What to do if you are worried or concerned about a child or young person?

**Child Protection**

If you are worried or concerned about the welfare or protection of a child or young person, you should, in the first instance, share that worry or concern with your Line Manager / Supervisor / Designated Child Protection Officer. Thereafter, child protection procedures should be followed without any unnecessary delay.

**You should contact the [Perth and Kinross Child Protection and Duty Team](#) or Police Scotland:**

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<tr>
<th>Perth and Kinross Child Protection and Duty Team - (24 hours)</th>
<th>01738 476768</th>
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<td>Police Scotland Non - Emergency Number</td>
<td>101</td>
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<tr>
<td>In an Emergency</td>
<td>Call 999</td>
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</tbody>
</table>

**Perth and Kinross Information and Advice Leaflet: Child Protection and Duty Team**

**Document Control:**

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<th>Perth and Kinross Child Protection Committee</th>
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Foreword

The protection of children and young people is everyone's job and everyone's responsibility. There is no more important task.


We take this responsibility seriously and we are determined to support all children and young people to be the best they can be, keep them safe and to protect them from harm and abuse. We do this by providing strong leadership, direction, challenge, support and scrutiny to the work of Perth and Kinross Child Protection Committee (CPC).

Perth and Kinross CPC has produced these Inter-Agency Child Protection Guidelines to support and empower the practice of all practitioners in the public, private and third sector organisations across Perth and Kinross. The guidelines complement, but do not replace existing single service and agency child protection guidance.

These guidelines reflect the existing and emerging national child protection legislative and policy context. They are underpinned by Getting it right for every child, which provides the firm practice base to safeguard, support and promote the wellbeing of all children and young people and to protect all children and young people from harm and abuse.

They have, as far as possible, been future-proofed, remain dynamic and we commend their use across Perth and Kinross.

Bernadette Malone
Chief Executive
Perth and Kinross Council

Lesley McIay
Chief Executive
NHS Tayside

Paul Anderson
Chief Superintendent
Police Scotland – Tayside Division

Anne Gerry
Locality Reporter Manager
Scottish Children’s Reporter Administration

Date: 29 August 2017
Introduction

These Inter-Agency Child Protection Guidelines have been produced by Perth and Kinross Child Protection Committee (CPC) and are specifically aimed at those practitioners, services and agencies who are working to protect vulnerable children and young people.

These guidelines are dynamic, reflect the current national child protection legislative and policy context in Scotland and have been written to anticipate new and emerging ways of working.

They translate the National Guidance for Child Protection in Scotland 2014 (Scottish Government: 2014) into our local single and multi-agency partnership working arrangements and provide a useful working framework for our local child protection services.

Guidelines cannot in themselves protect children and young people; a competent, confident and skilful workforce, working together with a vigilant public can.

Child protection is important and it is essential that everyone understands the contribution they have to make in keeping all children and young people safe and protected from harm and abuse.

Whilst these guidelines are intended to act as a practical reference point for all practitioners, they should not be regarded as exhaustive or exclusive.

Whilst they do not constitute legal advice, they do aim to provide clear and unambiguous guidance to all staff which should support and empower them to safeguard, support and promote the wellbeing of all children and young people and to protect all children and young people from harm and abuse.

Jacquie Pepper

Chair of Perth and Kinross Child Protection Committee (CPC)

Date: 29 August 2017
How to Use these Child Protection Guidelines

These Guidelines have been produced to support and empower practitioners and managers working across the public, private and third sectors within Perth and Kinross.

They reflect the National Guidance for Child Protection in Scotland 2014 and recent child protection legislative, policy and practice developments. They also take cognisance of known, emerging and forthcoming policy and practice developments and have, as far as possible been future-proofed.

These Guidelines do not replace the National Guidance for Child Protection in Scotland 2014, nor do they replace any existing single service or agency child protection policies, procedures and/or guidelines. On the contrary, they aim to support and complement them.

These Guidelines provide the over-arching framework for child protection and set out our local procedures for protecting children and young people.

These guidelines are divided into five separate parts:

**Part I** describes the current and emerging, national legislative and policy context which supports and underpins child protection practice across Scotland and here within Perth and Kinross.

**Part II** provides a glossary of key terms and definitions, currently used in child protection and includes useful checklists on indicative signs and symptoms of potential harm and abuse.

**Part III** describes the key component processes of child protection practice - including early recognition and response; what to do if you are worried or concerned about a child or young person; local multi-agency screening arrangements for child concern reports and unborn baby referrals; inter-agency referral discussions; advice on information sharing, confidentiality and consent; joint investigative interviewing; identifying and managing risk; health assessments and medical examinations; child protection case conferences and the child protection register.

**Part IV** provides further information and advice on a wide range of complex / additional child protection related issues in specific circumstances, which practitioners and managers may identify and / or become involved in.

**Part V** provides a number of appendices with additional information on the roles and responsibilities of various partnerships, services and agencies involved in local child protection arrangements; electronic key legislative and policy links; key local publications; useful web links; defined acronyms used throughout this document and in child protection work more generally and a list of useful local contact numbers.

Throughout these Guidelines, practitioners and managers will find many intelligent and helpful electronic links for quick and easy reference. These Guidelines remain a dynamic resource subject to ongoing review and amendment, in keeping with emerging and future child protection legislative, policy and practice developments.
Table of Contents

Foreword 3
Introduction 4
Our Vision and Commitment 9

Part I Child Protection in Context
Context 11
Policy Context 17
Legislative Context 20

Part II Child Protection Key Definitions, Signs and Symptoms of Abuse and Neglect
Key Definitions 26
What is Child Abuse and Child Neglect? 28
What is Child Protection? 29
What is Harm and Significant Harm in a Child Protection Context? 30
Who is a Child in Need? 31
Signs and Symptoms of Abuse and Neglect 32

Part III Child Protection Practice
Responding to Concerns about Children or Young People 38
Child Concern Report (CCR) 40
Unborn Baby Referral 40
Multi-Agency Screening Arrangements (MASG) 41
Child Protection Investigation 44
Part IV Child Protection in Specific Circumstances

Whistleblowing and Child Protection 110
Unseen and / or Hidden Children 111
Hostile / Non-Engaging (Including Disguised Compliance) Parents and Carers 113
Bullying 116
Trafficking and Exploitation 117
Child Sexual Exploitation (CSE) 122
OnLine and Mobile Phone Child Safety 127
Missing Persons 128
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing Children and Young People / Runaways</td>
<td>133</td>
</tr>
<tr>
<td>Children Affected by Disability</td>
<td>135</td>
</tr>
<tr>
<td>Getting Our Priorities Right (GOPR): Working Together with Children, Young People and Families Affected by Problematic Alcohol and / or Drug Use</td>
<td>138</td>
</tr>
<tr>
<td>Children and Young People Affected by Parental Mental Health Difficulties</td>
<td>141</td>
</tr>
<tr>
<td>Children and Young People at Risk of Self Harm</td>
<td>143</td>
</tr>
<tr>
<td>Children and Young People at Risk of Suicide</td>
<td>144</td>
</tr>
<tr>
<td>Domestic Abuse (DA) and Violence Against Women and Girls (VAWG)</td>
<td>146</td>
</tr>
<tr>
<td>Honour-Based Violence (HBV)</td>
<td>149</td>
</tr>
<tr>
<td>Forced Marriage (FM)</td>
<td>150</td>
</tr>
<tr>
<td>Female Genital Mutilation (FGM)</td>
<td>153</td>
</tr>
<tr>
<td><strong>Part V Appendices</strong></td>
<td></td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td>157</td>
</tr>
<tr>
<td>Policy Context</td>
<td>176</td>
</tr>
<tr>
<td>Legislative Context</td>
<td>178</td>
</tr>
<tr>
<td>Useful Links – Perth and Kinross Local Guidance</td>
<td>180</td>
</tr>
<tr>
<td>Useful Web Links</td>
<td>181</td>
</tr>
<tr>
<td>Key Contact Details</td>
<td>184</td>
</tr>
<tr>
<td>Acronyms</td>
<td>187</td>
</tr>
</tbody>
</table>
Our Vision and Commitment to the Care and Protection of Children and Young People in Perth and Kinross

Across Perth and Kinross, it is still everyone's job and everyone's responsibility to:

- get it right for every child and young person;
- enable and support all children and young people to be the best they can be;
- improve the life chances of all children and young people;
- reduce the health inequalities of all children and young people;
- safeguard, support and promote the wellbeing of all children and young people;
- keep all children and young people safe; healthy; achieving; nurtured; active; respected; responsible and included;
- protect all children and young people from harm and abuse;
- ensure that all children and young people are cared for and grow and develop in a safe, protected and comfortable environment at home, on line, at school and in the community;
- ensure the welfare of all children and young people remains paramount;
- ensure all actions taken are child-centred and in the best interests of all children and young people;
- ensure we are protecting the rights of, and meeting the needs of, all children and young people, taking cognisance of their age; gender; sexual orientation; language; culture; religion and / or any additional support needs;
- ensure that all children and young people get the help they need; when they need it and for as long as they need it;
- ensure that all children and young people get the right help; at the right time and from the right people;
- ensure that all children and young people are listened to; understood and respected;
- ensure that all children and young people are taken seriously and treated with dignity and respect; and
- ensure that all parents, carers or any other person with parental responsibilities are encouraged and supported to provide the appropriate emotional and physical care for their children, except in exceptional circumstances.
Part I

Child Protection in Context
Context

The Scottish Government wants Scotland to be the best place in the world for children and young people to grow up so that they become: successful learners; confident individuals; effective contributors and responsible citizens.

“Our children and young people will have the best start in life and Tayside will be the best place in Scotland to grow up”

All children and young people (including unborn babies) have the right to be cared for; protected from harm and abuse and to grow up in a safe environment, in which their rights are respected, their wellbeing needs are met and they are protected from harm and abuse.

Children and young people should get the help they need, when they need it, for as long as they need it. They should also get the right help, at the right time, from the right people and their welfare is always paramount.

Most children and young people get all the help and support they need from their parents, carers and families, in addition to the universal services of education and health. However, on some occasions, some children and young people may need further help and support in order to safeguard, support and promote their wellbeing and to protect them from harm and abuse.

Supporting the wellbeing of all children and young people and protecting them from harm and abuse is everyone's job and everyone's responsibility in Perth and Kinross. This is a shared responsibility for all practitioners and managers working across the public, private and third sectors.

All practitioners must play their part in supporting the wellbeing of children and young people to ensure they are safe, healthy, achieving, nurtured, active, respected, responsible and included and protected from harm and abuse.

It is important that all practitioners understand these responsibilities; their duties of care; the relationship between Getting it right for every child and Child Protection; the respective key language / terminology; the levels and pathways of intervention and when each approach applies.

Getting it right for every child (GIRFEC)

GIRFEC is the national approach in Scotland to improving outcomes and supporting the wellbeing of all our children and young people, by offering the right help, at the right time, from the right people. It supports them and their parents, carers or any other person with parental responsibilities to work in partnership with the services and agencies that can help them.
GIRFEC has its origins in the United Nations Convention on the Rights of the Child (UNCRC), which outlines the rights of children and young people to have their basic needs met and to reach their full potential.

GIRFEC puts the rights and wellbeing of all children and young people at the heart of the services that support them - such as early years services, schools and the NHS - to ensure that everyone works together to improve outcomes for a child or young person. Taking a holistic view of the wellbeing of a child or young person is at the heart of the GIRFEC approach.

Services and community organisations across Scotland already use the GIRFEC approach to ensure the way they support children, young people and their parents, carers or any other person with parental responsibilities is consistent and effective.

The GIRFEC approach is not new and has grown over a number of years from the practice of health and education professionals and feedback from the children and families they support.

GIRFEC Principles

The Principles behind the GIRFEC approach:

- *is child-focused* - it ensures the child or young person - and their family - is at the centre of decision-making and the support available to them;

- *is based on an understanding of the wellbeing of a child* - it looks at a child or young person’s overall wellbeing – how safe, healthy, achieving, nurtured, active, respected, responsible and included they are – so that the right support can be offered at the right time;

- *is based on tackling needs early* - it aims to ensure needs are identified as early as possible to avoid bigger concerns or problems developing; and

- *requires joined-up working* - it is about children, young people, their parents, carers or any other person with parental responsibilities and the services they need, working together in a coordinated way to meet the specific needs and improve their wellbeing.

GIRFEC is for all children and young people because it is impossible to predict if or when they might need extra support. GIRFEC is about promoting, supporting and safeguarding the wellbeing of all children and young people.

GIRFEC Elements

Key elements of the GIRFEC approach have been and / or are being introduced into law under The Children and Young People (Scotland) Act 2014 and include:

- a description of how people working with children, young people and their parents, carers or any other person with parental responsibilities understand and consider a child or young person’s wellbeing;

- children, young people and families can expect services to work together to provide support and help;
• a **Named Person** is available, as a central point of contact for children, young people and their parents, carers or any other person with parental responsibilities, who will provide advice, information, support and help to access other services if needed; and

• children and young people who need extra support which is not generally available will have a **Child’s Plan**.

**For children, young people and families GIRFEC means:**

• they understand what is happening and why;

• they have been listened to carefully and their wishes have been heard, understood and taken into consideration;

• they feel confident about the help you are getting;

• they are appropriately involved in discussions and decisions that affect them;

• they can rely on appropriate help being available as soon as possible; and

• they experience a more straightforward and co-ordinated response from the people working with them.

**For people working in children's and adult services GIRFEC means:**

• the child or young person is at the centre of their work, understanding what their unique needs are and how they can help

• they use common tools, language and processes to consider a child or young person’s **wellbeing**, working closely with them, their parents, carers or any other person with parental responsibilities and other professionals, supporting them where appropriate; and

• they feel confident that they have the right information to provide the best support they can to a child or young person and their parents, carers or any other person with parental responsibilities.

Further information and advice on GIRFEC and in particular key definitions, terminology and language including **Named Person**, **Child’s Plan** and **Lead Professional** are contained throughout these guidelines.

In addition, the Scottish Government has developed a **Practitioner's GIRFEC Information Pack** which practitioners may find helpful.

**Wellbeing**

**Wellbeing** sits at the heart of the GIRFEC approach and reflects the need to tailor the support and help that children, young people and their parents, carers or any other person with parental responsibilities are offered to support their **wellbeing**.

A child or young person’s **wellbeing** is influenced by everything around them and the different experiences and needs they have at different times in their lives.
Enhancing **Wellbeing** is fundamental to preventing difficulties escalating and avoiding the circumstances which may lead to children and young people experiencing harm or abuse.

To help make sure everyone - children, young people, their parents, carers or any other person with parental responsibilities and the services that support them - has a common understanding of what **wellbeing** means, we describe it in terms of **eight wellbeing indicators**.

The **eight wellbeing indicators** are commonly referred to by their initial letters - SHANARRI:

- **Safe**
  Protected from abuse, neglect or harm at home, at school and in the community.

