve Education; and other services working together to ensure safety child safe, as appropriate. IRD participants must be sufficiently senior to assess and discuss available information and make decisions on behalf of their agencies. They must have access to agency guidance, training and supervision in relation to this role.
23. Social Work Services have lead responsibility for enquiries relating to children who are experiencing or are likely to experience significant harm and assessments of children in need. The Police have lead responsibility for criminal investigations relating to child abuse and neglect; and share responsibilities to keep the child safe. A designated health professional will lead on the need for and nature of recommended health assessments as part of the process.
24. These are separate but interconnected processes which require joint information gathering; information sharing, assessment and decision-making. Core agencies must plan together to ensure co-ordinated action.
25. It will usually be appropriate to involve and integrate additional information relevant to the task from a named person or other professionals who know the child well at the IRD stage. Education is a critical source of contextual information about each child of nursery or school age.
26. Core agencies and relevant services consulted at the IRD stage must research the information systems available to them in order to share necessary, proportionate and relevant information for the purpose of effective decision-making.

Timing

27. The IRD must be convened as soon as reasonably practical. Where there is a risk to the life of a child or the likelihood of immediate risk or significant harm, intervention must not be delayed pending receipt of information gathering/sharing.
28. Outwith core hours, the IRD may focus only on immediate protective actions with the understanding that a more comprehensive IRD will continue as soon as practical. This should normally be on the next working day.

Process

29. An IRD must be co-ordinated. It may be a process rather than a single event. Information must be gathered and shared, to the point of sufficiency to support agreement about a co-ordinated response.
30. This discussion may take place in person or by telephone conference or video conference. Factors such as urgency and geography will determine how the IRD is affected. All core agencies must participate.
31. An IRD process is closed when a reasoned and evidenced inter-agency decision has been made and recorded about joint or single agency assessment and action up until the point of:
 - Child protection planning meetings (CPPM) or
 - Decision made that a CPCC is not required
32. Closure may also follow a reasoned decision to take no further immediate action.

Priorities

33. IRD provides a strategic basis for authorisation for the next stage in joint or single agency assessment. As such an IRD will give priority consideration to:
 - the safety and needs of the child/children involved
 - level of risk faced by child/children and by others in this context
 - evidence that a crime or offence may have been committed or may be committed against a child or any other child within the same context
 - legal measures that may be necessary

Decisions and planning

34. Participants must consider priority considerations above will lead to decisions about:
- What decisions must be taken about the immediate safety and wellbeing of the child?
 - Is an inter-agency child protection assessment required?
 - Is a single agency investigation and follow-up preferred and why?
 - If no further investigation is required, what are the reasons for this?
 - Is a joint investigative interview (JII) required and, if so, what are the arrangements for this? (Including who will carry it out, location of interview and in what timescales.)
 - Is a medical examination required? If so, should this be a comprehensive medical examination, a specialist paediatric or Joint Paediatric Forensic Examination for cases of potential non-accidental injury or suspected sexual abuse?
 - Is early referral to the Principal Reporter needed for consideration of grounds for compulsory measures?
 - Consideration of registration. See below* on learning from adapted practice in the Covid-19 pandemic
35. If a child protection investigation occurs, a CPPM will follow within 28 days unless there is an IRD decision that this is not required. A senior manager, on review of available information, may insist that a CPPM is held. If a CPPM is not necessary, proportionate, co-ordinated support may still be required.
36. Exceptions to the 28 day timescale must be agreed by the accountable senior manager within the statutory Social Work service. He or she must be satisfied that an interim safety plan is in place, and effective up to the date of CPPM. Reasons for extension must be recorded and agreed by the relevant senior manager. ([Appendix](#))

Essential considerations

37. Those involved in joint planning and decision-making will consider:
- how information about investigation can best be shared with the child taking into account their capacity and maturity
 - how information can best be shared with family and whether information should not be shared if this may jeopardise a Police investigation or place the child, or any other child, at risk of significant harm
 - feelings and views of the child about aspects of investigation
 - how the IRD decisions can be reviewed as necessary if significant new information arises
 - keeping a named person appropriately informed and involved; identifying a lead professional and professionals in the core group who will work with the interim safety plan.

Lead Professional

38. A lead professional who will be a qualified Social Worker is required within a child protection investigation, to ensure co-ordination of assessment and next steps within a developing but coherent single plan. They provide a point of contact for family/carers/advocates/guardians and professionals who need support to gain sufficient understanding of what is happening stage by stage. They may provide a signpost for additional advice and support. The IRD record should identify this person before closure.

Lack of Consensus

39. If any agency involved in the IRD disagrees with the decision of any party and where a compromise cannot be reached, consultation with senior managers from core agencies should take place in order to reach a decision. The points of disagreement and resolution must be recorded on the IRD Record. There should be no delays in protective action as a result of the disagreement and the majority decision will apply to **avoid delay beyond 24 hours**.

Concerns about multiple children

40. Concerns that relate to multiple families or a group of children may necessitate a level of additional co-ordinated case discussion to that of the individual IRD for each child. This should allow consideration of context and patterns of concern; and lead to a strategic and co-ordinated response.

Additional Information

41. An IRD can be reconvened if new information arises which could lead to a reconsideration of the required inter-agency response.

Quality assurance and review of IRDs

42. Local areas should ensure that quality control systems are in place to support consistent standards; recognition of patterns in practice or context of concerns; and to support improvement. Quality assurance would usually be achieved through:
- regular reviews of IRDs by senior representatives of core agencies.
 - Where parallel processes are set up for categories of risk, (e.g. in relation to 'screening' apparently high risk situations pre-birth), then they should be no less robust in terms of information sharing, recording, authority of decision-making and quality assurance.
 - A vehicle for secure electronic sharing of the IRD Record between core agencies promotes effective and consistent practice; and makes review, quality assurance and analysis of trends feasible.

Interface with other processes

43. Children and young people who are believed to have harmed others may also require co-ordinated information sharing and decision-making. They may also have experienced abuse. Investigative processes must safeguard and protect their wellbeing as a primary consideration.
44. **Reports to Child Protection Committees** should consider integration of reporting on IRD in order to inform improvement through training, management and strategic improvements to systems and practice.

Joint Investigative Interviews (JII)

(Outline guidance on JII purposes, components and processes)

45. An IRD may decide on the need for a JII, the purposes of which 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 may have been committed against the child or anyone else
 - gather sufficient evidence which may lead to a ground of referral to a children's hearing being established

The joint investigation can also provide evidence in court proceedings, such as a criminal trial or a Children's Hearing proof.

Approach

46. Taking a child-centred approach to planning interviews is vital in securing best evidence and providing the necessary support for the child before and after the interview. The analysis of interviews will help named persons and lead professionals in their planning for the support, protection and recovery of the child consistent with the GIRFEC approach and [national practice model](#).

Decisions

47. A decision to progress with a Joint Investigative Interview requires IRD participants to identify the aims and objectives of the interview. IRD participants must oversee and coordinate all stages of the [child protection investigation](#). A pre-interview briefing and planning meeting is necessary before any JII.

Scottish Child Interview Model

48. Revised National Guidance to Joint Interviewing will be published to replace current national guidance (Scottish Government, 2011). Meanwhile, current national guidance, 'The approach to investigative interviewing of children' is trauma-informed, and achieves the best evidence through robust planning and interview techniques. The approach is based upon four component parts: strategy, planning, actions and outcomes, underpinned by on-going support and evaluation. A national pilot and training programme will support implementation of the Scottish Child Interview Model from 2020.

Strategy

49. The strategy developed by the IRD informs planning for the interview, which will be undertaken by the Joint Investigative Interviewers. The strategy must continue to be developed in light of new information as it emerges.

Interviewers must suggest changes to the strategy if information about the child's needs, which indicates this is required, comes to light.

Planning

50. Supporting the child's needs during the interview is made more complex because of the need to consider their strengths and resources; any complex needs; cognitive factors; experiences of trauma and adversity; context and motivation; and relationships. To address this complexity, effective interview planning is essential, and must consider practicalities such as location, transport, timing, breaks and communication between interviewers during interview.
51. The blend of Social Workers and Police officers in the development of the Topic Identification Plan where all relevant topics to be covered during the interview are identified for the interview is crucial.

Action

52. The interview is undertaken using an agreed protocol and incorporating robust planning. Wherever possible, to reduce the child's anxiety about the process and minimise the risk of further traumatising, there should only be one interviewer in the room with the child. The second interviewer would participate in the interview from a separate room, observing and contributing to the conduct of the interview. The lead interviewer has primary responsibility for leading the interview, asking questions and gathering information.
53. A child has a right to specify gender of the interviewer if the child is believed to have been the victim of particular offences as defined by the terms of the Section 8 of the Victims and Witnesses (Scotland) Act 2014; and this should be granted wherever possible.

54. For detailed roles and responsibilities see Guidance on [Joint Investigative Interviewing of Children in Scotland](#).

Consent

55. The child's consent is not explicitly required. Social Workers and Police officers have a duty to investigate as detailed in Section 60 of the Children's Hearings (Scotland) Act 2011 and Section 20 of the Police, Fire and Reform Act 2012.

The consent of a parent or guardian is not required prior to undertaking a Joint Investigative Interview. Through discussion they would be made aware that the interview is taking place unless there is a good reason not to, for example where there are strong grounds to suspect that they are involved in the abuse.

Recording

56. Joint Investigative Interviewers must be trained and competent in the use of recording equipment. Joint Investigative Interviews must be visually recorded unless there are specific reasons why this may be inappropriate for the individual child.

Authority and expertise

57. Joint Investigative Interviewers in Scotland will be trained to develop the specific understanding, knowledge and specialised skills required for the effective forensic interviewing of children and vulnerable witnesses.

Core Professionals

58. Joint Investigative Interviews are planned for and undertaken by two interviewers, one Police officer and one Social Worker, identified by the IRD. During the Joint Investigative Interview, one interviewer will take on the role of Lead Interviewer and one will take on the role of Second Interviewer. The lead interviewer may be from either Police or Social Work and roles will be agreed at the planning stage after due consideration of all relevant factors.

Support and Evaluation

59. Joint Investigative Interviewers require effective support, quality assurance and rigorous evaluation to undertake their role. Local areas require to have in place quality assurance arrangements to govern the application of the Scottish Child Interview Model and multi-agency evaluation arrangements to support continuous improvement of local arrangements to protect children and young people. Multi-agency evaluation of joint investigative interviewing practice should form an integral part of these arrangements.
60. The relationship between support and evaluation is one which must be carefully managed.

Health assessment and medical examination

Outline guidance on purposes, components and processes

Purpose

61. The health assessment of a child for whom there are child protection concerns aims:
 - to establish what immediate treatment the child may need
 - to provide a specialist medical opinion on whether or not child abuse or neglect may be a likely or unlikely cause of the child's presentation
 - to support multi-agency planning and decision-making
 - to establish if there are unmet health needs, and to secure any on-going health care (including mental health), investigations, monitoring and treatment that the child may require
 - to listen to and to reassure the child
 - to listen to and reassure the family as far as possible in relation to longer term health needs
62. **The decision to carry out** a medical assessment of a child will be made by a paediatrician with child protection expertise. The decision to conduct a medical examination may:
 - follow from an IRD and inter-agency agreement about the timing, type and purpose of assessment.
 - follow when a person presents to health services. This includes the possibility of self-referral for victims of rape and sexual assault who are over 16-years-old. This service is currently a possibility in specific services in some parts of Scotland. The Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill proposes to ensure that the service is accessible nationally. Guidance will be available in the Clinical Pathway for Children and Young People who have disclosed sexual abuse; and in a Protocol for self-referral
63. Medical examinations may be carried out by a single paediatrician, two paediatricians, or jointly with a paediatrician and a forensic physician (Joint Paediatric Forensic Examination ((JPFE)). The type of medical examination is decided by a paediatrician informed by IRD/multi-agency discussion with Police, Social Work and other relevant Health staff.
64. Through careful planning, the number of examinations will be kept to a minimum.

65. **Specialist paediatric or Joint Paediatric Forensic Examination (JPFE) is appropriate when:**

- the child requires a specialist assessment or treatment from another department (for example, multiple fractures, signs of abusive head trauma).
- the account of the injuries provided by the carer does not provide an acceptable explanation of the child's presentation.
- the result of the initial assessment is inconclusive and a specialist's opinion is needed to establish the diagnosis.
- lack of corroboration, for example by way of a clear statement from another child or adult witness, indicates that forensic examination, including the taking of photographs, may be necessary to support criminal proceedings against a perpetrator, and legal processes to protect the child.
- the child's condition (for example, repeated episodes of unexplained bruising) requires further investigation.
- in cases of suspected child sexual abuse.

66. **A comprehensive medical examination for neglect** can be arranged and planned for within localities when all relevant information has been collated. However there may be extreme cases of neglect that require urgent discussion with the Child Protection Paediatrician.

67. Significant new information may arise from a medical examination that requires the reconvening of an IRD.

Preparation

68. As far as can be achieved in the circumstances, the examining doctor should have:

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

69. Social Work services or the Police should ensure that the child and parent(s) (and/or any other trusted adult accompanying the child) have the opportunity to hear about what is happening, why and where so that they have an opportunity to ask questions and gain reassurance.

70. Consideration will be given to how the child may be examined in child-friendly surroundings, with the right support for their age, stage and understanding.
71. **Consent** must be obtained in one of the following ways.
- from a parent or carer with parental rights
 - from a young person assessed to have capacity
 - through a court order
72. The Age of Legal Capacity (Scotland) Act 1991 allows a child under the age of 16 to consent to any medical procedure or practice if in the opinion of the qualified medical practitioner the child is capable of understanding the nature and possible consequences of the proposed examination or procedure. Children who are assessed as having capacity to consent can withhold their consent to any part of the medical examination, for example, the taking of blood, or a video recording. Consent must be documented within medical notes and must reflect which parts of the process have been consented to and by whom. This includes consent to forensic medical examination.
73. In order to ensure that children and their families give properly informed consent to medical examinations, the examining doctor, assisted if necessary by the Social Worker or Police officer, should provide information about all aspects of the procedure and how the results may be used. Where a medical examination is thought necessary for the purposes of obtaining evidence in criminal proceedings but the parents/carers refuse their consent, the Procurator Fiscal may, in exceptional circumstances, consider obtaining a warrant for this purpose.
74. However, where a child who has legal capacity to consent declines to do so, the Procurator Fiscal will not seek a warrant. If the local authority believes that a medical examination is required to find out whether concerns about a child's safety or welfare are justified, and parents refuse consent, the local authority may apply to a Sheriff for a Child Assessment Order, or a Child Protection Order with a condition of medical examination. This is still subject to child's consent (under section 186 of the 2011 Act).

Timing of medical examinations

75. Timing of the medical examination is agreed jointly by the medical examiners and the other agencies involved.
76. Child protection assessments should be carried out, in the child's interests, during the day, unless there is a forensic need or other clinical indication of urgency.
77. In some cases, when there is not a forensic urgency, it may be a priority that the child has had time to rest and prepare. This may also allow for more information to become available. The majority of cases arise in working hours, and a comprehensive medical assessment will be carried out locally and quickly.
78. In cases of suspected or reported non-recent sexual abuse, examinations should be planned during normal working hours.
79. Local arrangements must be in place for medical examinations out of hours, where these differ from daytime/weekday arrangements. Care will be taken to ensure that forensic trace evidence is not lost.
80. The Clinical Pathway for Children and Young People who have disclosed sexual abuse is relevant for children under 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) (Scottish Government 2020). The Pathway will be reviewed following the publication of the revised Child Protection Guidance. Guidance on the Adult Clinical Pathway (2020) has overlapping relevance for those over 16 years of age (Scottish Government 2020).
81. More detailed information about the roles and responsibilities of all doctors can be found in [General Medical Council Guidance on Protecting Children and Young People](#) (2018).

Emergency legal measures to protect children at risk of significant harm

(Summary of legal options)

82. Urgent action may be required before or after a CPPM to protect a child from actual or likely significant harm, or until compulsory measures of supervision can be put in place by the Children's Hearing System. There are a variety of options to fit circumstances. All references to "the 2011 Act" are to the Children's Hearings (Scotland) Act 2011.
83. **Voluntary accommodation:** When a child's parents or carers do not object, the local authority may accommodate the child to keep the child safe whilst concerns about the child's safety, or reports or suspicions of abuse or neglect, can be assessed. Others in the child's extended family or social network may offer to look after the child in the interim. This is provided for under s25 of the Children (Scotland) Act 1995. A local authority may provide accommodation for any child within their area if they consider that to do so would safeguard or promote the child's welfare. A local authority must provide accommodation for any child who, residing or having been found within their area, appears to them to require such provision because no-one has parental responsibility for him, or the child is lost or abandoned, or the person who has been caring for him is prevented, whether or not permanently and for whatever reason, from providing him with suitable accommodation or care.
84. Before providing this accommodation, the local authority must have regard so far as practicable to a child's views, taking account of the child's age and maturity. The local authority must not provide such accommodation for a child if a person who has parental responsibilities and the parental right to regulate the child's residence or the right to control, direct or guide the child's upbringing, and who is willing to provide or arrange accommodation for the child, objects. Despite this objection, the local authority may continue to provide accommodation for a child over 16 who agrees to be accommodated or where a person or persons who have been granted a residence order all agree to the accommodation. A person with parental responsibilities and rights (as referred to above) may remove the child from such accommodation at any time, but where the child has been accommodated for a continuous period of 6 months, 14 days written notice will be required before the child can be removed.
85. **A child may request refuge** and if the child appears at risk of harm, may be provided with short term refuge (up to 7 days in defined circumstances, exceptionally up to 14 days) by the local authority or a person who is approved by the local authority for this purpose. (s38 Children (Scotland) Act 1995.

86. **Child Protection Orders (CPO):** In practice, child protection orders are usually applied for by a local authority. However, anyone, including the local authority, can apply for a child protection order under the following criteria when there are reasonable grounds to believe that: the child has been, or is being, treated in such a way that the child is suffering or is likely to suffer significant harm; or the child has been, or is being, neglected, and as a result of the neglect the child is suffering or is likely to suffer significant harm; or the child is likely to suffer significant harm if the child is not removed to and kept in a place of safety; or the child is likely to suffer significant harm if the child does not remain in the place at which the child is staying (whether or not the child is resident there) and the order is necessary to protect the child from that harm or from further harm. (s39 of the 2011 Act).
87. The local authority (but only the local authority) can also apply for a child protection order using the following criteria:
- a. that the local authority has reasonable grounds to suspect that:
 - i. the child has been, or is being, treated in such a way that the child is suffering or is likely to suffer significant harm
 - ii. the child has been, or is being neglected and as a result of the neglect the child is suffering or is likely to suffer significant harm
 - iii. the child will be treated or neglected in such a way that is likely to cause significant harm.
 - b. the local authority is making enquires to allow it to decide whether to take action to safeguard the welfare of the child, or is causing those enquiries to be made, and
 - c. those enquiries are being frustrated by access to the child being unreasonably denied, and
 - d. the local authority has reasonable cause to believe that access is required as a matter of urgency. (s38 of the 2011 Act).
88. When a Sheriff has made a child protection order and the Principal Reporter is satisfied that the criteria for the making of the child protection order are met a children's hearing must take place on the second working day after the child is removed to a place of safety, where the order authorises removal of the child to a place of safety. Where the order prevents the removal of a child from a place, the hearing must take place on the second working day after the order is made.

89. The purpose of this hearing is to consider:
- the circumstances which led to the making of the child protection order
 - whether the conditions for the making of the child protection order continue to be met
 - whether it is necessary that the order remain in place
 - whether any variations are required to any directions attached to the order CPO contains 'directions' which function in the same way as a measure attached to a compulsory supervision order.
90. A child protection order can have one or more of the following directions attached:
- **a non-disclosure direction.** This is a direction specifying that information in relation to the child, for example the place of safety where the child is being kept, must not be disclosed to a named person or class of persons.
 - **a contact direction.** This is a direction regulating contact between the child and a named person or class of persons.
 - **a parental responsibilities and rights direction.** This is a direction regulating parental responsibilities or rights in relation to the child, medical examination and/or treatment as an example.
91. **Legal assistance:** The child is automatically entitled to legal aid to be assisted by a solicitor at a second working day hearing. This is subject to the child having the capacity to give instructions to a solicitor.
92. A Police constable may immediately remove a child to a place of safety where he or she is satisfied that the conditions for making a Child Protection Order under s.39 of the 2011 Act (above) are met; that it is not practicable to apply to a Sheriff for such an order; and that the child requires to be removed to a place of safety to protect them from significant harm or from further harm. The child can only be kept in a place of safety for a period of 24 hours and further protective measures may therefore have to be sought within that period. The constable must inform the Principal Reporter as soon as practicable after removing the child. The Principal Reporter has the power to require the constable to release the child, if satisfied that the criteria for keeping the child in a place of safety are no longer met, or it is not in the child's best interests to remain in a place of safety. (s56 of the 2011 Act).
93. Application can be made to a Justice of the Peace for an order requiring a child to be produced to a specified person or placing or keeping a child in a place of safety. Such an order may be granted if the Justice of the Peace is satisfied of similar criteria to that for a CPO and that it is not practicable to apply to the Sheriff for a CPO. These orders last for a maximum of 24 hours or a Sheriff's determination of a CPO application if earlier. The applicant must inform the Principal Reporter as soon as practicable after the order is made. The Principal Reporter has the power to terminate the order, if satisfied that the criteria for making the order are no longer met, or the order is no longer in the child's best interests. (s55 of the 2011 Act).

94. **Child Assessment Order:** The 2011 Act (s35 and s36) makes provision for the local authority to apply for a Child Assessment Order if it has reasonable cause to suspect that a child has been, or is being treated or neglected in such a way that the child is suffering or is likely to suffer significant harm; that an assessment is needed to establish whether there is reasonable cause to believe that the child is being so treated or neglected; and that it is unlikely that an assessment to establish this could be carried out (or carried out satisfactorily) without obtaining the order (for example, where those with parental responsibility are preventing an assessment of the child being undertaken to confirm or refute the concern). The Child Assessment Order can require the parents or carers to produce the child and allow any necessary assessment to take place so that practitioners can decide whether they should act to safeguard the child's welfare. On application to the Sheriff for a Child Assessment Order, if the Sheriff believes that the conditions for making a Child Protection Order exist, he/she will issue a Child Protection Order instead.
95. The authority may ask, or the Sheriff may direct, someone such as a GP, paediatrician or psychiatrist to carry out all or any part of the assessment. The order may also authorise the taking of the child to a specified place, and keeping them there, for the purpose of carrying out the assessment and may make directions as to contact if it does so. Practitioners must assist in carrying out these assessments when asked to do so. Where the child is of sufficient age and understanding, they may refuse consent to a medical examination or treatment whether or not a Child Assessment Order is made. For further information, see the section above on health assessments.
96. **An Exclusion Order** may be granted when on application of a local authority when a sheriff is satisfied, that excluding a named person from the family home is necessary for the protection of the child, irrespective of whether the child is for the time being residing in the family home. The order will only be granted and only if it better safeguards the child's welfare than the removal of the child from the family home. The test for granting is that the child has suffered, is suffering, or is likely to suffer, significant harm as a result of any conduct, or any threatened or reasonably apprehended conduct, of the named person. (s76 Children (Scotland) Act 1995). A power of arrest may be attached to the conditions of such an order. The maximum duration of such an order is 6 months.
97. Above the specific considerations relating to each emergency situation the three overarching principles contained in the 2011 Act (as amended by the Children (Scotland) Act 2020) which must be applied when children's hearings are making all decisions about a child are:
- The need to safeguard and promote the welfare of the child throughout the child's childhood is the paramount consideration.
 - The child must be given an opportunity to express views in a manner suitable to the child, and panel members must have regard to any views expressed by the child, taking into account the child's age and maturity. There is an exception if, (a) the child is not capable of forming a view, or (b) the location of the child is not known.
 - An order is only to be made if the children's hearing considers it is better for the child that a compulsory supervision order, or warrant, is in force than if not.

98. **Preparation and reporting:** A fully updated child's plan may not be available to panel members at a second working day hearing. Therefore, practitioners attending need to prepare thoroughly for the hearing. The evidence, patterns, perspectives and analysis which inform a recommendation in a child's best interests must be presented in an accessible way in order to enable a safe, competent, child-focused process and outcome.

Changes to legislation and guidance during Covid-19

99. The Coronavirus (Scotland) Acts 2020, (Schedule 3, Part 1) provide for temporary and limited flexibility in relation to Child Assessment Orders, Child Protection Orders, compulsory supervision orders, and place of safety placements. Guidance on the Act also outlines the limits of these flexibilities; and aspects of the organisation of Children's Hearings, including provision for remote attendance, the need for which may persist beyond the early phases of the pandemic for some children and families, for infection control reasons. In those instances when the use of the legislation appears necessary, this must be consistent with protecting the safety, rights and best interests of the child. Justification for use must be recorded. The need for implementation and/or revision of these measures will be kept under regular review by Scottish Ministers. Therefore guidance in the next section on emergency measures must be considered in the light of the current status of this legislation.

Interim Safety Plan

(Guidance on immediate safety planning before a CPPM is held)

- The purpose of an interim safety plan is to provide an immediate plan that ensures those persons and services essential to a child's safety and wellbeing understand and agree about what they must do to ensure a child's safety until such time as a CPPM is held.
- An interim safety plan is about safety right now. It is operational immediately.
- The safety plan must consist of plain language and practical detail, with no acronyms and no professional jargon.
- The needs and the harm that the plan must address must be defined.
- If risk of harm is high in a specific context, this will be specified. Agreement must be defined about how to avoid or minimise this risk.
- The actions that persons or services will take will be described.
- The child will be supported in understanding who they can speak with or contact at any time. A child's version of the interim safety plan is recommended, developed with the child's help and understanding as appropriate in each situation.
- The ways in which any person or service party to the plan can safely and immediately signal concern and get help will be defined.
- Where persons have demonstrated that they are protective in this situation, their agreement and understanding of their role within the immediate safety plan will be defined.
- The ways in which the child's safety and experience, and the components of the plan, will be seen and heard until a case CPPM is held.
- Contact details for those with defined responsibilities within the interim safety plan will be included.

Domestic abuse considerations in safety planning

100. Effective safety planning will depend on practitioner-applied awareness of:

- the child's trauma from abuse, and from seeing and hearing abuse
- physical, emotional, educational, developmental, social, behavioural impact on child
- the non-abusing parents' need for a safe space to talk and a safe way of receiving information (away from perpetrator)
- the perpetrator's pattern of coercive control
- multiple impact on income, housing, relationships, health
- how support for non-abusing parents will also support children
- when a non-abusing parent's ability to parent has been compromised
- protective factors in the child's world relevant to safety plans
- the children's needs for advocates that they trust
- potentially heightened risk following separation
- multi-agency approaches that keep women's and children's needs at the centre

Police must always be notified of a threat to life or injury of a person. When a child is affected or is likely to be affected by such a risk, police will immediately consider the need for an IRD; and an IRD would normally be expected unless there is clear and sufficient evidence to discount the risk of significant harm deriving from such a threat.

Additional Guidance on domestic abuse is provided below in [Part 4](#).

Involving children and families in child protection processes

General principles

101. Children must be helped to understand how child protection procedures work, how they can be involved, and how they can contribute to decisions about their future. Children's views must be sought and listened to at every stage of the child protection process, and given information about the decisions being made as appropriate to their age, stage and understanding. Preparation is needed for key meetings.
102. Advocacy Services may assist in this process. Consistency of advocacy worker should be sought when they are involved. Within the context of the Hearings, s122 of the Children's Hearings (Scotland) Act 2011 will be implemented from 2020, opening up the offer of advocacy nationally. ([Advocacy in the Children's Hearings System – National Practice Model – Guidance](#))
103. When a child has additional support needs, is deaf or hard of hearing, has a disability, or when English is not their first language, advice and support is required to ensure that they are fully involved in what is happening.
104. Some children may have experienced grooming, or coercion including threats, and they may fear reprisals if they disclose. In some instances, a child or young person may be too distressed to speak to investigating agencies, or they may believe that they are complicit in the abuse. Materials developed as part of the [National Trauma Framework](#) are relevant.
105. A thorough assessment should be made of the child or young person's needs, and services provided to meet those needs. Therapeutic, practical and emotional support may be required. Consideration should be given to confidential and independent counselling services for victims and families.
106. Agencies who know the child or adult, including Third Sector organisations, may be involved in planning the investigation to ensure that it is managed in a child-centred way, taking care not to prejudice efforts to collect evidence for any criminal prosecution. Guidelines should be agreed with local Procurators Fiscal and counselling and welfare services on disclosure of information to avoid the contamination of evidence.
107. Parents and carers should be treated with respect. Where possible and appropriate they should be leading contributors to safety planning. They should be given as much information as possible about the processes and outcomes of any investigation. Parents and carers should feel confident about their part in safety plans. They need to be confident that practitioners are being open and honest with them so that they, in turn, feel confident about providing vital information about the child, themselves and their circumstances. Working in partnership with one or more family members is likely to have long-term beneficial outcomes for the child, and staff must take account of a family's strengths as well as its weaknesses. Practitioners must seek to achieve a shared understanding with parents about concerns and about steps needed to ensure safety.

108. Parents, carers and family members can contribute valuable information, not only to the assessment and any subsequent actions, but also to decisions about how and when a child will be interviewed. Children and families need time to take in and understand concerns and processes. The views of parents and carers should always be recorded and taken into account. Decisions should also be made with their agreement, whenever possible, unless doing so would place the child at risk of significant harm or impede any criminal investigation.
109. Parents and carers, and children of sufficient age and understanding, should be given a written record of decisions taken about the outcome of an investigation, unless this is likely to impede any criminal investigation. In addition to receiving a copy of the decisions (which may include interim safety planning), they should be given the opportunity to discuss the decisions and their implications with a Social Worker or another relevant professional to ensure shared understanding. This does not mean, however, that parents or carers should attend all meetings which are held in connection with their family. Sometimes, it will be appropriate and necessary for practitioners to meet without parents or carers in order to reflect on their own practice in a particular case, consider matters of a particularly sensitive or confidential nature, or deal with a matter which is likely to lead to criminal inquiries. Consistent and reliable relationships from professionals are an essential part in development of trust.
110. When there are child protection concerns and one of the parents or carers has learning difficulties, the use of an independent advocacy service, where available, will be considered. Professionals should be skilled, or seek appropriate support, in communicating with parents with learning difficulties. Practitioners need to take time when communicating. Verbal and written information should be accessible for the person. Extra time will be needed to talk through what is happening.
111. In cases of familial abuse, practitioners should ensure the non-abusing parent or carer is involved as much as possible. Practitioners need to be wary of making judgements on parents and carers who are likely to be in a state of shock and experiencing great anxiety. While the priority should always be the protection and welfare of the child, practitioners should attempt to engage with the non-abusing parent/carer and determine what supports are necessary to help them care for the child.
112. Equally, practitioners should be sensitive to the impact of abuse and the subsequent investigation on siblings and extended family members. Consideration should be given to their needs in such circumstances, and to the likely impact on their ability to deal with the situation.

***Learning from adapted practice during the Covid-19 pandemic**

113. During the Covid-19 pandemic, it has been necessary to adapt practice to ensure continuity of child protection processes. It has proven safe and effective to allow consideration of the decision to place a child's name on the child protection register through multi-agency consensus rather than through a face to face meeting. This might happen at IRD or subsequently by agreement of locally identified managers in Health, Police and Social Work.
114. In such cases, these managers should take account of the views of the team around the child, medical and other specialist advice, and the particular perspectives of the child and family. The reasons for the decision should be documented in child's plans and agency records. This more flexible process should not allow any widening of the criteria for child protection registration, which continues to be that there are reasonable grounds to believe that a 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.
115. This adapted process may be sustained as a safe option beyond 2020. The review process and timescale can be considered at the point of registration. De-registration should occur when a child no longer requires a child protection plan.
116. [Supplementary National Guidance on Child Protection](#) during the Covid-19 pandemic outlines relevant expectations and adaptations. (2020)

Child Protection Assessment and Planning

117. The Child's Protection Plan Meeting (CPPM) is a formal multi-disciplinary meeting, which must include representation from the core agencies (Social Work, Health and Police) as well as any other agencies currently working with the child and their family. The child and relevant family members should be invited and supported to attend, and where they are unable to attend in person their views must be sought and represented at the meeting. Where possible, participants should be given a minimum of five days notice of the decision to convene a CPPM.
118. The purpose of the meeting is to ensure information is shared, to carry out a collective assessment of risk, and to agree a plan to minimise risk of harm to the child. The CPPM must decide whether the child is at risk of significant harm and requires a co-ordinated, multi-disciplinary Child Protection Plan.
119. Where a Child Protection Plan is required, the child's name must be added to the Child Protection Register. In addition, CPPMs must consider whether a referral to the Principal Reporter is required if this has not already been done. Where the CPPM has identified immediate risk of significant harm to the child, action should be taken without delay, using emergency measures. Any decision to refer to the Principal Reporter should be actioned straight away. A referral to the Principal Reporter should include relevant and proportionate information, including the reasons for the referral, and where possible including the child's plan and a full assessment of risk and need.
120. Prior to the CPPM, agencies will have been working to an Interim Safety Plan since the point of IRD. The CPPM should review this plan and develop a Child Protection Plan.
121. Consideration should be given to immediate and short-term risks as well as longer term risks to the child. For the avoidance of drift and uncertainty of purpose, it is recommended that the Plan's objectives be Specific, Measurable, Attainable, Relevant, Timebound, Evaluated and Re-evaluated ('SMARTER'). Interventions should be proportionate, and linked to intended outcomes in ways understood by all involved, especially children and parents.
122. **The Child Protection Plan must:**
 - Be developed in collaboration and consultation with the child and their family.
 - Link actions to intended reduction or elimination of risk
 - Be current and consider the child's short, medium and long-term outcomes.
 - Clearly state who is responsible for each action
 - Include a named Lead Professional
 - Include named key contributors (the Core Group)
 - Include detailed contingencies

123. The **Core Group** are those who have direct and on-going involvement with the child and/or family. They are responsible for implementing, monitoring and reviewing the Child Protection Plan, in partnership with children and parents. Consider the sensitive direct involvement of children and/or their views. The Core Group should:
- be co-ordinated by the lead professional
 - meet in person on a regular basis to carry out their functions, the first time being within 15 days of the CPPM.
 - keep effective communication between all services and agencies involved with the child and parents/carers
 - activate contingency plans promptly when progress is not made or circumstances deteriorate
 - refer the need for any significant changes in the Child Protection plan to the CPPM chair within 3 calendar days, or as urgently as necessary to safeguard the child
 - individually and collectively, they must be alert to escalating concerns, triggering immediate response, additional support and/or a review CPPM as appropriate.

Child Protection Plan and fit with child's plan

124. Where a child is believed to be at actual or potential risk of significant harm, they will require a multi-agency Child Protection Plan with specified actions to reduce risk. The child's name must be placed on the Child Protection Register.
125. If there is already a multi-agency child's plan in place, this will need to be considered in light of the concerns about the child. There will be a multi-agency child's plan when co-ordinated actions between services are required to meet the child's wellbeing needs.
126. There should be a single plan of action, managed and reviewed through a single meeting structure even if the child is involved in several processes. The child's plan will incorporate and prioritise the Child Protection Plan where the criteria for placing a child's name on the Child Protection Register (as defined in Part 1) are met.
127. **Review CPPMs** should be held within 6 months of the CPPM with the exception of reviews that follow a pre-birth CPPM, which are recommended at an earlier juncture, at a time to be set by the CPPM (See below). A Core Group can also trigger the request for a review. Thereafter, reviews should take place six-monthly, or earlier if circumstances change. Where a child is no longer considered to be at risk of significant harm and the Child Protection Plan no longer forms part of a child's plan, their name should be removed from the Child Protection Register by the review CPPM (referred to as de-registration). The child and their family/carers may still require on-going support and this should be managed through the child's plan.

Child Protection Assessment and Planning

Pre-birth Child Protection Planning Meetings

- Pre-birth CPPMs will consider whether serious professional concerns exist about the likelihood of harm to an unborn or newly born baby due to neglect or abuse.
 - In advance of the child's birth participants need to prepare an inter-agency plan which will meet the needs of the baby and mother prior to and following birth, minimising risk of harm.
 - Plans for discharge from hospital and handover to community-based supports must be clearly set out in the inter-agency plan.
 - Pre-birth CPPMs will be held as soon as possible. This should be within 28 days of the concern being raised, and always within 28 weeks of gestation.
 - There may be exceptions to this where the pregnancy is in the very early stages. However, concerns may still be sufficient to warrant an inter-agency assessment.
 - The CPPM may place the unborn baby on the Child Protection Register before birth. If the child is registered the Child Protection Plan must stipulate who is responsible for notifying the birth of the child and what steps need to be taken at that point (e.g. referral to the Principal Reporter). Legal measures such as referral to the Reporter and application for a CPO can only be made at birth.
128. **Reviews of Pre-birth CPPMs.** A review may be held within three months of the previous CPPM. There should be latitude for professional judgement about the most appropriate timing post-birth. This does not preclude an earlier review where changes to the child's living situation are enough to remove or significantly reduce risks. Careful consideration is required about early decisions to remove a baby's name from the register, for example by ensuring that necessary supports are in place.
129. Where a child protection plan is in place prior to a child's birth, the child must not be discharged from hospital following birth until a pre-discharge meeting has been held. This meeting should include the Core Group members and the child's relevant family members, as well as hospital-based maternity ward staff.
130. The purpose of this meeting is to agree arrangements for the care of the child following discharge from hospital. This should include consideration of the role and level of involvement of community-based supports. Where the decision of this meeting is that the child would be at risk of significant harm by being discharged to the care of their parent/s, the child protection plan should be amended to reflect this, and proportionate action should be taken to keep the child safe.

Further consideration of pre-birth support and safety planning may be found in [Part 4](#) of this Guidance

Child Protection Assessment and Planning

Transfer of cases

131. Geographical moves are a time of accentuated stress and risk for children and families. CPPMs must be held to ensure proper transfer of information and responsibilities when a Child Protection Plan is currently in place. Only a review CPPM can de-register a child from the Child Protection Register. Where it is known that a child and/or their family are moving permanently to another local authority area, the original local authority will notify the receiving local authority immediately, then follow up the notification in writing. At the transfer CPPM, the minimum requirement for attendance will be the originating local authority's Social Worker and manager and the receiving local authority Social Worker and their manager, as well as representatives from appropriate services including Health and education.
132. Where the child moves to another authority the originating authority must assess the change in circumstances. If there is felt to be a reduction in risk, the originating authority should arrange a review CPPM to consider the need for on-going registration or, if appropriate, de-registration. In such circumstances it would be best practice for an appropriate member of staff from the receiving authority to attend the review. Where the original authority considers that the risk is on-going or even increased by the move, the receiving local authority is responsible for convening the transfer CPPM. This should be held within the timescales of the receiving local authority.
133. Where a child and their family move from one Scottish authority to another and the child has a Child Protection Plan, the originating authority must ensure that the relevant child's records are made available to the receiving authority for the purposes of the assessment of current and future risk and need. Where a child was on the Child Protection Register previously in another area, the receiving authority should request the child's file from the previous authority (if still available).

Child Protection Planning Meetings

Guidance on chairing, participation, recording and decision-making

Chairing

134. CPPMS chairs will:

- have significant experience in child protection practice
- have sufficient authority, skill and experience to carry out the functions of the chair.
- be able to challenge all contributing services on progress.
- be from Social Work services (although senior staff members from other core agencies may agree to take on the role for agreed reasons)
- be able to access suitable training and peer support

135. Some areas provide a measure of independence within the chairing of child protection planning meetings by ensuring that those acting in this role have no direct involvement in supervisory function in relation to any practitioner in the case. As far as possible, the same person should chair initial and review CPPMs.

The chair's role:

136. This includes:

- agreeing who to invite and ensuring that all persons invited to the CPPM understand its purpose, functions and the relevance of their particular contribution.
- meeting with parents/carers to explain the nature of the meeting, and possible outcomes.
- ensuring that the parents/carers and child's views are taken into account.
- confirming the identity and role of the Lead Professional at the meeting.
- facilitating information-sharing, analysis and consensus about the risks and protective factors.
- facilitating decisions and determining the way forward as necessary.
- ensuring consideration of referral to Principal Reporter.
- where a child's name is placed on the Register, outlining decisions that will help shape the initial Child Protection Plan (to be developed at the first Core Group meeting), identifying the Lead Professional (if not already appointed), and advising parents/carers about local dispute resolution processes.
- facilitating the identification of a Core Group of staff responsible for implementing and monitoring the Child Protection Plan.
- agreeing review dates which keep to national timescales.
- following up on actions and responsibilities when these have not been met.
- ensuring that arrangements are made for any practitioner forming part of the Core Group who was not present at the CPPM to be informed immediately about the outcome of the CPPM and the decisions made. A copy of the Child Protection Plan must be sent to them.

137. **Participation:** The people involved in a CPPM should be limited to those with a need to know, or those who are essential to an effective plan. Participants attending are there to take active part, represent their agency, and share information to ensure that risks can be identified and addressed. They have a responsibility to share information, and to clarify other shared information as necessary. Participants need to understand the CPP, purpose, functions and the relevance of their particular contribution. The Chair, in conjunction with the lead professional, will decide who to invite. Consideration should be given to inviting the following:

- the child
- parents, carers and family members, including all those with parental responsibility, and if required, a support person or advocate for the child and/or family
- Social Worker and other Social Work practitioners essential to the formation of this plan
- the Police – who should continue to be involved if there is continuing Police involvement in the case
- (supported) foster carers
- early learning and child care staff, or most appropriate education professional
- primary and acute health professionals, or child and adolescent mental health services if appropriate
- adult mental health services/addiction services if appropriate
- Third Sector organisations supporting children and families
- housing/support workers
- representative of the Armed Services, in cases where there is a service connection
- on occasion a Principal Reporter may be invited to attend, although their legal position means they can only act as an observer and cannot be involved in the decision-making

*Consideration should be given to how to respond to a situation when a parent or carer refuses to allow a child or young person access to information and advocacy services in relation to child protection processes.

Quorate

138. There must be a sufficient number of multi-agency professionals contributing to the information sharing and analysis to enable safe decisions and effective planning. Minimum attendance would be expected from children's Social Work, Police (as relevant), community child health and early learning and childcare, with prepared parental involvement.

139. Where a CPPM is inquorate it should not ordinarily proceed, and in such circumstances the Chair must ensure that either:
- an interim safety plan is produced, or
 - the existing plan is reviewed with the professionals and the family members that do attend, so as to safeguard the welfare of the child or children
 - another early CPPM date must be set immediately to be held within 10 working days
140. In exceptional circumstances, the Chair may decide to proceed despite lack of agency representation. This would be relevant where a child has not had relevant contact with all key agencies (e.g. pre-birth CPPM), or sufficient information is available and a delay is likely to be harmful to the child. Where an inquorate CPPM is held the Child Protection Chair must ensure that the reasons for proceeding with the CPPM, and any arrangements to safeguard the child in the meantime, are noted in the CPPM record. An early review CPPM should be arranged immediately. Two consecutive inquorate CPPMs must not be held. Inquorate CPPMs cannot remove a child protection plan.

Parents/carers participation in CPPMs

141. Involvement of children and families in child protection processes is considered in general terms above. Parents, carers or others with parental responsibilities should be invited to the CPPM. They need sufficient time and support before and during the meeting to understand shared information, including concerns and decisions.
142. In exceptional circumstances, the chair may determine that a parent or carer should not be invited to, or should be excluded from attending, the CPPM (for example, where bail conditions preclude contact or there are concerns that they present a significant risk to others attending, including the child or young person). The reasons for such a decision need to be clearly documented. Their views should still be obtained and shared at the meeting and the chair should identify who will notify them of the outcome and the timescale for carrying this out. This should be noted in the record of the meeting.
143. The chair should encourage the parent or carer to express their views, while bearing in mind that they may have negative feelings regarding practitioners' intervention in their family. The chair should make certain that parents/carers are informed in advance about how information and discussion will be presented and managed. Parents/carers may need to bring someone to support them when they attend a CPPM. This may be a friend or another family member, at the discretion of the chair, or an advocacy worker. This person is there solely to support the parent/carer and has no other role within the CPPM.
144. Information about CPPMs should be made available to children and parents/carers. This may be in the form of local leaflets or national public information. Guidance on parents/carers attendance at CPPMs should be contained in local inter-agency child protection procedures.

Children's participation in CPPMs

- Consideration should be given to inviting children and young people to CPPMs. They should be given the information they need in a way that helps them understand and take part. The emotional impact of attending a meeting must be considered. CPPMs can be disturbing or confusing for children who attend, but the development of a child protection/child safety plan must take into account the child's perspective.
- A decision not to invite the child or young person should be verbally communicated to them, unless there are reasons not to do so. Children and young people attending should be prepared beforehand so that they can participate in a meaningful way, and thought should be given to making the meeting as child – and family-friendly as possible.
- Even if a child does not attend the meeting, their views are still necessary before and after the meeting, ensuring that for babies and infants their presentation and pattern of behaviours need to be considered.
- The child's views are obtained, presented, considered and recorded during the meeting, regardless of whether or not they are present. Consideration should be given to whether a child should attend the Core Group.
- Reasons for agreeing that older children and young people should or should not attend a CPPM or Core Group meeting should be noted, along with details of the factors that lead to the decision. This should be recorded in the meeting record.

CPPM Record

- The person taking responsibility for the record of the meeting must be sufficiently trained, and should not be the meeting chair. The aim of the record is to provide essential information from the meeting in a form that all involved in the Child Protection Plan can understand.
- Essential information includes those invited; attendees and absentees; reasons for child/parents/carers non-attendance; reports received; a summary of the information shared; the risks and protective factors identified; the views of the child and parents/carers; the decisions, reasons for the decisions and note of any dissent; the outline of the Child Protection Plan agreed at the meeting, detailing the required outcomes, timescales and contingency plans; the name of the Lead Professional, and membership of the Core Group.
- Participants, invitees who were unable to attend and Core Group members should receive the record when approved by the chair within five calendar days of the CPPM.

Provision of reports

- Reports should be produced to ensure that relevant and sufficient information is effectively shared with CPPM participants in order to support good decision-making. From single agency reports, an integrated report should be produced by the Lead Professional in advance of the CPPM meeting. If this is not possible, for example due to last minute provision of single agency information to the Lead Professional, then this information must be integrated afterwards. The aim is to develop shared understanding of inter-agency reports for CPPMs. These arrangements should be covered by local protocols.
- The report/s should include all relevant information and a chronology, to be completed by the Lead Professional. ([Practice Guide to Chronologies](#), Care Inspectorate, 2017). They should also include information pertaining to significant adults in the child's life, and provide a clear overview of the risks, vulnerabilities and protective factors, as well as the child's views. Other children in the household or extended family should also be considered.
- Invitees have a responsibility to share the content of the report(s) with the child and family in an accessible, comprehensible way. Prior to an initial CPPM, consideration needs to be given as to the most appropriate means of sharing reports with the child and family, and to when it should be done.
- It is recognised that a full comprehensive risk assessment may not be achievable within the timescales of the first CPPM, or the first Core Group. Therefore, it should be recognised that the early Child Protection Plan may need to be provisional until a fuller assessment can be undertaken.

Restricted access information

- Restricted access information is information that cannot be shared freely with the child or parent/carer, or anyone supporting them. The information will be shared with the other participants at the CPPM. Such information may not be shared with any other person without the explicit permission of the provider. If it is necessary to have a segment of the CPPM without parents present for this reason, the Chair will prepare them for this and explain the reasons why this has to occur.
- Restricted information includes sub-judice information which could compromise legal proceedings; information from a third party that could identify them if shared; information about an individual that may not be known to others, even close family members, such as medical history and intelligence reports; and information that, if shared, could place any individual(s) at risk, such as a home address or school which is unknown to an ex-partner.

Reaching decisions in the CPPM

- All participants at a CPPM with significant involvement with the child and family have a responsibility to contribute to a view of the level of risk, the need for a Child Protection Plan, and the decision as to whether or not to place the child's name on the Child Protection Register.
- Where there is no consensus, the Chair will use his or her professional judgement to make the final decision, based on an analysis of the issues raised.
- **A summary of key decisions and agreed tasks**, as approved by the chair, should be circulated within one day of the CPPM. Participants should receive a copy of the agreed Child Protection Plan within five calendar days of the CPPM.

Dissent, dispute and complaint

145. Local guidelines should define the mechanisms by which dissent and dispute or complaint will be resolved and decisions approved. This could include challenges about the inter-agency process, decision-making and outcomes, challenges by children/young people or their parents/carers about the CPPM decisions, or complaints about practitioner behaviour.

Pending dispute resolution process:

- if actions are required to ensure the child's immediate safety, they should be prioritised and progressed without delay
 - the child's name will be added to Child Protection Register
 - the Child Protection Plan should be developed as required
 - The agencies and services involved in child protection work have complaints procedures, which should be followed where there is a complaint about an individual practitioner.
146. When a practitioner wishes to raise an issue about the process, or disagrees with CPPM decisions, communication and concerns should be channelled through their agency line management.
- There should be clearly defined local arrangements for challenging inter-agency CPPM processes.
 - If a parent or carer wishes to challenge the decisions of the CPPM, they should follow processes defined in local inter-agency child protection procedures. If the complaint is about a specific practitioner, they should follow the relevant agency's complaints procedures. Children and young people should have access to guidance that they can understand about how to challenge a decision or make a complaint from any of the practitioners with whom they have contact.

Assessment and planning: prompts to reflection

- Are needs, strengths and risks for the child central within this assessment?
- Have the child's feelings, thoughts and experience been taken into account, as far as can be ascertained at their age and stage?
- Can children and adults involved understand assessment and reporting processes?
- How do we support understanding and participation, taking account of the emotional stage, language and culture of children and adults involved?
- Are motivations, views and understanding of parents/carers represented?
- Are expected steps to change represented?
- Are barriers to change explored and addressed?
- Has consideration been given to safe and effective involvement of the wider family?
- Has consideration been given to the child's present and future needs for relationship with those who are important to the child, including siblings?
- Are resilience factors identified and promoted within recommended plans?
- Have specialist aspects of assessment and support been considered and integrated when necessary?
- Have the comparative advantages of legal options been considered?
- For what reasons may formal/compulsory measures be needed?
- Is the assessment and planning co-ordinated as far as is appropriate, by a lead professional?
- Does the assessment and plan reflect co-operation around child and family within all relevant child and adult services?
- Are contingency plans as clear as possible at this stage?

Chronologies

Definition and outline guidance on use of chronologies in child protection assessment and planning

147. **A chronology is:**

- a summary of events key to the understanding of need and risk, extracted from comprehensive case records and organised in date order.
- a summary which reflects both strengths and concerns evidenced over time.
- a summary which highlights patterns and incidents critical to understanding of need, risk and harm.
- a tool which should be used to inform understanding of need and risk. In this context, this means risk of significant harm to a child.

148. **A chronology may be:**

- single agency
- multi-agency

149. **A multi-agency chronology** must comply with information sharing guidance and protocols in the way that it is developed, held, shared and reviewed. It must be accurate, relevant and proportionate to purpose.

150. A multi-agency chronology:

- is a synthesis which draws on single agency chronologies
- reflects relevant experiences and impact of events for child and family
- will include turning points, indications of progress and/or relapse
- will inform analysis, but is not in itself an assessment
- may evolve in a flexible way to integrate further necessary detail
- may highlight further assessment, exploration or support that may be needed
- is a tool which should be used in supervision
 - A chronology, whether single or multi-agency
- is not a comprehensive case record and cannot substitute for such records
- is not a list of exclusively adverse circumstances

151. **The Lead Professional** will consolidate a multi-agency chronology for each Child Protection Planning Meeting. Contribution to the chronology is a collective responsibility. Forming a chronology should assist a shared understanding with and between those involved in developing a Child Protection Plan about strengths, needs and concerns over time, for the purpose of reducing risk of significant harm to a child.

152. The Lead Professional must therefore be clear about the purpose of the multi-agency chronology; the nature and sequence of the facts that should be captured at this juncture. The perspective of child and family at the centre of the child protection process should be explored to gain understanding of impact of events and to check their perception of accuracy.
153. **The format of a chronology** should record purpose, authorship and date of completion. It should include the nature and sequence of events; outcomes or impact on child and family; sources of information; and responses to events as necessary for the purpose of this product.

Child giving evidence in criminal and civil proceedings

1. Children might be required to give evidence in court in criminal prosecution of suspected or reported perpetrators of abuse or neglect and also in civil proceedings, which would usually be in relation to children's hearing proofs. A child might be required to give evidence about the same matters both in a criminal trial and in a children's hearing proof application. If the child has been referred to a children's hearing for the same matter, then proof proceedings are likely to take place before any criminal trial.
2. Decisions regarding any criminal prosecution will be taken by the Procurator Fiscal. When a decision is taken to raise criminal proceedings in which the child or children will be cited as witnesses and asked to give evidence, the relevant Social Worker should discuss the case with the Police.
3. The Police will advise the Procurator Fiscal of any concerns about the risk of further abuse of, or interference with, witnesses in the case, and with any other children to whom the suspected or reported perpetrator has access. This information is vital to assist Procurators Fiscal and the court to make informed decisions about bail, and any additional special measures which may be required.
4. If a suspected or reported perpetrator of abuse is to be prosecuted, or where there are children's hearings proofs proceedings at which the child will give evidence, child witnesses should always be given information and support to prepare them for the experience of being a witness in court.
5. The CPPM may provide an opportunity for Social Work services, the Principal Reporter and Procurator Fiscal to discuss recommendations about bail and any necessary conditions. The Sheriff will decide whether to grant bail or not. Agencies should consider the potential impact of an unsuccessful prosecution or hostile cross-examination of a child, and the implications for the future protection of that child and others.
6. Police and Social Work services should agree arrangements for convening planning meetings, setting up systems for sharing and updating information about the investigations 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 Principal 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.
7. Local authorities and other agencies must consider a range of issues, including whether the child needs counselling or therapy before criminal proceedings are concluded. The needs of the child take priority, and counselling should not be withheld solely on the basis of a forthcoming prosecution or proof. There is a [Code of Practice](#) aimed at facilitating the provision of therapeutic support to child witnesses in court proceedings.

8. Where counselling does take place, the person(s) offering counselling may be called as witnesses to explain the nature, extent and reasons for the counselling. Welfare agencies should discuss therapeutic intervention with the Procurator Fiscal so that they are aware of the potential impact of such counselling on any court proceedings.
9. Special measures available for all child witnesses cited to attend include the following options:
 - evidence being taken by a commissioner (which means that the child's evidence is taken at a special hearing, which can take place outwith the court, in advance of the proof or trial, and is recorded)
 - a ban on questioning by the person who is alleged to have perpetrated certain actions;
 - having a support person present
 - screens so that the child cannot see the accused (in a criminal case) or other people who are entitled to be present (in other cases)
 - giving evidence via a CCTV link from another room within the court building or from a remote site, as appropriate (most often used in criminal prosecutions, or where the proof relates to offence grounds referred to a children's hearing and prior statements treated as evidence in chief)
 - prior statements treated as evidence in chief in criminal proceedings
 - in children's hearings proofs relating to non-offence grounds, the Reporter will seek to use the Police and Social Work interview, (the JII), in place of the child having to give evidence in person. This is a judgement call in each case and it cannot be ruled out as a possibility that a CCTV link will be used.
10. As well as these special measures, the Sheriff or Judge can take a range of other steps to help the child give evidence and protect his or her welfare whilst giving evidence, for example by deciding in advance what questions can and cannot be asked, by agreeing the child should have regular breaks, and by limiting the duration of questioning.
11. The Children (Scotland) Bill (anticipated to receive royal assent in 2020) creates a new special measure which prevents parties to civil cases and children's hearings proofs, in certain circumstances, from personally conducting their own case. This would apply, subject to some exceptions, where a witness is a victim of certain conduct, including domestic abuse, or certain other offences.
12. Consideration should be given as to who may act as a support person for the child. In all cases, the person citing the witness, (eg the Procurator Fiscal or defence lawyer), will make an application to the court on which option is the most appropriate. The child's own views and those of the child's parent or carer should also feed into the decision-making process. The final decision on which option is the most appropriate rests with the Sheriff or Judge.
13. Professionals involved in supporting the child may be asked to provide information to the party citing the child to ensure that the court is provided with enough information about the child's needs to inform the decision about what special measures and other supports are required.

14. Section 271 BZA of the [Criminal Procedure \(Scotland\) Act 1995](#) (inserted by the Vulnerable Witnesses (Criminal Evidence) (Scotland) Act 2019) provides that child witnesses are required to give evidence in respect of both solemn proceeding and in respect of certain listed offences by means of a prior statement and/or a pre-recorded Commission hearing in advance of the trial, unless certain exceptions apply. These exceptions are if either the fairness of the trial or the child's best interests would be prejudiced by such a course of action, or if the child is 12 or over, has expressed a wish to give live evidence, and it would be in their best interests to do so. The most efficient means of complying with the requirements of the Act will be that the child's evidence in chief will be given by means of his or her recorded JII; and that cross-examination and re-examination will occur by means of evidence taken by commissioner. If the JII is not suitable for use in criminal proceedings, all of the child's evidence will require to be taken by a Commissioner. This rule came into force in January 2020 in respect of many, but not all, High Court cases in 2020.
15. The Act requires there to be a ground rules hearing prior to evidence being taken by commissioner, and specifies some issues which must be considered. The Act makes provision to allow for evidence to be taken by Commissioner to take place even before the indictment has been served. However, there remain significant legal barriers to holding Commissioner hearings in advance of service of an indictment. Therefore, many Commissioner hearings will continue to take place after an indictment has been served. Work is on-going to reduce the time between the offence being reported and the date on which an indictment is served. Improvements in facilities for witnesses to give their evidence in Commissioner Hearings or by live tv link to court are in progress. ([Vulnerable Witness \(Criminal Evidence\) \(Scotland\) Act 2019](#))

Criminal Injuries Compensation

Ensuring consideration during child protection planning

154. Children who have suffered significant harm either within or outwith the family as a result of abuse may be eligible for criminal injuries compensation. Other children or non-abusing adults who have a loving relationship with the abused child may also be eligible for compensation if they suffer a mental injury as a result of witnessing the abuse or its immediate aftermath. Professionals should be aware of this scheme, and should consider whether any child for whom they are responsible is eligible to apply. They should also ensure that applications are progressed timeously.
155. Where the victim was under the age of 18 at the time of the incident, and it is reported to the Police before their 18th birthday, an application for compensation can be made until the victim turns 20. Where the victim was under the age of 18 at the time of the incident but it was not reported to the Police before their 18th birthday, an application for compensation can be made up to two years from the first report to the Police. Applications from adults should be made within two years from the date of the crime. These time limits can only be extended in exceptional circumstances. The Criminal Injuries Compensation Authority (CICA) does not need to wait for the outcome of a criminal trial if there is already enough information to make a decision on a case, so application can be made without delay for this reason. Decisions are made on 'balance of probabilities.' ([Criminal Injuries Compensation Act 1995](#)).
156. Consideration as to whether or not the Criminal Injuries Compensation Scheme may apply should be a standing item at all initial and review CPPMs (or 'Looked After' Reviews if appropriate). It is the responsibility of the chair of the review to ensure that reasons are recorded within the record of the meeting as to why the decision was reached whether to proceed or not to proceed with an application.
157. It is crucial that scrutiny is given to the above as the Local Authority can be held liable if it fails to make a claim. Action may also be taken against the Local Authority if it accepts an inadequate offer of compensation on behalf of a child. Children and young people who have been abused in residential care are also entitled to claim compensation.

General Principles

General principles that underpin the consideration and conduct of investigative activities in relation to children who may be harmed and those who may cause harm to others may be summarised as below.

Rights: The child's present feelings, views and future rights are respected and protected at every stage.

Safety: Processes are both careful and robust, promoting the safety of those involved by discovering the truth within the most harmful circumstances.

Wellbeing: The wellbeing of the child is the lens through which all decisions and actions are taken.

Preparation: Processes include early discussion between the lead agencies, co-ordination and partnership with those responsible for the child's care.

Understanding: Each stage and any change or decision is explained in a way that makes sense to each child and those responsible for their safe care, taking into account culture, capacity, age and stage.

Support: Support will be provided for children and families involved in these processes.

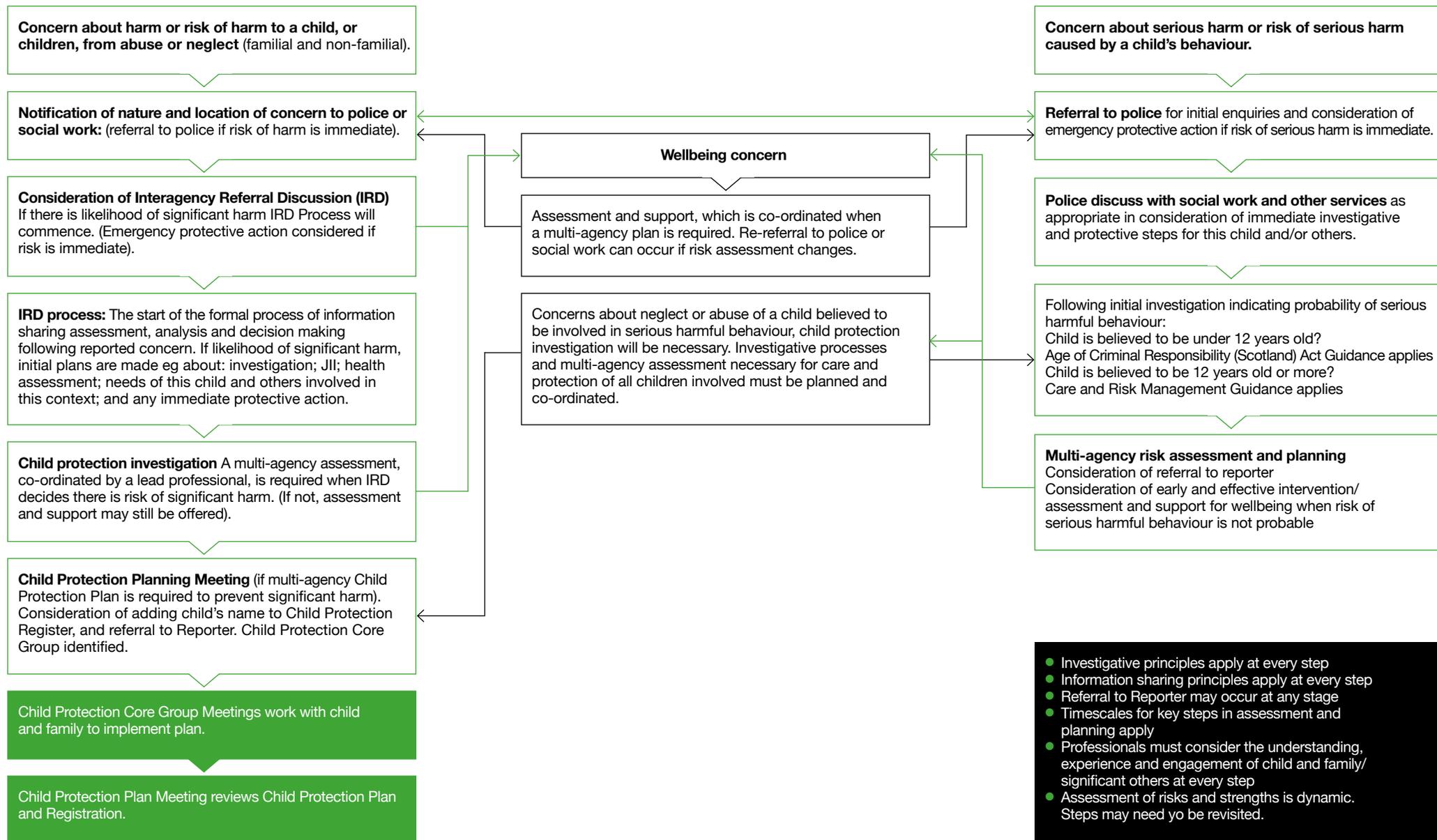
Skill: Professionals involved are afforded the training and supervision that ensures a co-ordinated and child-centred process.

Pace: Preparation and pace of exploration is patient and attuned to the impact of trauma upon the needs and feelings of each child.

Place: Investigative processes are conducted in an environment which is child-friendly and amenable to those attending for the child's support.

Improvement: Processes will be evaluated and improved to ensure adherence to standards.

Child Protection Process



- Investigative principles apply at every step
- Information sharing principles apply at every step
- Referral to Reporter may occur at any stage
- Timescales for key steps in assessment and planning apply
- Professionals must consider the understanding, experience and engagement of child and family/ significant others at every step
- Assessment of risks and strengths is dynamic. Steps may need to be revisited.

Part 4: SPECIFIC CONCERNS

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Introduction

1. Part 2b described common themes in multi-agency assessment. Part 3 defined steps in child protection. This Part of the Guidance goes beyond general components to consider additional emphases within specific areas of practice. A common thread binding all specialisms is the need to consider the relevance of interactions between the child, their family/significant others and their 'community' context/wider world. This is consistent with the GIRFEC approach and findings from the [Independent Care Review](#) "When children talk about wanting to be safe, they talk about having relationships that are real, loving and consistent."

Poverty

2. Practitioners should be careful not to stigmatise families through highlighting the impact of poverty in families. Most families experiencing poverty provide safe and loving homes. However poverty can cause as well as accelerate neglect and the risk of other harms. Consideration of the impact of poverty on children is a core consideration in child protection assessment and family support. Recent research indicates the disproportionate number of children placed apart from their families within the poorest neighbourhoods in Scotland. (Bywaters et al 2017). Northern Ireland's anti-poverty framework (2018) and the BASW anti-poverty Guide (2019) have been strongly influenced by this research.
3. Intersection: Poverty intersects with other stressors upon families, including disability, ill Health, poor housing, barriers to employment, and racial discrimination. There are interactions between poverty and other challenges in dispersed Scottish rural and island communities that are of specific concern within Social Work (Turbett 2019). The emotional and economic isolation of rural victims of domestic abuse has been highlighted by English research (NRCN 2019). Poverty must never be a reason for removal of children from the care of their family.
4. Local authorities safeguarding of children encompasses support for migrant families who have no recourse to public funds. These families face a high risk of poverty and destitution. Guidance on migrant rights and entitlements is linked [here](#).
5. Analysis: Individual practitioners may have little influence on structural inequalities. However, in each situation, multi-agency planning to protect children should seek to maximise appropriate resources for the family and address the distinctive context and relevance of deprivation. In this process, the My World Triangle prompts practical consideration of material barriers to wellbeing for each child. This should also prompt consideration of those instances when material affluence can mask emotional neglect and abuse (Bernard 2019).
6. Strategic direction: Without further systematic intervention, relative child poverty is likely to continue to rise in Scotland, from 23% in 2016-17 to 27% in 2023-24 (De Agostini/Scottish Parliament 2019), or as high as 29% (Resolution Foundation 2019). There is a need to ensure connection between local poverty analysis and planning with national strategy and policy (McKendrick 2018). The Child Poverty (Scotland) Act 2017 received Royal Assent on 18 December 2017. This creates national definitions and targets to be met in relation to child poverty by 1 April 2030. Local authorities have duties under the Community Empowerment (Scotland) Act 2015, the Children and Young People (Scotland) Act 2014 and the broader social policy framework of the Scottish Government, to improve the health and wellbeing of children living in poverty. Actions to prevent and mitigate child poverty at the local level are likely to have direct and indirect impact on child wellbeing, safety and protection. The Independent Care Review has stressed that "There must be significant, on-going and persistent commitment to ending poverty and mitigating its impacts for Scotland's children, families and communities".