- **Healthy**
  Having the highest attainable standards of physical and mental ill-health, access to suitable healthcare and support in learning to make healthy, safe choices.

- **Achieving**
  Being supported and guided in learning and in the development of skills, confidence and self-esteem, at home, in school and in the community.

- **Nurtured**
  Having a nurturing place to live in a family setting, with additional help if needed, or, where possible, in a suitable care setting.

- **Active**
  Having opportunities to take part in activities such as play, recreation and sport, which contribute to healthy growth and development, at home, in school and in the community.

- **Respected**
  Having the opportunity, along with carers, to be heard and involved in decisions that affect them.

- **Responsible**
  Having opportunities and encouragement to play active and responsible roles at home, in school and in the community and where necessary, having appropriate guidance and supervision and being involved in decisions that affect them.

- **Included**
  Having help to overcome social, educational, physical and economic inequalities and being accepted as part of the community in which they live and learn.

**Wellbeing** is multi-dimensional. A child or young person’s wellbeing in relation to one indicator may impact on and interact with their wellbeing in relation to other indicators. Each child and young person is unique and there is no set level of wellbeing that children should achieve.
Each child or young person should be helped to reach their full potential as an individual. The eight wellbeing indicators help make it easier for everyone to be consistent in how they consider the quality of a child or young person’s life at a particular point in time.

Families and people working with children and young people can use the eight wellbeing indicators to identify what help a child or young person needs in order to help them access the right support or advice.

All services working with children and young people, and those who care for them, must play their part to promote, support and safeguard children and young people's wellbeing.

Child Protection

Child protection is not something which sits separately from wellbeing. Child protection services continue to protect children and young people at risk of significant harm. The provisions of The Children and Young People (Scotland) Act 2014 have not changed any requirement to follow local child protection procedures.

Fundamentally child protection sits within, and should be seen as, an integral part of the wider Getting it right for every child approach. Both are inextricably linked and prerequisites in improving outcomes for children and young people, keeping them safe and protecting them from harm and abuse. Enhancing wellbeing can serve to protect children and avoid the circumstances which might lead to abuse, neglect or harm.

Child protection practice sits within a spectrum of early intervention and effective family support. Child protection is everyone's responsibility and it's everyone's job to make sure all children and young people are alright. Child protection is particularly the responsibility of all practitioners and managers who work with children and families, regardless of whether that work brings them into direct contact with children and young people or not.

Child protection means protecting a child or young person from abuse or neglect.

Abuse and neglect are forms of maltreatment of a child or young person. Abuse and neglect can present in many ways; some may be obvious and others difficult to spot. Abuse and neglect need not have taken place; it is sufficient for a risk assessment to have identified a likelihood or risk of significant harm from abuse or neglect. Understanding the concept and nature of risk is important for all practitioners and managers.

A wellbeing need or an accumulation of wellbeing needs, when taken together, can lead to a child or young person being at risk of significant harm. The National Guidance for Child Protection in Scotland 2014 describes in more detail and how to identify when a child or young person may be in need of protection. A risk of significant harm often relates to how safe, healthy and nurtured a child or young person is, but the other wellbeing indicators may also be affected and should always be considered in this context too.
**Significant harm** is a complex matter and subject to professional judgment based on a multi-agency assessment of the circumstances of the child or young person and their family. There are no absolute criteria for judging what constitutes significant harm.

**Significant harm** can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time. It is essential that when considering the presence or likelihood of significant harm that the impact (or potential impact) on the child or young person takes priority and not simply the suspected or reported abusive behaviour.

In order to understand the concept of significant harm, it is helpful to look first at the relevant definitions:

- **Harm** means the ill treatment or the impairment of the health or development of the child or young person, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context, development can mean physical, intellectual, emotional, social or behavioural development and health can mean physical or mental ill-health.

Whether the harm suffered, or likely to be suffered, by a child or young person is significant is determined by comparing the child or young person's health and development with what might be reasonably expected of a similar child or young person.

In assessing the severity of ill treatment or future ill treatment, it may be important to take account of:

- the degree and extent of physical harm;
- the duration and frequency of abuse and neglect;
- the extent of premeditation; and
- the presence or degree of threat, coercion, sadism; and bizarre or unusual elements.

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 or young person's physical and psychological development.

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, either through an act of commission or omission;
- the impact on the child or young person's health and development, taking into account their age and stage of development;
- the child or young person's development within the context of their family and wider environment;
- the context in which a harmful incident or behaviour occurred;
• any particular needs, such as a medical condition, communication impairment or disability, that may affect the child or young person's development, make them more vulnerable to harm or influence the level and type of care provided by the family;

• the capacity of their parents, carers or any other person with parental responsibilities to meet adequately the child or young person's needs; and

• the wider and environmental family context.

Child protection requires taking prompt action to protect a child or young person where a child or young person is considered to be at risk of significant harm. Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies so that they can decide whether the harm is, or is likely to be significant.

Policy Context

Underpinning these Inter-Agency Child Protection Guidelines and the previously described local practice context, there is a significant and substantial policy context relating to wellbeing and child protection. The full extent of this policy context can be found at Appendix II. The following is a snapshot of the current and key policy developments considered to be relevant:

Getting it right for every child (GIRFEC)

GIRFEC is the national approach in Scotland to improving outcomes and supporting the wellbeing of all our children and young people, by offering the right help, at the right time, from the right people. It supports them and their parents, carers or any other person with parental responsibilities to work in partnership with the services and agencies that can help them.

GIRFEC has its origins in the United Nations Convention on the Rights of the Child (UNCRC), which outlines the rights of children and young people to have their basic needs met and to reach their full potential.

GIRFEC puts the rights and wellbeing of all children and young people at the heart of the services that support them - such as early years services, schools and the NHS - to ensure that everyone works together to improve outcomes for a child or young person. Taking a holistic view of the wellbeing of a child or young person is at the heart of the GIRFEC approach.

UN Convention on the Rights of the Child (UNCRC)

The United Nations Convention on the Rights of the Child (UNCRC) is a legally-binding international agreement setting out the civil, political, economic, social and cultural rights of every child and young person, regardless of their race, religion or abilities. The UNCRC consists of 54 articles that set out children's rights and how governments should work together to make them available to all children.

Since it was adopted by the United Nations in November 1989, 194 countries have signed up to the UNCRC, with only two countries in the world still to ratify. All countries that sign up to the UNCRC are bound by international law to ensure it is implemented.
Under the terms of the convention, governments are required to meet children’s basic needs and help them reach their full potential. Central to this is the acknowledgment that every child has basic fundamental rights. These include the right to:

- life, survival and development;
- protection from violence, abuse or neglect;
- an education that enables children to fulfil their potential;
- be raised by, or have a relationship with, their parents or carers; and
- express their opinions and be listened to.

**Early Years Framework**

The [Early Years Framework](#) published in 2008, sets out 10 overlapping elements which need to come together to deliver the following shared vision for early years - “to make Scotland the best place in the world to grow up in by improving outcomes and reducing inequalities for all babies, children, mothers, fathers and families across Scotland to ensure that all children have the best start in life and are ready to succeed”.

This is a concerted, long-term effort involving all partners working across a range of policies and services to deliver transformational change. Partners across Scotland are building a shared understanding of why children’s early years experiences are so important and how big a part they play both in individual life outcomes as well as the future social and economic success of Scotland.

It’s about bringing together all those involved in the lives of babies and children from birth onwards to ensure there are positive opportunities for children to get the start in life that will provide them with a strong platform for healthy growth, development and attainment.

Putting this vision into action is the world’s first national multi-agency, quality improvement programme – the [Early Years Collaborative](#). The Early Years Collaborative is a coalition of Community Planning Partners, including social services, health, education, police and third sector professionals committed to ensuring that every baby, child, mother, father and family in Scotland has access to the best supports available.

The [Early Years Framework](#) highlights the importance of all national and local agencies, the third sector and independent sector working together to deliver improved outcomes for children. The Framework identifies the 10 key elements of transformational change in the early years and these are:

- a coherent approach;
- helping children, families and communities to secure outcomes for themselves.
- breaking cycles of poverty, inequality and poor outcomes in and through early years;
- a focus on engagement and empowerment of children, families and communities;
- using the strength of universal services to deliver prevention and early intervention;
- putting quality at the heart of service delivery;
• services that meet the needs of children and families;
• improving outcomes and children's quality of life through play;
• simplifying and streamlining delivery; and
• more effective collaboration.

The Early Years Framework is particularly relevant, but not limited to, the delivery of three of the National Outcomes:

• our children have the best start in life and are ready to succeed;
• we have improved the life chances for children, young people and families at risk; and
• our young people are successful learners, confident individuals, effective contributors and responsible citizens.

In addition to the above, three further Scottish Government key child protection policy developments remain relevant to child protection:

Protecting Children and Young People: Children’s Charter

The Children's Charter (Scottish Government: 2014) describes, in child-friendly language, the views and expectations of children and young people. It also confirms what makes them feel safe.

The thirteen key messages for practitioners, services / agencies are:

• get to know us;
• speak with us;
• listen to us;
• take us seriously;
• involve us;
• respect our privacy;
• be responsible to us;
• think about our lives as a whole;
• think carefully about how you use information about us;
• put us in touch with the right people;
• use your power to help;
• make things happen when they should; and
• help us to be safe.
Protecting Children and Young People: Framework for Standards

The Framework for Standards (Scottish Government: 2014) effectively translates the above messages from the Children's Charter into child protection practice, by providing eight high level generic statements, all supported by additional narrative / text. The eight standard statements are:

**Standard 1:** Children get the help they need when they need it;

**Standard 2:** Professionals take timely and effective action to protect children;

**Standard 3:** Professionals ensure children are listened to and respected;

**Standard 4:** Agencies and professionals share information about children where it is necessary to protect them;

**Standard 5:** Agencies and professionals work together to assess needs and risks and develop effective plans;

**Standard 6:** Professionals are competent and confident;

**Standard 7:** Agencies work in partnership with members of the community to protect children; and

**Standard 8:** Agencies, individually and collectively, demonstrate leadership and accountability for their work and its effectiveness.

National Guidance for Child Protection in Scotland 2014

The National Guidance for Child Protection in Scotland 2014 was first published by the Scottish Government in 2010 and refreshed in 2014 to ensure that it remains relevant and up to date.

This guidance is for all services, agencies, professional bodies, professional organisations and individuals working within children's services and adult services.

This guidance provides a national framework for agencies and practitioners at a local level to understand and agree processes for working together to support, promote and safeguard the wellbeing of children and young people.

It sets out expectations for strategic planning of services to protect children and young people and highlights key responsibilities for services and organisations, both individual and shared, and includes guidance for Child Protection Committees.

It also serves as a practical reference point and resource for all practitioners by providing guidance on a wide range of specific areas of child protection practice and key issues in child protection, including Child Sexual Exploitation (CSE).

Legislative Context

Underpinning these Inter-Agency Child Protection Guidelines and the previously described policy and local practice context, there is a significant and substantial legislative context relating to wellbeing and child protection. The full extent of this legislative context can be found at Appendix III. The following is a snapshot of the current and key legislative developments considered to be relevant:
The Social Work (Scotland) Act 1968

Although amended many times over the years, this legislation provides the primary mandate for social work intervention in Scotland.

This 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 more specifically set out the duties owed to children in need, the overarching mandate remains that it is the duty of the local authority to ensure that social work services are made available across their jurisdiction area.

The Age of Legal Capacity (Scotland) Act 1991

This Act sets out the framework for assessing the capacity of children and young people. It provides that a person under the age of 16 years has legal capacity to consent on his or her own behalf to any surgical, medical, or dental procedure or treatment, including psychological or psychiatric examination, where in the opinion of an attending qualified medical practitioner, she / he is capable of understanding the nature and possible consequence of the procedure or treatment. Children and young people who have legal capacity in relation to medical treatment may also withhold their consent to treatment.

The Children (Scotland) Act 1995

This remains one of the primary pieces of legislation relating to children and young people and marks a significant stage in the development of legislation on the care of children in Scotland. It is centred on the needs of children and their families and defines both parental responsibilities and rights in relation to children. It sets out the duties and powers available to Councils to support children and their families on a voluntary basis.

The Data Protection Act 1998

This Act sets out the law relating to information sharing. It sets out when data can be "processed" and the responsibilities of data controllers within any organisation to ensure that the key principles set out in the Act are adhered to by all staff. Of particular note in the child protection context are those sections of the Act that relate to confidentiality, sharing of information and disclosure of personal and sensitive information. For further information, see the section on Information Sharing, Confidentiality and Consent.

The Human Rights Act 1998

All legislation passed by either the UK or Scottish Parliament must be compatible with the European Convention on Human Rights (ECHR). In so far as it is possible, public authorities must read and give effect to legislation in a way which is compatible with the Convention. Sometimes there may be a potential conflict of interest between children and adults and a balancing of competing rights will be required.
The Protection of Vulnerable Groups (Scotland) Act 2007

This legislation introduced the Protecting 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 responsibilities of employers.

The Children’s Hearings (Scotland) Act 2011

This legislation sets out the framework for the care and protection of children through the making of Compulsory Measures of Supervision. The Act sets out when referrals must be made to the Children’s Reporter; the mechanisms for the making of Compulsory Measures of Supervision and the forms such measures may take.

This Act also sets out the legislation governing emergency measures for the protection of children, including child protection orders 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.

Child Assessment Orders (CAO)

Section 35 of The Children’s Hearings (Scotland) Act 2011 allows the local authority (normally social work services) to apply to the Sheriff for a child assessment order, in certain circumstances, in respect of a specific child or young person.

A child assessment order, if granted by the Sheriff, allows for an assessment of a child’s health and development or for an assessment into the way in which the child has been or is being treated or neglected.

A child assessment order, if granted, may require any person in a position to do so to produce the child and for the purposes of carrying out the assessment, authorise the taking of the child to any place and the keeping of the child at that place or any other place for a period specified in the order.

A child assessment order must specify the period during which it has effect. This period must begin no later than 24 hours after the order is granted and must not exceed three days. Alternatively, the Sheriff may, instead of making a child assessment order, make a child protection order. Unlike a Child Protection Order, a Child Assessment Order does not automatically feed into the Children’s Hearings System.

Child Protection Orders (CPO)

Section 37 of The Children’s Hearings (Scotland) Act 2011 allows any person, including the local authority (normally social work services) to apply to the Sheriff for a child protection order, in certain circumstances, in respect of a specific child.

A child protection order, if granted by the sheriff, allows for one or more of the following:

a) requiring any person in a position to do so to produce the child to a specified person,
b) authorising the removal of the child by the specified person to a place of safety and the keeping of the child in that place,

c) authorising the prevention of the removal of the child from any place where the child is staying (whether or not the child is resident there),

d) authorising the carrying out of an assessment of:

i. the child's health or development, or

ii. the way in which the child has been or is being treated or neglected.