REFERENCES AND RESOURCES

When services find it hard to engage

7. Terms: 'Resistance' and 'disguised compliance' (usually meaning disguised non-compliance or non-effective compliance), are terms sometimes used when services find it hard to engage with families. Such terms imply that the location of responsibility for this block lies with children and families.
8. 'Non-engagement' covers a spectrum of failures that are all a product of interaction. The tone of engagement and painful previous experience of services may both play a part.
9. Inclusive protection and support of children involves engaging with the risks and strengths presented by fathers and/or the men that are most significant to the child's safety and wellbeing. This component of protection and support is sometimes absent.
10. Non-engagement on the part of service users may take the form of aggression, manipulation, concealment, superficiality, blaming and 'splitting' professionals, inaction or selective action. Children who experience frequent changes of address within such a pattern may be at increased risk.
11. Effective child protection is a constant search for 'meeting points'. This is likely to depend on appreciation of the feelings and context of avoidant or oppositional communications. These might include fear, distrust, exhaustion, shock, isolation, intoxication, anxiety, depression, stigma, denial, blame, shame, deflection, trauma, attachment history, incapacity or confusion. Some will have had traumatic experience of being coerced and controlled. Others may already have had a child removed.
12. Developing a shared sense of purpose in relation to what needs to change for the safety of a child involves offering choices, respecting proven positives and anticipating difficulties together. Collaboration may also involve some degree of structured coercion, as far as necessary in each situation. This is not inconsistent with work 'in relationship', step by achievable step. Widening the circle should be considered – engaging others who can be partner in relation to the child's safety plan.
13. Development of a working alliance does not include condoning harmful behaviour or conditions. Deviation from a child protection plan must be explored in detail and addressed in practical terms.
14. Co-operation is no assurance of readiness to change, of capacity to change, or of change in the child's experience. Co-operation can only be gauged by evidence of change in those behaviours defined as a necessary focus for the sake of the child's safety.
15. Failures in engagement are interactive – a shared responsibility. Persistent failure in engagement can contribute to significant harm as indicated in the triennial analysis of Significant Case Reviews (Care Inspectorate 2019). When children are subject to compulsory measures, the Principal Reporter must be informed if services cannot gain access. More urgent steps may be taken if necessary, especially if babies and other very young children are involved.

16. Effective co-operation can fail at any point, sometimes rapidly. Anticipation of and planning for predictable cycles of stress response is a necessary part of child protection planning. With most complex and interactive risks, progress is unlikely to be linear.
17. Encouraging hope promotes collaborative goal-setting. Unrealistic goal-setting without sufficient continuity of support will erode the potential to sustain safety. Motivational interviewing (Forrester et al 2012) may provide skills and concepts for approaching resistance, so long as a focus is kept on the child's welfare and safety. Honesty, transparency, curiosity and caution are steps on the road to effective alliance.
18. Solution-focused and strengths-based approaches may be optimal. This should be backed by careful recording, multi-agency assessment and chronology in order to gauge progress and guard against drift.
19. Practitioners encounter hostility and aggression. Sometimes this can be anticipated in the location and planning of some meetings. Sometimes it is necessary to withdraw to minimise risk. In all such situations practitioners should be supported and supervised to ensure retention of focus on the child's safety needs, and to support the wellbeing and safety of staff.

REFERENCES AND RESOURCES

Protection of Disabled children

20. **Disabled children are children first and foremost.** Each child has unique potential. Their needs must be considered in the context of a holistic assessment of the child and the intersecting strengths and risks in their world.
21. **'Disabled children' is a broad term** which may be applied to children with a broad range of physical, emotional, developmental, learning, communication and Healthcare needs. The term is applicable when these needs have a substantial and long-term impact on a child's ability to engage fully in normal day-to-day activities. Some children (and some adults) are affected by disabilities and developmental delays that have never been assessed or diagnosed.
22. **Most parents of disabled children provide safe and loving homes.** Their expertise, commitment, willingness to work in partnership, motivation and hope are potentially strong protective factors.
23. **However,** children with communication impairments, behavioural disorders, learning disabilities and sensory impairments may be additionally vulnerable to abuse and neglect.
24. **Disabled children have an equal right to be safe.** Structures, processes and attitudes may open or close doors to safety. Effective protection requires extra preparation and consideration of the impact of any disability for a child within child protection processes.
25. **The experience of each child must be central.** Their voice and feelings must be heard when people make decisions that involve them. Some disabled children require specific assistance and communication support so that they can share their experience and participate. This must be provided. Some children have profound difficulties in communicating their experience and require special consideration to ensure attunement to their experience, and attention to ensure their wellbeing and safety.

26. **Rights and support:** Disabled children and children affected by the disability of another family member are entitled to support as a child “in need” as defined in section 93(4) of the Children (Scotland) Act 1995 for the purpose of meeting requirements under Part 2 of that Act to safeguard and promote their welfare etc. The Equality Act 2010, the UNCRC (Article 23) and the [United Nations Convention on the Rights of Persons with Disabilities](#) help to reinforce and promote the rights of disabled children.
27. **Protecting disabled children is a shared responsibility** for all involved, requiring close collaboration between specialist practitioners, those leading child protection investigation and parents or carers and advocacy services, as relevant in each situation.
28. **Incidence of abuse of disabled children is likely to be under reported.** Some people may find it hard to believe that disabled children are at risk of abuse.
29. **Invisibility of abuse** is more likely when children are afraid, isolated or do not understand what is happening, and also when those around are not responsive to their distress. Distressed reactions do not necessarily relate to disability. Direct communication with children is essential when there are concerns. Supportive relationships with practitioners who know the child are protective.
30. **Interacting factors:** Risks which may be accentuated by some disabilities can combine with unrelated factors. Interacting factors may include:
 - a child’s dependency on support for communication, mobility, manual handling, intimate care, feeding and/or invasive health procedures
 - a child’s understanding of abusive behaviour and ability to resist
 - availability of sex education and support for understanding
 - a child’s experience of asserting choice
 - availability of a trusted person within or outside the family
 - availability of advocacy and communication
 - fear of abusers, of rejection or blame
 - additional vulnerability to online abuse
 - attachment history, including significant losses, disruptions and trauma
 - neglectful or abusive responses to the child relating to parent or carer needs or cultural attitudes
 - **Harm may be accentuated by** many intersecting contextual factors, including the impact of poverty and housing insecurity; lack of support for parents who have learning disabilities or physical or mental health problems; domestic abuse; parental substance use; family isolation from positive community relationships or professional support; immigration status anxieties; insecurities in relation to leave to remain in the country, access to funds and housing; and abusive, coercive control within the family or care setting.
31. **Barriers to effective protection** can occur at any stage in support and child protection processes:
 - when nobody listens to the child and those who know the child best
 - if the child’s communications and reactions are not understood
 - when there is a lack of curiosity, competence and confidence in exploring reasons for distress or signs of maltreatment
 - when there is a lack of practitioner awareness of the impact of neglect
 - when there are delays or fragmentation in the assessment and sharing of information, or the co-ordination and planning of assessment and support

32. **Some disabled children may behave harmfully to others.** In some situations, a limited understanding (e.g. of boundaries) and reduced self-control may play a part in the interaction of reasons for this.
33. **Training** about the susceptibility of disabled children to abuse is essential in order to build confidence and awareness among those working with children. This includes staff such as bus drivers, care assistants, escorts and personal assistants.
34. **All staff working with disabled children** must have an awareness of child protection processes as described in Part 3 of this Guidance. They must understand and know how to respond when a child may be showing or telling about abuse.
35. **Some roles and tasks require provision of additional training,** guidance and supervision. For example, practitioners involved in child protection investigation will need additional guidance and training in relation to indicators of concern; consideration of a child's wishes, feelings, support and communication needs; and investigative interviewing, as appropriate. There is a need for guidance and training for practitioners working with people with learning disabilities in the field of sexual health and relationships.
36. **Care assistants who are employed directly by parents and carers** may have variable knowledge, skill and training. Access to clear local guidance on self-directed support and safe practice in contracting services is an essential component of preventative strategy that goes beyond the scope of Child Protection Guidance. Guidance on the Disclosure (Scotland) Act 2020, when implemented, will be of relevance.
37. **Significant transitions** require assessment and must be planned in good time, together with parents and carers, in accordance with applicable local procedure. These are phases of heightened and predictable vulnerability, as children move between services or life stages. Disabled children and young adults must be provided with appropriately adapted learning methods and resources so that they can help to keep themselves safe as they grow up.
38. **Child Protection Committees** should be confident that there are local procedures which encompass disabled children. Local procedures should outline the interface of child and adult protection processes in local systems as indicated above. The Third Sector has a significant role with disabled children. Local procedures must describe how child protection concerns are progressed by statutory agencies in partnership.
39. **Robust assessment and data recording processes** support improvement in child protection assessment and planning. For example, when a child has a disability, the type and, if relevant, the severity of that disability should be recorded, along with the implications for the child's support and communication needs.

REFERENCES AND RESOURCES

Parents with learning disabilities

40. People with learning disabilities are all individuals with unique needs. A learning disability affects a person's development, can be significant, and will be lifelong. This means that a person with a learning disability may need help to understand information, learn skills and live a fulfilling life. Some people with learning disabilities also have specific Healthcare needs and require support to communicate. Some people and organisations prefer the broader term 'learning difficulties'. Societal attitudes, service structures and resources impact on the extent to which a learning disability becomes a barrier for people living a fulfilling life.
41. Provisional national statistics indicate there are 23,446 adults with learning disabilities known to local authorities across Scotland. It has been estimated that there may be 5000 parents in Scotland with learning disabilities. The Scottish Learning Disabilities Observatory is developing a national data picture.
42. An estimated 40%-60% of parents with a learning disability do not live with their children. The children of parents with a learning disability are more likely than any other group of children to be removed from their parents' care. This is often due to the context of risk. For example, parents with a learning disability are often confused by services and disproportionately affected by poverty, social isolation, stress, mental health problems, low literacy and communication difficulties.
43. Contextual factors can interact with systemic factors including lack of:
 - strategic leadership
 - worker expertise and understanding
 - inter-disciplinary co-operation
 - sufficient, tailored and sustained support
44. Late recognition of risk and episodic child protection in crisis is neither fair nor effective. By contrast, effective child protection addresses need early and entails assessment, support and planning which:
 - has a focus on the child's needs in connection with the needs of each parent and the strengths and gaps within the family network
 - ensures that parents understand and are involved with what is happening, the reasons for meetings, accessible information, and involvement of advocacy as required
 - includes targeted specialist assessment and co-ordinated, multi-disciplinary support plans
 - looks ahead to long-term needs and different situations, including predictable life transitions
 - is flexible, including a range of assessment methods and support services, some of which are 'at home' and can be adjusted to changing needs
 - is step-by-step, applying appropriate assessment tools and support in order to grow parenting skills on an on-going basis. *Some specific, pre-birth considerations are included in the section on pre-birth support.

REFERENCES AND RESOURCES

Impact of mental health or health problems on children

45. Poor parental health (for both mothers and fathers, both mental and physical) can be a contributor to mental health problems in children and young people. The stigma associated with mental health problems means that many families are reluctant to access services because of a fear about what will happen next. Parents and carers may worry about being judged, and that they will be deemed incapable of caring for their children.
46. Parental use of alcohol and/or drugs can be both a reciprocal cause and effect of mental ill health. Early trauma and current domestic abuse can reinforce a cumulative cycle of harm in which individuals are known to child protection systems. Safety is likely to depend on persistent support for parents with complex interacting difficulties, especially if they disengage or disguise their own struggles when risks to children are rising.
47. Emotional accessibility and the reliability of parents or carers is a key feature of child protection assessment, and should be an objective in the planning of support. Children are affected when a parent is unable to anticipate or prioritise his or her needs, or by a parent's distress, disturbance, delusions and lack of insight. Some children are deeply affected by being separated from a mentally ill parent. Some children take on premature caring responsibilities due to parental illness. Child protection in this context requires compassionate recognition of the child's experience in this dynamic, while remaining focused on the child's needs. Whenever safely possible, widening the circle of support and building on family strengths may be key to sustained protective planning.
48. Adult mental health services should ensure children's safety is considered in treatment and support of parents.
49. Child protection processes often increase feelings of anxiety, stigma and isolation. The tone of engagement can accelerate or defuse risk of harm and self-harm. Recognition of the parent's experience is a starting point.

REFERENCES AND RESOURCES

Children and young people experiencing mental health problems

50. Children can experience a range of mental health problems, from depression and anxiety through to psychosis. While most will recover, many are left with unresolved difficulties or undiagnosed illnesses that can follow them into adult life. Parents and carers may be bewildered or frightened by their child's behaviour, or concerned that they are the cause of such behaviour. Child protection is a crucial component of the service response to children and young people experiencing mental health problems. Local training and policy should reflect the need for awareness of these issues.
51. Every child's needs and circumstances are unique to that individual. There are no single causal connections. However, factors which make it more likely a child will experience mental health problems include:
 - Experience of neglect and abuse
 - long-term physical illness
 - insecurities in primary attachments

- domestic abuse
 - problematic drug or alcohol use and offending
 - bereavement and separation
 - experiences of bullying, discrimination, isolation and exclusion
 - living in poverty or being homeless
 - premature and overwhelming caring responsibilities
 - experience of long-term struggle in educational settings
52. 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 ill Health. For others, a need to control, coupled with lack of insight into or regard for the feelings and needs of others may lead to them preying on the vulnerabilities of other children. Co-ordinated inter-agency work, and close collaboration with parents or carers, is essential to mitigate risks for these children and for others.
53. Mental and emotional wellbeing should be addressed, applying the same principles of early intervention and prevention that underlie the GIRFEC approach to supporting a child's whole wellbeing. There is a range of services that should be available locally to supplement the specialist support that CAMHS can provide, including counselling services in schools, and community wellbeing service support for children, young people and their families. Lead professionals should be aware of the range of potential services in their areas, and able to work with relevant professionals in these services where required and appropriate.
54. Practitioners involved in child protection must be trauma-informed in their approach ([the knowledge and skills framework \(2017\)](#); [the trauma training plan \(2019\)](#)) The pervasive relevance of this concept to child protection work is symbolised in [Figure 2 P4. National Trauma Training Plan/NES 2019](#). Early recognition of and response to the impact of trauma is required, alongside a collaborative response between adult and children's services when a multi-agency plan is needed to protect a child from significant harm.
55. Transitions between placements; schools; child and adult services, stages of recovery and phases of relationship are all zones in which insecurities surface. They require anticipatory and follow-up planning if there is a child at risk of significant harm. Children who have been through criminal justice processes, are looked after, have learning disabilities, identify as LGBT and live in low-income households are all among groups that have a much greater probability of experiencing mental health problems (Audit Scotland 2018). For these reasons, child protection assessment and support planning should consider what we can do to recognise and respond with care to an apparent intersection of vulnerabilities.
56. Children who experience adversity and trauma are, in adulthood, more likely to become parents at a young age, experience poor mental health, use substances, have contact with the criminal justice system, and experience poor physical Health. 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. (Mental Welfare Commission 2019)

57. Unaccompanied asylum seeking children may be particularly vulnerable to mental health problems. They may have experienced traumatic events before arrival. Some will have been trafficked, and some will have on-going fears relating to this, in addition to insecurities about the future. Many will have no awareness of the support available to them, making it difficult for them to access services. Therefore any child protection planning should fit within a co-ordinated, relational and holistic approach, with access to independent advocacy as appropriate.
58. Third Sector and community support is critical. Recommendations made by the Children and Young People's Mental Health Taskforce (Scottish Government 2019) encapsulate a whole-system approach to addressing mental ill Health.

REFERENCES AND RESOURCES

Suicide and self-harm affecting children

59. Suicide is an act of deliberate self-harm which results in death. Self-harm refers to self-poisoning or self-injury, irrespective of the apparent purpose of the act. Self-harm is generally a way of coping with overwhelming emotional distress. Many people self-harm where there is no suicidal intent. However, those who self-harm can be at a higher risk of suicide. Self-harm may combine with other expressions of distress and disturbance. If there are concerns that abuse or neglect are associated with self-harm, child protection processes apply.
60. Suicidal thoughts in children may be triggered by an event. However they are usually caused by an accumulation and interaction of vulnerabilities and experiences. Suicidal thoughts and self-harming behaviour are more common among those children who have been impacted by neglect, abuse, disrupted attachment, rejection, alienation, traumatic separation and loss. Children will also need support when they are impacted by the mental ill Health, self-harm or suicide of others.
61. Parents, carers and peers may be the first to become aware of risk or distress. Frontline workers in Health, education, social care, the Police, the voluntary sector and the prison service need to be alert to circumstances where individuals may be at heightened risk, and should maintain awareness of what to do to support young adults.
62. A trauma-informed initial response can often significantly reduce risk and feelings of pain, isolation and despair. Depending on the immediate urgency of the situation and the capacity, mental and physical state of the person, in almost all instances it will be effective to take time to:
 - take the threat of harm seriously and listen calmly
 - recognise expressed feelings, showing warmth and empathy
 - raise awareness that the person has some control, options and possibilities for a way forward, one step at a time
 - ensure there is more than one person who can be responsive when emotional support is next urgently needed
63. In complex situations, preventative responses are likely to involve prompt multi-agency assessment. This may involve collaboration between children and adult services, and support for family or carers as well as for the child. Awareness of online risks and triggers may be critical for young people whose relationships and emotional fluctuations may be vectored through digital media.

REFERENCES AND RESOURCES

Responding to neglect and emotional abuse

- Neglect covers a broad range of potentially co-existent physical and emotional maltreatment. This includes harm caused pre-birth for example due to parental alcohol and drug use or paternal violence. The causes and effects of neglect filter in to all the other sections in Part 4 of this Guidance.
64. The focus on preventative support in Statutory Guidance on Part 12 of the [Children and Young People \(Scotland\) Act 2014](#) is relevant when children are at risk of becoming looked after. The Independent Care Review states: “Where children are safe in their families and feel loved they must stay – and families must be given support together to nurture that love and overcome the difficulties which get in the way.”
 65. Criminal offences currently termed “cruelty” towards children under 16 years by persons with charge or care of, or parental responsibilities for that child are defined under section 12 of the [Children and Young Persons \(Scotland\) Act 1937](#). These offences are currently subject to consultation and review. These offences include the wilful ill-treatment, neglect, abandonment or exposure to this, in a manner likely to cause unnecessary suffering or injury to health (including mental health).
 66. Emotional abuse and neglect are the most common recorded concerns leading to the placing of children on the child protection register. Children may experience neglect and other forms of abuse at the same time. ‘Lack of parental care’ was the most common ground for referral to the Scottish Children’s Reporter Administration. (SCRA 2018). The average age for such referrals was 6 years. Practitioners will be aware of the urgency and need of a supportive response when very young children are involved. Teenage neglect is less often recognised.
 67. Single incidents of extreme neglect can be significantly harmful. However, neglect and emotional abuse are usually associated with the term ‘persistent’. This refers to a pattern, which may be either continuous or intermittent, which has either caused or is likely to cause significant harm. For example, neglect may involve lack of physical care, including care for health and safety, the unreliability or unavailability of emotional care, and lack of developmental care.
 68. Emotional abuse includes parental behaviour or exposure to adult behaviour that evokes fear, humiliation, distress, despair and a closing down of self-expression. This can cause immediate and long-term harm, because of the traumatic impact, the impact on development and how a child learns to feel about themselves, their relationships and the world. Extreme overprotection can also impair development. The effect of these harms are complicated when parents place all the responsibility for troubled or frozen behaviour on to the child.
 69. Practitioners must be able to describe the interactions of concern. There must be a basis for the belief that these will be harmful. Descriptions in plain language are more useful than non-specific general terms like ‘emotional abuse’.

70. A proportionate response to concerns requires an awareness of healthy development at each age and stage, and contrasting indicators associated with the need for support. For example, it is necessary to be curious about the reasons for:
- abnormally quiet and unresponsive infants with signs of developmental delay.
 - pre-school children who show abnormally frequent and persistent aggression and frustration; or who may be withdrawn, watchful and avoidant of parents or carers; or indiscriminate in their affectionate with strangers.
 - primary school age children who show an abnormally poor attention span, lacking an ability to be absorbed in play either alone or especially with others, who lack confidence and self-esteem and show unusual impulsivity and sharp mood swings, or an abnormal lack of concentration, confidence and/or social skills.
 - children in secondary school who show an abnormal lack of self-confidence, who lack trust in others, are self-isolating or have difficulty sustaining friendships, who steal, bully others, run away, or who show signs of eating disorders, self-harm or depression.
71. Signs of concern may be physical, emotional, behavioural, educational or relational. Some concerns are visible. However, there are neglected children who are abnormally quiet and compliant and become invisible. The experience and impact of neglect is individual to that child, just as the intersection of causes is distinctive in each situation. Practitioners who are involved in assessment, planning and support must try to understand the quality of daily life experience and relationships of the child and their parents. That may take time.
72. Domestic abuse, parental alcohol and drug use, isolation, poverty, chronic or acute health problems and severe housing stress are common examples of factors that can contribute to conditions and interactions that cause harm. Some cultural groups may experience disproportionate deprivation. They are also more likely to experience confusion and disempowerment within statutory decision-making systems (Henderson, Kurlus, SCRA 2017). In all situations, respect for culture and recognition of the context of harmful interaction promotes the likelihood of effective engagement.
73. Affluence and achievement can also be isolating, and sometimes mask emotional neglect. It may take much longer to recognise what is absent. Developing a supportive working relationship with articulate, well-resourced and high-achieving families requires a confidence in role, skill, sensitivity and honesty, as well as keeping the child's experience as the central focus.
74. Persistent neglect can have a lifelong impact, and may be associated with the onset of physical and mental health problems, suicidal behaviour, eating disorders and obesity, alcohol and substance abuse, aggression, violence and criminal behaviour, high-risk sexual behaviour and homelessness. These are not inevitable consequences. Many parents who have experienced chronic neglect find ways forward and succeed in sustaining safe and loving care for their children. Some struggle to recall feelings associated with past trauma or deprivation.
75. The effects of neglect and emotional maltreatment may emerge in troubled or depressed teenage behaviour. Neglect may cause an increased vulnerability to exploitation, harmful and self-harming behaviour in teenage years. These patterns can contribute to neglect in the next generation. Young parents who have been neglected are more likely to need additional support to tune in to and build secure attachment with their own children. Parenting challenges tend to expose past hurts. Practitioners should seek to understand what lies behind neglectful behaviour and build on positive skills and relationships in order to increase safety and resilience through stressful times.

76. Protection of children from harm depends on early, inter-agency support in collaboration with parents, before the urgency of risk of significant harm draws children in to child protection systems. Uncertainties about definitions and thresholds can delay recognition and support.
77. Early signs of neglect must be taken seriously. Provision of early help can defuse the need for child protection processes. An Inter-agency Referral Discussion becomes necessary when there is reason to believe the impact of neglect or emotional abuse could lead to significant harm.
78. The impact of neglect and/or emotional abuse upon a child will be affected by how early maltreatment occurred, the severity and type of maltreatment, the response of the child (which may include shame, anger and self-blame), the nature of relationships within which neglect occurred, and any steps taken to safeguard, protect or support the child during neglectful phases.
79. A comprehensive health assessment is recommended as part of a multi-agency assessment for all children where chronic neglect is a concern. Assessment and planning must be co-ordinated, collaborative and practical, addressing specific risks and the way risks interact. Plans should also be clear about the transfer of professional responsibilities at times of transition.
80. A structured framework for assessment of neglect is recommended in order to improve the quality and consistency of assessment. Practitioners who are confident about their use are more likely to promote purposeful, step-by-step working relationships with parents. The Graded Care Profile (GCP) (Srivastava 1997) has been adapted and used since 2009. Version 2 of this framework has been evaluated (NSPCC 2018) and adaptations are being tested in some parts of Scotland.
81. Strength based approaches and a systematic, structured approach to assessment can be applied together. At all junctures in assessment, planning and support, the aim is to find a meeting point and shared understanding about what needs to change to keep the child safe and well, and how this will be achieved within a timescale that is right for the children involved. This clarity is essential in the context of compulsory measures.
82. The [concept of capacity to change](#) may promote transparency of goals, methods, shared responsibilities and timescales. Advocacy and Third Sector supports may play a key part in motivational support and work for change.
83. When children have experienced chronic neglect, they may not be used to adults being or becoming predictable, kind and nurturing. They can be distrustful and anxious, and may behave in ways that seem rejecting or angry. This is demanding for parents or carers seeking to offer a secure base and safe home. To prevent secondary harmful cycles occurring when children are accommodated, carers and children may need additional support in understanding and response to these dynamics.
84. When children have had to be removed from parental care in cases of neglect, effective child protection leads into careful assessment of re-unification and transitional support needs. For example, NSPCC resources designed for use within English legislation offer guidance (NSPCC 2015). ([Reunification: An evidence-informed framework for return home practice](#)). Progress is rarely linear and final. Any good plan should include sufficient continuity of, or access to support for predictable and unpredictable crises.

REFERENCES AND RESOURCES

Domestic Abuse

85. This section has a focus on child protection response. Further detail is provided in appended links to practice notes.
86. **Definition:** Domestic abuse is any form of physical, verbal, sexual, psychological or financial abuse which might amount to criminal conduct and which takes place within the context of a relationship. The relationship may be between partners (married, cohabiting, in a civil partnership or otherwise), or ex-partners. The abuse may be committed in the home or elsewhere, including online. Domestic abuse includes degrading, threatening and humiliating behaviour predominantly by men and predominantly towards women. It is a gendered crime and is underpinned by attitudes and inequalities between men and women that continue to be prevalent in society. It may be committed in the home or elsewhere; and may include online activity. There is significant evidence of links between domestic abuse and emotional, physical and sexual abuse of children, and children themselves can experience domestic abuse as ‘coercive control’ of the whole family environment, not just of their mother.
87. **Prevalence:** There were 60,641 domestic abuse incidents known to Police Scotland in 2018-2019. This was a 2% rise from 2017-2018. In 2018-19, 2,673 children were referred to the Reporter under section 67(1)(f) of the Children’s Hearings (Scotland) Act 2011, due to a “close connection with a person who has carried out domestic abuse”. (SCRA 2019). This does not include children referred on other grounds who may also have experienced domestic abuse. For the estimated 2,668 children on the child protection register at 31 July 2018, there were 6,830 concerns relating to domestic abuse at the case conferences at which they were registered.
88. **Violence against women and girls** refers to a range of actions that harm, or cause suffering and indignity to, women and children. These include but are not limited to physical, sexual and psychological violence in the family, general community or in institutions. This includes domestic abuse, rape, incest and child sexual abuse; sexual harassment and intimidation at work, online, at home or in public; commercial sexual exploitation including prostitution, pornography and trafficking; and so called ‘honour-based’ violence, including dowry-related violence, female genital mutilation, forced and child marriages, and ‘honour’ crimes. The Scottish Government’s definition of violence against women and girls is based on the United Nations Declaration on the Elimination of Violence Against Women. (Equally safe: national strategy).
89. **Offence:** The criminal offence of Domestic Abuse is detailed in sections 1 and 2 of the Domestic Abuse (Scotland) Act 2018. Offences cover behaviour likely to cause a partner or ex-partner to suffer physical or psychological harm (including fear, alarm and distress). This can range from behaviour that is violent, threatening or intimidating or has effects such as dependency, isolation from friends or family, controlling, depriving or restricting freedom of action or which is frightening, humiliating, degrading or punishing.
90. Statutory aggravation of the offence in relation to a child is defined at section 5 of the 2018 Act. This applies if a child sees, hears, or is present during or is likely to be adversely affected by the offence of domestic abuse. There does not have to be evidence that the child is aware, understands or has been adversely affected by the domestic abuse and a single source of evidence is sufficient for the offence to be aggravated.

91. **Emotional and psychological harm.** Children are harmed by experiencing behaviour that is, intimidating and degrading, threatening, exposing of intimate information, or accusing and blaming. Coercive and controlling behaviour is also harmful. Examples of coercive and controlling behaviour include when the child and non-abusive parent are isolated from friends and family, or when abusers cut off the non-abusive parent's access to a phone or a bank account. Chronic trauma can disrupt attachment, achievement, concentration and wider relationships. The traumatic impact of domestic abuse is often masked, and emerges indirectly in anxious or troubled behaviours in teenage years. As highlighted throughout this guidance, a trauma-informed approach is required by all involved practitioners (NES 2019).
92. **Abuse between young people:** Young people may experience abuse and coercive control in their own relationships outside of the family home. As within adult domestic abuse, this can include physical, sexual and emotional abuse. This is often unrecognised, and victims may choose not to disclose. Social media and digital technology may be used to perpetrate abuse.
93. **Response:** Members of the public or non-statutory services concerned for the safety of a child or parent should contact Police Scotland or Social Work. As far as possible, taking into account the urgency of the situation, this should be in collaboration with the non-abusing parent/carer.
94. On all occasions when children are present during an incident that requires the police to attend, officers in attendance will consider all information, including previous incidents, to assess whether there is a child wellbeing or protection concern. Information about the incident will be considered for sharing by Divisional Concern Hubs with appropriate statutory and non-statutory agencies who have support, wellbeing or health responsibilities, or who provide domestic abuse advocacy services (COPFS 2019).
95. The child protection response by statutory agencies will depend on professional judgement about the risk of harm and the urgency of the circumstances. Domestic abuse is always a wellbeing concern. It may be a child protection concern if there is evidence that significant harm has occurred or may occur. Professional judgement involves consideration of key factors such as the child's experience, needs and voice (and those of other children affected); the non-abusing parent's views, choices, strengths and abilities to use available supports; the presence of other complicating factors such as parental alcohol and drug use; and the abuser's pattern of coercive control.
96. Only where professional judgement indicates the likelihood of risk of significant harm, an IRD will be triggered as outlined in Part 3 of this Guidance.
97. In some cases the risk from the perpetrator is very high. Multi-agency planning and partnership with the non-abusive parent must protect the child. It can be difficult to achieve safe collaboration with a non-abusing parent/carer if they deny, or do not recognise, the risk posed by the perpetrator towards the child.
 - **GP and hospital services** must be alert to the needs of victims of abuse, and especially those who are pregnant and have mental Health, drug and alcohol difficulties. Domestic abuse may begin during pregnancy.
 - **Third Sector organisations**, such as Scottish Women's Aid, play an essential role in developing and providing services for women. A National Domestic Abuse and Forced Marriage Helpline is open 24/7, 365 days a year. This is available for professionals seeking advice, as well as for individuals who are at risk of or experiencing domestic abuse.

98. **Disclosure Scheme for Domestic Abuse Scotland (DSDAS)** aims to provide a way of sharing information about a partner's abusive past with a potential victim. It gives people at risk of domestic abuse the information needed to make an informed decision on whether to continue the relationship. Disclosures are only made where it is lawful, proportionate and necessary to do so.
99. **Sex Offender Community Disclosure Scheme (Keeping Children Safe)** was introduced across Scotland in 2011 and is managed by Police Scotland. The scheme enables parents, carers or guardians to make a formal request for information about a named person who may have contact with their child if they are concerned that he or she may be a risk to their child's safety and wellbeing. A review was carried out in 2017, following which an online application form was developed to make the process more accessible.
100. In cases where Police Scotland believes that an individual poses a risk to the child concerned, discussions will take place with partner agencies, and steps agreed and progressed to ensure the child's safety. Where applicable, relevant information is provided to the child's parent, carer or guardian.
101. Police Scotland provides governance and co-ordination for the scheme to ensure it is publicised widely and embedded in national Police training.
102. **Multi-Agency Risk Assessment Conferences (MARAC)** are local meetings where representatives from statutory and non-statutory agencies meet to discuss individuals at high risk of serious harm or murder as a result of domestic abuse. A referral to a MARAC should be considered at the point this risk is identified. MARACs can play a vital role in terms of safety planning for victims of domestic abuse and their children. Safelives, a UK-wide domestic abuse charity, has developed a suite of resources to help ensure that each MARAC keeps as many victims of domestic abuse as possible safe.
103. **Multi-Agency Tasking and Co-ordination (MATAC)** is a Police Scotland-led and chaired initiative to identify and manage the most harmful domestic abuse perpetrators. MATAC aims to effectively tackle offending by domestic abuse perpetrators who present the greatest risk of harm. It does this through:
 - effective partnership working to identify those domestic abuse perpetrators who present the greatest risk of harm.
 - multi-agency information sharing to support intelligence development and proactive enforcement action against identified perpetrators.
 - using tasking and co-ordination to proactively investigate identified perpetrators, using relevant and legitimate tactics.