A child protection order may also include any other authorisation or requirement necessary to safeguard or promote the welfare of the child.

A Sheriff can attach conditions to a Child Protection Order. A Children’s Hearing is convened on the second working day after the Child Protection Order is implemented. If the Children's Hearing agree to continue the Child Protection Order than a further Children's Hearing must be convened on the eighth working day. Thereafter, the normal Children’s Hearing process is followed.

**Exclusion Orders (EO)**

Section 76 of The Children (Scotland) Act 1995 allows the local authority (normally social work services) to apply to the Sheriff for an Exclusion Order in certain circumstances.

An Exclusion Order, if granted, will exclude an abuser from the home where the child or young person is residing. It may also interdict the person from being in the vicinity of the home and may also regulate contact between the person and the child or young person.

An Exclusion Order may last for 6 months. After that, a further application would need to be made, if the circumstances still warranted it. Unlike a Child Protection Order, an Exclusion Order does not automatically feed into the Children’s Hearings system.

**Emergency Powers**

Section 56 of The Children's Hearings (Scotland) Act 2011 allows a police officer to remove a child to a place of safety in certain circumstances.

Section 56 states that a constable may remove a child to a place of safety and keep the child there if the constable is satisfied that the removal of the child is necessary to protect the child from harm or from further harm, and it is not practicable in the circumstances for an application for a child protection order to be made to or considered by the sheriff. Section 56 also states that as soon as practicable after a constable removes a child under this section, the constable must inform the Principal Reporter and the child may not be kept in a place of safety under this section for a period of more than 24 hours.

In Perth and Kinross all applications to the Sheriff for Child Assessment Orders (CAO) and Child Protection Orders (CPO) are made via Perth and Kinross Council Legal Services.
The Police and Fire Reform (Scotland) Act 2012

This legislation lays down the duty of a Constable and the 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:

- prevent and detect crime;
- maintain order;
- protect life and property; and
- to take such lawful measures and make such reports to the appropriate prosecutor as maybe needed to bring offenders with all due speed to justice.

The Children and Young People (Scotland) Act 2014

Not all of the provisions in this legislation have been implemented at the time of writing; however it is a significant piece of legislation about children's rights and services and practitioners should be aware of its existence.

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 statutory operation of the Named Person and Child’s Plan;
- 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; some amendments to children's hearings legislation;
- appeals against detention in secure accommodation; and
- the provision of free school lunches.

There are different implementation dates for different Parts of the Act, and practitioners working in children's services should ensure they keep up to date with the changes being made as the different Parts of the Act are brought into force. Further guidance is being produced to support the ongoing implementation of the Act.
Part II

Child Protection Key Definitions, Signs and Symptoms of Abuse and Neglect
Key Definitions

A clear and consistent understanding of the different concepts and terminology in child protection is essential. If action to support and protect children is to be informed and effective; all practitioners and managers must have a clear and consistent understanding of what is meant by terms such as child; parent or carer; child abuse; harm; significant harm; neglect; exploitation and child protection. The following section provides definitions and explanations about key terms used within child protection processes.

Child

A child can be termed differently in different legal contexts.

For the purposes of this guidance a child is defined as a person who has not attained the age of 18 years. However, in terms of the protective interventions that can be taken, it will depend on the circumstances and legislation relevant to the child or young person at that relevant time.

The following legislation is considered to be relevant:

In terms of Section 93(2) (a) and (b) of The Children (Scotland) Act 1995 a child is defined as:

- a child who has not attained the age of sixteen years;
- a child over the age of sixteen years who has not attained the age of eighteen years and in respect of whom a supervision requirement is in force; or
- a child whose case has been referred to a children’s hearing by virtue of section 33 of this Act.

In terms of Section 199 of The Children’s Hearings (Scotland) Act 2011 a child means a person who is under 16 years of age with some exceptions.

In terms of Section 97 (1) of The Children and Young People (Scotland) Act 2014 a child means a person who has not attained the age of 18 years.

In terms of Section 40 of The Human Trafficking and Exploitation (Scotland) Act 2015 a child is defined as any person under 18 years of age.

The UN Convention on the Rights of the Child (UNCRC) applies to anyone under the age of 18. However, Article 1 states that this is the case unless majority is attained earlier under the law applicable to the child.

Young people aged between 16 and 18 are potentially vulnerable to falling “between the gaps” and local services must ensure that processes are in place to enable staff to offer ongoing support and protection as needed, via continuous single planning for the young person.
Where a young person between the age of 16 and 18 requires protection, services will need to consider which legislation, if any, can be applied. This will depend on the young person's individual circumstances as well as on the particular legislation or policy framework. Special consideration will need to be given to the issue of consent and whether an intervention can be undertaken where a young person has withheld their consent.

**Parent**

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

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.

**Carer**

A *carer* is someone other than a parent who has rights / responsibilities for looking after a child or young person. *Relevant persons* have extensive rights within the Children’s Hearings system, including the right to attend Children’s Hearings, receive all relevant documentation and challenge decisions taken within those proceedings. A *carer* may be a “relevant person” within the Children’s Hearing system.

**Kinship Carer**

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

Before making such a decision the authority must, so far as reasonably practicable, obtain and record in writing the information specified in Schedule 3 to the Regulations and, taking into account that information, carry out an assessment of that person’s suitability to care for the child. Local authorities' duties are designed to ensure that they do not make or sustain placements that are not safe or in the child's best interests and that placements are subject to regular review.

Preventative and protective work is necessary to support carers and, in particular, kinship carers who may face added challenges. These include the potential risks posed by parents or carers; where the kinship carer is a grandparent, this may mean making decisions as to how best to protect
their grandchild or grandchildren from their own child. Kinship carers may have ambivalent feelings about the circumstances that have resulted in them having to care for a child or young person. Services should be sensitive to these issues and offer support wherever possible.

Informal kinship care refers to care arrangements made by parents, carers 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 foster carer, nor is assessment of such a carer by the local authority a legal requirement.

Private Fostering

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.

Within Perth and Kinross, Information and Advice Leaflets on Private Fostering have been produced, which describe the responsibilities for local authorities and for those who may be looking after someone else’s child. Practitioners may find these helpful:

Private Fostering – Information for Services and Agencies
Private Fostering - Information for Parents or Carers

What is Child Abuse and Child Neglect?

Abuse and neglect are forms of maltreatment of a child or young person. Somebody may abuse or neglect a child or young person by inflicting, or by failing to act to prevent, significant harm to the child. Children and young people may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger. Assessments will need to consider whether abuse has occurred or is likely to occur.

The following definitions show some of the ways in which abuse may be experienced by a child or young person but are not exhaustive, as the individual circumstances of abuse will vary.

Physical Abuse

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

Emotional Abuse

Emotional abuse is persistent emotional neglect or ill treatment that has severe and persistent adverse effects on a child or young person's emotional development. It may involve conveying to a
child or young person that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of another person. It may involve the imposition of age-or developmentally-inappropriate expectations on a child or young person. It may involve causing children and young people to feel frightened or in danger, or exploiting or corrupting children and young people. Some level of emotional abuse is present in all types of ill treatment of a child or young person; it can also occur independently of other forms of abuse.

**Sexual Abuse**

Sexual abuse is any act that involves the child or young person in any activity for the sexual gratification of another person, whether or not it is claimed that the child or young person either consented or assented. Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child or young person is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children or young people in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child or young person or encouraging children and young people to behave in sexually inappropriate ways (also see the section on Child Sexual Exploitation).

**Neglect**

Neglect is the persistent failure to meet a child or young person's basic physical and / or psychological needs, likely to result in the serious impairment of the child or young person's health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, to protect a child or young person from physical harm or danger, or to ensure access to appropriate medical care or treatment. It may also include neglect of, or failure to respond to, a child or young person's basic emotional needs.

Neglect may also result in the child or young person being diagnosed as suffering from “non-organic failure to thrive”, where they have significantly failed to reach normal weight and growth or development milestones and where physical and genetic reasons have been medically eliminated. In its extreme form children and young person can be at serious risk from the effects of malnutrition, lack of nurturing and stimulation. This can lead to serious long-term effects such as greater susceptibility to serious childhood illnesses and reduction in potential stature. With young children in particular, the consequences may be life-threatening within a relatively short period of time.

**What is Child Protection?**

Child protection means protecting a child or young person from child abuse or neglect. Abuse or neglect need not have taken place; it is sufficient for a risk assessment to have identified a likelihood or risk of significant harm from abuse or neglect.

Equally, in instances where a child or young person may have been abused or neglected, but the risk of future abuse has not been identified, the child or young person and their family may require support and recovery services but not a Child Protection Plan. In such cases, an investigation may still be necessary to determine whether a criminal investigation is needed and to inform an
assessment that a Child Protection Plan is not required.

There are also circumstances where, although abuse has taken place, formal child protection procedures are not required. For example, the child or young person’s family may take protective action by removing the child or young person from the source of risk.

Children and young people who are abused by strangers would not necessarily require a Child Protection Plan unless the abuse occurred in circumstances resulting from a failure in the family to protect the child or young person.

Similarly, if a young child is abused by a stranger, a Child Protection Plan may be required only if the family were in some way responsible for the abuse occurring in the first instance, or were unable to adequately protect the child or young person in the future without the support of a Child Protection Plan.

**What is Harm and Significant Harm in a Child Protection Context?**

*Child protection* is closely linked to the risk of significant harm. *Significant harm* is a complex matter and subject to professional judgement based on a multi-agency assessment of the circumstances of the child or young person and their family. Where there are concerns about harm, abuse or neglect, these must be shared with the relevant agencies so that they can decide together whether the harm is, or is likely to be, significant.

*Significant harm* can result from a specific incident, a series of incidents or an accumulation of concerns over a period of time. It is essential that when considering the presence or likelihood of *significant harm* that the impact (or potential impact) on the child or young person takes priority and not simply the suspected or reported abusive behaviour. The following sections illustrate considerations that need to be taken into account when exercising that professional judgement.

In order to understand the concept of *significant harm*, it is helpful to look first at the relevant definitions:

- **Harm** means the ill treatment or the impairment of the health or development of the child or young person, including, for example, impairment suffered as a result of seeing or hearing the ill treatment of another. In this context, development can mean physical, intellectual, emotional, social or behavioural development and health can mean physical or mental ill-health.

- Whether the harm suffered, or likely to be suffered, by a child or young person is *significant harm* is determined by comparing the child or young person’s health and development with what might be reasonably expected of a similar / unaffected child or young person.

There are no absolute criteria for judging what constitutes *significant harm*. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.
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 or young person’s physical and psychological development.

To understand and identify significant harm, it is necessary to consider:

- the nature of harm, either through an act of commission or omission;
- the impact on the child or young person’s health and development, taking into account their age and stage of development;
- the child or young person’s development within the context of their family and wider environment;
- the context in which a harmful incident or behaviour occurred;
- any particular needs, such as a medical condition, communication impairment or disability, that may affect the child or young person’s development, make them more vulnerable to harm or influence the level and type of care provided by the family; and
- the capacity of parents or carers to meet adequately the child or young person’s needs; and the wider family and environmental context.

The reactions, perceptions, wishes and feelings of the child or young person 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 and young people do as well as what they say, and to bear in mind that children and young people may experience a strong desire to be loyal to their parents or carers (who may also hold some power over the child or young person). Steps should be taken to ensure that any accounts of adverse experiences given by children and young people are accurate and complete, and that they are recorded fully.

**Who is a Child in Need?**

The concept of need as defined in Section 93 (2) (b) of The Children (Scotland) Act 1995 and relates to a child or young person being in need of care and attention because:

- he / she is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining a reasonable standard of health or development unless they are provided for him/her under or by virtue of that Part of the Act by services provided by a local authority;
- his / her health or development is likely to be significantly impaired or further impaired unless such services are provided;
- he / she is disabled; or
- he / she is adversely affected by the disability of any other person in his/her family; and
- children and young people with particular vulnerabilities or disabilities aged between 16 and
18 are potentially at risk of falling between services and local authorities must ensure that staff offer ongoing support and protection as required.

Signs and Symptoms of Abuse and Neglect

A child or young person who has been abused and / or neglected (or both) may show obvious physical signs and symptoms of such abuse and / or neglect. The following schedules provide some indicators which practitioners may find helpful when trying to identify child abuse and / or neglect. These should not be considered as an exhaustive list.

General Presentations

• conflicting explanations or inconsistent reports of:
  ▪ medical treatment;
  ▪ reasons for marks or injuries; and
  ▪ reasons for absence from school or medical appointments.
• obvious, non-accidental marks of hand, belt, stick, etc;
• injuries in young children (under 1 year);
• injuries of different ages;
• delay in parents or carers seeking medical attention for their child;
• children and young people brought for medical attention by the parent or carer who was not present when the injury was sustained;
• features of general neglect of the child or young person’s physical or emotional needs;
• inappropriate behaviour (including sexualised play or activity) or demeanour of the child, young person or parent or carer;
• unusual illness suggestive of a fictitious origin; and
• child or young person's name already entered on the Child Protection Register.

Physical Abuse

The following indicators may be helpful to practitioners when considering the possibility of physical abuse:

Bruises

Black eyes are particularly suspicious if:

• both eyes are black (most accidents cause only one);
• there is an absence of bruising to the forehead or nose;
• there is a suspicion of skull fracture (black eyes can be caused by blood seeping down from an injury above);
• bruising in or around the mouth (especially in young babies);
• grasp marks on the arm or on the chest of a small child;
• finger marks (three or four small bruises on one side of the face and one on the other);
• symmetrical bruising (particularly on the ears);
• outline bruising (e.g. belt marks, hand prints);
• linear bruising (commonly on the buttocks or back);
• bruising on soft tissue with no satisfactory explanation; and
• petechial bruising (petechial – small spot caused by an effusions of blood under the skin),
  tiny red marks on the face particularly in or around the eyes and neck, also the ears,
  indicative of shaking or constriction.

**NB** – Most falls or accidents produce one bruise on an area of the body, usually on a bony protuberance. A child or young person who falls downstairs generally has only one or two bruises. Bruising in accidents is usually on the front of the body as children and young people generally fall forwards. Additionally there may be marks on their hands if they have tried to protect themselves and attempt to break their fall.

The following are uncommon areas for accidental bruising:
• back;
• back of legs;
• buttocks (except occasionally along the bony protuberance of the spine);
• neck;
• mouth;
• cheeks;
• behind the ear;
• stomach;
• chest;
• under arm; and
• genital and rectal areas.

**Bites**

These can leave clear impressions of teeth and the scientific specialism of Odontology can often identify the abuser.
Burns and Scalds

Distinguishing between accidental and non-accidental burns is problematic but as a general rule burns and scalds with clear outlines are suspicious. Similarly burns of uniform depth over a large area should arouse suspicion. Equally splash marks about the main burn area (caused ostensibly by hot liquid being thrown).

\textbf{NB} – Concerns should be raised where the adult responsible for filling a bath has failed to check the temperature of the bath. A child or young person is unlikely to sit down voluntarily in an excessively hot bath and equally cannot physically scald their bottom without also scalding their feet. A child or young person voluntarily stepping into a bath filled with too hot water will naturally struggle to hop back out again causing splash marks.

Scars

Many children and young people have scars but staff should be vigilant about an exceptionally large number of differing age scars (particularly if combined with fresh bruising), unusually shaped scars (e.g. circular ones resulting from cigarette burns) or of large scars from burns or lacerations that have not received medical attention.

Fractures

These should arouse suspicion if there is discrepant history of causation, swelling or discolouration over a bone or joint. The most common non-accidental fractures are to the long bones, i.e. the arms or legs. Generally, fractures also carry pain and it is difficult for a parent or carer to justify being unaware that a child or young person has been injured in this manner. It would be rare for a non ambulant child to sustain an accidental limb fracture.

Genital / Anal Area

It would be unusual for a child or young person to have bruising or bleeding in these areas and medical opinion should be sought.

Shaken Baby Syndrome

This term refers to the constellation of non-accidental injuries occurring in infants and young children as a consequence of violent shaking. The action can prove fatal.

Poisoning

Poisoning often occurs in fictitious illness syndrome (Munchausen Syndrome by Proxy). Again medical advice should be sought in respect of both child or young person and presenting parent or carer.

Emotional Abuse

The following indicators may be helpful to practitioners when considering the possibility of emotional abuse. In some circumstances they will be applicable to an individual child or young person, in others it may reflect upon all siblings:
Parents’ Behaviour

- rejection;
- denigration;
- scapegoating;
- denial of opportunities for exploration, play and socialisation appropriate to their stage of development;
- under stimulation;
- sensory deprivation;
- unrealistic expectations of the child;
- marked contrast in material provision afforded to other siblings;
- isolation from normal social experiences preventing the child forming friendships;
- requesting the child be removed from the home or highlighting difficulties in coping with a child about whose care there is existing professional concerns; and
- domestic violence between care givers.

The effects on children and young people who witness domestic abuse are serious. The possibility of such children or young people also being physically abused must be a realistic concern.

Child’s Behaviour

- frozen watchfulness;
- fear of carers;
- refusal to speak; and
- severe hostility or aggression towards other children.

Sexual Abuse

Children and young people can disclose either spontaneously or in a premeditated way. This is often dependent on their age. The following indicators may be helpful to practitioners when considering the possibility of sexual abuse:

Physical Indicators

- injuries to the genital area;
- infections or abnormal discharge in the genital area;
- complaints of genital itching or pain;
- depression and withdrawal;
- wetting and soiling, day and night;
- sleep disturbances or nightmares;
- recurrent illnesses, especially venereal disease;
• anorexia or bulimia;
• pregnancy; and
• phobias or panic attacks

General Indicators

• self harming;
• exhibiting sexual awareness inappropriate for age of child or young person;
• acting in a sexually explicit manner e.g. very young child inserting objects into their vagina;
• sudden changes in behaviour or school performance or attendance;
• displays of affection which are sexually suggestive;
• tendency to cling or need constant reassurance;
• tendency to cry easily;
• regression to earlier behaviour such as thumb sucking, acting as a baby;
• distrust of a familiar adult or anxiety about being left with a relative, babysitter or lodger;
• unexplained gifts or amounts of money;
• secretive behaviour; and
• fear of undressing for gym classes or swimming lessons.

Neglect

The following indicators may be helpful to practitioners when considering the possibility of neglect:

• lack of appropriate food;
• inappropriate or erratic feeding;
• hair loss;
• lack of adequate clothing;
• circulation disorders;
• Unhygienic home conditions;
• lack of protection or exposure to dangers involving moral danger, or lack of supervision appropriate to a child’s age which has arisen due to familial abuse of substances;
• failure to seek appropriate medical attention; and
• general failure to achieve developmental milestones.
Part III

Child Protection Practice
Responding to Concerns about Children or Young People

Child protection is important and it is essential that everyone understand the contribution they have to make in keeping all children and young people safe and protected from harm and abuse.

All staff who work with and / or come into contact with children, young people and their families have a role to play in child protection. Staff should be alert to signs and symptoms which may indicate that a child or young person is being exposed to harm and abuse.

All staff must ensure they understand their own service or agency child protection procedures; know how, where and when to access them and know who their Designated Child Protection Officer is and how to contact him / her.

If you are worried or concerned about a child or young person staff should ask themselves:

1. What have I seen?
2. What have I heard?
3. What do I feel is unusual or different?
4. What has actually happened?
5. What is my worry or concern?
6. Does it look right?
7. Does it sound right?
8. Does it feel right?

Practitioners have a duty of care to others. Practitioners should trust their intuition or gut feelings. Practitioners should embrace a professional curiosity approach, and if necessary an assertive approach. Practitioners should be particularly aware of non-compliance and / or disguised compliance. Practitioners have authority to question, challenge and raise concern about children and young people. In doing so practitioners should exercise their professional judgement and adopt a common sense approach. If it looks, sounds or feels wrong then it probably is wrong.

Practitioners may also find the Five Key GIRFEC Questions helpful in determining their next steps:

1. What is getting in the way of this child’s or young person’s wellbeing?
2. Do I have all the information I need to help this child or young person?
3. What can I do now to help this child or young person?
4. What can my agency do to help this child or young person?
5. What additional help, if any, may be needed from others?

If a child or young person discloses that they have been harmed or abused, or this is brought to the attention of a practitioner or a manager then:
DO:

- ensure they are safe and protected from any further harm and abuse;
- stay calm - no matter how difficult it may be to listen to;
- provide reassurance - tell them they are not to blame and that you know how difficult it must be for them;
- listen to them and believe in them;
- take them seriously;
- keep any questions to an absolute minimum, nod and acknowledge what they are saying;
- ask open questions only - who; what; where and when type questions;
- make sure you understand what they are telling you;
- write down everything that they tell you as soon as possible - using their words if possible;
- be honest - tell the them what you are going to do next; why you need to do it and that you are going to have to speak to someone who can help them;
- make a note of the time, date and place where this took place and who was present; and
- remember - doing nothing is not an option - act promptly and immediately, report your worry or concerns to your Line Manager, Supervisor or Designated Child Protection Officer.

DO NOT:

- panic;
- interrupt them;
- ask them to repeat what they are saying;
- ask them probing, leading and / or closed questions and do not ask them any why questions;
- make any assumptions about what they are telling you;
- make negative comments or facial expressions;
- start any investigation whatsoever;
- approach the alleged abuser;
- keep this to yourself;
- assume somebody else will do something and / or deal with it;
- delay unnecessarily;
- make promises to keep secrets; and
- promise confidentiality.
Practitioners may also find the following two Practice Checklists helpful in identifying and determining their response to a concern or worry they may have about a child or young person: Practice Checklist 1 and Practice Checklist 2.

Child Protection

If you are worried or concerned about the welfare or protection of a child or young person, you should, in the first instance, share that worry or concern with your Line Manager / Supervisor / Designated Child Protection Officer. Thereafter, child protection procedures should be followed without any unnecessary delay.

You should contact the Perth and Kinross Child Protection and Duty Team or Police Scotland:

| Perth and Kinross Child Protection and Duty Team - (24 hours) | 01738 476768 |
| Police Scotland Non - Emergency Number | 101 |
| In an Emergency | Call 999 |

Perth and Kinross Information and Advice Leaflet: Child Protection and Duty Team

Child Concern Report (CCR)

A Child Concern Report (CCR) is a mechanism by which any practitioner or manager across the public, private or third sector, or indeed, any member of the public can raise any worry or concern they may have about a child or young person's health and / or wellbeing; or in relation to whether or not the child or young person is safe and / or in need of care and protection. The majority of Child Concern Reports continue to come from the Police; albeit not exclusively.

Unborn Baby Referral

An Unborn Baby Referral is a mechanism by which any practitioner or manager across the public, private or third sectors can raise any worry or concern they may have about an unborn baby's health and / or wellbeing; or in relation to whether or not that baby will be safe and / or in need of care and protection, pre-birth and / or after birth. This allows for early and effective intervention and support to be provided to the vulnerable unborn baby and mother.

Worries or concerns regarding an unborn baby, or a child or a young person can relate to a single issue or incident, or to an accumulation of such events over time. The reasons for such a concern can be many and / or complex; related either to the behaviours of the parent or carer or other significant adult (s) in the child, young person or unborn baby's family environment, or to previously known or emerging vulnerability factors, risks and / or needs.

All services and agencies within Perth and Kinross must have in place their own arrangements for the identification of such worries or concerns and must have in place their own robust
arrangements for sharing these worries or concerns timeously and proportionately with other key services or agencies.

Child Concern Reports and Unborn Baby Referrals within Perth and Kinross are subject to multi-agency early screening arrangements which determine the next steps. Where, after multi-agency screening arrangements, a Child Concern Report or an Unborn Baby Referral, indicates that a child, young person or unborn baby is in need of care and protection from harm, abuse or neglect; or there is a likelihood or risk of significant harm, abuse or neglect, then it will trigger a Child Protection Investigation and in turn an Inter-Agency Referral Discussion (IRD).

**Note:** Irrespective of the multi-agency early screening arrangement processes, issues which are clearly of a child protection nature (including CCRs and Unborn Baby Referrals) are fast-tracked, without delay, via the Police and / or the Child Protection and Duty Team and via single service or agency child protection procedures. These will commonly lead to a Child Protection Investigation and in turn will always trigger an Inter-Agency Referral Discussion (IRD).

**Multi-Agency Screening Arrangements (MASG)**

Relevant Child Concern Reports and Unborn Baby Referrals within Perth and Kinross are subject to early multi-agency early screening arrangements at the Perth and Kinross Multi-Agency Screening Group (MASG), which will determine the next steps.

**Membership of the MASG**

The constituent membership of the MASG includes:

- Team Leader, Child Protection and Duty Team, Services for Children, Young People and Families; Perth and Kinross Council;
- Health Representative, NHS Tayside, Perth and Kinross;
- Constable, Risk and Concern Hub, Police Scotland - Tayside Division; and
- Education Support Officer, Education and Children's Services, Perth and Kinross Council.

Dependent on the nature of any Police Child Concern Reports or Unborn Baby Referrals, other practitioners, services or agencies can be invited to attend the MASG, as and when required.

All constituent members of the MASG must have in place Designated Deputies; who must attend the MASG in their absence and / or on their behalf. Designated Deputies must have full delegated responsibility and authority to make decisions on behalf of the MASG member, service or agency they represent.

**Meetings of the MASG**

The MASG will meet formally every Tuesday at 1400 hours in Pullar House, Perth. All constituent members of the MASG or their Designated Deputy must attend. Other practitioners, services or agencies will be invited to attend as and when required.
Meetings of the MASG must be chaired by one of the constituent members and the chairing of MASG meetings will rotate on a monthly basis. The MASG is also supported by an Administrator. All discussions and decision making at MASG meetings are noted and recorded.

Remit of the MASG
The remit of the MASG is to screen and assess, on a multi-agency basis, relevant Child Concern Reports submitted by Police Scotland and all Unborn Baby Referrals submitted from any other practitioner, service or agency. Unborn Baby Referrals are always considered independently at a separate Unborn Baby MASG which meets on the first and third Tuesday of each month.

Screening includes recording; sharing; exchanging; researching; discussing; analysing and agreeing the next steps. In doing so, all constituent members of the MASG must follow their own single service or agency guidance.

All single service or agency guidance must be in the form of written instructions (guidance); must describe the single service or agency screening arrangements and the requirements of the constituent members of the MASG, prior to, during and after the MASG meetings. It is vitally important that these screening arrangements are consistent across the constituent members of the MASG. MASG processes are kept under constant review.

Process of the MASG
The following describes the process of the MASG, before, during and after the meeting:

Before the MASG
- Child Concern Reports are recorded by the MASG Administrator;
- Child Concern Reports which relate to young people over 16 are dealt with via existing Adult Protection Procedures;
- Unborn Baby Referrals are dealt with via separate MASG Unborn Baby Meetings;
- Child Concern Reports which relate to Youth Offending are shared proportionately with Services for Young People and Education (Schools) as per our Early and Effective Intervention processes;
- Child Concern Reports which relate to an already Allocated Case (Open to Children’s Social Work Services) are passed directly to the Lead Professional (Social Worker) for further investigation and assessment;
- Child Concern Reports are shared proportionately and securely with constituent members of the MASG on a daily basis (Monday to Friday);
- Constituent members of the MASG research their own service or agency case files and / or databases and decide what information they need to share and who they need to share information with in their own service or agency;
- Constituent members of the MASG must then share, seek and exchange information proportionately; and
Constituent members of the MASG must then collate together all information (relevant and appropriate to the Child Concern Report or Unborn Baby Referral), including historic information, background information and current information in relation to the child, young person or unborn baby prior to the next weekly MASG meeting taking place.

**At / During the MASG**

- Constituent members then attend the weekly MASG meeting;
- Each Child Concern Report or Unborn Baby Referral is considered individually;
- All participants of the MASG share and exchange relevant information proportionately;
- All information is examined and analysed - individually and collectively;
- All constituent members of the MASG collectively identify all known vulnerabilities, risks and needs;
- All constituent members of the MASG agree the next steps and/or course of action and the need for allocation and further assessment. Any unresolved disagreements and/or disputes are similarly recorded; and
- All constituent members of the MASG agree what information is to be shared and who it is to be shared with.

**After / Following the MASG**

- Following the MASG, a summary is recorded by the MASG Administrator; an Action List is provided to all participants of the MASG and to any relevant others who were absent from the MASG;
- All participants of the MASG and/or any others who were absent from the MASG are responsible for updating their own service or agency case file records and/or databases with the outcomes of the MASG; and
- All agreed Actions Points are then followed up and/or complied with.

**Outcomes from the MASG**

There are a number of possible outcomes from the MASG:

**Child Concern Reports**

- Single Agency Response – Education (Named Person);
- Single Agency Response – Health (Named Person);
- Social Work Assessment & Response - Duty Team / Intensive Support Team;
- Multi-Agency Response;
- Referral to Third Sector Agency;
- Referral to the Children’s Reporter (SCRA);
- Further Discussion Required at MASG; and
• Moved outwith Perth and Kinross – Information Shared Proportionately with Other Area.

Unborn Baby Referrals

• Single Agency Response – Health Only;
• Referral to Social Work for Pre-Birth Risk Assessment and Response;
• Multi-Agency Response (Health and Others);
• Non-Continuing Pregnancy; and
• Moved outwith Perth and Kinross – Information Shared Proportionately with Other Area.

Note: Irrespective of the multi-agency early screening arrangement processes, issues which are clearly of a child protection nature (including CCRs and Unborn Baby Referrals) are fast-tracked, without delay, via the Police and / or the Child Protection and Duty Team and via single service or agency child protection procedures. These will commonly lead to a Child Protection Investigation and in turn will always trigger an Inter-Agency Referral Discussion (IRD).