Systematic responses

Safe and Together

The Safe and Together Model is based on partnering with domestic abuse survivors and intervening with domestic abuse perpetrators in order to ensure the safety and wellbeing of children. The Safe and Together* approach includes principles and elements essential to safe practice. These are to:

- keep the child safe with the non-abusive parent
- form a supportive partnership with the non-abusive parent
- hold the abusive parent accountable for their abuse

Within this approach, practitioners from statutory and non-statutory agencies work collaboratively and reach consensus to ensure the safety and wellbeing of children living with domestic abuse (Humphreys, Healey and Mandel 2018). Practitioners will:

- locate responsibility for the abuse with the perpetrator and recognise their abuse is a parenting choice
- get as much information about fathering and father's parenting choices as about mothering and find out about the pattern of abuse and how this affects choices available to the non-abusing parent
- explore the perpetrator's pattern of coercive control to identify all forms of abuse and control in both current and previous relationships, rather than outlining singular incidents of physical violence
- assess how abuse has harmed the child, including descriptions of direct physical, emotional and sexual abuse from the perpetrator to the child, as well as the way in which the domestic abuse has harmed them
- assess wider wellbeing impact upon the child
- define how the non-abusing parent has promoted the safety, wellbeing, stability and nurture of their children
- assess the interaction of other factors like substance abuse, mental Health, culture, and how other socio-economic factors are considered and addressed

The Caledonian System is implemented in many Scottish local authorities (2019). This is an integrated approach to address men's domestic abuse and to improve the lives of women, children and men. It does this by working with men convicted of domestic abuse-related offences on a programme to reduce their re-offending while offering integrated services to women and children. The Men's Service uses a challenging but trauma sensitive approach with cognitive behavioural techniques to encourage men to recognise their abuse and take responsibility for themselves and their relationship with their ex/partners and children. The Women's and Children's Services support women and children and advocate for their rights. Men will be referred to the programme if they have been convicted of offences involving domestic abuse.

Learning from lived experience: bridges to safety

The following features of practice have been associated with safer practice by those consulted in review of this Guidance.

- finding a safe way to talk to non-abusing parent in private (away from perpetrator)
- ensuring children's experience and views are given due weight in decision-making, especially about contact
- recognising positive steps to protect the child
- responding early within universal services, including early referral to specialist domestic abuse services
- applying training, experience and supervision that generates an informed understanding of the dynamics of domestic abuse
- supporting the non-abusing parent, which in turn supports the child
- understanding when a non-abusing parent's ability to effectively parent has been compromised by the perpetrator's abuse, and providing support accordingly
- recognising and integrating protective factors in safety planning
- supporting children in finding an advocate who they trust
- being clear about confidentiality, and explaining to children and women what information will and will not be shared about them, why and with whom
- being aware of the consequences of sharing information with perpetrators, and taking heed of women's and children's fear of reprisal from a perpetrator

104. **Child abduction in the context of domestic abuse.** [Section 6](#) of the Child Abduction Act 1984 creates a criminal offence in Scotland for a person connected with a child under 16 to take or send the child out of the UK without appropriate consent where there is a UK court order in place awarding custody of the child to any person or which makes the child award of court or where there is a UK court order in place prohibiting the child's removal.
105. Where no such court order is in place, the parent or person with rights of custody can use civil law under the 1980 Hague Convention on the Civil Aspects of International Child Abduction to seek return of the child, or access rights. Where the country to which the child has been abducted is not a party to the Hague convention, advice should be sought from the Foreign and Commonwealth Office (FCO).

REFERENCES AND RESOURCES

Children and families affected by alcohol and drug use

Guidance on neglect domestic abuse and pre-birth child protection are adjacent in this section and closely inter-related.

106. **Public, child and family health:** Parental alcohol and drug use is a significant public health problem present in all income groups, cultures and areas of Scotland. Directly and indirectly, it contributes to the abuse and neglect of thousands of children and can cause harm through various forms of loss, through imprisonment, illness, disturbed and broken relationships and death. Parental alcohol and drug use overlaps and intersects with domestic abuse, neglect, emotional abuse and parental mental ill health as a dominant reasons for child protection registration and the need for children to be Looked After. There is a strong link between problem drug and alcohol use, deprivation, and trauma. In this context compassion, understanding and workforce resilience are essential within effective child protection.
107. **Prevalence:** The availability, relative cheapness and social acceptability of alcohol make it the substance with most widespread impact. Alcohol-related deaths are twice as high in Scotland as the rest of the UK. Over the last ten years, drug-related deaths have risen in Scotland and are the highest in Europe. Opioids are implicated in most drug-related deaths. In May 2016, the Psychoactive Substances Act 2016 came into force across the UK. The 2016 Act creates a blanket ban on the production, distribution, sale and supply of psychoactive substances in the UK (which is underpinned by criminal offences and civil sanctions). However, novel psychoactive substances are still a growing cause of harm. NHS Scotland estimates 55,800 to 58,900 individuals had substance use problems in 2015/16. Of these, 71% were male, concentrated in the 15-24 age bracket. Drug problems in people aged over 35 is now a growing issue.
108. **Significant harm** is not an inevitable consequence of parental alcohol and drug use. The probability of significant harm will relate to the extent to which each child's needs (as considered within the context of the My World Triangle) are met, blocked or disrupted by the causes, cycle, circumstances and consequences of seeking, paying for, using and experiencing substances by the parent(s). The significance and urgency of the impact will depend on factors to do with the drug, the pattern, the parents, the child, and the multi-dimensional impact upon safety, Health, nurture and, by chronic interaction, to all aspects of wellbeing. Every drug-related concern about a child has a distinct context, history and degree of urgency.
109. **Harm may be multi-dimensional**, affecting physical and mental health and development, relationships, behaviour, identity and survival. This could include physical and neurological damage, or death in utero. Foetal Alcohol Spectrum Disorder (FASD) is the leading known worldwide preventable cause of neurodevelopmental disorder, with maternal use of alcohol during pregnancy leading to learning and behavioural difficulties. It potentially has lifelong implications, affecting not just babies and children but also young people, and adults and their families, who will be living with the impact of the condition. Where child protection concerns in pregnancy include the use of alcohol, this must form a focus for multi-agency support.
110. It is essential to consider and take steps to safeguard children from harm caused by access to substances in the home.

111. Children affected by parental alcohol and drug use may experience neglect, feelings of fear, blame, abandonment, anger and shame. Children who may not be recognised as Young Carers may have to care for children, or for adults. Secrecy and denial are recurrent features within families affected by alcohol and drug use. Divisions occur within families where there is pressure to contain knowledge of substance use. Children's potential to experience and develop trusting, secure relationships are compromised. Many parents feel marginalised outside the home, and inside the home they do not know how to acknowledge or discuss their substance issues with their children. Stigma accompanying parental alcohol and drug use affects children, locks in secrecy and remains a barrier to connection with universal services, treatment and support.
112. **Child protection approach.** Although specialist assessment and support may be required, key elements of the general approach to assessment, and of the steps indicated in parts 2b and 3 of this Guidance, apply.
113. **Parents value** clear, consistent and honest messages about their progress when delivered in the context of trusted relationships and intensive support. Parents need holistic help that takes into account damaging early-life experiences (Dawe et al (2018)). Parenting and fatherhood-focused interventions should be considered within substance abuse treatment programmes, unless there are compelling (e.g. child safety) reasons not to do so. Child protection planning should not be exclusively reliant on maternal change and responsibility. Aims, methods, steps, choices, expectations and lines of communication should be crystal clear to all involved, especially parents and children. Components will be tailored to needs and resources. Parents under Pressure is an example of an intensive, modular, community-based programme which has been subject to robust evaluation (Barlow et al 2018).
114. **Capacity to change and decision-making:** It may be very difficult to predict parenting capacity with confidence. When assessment relates to the risk of significant harm, the assessment should include an evaluation of [capacity to change](#) within a timescale that will meet the child's needs. A combination of practices may be required to support safe decision-making and to offset the risk of selective attention to information confirming previous judgements. This combination may include the use of approved, structured risk assessment tools, careful assessment of family functioning, and involvement of families in shared decision-making around the nature and focus of child protection plans.
115. **Professional judgement** about the likelihood of significant harm involves multi-agency consideration of the interaction, accumulation, immediacy and likely continuity of risks and strengths in each situation. Parental needs may obscure the child's needs. Drug use may bring on mental health disorders in a reciprocal and cyclical manner. Mental disorders can also lead to drug use, possibly as a means of 'self-medication.' Parents experiencing anxiety or depression may rely on alcohol, tobacco, and other drugs to temporarily alleviate their symptoms. Both drug use disorders and other mental illnesses are influenced by overlapping factors such as genetic vulnerabilities, early trauma, or the current experience of domestic abuse.
116. **Connected child protection:** Follow-up support is required for parents who have involuntarily lost their children through child protection and permanence processes, in order to anticipate and prevent a repeat cycle of risk, separation and loss.
117. **Policy, strategy and local process:** The Scottish Government aims to make stronger links with housing, education and justice to focus recovery from parental alcohol and drug use and support beyond Health. The national approaches to alcohol and drug harms are outlined in Rights, Respect and Recovery (Scottish Government 2018) and the Alcohol Framework (Scottish Government 2018).

The Framework to Reduce the Use of and Harm from Alcohol and Drugs (Scottish Government/ COSLA 2019) describes the roles of Alcohol and Drug Partnerships and governance within Integration authorities. Audit Scotland (2019) has reported on the efficacy of current approaches. Child Protection Committees, Adult Protection Committees and Chief Officers must work together to ensure local procedures, services and assessment frameworks are in place, that transitional protocols are in place for vulnerable young adults. and that there are evaluative mechanisms to ensure an understanding of how well services are working locally in relation to child protection response in this context.

118. **Substances, policy and law:** While non-specialists should not be expected to know or judge compound details, a broad sense of the landscape may be helpful. Introductory training tools and graphics may be accessed at ([Adley/UK Drugwatch 2017](#)). A recent Scottish Parliament research briefing summarises legislation and policy (Davies 2017).

REFERENCES AND RESOURCES

Physical abuse, Equal Protection, and restraint

119. Physical abuse is the causing of physical harm to a child or young person. Although there is a distinction between inflicted and non-inflicted physical harm, some accidents may be attributed to neglect and lack of supervision. This might include exposing a child to parental alcohol and drug use or domestic abuse, which may constitute an 'aggravation by reason of involving a child' under section 5 of the Domestic Abuse (Scotland) Act 2018, for the purpose of the domestic abuse in section 1(1) of that Act.
120. Professional guidelines and evidence reviews are available about assessment of suspected physical maltreatment, including, for example: suspicious bruising; human bite marks; burns and scald; fractures; inter-cranial injuries; abusive head injuries and facial or mouth injury.
121. Concerns are heightened if there is no explanation for the injuries, explanations shift during assessment, explanations do not fit the injuries, or there are unreasonable delays in seeking treatment. In relation to fractures, no one fracture in isolation is specific for physical abuse. The younger the child, the greater the likelihood of abuse. The majority of abused children with fractures are less than 18 months old, whereas most accidental fractures occur in children over five years. Bruising is the most common presenting feature of physical abuse in children. Accidental bruising increases with increased mobility. The presence of bruising in infants who are not independently mobile, including those who are not yet crawling or walking independently, requires thorough investigation, as it is extremely rare for a non-mobile infant to sustain accidental bruising.
122. In some instances, despite medical examination, there will be continuing uncertainty about explanations for injuries.
123. The need for and nature of any immediate action will relate to considerations including the child's presentation, apparent fears, the significance of the injuries, the attitude of responsible adults to the injuries, the likelihood of contact with a person who may have caused the injuries and the availability of a safe and responsive parent or carer.

Equal Protection

124. The [Children \(Equal Protection from Assault\) \(Scotland\) Act 2019](#) fully comes into force on 7 November 2020. The common law defence of “reasonable chastisement” will be removed (section 1 of the Act). Under section 2 of the Act, which came in to force on 8 November 2019, the Scottish Ministers must promote public awareness and understanding about the effect of the Act. The Act is consistent with the growing body of international evidence showing that physical punishment of children can lead to long-term negative outcomes.
125. The Lord Advocate has stated that he will issue guidelines to the Chief Constable of Police Scotland on the investigation and reporting of allegations of assaults by parents or carers on children. Those guidelines and prosecutorial policy will support a proportionate response to allegations of assaults on children by parents and carers. When appropriate, that response may include the use of informal response by the Police, recorded Police warnings, diversion and other alternatives from prosecution.
126. In relation to child protection processes the general considerations in Section 2b of this Guidance on assessment, and Section 3 on steps in child protection processes, apply.
127. When concerns fall short of the significant harm threshold, this must not stop the provision of proportionate co-ordinated support. There may be some variation in family, community or cultural attitudes to parenting, for example in relation to reasonable discipline. Cultural sensitivity is essential alongside practitioners’ central focus on a child’s needs for protection from harm; and the needs of a family for support to reduce stress and associated risk.
128. Where there is an apparent need for compulsory measures, consideration will be given to referral to the Reporter.

Restraint

- ‘Restraint’ may be defined as an act carried out with the purpose of restricting an individual’s movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference, for example removing someone’s walking frame to prevent them moving around (Equalities and Human Rights Commission 2019).
129. Restraint usually involves a parent, carer or professional making physical contact with a child, although there may be examples of indirect restraint for people with disabilities or young children which prevent access or egress. Restraint is to be distinguished from punishment in that it is for the purposes of protection, not discipline. Restraint, if used inappropriately, excessively or harmfully, could result in a charge of assault being brought.
 130. Use of restraint carries risks and can be extremely damaging to children and young people. It may, however, be the only realistic response in some situations and as a last resort (for example, to prevent a child running into a busy road or to prevent a violent act against another person). Adults should do everything they can to understand the child before using restraint, especially if the child is upset or frightened. Restraint should never hurt a child, and it should only ever happen for the shortest time possible. Restraint should never be used as punishment, or as a way to make someone ‘behave’.

131. Children with communication difficulties, learning disabilities, autistic spectrum conditions and mental health difficulties are especially vulnerable to inappropriate use of restraint in education, health and social care settings. Wherever possible use of restraint should be avoided. Agency protocols must support proactive, preventative, non-restrictive responses to distressed and challenging behaviour. This begins with forming an understanding of the needs behind the behaviours, and forming strategies with each individual child to protect their safety and rights, and those of others involved.
132. In line with the Health and Social Care Standards (2017), Children receiving services through the NHS, as well as services registered with the Care Inspectorate and Healthcare Improvement Scotland, should be able to expect that while they will be kept safe and protected from avoidable harm, any intervention that he/she experiences is safe and effective. This requires appropriate staff training and development, supervision and support.
133. The physical and psychological impact of restraint must be considered. Physical restraint provokes strong feelings and children may be left physically or emotionally hurt. Even if a child has not directly experienced restraint, they may be scared that it will happen in future or have been upset by seeing others restrained.
134. In order to avoid a breach of a child's rights, restraint must be lawful, necessary and proportionate. The key question for everyone involved with children and young people who express distressed behaviour should be: "What is in the best interests of the child and/or those around them in view of the risks presented?"

REFERENCES AND RESOURCES

When obesity is a cause for escalating concerns about risk of harm

135. Severe obesity is not an automatic flag for child protection concerns. However NHS Scotland Standards (2019) have been developed in recognition of the complexity of the condition and in view of some situations in which significant harm or death may result from neglectful circumstances.
136. A child's health condition and sustained recovery is likely to be influenced by a complex interaction of factors such as physical, emotional and cognitive abilities, environmental, familial and social issues. Professional curiosity is necessary and practitioners should be alert to the possibility of neglect and need for support due to an interaction of such factors.
137. If efforts by health services to provide information, guidance and support have been unsuccessful due to avoidance, hostility, denial, inability or unwillingness to follow essential clinical advice to prevent harm, these would be strong indications of the need to escalate concern. It will be essential to understand and address the barriers to teamwork around the child's or young person's needs, without delay.

REFERENCES AND RESOURCES

Child Sexual Abuse

138. **Definition:** Child sexual abuse (CSA) is an act that involves a child under 16 years of age in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening.
139. For those who may be victims of sexual offences aged 16-17 and who are at risk of significant harm, child protection procedures should be considered, and must be applied when there is concern about sexual exploitation or trafficking.
140. **Sexual abuse 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, indecent images, or in watching sexual activities, using sexual language towards a child, or encouraging children to behave in sexually inappropriate ways. Children who experience sexual abuse may experience multiple forms of abuse and neglect within and beyond the family.
141. **Overlapping categories of sexual abuse** are represented in the diagram below. All require a child protection response. A child may experience multiple forms of maltreatment from different persons. Exposure to other forms of harm, such as domestic abuse or parental alcohol and drug use, may increase vulnerability to sexual abuse.

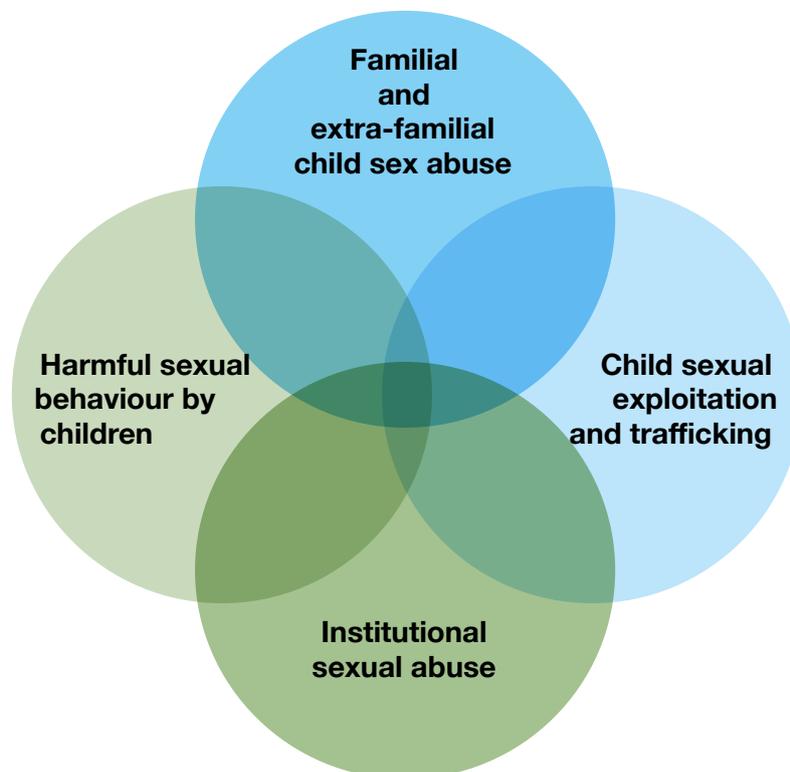


Figure 1: Intersecting forms of sexual abuse(Barnardos)

142. **Children rarely come forward to disclose sexual abuse**, especially when it occurs within the family network. Therefore, parents, professionals and the public must be aware of potential signs of child sexual abuse. This includes recognising indications of abusive relationships between an adult and a child, or between two children. Sexual abuse in the family may be perpetrated by a family member (including a member of the extended family) or by a person close to or known to, the family, such as a neighbour, family friend, partner of a parent, or another trusted adult. Children under the age of 18 may also sexually abuse others within the family. Children under the age of 18 may also sexually abuse others within the family (as indicated in para 194-7 below.)
143. **Abuse of power and trust**, secrecy, trauma, a realistic or an imagined fear of the consequences may all paralyse the ability of many victims to speak out, or cause subsequent retraction. Some children may be unable to seek help because of their age, understanding or disabilities. There may be underreporting in some communities if dynamics such as obedience to paternal authority, shame and family honour act as isolating factors. It is common for survivors not to disclose the fact of the abuse until adulthood. For some, feelings of fear and shame are a permanent block to sharing, even if the abuse happened a long time ago.
144. **The person that may first hear, realise or suspect** that a child is being abused may be a non-abusing parent, sibling, friend, carer or keyworker. This could be at an unexpected moment, in a moment of high stress, or in a moment of sufficient safety. Third Sector organisations may be crucial intermediaries. The response of those to whom a child signals alarm may determine what the child then shares. Sometimes children try to tell or signal their anxiety and this is not heard. Some 'telling' happens indirectly through presentation, and sometimes the telling happens gradually.
145. **What a child needs** when trying to share or signal an abusive experience for the first time is likely to depend on age, understanding and context. It may depend on whether the child is in a state of crisis or acute fear, or whether it has become possible at that moment because the intuitive or learned sense of safety with the other person provides enough containment to allow painful experience to be shared.
146. **Most children need to know they have been heard** and that how they feel has been recognised by someone who has remained quiet and calm and has not suggested details or judged actions. Sometimes this may include hearing confused feelings about the abuser. In most situations the child will need to know that the listener cares for them and will help to keep them safe, but cannot keep secrets that are harmful to the child (or to others), and will have to talk to someone else about how best to help. The person first hearing or recognising the abuse can help by keeping the door open for the child to talk further. The child may need support in getting through the rest of the day or night, as feelings of fear and exposure can rise. They may need to feel they are not alone, that there are people who will listen and help, and that there are also people who do not need to know.
147. **Indicators of abuse** of a child may be physical, behavioural, social or psychosomatic. For example, they could include a combination of: concerning changes in behaviour at home or in school; avoidance of an adult; sexually inappropriate behaviour; health anxieties such as soreness in the genital and anal areas; sexually transmitted infections; pregnancy; and other indirect signals of anxiety. These may include feelings of isolation, stigma and difficulty in trusting others; sexualised behaviour, low self-esteem, withdrawal, aggression and disruptive behaviours; self-destructive behaviours and/or substance abuse. None of these examples are in themselves signs of sexual abuse. All necessitate professional curiosity about what lies behind these symptoms.

148. **Contextual considerations.** Practitioners involved in assessment, planning and intervention should consider the dimensions of risk ‘online’, in the family, and in the community. There may be a concentration of risk in specific locations.
149. **Investigative components and processes** when there is a concern about risk of significant harm are outlined in Part 3 of this Guidance. They should be co-ordinated and multi-disciplinary. When required, joint investigative interviewing will be carefully planned and trauma-informed. The national approach will be supported in forthcoming revised guidance. All practitioners should be trauma-aware. There must also be recognition that the process of sharing may not be a neat single event. Detail or experience may be released in fragments, at times, in a manner, and with persons determined by the child.
150. **There is no single cause or explanation for the occurrence of child sexual abuse (CSA).** The internet is a powerful vector for the development of the demand for sexual images of children and for sex with children. Perpetrators have often experienced traumatic maltreatment themselves as children. Some but not all are sexually fixated on children. Confused boundaries and parental use of alcohol or drugs can contribute to an environment in which multiple harms occur. Some children are more vulnerable to predatory behaviour due to age or disabilities.
151. **The impact of CSA** is affected by the interaction of many factors including the age when it started, the nature and duration of the abuse and the relationship with the perpetrator. There are many mediating variables to do with non-abusive adults, the child and their wider environment. A distinctive interaction of risk and resilience factors plays out for each person in their world, over time. Effects often endure throughout adult life. They affect physical and mental Health, family and intimate relationships, faith, education and work. Victims and survivors can also be more likely to experience sexual, physical or emotional abuse again (Fisher et al 2017). Those traumatised by CSA may be disproportionately represented in prison, homeless facilities and psychiatric care (Nelson 2017).
152. **Supervision and training** is essential for development and support of the skills and knowledge that opens rather than closes doors for children; and informs confident work with families. Practitioners need both critical consultation and support in emotional territory that may have disturbing resonance.
153. Child protection practitioners should be reflective about political discourse on child sexual abuse, and the potential impact upon the response to concerns about it (Lovett 2018 p12). There have been fluctuations in reporting of sexual abuse in the UK. This may be linked to fluctuations in public awareness and attitude following high profile inquiries.
154. **Prevention, interruption and deterrence** of child sexual abuse requires strong collaborative intent within national policy, public and community education, parenting support, and evolving technological strategies. Children’s Services Plans provide an opportunity to develop community or parent/child-focused prevention strategies to aid the identification or prevention of child sexual abuse in the family environment, as well as the recognition and interruption of wider exploitation. Child protection guidance is just a part of the foundation for protective action.
155. **Resources supporting early recognition and prevention** of child sexual abuse have been developed for individuals, families and practitioners by ‘Stop it now’ (Scotland) at: <https://www.stopitnow.org.uk/stop-it-now-scotland/resources/> and <https://www.theupstreamproject.org.uk/identify>

Sexual offences and signposts to legislation

It is illegal to:

- cause or incite a child to engage in sexual activity
- arrange or facilitate a child sex offence
- meet a child following sexual grooming
- have sexual communication with a child
- take, make or have indecent photographs of children
- sexually exploit a child (including paying for or arranging sexual services of a child)

[Part 4 of the Sexual Offences \(Scotland\) Act 2009](#) lists offences criminalising sexual activity with a child under the age of 16 as categorized by the age of the victim’.

Part 5 of that Act provides for offences concerning **sexual abuse of trust**. The Act provides that it shall be an offence for a person, over the age of 18, in a position of trust over a child or young person under the age of 18, or a person with a mental disorder, to intentionally engage in sexual activity with that child or person. (Note the proposed revision to sexual abuse of trust alongside reform of section 12 of Children and Young Persons (Scotland) Act 1937).

Child Abuse Images – The taking, distribution, publication and possession of indecent images of children under the age of 18 is prohibited by Section 52 and Section 52A of the Civic Government (Scotland) Act 1982 (as amended by the [Protection of Children and Prevention of Sexual Offences \(Scotland\) Act 2005](#)).

The **Abusive Behaviour and Sexual Harm (Scotland) Act 2016** (s2) makes it a criminal offence to disclose or threaten to disclose intimate sexual images.

Sharing of Intimate Images (sometimes referred to as ‘sexting’), is a term referring to the production and sharing of youth-produced intimate or sexual imagery by children who are under the age of 18. The imagery includes nude or nearly nude images and/or sexual acts. ‘Sexting’ does not include children sharing adult pornography or exchanging sexual texts which do not contain imagery. Neither does it include the sharing of sexual photos and videos of people under the age of 18 with or by adults, which would be a form of child sexual abuse and which must be referred to the Police immediately by the designated child protection lead.

[The Protection of Children and Prevention of Sexual Offences \(Scotland\) Act 2005](#) provides for an offence of ‘grooming’ which makes it an offence for a person to meet or travel to meet children under the age of 16 for the purposes of committing a sexual offence following earlier communications (section 1), and for specific offences concerning the sexual exploitation of children under the age of 18 through prostitution (e.g. section 9) or the sale of sexually abusive imagery.

The 2005 Act also includes Risk of Sexual Harm Orders (RSHOs), which are civil preventative orders aimed at protecting children from those who display inappropriate sexual behaviour towards them. To obtain a RSHO, it is not necessary for the individual to have a conviction for a sexual (or any) offence. However, they must have done one or more of the following acts on at least two occasions:

- engaged in sexual activity involving a child or in the presence of a child
- caused or incited a child to watch a person engaging in sexual activity or to look at a moving or still image that is sexual
- given a child anything that relates to sexual activity or contains a reference to such activity
- communicated with a child when part of the communication is sexual

and as a result of those acts there is reasonable cause to believe a RoSHO is necessary

The 2005 Act extends the use of Sexual Offences Prevention Orders (SOPOs), so that they can be applied to those convicted of sex offences by the court when they are sentenced. Both SOPOs and RSHOs place conditions (i.e. prohibitions and positive obligations) on those subject to the orders.

It is intended that RSHOs will be replaced in 2021 by Sexual Risk Orders ('SROs') as provided for by Sections 26-38 of the Abusive Behaviour and Sexual Harm (Scotland) Act 2016. The grounds and conditions on which the SROs can be made are wider than those for the previous order, so it could be used by the police to manage risk against adults as well as children. A court will be able to grant a new order if it is satisfied that it is necessary to protect a person from "sexual harm".

Accompanying Scottish guidance will be available on the application for, as well as the application of, SROs.

Also relevant

- [Vulnerable Witnesses \(Criminal Evidence\) \(Scotland\) Act 2019](#)
- Definitions and legal references in relation to CSE may be found in a practitioner briefing (Scottish Government 2016)

<https://www.gov.scot/publications/child-sexual-exploitation-definition-practitioner-briefing-paper/>

REFERENCES AND RESOURCES

Child Sexual Exploitation

156. **Definition:** Child sexual exploitation (CSE) is a form of child sexual abuse in which a person or persons of any age take advantage of a power imbalance to force or entice a child into engaging in sexual activity, in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not excuse or mitigate the abusive nature of the act.
157. **'Child'** in this context means child or young person up to age 18. Boys as well as girls may be victims. Although CSE is not a specific criminal offence in itself, there is a range of criminal and civil options that can be used to disrupt and prosecute this form of abuse. A practitioner definition briefing is linked [here](#).
158. **A child protection response is required**, the manner of which will be determined following an [inter-agency referral discussion](#). 'Disclosure' is not a pre-requisite for a child protection investigation. CSE is under-recognised.
159. **Exchange** is the distinguishing factor in the various forms of CSE. The nature of the exchange may be material and emotional, including, food, accommodation, drugs, alcohol, cigarettes, gifts, affection, or a sense of belonging. In some situations the abuser or facilitator may also achieve financial gain or status. Alcohol or drugs may be given to the child. Exchange may take the form of compliance with sexual activity in order to avert a threat of harm to the child or to someone close to them. Children who have shared images of themselves may experience threats unless they comply with an abuser's demands. Perpetrators manipulate and apply coercive control.
160. **In all forms of CSE there is an imbalance of power.** This may relate to the abuser's age, gender, intellect, physical strength or other resources. Grooming may draw a child in to the abusive process or event. Grooming means targeting, befriending and establishing an emotional link with a child. Violence and intimidation may form part of the coercion.
- **A child may be drawn in to CSE** in search of some form of affection, relationship or belonging. The child may or may not understand this as abuse. This does not equate to choice and consent, even for a 16 or 17 year old who might legally consent to sex.
161. **CSE may be associated with child criminal exploitation (CCE).** CCE is not defined in law but is a term that has come to be associated with 'county lines'. County lines is a term used in the UK to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other forms of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.
162. Child criminal exploitation occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child into any criminal activity, in exchange for something the victim needs or wants, for the financial or other advantage of the perpetrator or facilitator, or through violence or the threat of violence. The victim may have been criminally exploited, even if the activity appears consensual. Child criminal exploitation does not always involve physical contact – it can also occur through the use of technology. The criminal exploitation of children is not confined to county lines but can also include other forms of criminal activity such as theft, acquisitive crime, knife crimes and other forms of criminality. CCE requires a child protection response. Further information may be found in the section on CCE below.

163. **CSE is often hidden.** As with other forms of sexual abuse, the process of disclosure is rarely a discrete event, and patterns of disclosure and retraction are common. It may take many years, or may never happen. Fear, anticipation of stigma, reprisal, loss and shame that might follow disclosure intersect differently for each child. They are among the most common barriers to early recognition and help, alongside feelings of entrapment and helplessness. Shame and fear may be more pronounced within some cultural groups. Boys who have been abused often struggle to share their experience throughout life. Both containment and disclosure can be profoundly disturbing for the child and others closely affected. A trauma-informed approach to assessment and support is essential at all stages.
164. **Sexual exploitation can occur through digital technology,** in direct contact, or through a combination of both. Its occurrence often goes unrecognised and victims can feel isolated in plain sight. CSE of teenagers is more common than victimisation of young children.
165. **CSE may be perpetrated by:**
- family members, including being sold for sex
 - older adults
 - peer networks, within which abuse of power may occur
 - gangs
 - criminal networks (see appended note on ‘county lines’)
166. **Information and Communication Technologies (ICT)** are often a vector for:
- grooming online for sexual abuse offline
 - children viewing abusive images of children
 - selling children online for abuse offline
 - making abusive images of children
 - sharing and viewing abusive images of children
 - access to chat lines via the internet, social media, and online gaming platforms or mobile phones
 - encouragement of sexting
- ([see further guidance in this section](#)).
167. **It is the shared responsibility of professionals, parents and carers** to support children’s resilience, security and safe use of online technologies. Recommended links and resources may be found in the reference section.

Factors that may interact to create vulnerability

- Abuse, neglect or an early adverse experience
- Disrupted family life, including family breakdown and care experience
- Domestic abuse
- Bullying and peer pressure
- Absence from education
- Running from home or care
- Experience of exclusion or isolation, especially in transitional phases
- Drug and alcohol use
- Poverty or homelessness
- Poor health and low self-esteem
- Learning disabilities and autism
- Living with attitudes that normalise exploitation and violence in sexual relationships
- Access to adult pornography and experience of attitudes that normalise sexual violence
- Exploration of same-sex relationships and questioning of sexual orientation or gender identity can also result in children who identify as lesbian, gay, bisexual, transgender or questioning (LGBTQ) being more vulnerable to CSE

Possible indicators of CSE

- Going missing from home or school during the day, overnight or longer
- Multiple callers/visitors including unknown adults/older young people
- Entering/leaving vehicles driven by unknown adults
- Evidence of/suspicion of physical or sexual assault
- Disclosure of assault followed by withdrawal of an allegation
- Unplanned pregnancy and/or Sexually Transmitted Infections (STIs)
- Peers involved in sexual exploitation
- Drug/alcohol use
- Isolation from peers/social networks
- Exclusion or unexplained absences from school or college
- Relationships with controlling adults
- Unexplained money or 'gifts', including expensive clothing, new phones and other items
- Frequenting areas known for adult prostitution
- Children under 13 years asking for sexual health advice
- Concerning use of mobile/internet/online devices (sending/receiving sexual images)
- Multiple phones or sims, being protective of a phone, abnormally high volume of secretive calls, change in behaviour as a result of phone contacts
- Depression, self-harm and suicidal thoughts

However, CSE can occur without obvious indicators, and careful assessment is needed to explore the meaning of the indicators above, which may be related to other issues.

168. **Some CSE involves trafficking and criminal exploitation.** This is when children are recruited, transported or exchanged in order to be exploited. Travel may include short distances (e.g. taxi rides) or medium distances (e.g. across a rural/island region or into an urban centre), as well as international travel. Assessments of possible CSE should consider if a child has been trafficked for the purposes of CSE. The immediate priority is to secure the safety and respond to the needs of the child. They should also be referred to the National Referral Mechanism (NRM) as explained below in the section on child trafficking. Not all trafficking involves CSE.
169. **Some children and young people involved in CSE may be coerced into committing crimes** by those who perpetrate CSE. This could include committing crime to escape abusers, or as a cry for help. Those who experience CSE may experience a punitive and criminalising response for engaging in antisocial behaviour, and may not be recognised as children who have been sexually exploited. It is essential that professionals engage with them, listen, and take time to understand the context of behaviour and choices with which the child has been faced. Victims of CSE require protection and support.

170. **Children who run away** find themselves making survival choices when they have nowhere to stay and feel alone. Abusers may befriend a child before or after they run, offer false sanctuary, or encourage the involvement of peers. Some children run to avoid abuse or out of fear of abusers, or of the consequences of being held to account for behaviours. A non-believing response from professionals or family increases risk of running. The [National missing person's framework for Scotland](#) provides guidance for a multi-agency response when an individual goes missing, outlining roles and responsibilities, and including questions to use in risk assessment for concerns including sexual exploitation (Scottish Government, 2017).
171. **Recruitment by children of other children** for CSE does occur. The power and traumatic bond between abusers and victims can drive this process. Where a child is both a victim and has been involved in CSE of others, they require an approach to assessment and intervention that has a focus on their trauma and needs.
172. **In some situations CSE has been continuing within communities**, locations or institutions and authorities and the public have not suspected or responded to early signs of abuse.
173. **The core components of the GIRFEC National Practice Model apply** within an effective child protection response to suspected CSE. A Sexual Exploitation Risk Assessment Framework is being reviewed and revised (Barnardos Scotland 2020). Child protection Committees must oversee relevant local inter-agency procedures and assessment frameworks.
174. **The National Action Plan to prevent and Tackle Child Sexual Exploitation** published in 2016, set out the Scottish Government's plan to tackle the issue of child sexual exploitation. It focuses on prevention of abuse, prosecution, and supporting children and young people affected by child sexual exploitation. A [Report on the Delivery of the Action Plan](#) was published in 2020.

REFERENCES AND RESOURCES

Indecent images and internet-enabled sexual offending by adults

175. Internet-enabled sexual offending includes possession, exchange and distribution of indecent images of and/or with children (IIOC); production of IIOC; sexual solicitation (online interaction with minors for sexual purposes); non-consensual sharing of sexual images; and conspiracy crimes such as working with others to distribute IIOC or to solicit children. Relevant legislation is signposted above in the section on child sexual abuse.
176. Most people who offend are male. Many are in relationships and have children. Motivations vary: some have a long-standing sexual interest in children, while some behaviours are exploratory or relate to the seeking out of extreme sexual material.
177. Beyond the direct and indirect abuse of children caused by the behaviour listed above, practitioners concerned with child protection will be concerned to know:
- is this person likely to commit a contact sexual offence with a child?
 - has the person already committed contact sexual offences with a child?
178. The Risk Management Authority in Scotland's recent [review of current evidence](#) suggests that those convicted for viewing IIOC only are in general less likely to commit further sexual offences than other types of sexual offenders. When they do re-offend, it tends to be repeat viewing of IIOC.

179. Those convicted of viewing IIOC who are assessed as low risk for contact sexual abuse tend not to have a history of previous sexual convictions or other offending. They tend not have a history of alcohol or drug use, domestic abuse, or other sexually inappropriate behaviour. However, when those convicted of viewing IIOC have been known for such behaviours and/or previous convictions, this can indicate an increased risk of sexual offending. If children were present while the material was being viewed, or if the material features children or adults known to the suspect, this also significantly increases risk.
180. Some parents who have no criminal history who are arrested for downloading IIOC may have provided their children with positive parenting. Some may have been victims of abuse in the past themselves. Investigation by Police Scotland and an inter-agency referral discussion (IRD) is necessary for child protection processes. This can be experienced as devastating by the person who has committed the offence, their children and partner. Shame, loss, fear, general anxiety and financial insecurity may be intensified by family, community and public reactions. Parents may not know what to say to their children and children may need support in these circumstances.
181. Although the consensus is that the majority of those charged with IIOC offenders present a low risk of contact sexual abuse to children, there will be individuals who do pose such a risk within the viewing population and who have, or who will, abuse children. Additionally, for those deemed 'low risk', this does not equate to no risk. For this reason, where the individual who has committed an offence has access to children, a holistic and in-depth assessment by skilled and experienced practitioners should be the norm. Multi-agency assessment and close co-operation between child and family services and criminal justice Social Work is needed to evaluate the level of risk to children, and to recommend proportionate protective measures. This is a complex analysis. There may be no other police intelligence or indicators of significant harm. Dynamic variables include the degree of acceptance and attitude of the person who has committed the offence, along with acceptance of the potential risk by the non-abusing parent and immediate family, as well as the partner relationship, parenting styles, and the age, needs and circumstances of the children.
182. If risk is low, if the children feel safe to speak to key adults, and if comprehensive adult safeguards are in place, then it may not be necessary to compel the person to leave the family home while a full assessment is undertaken. In other circumstances there may be sufficient uncertainty about risk such as to require the taking of steps to ensure that the person does leave until a multi-agency assessment can review the options and form a child protection plan. A written, shared family safety policy understood by all is needed to define arrangements for supervised contact, entry into children's rooms, sleep-overs, and any situations in which risk might be predicted.
183. If accessed or required, the efficacy of treatment for those convicted for viewing of IIOC is not well researched. The person's engagement, understanding of their offending behaviour and evidence of change will be the subject of a post-programme report.
184. Children also access illegal and extreme material on the internet. For some, this behaviour can become compulsive and developmentally harmful. When such concerns arise, practitioners must explore the relevant history and context in order to identify any risks to the young person, as well as from them towards other children. Other guidance in this section covers harmful sexual behaviour by children and other forms of sexual abuse and exploitation.

REFERENCES AND RESOURCES

Children and young people who display harmful sexual behaviour

- 185. Harmful sexual behaviour (HSB) is defined as ‘sexual behaviour(s) expressed by children and young people under the age of 18 years that are developmentally inappropriate, may be harmful towards self or others and/or may be abusive towards another child or young person or adult’ (Hackett, 2014).
- 186. Children’s sexual behaviour may be described on a continuum ranging from normal to uncommon behaviours, including serious sexual violence.

Normal	Inappropriate	Problematic	Abusive	Violent
Developmentally expected	Single instances of inappropriate sexual behaviour	Problematic and concerning behaviours	Victimising intent or outcome	Physically violent sexual abuse
Socially acceptable	Socially acceptable behaviour within peer group	Developmentally unusual and socially unexpected	Includes misuse of power	Highly intrusive
Consensual, mutual, reciprocal	Context for behaviour may be inappropriate	No overt elements of victimisation	Coercion and force to ensure victim compliance	Instrumental violence which is physiologically and/or sexually arousing to the perpetrator
Shared decision-making	Generally consensual and reciprocal	Consent issues may be unclear	Intrusive	Sadism
		May lack reciprocity or equal power	Informed consent lacking or not able to be freely given by victim	
		May include levels of compulsivity	May include elements of expressive violence	

- 187. Practitioners’ ability to determine if a child’s sexual behaviour is harmful 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. Resources such as the [Brook Traffic Light tool](#) can be useful in recognition of potential child protection concerns about children’s sexual behaviour.

188. **Assessment of harmful behaviour is indicated** if the behaviour meets any or all of the following criteria:
- it occurs at a frequency greater than would be developmentally expected
 - it interferes with the child's development
 - it occurs in a context of coercion, intimidation or force
 - it is associated with emotional distress
 - it occurs between children of divergent ages or abilities
 - it repeatedly recurs in secrecy after intervention by caregivers (Chaffin et al., 2002)
189. **Some young people sexually abuse other young people.** Harmful sexual behaviour may be within the context of relationships, or it may be exploitative abuse that falls within the definition of child sexual exploitation. Both forms of harm may co-occur.
190. Children may be involved in sexual discussions or acts, whether directly or through the use of digital technology. This may include the sharing of images that are harmful to self and/or others, given their age or stage of development (Hollis, et al., 2017).
191. **Behaviours vary** in nature, degree of force, motivation, context, level of intent, level of sexual arousal, and the age and gender of victims. Just as there is a continuum of behaviour, there needs to be a continuum of potential responses, ranging from broad educational input on consent and relationships, through to multi-agency public protection arrangements for serious sexual offences.
192. **Those children who harm may have been harmed themselves.** Many will have unmet emotional needs, use coercion and aggression as coping strategies, have poor emotional regulation, have experienced pre-adolescent sexualisation, and/or have unresolved trauma. Some may have developmental delay, intellectual impairment or be affected by autism.
193. **Immediate response** to harmful sexual behaviour depends on interacting considerations relating to risk, age and context. In all actions and decisions the primary professional consideration must be to safeguard and promote the wellbeing of the children involved.
194. **In all cases** where a child or young person displays sexual behaviour that may cause significant harm, immediate consideration should be given as to whether action should be taken under child protection procedures, in order to protect the victim and to tackle concerns about what has caused the child/young person to behave in such a way.
195. **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 harmful or problematic sexual behaviour, and a risk management plan drawn up to support the placement. Teamwork between all involved is the key to safety.
196. **Where concerns are below the threshold of significant harm** towards or caused by a child, there may still be a need for co-ordinated assessment and support to address the needs underpinning troubled or troubling behaviour.

197. **Sexual abuse between siblings**, when they are children, may be the most common form of intra-familial child sexual abuse, although data on prevalence is scant. Professionals need to be precise about the language they use to label sexual behaviours of siblings which can include developmentally normal sexual interactions between young sibling children; problematic sexual behaviour between siblings which may be harmful to each child involved; and sibling sexual abuse which could include a range of persistent and exploitative behaviour which can be significantly harmful immediately and over the lifespan.
198. Some children abused by siblings think they will not be believed . Children who have sexually abused a sibling may often have experienced abuse and trauma themselves. Their needs as children must also be recognised and supported alongside assessment of risk, safety plans and options for management of sibling contact if siblings are separated. Family relationships and needs must be considered as a whole. The cultural context must be considered in assessment and approach to support.
199. Every individual and every relationship in the family may be impacted. The recognition of sibling abuse usually creates a crisis for the family as a whole. Parents can feel torn between the need to support and protect each child. Their response is a key variable in assessment, interim safety planning and a co-ordinated inter-agency plans supporting recovery. Sensitive support is therefore necessary to help the family recognise where harm has occurred while also encouraging them to recognise that change and healthier relationships are possible. (Allardyce & Yates, 2020)

The Age of Criminal Responsibility (Scotland) Act 2019 is being implemented in stages, as from 2020. The Act raises the age of criminal responsibility in respect of children under 12 years of age, but makes provision for their referral to a children's hearing on grounds other than having committed an offence. This could apply to children who are suspected of violent or dangerous behaviour which has caused or risks causing serious physical harm to another person or who, by behaving in a sexually violent or sexually coercive way, have caused or risked causing harm (whether physical or not) to another person. Key components of this Act are summarised below alongside a [flow chart](#) depicting the relationship between provisions in the Act and Child Protection Processes.

Care and Risk Management (CARM) processes may be applied when a child (aged between 12-17) has been involved in an incident of a serious nature (irrespective of the legal status of the incident) or where a pattern of significant escalation of lesser behaviours suggests that an incident of a serious nature may be imminent. The lynchpin of effective CARM processes is the inter-agency referral discussion that must occur when concerns of this nature arise.

Early and Effective Intervention (EEI) is not a 'disposal option' but rather a co-ordinated, planned support for children who come to the attention of the Police for offending, concerning or harmful behaviour. Police Scotland 'risk and concern hubs' should identify when referral for an IRD under child protection processes or EEI may be appropriate. EEI should include the concerning and harmful behaviour of children aged under 12 years.

Referral to the Principal Reporter can be considered at any stage if there are reasons to believe a child may need compulsory measures. One of the potential grounds for a hearing is that the child's conduct has had, or is likely to have, a serious adverse effect on the Health, safety or development of the child or another person. Children's Hearings (Scotland) Act 2011, section 67(2)(m).

200. **When parents find that their child has acted in a way** that has sexually harmed others, they may experience feelings of shock, denial, confusion, guilt, shame, anger, isolation and powerlessness. Feelings of hurt, love and anger can merge with conflicted priorities, particularly when the victim of harm is a member of their own family. Parents have a critical role in promoting safety and helping their child move on from behaviour that may harm themselves or others. Parents often need sensitive support to help them understand what has occurred and how to work together.
201. **Every child's plan** should be holistic and tailored to need and context. Risk assessment and management measures and interventions are essential, but should be balanced with nurture and encouragement. Plans should build on those skills and relationships that promote resilience. The GIRFEC Wellbeing indicators apply. In addition, each child should receive individual attention within a systemic approach, so that they become more able to:
- understand their feelings and behaviour
 - meet their own needs in a socially acceptable way
 - develop skills in the context of home, school and community
 - enjoy positive relationships at home, at school and in the community
 - encourage and sustain longer term change, anticipating stresses

REFERENCES AND RESOURCES

Child protection in the digital environment/online safety

202. The internet, online services and associated technologies are an integral part of our everyday lives, and particularly so for our children and young people. It offers many opportunities that support learning, engaging with others and, crucially, helping young people to find the right support and help. We want all individuals, including those who may be more vulnerable, children and young people, to be empowered and confident to access the digital world creatively and fearlessly. Protecting children from online harm is a challenging outcome in a fast changing media environment in which a sense of anonymity and disinhibition can escalate risks. Signposts to key legislation in relation to sexual offences are provided above in the section on child sexual abuse.
203. **Definition:** Online child abuse is any type of abuse that occurs in the digital environment and the internet, facilitated through technology and devices such as computers, tablets, mobile phones, gaming devices and other online-enabled devices. If abusive content is recorded, uploaded or shared by others online, there is a risk of on-going experience of abuse. Online abuse can include online bullying; emotional abuse and blackmail; sharing of intimate images; grooming behaviour, coercion and preparatory behaviour for abuse including radicalisation; child sexual abuse and sexual exploitation as described above. Perpetrators may be strangers, family members, friends or professionals.
204. Primary protection involves collaborative, preventative action. Listening to the views of children and young people is critical in ensuring the on-going development of protective efforts are relevant and beneficial. Exposure to risk of online sexual harm is a common experience.
205. **Prevalence:** A Crime Audit published by Her Majesty's Inspectorate of Constabulary in Scotland (HMICS) in 2016 reported that 11.4% of recorded sexual incidents had a cyber-element to it, a significant proportion of these involved children.
206. **Education/Training:** Children should access education that addresses online sexual harm before spending unsupervised time online. This should include information about why it occurs, the different forms it can take, how to identify it, its possible impacts, and what to do if it happens. Children need help to understand what constitutes harm within the context of peer relationships or existing online networks. The 'normality' of such occurrences can reduce awareness of harm caused to individuals and harm caused by creation of normative expectations, particularly sexual demands of girls.
207. Education around online sexual harm must be embedded in the school curriculum for children and young people. It is important that children and young people are supported in building their own resilience in the online world. Being online offers positive opportunities and avoidance-based messaging may be unhelpful. Schools are the most common source of learning about sexual harm, however family members, friends, peers and the media are also significant sources of learning. References for this section offer relevant resources and specific links.
208. Professionals involved in assessment and planning should develop a knowledge of online risks, the impact of technology on the lives of children and young people and the use of technology by parents and carers which may impact on children. They should consider the place of technology within the child's world, with a view to working together on plans relevant to the situation.

209. **Response:** In relation to youth produced sexual imagery, staff:
- must in any instance follow agency protocol, listen to the child, and report to the designated child protection lead.
 - must not view, download or share such imagery, or ask a child to share or download – **this is illegal**. It is relevant to take note of who the child says has sent the image, who has seen it, and the relevant host website if known, as this information could help in taking steps to remove it.
 - must, if the imagery has already been viewed, report this fact to the designated child protection lead.
 - must not delete the imagery or ask the child to delete it.
 - must not ask the child or children involved in the incident to disclose information regarding the imagery. This is the responsibility of the designated child protection lead.
 - must not share information about the incident to other members of staff, the child or children involved or their, or other, parents and/or carers.
 - must not say or do anything to blame or shame any child involved.
 - must explain to the child that the material must be reported, and reassure the child that they will receive support and help.
210. Reporting to Police Scotland or to Social Work for consideration of an inter-agency referral discussion (IRD) will normally be the recommended response to ensure the concern is placed in context, and that next steps are proportionate, supportive, and if necessary, co-ordinated. An IRD will be completed to allow appropriate child protection measures and on-going risk assessments to be progressed through joint information gathering, information sharing and decision-making through the IRD.
211. Information and advice on complaints procedures and reporting routes to social media providers about inappropriate content can be accessed [here](#).

REFERENCES AND RESOURCES

Under age sexual activity

212. This section should be read in conjunction with adjacent sections on sexual abuse and harmful sexual behaviour by children and young people. The Scottish Government (2019) has provided Guidance on key messages for professionals. A gender-based analysis informs national policy and guidance (Scottish Government 2017).
213. Protecting children means supporting them as they learn about Healthy, respectful, consensual and safe relationships. Practitioners require local service protocols which are clear about the law. They must be provided with key messages in support of professional judgement about proportionate, ethical response in each situation. There are situations that do not require child protection processes, in which a young person may need immediate support in relation to their sexual risks, development and relationships. These may be addressed either on a single agency or multiagency basis, depending on needs and circumstances.
214. Child protection concerns arise when the impact of under-age sexual activity could cause significant harm. In Scotland the law states that a young child (under 13 years of age) cannot consent to any form of sexual activity (section 27 of the Sexual Offences (Scotland) Act 2009). The 2009 Act maintains the age of consent at 16 whether a person is straight, lesbian, gay, bisexual and/or transgender. When there is reason to believe an offence against a child has been committed as defined in the 2009 Act, an IRD will be convened.

215. An IRD must also be convened with older children (over 13 years) who may have been pressured in to sexual activities involving force or exploitation, may have had indecent images taken, suggesting abuse or exploitation, or may otherwise be at risk of significant harm relating to sexual activity.
216. Section 37 of the Sexual Offences (Scotland) Act 2009 creates the offence of older children (aged between 13 and 16 years) engaging in sexual conduct with one another. Assessing risk of significant harm, deciding whether to hold an IRD and planning next steps will include considering:
- any power imbalance between the persons involved
 - age and age difference of the persons involved
 - overt aggression, manipulation, coercion or bribery
 - disinhibiting use of substances, under pressure or encouragement from a more dominant person or persons
 - the child's use of substances contributing to risk of harm
 - attempts to secure secrecy having been made by the dominant person, beyond what might be usual in a teenage relationship
 - previous concerns recorded by Police/Health/Social Work
 - persons involved denying, minimising or accepting concerns
 - evidence of 'grooming'
 - Practitioners must be aware of the power and trust inherent in their own position and communication with each child. They must be aware of the influence of their own language, attitudes and boundaries.
217. 'Consent' refers to a mutual process. Children need support in learning:
- that verbally obtained consent is necessary but not enough
 - to be sensitive to another person's feelings and fears, which may be communicated in an on-going process, not only in words but also in body language and non-verbal responses
 - that consent can be withdrawn at any time.
 - that consent is required every time sexual activity takes place, even if a person has previously consented
218. Power imbalances affect a child's understanding of consent and must form part of a practitioner's consideration when balancing issues of confidentiality, welfare and protection. A child's age, sexual identity, gender, disability, self-perception and ability to understand and exercise choice will all affect consent. Power imbalances can be created by fear, manipulation or threat. They can be created by differences in sexual knowledge, or by the dynamic when a child has been feeling excluded or unwanted. The social context and location of 'consent' may dismantle a child's ability to stand alone or stand aside and choose. Children may not understand exploitative behaviour as abuse.
219. If sexual activity is taking place/has taken place within a safe and mutually respectful relationship, then confidentiality should be maintained.

220. If a young person is under sixteen and sexually active, professionals considering breaching the young person's confidentiality must consider the circumstances of the specific case, consulting with child protection leads as appropriate. Decisions must be made in relation to this particular child, their needs in context, and the relevant legal basis. Breaching confidentiality must be justified and proportionate, taking into account the nature and probability of risk to the young person and/or others. The child's wishes and feelings must be heard and taken into account. The reasons for decisions made (for instance in relation to information sharing) must be recorded. Recognition should be given to the particular issues for LGBT young people. Schools should be alert to the fact that some young people may not have told everyone in their lives about their sexual orientation and/or gender identity, and 'outing' them could cause needless distress. If a child protection or wellbeing concern is raised, schools should follow their existing policies.
221. Children may express and then retract concerns, depending on what pressures are facing them. Practitioners must seek to keep the door open so that the child knows where they might go to share anxieties or questions. Parental support will in most situations be a crucial part of the picture. When there are interacting concerns about how family circumstances impact on the child's safety in the wider world, practitioners will take this context into account in contributing to assessment and planning to support safety and wellbeing.
222. Any child or young person under the age of 18 can be vulnerable to child sexual exploitation, which is a form of child sexual abuse in which a person(s), of any age, takes advantage of a power imbalance to force or entice a child into engaging in sexual activity in return for something received by the child and/or those perpetrating or facilitating the abuse. An Inter-agency referral discussion is required (IRD).

REFERENCES AND RESOURCES

Pre-birth assessment and support

223. All services providing for expectant mothers and babies must have protocols and supervisory structures in place to support equitable, proportionate, effective and timely action to keep mother and baby safe and well. A Pathway to Care for Vulnerable Families (0-3)(Scottish Government 2011) describes standard support expectations. The national approach to maternity and neonatal care is described in '[The best start: maternity and neonatal care plan executive summary](#)'.
224. All practitioners who work with expectant mothers must be aware of parental behaviour and circumstances that could cause significant harm to an unborn baby. They must be aware how to refer concerns about potential harm to statutory services; and confident about the lawful basis for information sharing. Child Protection Committees and Chief Officers will ensure frameworks for pre-birth assessment and support for children at risk are in place.
225. Health, police or social work will trigger an inter-agency referral discussion when there is reason to believe an unborn baby may be at risk of significant harm, as described in Part 3. The potential impact of an interaction of risk factors such as the removal of previous children; the impact of drug use; and/or the impact of domestic abuse and mental ill health upon mother and unborn baby should tip professional judgement towards the need for an IRD.

226. Guidance on Part 12 of the Children and Young People (Scotland) Act 2014 highlights that pregnancy can be a turning point for parents involved in alcohol and drug use and criminal behaviour. Relevant services should be provided to pregnant women who the local authority considers are going to give birth to a child who will be at risk of becoming looked after (section 68(5) of the 2014 Act) and the father of the child (“or a qualifying person in relation to an eligible pregnant woman” under s68(6) of the 2014 Act). The aim is to ensure that any decision-making is informed by assessment and support work begun at the earliest possible juncture; and geared to mother and baby’s specific needs, in the context of their family situation.
227. A pre-birth assessment can begin whenever pregnancy is confirmed. When there is risk of significant harm, it should begin as soon as possible. This provides the child with the best possible opportunity to thrive and gives parents maximum opportunity to engage, achieve an understanding with key practitioners and begin to work towards necessary changes.
228. Assessment should be multi-disciplinary, co-ordinated by a social worker as lead professional, consulting with key practitioners including GPs, midwives, family nurses, health visitors and relevant adult services. Professional judgement should be assisted by structured assessment tools. [General principles in Part2b](#) of this Guidance apply.
229. Practitioners should seek to engage early in the pregnancy when there are child protection concerns. Late allocation to social work can contribute to tensions in working relationship, making a robust assessment less possible. Continued uncertainty about the care plan will raise anxiety for expectant parents as the baby’s arrival approaches.
230. Parents who are in their teens; care experienced; who have had profoundly traumatic experiences; and parents with learning disabilities are among those likely to need additional and sustained support, explanation and advocacy. Parents who have had no experience or understanding of child protection systems, may struggle to understand processes. Cultural and language differences often add to gaps in understanding. Some assessment tools may be helpful (for example, [Best Beginnings: Parents with learning disabilities](#)).
231. Part 3 describes Child Protection Planning Meetings, Core Groups and discharge planning meetings. Timescales for planning meetings are summarised in the appendices. For all meetings, reports should be completed in time for parents to read and understand. Pre-birth involvement creates the opportunity for detailed care planning for the baby following the birth, ensuring sufficient continuity of multi-agency support, especially in the first year. When an assessment concludes that a baby cannot be safely cared for with birth relatives, foster carers can be engaged early in the process. This means carers and parents can meet before the birth to plan the transition and to support development and sustaining of relationships essential for the baby as appropriate, as the plan evolves.
232. In some situations ‘concurrent planning’ is appropriate. This involves intensive but time limited work with parent(s) towards the return of their child, within a timescale that is in the child’s interests; while holding the possibility that the temporary placement might offer permanent care if safe return to parents cannot be achieved (CORAM 2013).

233. Good outcomes are optimised by assessment of individual circumstances and supports required. A strength-based approach is advised. Family group decision-making can be a helpful vehicle in some circumstances. Evidence-based programmes can considerably increase successful outcomes. The Family Nurse Partnership was first implemented in NHS Lothian in 2010, FNP has since been expanded across the country. Additionally, the revised Health Visitor Pathway guidance was published in October 2015. The pathway offers a consistent approach to the health visitor role and services across Scotland. It presents a core home visiting programme as a minimum standard to be offered to all families with children 5 years of age and under. The refreshed Health Visitor role has a strong focus on prevention and early intervention.
234. Permanent, loving, nurturing relationships are what matter most to children. The optimal route to permanence depends on the needs and circumstances of the child. Permanence might be achieved through: the child returning or remaining within the family – with or after support; by kinship carers obtaining a Section 11 Order via the courts; and by means of adoption orders being granted by the court in favour of an adoptive parent. The first stage of Scottish research on permanence planning (Biehal et al 2019) underline that the pre-birth period is critical in terms of assessment and decision-making.

REFERENCES AND RESOURCES

Children who are looked after away from home

235. Child protection for children looked after away from home involves integration of some of the general features of good assessment and planning referenced below. It also involves clearly defined processes when child protection concerns, such as allegations against carers, arise in placement. Child protection concerns relating to unaccompanied children should be addressed by the same inter-agency processes as for a UK national.
236. **A looked after child** may be placed with kinship carers, with foster carers, prospective adopters, a residential school setting, or a young people's unit.
237. **The best protection is preventative support.** Thorough assessment of carers and of children's needs, alongside planning and support of placements, are key to ensuring that placements can meet children's needs for safety and nurture. Once in placement, trust and physical and emotional safety evolve through routine experiences of nurture, empathy, nourishment, sleep, daily achievement, understanding, play, choice and hope.
238. **A key outcome** of child protection and work with looked after children should be the development of a child's sense of stability and safety, achieved through the building of trusting and nurturing relationships with their adult care givers. This refers to exploring, promoting and sustaining relationships of enduring and protective significance. This includes relationships with brothers and sisters. "Where living with their family is not possible, children must stay with their brothers and sisters where safe to do so and belong to a loving home, staying there for as long as needed" (Independent Care Review, 2020).
239. **When children are placed quickly**, in response to a crisis, any initial discussion between those seeking and providing services must be thorough, to ensure the risks are recognised and can be sufficiently supported. This includes risk assessment about co-placement of children whose behaviour could pose risk to others.

240. **Growth of relationship, trust and recovery** is likely to depend on appreciation of the impact of trauma, neglect and disrupted attachment for each child, and of what each child is communicating not only by what they say, but what they do and how they present.
241. **Sustaining care:** It is to be expected that looked after children who have had to leave the care of their parents will usually experience complex emotions and distressed, disrupting behaviours. Many will have experienced separation and loss in their early years, and been emotionally and physically neglected or abused. Layers of trauma are likely to result in deep-rooted fearfulness, anxiety, lack of trust and confusion. A constant need for reassuring and soothing may often mask the child's underlying confusion, fear and emotional distress. This can be bewildering and exhausting for carers.
242. **Carers need guidance and support** to enable them to offer trauma-informed care, appropriate to the developmental needs and known life history of each child. The Independent Care Review has underlined the need for preventative support for kinship Carers, foster carers and adopters. ("Whatever the mode of arrangement, Scotland must ensure that children living in kinship care get the support they need to thrive." Independent Care Review, 2020)
243. **When looked after children are moving** between placements and between authorities, transitional arrangements must be negotiated and planned in order to avert what may otherwise emerge as child protection concerns. Sufficient transitional support when children move on from placements may likewise reduce crises that could be anticipated. The Independent Care Review has emphasised that, however urgent the situation, "...children and their carers must have access to information about their rights and entitlements at any point in their journey of care."
244. **Safer caring:** A co-produced family agreement, involving everyone living in the house, helps to ensure that each resident child and adult, and visitor, knows how to behave to keep everyone in the house feeling safe (including pets). This is advised for registered foster carers to ensure that everyone who lives in the household, and those who visit, know how family rules and boundaries work.
245. **Disabled children** who require extra time, skill and support, should only be placed with carers who have the time, skills and support to deliver safe care for each child placed.
246. **The lead professional** has a role in ensuring the integration of safety and child protection aspects within a holistic and co-ordinated child's assessment and plan. Any significant change in a child's behaviours and wellbeing must be recognised, and the underlying needs considered within a child's plan.
247. **Allegations against registered carers.** Children need to know who they can speak to when they have anxieties about where they are living or about behaviour of others outside the placement. Local Authorities must ensure that protocols for inter-agency investigation of allegations of abuse against carers are in place. Allegations about kinship carers with whom a child is placed should be explored in the same way as allegations about a child living with parents.
248. Lead professionals have a responsibility to clarify concerns raised around a looked after child in collaboration with the child protection services in their area. They will also need to liaise with service managers for fostering or residential services as required.

249. The main consideration in responding to any concern must be the safety of the child. Every looked-after child voicing a concern must be listened to and taken seriously. Concerns must be rigorously investigated. Equally, a carer's perspective should be heard. They must be treated fairly and with respect. Carers should be given information about the concern at the earliest point compatible with a thorough investigation. Where the concern involves reports of abuse, there will be an inter-agency referral discussion. The carer will be subject to investigation on the basis of local inter-agency protocols. Allegations of abuse by carers must be dealt with by appropriately trained child protection practitioners and managers.
250. Response to allegations should be proportionate to the nature of the concerns raised. Whatever the action to be taken, practitioners will need to discuss the needs of the child, the context of their care, key events in their lives at that time and any possible triggers for a concern being raised, either by the child or others. Fostering or residential service providers should be included in the discussion. All practitioners involved with protecting the child need to be fully informed about the role of carers, and the regulations that relate to their work. These meetings will facilitate the sharing and assessment of information, leading to a decision as to the next steps to be taken. If emergency action is required to protect the child, the consequences of all alternatives should be considered, despite the pressure to find immediate reduction of risk. Options for the way forward for a looked-after child are the same as for children in their own families.
251. When concerns about a looked after child are raised, it should be remembered that further disruption, such as a sudden move into a new care environment, will further compromise their recovery. The consequences of removing a child must be considered alongside their safety. Placement stability should be maintained when this is safely and possible. Each child's experience, views and presentation will be a central consideration.
252. **Parents of looked-after children.** Child protection practitioners must keep the child's needs and wellbeing central in listening to parental concerns. Development of respectful relationships between birth family and carers is essential for the child's short and long-term wellbeing and identity.
253. **Inequalities.** Children in the most deprived 10% of small neighbourhoods in Scotland are nearly 20 times more likely to be 'looked after' in care, or on the child protection register, than children in the least deprived neighbourhoods (Bywaters et al 2017). This is relevant at child, family, community and strategic levels to an understanding of the intersection of risks that must be addressed in child care and protection.

REFERENCES AND RESOURCES

Re-unification or 'return home'

254. Child protection and re-unification planning are connected in principle and process. To prevent repeated and compounded harm, re-unification for children who have experienced chronic abuse and neglect should be preceded by comprehensive assessment of whether or not the child should return home. Increased support is required when considering re-unification. Continued assessment and regular review is required.

Prompts below are recommended by Wilkins and Farmer (2015).