Child Protection Investigation

A Child Protection Investigation is carried out jointly by specially trained police officers and social workers. Such investigations are carried out where a Child Concern Report (including a child protection concern), or an Unborn Baby Referral, indicates that a child or young person is in need of care and protection from harm, abuse or neglect; or there is a likelihood or risk of significant harm, abuse or neglect. Where a Child Protection Investigation has been decided upon it will always trigger an Inter-Agency Referral Discussion (IRD) to determine the next steps.

Inter-Agency Referral Discussion (IRD)

An Inter-Agency Referral Discussion (IRD) must be held where multi-agency screening arrangements have determined that a child or young person is in need of care and protection from harm, abuse or neglect; or there is a likelihood or risk of significant harm, abuse or neglect indicating that a Child Protection Investigation is necessary. An IRD is the starting point to determine the next steps.

Participants of an IRD

An IRD is a discussion between practitioners, services or agencies. Participants in an IRD include representatives from police, social work, health and where appropriate education. Other service or agency representatives can also be invited to attend an IRD where deemed appropriate. Any one of the participants at an IRD can act as the Chairperson and he / she must be supported with guidance and an aide memoire.

Those invited to attend an IRD must have sufficient delegated authority from their service or agency to participate and make decisions. Ideally, those who attend an IRD must have received sufficient training to allow them to participate fully.
An IRD allows those present to share and exchange information proportionately; to make an initial multi-agency assessment of risks; to agree that a Child Protection Investigation is necessary and to decide the next steps.

Holding an IRD

In practice, an IRD is not a single one-off event; but rather a dynamic process which can include a series of ongoing discussions and / or meetings. An IRD can take place face-to-face at a meeting; or it can be a virtual meeting by way of tele / video conferencing; or it can be via e-mail and / or fax, using safe haven principles.

Urgency and geography will determine the nature of the IRD, but the underlying principle is that the core services and agencies participate in the sharing of relevant information. IRDs normally take place during the working week; albeit they can take place at weekends and outwith normal working hours; the principles are the same. An IRD must not be delayed unnecessarily, simply because one service or agency is not represented. In these circumstances, the IRD must go ahead and information from that service or agency shared and exchanged as soon as possible.

Discussion Process at an IRD

At an IRD, participants will discuss the source and full nature of the concern being raised. Whilst doing so they must proportionately share and exchange information that is considered relevant to that concern. There is an expectation that those who participate in an IRD will have previously researched their own service or agency databases and case file records thoroughly. This must include any historic information considered to be relevant. Information shared must be tested and where necessary, constructively challenged by the IRD participants.

Those present at an IRD must identify the risks to the child or young person; taking into account any vulnerability and / or protective factors. The focus at the IRD must be on keeping the child or young person safe and protected from any further risk of harm, abuse or neglect.

It is important that all participants fully participate in the IRD process and that an initial multi-agency assessment of risks is agreed by consensus. Similarly, multi-agency decision making must take place and any dissent must be recorded and made known to respective Line Managers / Supervisors immediately.

Discussions at the IRD must determine the following:

- Is the child or young person currently safe from any further risk of harm, abuse, neglect and / or exploitation?

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1 Safe Haven is a term used to explain an agreed set of arrangements that are in place in an organisation to ensure person identifiable information (e.g. clients and staff information) can be communicated safely and securely. Safe Haven Principles act as a safeguard for confidential information which enters or leaves an organisation, whether this is by facsimile (fax), verbal communication or other means, for example, email.
• Has all relevant service or agency information relating to the worry or concern been shared and exchanged proportionately; including historic concerns; are there any gaps and is further information required?

• Has the safety and wellbeing of the child or young person been carefully considered?

• Has the safety and wellbeing of any sibling; other child or young person in the household; or any other connected child or young person been carefully considered?

• Has a crime or offence been committed against the child or young person, and if so by whom?

• Has a crime or offence been committed against any sibling; other child or young person in the household; or any other connected child or young person, and if so by whom?

• Has the level of risk to the child or young person, sibling; other child or young person in the household; or any other connected child or young person, such that there is a need to consider further legal measures, i.e. a Child Protection Order?

• Has an initial multi-agency assessment of risks, vulnerability and/or protective factors been agreed and have diversity issues been carefully considered?

• Has feedback been agreed for the original referrer and/or what information is to be provided (if any) to the child and family and if so who is to provide this?

• Has there been any dissent from the IRD process and/or discussion and has this been recorded? and

• Are the multi-agency decisions agreed and actions planned sufficient, necessary and proportionate in the circumstances?

Decision Making and Outcomes of an IRD

Following the IRD discussion process, multi-agency decisions must be made in terms of the IRD outcomes and the next steps to be taken agreed. This must include decisions on the following:

• immediate legal measures are necessary - Child Protection Order; Child Assessment Order or Exclusive Order; Emergency Powers by the Police;

• joint police and social work child protection investigation is necessary;

• joint police and social work investigative interview (visually recorded interview) is necessary;

• medical examination (type to be agreed) is necessary;

• health assessment is necessary;

• referral to the Children’s Reporter (SCRA);

• single service or agency investigation and/or assessment is necessary;

• child protection case conference is necessary;

• voluntary support only is necessary; or

• no further help and/or support is necessary (most unlikely).
Recording of an IRD

It is vitally important that information relating to an IRD is recorded accurately by all service or agency representatives and also communicated accurately to those who may not have been in attendance. This must be recorded in the child or young person's service or agency case file notes (hard copy and electronic records).

As an absolute minimum, this must include:

- the time, date, place and type of IRD;
- which practitioners, services and agencies were present and any apologies noted;
- exact nature of the worry or concern and who referred;
- identity of the child or young person and family;
- notes of the service or agency information shared and exchanged;
- clear description of the risk discussed and identified;
- clear description of the vulnerability factors and / or protective factors discussed and identified;
- exact details of the multi-agency decision making;
- exact details of the next steps - course of action to be taken, by who and by when;
- what information is to be shared, by who and to whom;
- any dissent raised and / or discussed; and
- note of any further review meetings and / or debrief meetings planned.

It is vitally important that all participants of an IRD fully understand what has been discussed and agreed and that they individually record this in their own service or agency case file records and / or databases. This should also be communicated to any practitioner, service or agency that has been unable to attend an IRD and this must be communicated by the Chair of the IRD.

An IRD Recording Template and Aide Memoire have been developed to support all the participants of all IRDs.
Information Sharing, Confidentiality and Consent

Perth and Kinross Code of Practice: Information Sharing, Confidentiality and Consent


Perth and Kinross Information and Advice Leaflet: Information Sharing, Confidentiality and Consent (Children and Young People)

Perth and Kinross Information and Advice Leaflet: Information Sharing, Confidentiality and Consent (Parents and Carers)

Perth and Kinross has developed the above Practitioner’s Guide and Toolkit: Information Sharing, Confidentiality and Consent, which includes various component parts and a Code of Practice.

The appropriate sharing of information is vital in order to safeguard, support and promote the welfare of children and young people and the extent to which communication and the effective sharing of relevant information has been a key feature in many Significant Case Reviews.

It is therefore of the utmost importance that all managers and practitioners understand their respective duties; the legislative, policy and practice parameters relating to information sharing and the constraints of confidentiality and consent.

Procedures and guidance cannot in themselves protect children and young people from harm, abuse and exploitation; but a competent, confident and skilful workforce, working together with a vigilant public can.

The Code of Practice has been produced for all staff and volunteers working across the public, private and third sectors in Perth and Kinross. It is aimed at all people working in the frontline with children, young people and families who have to make decisions about sharing personal information or sensitive personal information on a case-by-case basis. It applies equally to those who work in children’s services and adult services; in particular to all staff working with children and their families.

The Code of Practice is advisory and does not attempt to replicate, or explain the extensive legislative and policy framework; but affirms and continues to support the Perth and Kinross Practitioner’s Guide and Toolkit: Information Sharing, Confidentiality and Consent. It aims to complement that approach and to support managers and practitioners in their decisions when considering whether they need to share information and what steps they need to take to ensure that they are doing so lawfully. It supports the application of sound professional judgment and
**empowers safe practice to safeguard, support and promote the welfare of children and young and protect them from harm, abuse and exploitation.**

**Information Sharing**

Early and effective intervention relies on good practice in the timely and appropriate sharing of information. Practitioners must understand when to share information; what information to share; how much information to share; who to share the information with and the way in which the information should be shared. Practitioners must also understand the possible adverse consequences of not sharing information.

*Proportionate* information sharing can assist with the successful implementation of *Getting it right for every child* in Perth and Kinross by ensuring that children and young people get the right help; at the right time; when they need it; for as long as they need it. The *welfare* of all children and young people is paramount.

All practitioners must be alert to the signs of *abuse or neglect*. *Abuse and neglect* are forms of child maltreatment and can present in many ways; some may be obvious and others difficult to spot. *Abuse and neglect* need not have taken place before practitioners initiate an appropriate response - it is sufficient to have identified a *likelihood or probability* of risk. Understanding the concept and nature of risk is important for all managers and practitioners.

Any practitioner who, in their *professional judgment*, is worried or concerned about the welfare or risks to a child or young person must take action:

- **doing nothing is not an option**;
- do not assume someone else will do something;
- do not delay unnecessarily – act quickly;
- keep focused on the child or young person;
- adopt a common sense approach; and
- if in any doubt speak to a colleague, line manager or supervisor.

Practitioners, who are worried or concerned about the care or protection of a child or young person, must in the first instance, follow the procedures in their own service or agency. They must share and discuss that worry or concern with their immediate Line Manager, Supervisor or Designated Child Protection Officer.

In their absence, practitioners should discuss their worries or concern with an alternative Manager. Additional advice can be obtained by contacting the *Perth and Kinross Child Protection and Duty Team* on Tel: 01738 476768 (24/7/365) or by E-Mail at childprotection@pkc.gov.uk. Advice can also be sought from individual service or agency Legal Services Departments.

Legislation underpinning information sharing includes *The Data Protection Act 1998*; *The Human Rights Act 1998* and the *European Convention on Human Rights (ECHR)*. This legislation supports lawful information sharing and should not be seen as a barrier. *The Data Protection Act*
1998 describes the eight data sharing principles which must underpin practice. Practitioners must understand these eight principles. If in doubt, practitioners must consult with their Line Managers.

**Data Protection Principles**

Practitioners must ensure information is:

1. processed fairly and lawfully (processing includes gathering; sharing; holding; changing; deleting; using; filing and destroying);
2. obtained only for one or more specified lawful purpose and is not shared in a manner incompatible with that purpose or purposes;
3. adequate, relevant and not excessive in relation to the purpose or purposes for which it was provided;
4. accurate and where necessary, kept up to date;
5. kept for no longer than is necessary for that purpose or purposes;
6. handled in accordance with the rights of individuals;
7. subject to appropriate technical and organisational measures to prevent the unauthorised or unlawful processing, or the accidental loss, destruction, or damage to that information; and
8. not transferred outside the European Economic Area unless adequate levels of protection are in place to protect the rights and freedoms of the individual to whom that information relates.

The key principle to consider when sharing information for the purposes of safeguarding, supporting and promoting the welfare of children is the first principle: that is that information must be processed fairly and lawfully. Information will not be considered to have been processed fairly and lawfully if:

- in relation to personal information, at least one of the conditions in Schedule 2 has been met; and
- in respect of sensitive personal information, at least one condition in Schedule 2 has been met, plus at least one condition is Schedule 3 is met.

Practitioners therefore need to understand what the conditions in each of the Schedules are and how they can be applied to each particular situation.

**Personal Information and Sensitive Personal Information**

*Personal information* means any information whatsoever which can identify a living person.

*Sensitive personal information* means any information relating to the racial or ethnic origin of a person; their political opinions; their religious beliefs of equivalents; their trade union membership or affiliation; their physical or mental ill-health; their sexual persuasion; their offending or alleged offending and / or criminal history.

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2 Personal information as defined in The Data Protection Act 1998 Part 1 Section 1.

3 Sensitive personal information as defined in The Data Protection Act 1998 Part 1 Section 2.
Data Sharing Conditions

The Data Protection Act 1998 also describes (in full) the data sharing conditions (Schedules 2 and 3) for sharing personal information and sensitive personal information.

The first condition in both Schedules is that the individual gives consent to their information being processed. Where consent is not obtained (and indeed there may be good reason why you would not wish to do so, particularly in the course of child protection and welfare investigations where the seeking of consent could undermine the process) then practitioners must then look at the other conditions.

The other conditions all require that the processing is necessary for a specific purpose (this in known as the "necessity test"). In terms of sharing information to safeguard, support and promote the welfare of children and young people the following conditions are considered to be the most relevant for practice:

<table>
<thead>
<tr>
<th>Schedule 2 Conditions (personal information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
</tr>
<tr>
<td>When the individual has freely given their informed consent to the sharing or other processing of their personal information. See Section 4 on Consent.</td>
</tr>
<tr>
<td>Exercise of a statutory function</td>
</tr>
<tr>
<td>When the sharing or other processing of personal information is necessary to carry out a statutory function to provide services or take action. This would include duties on services / agencies to assess and meet needs and to protect and promote the welfare of children and young people.</td>
</tr>
<tr>
<td>Legal obligation</td>
</tr>
<tr>
<td>When the sharing or other processing of personal information is necessary to comply with any legal obligation which the practitioner / service or agency are subject to. These will be agency specific obligations / requirements which agencies can specify, but would include an obligation to provide information or a report to Children's Reporter; where a child is need of care and protection; or to give evidence in a court.</td>
</tr>
<tr>
<td>Public functions in the public interest</td>
</tr>
<tr>
<td>When the sharing or other processing of personal information is necessary for the exercise of a public function in the public interest function. This would apply where a practitioner, service or agency are not bound by any specific duty or legal obligation, but have relevant information which would help another service or agency to fulfil its functions and it would be in the public interest to do so. For example a voluntary organisation sharing personal information with the local authority to help them in a child protection investigation. NOTE: This does not allow SENSITIVE personal information to be shared.</td>
</tr>
<tr>
<td>Vital interests</td>
</tr>
<tr>
<td>When the sharing or other processing of personal information is necessary to protect life and limb. If no other condition can be satisfied this could be applied to cases where there is a real risk of significant harm to an individual.</td>
</tr>
</tbody>
</table>
## Schedule 3 Conditions (sensitive personal information)

<table>
<thead>
<tr>
<th>Explicit consent</th>
<th>When the individual has freely given their explicit and informed consent to the sharing or other processing of their sensitive personal information. See Section 4 on Consent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise of a statutory function</td>
<td>When the sharing or other processing of sensitive personal information is necessary to carry out a statutory function to provide services or take action. This would include duties on services / agencies to assess and meet needs and to protect and promote the welfare of children and young people.</td>
</tr>
<tr>
<td>Medical purposes</td>
<td>When the sharing or other processing of sensitive personal information is undertaken by a health professional and is necessary for medical purposes; including preventative medicine; medical diagnosis and the provision of care and treatment.</td>
</tr>
<tr>
<td>Vital interests</td>
<td>When the sharing of sensitive personal information is necessary to protect life and limb. If no other condition can be satisfied this could be applied to cases where there is a real risk of significant harm to an individual and where consent cannot be given or where consent cannot reasonably be obtained or where consent has been unreasonably withheld.</td>
</tr>
</tbody>
</table>

Practitioners must always exercise professional judgement and common sense when sharing information. They must understand what condition (s) they are relying upon when sharing information and must only share the necessary information proportionately.