- View the plan from the child's perspective, gradually, stage by stage. Consider the child's timescales and need for emotional security. Ensure the child has persons they can trust and with whom they can share how they are coping with changes. Begin to think about what would be needed for re-unification from the beginning of the placement.
- Strength-based approaches (such as family group decision-making) may be helpful to enlist the co-operation and understanding of key family members, to build a package of supports, and to consider options and contingency plans.
- A methodical and structured approach to assessment and re-unification is recommended. This is crucial when there are long-term and interacting concerns, such as use of alcohol or drugs leading to chronic neglect.
- Previous failed re-unification plans should be taken into account. Analysis of the child, family history and strengths and concerns within and beyond the family is needed. Professional judgement about the likelihood of re-unification should integrate multi-agency perspectives and assessment of capacity to change, and supervisory review of evidence and analysis.
- Relationships that will have lasting value to the child should be supported. Assess and plan for provision of any additional support needs a child may have, for instance in relation to mental Health. Give families reasonable opportunity and support to make the changes while keeping child's safety and best interests central to decision-making.
- Seek to understand and adapt to cultural differences. Seek to work as a team with family, carers and key professionals in preparing for change and re-unification, as appropriate. Ensure there is evidence of parental abilities to sustain change.
- Help children and parents to work with practitioners to agree goals and understand what is happening at each stage. Agree lines of communication. Agree how to keep progress under close review. Consider how required support can be sustained, stepped up and stepped down as needed. Ensure that following re-unification, the child is seen and heard regularly, so that significant changes are noticed and can trigger supportive response.

REFERENCES AND RESOURCES

Preventing repeat removal of children

255. “If children are removed from the care of their parents, Scotland must not abandon those families. Families must continue to be provided with therapeutic support, advocacy and engagement in line with principles of intensive family support” (Independent Care Review, 2020)
256. Young women who have been unable to safely parent one child are most at risk of repeating the process. For vulnerable women, the interval between a child being removed and subsequent pregnancies are frequently short. However, co-ordinated planning and support for parents who have a child removed often ceases after removal, unless another child is at risk in the home.
257. When parents have complex and challenging needs, support to break the cycle, take control of their lives and develop new skills is essential. Such work is likely to require a holistic approach, in which key workers show persistence, proactivity, understanding, flexibility and work in relationship. Prevention and protection are inseparable concerns in this challenging area of practice.

REFERENCES AND RESOURCES

Children and young people who are missing

258. [The Scottish Government National Missing Person’s Framework](#) describes a missing person as anyone whose whereabouts are unknown and:
- where the circumstances are out of character
 - the context suggests the person may be subject to crime
 - the person is at risk of harm to themselves or another
259. The Framework defines the roles and responsibilities of key partners in relation to prevention, response, support and protection of children and other vulnerable persons who may be regarded as missing.
260. In a child protection context ‘missing’ may cover a wide range of circumstances including:
- children and their families with whom statutory services such as Health, education or Social Work have lost contact, and either the family location is not known, or for whatever reasons there has been no response to attempts to see the child
 - children who are not known by or have been hidden from universal services
 - children under 16 who have gone ‘missing’ from home, or under 18 from care, those who have run away, or been abducted either within or across borders
 - ‘missing’ may include those who have been forced to leave their home base, or whose whereabouts are unknown. This may be for a wide range of reasons including injury, abuse outside the home including sexual exploitation, escape from abuse, including honour based abuse and forced marriage, experience of crime, mental health problems, emotional distress, lack of understanding or confusion, a wish to be somewhere else doing something else, pressure from others within or beyond the home base, bullying, the need to see another person, or some other compelling reason.

261. **Acting on concerns:** If practitioners are concerned that a child or young person is ‘missing’, they should make every effort to make contact, visit if appropriate, and see that the child is safe and well. Health services may have cause to become concerned when significant appointments are missed without explanation, or missed consistently. This should be followed up. A recording of ‘did not attend’ is not sufficient. If practitioners are concerned a child may be at risk of harm, Police or Social Work services should be contacted. Consideration should be given to an IRD, if there appears to be risk of significant harm as described in Part 3.
262. **Child protection concerns may relate to** risk of harm which may have caused a child to go ‘missing’, risk of harm while a child is missing, potential on-going risks when a child has returned or been returned, or any combination of these dimensions.
263. **Multi-agency risk assessment and co-ordination** is essential for locating the child, consideration of options, and support. This could extend in cases of immediate urgency, up to the issuing of a Child Rescue Alert, or media alerts through the Police when there is a reasonable belief that a child is in imminent danger and there is sufficient information available to enable the public to assist the Police in locating the child. If a person or agency suspects that a child has been taken by, or is under the influence of, a third party (which may include parental abduction or ‘grooming’), the Police must be notified as soon as possible.
264. **Children missing from education** include those of compulsory school age who are not on a school roll and are not being educated otherwise (at home, privately or subject to any alternative educational provision). They have usually not attended school for a period of time (up to four weeks, but substantially less for a child with welfare concerns). School staff should be aware of local procedures and the role of the Children Missing from Education Co-ordinator.
265. **The Children Missing from Education (Scotland) Service** provides guidance and advice on good practice concerning cases of children missing from education, and checks the national electronic School2School transfer system (S2S) to see if the child has enrolled at another publicly funded school in Scotland. The CME Service facilitates agreements between local authorities, national agencies and partners in England, Wales, Northern Ireland and Ireland to allow exchanges of information, and will support local authorities in using these agreements. A list of Children missing from education: resources contains guidance and contact lists.
266. **Non-attendance and missing during the day:** Local authorities should have clear guidance on attendance policy and school staff should be aware of the procedures to follow when a child does not appear at school or goes missing during the day. Should there be any concern that the child may be at risk of harm, it is essential that local child protection procedures are followed.
267. **Unknown to education and home educated:** A child may be unknown to services as a result of their removal from mainstream education, or because they have never having been enrolled within an education authority. Where this is the result of a decision being made to educate them at home this should not, in itself, be regarded as a child protection concern. For further information, see the [Government Home Education Guidance](#).
268. **Children in care settings** such as residential or foster care are often reported missing. There were 7,598 Missing Persons Investigations by Police Scotland in relation to looked-after and accommodated children in 2017-18. The risk of harm for these children is often increased by their existing vulnerability, and referral to the Police may be necessary. However, there may be circumstances in which there is considered to be no risk, or a tolerable level of risk, in relation to a young person; for example, when they fail to return from a known location, and there are no concerns about their wellbeing.

269. Considering a person 'not at home' rather than missing should only be used where it has previously been agreed that it might be an appropriate response for this child in these circumstances. However, it is necessary to have clear and consistent local inter-agency protocol and definitions. The protocol should outline the approach to prevention planning and risk assessment, a process for return discussions, and follow-up intervention processes to deal with escalating concerns from repeat episodes. 'Prevention' includes consideration of the element of risk, and recommended responses within a child's assessment and plan.
270. **Partnership agreements:** The Pilot National Partnership Agreement for Looked After Children who go missing from Residential and Foster Care in Scotland (CELCIS 2018) indicated that local partnership agreements and regular liaison meetings between Police Scotland and relevant local authority staff can support consistent, safe and effective information sharing and response. The role of the Police Missing Persons Operational Co-ordinator is key within such partnerships.
271. **Children on the child protection register:** Local protocols will ensure that when a child whose name is on the child protection register goes missing, the appropriate local authority manager (and person accountable for the Child Protection Register if different) should be notified. Co-ordinated efforts should be made to trace the child and assess circumstances. A Review Child Protection Planning Meeting should be convened. Health and education services should be notified to ensure that the child will be identified if they present at another health or education setting.
272. **Stranger abduction.** A child may fail to return because they have been the victim of a crime. Police will give consideration to the relevance of section 171 of the Children's Hearings (Scotland) Act 2011 (offences related to children absconding from places where they are being kept by virtue of orders by a children's hearing or court or by virtue of a warrant) when there is evidence that a person has assisted them to abscond, concealed them, or prevented them returning. Previous Guidance in this section on child sexual exploitation, trafficking, female genital mutilation and forced marriage may be relevant, alongside Part 2b on assessment and contextual safeguarding.
273. **Missing across borders.** When there are concerns about a child who may be at risk of significant harm moving back to their country of origin or elsewhere abroad, it may be necessary to liaise with overseas Social Work services to ensure that the child has returned, and that their safety is being assessed locally. The relevant embassy or consulate may be able to provide contacts for appropriate authorities. International conventions provide a framework to assist professionals seeking to collaborate with their counterparts in other countries. Signatories have agreed to cooperate with the UK, and have established a Central Authority for that purpose.
274. **Abduction in the context of domestic abuse.** In situations where abducting mothers have been fleeing domestic abuse, they may be involved in return proceedings under the 1980 Hague Abduction Convention on the Civil Aspects of Child Abduction and the Brussels IIa Regulation (EC) No 2201/2003. General considerations in this Guidance to those facing domestic abuse apply. Mothers are likely to require legal advice and support to ensure that there are protective measures in place for the child's safety and best interests within return arrangements.
275. **Children and young adults:** Part (1.1) of this Guidance outlines the potential overlap between child protection and the protective duties under the Adult Support and Protection (Scotland) Act 2007 (with revised Code of Practice April 2014), the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care & Treatment) (Scotland) Act 2003.

276. **Each agency** needs to develop its own policies and protocols to manage risk and track missing children. Local areas should consider a strategic multi-agency collaborative framework, including relevant Third Sector agencies and independent schools, to support individual agency procedures for responding to and tracking missing children.
277. **Local Child and Adult Protection Committees** should ensure that there are specific and appropriate arrangements in place through guidance, protocols or procedures, which are known and implemented by relevant services. These should include response to children in transitional phases in which they may be at risk of abuse while missing, and adult services and legislation may also apply.

REFERENCES AND RESOURCES

Protecting unaccompanied asylum-seeking and trafficked children

278. **An unaccompanied asylum-seeking child** (sometimes referred to as a child seeking international protection) is defined in UK immigration rules by the Home Office as a person under 18 years of age when the claim is submitted; applying for asylum in their own right; separated from both parents; and is not being cared for by an adult who in law or by custom has responsibility to do so.
279. **Unaccompanied asylum-seeking children are the responsibility of the local authority** in which they are found and require to be accommodated and supported under section 25 of the Children (Scotland) Act 1995. They are entitled, as any other child, to the full range of supports that can be made available to children under this and associated legislation and provisions. They should be allocated a Social Worker. They should be supported in accessing the full range of health care and education opportunities available to UK born children. Children who are outside their country of origin and separated from their parents, or legal or customary care giver, are the responsibility of the local authorities, who will assess their needs and offer support.
280. Children, variously categorised for reasons beyond their control, are children first, requiring care and protection from abuse and neglect. Whatever the immigration and asylum status of a child, immediate and continuing safety is the priority. The UNCRC (Article 22) defines the right of any child seeking refugee status to receive appropriate protection and humanitarian assistance. The status of a child may change (e.g. from unaccompanied to 'accompanied') without necessarily reducing risks.
281. **Determination of immigration and asylum status** is a reserved matter for the UK Government. However, child protection and care in Scotland is the responsibility of statutory services in Scotland. It is unlawful for Social Workers to advise on immigration matters. Only those with the relevant qualification can advise if working in organisations regulated by OISC (Office of the Immigration Services Commissioner).
282. **Refugee status:** Decision-making on asylum is reserved to the Home Office. Social Workers are not responsible for determining whether a child (in terms of the Refugee Convention 1951 Article 1A) "... has a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country". Under current UK law, a person accepted as meeting the definition above will be granted Refugee Status and will receive Leave to Remain in the UK for a period of 5 years, after which they can apply for Indefinite Leave to Remain.

Principles essential to protecting unaccompanied children

- Unaccompanied children experience a confusing interaction of systems and rules. Article 3 of UNCRC is a foundation for ethical and effective practice across services. “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.” Within the UNCRC, ‘best interests’, relate to a child’s well-being. This should include consideration of the needs and views of the child. The ‘best interests’ principle is reflected in section 55 of the Borders, Citizenship and Immigration Act 2009, which places duties on the Secretary of State for the Home Department to ensure that immigration, asylum, nationality and customs functions are discharged having regard to the need to safeguard and promote the welfare of children in the UK (and this is as further reinforced in Home Office [statutory guidance to section 55](#)). In Scotland, section 17 of the Children (Scotland) Act 1995 places duties on local authorities in relation to looked-after children, including those placed because they have arrived unaccompanied.
- The European Convention on Human Rights (ECHR) potentially applies. It was incorporated into UK law by the Human Rights Act 1998 and is also reflected in the Scotland Act 1998. The ECHR protects and defines the right to life (Article 2); rights to respect for private, home and family life (Article 8); physical integrity and safety; freedom from torture, inhuman and degrading treatment (Article 3); protection from trafficking, slavery and forced labour (Article 4). It also includes rights to work, education and freedom of expression (Article 10), and the right not to be discriminated against (Article 14).
- Further guidance on children’s asylum claims (Home Office 2019) may be found at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/825735/children_s-asylum-claims-v3.0ext.pdf

283. **Routes of Arrival.** The most common routes of arrival of unaccompanied children include:
- ‘Spontaneous’ arrivals in local authorities, transport hubs or ports of entry.
 - Transfers through the [National Transfer Scheme](#) (NTS), which is provided for through section 69 of the Immigration Act 2016, and allows for the legal transfer of unaccompanied asylum-seeking children from one local authority to another local authority in the UK, on a voluntary basis.
 - Transfers through [Section 67 of the Immigration Act 2016](#) (‘the Dubs Amendment’) which require the UK Government to relocate and support 480 unaccompanied refugee children from Europe.
 - Resettlement through the [Vulnerable Children’s Resettlement Scheme](#) (VCRS) will shortly be replaced by a new global settlement programme.
 - Family re-unification through [Dublin III Regulations](#) which is a legal measure that allows for the re-unification of unaccompanied children in Europe with family members in the UK and vice versa. The UK Government are currently in negotiations with EU on this and a [draft agreement on the transfer of unaccompanied asylum-seeking children](#) was published in May 2020.
284. **Age assessment.** The Human Trafficking and Exploitation (Scotland) Act 2015 makes provision for a presumption of age in relation to suspected child victims of human trafficking to be given the benefit of the doubt in circumstances of assessing age. If there is uncertainty about a suspected victim’s age and reasonable grounds to believe they may be a child (under 18 years of age), a relevant authority such as a health board or a local authority should in exercising various statutory functions assume that the victim is a child (under 18 years of age) for the purpose of providing immediate support and services to the child until their age is formally established.
285. In cases where a young person is not necessarily thought to be a victim of trafficking, young people are increasingly being given the benefit of the doubt for the purposes of support during the age assessment process. Whilst this has not been explicitly legislated for, this position is supported by case law as set out in the Age Assessment: practice guidance (Scottish Government 2018).
286. **Communication and interpreting:** Practitioners must be aware of and plan for additional communication support and interpreting needs when disability and/or language difference is a barrier to understanding.
287. **Protective response is personal:** Children in these categories often feel alone and afraid. They need calmness, they need to be listened to and heard. They need acknowledgement, acceptance, respect, honesty, sensitivity and care. First impressions of kindness or coldness have an impact. If a practitioner is accessible, responsive and reliable, this will promote trust and recovery. If the child absconds they need to know they can return.
288. Past trauma, persistent feelings of threat and anxiety about asylum decisions (when relevant) significantly impact on children’s mental Health. Re-telling stories several times (and not just for asylum purposes), is a common source of anxiety for young people. Alongside having a safe space to remember, they may also need encouragement and enough space to forget and form new routines and relationships, and to reconnect or maintain contact with families if safe to do so. For those who have travelled across borders, the strangeness, separations, language differences and confusing systems all combine to add to experiences which can be frightening, unsettling and re-traumatising.

REFERENCES AND RESOURCES

Child trafficking and criminal exploitation

289. **Definition:** The legal definition of the offence of human trafficking in Scotland is set out in the Human Trafficking and Exploitation (Scotland) Act 2015 ('the 2015 Act'). A person commits an offence of human trafficking if a 'relevant action' is taken with a view to another person being exploited (section 1). The offence of human trafficking is aggravated by being committed against a child (as defined in the 2015 Act as a person under the age of 18-years-old) – see section 7.
290. **Relevant action:** Section 1(2) of the 2015 Act defines 'relevant action' as any of the following: recruiting another person; transporting or transferring another person; harbouring or receiving another person; exchanging or transferring control over another person; or arranging or facilitating any of those actions. It is irrelevant whether the person consents to any part of the action. Travel between two places is not a requirement for an offence of human trafficking to have taken place.
- **Exploitation:** The 2015 Act (section 3) describes what constitutes exploitation for the purposes of the offence of human trafficking. The following are examples of exploitation:
 - prostitution and sexual exploitation
 - criminal exploitation
 - slavery, servitude and forced or compulsory labour
 - securing services and benefits
 - financial exploitation/benefit fraud
 - removal of organs
 - debt bondage
 - begging
291. **Child trafficking and exploitation is abuse**, and an immediate child protection response is required, and an Inter-agency Referral Discussion (IRD) should be undertaken when there is reason to believe a child may have been trafficked or exploited.
292. **Awareness and recognition:** A child may not realise, divulge or agree that they have been trafficked or exploited. The child may be:
- at risk of being moved, especially when inquiries begin
 - threatened with personal or family harm if they speak out
 - unaware that they are a victim of trafficking
293. **Trafficking occurs both within Scotland and between Scotland and other countries.** UK children can be the victims of trafficking. It is estimated that around 40% of unaccompanied children have experienced trafficking and exploitation. Current figures for the National Referral Mechanism (which is a UK-wide process for identifying and referring potential victims of trafficking and ensuring they receive the appropriate support) for England and Wales indicate that the highest number of referrals are for UK children who have been internally trafficked. The number of referrals from Scotland for UK children is lower but is growing.

294. **Incidence:** Trafficking is a largely hidden crime. It can be difficult to identify victims. Statistics are uncertain and incomplete. The numbers of children referred to the NRM across the UK has risen annually since 2009, and in 2016-2018 the number of children referred has increased significantly, partly due to referrals of UK national children in relation to child sexual exploitation and Child Criminal Exploitation ('CCE'). In Scotland, between 2012-18 the majority of children known to have been trafficked have been from South East Asia (particularly Vietnam), East Asia, Africa and Eastern Europe. Across the UK as a whole, UK nationals accounted for the largest number of children known to have been trafficked in 2018.

Child Criminal Exploitation (CCE)

295. **CCE** is not defined in law but practitioners should be alert to the possibility that some children who are victims of trafficking may be exploited by gangs and organised criminal networks (CCE can be associated with the term, and can be known as "County Lines"). Gangs which export illegal drugs into one or more importing areas (within the UK) may use dedicated mobile phone lines or other form of 'deal line'. Such gangs are known to exploit children and vulnerable adults to move (and store) drugs and money. They will often use coercion, intimidation, violence (including sexual violence) and weapons.
296. Child criminal exploitation takes a variety of different forms. It can include children being forced to work in cannabis factories, being coerced into moving drugs or money across the country, forced to shoplift or pickpocket, or to threaten other young people. All forms of criminal exploitation have a detrimental impact on a child's life. As such, any child being forced or coerced to commit crime must be seen as a victim of exploitation.
297. Child criminal exploitation is often unrecognised and this can mean children are more likely to be prosecuted for offending behaviour, rather than being recognised as victims of exploitation. It is critical for professionals to be aware of indicators of trafficking and exploitation, and to take appropriate safeguarding and procedural steps. This is particularly important because a prosecution against someone who has committed a criminal act as a result of being trafficked or exploited would in some circumstances be contrary to obligations imposed by European and national law. Section 8 of the 2015 Act requires the Lord Advocate to publish instructions about the prosecution of persons who are, or appear to be, victims of an offence of human trafficking. [The Lord Advocate's instructions for Prosecutors when considering Prosecution of Victims of Human Trafficking and Exploitation](#) that there is "a strong presumption against prosecution" of a child victim of human trafficking or exploitation who has committed an offence in the course of, or as a consequence of, being the victim of human trafficking or exploitation. Too often children are criminalised rather than seen as victims of criminal exploitation and given the appropriate child protection response.
298. Being aware of the indicators and risks that may suggest children and young people are being exploited and abused in such a manner is the initial step that professionals need to take. Then, considering how this is being facilitated, by whom, and for what purpose, may evidence there is child criminal exploitation occurring, which should inform the agencies involved and the approach to be taken to protect and intervene.
299. Contextual safeguarding needs to be considered in managing the risks posed to and from the young person, as a traditional focus on solely the family rather than wider relationships may not suffice in managing presenting behaviours.

300. **‘Cuckooing’:** Practitioners should also be alert to reports which may indicate someone’s home has been taken over by intimidation or other means for the purpose of criminal activities. Signs of ‘cuckooing’ might include reports of:
- bags of clothing or bedding around the address
 - increased visitors throughout the day or night
 - increased vehicles outside the address, including taxis, new vehicles and hire cars
 - increased anti-social behaviour in the area
 - disengagement with support services
 - drug paraphernalia around the address, and the smell of drugs such as cannabis
 - barricades within and around the address, including weapons

Initial assessment and response to trafficking and exploitation

301. An assessment should always be comprehensive and follow GIRFEC principles. There are no risk-assessment tools that can predict the risk of trafficking or definitively identify those who have been trafficked. However, an indicator matrix has been developed to assist the recognition of such abuse both within the UK and across borders. The indicators complement and do not replace child protection procedures. (*Indicators in use across the UK reflect those applied in international texts and trafficking practice handbooks (IOM 2009; UNODC 2018 and [Operational Indicators of trafficking in human beings, 2009](#)); and in identification of child sexual exploitation (Hynes 2015).
302. **If an agency or practitioner has concerns that a child may have been trafficked** they should consult the indicator matrix* and should always
- contact Social Work or Police Scotland but not contact carers initially or seek their consent
 - follow inter-agency child protection procedures
 - an Inter-agency Referral Discussion must follow
303. **National Referral Mechanism (NRM):** The UK has a responsibility to identify and record cases of child trafficking under The Council of Europe Convention on Action Against Trafficking in Human Beings. The NRM was set up by the Home Office to help victims of trafficking receive support, and to gather intelligence to help interrupt trafficking. Any child suspected of being a victim of trafficking should be referred to the NRM through the new digital platform. Best practice in Scotland is to ensure that referral to the NRM follows on from Child Protection processes, including an IRD, to ensure that the referral has captured all the relevant information pertaining to the child.

Independent Child Trafficking Guardians

304. The Scottish Guardianship Service provides a Guardian to migrant unaccompanied children and young people in Scotland. The Guardians provide assistance and support in navigating the complex welfare, care, immigration, asylum and trafficking systems, often in a foreign language. The Guardian can advocate for children in engaging with the various authorities, and can speak on the child’s behalf to avoid the need for them to re-live their experiences through constant re-telling of their story to different authorities.

305. A new statutory service for an Independent Child Trafficking Guardian (ICTG) will be implemented in 2021 for a child under 18 years for whom a relevant authority has reasonable grounds to believe has been trafficked or is vulnerable to becoming a victim of trafficking, and for whom no-one in the UK has parental rights or responsibilities. This will put the role of the Guardian on statutory footing with other support services. International research has shown that unaccompanied and trafficked children benefit enormously from guardianship arrangements.

Effective response to child trafficking depends on a Child Protection response

306. Protocols, developed through Child Protection Committees, should emphasise the following matters:
- central and immediate focus on the child's safety, health and wellbeing
 - practitioner awareness of indicators of potential abuse across agencies
 - provision of a guardian for eligible children
 - inter-agency systems that support identification and recording
 - sufficient awareness of legal framework within core agencies
 - prompt inter-agency referral discussion and response
 - referral to the NRM following Scottish Child Protection processes (including IRD)
 - consideration of the use of interpreters
 - consideration of support needs of children who may be traumatised
 - prevention and disruption of trafficking
 - rigorous prosecution of offenders
 - provision of assistance and support for victims
 - protecting victims' rights in criminal proceedings
307. The 2015 Act (Part 4) introduced Trafficking and Exploitation Prevention Orders (TEPOs) in June 2017, and Trafficking and Exploitation Risk Orders (TEROs) in October 2017. TEPOs can impose prohibitions or requirements on those who have committed a trafficking or exploitation offence, or who may commit such an offence, as well as those who in certain circumstances were acquitted of such an offence or who were found to be unfit for trial. TEROs may be imposed in respect of adults where there is a risk that the adult may commit a relevant trafficking or exploitation offence. TEPOs and TEROs could impose prohibitions or in relation to Scotland or elsewhere and could include other prohibitions e.g. on foreign travel.

REFERENCES AND RESOURCES

Protection in transitional phases

308. **Meaning:** A significant trauma, loss or change in a child's care, core relationships and services may have a ripple effect, not only for the child, but also for those to whom they feel closest. This interaction informs effective assessment and planning of support during phases in which there may be heightened risks, as well as opportunities for growth.

309. **Examples of transitional risks and opportunities**

- Children who have been impacted by abuse or neglect, who are now moving onto adult life and services.
- Children who are impacted by parental health problems, or by drug and alcohol problems, and are now moving onto adult life and services.
- Children with complex disabilities who are moving onto adult life and services. They and their families often experience a sequence of service changes and loss of known professional supports within an age band during which their fundamental health and wellbeing needs may change little.
- Children moving between care placements or moving on from family based, residential or secure care arrangements. Some of the most emotionally isolated and risky transitional phases may occur several years after the movement between or out of these settings.
- Parents who have lost a child involuntarily through statutory processes. There may be phases of heightened risk and opportunity to engage following such removal. Disengagement by and from services may increase the risk of repeat removal(s).
- Children in transitional phases who are isolated or separated from those to whom they feel closest, or from those who would help them now and in future.
- Children in transitional phases within families who find services inaccessible or incomprehensible.

310. **Anticipation and prevention:** In and of themselves, such phases do not trigger ‘child protection’ or ‘adult protection’ processes. There may be trigger points or critical moments when a child is excluded, isolated, hurt or afraid, when proactive support can make a long-term difference. Early collaborative planning and sufficient co-ordination and continuity of support are key to effective support through predictable transitions. This Guidance advocates an approach that is rights-based, has a focus on relationships, and seeks to build on resilience. Some areas have developed Young Person Support and Protection Protocols which raise awareness and signpost appropriate processes for children and young adults across a range of concerns, when there is a pattern of escalating concerns.

Signposts in this Guidance: The legal interface between child and adult protection processes are outlined in Part 1 of this Guidance, under the definitions of “child’ and ‘principles in child protection’. In Part 2 the interface between child and adult protection is considered in relation to roles and responsibilities. The components of assessment and planning in Part 2b invite consideration of transitional needs. In relation to specific areas of risk, practitioners should apply evaluated and locally approved frameworks in the use of which they are trained and supervised.

REFERENCES AND RESOURCES

Bullying

The paragraphs below should be read alongside sections of overlapping relevance in this part of the Guidance, including child protection in the digital environment, hate crime, and seriously harmful behaviours and harmful sexual behaviours by children.

311. **Meaning:** In Scotland there is no legal definition of 'bullying'. '[Respect for All: National approach to anti-bullying](#)' provides the framework for anti-bullying work in Scotland and defines bullying as "both behaviour and impact: the impact is on a person's capacity to feel in control of themselves. Bullying takes place in the context of relationships; it is behaviour that can make people feel hurt, threatened, frightened and left out. This behaviour happens face-to-face and online" (Respect for All, 2017). Although the actual behaviour may not be repeated, the threat may be sustained over time, typically by actions, looks, messages, confrontations, physical interventions or the fear of these.
312. **Bullying can occur** between children and young people, and between adults and children. Online bullying should not be treated differently from face-to-face bullying. Bullying behaviour may be motivated by prejudice due to perceived or actual differences. This may lead to racism, sexism, homophobia, biphobia or transphobia, or prejudice and discrimination towards disability or faith ([see section on hate crime](#)).
313. **Online bullying** (sometimes called 'cyber-bullying') is technology-assisted. It can involve the circulation or sharing of rumours, messages, gaming and images. Bullying can cause significant and sustained harm and requires agency policies and protocols that are holistic, preventative, proactive and supportive. Bullying of any kind must be addressed quickly whenever it arises.
314. **'Peer-on-peer abuse'** may be used to refer to any form of physical, sexual, emotional and financial abuse, and coercive control, exercised between children and within children's relationships (both intimate and non-intimate). The term 'peer-on-peer' can obscure significant age and power differences.

Protective and preventative responses

315. An anti-bullying policy is a clear commitment to develop a respectful, equitable and inclusive culture and ethos within an organisation or establishment. Anti-bullying policies should be developed in partnership with children and young people, parents and carers, and staff, including volunteers.
316. Support should seek to prevent the 'criminalising' of children and young people wherever possible. However, adults and children and young people can seek appropriate advice from Police Scotland if they feel a crime may have taken place.
317. Consideration should be given to the context in which bullying has occurred. References to contextual safeguarding in part 2b and below may be of relevance. There is a range of relationship-based approaches that can improve relationships and behaviour, promote equality and challenge inequality, and develop emotional wellbeing to help prevent and address bullying which includes restorative approaches, solution oriented approaches, nurturing approaches, mentoring and peer support.

318. Education and Social Work services will consider triggering an IRD when there is risk of significant harm to a child from bullying or peer-on-peer abuse. Referral to the Reporter will be considered when there is an apparent need for compulsory measures. When a crime is reported, the Police will investigate, respond and consider the need for an Inter-agency Referral Discussion under child protection procedures as defined in Part 3.

REFERENCES AND RESOURCES

Hate Crime

The paragraphs below should be read alongside sections in this Part of the Guidance concerning child protection in the digital environment, bullying and harmful behaviours by children.

1. **Definition:** Hate crime is the term used to describe behaviour which is both criminal and rooted in prejudice. Hate crime can be verbal or physical and can be online or face-to-face. It has hugely damaging effects on the victims, their families and communities. Current hate crime legislation in Scotland allows any existing offence to be aggravated by prejudice in respect of one or more of the protected characteristics of race, religion, disability, sexual orientation and transgender identity. Prejudice or hostility also lies at the heart of some other offences which are recognised as hate crimes. These include racially aggravated harassment and stirring up of racial hatred. The Hate Crime and Public Order (Scotland) Bill which was introduced to the Scottish Parliament on 23 April 2020 consolidates, modernises and extends hate crime legislation in Scotland. It adds age as an additional characteristic and creates a new offence of 'stirring up of hatred', that will apply in relation to all protected groups protected by current hate crime laws. The Bill includes a power to enable the characteristic of 'sex' to be added to the lists of protected characteristics by regulations at a later date.
2. **Impact:** The effects of hate crime can be emotional or physical and may impact on children's sense of security, identity and emotional wellbeing. Children who are victims of hate crime may experience high levels of anxiety, difficulty sleeping and potentially, suicidal feelings.
3. **Prevention:** Prejudice is learned from a young age. Therefore, children who have caused harm may not understand the consequences of their behaviour or the harm caused.

There are many initiatives within Scottish schools to address prejudice-based bullying and hate crime (EHRC, 2017). It is likely to be an important facet of preventative, educational and rehabilitative action that offenders are given an opportunity to understand what a hate crime is and the impact that it has on individuals, families and communities.

4. **Response:** Support should seek to prevent the criminalizing of children and young people wherever possible, unless in the public interest. However, adults, children and young people can seek appropriate advice from Police Scotland if they feel a crime may have taken place.
5. Anyone who has experienced or witnessed a hate crime should be encouraged to report it directly to the Police, a trusted adult or by using a third-party reporting centre. Third-party reporting allows victims and witnesses to report an incident without contacting the Police directly. There are third-party reporting centres across Scotland, ranging from housing associations to victim support offices and voluntary groups, where specially trained staff provide support and assistance in submitting a report to the Police. [Find your nearest Third Party Reporting Centre](#). Police response will include the consideration of the need for an inter-agency referral discussion, taking in to account the impact, circumstances and protective and support needs of those involved.

6. Hate crime is often not reported to the Police. Tackling underreporting of hate crime and initiatives to deter people from committing hate crime remain key priorities for the Scottish Government, Police Scotland and COPFS. Scottish Government has committed to modernising the current law on hate crime, and will introduce a consolidated hate crime bill.

REFERENCES AND RESOURCES

Serious harmful behaviour shown by children above and below age 12

7. Serious harmful behaviour in this context means behaving in a violent or dangerous way which causes or risks causing serious physical harm to another person, or sexually violent or sexually coercive behaviour, which has caused or risks causing harm (whether physical or not) to another person. (Please refer to section 15 above for further information about response to sexually harmful behaviour by children). The Framework for Risk Assessment Management and Evaluation (FRAME) for children aged 12-17 (under revision 2020) will further detail 'risk of serious harm' and standards of practice for this age group. Consideration must be given not only to the to the impact of threat and physical or psychological trauma caused; but also to the level of intent, use of force or coercion and potential as well as actual harm.
8. Children that behave in this way may themselves have been abused or neglected. Whether or not they have been maltreated, they are likely to have additional needs relating to their behaviour or the impact of their behaviour. While the Police and statutory services will take action to protect the safety of those involved in the situation and attend to the needs of victims, all investigative and planning activity triggered by a child's harmful behaviour must have regard for the child's wellbeing as a primary consideration.
9. Once the Age of Criminal Responsibility (Scotland) Act 2019 ("the 2019 Act") is fully implemented, a child under the age of 12 years will no longer be able to commit an offence in Scotland. This reform is the primary purpose of the Act, which received Royal Assent on 11 June 2019. Statutory Guidance will be published.
10. The 2019 Act provides Police powers for immediate and planned investigation of seriously harmful behaviour. The 2019 Act includes provision for Police response to a situation in which a child is behaving in a way that is causing or risks causing significant harm to another person, by removing a child to a place of safety. Appropriate arrangements will be made in co-ordination with the local authority.
11. Co-ordinated planning of investigation and action will be described in statutory guidance on the Act. General principles underpinning all investigative and planning processes are summarised in [Part 3](#) of this Guidance. If child protection concerns arise in relation to the child who has behaved harmfully to others then standard components of IRD processes apply. The immediacy of risk of harm to the child or children involved will determine the steps and prioritisation of steps taken.
12. If a formal interview is required under the terms of the 2019 Act, a legally qualified and approved Child Interview Rights Practitioner must be involved, for the purposes of protecting the rights of the child.
13. Discovering what happened in harmful circumstances is dependent upon trauma-informed, child-centred processes. This includes communication and co-ordination with those who care about and have responsibilities towards the child and other children closely affected.

14. The Principal Reporter can no longer refer a child to a children's hearing on offence grounds, where the offence took place when the child was under 12 years of age. As explained above, once the 2019 Act is fully implemented, a child under the age of 12 years will no longer be able to commit an offence in Scotland. However, the Principal Reporter can refer a child to a children's hearing on non-offence grounds that may include reference to any serious harmful behaviour by the child.
15. If it appears that behaviours observed or reported fall short of risking or causing 'serious harm', the local processes for proportionate, co-ordinated 'Early and Effective Intervention' will apply within the Whole Systems Approach adopted in most areas. GIRFEC and Early and Effective Intervention aim to prevent children entering into formal systems if compulsory measures are not needed.
16. The Framework for Risk Assessment and Management and Evaluation sets out standards for children involved with offending behaviour as distinct from adults who offend. Effective practice requires joined-up planning at operational, tactical and strategic levels between criminal justice, adult protection, child protection and childcare services.
17. If it appears that a young person 12-17 is responsible for seriously harmful acts, local Care and Risk Management processes apply. These should reflect Revised national guidance on Care and Risk Management (revision forthcoming). Although children of this age may be charged with an offence, the investigative and planning principles that are summarised in Part 3 of this Guidance apply.
18. **Alleged offences of a serious nature involving children aged 12 or over** can be referred to the Procurator Fiscal. Children aged 12 or over can be prosecuted, however the offences must fall within the category of offences outlined within the Lord Advocates Guidelines to the Chief Constable on the Reporting of Offences to the Procurator Fiscal of Offences alleged to have been committed by Children:

Category 1: offences which require by law to be prosecuted on indictment or which are so serious as normally to give rise to solemn proceedings on the instructions of the Lord Advocate in the public interest.

Category 2: offences alleged to have been committed by children aged 15 years or over which in the event of conviction oblige or permit a court to order disqualification from driving.

Category 3: offences alleged to have been committed by people who are aged 16 or 17, and who are classified as children by section 199 of the Children's Hearing (Scotland) Act 2011.
19. Children aged 12 or over who are referred to the Procurator Fiscal are also referred to the Children's Reporter, and the Procurator Fiscal makes a decision whether the child can be dealt with in the children's hearing system or whether the case will be dealt with by the Procurator Fiscal after discussing the child with the Children's Reporter.
20. Children aged 16 or 17 who are subject to compulsory supervision through the children's hearings system can continue to be managed in this system or can be prosecuted. This decision is made by the Procurator Fiscal following discussion with the Children's Reporter. Where criminal proceedings are initiated in court, the court can, upon conviction, choose to remit the child back to the children's hearings system for disposal under section 49 of the Criminal Procedure (Scotland) Act 1995.
21. Where a child aged 12 or over is referred to a children's hearing on the ground that they have committed an offence, in any resulting proof proceedings in the Sheriff Court the standard of proof is the same as the test that applies in criminal proceedings: beyond reasonable doubt.

22. The Scottish Government has consulted (2020) on raising the age at which a young person can be referred to a children's hearing from 16 to 18.
23. **The Principal Reporter** will consider other factors as well as the sufficiency of evidence relating to the grounds when deciding whether to call a hearing. The child's development, parenting and family and environmental factors are taken into account alongside the history of co-operation with any previous intervention; the impact of any previous intervention; the current motivation to change; and the willingness to co-operate with any intervention. Where a child is not referred to a children's hearing, the Principal Reporter may refer the child back to the local authority for them to work with the child on a voluntary basis, or may take no further action. A fundamental principle of the children's hearings system is that the hearing will consider the individual circumstances of each child, and should not make orders in respect of the child, such as compulsory supervision orders, unless to do so is better for the child.

REFERENCES AND RESOURCES

Vulnerability to being drawn into terrorism

24. The Counter Terrorism and Security Act 2015 places a duty on specified authorities in Scotland such as local authorities to have due regard to the need to prevent people from being drawn into terrorism. It also places an obligation on local authorities to ensure that a panel of persons is in place for its area to assess the extent to which identified individuals are vulnerable to being drawn into terrorism and, where appropriate, arrange for support to be provided. Guidance on Prevent Multi-Agency panels will be available (on gov.uk) from summer 2020. When assessing referrals to such panels, local authorities and their partners should consider how best to align such assessments with child protection legislation and guidance.

REFERENCES AND RESOURCES

Complex investigations

25. **'Complex investigations'** refer to multi-agency response when there is reasonable concern about abuse involving one or more abusers and a number of related or non-related abused children or young people. The abusers concerned may be acting in an organised way to abuse children. Some such individuals and networks act in isolation. Others may use an institutional framework or position of authority to groom and abuse children. Guidance may be found above in this section on response to child trafficking.

The nature of 'complexity' may be affected by environment in which abuse occurs. This may be an institution, establishment, club, group, internet-based, or a combination of scenes or locations. Additional complexity may also relate to the length of time between the abuse and the report, or due to the extended period of time over which abuse may have occurred.

26. **'Institutional abuse'** is a term which may be used to encompass abuse in an institutional setting which may include non-accidental injury, sexual abuse, neglect in delivery of care and supervision, emotional abuse, or a combination of these.
27. **'Ritual abuse'** refers to the use of strategies, beliefs and ideologies that legitimise sexual and other forms of exploitation to both victims and perpetrators of organised abuse. Ritual abuse is sometimes associated with other organised abuse, including child prostitution. Some victims may have experienced neglect and abuse both at home, and organised abuse in other settings. Vulnerability in one context can contribute to victimisation in another.

28. **Child abuse linked to** beliefs in witchcraft, spirit possession and other forms of the supernatural can lead to children being scapegoated and abused physically, sexually and emotionally. Fear of the supernatural is also known to be used to make children comply with being trafficked for domestic slavery or sexual exploitation. Such abuse is not confined to one faith, nationality or ethnic community. The number of known cases suggests that only a small minority of people who believe in witchcraft or spirit possession go on to abuse children. Abuse may happen at home or in another setting.
29. **Survivors of organised and ritual abuse** may only be able to report their experience many years later, with awareness often arising through 'flashback' memories. Survivor recovery may be further complicated if there has been involvement of family members, they have been made to recruit other victims, engage in abusive behaviour of others, or engage in the use and production of pornography. The imposition of beliefs and ideologies justifying the behaviour or the abusers may complicate investigation, support and recovery of those survivors who have been made to feel both shame and complicity.
30. **Considerations in planning interviews:** Where a child has been involved in pornography and filmed or become accustomed to their image being manipulated, recording of interviews may be particularly alarming. Local inter-agency child protection procedures should include contingency plans to deal with such cases.
31. **Scope:** Complex investigations may extend beyond the boundaries of individual services. The extent of concerns about abuse may not at first be apparent. When the factors above emerge, detailed planning is advised at strategic as well as at operational level. The purpose of such planning is to ensure a consistency of approach and clear areas of accountability, to scope investigations and the potential for these to grow, and to give initial consideration to options available. Standard IRD processes as described in Part 3 should begin such planning.
32. **A strategic management group will normally:** establish the terms of reference of the investigation; provide strategic leadership for the investigation; agree the staffing of the investigation; agree such protocols as may be necessary.
33. **Police and Social Work services** should agree arrangements for convening planning meetings, setting up systems for sharing and updating information about the investigations progress, and co-ordinating support. All relevant agencies and services should be involved in these discussions.
34. **Chief Officers** should be alerted in such circumstances, including where the concerns involve a child or children outside the area. Senior managers from Social Work services and the Police should ensure that arrangements for the investigation of linked cases are in place, so that children and adults are adequately protected.
35. **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 will require careful co-ordination of investigations, interviews, and other assessments.

36. If a number of families, parents and carers are involved, the local authority should make clear arrangements to keep them informed of events and plans. Parents/carers are usually entitled to the fullest possible information. If it is 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. This should be considered in the planning process. Parental involvement may need to be limited in order to safeguard the child. The reasons for this must be recorded.
37. **Early involvement of the Procurator Fiscal and the Principal Reporter** will be necessary. Police and Social Work services should agree a media and public communication strategy.
38. **Specialist skills:** The investigation of complex child abuse requires an investigating team with appropriate expertise. A teamwork approach is essential. It may be necessary to involve agencies which are trusted by the child or other witnesses. Specialist advice and support may be required from agencies with particular knowledge of the issues.
39. **Systemic issues:** Where there is evidence of institutional abuse, operational and strategic analysis should consider not only the responsibility of individuals, but also the contribution of culture, belief and systems within those institutions, organisations or communities which carried out the abuse. Common features include the isolation of victims and the privacy which may provide individuals with opportunity for the exploitation of power.
40. **Partnership across areas:** In anticipation of strategic and operational partnership that may be required from time to time, lead agencies should consider establishing links with neighbouring authorities and agencies to ensure access to necessary resources – including skilled staff and specific facilities such as interview suites – when dealing with complex multiple or organised abuse cases. Inter-agency procedures should reflect local arrangements to provide support, de-briefing or counselling for practitioners as necessary. For further information on supporting child witnesses, see the section on Criminal prosecutions.

REFERENCES AND RESOURCES

Female Genital Mutilation

41. **Female Genital Mutilation (FGM) is child abuse.** This traditional practice is an extreme form of gender-based abuse, causing significant and lifelong physical and emotional harm. Cultural considerations and sensitivities should not override the need of professionals to take action to protect a child at risk.
42. **Definition:** The legal definition of FGM 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 (section 1 of the Prohibition of Female Genital Mutilation (Scotland) Act 2005). The World Health Organization defines [four types of FGM](#). However, it should be noted that the term FGM is often not recognised by FGM practicing communities, and practitioners should use terms such as cutting or female circumcision instead.
43. **Occurrence:** FGM may be a risk from infancy through to adulthood, as the practice can take place in infancy, childhood and also before marriage. Disabled children may also be subjected to the practice. A girl or woman might be subjected to FGM more than once throughout her life. A girl or woman may be taken out of the country by family in order for the procedure to be carried out.

44. **Criminal offence:** FGM has been illegal in Scotland since 1985. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 made it a criminal offence to have FGM carried out either in Scotland or outside the United Kingdom. The Act also increased the maximum sentence on conviction on indictment from 5 to 14 years imprisonment (section 5 of the 2005 Act). The UK Parliament's Serious Crime Act 2015 extends the reach of extra-territorial offences in that Act to habitual (as well as permanent) UK residents. The Female Genital Mutilation (Protection and Guidance) Act 2020 makes provision for FGM Protection orders and for Statutory Guidance on FGM. This Bill will strengthen the existing legislative framework for the protection of women and girls from FGM.
45. **Psychological impact:** FGM can be imposed by families that are in other ways protective. By contrast it may be associated with other forms of gender-based violence and so called 'honour-based' abuse, which can include child and forced marriage. Sometimes FGM can be linked to trafficking. Children affected by FGM experience lifelong psychological trauma.
46. **Physical impact:** FGM procedures cause severe pain, emotional and physical shock. Complications can cause death. Effects can include haemorrhage, wound infections, urinary retention, injury to adjacent tissues, fracture or dislocation as a result of restraint, and damage to other organs. Long-term health consequences include: chronic vaginal and pelvic infections; difficulties during menstruation; difficulties in passing urine and chronic urine infections; renal impairment and possible renal failure; damage to reproductive system (including infertility); infibulation cysts; neuromas; keloid scar formation; complications in pregnancy; delay in the second stage of child birth; maternal or foetal death; and increased risk of sexually transmitted infections. Surgical interventions during pregnancy and childbirth may be required.
47. **Emotional impact:** Immediate and long-term emotional impact is further complicated because the decision is usually made by those who are respected, loved and trusted. Adult survivors who experienced FGM as children have reported losing trust in those who forced them to undergo the procedure. Others experience family conflict and/or separation, especially in families when parental attitudes are divided. Women may experience recurrent sexual, psychological and physiological problems. FGM may also cause severe post-traumatic stress and can be associated with subsequent drug and alcohol problems, although this is less likely in cultures where drug and alcohol use is considered 'shameful'.
48. **Awareness and response:** FGM or risk of FGM may first come to the attention of education or health professionals. A child can be considered at risk if they come from an FGM practicing community or if a close female relative is a survivor of FGM regardless of whether the community of origin traditionally practices FGM. A strong indicator could be the planning of an extended family holiday.
49. **Every situation should be considered individually,** rather than making automatic assumptions about levels of risk within specific communities.
50. Other child protection concerns may or may not co-exist. It is relevant to know if the family is from a community in which FGM is practised; if the girl's mother has experienced FGM; if the girl has a female sibling/cousin who has experienced FGM; and if it is known that the family is as yet not well integrated. Practitioners should be aware that attitudes within the same family may vary. Some women who have experienced FGM are opposed to their daughters undergoing it. Experience of coercive control and the size of the family/extended family/wider community may limit the protective capacity of some parents. Consideration should be given to how to give mothers safe and private space in which to talk. As with other forms of child protection work, there should be efforts to engage and seek a shared understanding in partnership with parents/carers, unless there are safety considerations. Survivors of FGM should be given the opportunity to speak with female practitioners.

51. **Co-ordinated response:** When it is believed that FGM has been carried out upon a child or when there is cause to believe it may occur, this should trigger an IRD, as outlined in Part 3. A strategy discussion may be advised in order to consider the whole situation and tailor the engagement, investigation and support process likely to be in the child's best interests. The plan should take into account that other female siblings or close relatives may also be at risk.
52. **Practice considerations:** A multi-agency approach is required. [National multi-agency guidance](#) (Scottish Government, 2017) provides indicators of good practice. Wherever possible, female practitioners are recommended for planned assessment. Practitioners will be sensitive to the time and privacy needed by those expressing concerns. Clear and simple language should be used. Those involved also need a clear understanding of the role of practitioners. Some children will not understand what has happened or what may happen. Care should be exercised in the use of interpreters and lay advisors from the same local community as the victim. ([The Scottish Translation, Interpretation and Communication Forum Good Practice Guidelines, 2004](#)).
53. **Strengthening the law:** As part of the National Action Plan to Prevent and Eradicate FGM (Scottish Government (2016), the Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 was recently enacted. In reviewing local guidance, agencies will need to take into account the new Act's requirements. These include FGM Protection Orders and Statutory Guidance.

REFERENCES AND RESOURCES

Honour-Based Abuse and Forced Marriage

319. **A forced marriage is a marriage conducted without the full and free consent of both parties, and where duress is a factor.** Duress can include physical, psychological, financial, sexual and emotional abuse. A forced marriage is different from 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.
320. **Forced marriage** is both a child protection and adult protection matter. Child protection processes will be considered up to the age of 18. Forced marriage may be a risk alongside other forms of so called 'honour-based' abuse (HBA).
321. **HBA includes** practices used to control behaviour within families, communities, or other social groups, to protect perceived cultural and religious beliefs and/or 'honour'. Such abuse can occur, for example, when perpetrators perceive that a relative has shamed or may potentially shame the family and/or community by breaking their honour code. This abuse can take many forms, including threatening behaviour, emotional blackmail, assault, rape, abduction, forced marriage, confinement and 'honour killing'.
322. **Perceived transgressions** which may trigger HBA include: supposedly "inappropriate" makeup or dress; having a boyfriend/girlfriend; forming a relationship with someone of a different faith; showing same-sex attraction or having a same-sex relationship; kissing or intimacy in a public place; pregnancy outside marriage; and rejecting or seeking to escape from a forced/arranged marriage. Particularly for women, seeking a divorce (regardless of the reasons behind this) is extremely stigmatised and can lead to ostracism and honour abuse.

323. **Children at risk:** Those who might identify as LGBT and disabled children may be at increased risk of forced marriage. For LGBT people this is seen as a way of ensuring that their LGBT identity is not made public. Forced marriages are also seen as a way of ensuring that someone who needs care has a spouse who can provide care. Further, immigration can be an aggravating factor towards forced marriage: by arranging a marriage of a UK citizen with someone from overseas, the overseas spouse is guaranteed an easier entry into the UK. An estimated 85% of forced marriage victims are girls and women. HBA support work is mainly conducted by women's organisations. However, boys, especially those who might identify as gay, bi-sexual or transgender are also affected by forced marriage, domestic abuse, coercive control and other forms of HBA. Practitioners should be aware that forced marriage is not restricted to any particular ethnic or religious community.
324. **Legal framework:** Forced marriage legislation should be used in conjunction with child and adult protection legislation. 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 Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011 came into force in November 2011 and introduced civil remedies for those at risk of forced marriage, and those who have already been forced into marriage. It introduced a civil Forced Marriage Protection Order (FMPO), which can be used to protect those at risk; it is a criminal offence to breach a FMPO. To extend protection for those at risk, the Scottish Government took the decision to criminalise forcing someone into marriage. The relevant legislation is contained in section 122 of the Anti-Social Behaviour, Crime and Policing Act 2014.
325. **The consequences of forced marriage** can be devastating for 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 become victims of domestic abuse. Rates of suicide and self-harm within forced marriages are high.
326. **Potential indicators** of honour-based abuse and forced marriages include:

Concerns voiced by child or person in child's network

- About going overseas 'to visit relatives' or attend a wedding.
- Concerns expressed about a dowry being collected (usually jewellery, clothing, other material possessions).
- A girl undergoing or at risk of undergoing FGM as part of her 'preparation' for the marriage.

Education concerns

- Absence, or persistent absence, from education.
- Request for extended leave of absence and failure to return from visits of 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 onto further/higher education.
- Sudden changes in appearance or behaviour (especially young girls changing their dress code dramatically to adopt culturally/religiously appropriate clothing).

Health concerns

- Self-harm.
- Attempted suicide.
- Depression.
- Eating disorders.
- Accompanied to doctors or clinics and prevented from speaking to health practitioners in confidence.
- Experience of female genital mutilation (FGM).

Police concerns

- Reports of domestic abuse, harassment or breaches of the peace at the family home.
- Threats to kill and attempts to kill or harm the potential victim or another family member (emotional blackmail).
- Truancy or persistent absence from school.

327. **Approach.** Direct engagement with the family is not advised, as it may aggravate and expedite the risk of a child being taken abroad for a marriage. It is always advisable to contact a specialist organisation or community advisor for support.

328. Practitioners involved in this work should have sufficient training and supervision to support application of the required knowledge and skills.

REFERENCES AND RESOURCES

Fabricated or Induced Illness

329. **Definition:** Fabricated or induced illness refers to a process in which a parent or caregiver induces illness or a sick role in a child by exaggeration, deliberate non-treatment, fabrication or falsification of signs of illness. The process can include maladministration of medication or other substances causing symptoms of illness, and interference with equipment, observation charts or other documents relevant to the child's Health. The caregiver may or may not genuinely believe the child to be ill.

330. **Impact** on the child can include actual physical harm, potential trauma, anxiety and confusion during multiple and sometimes invasive treatments and investigations, as well as social and emotional impairment of a child's development, identity and relationships.

331. **Occurrence:** Proven incidence is rare. It is more frequent in young children. A common feature is that the caregiver reports symptoms or signs, and health assessments cannot account for these signs. It can be a feature that symptoms are not seen by anyone other than the caregiver, that new symptoms are reported by the caregiver when one form of concern is resolved, or that multiple medical opinions are sought inappropriately.

332. **Response:** Where concerns do exist about the fabrication or induction of illness in a child, practitioners must work together in co-ordination, considering all the available evidence, in order to reach an understanding of the most probable reasons for the child's signs and symptoms of illnesses. Careful medical evaluation is always required to consider a range of possible diagnoses, including the possibility that some older children may present with fabricated symptoms, again requiring careful assessment, understanding and supportive response in relation to whatever the causes may be.
333. **An inter-agency referral discussion** will be necessary when risk of significant harm from abuse or neglect is identified as described in Part 3 of this Guidance. An IRD should be held in order to consider timing and responsibilities when co-ordinated investigation, planning and action are required, step by step, to ensure the child's physical and emotional safety and support. A chronology will be an essential feature within such a multi-agency assessment.
334. **All agencies and practitioners should** be aware of the potential indicators of illness being fabricated or induced in a child, and alert to the risk of harm that individual abusers, or potential abusers, may pose to children in whom illness is being fabricated or induced. Practitioners must work together to form a multi-agency assessment and plan. Work should be in collaboration with parents/caregivers unless to do so would place the child at increased risk of harm. In any criminal or civil proceedings, practitioners must be prepared to give evidence as required.

REFERENCES AND RESOURCES

Sudden unexpected death in infants and children

335. Most sudden unexpected deaths are explained and only a very small number may remain unexplained.
336. **Definitions:**
An unexpected death of a child is defined as the death of an infant or child (less than 16-years-old):
- which was not anticipated as a significant possibility, for example (without being prescriptive), 24 hours before the death
 - or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

Sudden unexplained death in childhood (SUDC) is the death of a child which remains unexplained after a thorough investigation.

337. **Sudden unexpected death in infancy (SUDI)** is deemed to have occurred when there is no known pre-existing condition which would make the death predictable. The majority of sudden unexpected deaths in infancy are explained as a result of natural causes, congenital anomalies or accidents, only a small number remain unexplained. All infant deaths which happen suddenly, and for which there is no apparent reason, are unexpected. From the outset, all such causes are unknown (or unascertained), and therefore defined as SUDIs until more information is available. 'Sudden Infant Death Syndrome' (SIDS) is a term which is used when there is no known pathology or risk factors present rather than a 'cause' of death in itself. This used to be termed 'cot death'.

338. **Occurrence:** SUDIs can occur during any sleep period not just a night time sleep. SUDIs account for the largest number of infant deaths in those aged 2-6 months. Only a few cases per year occur in Scotland between 12-24 months and unexplained deaths beyond this age are very rare. Infants may be discovered in their own cot or crib, sharing a sleep space such as an adult bed, sofa or chair, in their pram, car seat or infant carrier. A small proportion of such deaths do not happen during sleep and can also be caused by neglect, violence, malicious administration of substances or by the careless use of drugs.
339. **Processes:** In all situations a range of professionals are involved when a SUDI occurs. Not all professions will be involved in every SUDI. The interacting roles of professionals are outlined within Healthcare Improvement Scotland's Toolkit (<https://www.sudiscotland.org.uk/professional-guidance/>). In all situations, the sensitivity, skill and co-ordination of an inter-agency approach will significantly influence family experience within effective investigations. Investigations may form a helpful step within support for bereaved parents and relatives of the child or infant. Investigations are intended to help responsible services to understand the cause of death and, if necessary, formulate interventions to prevent future harm or deaths.
340. Since the cause of death is not at first known, a death certificate cannot be issued. All SUDIs and unexplained child deaths will be reported to the Procurator Fiscal. Police Scotland could be informed of the death from a number of sources. Investigations, which include a post-mortem examination, may take several months. They begin with the gathering of information from health services and police.
341. If cause of death cannot be established, 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).
342. The police have a leading role in the inter-agency investigation of infant and child deaths. Responsibility is to the safety and wellbeing of any other children or infants in the household or yet to be born that may be affected and when the death of a child or infant is reported to the police, a child death trained senior investigating officer will always be appointed to oversee the investigation, whether or not there are any obvious suspicious circumstances. Public authorities have a responsibility to investigate the cause of a suspicious or unlawful death in light of Article 2 of the European Convention on Human Rights (as incorporated into UK law by virtue of the Human Rights Act 1998).
343. Once the Procurator Fiscal is satisfied that there is no criminality involved permission is given for a SUDI review to take place. This is organised by health boards and will involve relevant inter-agency professionals and the family. This review will ascertain if there was a cause and any learning that could be put in place to prevent future deaths.
344. A collaborative and co-ordinated inter-agency approach is necessary in all situations. Child death trained Senior Investigating Officer may consider engaging officers for specialist tasks, such as: interviewing child witnesses; obtaining relevant and necessary background information from police, local authority and health, parent/carers and anyone else who may have information relevant. In cases where the child or infant 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 local policing divisions/police forces and local authorities in any area where the child or infant is known to have resided.

345. Child protection procedures: If initial investigations suggest death may have been caused by factors that imply potential risk of significant harm to other children due to abuse or neglect, an [IRD](#) is required under child protection procedures as described in Part 3 of this Guidance. These processes must plan content, timing and responsibilities within a multi-agency approach to investigation, planning and action, including support.
346. A national system is being introduced to ensure reviews take place into the death of every child in Scotland (all live born children up to their 18th birthday, and up to 26th birthday for those in receipt of aftercare or continuing care at the time of their death). A National Hub for the prevention of child deaths has been established within Healthcare Improvement Scotland in partnership with the Care Inspectorate and Scottish Government. Its focus is to rollout child death reviews across Scotland and to use evidence to inform practice in reducing child deaths in Scotland. The Hub will take a multi-disciplinary approach, focused on using evidence to deliver change. The process will not duplicate existing reviews, such as Significant Case Reviews or Fatal Accident Inquiries, but will use evidence from other reviews and data sources to look at how to improve shared learning.
347. As with all inter-agency assessment and action, a sensitive, collaborative, respectful approach is essential at every stage, with sharp attention to the necessary sharing of information and preservation of evidence. All inter-agency professionals should ensure that the family involved in the process are treated sensitively. Scottish Government have provided funding to develop National Bereavement Care Pathways (NBCP) for five types of baby loss including the sudden unexpected death of an infant. Chief Officers will ensure that staff have access to appropriate support during any investigations, particularly if the circumstances of the case lead to a significant case review.

REFERENCES AND RESOURCES

Community

348. The sections that follow indicate considerations in relation to ‘community’. The term community is used in a broad sense to encompass not only relationships that are connected to place, but also those that arise out of shared beliefs and values or common goals. Although this Guidance promotes consistent components of good practice across Scotland, effective child protection will require respect for distinctive elements of communities that influence not only the ecology of the child’s world, but also, potentially, the ecology of professional judgement – for example in a small rural community in which personal and professional boundaries may intersect more frequently.

Cultural and faith communities

349. **All faith organisations and cultural communities** in Scotland share in a commitment to the safety and protection of children.
350. **Increasing diversity:** Scotland’s population of 5,438,100 (2018) is increasingly diverse in culture, faith and language. After English, Polish, Urdu, Scots, Punjabi and Arabic are most frequently spoken. In 2017, 158 languages were spoken as the main home language by pupils in publicly funded schools. The 2011 census asked those living in Scotland to state their religious affiliations. 32% said Church of Scotland; 37% said no religion; 16% said Roman Catholic; 1.4% said Islam; and around 0.1% said each of Buddhism, Sikhism, Judaism, and Hinduism.

351. **Cultural sensitivity and competence:** Cultural respect must be a consistent thread through child care and protection. Competence in an unfamiliar cultural context may entail consultation about specific culture and/or faith by which the child and family live their daily life. It will involve development awareness of services that provide advocacy, advice and support attuned to culture and faith.
352. **Children's safety first:** Working across differences in culture and faith can influence professional response in child protection processes. For example, fear of being thought racist and unsympathetic can lead to professional inaction. (Lord Laming, 2003; Victoria Climbié Inquiry; para 16.7).
353. **The best protection is prevention.** For faith communities and organisations, clear, written and well-shared child protection and vulnerable adult policies and procedures are a first step to creating awareness and safety within the organisation/community. Volunteers, employees and those in positions of authority and pastoral responsibility need support in how they can recognise abuse; how they should respond to allegations or concerns about abuse; how they should record concerns and make appropriate referrals; and what behaviour towards children is acceptable and unacceptable within their role.
354. **Fundamental preventative** steps for faith organisations include: safe recruitment practices; safe practice in pastoral support with children and young people; online safety advice for appropriate use of digital and social media; child protection training for staff and volunteers; awareness raising within the faith community, for instance in relation to grooming processes; and the name and contact details for someone to speak to about any concerns.
355. **Faith organisations should have designated child protection leads** who have a role in passing on concerns about children to Police or Social Work, and in developing and maintaining organisational policies and procedures. These individuals should undertake regular training and be aware of the local Child Protection Committee and procedures. Faith organisations have a role in promoting awareness of information, resources and helplines in relation to child protection and, for example, forced marriage and honour-based abuse (see section below).
356. **Resilience:** Faith and spirituality can be a powerful resilience factor when children and families benefit from associated community, guidance, hope and meaning, particularly in the context of feelings of isolation and insecurity. Faith and faith organisations can be a source of resilience and hope, particularly when communities face threat, loss and disaster.
357. **Abuse of trust:** Positions of power, trust and authority can provide opportunities to abuse. Gender-based oppression, coercion and control or family honour may be a feature in dynamics that keep abuse secret.
358. **Families facing exceptional stress:** Practitioners will be aware that, even when supported by faith and community, many migrating families and their children face exceptional stress, due to immigration status, poverty and accommodation concerns. They may experience feelings of isolation, separation, alienation, anxiety, disappointment, frustration and confusion.
359. Disabled children may be more vulnerable to victimisation and scapegoating in some cultural settings. They are likely to be less able to resist or share their experience. There is a collective responsibility to be alert, to challenge inappropriate behaviour, avoid collusion and report apparently harmful behaviour to statutory services. Response must be carefully planned, with victims' experience and safety a central consideration.

360. **Experience of statutory services:** Statutory services will seek to ensure children's hearings and child protection processes respond equally well in all areas and communities. Recent research highlights challenges for ethnic minority families in contact with the Children's Hearings (Henderson et al 2017). These challenges include: isolation; language difference; poor translation; concerns about confidentiality; family reluctance to raise concerns and accept support; lack of awareness of services and how the law operates in Scotland; and fear of service intervention.
361. **Interpreting:** When interpreting services are required, planning of investigative processes will take extra time and care. The Scottish Refugee Council, in partnership with five local authorities, has developed guidance which includes use of interpreters (2019). Practical headlines may be summarised:
- Develop interpreting and translation policy and procedures.
 - Train practitioners in work with interpreters.
 - Never use friends/family members as interpreters in a formal context.
 - Never place responsibility for interpreting for parents upon children.
 - Offer people the option to request an interpreter of the same (or a different) gender for their appointments.
 - Brief and de-brief interpreters on expectations, procedures and remit.
 - Recognise that service providers have a duty of care to all parties.
 - Interpreters may need support after distressing interpreting sessions.
362. **Child abuse linked to faith and belief:** There may be tensions between a parent's beliefs and Scottish laws, for instance, in relation to physical chastisement. Where specific practices linked to tradition, faith or belief are harmful or used to justify behaviour that is abusive, then services must not hesitate to engage in order to understand and prevent further harm. [Female Genital Mutilation](#) is an example of a traditional practice which is a criminal offence in Scotland and will be treated as child abuse.
363. Practitioners may need additional training in order to work with child abuse linked to faith or belief. It can be advantageous when statutory and faith-based communities engage in dialogue in order to build trust, co-produce policy and share good practice.

REFERENCES AND RESOURCES

Children and families in the Defence Community

364. There are nearly 10,500 men and women in the Regular Armed Forces and 4,000 MOD civilians from across the UK and beyond working in Scotland. This does not include reservists – a significant and connected network of personnel and families with a feet in both civilian and service life. They and their families make a vital contribution to national and international security, and they are a vital social force within the Scottish economy and local communities.
365. There are communities that exist 'within' communities. For example, services, bases, units and regiments have networks and identities of their own. While service families may experience the full range of risks and concerns apparent in the civilian population, the resilience of and pressures upon service children and families can have a distinctive dynamic.

366. Practitioners should seek to understand how this cultural context plays a part in the experience of each child and their family if a child protection concern arises. Parental or sibling deployment (and return home) can have an impact on children's mental Health. British service personnel and veterans' health can be affected by pre-deployment stress, post-traumatic stress and re-integration stress following deployment or transition from service.
367. Increased parental stress is a natural feature for the parent who remains at home. Many service parents are very young when faced with these pressures and can feel isolated, despite a supportive service structure and community. As in some other community and institutional settings, it is possible for problems to remain hidden until a point of crisis.
368. When a child protection concern arises, generic processes apply as outlined in Part 3. However, there is an additional need to ensure teamwork between the relevant service welfare service liaison and the lead professional in statutory services.