Practitioners must always have due regard to Article 8 ECHR (right to respect for private and family life) and this will ensure their practice is compliant with The Data Protection Act 1998.

**Article 8 ECHR** states that everyone has the right to respect for his private and family life, his home and his correspondence. However, this right is not absolute and the Convention permits interference if it is:

- lawful;
- necessary and proportionate; and
- for one or more of the following legitimate aims:
  - the interests of national security;
  - the interests of public safety or the economic well-being of the country;
  - the prevention of disorder or crime;
  - the protection of health or morals; or
  - the protection of the rights and freedoms of others.

For the purposes of safeguarding, supporting and promoting the welfare of children, practitioners can therefore act to limit that right on the basis of either protecting the health or morals of an individual or protecting the rights and freedoms of others.
To test whether actions comply with the ECHR practitioners should ask themselves the following questions:

- Am I interfering with an Article 8 right?
- Is the action I propose to take lawful?
- Does the action pursue one of the legitimate aims?
- Is the action that I propose to take necessary to achieve that aim?
- Is the action proportionate? That is – am I doing only as much as I need to in order to achieve the aim?

Practitioners may be sharing information verbally face-to-face with other practitioners; over the telephone; in reports / assessments and / or at meetings. If doing so via fax and / or by e-mail, practitioners must ensure these networks are secure and must follow safe haven principles.

When sharing information, practitioners should record this clearly, accurately and concisely in the child or young person’s case file notes and / or any electronic system to prevent any misunderstanding and / or confusion on their part; on the other practitioner’s part and for future reference. Practitioners should ensure that all this information is kept safe, secure and that there is no unauthorised access to this information.

Practitioners should also be recording any circumstances where information is not being shared and the reason for that. Practitioners should also record any circumstances where there is a refusal to share information and the reason for that. In some circumstances, practitioners may decide not to share information, albeit this would be the exception, as opposed to the rule.

If a practitioner decides not to share and exchange information, then they must consider the following three key questions:

1. What are my reasons for deciding not to share information?
2. What harm could result if I do not share information? and
3. What are the implications for the child or young person, for me and / or my service, agency and / or organisation if I decide not to share information?

Any decision not to share and exchange information should be properly recorded, in both hard copy case files and / or in an electronic file, for future reference. Practitioners may find the following helpful in explaining these requirements:

- (UK) Information Commissioner’s Office (ICO) Letter of Advice 2013 – Information Sharing and
- (UK) Information Commissioner’s Office (ICO) Letter of Advice 2016 - Information Sharing and
- Presentation on Information Sharing by Maureen Falconer, Regional Manager, ICO: Scotland.

Safe Haven is a term used to explain an agreed set of arrangements that are in place in an organisation to ensure person identifiable information (e.g. clients and staff information) can be communicated safely and securely. Safe Haven Principles act as a safeguard for confidential information which enters or leaves an organisation, whether this is by facsimile (fax), verbal communication or other means, for example, email.
Confidentiality

Practitioners must work within the limitations and constraints of confidentiality. Not all information is confidential. Practitioners must never make that promise.

Confidentiality does not apply where the matter is clearly one of protecting children and young people. The welfare of children and young people is paramount.

Practitioners have a duty of care and are subject to a Common Law and Statutory Obligation of Confidence. Confidentiality is not an absolute right. Confidentiality must never be promised. It has long been established that just cause or excuse and/or acting in the public interest are defences to any action for breach of confidence.

The Data Protection Act 1998 does not prevent the sharing of information. On the contrary, professional judgment, common sense and an understanding of the data sharing principles; and Schedule 2 and Schedule 3 conditions can empower practice.

Over-riding the Duty of Confidentiality owed and sharing information, without consent, should only occur where practitioners can justify doing so in terms of the data sharing principles and where they can identify with a condition (s) specified in Schedule 2 and/or Schedule 3.

Consent

Practitioners must understand the limitations and constraints of consent. Only in exceptional circumstances should information be shared without consent.

Practitioners must only seek consent in circumstances where an individual has a real choice over the matter. Consent should not be regarded as freely given if the individual has no genuine or free choice or is unable to refuse or withdraw consent without detriment. Consent should not be sought where doing so would place a child or young person at further risk. On some occasions it may not be necessary, reasonable, appropriate or even possible to seek consent e.g. where the situation is urgent or the person cannot provide consent because of age, circumstances and/or capacity.

Consent does not apply where the matter is clearly one of protecting children and young people. The welfare of children and young people is paramount.

Seeking consent can be difficult. Where consent is sought, practitioners must ensure the person being asked to provide consent fully understands that request and its extent. Consent, when sought, must be informed and explicit:

- Informed - the individual (child or young person and their parents or carers or any other person with parental responsibilities) must understand what is being asked of them and must give their permission freely.

Footnote: Future proofed per the General Data Protection Regulation (GDPR) 2016: Recital 42.
• **Explicit** - the individual (child or young person and their parents or carers or any other person with parental responsibilities) positively gives their consent for their information to be shared.

Consent should be given by a clear affirmative act establishing a freely given, specific, informed and unambiguous indication of the individual’s agreement to the sharing of their personal information. This can take the form of a written statement, (including by electronic means) or an oral statement. However, consent in writing should be obtained wherever possible so that it can be easily evidenced if subsequently challenged or questioned.

Consent and discussions relating to consent must always be recorded in service or agency case file notes and / or on agency databases. There is no legal requirement for a specific Consent Form. Implied Consent is *not* sufficient. All discussions about consent must also be recorded, whether granted or not.

Consent to share **personal information** is a condition under **Schedule 2** and Explicit Consent to share **sensitive personal information** is a condition under **Schedule 3**.

The [Perth and Kinross Practitioner's Guide and Toolkit: Information Sharing, Confidentiality and Consent](#) provides further information and advice on:

- **Who can give consent?**
- **How to ask for, obtain and record consent?**
- **What to do if consent is refused?**
- **What if consent is withdrawn?**
- **What if someone is unable to provide informed consent?**

Practitioners should consult their Line Manager, Supervisor or Designated Child Protection Officer if there are any issues or doubts whatsoever about Consent. In their absence, practitioners should contact the [Perth and Kinross Child Protection and Duty Team](#) on Tel: 01738 476768 (24/7/365) or by E-Mail at [childprotection@pkc.gov.uk](mailto:childprotection@pkc.gov.uk). Advice can also be sought from service or agency Legal Services Departments.

**ICO: Scotland - Key Messages**

"In many cases, a risk to wellbeing can be a strong indication that the child or young person could be at risk of harm if the immediate matter is not addressed". (ICO: Scotland 2013).

"Where a practitioner believes, in their professional opinion, that there is risk to a child or young person that may lead to harm, proportionate sharing of information is unlikely to constitute a breach of the Act in such circumstances". (ICO: Scotland 2013).

"It is very important that the practitioner uses all available information before they decide whether or not to share. Experience, professional instinct and other available information will all help with the decision making process as will anonymised discussions with colleagues about the case. If ______

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6 Future proofed per the General Data Protection Regulation (GDPR) 2016: Recital 32.
there is any doubt about the wellbeing of the child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing”. (ICO: Scotland 2013).

"The ICO’s data sharing code recognises that obtaining consent for sharing information can be difficult. It should only be sought in circumstances where an individual has real choice over the matter, reflecting the need under Principle 1 of the DPA for processing to be fair to the individual concerned. For a professional to request consent from an individual whilst knowing that sharing will take place nonetheless, raises false expectations and endangers the client relationship”. (ICO: Scotland 2016).

Information Sharing for Child Protection: General Principles

National Guidance for Child Protection in Scotland 2014

- The wellbeing of a child is of central importance when making decisions to lawfully share information with or about them.

- Children have a right to express their views and have them taken into account when decisions are made about what should happen to them.

- The reasons why information needs to be shared and particular actions taken should be communicated openly and honestly with children and, where appropriate, their families.

- In general, information will normally only be shared with the consent of the child (depending on age and maturity). However where there is a risk to a child’s wellbeing, consent should not be sought and relevant information should be shared with other individuals or agencies as appropriate.

- At all times, information shared should be relevant, necessary and proportionate to the circumstances of the child, and limited to those who need to know.

- When gathering information about possible risks to a child, information should be sought from all relevant sources, including services that may be involved with other family members. Relevant historical information should also be taken into account.

- When information is shared, a record should be made of when it was shared, with whom, for what purpose, in what form and whether it was disclosed with or without informed consent. Similarly, any decision not to share information and the rationale should also be recorded.

- Agencies should provide clear guidance for practitioners on sharing information for example, the GMC guidance on Protecting Children and Young People. This should include advice on sharing information about adults who may pose a risk to children, dealing with disputes over information-sharing and clear policies on whistle-blowing.

- It is not necessary to seek consent when there is legislative requirement to share information; for example when making a referral to the Children’s Reporter, or the prevention and detection of crime.

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7 Extracted from the National Guidance for Child Protection in Scotland 2014 (Scottish Government 2014).
**Information Sharing in Child Protection: Policy Principles**

**Protecting Children and Young People: Framework for Standards**

Published in 2004, the Framework for Standards translates key messages from the Children’s Charter into child protection practice for all practitioners, services and/or agencies, by providing eight high level generic practice statements, all supported by additional narrative/text.

**Standard 4** relates directly to Information Sharing, Confidentiality and Consent.

1. **Agencies and professionals** share information about children where it is necessary to protect them.

2. **Professionals discuss any concerns and relevant information about a child or their circumstances with those other professionals or agencies with statutory responsibilities for the protection of children when it is in the child’s best interests to do so;**

3. **The needs of each child are the primary consideration when professionals decide how best to share information. All decisions and reasons for them are recorded;**

4. **Agencies actively manage and support the sharing of information recognising that confidentiality does not prevent sharing information where a child is in need of protection;**

5. **Professionals ensure that parents and children are made aware of, and check it is understood, what information:**
   - agencies hold;
   - how it is stored;
   - with whom it may be shared; and
   - under what circumstances information may be shared with others without their consent;

6. **Professionals identify what information each child and their parents are content to share freely;**

7. **Professionals take account of each child and their parent’s views when deciding when to share information without their consent and can provide reasons and explain to them when they have shared information without consent; and**

8. **Agencies and professionals store information securely.**

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8 Protecting Children and Young People: Framework for Standards (Scottish Executive 2004)

9 For the purposes of this guidance, **Agencies** - is widely defined and interpreted as meaning all services and agencies across the public, private and third sectors.

10 For the purposes of this guidance, **Professionals** - is widely defined and interpreted as meaning all practitioners, paid or unpaid, working directly with or occasionally with children, young people and their families.
INFORMATION SHARING FLOWCHART

A useful summary of the key considerations for all practitioners when considering when to share information; what information to share; who to share with; and how to share information.

**When To Share**

- **Share Information when Worried or Concerned about a Child or Young Person’s Welfare / Care & Protection**
- **Wellbeing: Safe; Healthy; Achieving Nurtured; Active; Respected; Responsible and Included**

**What To Share**

- **Share Information which is Relevant; Necessary; Legitimate; Appropriate and Proportionate**
- **Share Information Relating only to your Worry or Concern – Reduce or Remove Unnecessary Information or Data**

**Who To Share With**

- **Share Information on a Need to Know Basis Only**
- **Share Information with your Line Manager / Supervisor, Designated Child Protection Officer; Trusted Colleague; Lead Professional or other Key Workers**

**How To Share**

- **Share Information Verbally, Face-to-Face, at Meetings, Written Reports, or Assessments**
- **Share Information by Secure Methods Always follow Safe Haven Principles**
- **Ensure you Record Information Sharing Accurately**

**Always use your Professional Judgement / Instincts; Adopt a Common Sense Approach**

**Share Information Quickly; Efficiently and Effectively**

**Ensure you Record Information Sharing Accurately**
CONSENT FLOWCHART

A Practitioners’ Flowchart on Seeking Consent

Are You Worried or Concerned About a Child or Young Person’s Welfare / Protection?

Yes

Do I Need Consent to Share Information?

No

Do I need Consent to Share Information?

Yes

Seek Consent

Consent Given

No

Share Information

Share Information

Do Not Share Information
Information Sharing - Practice Examples

Scenario 1:
A health visitor is concerned about a young mother who is expecting her second child. She currently has a two year old son. The health visitor suspects that the young mother is the victim of domestic abuse by her partner and that she has been taking illegal drugs, all of which could have a harmful effect on her, her two year old son and her unborn baby.

Action:
The health visitor has a professional duty of care to the mother, the two year old boy and the unborn baby, all of whom are vulnerable and at risk of significant harm and abuse. The health visitor should explain to the mother why she is concerned. She should tell the mother that she is going to share these concerns with social work and the police and the reasons why. The health visitor, in these circumstances should not seek consent from the mother. The health visitor should make a record of that discussion and continue her support to this family.
(e.g. Consent is not required. Practitioners can rely on Schedule 2: necessary for the exercise of a statutory function or legal obligation or public functions in the public interest AND Schedule 3: necessary for the exercise of a statutory function or by a health professional for medical purposes).

Scenario 2:
A health visitor working with a pre-school child, not yet in a nursery placement, has identified a developmental delay in terms of the child’s speech and language. In her professional judgement she feels there is a need to refer that child to a speech and language therapist for further support and assessment.

Action:
The health visitor has a professional duty of care for this child and family. The health visitor should discuss her concern with the child’s parents / carers. She should explain the benefits of such a referral to speech and language and equally the detriment of not doing so. In these circumstances the health visitor should ask for parental agreement and consent to share information. If granted, she should make the referral. If not granted, the health visitor should not make that referral, but continue to support the child and family. The health visitor should make a record of that discussion and the granting or refusal of consent.
(e.g. Explicit Consent (Schedule 3) required and may be withheld or later withdrawn).

Scenario 3:
A teacher is aware that the mother of a 10 year old girl in her class died several months ago. The teacher notices that the girl is becoming withdrawn. On a regular basis she is emotionally distressed in the classroom and at times she talks about how much she misses her mum. The girl has no close female relative. The teacher has discussed this with other professional school staff, including the headteacher and they feel the girl would benefit from some external support and counselling.

Action:
The teacher and headteacher have a professional duty of care for this girl. The headteacher should discuss and explain the concern they have with the girl’s father and suggest to him that his daughter would benefit from external support and counselling. The headteacher should seek consent from the
father to obtain that help and support. If granted, the headteacher should make that referral. If not granted, the headteacher should not make that referral, but continue to support the child in the classroom and the wider environment of the school community. The headteacher should make a record of the discussion with the girl's father and the granting or refusal of consent. It may well be appropriate to review that decision at some point in the future.

(e.g. Explicit Consent (Schedule 3) required and may be withheld or later withdrawn).

Scenario 4:
A 15 year old girl tells her social worker she has entered into a sexual relationship with a 30 year old man who she describes as her new boyfriend. The social worker does not know the man and the girl refuses to identify him. She tells her social worker she has been staying out all night at parties; that her boyfriend says he loves her and is always buying her things. The girl tells the social worker they are not using contraception because they are always careful. The girl does not want her mum and dad to know. The social worker is concerned that the girl is being sexually abused and exploited.

Action:
The social worker has a professional duty of care for this girl. The social worker should discuss and explain his / her concerns with the girl. The social worker should explain to the girl that she could be the subject of abuse and sexual exploitation and her health could be endangered. The social worker should encourage and support the girl to seek medical advice and assistance. The social worker should tell the girl that he / she needs to share this information with health and police. The social worker does not need to seek consent. The social worker should make a record of that discussion and continue to support this girl.

(e.g. Consent is not required. Practitioners can rely on Schedule 2: necessary for the exercise of a statutory function or legal obligation or public functions in the public interest AND Schedule 3: necessary for the exercise of a statutory function).

Scenario 5:
A 14 year boy tells his teacher he does not want to go home after school. He says his mother has a new male partner and she does not care about him anymore. He says that some nights he does not get anything to eat or any sleep and when his mum and her partner are always drinking they usually end up shouting and fighting with each other and throwing things about. He says he is scared that something bad is going to happen to him.

Action:
The teacher has a professional duty of care for this boy. The teacher should explore and discuss this further with the boy to clarify his exact concerns. The boy should be supported in the school that afternoon and in the interim the teacher should inform the headteacher. Where in their professional judgment they consider this to be a child protection concern they should tell the boy they must share this with police and social work and do so without delay. The headteacher does not need to seek consent. The headteacher should make a record of that discussion and continue to support this boy in school.

(e.g. Consent not required. Practitioners can rely on Schedule 2: necessary for the exercise of a statutory function or public functions in the public interest).
Joint Investigative Interviewing


A Joint Investigative Interview is a formal, planned interview with a child or young person, carried out by specially trained police and social work staff, competent to conduct it, for the purpose of gaining the child or young person’s account of events (if any) which require further investigation. This interview is child-centred and sensitive to the child or young person's needs and capacity.

In Perth and Kinross, these interviews are carried out exclusively by trained police and social work staff, who have completed Joint Investigative Interviewing Training (JIIT) in accordance with the Scottish Government (2011): Guidance on Joint Investigative Interviewing of Child Witnesses in Scotland and the National Curricula: Joint Investigative Interviewing of Child Witnesses Training in Scotland.

The main purposes of a joint investigative interview are to:

- learn of the child or young person’s account of the circumstances that prompted the enquiry;
- gather information to permit decision making on whether the child or young person in question, or any other child or young person, is in need of protection;
- gather sufficient evidence to suggest whether a crime or offence may have been committed against the child or young person or anyone else; and
- gather evidence which may lead to a ground of referral to a children’s hearing being established.

Decisions to carry out a Joint Investigative Interview are made at the Inter-Agency Referral Discussion (IRD) stage. Whilst primarily a decision for social work and police, consultation with other services / agencies, including health, education and the third sector, should also take place, especially when the child or young person has additional support needs, learning disabilities and / or communication difficulties.

Other than in exceptional circumstances, in Perth and Kinross all Joint Investigative Interviews are visually recorded and take place at Almondbank House in Perth. Equipment can also be deployed to remote locations as / when necessary.
Identifying, Assessing and Managing Risk


What is Risk in a Child Protection Context?

Working with risk is at the heart of child protection. Risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person's life. Risks can therefore be both positive and negative.

Risk is part and parcel of everyday life: a toddler learning to walk is likely to be at risk from some stumbles and scrapes but this does not mean the child should not be encouraged to walk. Risks may be deemed acceptable; they may also be reduced by parents or carers or through the early intervention of universal services. At other times, a number of services or agencies may need to respond together as part of a co-ordinated intervention.

Only where risks cause, or are likely to cause, significant harm to a child or young person would a response under child protection be required. Where a child or young person has already been exposed to actual harm, assessment will mean looking at the extent to which they are at risk of repeated harm and at the potential effects of continued exposure over time. Consideration should also be given to the risk posed by the potential perpetrator.

The importance of good, accurate risk assessment within child protection cannot be overstated. All staff must apply their professional judgement in this highly uncertain, complex and rapidly changing environment. Decisions on intervention, supports offered or compulsory measures required to immediately protect the child or young person are dependent on professional analysis of accurate and relevant information and robust decision making. Failure to properly identify risk can lead to serious, and even fatal, outcomes for children and young people.

From a child protection perspective, it is the risk of significant harm that is central here: where concerns are raised about the potential significant harm to a child or young person, they should be considered child protection concerns.

There are no absolute criteria for judging what constitutes significant harm: sometimes, it can be a single traumatic event; often, it is a combination of significant events which can interrupt, change or damage the child or young person's physical and psychological development. The challenge for practitioners is identifying which children require protective measures.

When considering the immediate needs of a child or young person once a concern about their possible safety is raised, it is essential that practitioners consider the following questions:

1. Is this child or young person at immediate risk?
2. What is placing this child at immediate risk?
3. What needs to happen to remove this risk now?
The GIRFEC approach stresses the importance of understanding risks and needs within a framework of the child or young person’s whole world and wellbeing. Every child and young person needs to be healthy, achieving, nurtured, active, respected, responsible, included and, above all, safe.

When assessing a child or young person, all staff should therefore be alert to the potential risk factors in their life. The GIRFEC National Practice Model presents a series of tools that are integral to the use of risk assessment: the Wellbeing Indicators; the My World Triangle; and the Resilience Matrix.

**GIRFEC National Practice Model**

**Wellbeing Indicators**

The Wellbeing Indicators (a.k.a. SHANARRI Indicators) provide the broad framework for identifying a child or young person’s needs. They do so under eight headings, which should form the basis for single planning around the individual child: safe; healthy; achieving; nurtured; active; respected; responsible; and included. These headings are used to identify what needs to change in a child or young person’s life and they are a key element in the identification of concerns and management of risk:
**My World Triangle**

The *My World Triangle* serves as a starting point for considering what risks might be present in a child or young person's life. It focuses attention on the three dimensions of a child or young person’s world: *the child or young person themselves; their family* and *their wider environment.*

Once a concern has arisen, the *My World Triangle* is a useful tool for gathering information as part of an investigation; for focusing attention on areas where there may be risks of *significant harm*; or for assessing the factors that have caused the concerns to arise in the first place:

Practitioners using the *My World Triangle* will need to consider who is best placed to provide information in relation to the specific areas of a child or young person's life. This will include other practitioners, services or agencies and also the child, young person and their family.

The five key *GIRFEC* questions practitioners should consider are as follows;

1. *What is getting in the way of this child’s or young person’s wellbeing?*
2. *Do I have all the information I need to help this child or young person?*
3. *What can I do now to help this child or young person?*
4. *What can my agency do to help this child or young person?*
5. *What additional help, if any, may be needed from others?*

Clearly, not all the issues considered under the MY World Triangle will involve risk factors. Together, though, they provide a comprehensive outline of areas to be considered when assessing a child and young person's circumstances.
Resilience Matrix

Using the My World Triangle to identify risk factors is the first step in assessing risk. The next step is to look at how those factors impact on the individual child. The Resilience Matrix provides a framework for weighing up particular risks against protective factors for the individual child or young person. By helping practitioners make sense of the relationship between the child or young person's levels of vulnerability or resilience and the world around them; the Resilience Matrix may also help highlight areas of risk that need more comprehensive or specialist assessment and analysis. As the diagram below shows, the Resilience Matrix can be used to examine factors in relation to:

- vulnerability and unmet needs;
- adversity;
- strengths or protective factors; and
- resilience.

This step marks the start of the process of unpacking the individual child or young person's circumstances and exploring their potential impact. The child or young person's circumstances can be plotted on each of the two continuums; allowing the practitioner to see where the impact of these circumstances places them within the Resilience Matrix and, therefore, how at risk they are:

- resilience within a protective environment (low risk);
- resilience within adverse circumstances (medium risk);
- vulnerable within a protective environment (medium risk); and
- vulnerable within adverse circumstances (high risk).
Where it emerges that a vulnerable child or young person is living in a situation with a high level of adversity, a detailed risk assessment should be carried out.

**Assessing Risk**

Risk assessment is not static, nor can it be separated from risk management. Risk factors can reduce over time, or conversely, increase. Equally, changes in a child or family's circumstances can strengthen or limit protective factors. The process of identifying and managing risk must therefore also be dynamic, taking account of both current circumstances and previous experiences, and must consider the immediate impact as well as longer-term outcomes for children and young people.

Risk assessments are needed in numerous different situations, but there are two scenarios that are worth reviewing:

- where significant harm may arise from a single event; and
- where significant harm may result from an accumulation of events or circumstances.

**Risk Assessment of a Single Event**

In some child protection circumstances, urgent action is needed to protect the child from any further harm and the immediate safety of the child is the priority consideration. Where such concerns arise and can be immediately verifiable – for example, sexual assault or injury – risk assessment must be carried out straight away in order to guarantee the child or young person's safety.

However, once these steps have been taken, practitioners will need to determine the longer-term safety of the child or young person. Risk identification and management at this stage will focus on the likelihood of future significant harm to the child or young person, the family's capacity for change and the interventions needed to reduce risk of that significant harm.

In other circumstances, a specific, individual concern may be raised about a child or young person and professional judgement will be needed to determine the likelihood and scope of any significant harm. Further investigation may be required to determine the nature and circumstances of events and a balance will need to be struck between understanding what has happened and what may happen.

**Risk Assessment of Accumulative Concerns**

Children and young people are often identified as being at risk of significant harm not as a result of a one-off incident but rather because of increasing, ongoing concerns about their circumstances. These concerns may appear relatively minor in themselves but, together, trigger a need to act.

There may also be a need for ongoing assessment of a child or young person who is already subject to child protection actions. Practitioners will need to assess whether there have been any improvements in a child or young person's circumstances – for example, an increase in parenting capacity – and whether there are still important unmet needs.
Managing Risk through Child Protection Plans

Having identified risks to a child or young person and their actual or potential impact, the next step will be to consider strategies and interventions for reducing those risks. This will form part of the Child Protection Plan, incorporated within the Child’s Plan. Again, consideration should be given to immediate and short-term risks as well as longer-term risks to the child or young person. Objectives should be set out following the criteria SMARTER: Specific; Measurable; Attainable; Relevant; Timebound; Evaluate and Re-Evaluate.

Child Protection Plans, which have been incorporated into the Child’s Plan, should set out in detail the perceived risks and needs, what is required to reduce these risks and meet those needs, and who is expected to take any actions forward including parents or carers (as well as the child or young person themselves). Children, young people and their families need to understand clearly what is being done to support them and why.

Any interventions should be proportionate and clearly linked to a desired outcome for the child or young person. Progress can only be meaningfully measured if the action or activity has a positive impact on the child or young person. The Wellbeing Indicators can help to measure this progress. The Child Protection Plan which is incorporated into the Child’s Plan should include a detailed explanation of specific needs, risks, interventions and desired outcomes under each indicator.

They should also clearly identify:

- the key people involved and their responsibilities;
- outcomes and timescales;
- support and resources required and in particular, access to specialist resources;
- the process of monitoring and review; and
- any contingency plans and whether Compulsory Measures of Supervision should be required.

Risk Assessment Skills

Developing a suitable risk assessment procedure is only one part of risk assessment.

Undertaking risk assessments is a complex and demanding process and practitioners need to be equipped with the necessary skills and support to do this. This includes not only the use of a risk assessment tool itself, but also the knowledge base and skills that are required to inform professional analysis and evidence-based decision-making.

Staff need to understand their own roles and responsibilities towards children and the role of other services. Knowledge of child development and the impact of abuse on children and young people is an essential component of risk assessment, as is understanding the need for good communication and information-sharing skills. It is important that practitioners are aware of the latest thinking on how risk indicators affect children and young people, how they can interact together, different tools for identifying these risks and the appropriate actions to take, and the efficacy of existing and new approaches to supporting children and young people.
Managing Risks is Other Circumstances / Environments (i.e. not Child Protection)

In day-to-day practice environments, risk situations have to be managed in many different ways, by different practitioners. These situations will require staff to exercise professional judgement and a common-sense approach, as not all these circumstances automatically indicate or dictate the need for a child protection response.

The need for risk management occurs when it is considered that a child or young person poses a risk to themselves or others. Abuse by one child or young person on another should always be treated seriously and will involve multi-agency partnership working to protect both the victim and the alleged perpetrator. There are everyday situations where children and young people have to come together, such as in nursery or school environment. Careful management of risk is critical to avoid any escalation of relationship difficulties and the potential for labelling, as well as for the protection of the care and welfare of all relevant children and young people.

As noted in national guidance there is a need to ensure that there are appropriate risk management arrangements in place to identify those most at risk and to ensure appropriate sharing of such concerns at an early stage. This sharing is to ensure that risk management strategies can be developed and safety plans be put in place for specific situations.

Within an education facility this could include management of situational risk within a school building and in respect of particular peers of an alleged victim. In each case it is acknowledged that management of these situations is very challenging and can be stressful and emotionally draining for those concerned. This stress can be mitigated by a collaborative approach, promoting coherent joint ownership and by individual support to the practitioners concerned.

Principles for Good Practice

Practitioners should consider the following as good practice in risk management in schools and other community environments:

- being able to recognise behaviours which can impact upon a child or young person's wellbeing;
- being alert to the signs and indicators of harm, abuse and neglect and knowing what to do and who to contact if worried or concerned about a child or young person (see Parts II and III);
- promoting good information sharing, communication and collaboration between relevant practitioners, services and agencies with a clear understanding of each others roles and responsibilities e.g. at multi-agency practitioner meetings (see Part III);
- developing individualised responses, according to the unique circumstances of any given situation, taking time to consider all the known and any unknown facts (See Practice Checklist 1 and Practice Checklist 2);
- sharing information proportionately with Supervisors / Line Managers, e.g. Designated Child Protection Officers; Guidance Teachers, Headteachers, on in their absence with peers;
• seeking relevant support and advice from the *Perth and Kinross Child Protection and Duty Team*; or from the Schools Inclusion Team;

• giving due consideration to the safety of all involved - the welfare of all children and young people remains paramount;

• ensuring appropriate, proportionate and timely risk assessment are carried out - using recognised toolkits e.g. Practice Checklist 1 and Practice Checklist 2 and GOPR Checklists; Sexualised Behaviour Risk Assessment Forms in Schools;

• ensuring risk management is "*embedded within systems around the child or young person and promoted by those who supervise and monitor the child on a daily basis*";

• developing plans based on risk assessment for each relevant environment - ensuring individual practitioner key responsibilities are understood;

• recognising the need for effective monitoring and review, reflecting the dynamic nature of risk - risk assessment is not a one-off event but a continuum;

• ensuring support matches the needs of the child or young person and continues for as along as is necessary;

• plans can cover both risk assessment and risk management along with risk reduction;

• involving the child, young person and their family in the process; and

• seeing schools as a community 'hub' where worries or concerns can be shared and discussed safely.