REFERENCES AND RESOURCES

Child protection in the context of disasters and public emergencies

369. **Meaning:** 'Child protection in disasters and emergencies' encompasses the prevention of and responses to abuse, neglect, exploitation, and violence against children in times of emergency, whether caused by natural or man-made disasters, conflicts, or other exceptional crises that threaten to overwhelm essential structures. The current Covid-19 pandemic has been a public emergency. Child protection in this context must address all forms of physical and psychological abuse, sexual and gender-based violence, armed conflict, and deprivation of basic needs.
370. **Relevance:** Child protection following disasters is a matter of ethical and practical relevance in prevention, preparation, emergency responses and provision of subsequent assessments, planning, and diverse forms of support for children. For example:
- Disasters in various forms have occurred in recent memory in Scotland due to terrorism (Lockerbie and Glasgow airport), mass shooting of children (Dunblane), and industrial disasters (Piper Alpha).
 - We have children reaching the UK or seeking to do so, who have become more vulnerable when they and their families have had to leave their homes to seek sanctuary overseas due to disasters. Children and their families experience unanticipated loss and separation, trauma, exhaustion and confusion. They face multi-dimensional risks and insecurities during these transitions, but also have skills and strengths that those intervening should extend and support. (The section above on [unaccompanied and trafficked children](#) may be relevant in this context.)
 - A minority of those providing aid and others targeting 'lone' children in disaster contexts may behave abusively.
 - Beyond immediate impact, the process of adjustment to disasters may be an invisible, long-term and cyclical process for children, families, practitioners and volunteers, becoming an ingredient in other crises and vulnerabilities.
 - Strengthening children's (families', kin's and communities') capacities to cope with future disasters is a critical preventative function for protecting children.
 - **Legal basis for response to national disasters:** Emergency legislation may be necessary in response to public emergencies, as has been the case during the Covid-19 pandemic. In relation to events of national impact in Scotland, The Civil Contingencies Act 2004 and the Civil

Contingencies Act 2004 (Contingency Planning) (Scotland) Regulations 2005 (as amended) outline the immediate responsibilities of key organisations and their duty to prepare for civil emergencies within Scotland. The balance of activity and interaction between Scottish Ministers and the UK Government will depend on the nature of the incident.

371. **Organisational response:** The scale and nature of the emergency will determine the scope of organisational response. The Covid-19 pandemic required national and international response. In Scotland, central and local adaptations have had to be rapid, comprehensive and consistent in order to control infection, sustain essential services and protect those most vulnerable. [Supplementary guidance on child protection](#) was published by Scottish Government alongside other essential guidance. When emergencies are of a more local nature, Scottish Government have set out principles of emergency response in Scotland in, [Preparing Scotland: Scottish Guidance on Resilience](#). Responder organisations must come together through Regional Resilience Partnerships (North of Scotland, East of Scotland and West of Scotland), and will provide such strategic support for multi-agency planning as may be necessary.
372. **Protective practice with children and families:** a child safeguarding lens is necessary in prevention, preparedness, immediate relief, recovery and reconstruction. The Covid-19 pandemic heightened some risks in relation to domestic and online abuse and as a result of suspension or reduction in direct contact with services. Conversely, support, relationship and essential decision-making have been sustained through a creative blend of technology assisted communication and essential direct contact within public health protection guidelines.
373. Gender, age, ethnicity, disability, sexual orientation, culture including language, religion, and economic status are all factors that should be considered in relation to risk and recovery. Assessment and development of plans to protect and support children, families and communities should (as with all areas of practice within this Guidance), be co-ordinated as necessary and formed together with those involved, including children, their families, communities and local child protection agencies.

REFERENCES AND RESOURCES

Historical (non-recent) reports of abuse

374. **Definition:** The term 'historical abuse', often referred to as non-recent abuse, refers to reports of neglect, emotional, physical and sexual abuse which took place before the victim was 16 (or 18, in particular circumstances) and which have been made after a significant time lapse. The complainant may be an adult, but could be a young person making reports of abuse in earlier childhood. The reports may relate to a person's experience in the family home, community or while they were a looked-after and accommodated child in a residential, kinship or foster care setting.
375. **Coming forward:** A person may share account of historical abuse in the context of a therapeutic or counselling setting, within the statutory or Third Sector. Others may report historical abuse directly to the Police, Social Work services, health or education. It is possible that the person reporting historical abuse may not be a direct service user but a parent/carer, partner or other family member of a person accessing these services. People reporting historical abuse may state that the perpetrator is deceased, suggesting that there are no current child protection concerns. However, they may still want to be advised that they can share information with Police Scotland to make a report to allow them to consider information further. ([Adult Survivors of Child Abuse, Police Scotland](#)).

376. **Professional response:** Any reasonable professional concern that a child may be at significant risk of harm will always over-ride a professional or agency requirement to keep information confidential. All service providers have a responsibility to act to make sure that a child whose safety or welfare may be at risk is protected from harm. Service users should always be made aware of the circumstances when confidentiality needs to be breached, preferably during the initial stages of contact with a service.
377. When a report of historical child abuse is received by any agency, consideration needs to be given to the investigation of any current child protection concerns. This should include determining whether there are any children potentially still at risk from the suspected perpetrator(s). This may be in a professional capacity such as in a residential or foster care setting, within a personal family setting in the wider community, within other institutional settings, or a combination.
378. A person sharing their experience of abuse may be unable or unwilling to go to the Police. Consideration should be given as to whether the person requires support and protection as an adult at risk of harm. Their needs must be balanced against the need to protect any child/children who might currently be exposed to risk from the suspected perpetrator(s). Where possible, there should be an agreement between agencies to allow individual support plans to be put in place.
379. Services supporting or taking part in investigations relating to persons reporting historical abuse should be mindful of potential barriers to making a report. As with other disclosures of abuse these may include a fear of not being believed, and uncertainty about how investigations will proceed. Feelings of distrust or suspicion may also arise, particularly if the abuse has happened within a care setting.
380. Referral of concerns about historical abuse to Police Scotland or Social Work will lead to consideration of an IRD in accord with Part 3 of this Guidance. A planned and co-ordinated approach should balance current child protection risks with support for the person. A trauma-informed approach is necessary in the planning and investigation of abusive experiences. Where investigations into reports of historical abuse suggest that the reported abuse was part of a wider organised network or involved multiple abusers, agencies should follow this guidance. For further information, see the section on Complex child abuse investigations above.
381. **Access to records:** Investigation of reports of historical abuse will entail accessing relevant records. For example it may become necessary to access information from local authorities and relevant agencies in relation to former staff and carers. Local guidelines should include clear protocols on record-keeping and record management, including record retrieval, which could be for the purpose of assisting complex investigations.
382. **Redress:** Scottish Government has progressed a package of reparations for survivors of abuse in care in the context of the Action Plan on Justice for Victims of Historic Child Abuse (2014) and the SHRC Human Rights Framework for Justice and Remedies for Historic Child Abuse (2010). A statutory financial redress will form part of a wider package of measures and the Redress for Survivors (Historical Child Abuse in Care) (Scotland) Bill was introduced on 13/8/20. Advance Payments are being made on a discretionary basis to those who experienced abuse in care in Scotland and have a terminal illness, or who are age 68 or over. Further information and guidance on eligibility and how to apply for an Advance Payment can be found [here](#). The Advance Payment Scheme will remain open until the statutory redress scheme is operational.

Further support and information

People reporting historical abuse should be offered on-going emotional support. Local guidelines should set out referral routes to local services that specialise in childhood abuse and trauma and may be able to offer immediate helpline support, including:

- [Breathing Space](#)
- [Samaritans Scotland](#)

National support initiatives:

- [Future Pathways Scotland's In care survivor support fund](#) – Future Pathways is the Scottish Government-funded national support service for adult survivors of childhood abuse whilst in care.
- [The Survivors of Childhood Abuse Support Fund \(2020-2024\)](#) is a new fund which will commence in April 2024 which is aimed at Third Sector and community-based organisations who support adult survivors of childhood abuse.

Further information

- [The Scottish Child Abuse Inquiry](#) in to the abuse of children in care (up to age 18) is on-going, with investigations in to allegations of historical abuse of children in care, including children in foster care and residential schools. The Inquiry will report to Ministers upon recommended changes in policy, law and practice.
- [Social Work](#): A network for staff involved in improving practice in relation to historical abuse is co-ordinated by Social Work Scotland.

Child protection themes

The themes that have been recurrent in this Guidance may be summarised as follows:

1. **Attention to the child's needs, rights, voice and experience is fundamental.**
This requires recognition of risk of harm to a child; risk of harm to others from a child; and recognition of the context in which such risks occur.
2. **Recognition and engagement with family** entails attention to the needs, strengths, perspective and experience of those family members who are key to the child's safety and wellbeing.
3. **Information sharing** that is protective must be relevant, proportionate, accurate, timely, necessary, and lawful.
4. **Multi-disciplinary assessment** of risk and strength should be structured and formed in collaboration between professionals, child and family. It should include analysis of what needs to change to prevent harm to the child, through the consideration of the interaction of factors that may help or hinder change.
5. **Co-ordinated and collaborative planning** requires agreed steps, expectations, responsibilities, outcomes, supports and timescales. Strength-based approaches may assist in bringing professionals and family together in shared objectives.
6. **Practical help** that is responsive to need also involves qualities in professional relationship, including reliability, honesty, respect, care, accessibility and encouragement.
7. **Workforce:** effective child protection depends on sufficient training in core knowledge, skills and values applicable to role, the supervision, support and leadership that sustains ethical practice, and a learning culture that integrates learning from mistakes.

APPENDIX A: GLOSSARY OF TERMS

Advocacy: A term used within different contexts in this Guidance. Listening to a child, or an adult who cares for the child and working out with them how to represent their views, experiences and needs within assessment, planning and decision-making processes. The terms of some forms of advocacy are provided for in statute.

Care and Risk Management (CARM): Processes which are applied when a child between the ages of 12 and 17 has been involved in behaviours which could cause serious harm to others. This includes sexual or violent behaviour which may cause serious harm. CARM processes are also applicable when an escalation of behaviours suggests that an incident of a seriously harmful nature may be imminent.

Chief Officers Group: The collective expression for the Local Police Commander and Chief Executives of the local authority and NHS Board in each local area. Chief Officers are individually and collectively responsible for the leadership, direction and scrutiny of their respective child protection services and their Child Protection Committees.

Child: Child protection processes within this Guidance relate to unborn babies and children and young people under the age of 18 years. (Part 1 seeks to summarise some of the relevant legal definitions of 'child' in Scotland, and the applicability of legislation relating to the protection of young adults).

Child abuse and child neglect: Abuse and neglect are forms of maltreatment of a child. Somebody may abuse a child by inflicting, or by failing to prevent harm to a child.

- Emotional abuse is persistent emotional neglect or ill treatment of a child causing severe and lasting adverse effects on the child's emotional development. 'Persistent' means there is a continuous or intermittent pattern which has caused, or is likely to cause, significant harm.
- Neglect consists in persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in the serious impairment of the child's health or development. There can also be single instances of neglectful behaviour that cause significant harm. Neglect can arise in the context of systemic stresses such as poverty, and is an indicator of support needs (see also below).
- Physical abuse is the causing of physical harm to a child or young person.
- Child sexual abuse is an act that involves a child under 16 in any activity for the sexual gratification of another, whether or not it is claimed that the child either consented or assented. For those who may be victims of sexual offences aged 16-17, child protection procedures should be considered; and must be applied when there is concern child about sexual exploitation or trafficking.

Child's plan/Child Protection Plan: Where those working with the child and family have evidence to indicate that support across services may be required to meet the child's wellbeing needs, a child's plan is drawn up to co-ordinate a single plan of action. This should be managed and reviewed through a single planning process, including a single meeting structure, even if the child is involved in several processes. The child's plan will incorporate a Child Protection Plan if the criteria for registration are met, namely risk of significant harm requiring a multi-agency plan. The Child Protection Plan must focus on actions to reduce risk.

Child Protection: The processes involved in consideration, assessment and planning of required action, together with the actions themselves, where there are concerns that a child may be at risk of harm from abuse, neglect or exploitation.

- **Child Protection Guidance** provides overall direction for agencies and professional disciplines where there are concerns that a child may be at risk of harm.
- **Child Protection Procedures** are initiated when Police, Social Work or Health professionals determine that a child may have been abused or may be at risk of significant harm, and when an Inter-agency Referral Discussion (see below) takes place.

Child's Protection Plan Meeting: A multi-disciplinary meeting, formerly termed a Child Protection Case Conference. Involvement of child and relevant family members should be supported. The purpose of the meeting is to consider and agree an assessment of risk and form a plan of required action to protect a child or young person. Participants are those persons essential to the child protection plan.

Child Protection Committee: The locally-based, inter-agency strategic partnership responsible for child protection policy and practice across the public, private and Third Sectors. Working on behalf of Chief Officers, its role is to provide individual and collective leadership and direction for the management of child protection services in its area.

Child Protection Register: All local authorities are responsible for maintaining a central register, known as the Child Protection Register as described in Part 1 of this Guidance. This is a list of all children, including unborn babies, who are subject to a Child Protection Plan.

Core group: A group of identified practitioners, and child/family including the Lead Professional, who liaise regularly between Child's Protection Plan Meetings to ensure that actions are being progressed and to monitor risk. This may be a smaller group than the team around the Child, involving those practitioners with direct and regular engagement.

Disabled children: A term used in this Guidance and in Scottish Government policy documents to reflect a social model of disability in which the barriers created by society are recognised as a cause of disadvantage and exclusion, rather than the impairment itself. ([p7. A Fairer Scotland for Disabled People.](#)) It is the right of individuals, families and groups to use terms which feel acceptable to them, such as 'children with disabilities'.

Domestic abuse: Domestic abuse is a form of gender-based violence, committed predominantly by men, predominantly towards women. It is any form of physical, verbal, sexual, psychological or financial abuse which might amount to criminal conduct and takes place within the context of a relationship between partners (married, cohabiting, civil partnership or otherwise), or ex-partners. Abuse may include controlling, isolating, degrading, threatening and humiliating behaviour. It may be committed in the home or elsewhere; and may include online activity. The offence of domestic abuse is defined in the Domestic Abuse (Scotland) Act 2018.

Harm: Impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. Risk in this context refers to the probability of harm given the presence of adverse factors in a child's life. There is no statutory definition or uniform defining criteria for significant harm, which refers to serious interruption, change or damage to a child's physical, emotional, intellectual or behavioural health and development.

Inter-agency Referral Discussion (IRD): The start of the formal process of information sharing, assessment, analysis and decision-making following reported concern about abuse or neglect of a child or young person under the age of 18 years, in relation to familial and non-familial concerns. This may include discussion of concern relating to siblings or other children within the same context, and can refer to an unborn baby that may be exposed to current or future risk.

Joint Investigative Interviews (JII): These are formal interviews of children conducted by trained Police officers and Social Workers where there is a concern that a child is a victim of, or witness to, criminal conduct, and where there is information to suggest that the child has been or is being abused or neglected, or may be at risk of significant harm.

Lead professional: The social worker who leads and co-ordinates the multi-disciplinary child protection assessment, and oversees implementation of actions to protect the child.

My World Triangle: Within the GIRFEC National Practice Model, the My World Triangle is a starting point for considering what risks might be present in a child's life. The Triangle focuses attention on the three dimensions of a child's world: the child, their family, and their wider environment.

Named person: A professional point of contact in universal services, both to support children and their parents or carers when there is a need, and to act as a point of contact for other practitioners who may have a concern about the child's wellbeing. Refreshed GIRFEC Policy and Practice Guidance is forthcoming.

Neglect: Neglect may be experienced by children in families that are not abusive, as a consequence of systemic stresses such as poverty, and this is an indicator of support needs.

Notification of Concern: Where concerns about possible harm to a child arise, these should always be shared with the appropriate agency (normally Police or Social Work) so that staff responsible for investigating the circumstances can determine whether that harm is significant. Where a practitioner has a concern about a child's wellbeing, this can be shared with a named person where this has been discussed with the family.

Parents and carers: A 'parent' is someone who is the genetic or adoptive mother or father of the child. This is subject to the Human Fertilisation and Embryology Act 2008, which sets out which persons are to be treated as the parents of a child conceived through assisted reproduction. A 'carer' is someone other than a parent who is looking after a young person.

Resilience: This refers to positive adaptation despite serious adversities and threats to a child's development. Within the GIRFEC National Practice Model, the resilience matrix is a tool which promotes consideration of the dynamic interaction of stresses and protective factors in the child's world.

Team Around The Child: Those practitioners who support the child and family, and are likely to be participants at a child's plan meeting.

Wellbeing Indicators: A holistic and rights informed framework, within the GIRFEC National Practice Model, which outlines a child's wellbeing needs under eight headings: safe, healthy, achieving, nurtured, active, respected, responsible and included (SHANARRI).

APPENDIX B: ACRONYMS

ACR: Age of Criminal Responsibility

CAMHS: Child and Adolescent Mental Health Service

CARM: Care and Risk Management

CCE: Child Criminal Exploitation

CELCIS: Centre for Excellence for Children's Care and Protection

CHS: Children's Hearings Scotland

CICA: Criminal Injuries Compensation Authority

CPO: Child Protection Order

COG: Chief Officers Group

CSA: Child sexual abuse

CPC: Child Protection Committee

CPCC: Child Protection Committee Chairs

COPFS: Crown Office and Procurator Fiscal Services

COSLA: Convention of Scottish Local Authorities

CSO: Compulsory supervision order

CYCJ: Centre for Youth and Criminal Justice

CPPM: Child Protection Planning Meeting

CSE: Child Sexual Exploitation

CSWO: Chief Social Work Officer

ECHR: European Convention on Human Rights

EHRC: Equality and Human Rights Commission

FASD: Foetal Alcohol Spectrum Disorder

FGC/FGDM: Family Group Conferencing/Family Group Decision Making

FGM: Female Genital Mutilation

FII: Fabricated or Induced Illness

FNP: Family Nurse Partnership

GIRFEC: Getting it right for every child

HBA: Honour-based abuse

HIS: Healthcare Improvement Scotland

HMICS: Her Majesty's Inspectorate of Constabulary in Scotland

ICR: Independent Care Review

ICT: Information and Communication Technologies

IRD: Inter-agency referral discussion

JII: Joint Investigative Interview

JPFE: Joint Paediatric Forensic Examination

PRR: parental responsibilities and rights

LAAC: Looked after and accommodated child

NES: NHS Education Scotland

MAPPA: Multi-Agency Public Protection Arrangements

MARAC: Multi-Agency Risk Assessment Conferences

MATAC: Multi-Agency Tasking and Co-ordination

RMA: Risk Management Authority

RSHO: Risk of Sexual Harm Orders

SID: Sudden Infant Death

SCRA: Scottish Children's Reporter Administration

SCLD: Scottish Commission for Learning Disability

SHANARRI: Getting it right for every child wellbeing indicators – safe, healthy, active, nurtured, achieving, respected, responsible, included.

SOS: Signs of Safety

SPS: Scottish Prison Service

SUDI: Sudden unexpected death in infancy

TEPOs: Trafficking and Exploitation Prevention Orders

TEROs: Trafficking and Exploitation Risk Orders

UASC: unaccompanied asylum seeking child

UNCRC: United Nations Convention on Rights of the Child

VaWG: violence against women and girls

VISOR: Violent and Sex Offender Register

APPENDIX C: LEGISLATION: LIST OF OTHER RELEVANT LEGISLATION

This appendix supplements the chapter on legislation above (for further information, see the chapter on Legislation).

Legislation defining offences against children

- [Children and Young Persons \(Scotland\) Act 1937, Section 12](#)
- [Protection from Abuse \(Scotland\) Act 2001](#)
- [Prohibition of Female Genital Mutilation \(Scotland\) Act 2005](#)
- [Female Genital Mutilation \(Protection and Guidance\) \(Scotland\) Act 2020](#)
- [Sexual Offences \(Scotland\) Act 2009](#)
- [Children's Hearings \(Scotland\) Act 2011](#)
- [Children and Young People \(Scotland\) Act 2014](#)
- [Abusive Behaviour and Sexual Harm \(Scotland\) Act 2016](#)
- [The Protection of Children and Prevention of Sexual Offences \(Scotland\) Act 2005](#)
- [Human Trafficking and Exploitation \(Scotland\) Act 2015](#)
- [Civic Government \(Scotland\) Act 1982](#)
- [Children \(Equal Protection from Assault\) \(Scotland\) Act 2019](#)

Legislation on managing adults who may pose a risk to children

- [Criminal Justice and Licensing \(Scotland\) Act 2010](#)
- [Domestic Abuse \(Scotland\) Act 2011](#)
- [Domestic Abuse \(Scotland\) Act 2018](#)

Legislation on criminal proceedings and witness supports

- [Sexual Offences \(Procedure and Evidence\) \(Scotland\) Act 2002](#)
- [Vulnerable Witnesses \(Scotland\) Act 2004](#)
- [Vulnerable Witnesses \(Criminal Evidence\) \(Scotland\) Act 2019](#)
- [Age of Criminal Responsibility \(Scotland\) Act 2019](#)

Additional legislation

- [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003](#)
- [Anti-social Behaviour \(Scotland\) Act 2004](#)
- [Adult Support and Protection \(Scotland\) Act 2007](#)
- [Adoption and Children \(Scotland\) Act 2007](#)
- [Equality Act 2010](#)
- [The Forced Marriage etc. \(Protection and Jurisdiction\) \(Scotland\) Act 2011](#)
- [General Data Protection Regulation \(GDPR\)/Data Protection Act 2018](#)
- [Children \(Scotland\) Act 2020](#)

Emergency legislation under regular review

- [Coronavirus \(Scotland\) Act 2020 – Guidance on looked-after children and children’s hearings provisions](#)

Proposed legislation currently being considered by the Scottish Parliament

- [The Forensic Medical Services \(Victims of Sexual Offences\) \(Scotland\) Bill](#)
- [The United Nations Convention on the Rights of the Child \(Incorporation\) \(Scotland\) Bill](#)

APPENDIX D: TIMESCALES FOR STAGES IN CHILD PROTECTION PROCESSES

When to share a child protection concern with Police or Social Work?	Without delay, following consultation with line manager/child protection lead where this applies.
When to hold an Inter-agency referral discussion?	As soon as reasonably practical. Outwith core hours, the IRD may focus on immediate protective actions. A more comprehensive IRD will continue as soon as practical. This should normally be on the next working day.
How much notice should participants be given of a CPPM?	Best practice is a minimum of 5 days. This is not a statutory minimum but this must be adhered to wherever possible.
When to hold a CPPM?	If a child protection investigation has been progressed a CPPM will follow within 28 days unless there is an IRD decision that this is not required.
When to hold an unborn child CPPM?	As soon as possible. Within 28 days of concern being raised. Always within 28 weeks of gestation.
When a CPPM is inquorate, how soon must it be reconvened?	Within 10 days
How soon should participants receive a record of the CPPM?	Within 5 days
How soon should a core group meet after a CPPM?	Within 15 days
How soon should core group refer significant changes or concerns within the plan to CPPM Chair/lead professional?	As urgently as necessary and always within 3 days of the change/concern being identified.
When should a CP Plan be reviewed?	Within 3 months of a pre-birth CPPM but there should be latitude for professional judgement about the most appropriate timing post-birth. Within 6 months of the initial CPPM and thereafter 6 monthly or earlier if circumstances change significantly.
When to refer to the Reporter?	At any stage when compulsory measures appear necessary. Single agencies and individuals can also refer.

APPENDIX E: UNITED NATIONS CONVENTION ON RIGHTS OF THE CHILD

Protecting rights, protecting children: signposts to Convention Articles

Best interests of child as the primary consideration in all actions	3
Child's right to life, survival and development	6
Protection from all forms of physical and mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation. Duty to provide programmes of support for child and carer; and for prevention, identification, reporting, referral and treatment	19.1 19.2
Protection from all forms of sexual abuse and exploitation; including exploitation through work which may be hazardous to child's development. Duties of States Parties to promote physical and psychological recovery from abuse and neglect.	34, 36, 32, 39
Protection from all forms of torture, inhuman or degrading treatment or punishment. Protection from unlawful deprivation of liberty and right to prompt access to legal and other assistance if deprived of liberty.	37, 37d
Prevention of abduction, sale and trafficking of children	35
Right of child capable of forming views to express views freely in all matters affecting the child, the views being given due weight in accordance with age and maturity	12
Respect for rights without discrimination	2
A mentally or physically disabled child should enjoy a full life in conditions which facilitate self-reliance and active participation	23
Right to: the highest attainable standard of health and to facilities for treatment of illness and rehabilitation; preventative health care and parental guidance; and protection from traditional practices harmful to health	24, 24.3
Protection from illicit use of narcotic drugs and psychotropic substances	33
Respect for rights and duties of parents and family	5
Right to know and be cared for by parents (subject to best interests)	7
Assistance to parents and legal guardians in child-rearing responsibilities	18.2
A child shall not be separated from parents against his or her will except when competent authorities decide; subject to judicial review and in accordance with applicable law and procedures that this is necessary for the best interests of the child.	9
Right to preserve personal relations when separated except if contrary to child's interests	9.3
A child temporarily or permanently deprived of his or her family environment shall be entitled to special protection and assistance provided by the state; and right to review for children placed for reasons of care, protection or treatment.	20, 25

Right to a standard of living adequate for physical, mental, spiritual and moral development. Primary responsibilities of parents; and duties of States Parties to support parents.	27.1, 27.2, 27.3
Right to education and to experience education encompassing core intentions; to enjoy rest and play; and to participate in cultural and artistic life	28, 29a-e, 31
Right to preserve identity; and to enjoy own culture, faith or language	8, 30
Freedom of expression; of thought, conscience and religion; of association	13, 14, 15
Protection from unlawful interference with his or her privacy, family home or correspondence; and from unlawful attacks on honour and reputation	16
Rights of children who infringe the law; considering age, circumstances; and wellbeing	40
Appropriate guidelines for protection from information and material injurious to wellbeing	17e
Recognition of adoption subject to best interests as paramount consideration	21
Child seeking refugee status shall receive appropriate protection and humanitarian assistance	22
Respect for international humanitarian law and protection of children affected by armed conflict	38
Protection from illicit transfer and non-return of children abroad	11
States Parties' duty to take all reasonable measures to implement Convention rights	4

APPENDIX F: RESOURCES AND REFERENCES

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- Scottish Government/Police Scotland (2020 forthcoming) Child sexual exploitation disruption toolkit

A child concerned about risk of sexual abuse or exploitation should considering contacting

- [Childline](#) on 0800 1111.
- Childline online to seek help through <https://www.childline.org.uk/>
- CEOP and make an online report The Child |Exploitation and Online Protection Centre (CEOP) <https://www.ceop.Police.uk/ceop-reporting/>
- Police Scotland: call 101 (or in an emergency 999).
- [ParentLine Scotland](#): 0800 028 2233 or email: parentlinescotland@children1st.org.uk. ParentLine's opening hours are from 9am-10pm (Mon-Fri) and 12 noon-8pm at weekends.
- 24 hour NSPCC helpline: 0808 800 5000.
- Local authority childrens services: <https://www.celcis.org/knowledge-bank/protecting-children/worried-about-child-or-young-person/>
- [Crimestoppers](#): 0800 555 111.

Advice and support for parents, carers and professionals

- Thinkuknow <https://www.thinkuknow.co.uk>
- Childnet <https://www.childnet.com/>
- Internet Matters <https://www.internetmatters.org/about-us/>
- NSPCC <https://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/>
- 5Rights <https://5rightsfoundation.com/>
- Respectme <http://respectme.org.uk/adults/online-bullying/>
- UK Safer Internet Centre <https://www.saferinternet.org.uk/>

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<https://whatworks-csc.org.uk/evidence-store/>
- Rape Crisis: Deaf Access to Support.
<https://www.rapecrisisscotland.org.uk/help-deaf-access-to-support/>
- Police Scotland/Social Work Scotland (2020); Joint Investigative Interviewing: trauma informed practice training materials
- Scottish Government (provisional for 2020) Revised Guidance for Joint Investigative Interviews

Links:

- Stop It Now! (Scotland) work to prevent child abuse happening, whether online or in person.
<https://www.stopitnow.org.uk/scotland.htm>. They provide support to post arrest online offenders and their families.
- Think U Know: guidance and resources for professionals, families and children.
<https://www.thinkuknow.co.uk/>
- More detailed guidance developed in England for child protection assessments in situations such as these can be found at: London Safeguarding Children's Board (2010) London guidelines for assessing children and families affected by adults viewing child sexual abuse images on the Internet. (https://dera.ioe.ac.uk/2028/1/final_cads_guidelines.pdf)

Harmful sexual behaviour by children

(See references: [Serious harmful behaviour by children above and below aged 12](#))

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- Internet Watch Foundation: resources and useful links relating to eating disorders, chatroom safety, support organisations, computer crime, counselling, cyberbullying, fraud, gaming, gore sites, grooming, harmful content, hate crime, human trafficking, stalking, legal issues, mobile phone operator codes of practice, online safety for children and their families, online terrorism and reporting, phishing, photographs of children, rating and filtering, revenge porn, school safety advice, spam, suicide websites, victim support <https://www.iwf.org.uk/resources>
- South West Grid for Learning: resources, training, tools and links: <https://swgfl.org.uk/online-safety/>
- South West Grid for learning: professionals online safety helpline <https://swgfl.org.uk/services/professionals-online-safety-helpline/>
- Think U Know: https://www.thinkuknow.co.uk/14_plus/
- UK Safer Internet Centre <https://www.saferinternet.org.uk/:resources;helpline;pupil-powered-e-safety>
- UK Safer Internet Centre: research highlights <https://www.saferinternet.org.uk/research/research-highlight-series>
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- Brook Sexual Behaviours Traffic Light Tool (13-17) Guidance: <https://legacy.brook.org.uk/our-work/using-the-sexual-behaviours-traffic-light-tool>
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Children Looked After Away from Home

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Children Missing

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- **Missing People:** Police Scotland works in close partnership with the Missing People Charity which can be called free on 116 000. www.missingpeople.org.uk
- **Reunite:** support and advice in the context of child abduction www.reunite.org
- **Runaway Helpline service** is for people who are thinking about running away, have already run away or have been away and want to come back. It is a free, confidential, 24 hour service, for calls or texts on 116000 or for email support on 116000@runawayhelpline.org.uk
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Children abducted across Borders – legal references

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- Under the Hague and European Conventions the Minister for Justice acts as the Central Authority, supported by Scottish Government. The Central Authority for Scotland's role is that of a facilitator and information point between Contracting States, legal representatives and members of the public.
- **Children and Families Across Borders** (CFAB), UK branch of the International Social Service (ISS) network, with partners in 120 countries. (link: http://cfab-dev.bitmachine.co.uk/sites/default/files/2016-09/International_Child_Protection_CFAB_June_2016_0.pdf)

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Support and advice

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- Amina Muslim Women's Resource Centre www.mwrc.org.uk
- Daughters of Eve www.dofeve.org
- Hemat Gryffe Womens' Aid: <http://www.hematgryffe.org.uk/>
- Forward www.forwarduk.org.uk
- Karma Nirvana www.karmanirvana.org.uk
- Kenyan Women in Scotland Association: <https://www.kwisa.org.uk/about-us>
- One Scotland Website www.onescotland.org
- Rape Crisis www.rapecrisisscotland.org.uk
- Scottish Women's Aid www.scottishwomensaid.org.uk
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- Women's Support Project www.womenssupportproject.org.uk
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- Scotland's domestic abuse and forced marriage helpline: <https://sdafmh.org.uk/>
- One Scotland: Forced marriage advice:
<https://onescotland.org/equality-themes/gender/forced-marriage/>
- UK Government (Home Office and Commonwealth Forced Marriage Unit)
<https://www.gov.uk/guidance/forced-marriage>

Fabricated and induced illness

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Culture and faith communities

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APPENDIX G: ARMED SERVICES CHILD PROTECTION CONTACTS

1. Points of contact (2019) for the relevant Service agencies in child protection matters are:

Royal Navy and Royal Marines

2. Naval Service Family and People Support (NS FPS) is managed and staffed by Registered Social Workers and Defence Specialist Welfare Workers. They provide a confidential and professional service to all Naval Personnel and their families, liaising as appropriate with local authority children's social care.

Child protection issues involving the family of a member of the Royal Navy or Royal Marines is to be reported initially to the relevant Local Authority and referred to NS FPS as required.

- **NS FPS Portal**
0800 145 6088

Email: Navynps-peoplesptnsfpsptl@mod.gov.uk

Army

3. Staffed by Registered Social Workers and trained and supervised Army Welfare Workers, the Army Welfare Service (AWS) provides professional social care support to Army personnel and their families. AWS works in partnership with local authorities, particularly where a child is subject to safeguarding concerns.

Child protection issues involving the family of a member of the Army is to be reported initially to the relevant local authority. Local authorities who have any enquiries or concerns regarding safeguarding or promoting the wellbeing of a child from an Army family should contact the AWS Intake and Assessment Team (IAT):

- **Army Welfare Service**
01904 882053

Email: RC-AWS-IAT-0Mailbox@mod.gov.uk

Royal Air Force

4. Welfare Support for families in the RAF is managed as a normal function of Command and co-ordinated by each Station's Personnel Officer, the Officer Commanding Personnel Management Squadron (OCPMS) or the Officer Commanding Base Support Wing depending on the size of the Station.
5. A number of qualified SSAFA Social Workers and trained professionally supervised Personal and Family Support Workers are located throughout the UK to assist the chain of Command in providing welfare support and safeguarding advice.
6. Child protection issues involving the family of a member of the RAF is to be reported initially to the relevant local authority with the support of SSAFA locally. Local authorities who have any enquiries or concerns regarding safeguarding or promoting the wellbeing of a child from an RAF family should contact the parent's unit, or if this is not known, contact the OC PMS/OC BSW of the nearest RAF Unit.

Additionally, SSAFA can be contacted at:

- **SSAFA**
03000 111 723

Email: psswsraf@ssafa.org.uk

Overseas

7. When Service families or civilians working with the Armed Forces are based overseas the responsibility for safeguarding and promoting the welfare of their children is vested in the Ministry of Defence.

The Ministry of Defence contact is through the Global Safeguarding Team at the Directorate of Children and Young People:

- **Global Safeguarding Team**
01980 618710

Email: DCYP-Safeguarding@mod.gov.uk

APPENDIX H:

PRACTICE NOTES – These are being developed to provide detailed content on a range of specific issues. They will be published in 2021.