**Risk Reduction**

In addition to risk management there is a need to focus on risk reduction. Risk reduction should be seen as a planned programme of risk management work aimed at helping a child or young person by improving their *wellbeing*. This means:

• ensuring that the risk assessment and risk management process includes a means of identifying the most relevant areas for intervention with each child or young person;

• viewing individual intervention as part of a systemic approach rather than as an isolated consideration;

• designing interventions that support long-term maintenance of therapeutic change by empowering the child and young person; and

• regularly evaluating the effectiveness of interventions.
Comprehensive Health Assessments and Medical Examinations

Joint Protocol for the Joint Paediatric / Forensic Medical Examinations of Children and Young People Across Tayside

The following guidance has to be considered in conjunction with the more detailed guidance above.

Occasionally, following multi-agency screening arrangements of Child Concern Reports and in keeping with Child Protection Investigations and Inter-Agency Referral Discussion (IRD) arrangements, a joint police and social work child protection investigation may determine the need for a comprehensive health assessment and / or a medical examination to be carried out on a child or young person.

A comprehensive health assessment and / or medical examination can often provide reassurance that no long term physical injury or health risk has occurred and when conducted sensitively, may be the start of a healing experience / process for both the child or young person and their family. The decision on whether an actual comprehensive health assessment and / or medical examination is appropriate should be made during the child protection planning and investigation stage with social work, police and with the involvement of relevant health professionals.

Medical examinations will only be carried out where this is deemed to be necessary and in the best interests of the child. It is recognised that medical examinations may be traumatic for the child or young person and / or their parents or carers. Therefore it is important that practitioners inform and consult the child or young person and their parents or carers about the need for the medical examination and the process.

Comprehensive Health Assessment

A thorough comprehensive health assessment of a child or young person’s health needs is an essential part of the joint child protection investigation process, particularly where abuse and / or neglect is suspected.

A comprehensive health assessment should also aim to identify unmet health and welfare needs in a very vulnerable child or young person and is integral to the child protection process. A comprehensive health assessment of a child or young person’s family medical history can also assist with the planning, investigation and management of risk and need.

A comprehensive health assessment should always be considered in cases of child abuse and neglect; even when information from other services or agencies show little, or no obvious health needs.

Accurate and comprehensive entries made in the health records are essential. In some cases of child abuse and neglect, there will be no obvious signs or symptoms and some children will require diagnostic procedures only available in a well-equipped hospital or clinic.
The comprehensive health assessment has five purposes:

1. to establish what immediate treatment the child or young person may need;
2. to provide information that may or may not support a diagnosis of child abuse when taken in conjunction with other assessments, so that agencies can initiate further investigations, if appropriate;
3. to provide information or evidence, if appropriate, to sustain criminal proceedings or care plans;
4. to secure any ongoing health care (including mental ill-health), monitoring and treatment that the child or young person may require; and
5. to reassure the child or young person and the family as far as possible that no long-term physical damage or health risk has occurred.

In order to make the most effective contribution, the examining doctor must have all the relevant information about the cause for concern and the known background of the family or other relevant adults; including previous instances of abuse / neglect or suspected abuse or neglect. Wherever possible, information from the joint investigative interview should be made available to the examining doctor (s).

**Joint Paediatric / Forensic Medical Examination**

A joint paediatric / forensic medical examination may need to be carried out under the following circumstances:

1. the child or young person urgently requires more specialist assessment or treatment at a paediatric department (for example, if they have a head injury or suspected fractures);
2. the account of the injuries provided by the parent or carer does not provide an acceptable explanation of the child or young person's condition;
3. the result of the initial assessment is inconclusive and a specialist's opinion is needed to establish the diagnosis;
4. lack of corroboration of the report; such as a clear statement from another child or young person or adult witness, indicates that a forensic medical examination, including the taking of photographs, may be necessary to support criminal proceedings against a perpetrator and legal remedies to protect the child or young person;
5. the child or young person's condition (for example unexplained bruising) requires further investigation; and
6. in cases of suspected child sexual abuse, as the medical examination has to be carried out by medical practitioners with specialist skills using specialist equipment.

The decision whether a joint paediatric / forensic medical examination should be carried out will be made during the discussions between social work, police and relevant health professionals. Where there is a lack of consensus, this should be resolved by the examining doctor referring the child or young person for a second opinion to a senior paediatric colleague with specialist experience in child protection.
The joint paediatric / forensic medical examination combines a comprehensive health assessment with the need for corroboration of forensic findings and the taking of appropriate specimens for trace evidence including, for example, semen, blood or transferred fibres.

While the paediatrician is responsible for assessing the child or young person’s health and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up, the forensic physician (also known as forensic medical examiner, child medical examiner, or police casualty surgeon) is responsible for the forensic element of the examination and fulfils the legal requirements in terms of, for example, preserving the chain of evidence.

The presence of two doctors in the joint paediatric / forensic medical examination is important for the corroboration of medical evidence in any subsequent criminal proceeding and is also good medical practice.

Consent to Medical Treatment and Examination

In considering the medical treatment and examination of a child or young person under 16, The Age of Legal Capacity (Scotland) Act 1991 will apply. The examining medical practitioner can accept the child or young person’s consent to a medical examination if it is considered by the medical examiner that the child has capacity to understand the implications of such an examination.

For children and young people not deemed to have the capacity to consent, parental consent will be required unless other steps have been taken (such as by direction of a Child Protection / Assessment Order granted by a Sheriff) to obtain legal authority to proceed without parental consent. Parental consent should be sought if the parent or carers have parental rights and responsibilities and the child or young person is under 16, unless this is clearly contrary to the safety and best interests of the child or young person (for example, in urgent circumstances).

If the local authority believes that a medical examination is required to find out whether concerns about a child or young person’s safety or welfare are justified and the parents or carers refuse consent, the local authority may apply to a Sheriff for a Child Protection Order or a Child Assessment Order with a condition of medical examination but only if the child or young person is at risk of significant harm and the legal tests for these orders are met. A child or young person subject to a Child Protection Order or a Child Assessment Order may still withhold their consent to examination or assessment if they are deemed to have legal capacity.

_In practice no child or young person will be made to undergo a medical examination where they refuse to give consent either by word or actions._

Arranging a Medical Examination

The number of examinations to which a child or young person is subjected must be kept to a minimum. Careful planning of the medical component of the examination by experienced medical staff will facilitate this. In planning the medical investigation, it is important to remember that
it is the duty of the police to provide best evidence, including medical evidence, to the Procurator Fiscal and the Children's Reporter in appropriate cases.

Where it is clear that a forensic opinion will be required – for example, where there is an allegation or observation of serious physical assault or injury or a disclosure of sexual abuse – the forensic medical examination should also include a comprehensive health assessment.

The timing of the medical examination should be agreed jointly by the medical examiners and the other services / agencies involved. It may not be in the child or young person’s best interests to rush to an immediate examination. It may be more appropriate to wait until the child or young person has had time to rest and prepare; this may also allow for more information to become available.

It is expected that in the great majority of cases arising in working hours, a comprehensive health assessment will be carried out locally and quickly by a doctor who knows the child, young person and / or the family and is competent to carry out such an assessment. If an assessment cannot be arranged through normal local contacts, the paediatrician responsible for child protection should be contacted. The decision on how best to proceed should always be made in discussion with the other services and agencies involved.

In cases of suspected or reported sexual abuse where the incident has taken place some time previously, the examination must be carefully planned to take place during working hours when skilled personnel and specialist staff are available. Where the incident is believed to have taken place more recently, care must be taken to ensure that forensic trace evidence is not lost. Particular care should be taken to retain clothing and bedding, and to avoid bathing.

Within Perth and Kinross, medical examinations are requested via the Perth and Kinross Child Protection and Duty Team and / or the Police Public Protection Unit in partnership with the NHS Tayside On-Call Duty Paediatrician (24/7/365).

Chronologies

Tayside Practitioner's Guidance: Chronologies  Chronology Template
Getting it Right for Every Child: GIRFEC Briefing for Practitioners No 8: Single Agency and Integrated Chronologies (Scottish Government: 2012)
Practice Guide to Chronologies (Care Inspectorate: 2017)

The Tayside Practitioner's Guidance: Chronologies has been produced to provide all practitioners working and / or involved with children, young people and their families across Tayside, with clear practice guidance on the effective use of Chronologies.

The guidance sets out to provide minimum standards: aimed at ensuring a consistent approach to collating, sharing and exchanging information, thus enabling the identification and consideration of needs, patterns and risks. This guidance should complement, not replace, any existing single service and / or agency Chronology guidance.
About Chronologies

Chronologies have become one of the most talked about and least understood analytical tools in modern child care and/or protection practice. Between and across services and/or agencies, there is no single, agreed definition and understanding of what constitutes a Chronology. It means different things to different services, agencies and indeed practitioners. However, in general, the principles are the same.

It is clear that ‘one size does not fit all’ and that there are various models and approaches being taken to Chronologies. Given where individual services and/or agencies are at now, in terms of local practice and/or IT support systems, it remains outwith the scope of this guidance to suggest system changes.

However Chronologies remain a critical tool in child care and/or protection practice and allow for the collation and management of key information relating to a child or young person’s wellbeing. Chronologies also support practitioners to identify patterns of risk factors which are having an adverse impact on a child or young person’s wellbeing.

Single Agency Chronology

The Getting it Right for Every Child: GIRFEC Briefing for Practitioners No 8: Single Agency and Integrated Chronologies states:

“A Single Agency Chronology provides a brief description and summarised account of events in date order. It should be used as an analytical tool to assist in the understanding of the impact of life events and to inform decision making. Integration of Single Agency Chronologies can establish a wider context from the agencies involved with a child or young person”.

Integrated Chronology

The Getting it Right for Every Child: GIRFEC Briefing for Practitioners No 8: Single Agency and Integrated Chronologies also states:

“An Integrated Chronology is produced as part of a specific multi agency intervention and will include only information extracted from Single Agency Chronologies that is relevant and proportionate to support that intervention”.

In summary, Chronologies provide a key link in the chain of understanding needs/risks, including the need for protection from harm. Setting out key events in sequential date order, they give a summary timeline of child and family circumstances [or those of an individual using adult services], patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment (Care Inspectorate: 2017).
A Chronology can be Single Agency and / or Integrated; the principles are basically the same.

For the purposes of this guidance, given that the principles are basically the same; this guidance shall focus on Integrated Chronologies.

An Integrated Chronology can:

- be used to record significant events (positive and negative) that have had, or continue to have, significance and / or an impact (positive and negative) on / to the child and / or young person’s wellbeing;
- provide a clear account of all events in a child or young person’s life to date, drawing upon the knowledge and information held by each practitioner, service and / or agency involved with that child and / or young person;
- identify protective factors, resilience, strengths and / or weaknesses in a child and / or young person’s life and / or family;
- provide an early indication of an emerging pattern of wellbeing concerns, risks and / or needs; and
- be critical to decision making and / or in the legal process (children’s hearings and in court) and must therefore be factually correct.

Having a Chronology

Every child or young person, who has a Child's Plan, should have in place an up-to-date Single Agency Chronology and / or an Integrated Chronology.

A Single Agency Chronology should be produced and kept by all practitioners, services and / or agencies, in particular by Named Persons, where there is any concern about a child / young person’s wellbeing.

An Integrated Chronology should be produced by the Lead Professional as part of a specific multi-agency intervention taken to safeguard, support and promote a child and / or young person’s wellbeing.

Included in a Chronology

An Integrated Chronology should only include single service and / or agency factors, concerns, events, incidents, milestones and / or circumstances in a child or young person’s life, which are considered to be significant by the individual practitioners.

It should only include information that is relevant; necessary; legitimate; appropriate and proportionate for sharing with other services, agencies and / or practitioners.

An Integrated Chronology is not a record of every practitioner, service and / or agency’s involvement with a child or young person.
To be useful, an *Integrated Chronology* must be kept up-to-date through the contributions of all relevant practitioners, services and / or agencies and can inform risk assessment, decision making and care planning.

An *Integrated Chronology* must be managed effectively, reviewed regularly and it must be:

- factual, accurate, current and evidence-based;
- in a neutral language, suitable for all practitioners and children, young people to read and understand;
- presented in time and date order;
- succinct – if every factor, concern, event, incident, milestone and circumstance etc is recorded, then the chronology loses its value and impact;
- simple in format – ensuring that information can be efficiently managed, merged and sorted; and
- in an agreed typed format.

An *Integrated Chronology* is *not a replacement* for:

- individual practitioner professional judgment, knowledge, skills and / or simple gut feeling;
- direct discussion between practitioners, both intra and inter-agency;
- a list of meetings;
- joint partnership working;
- early identification, intervention and support;
- substitute case file recording;
- assessment but part of an assessment and planning; and
- an end in itself.

**Starting a Chronology**

All practitioners, working with and / or involved with a child or young person, should have in place robust methods of recording and maintaining information or events about the children and young people they are involved with. This should be recorded in their respective service and / or agency case file records and / or electronic databases.

All services and / or agencies should have in place their own guidance for case file management and recording practices, which should include single service and / or agency advice on Chronology recording.

Chronologies should be started when there is a concern about a child or young person’s wellbeing.
Chronologies should be started from birth; however in some cases it will be relevant to start the Chronology pre-birth. This will show emerging patterns of risk before the baby is born. If started pre-birth, single services, agencies and / or practitioners will need to agree where and how that Chronology is to be recorded.

*An Integrated Chronology* will be particularly useful where two or more services and / or agencies have an involvement with a child or young person and support is being provided through a *Child's Plan* under the coordination of a *Lead Professional*.

*An Integrated Chronology* should be produced as part of a specific multi-agency intervention and will only include information extracted from single services and / or agencies that is *relevant and proportionate* to support that intervention.

*An Integrated Chronology* may also be required as:

- part of an assessment process to identify immediate, short term and longer term vulnerabilities, needs and risks;
- part of a planning process / meeting to meet needs and risk;
- part of a review process to identify improvement, outcomes or otherwise;
- part of a case file review process to identify good practice;
- part of an initial case review, significant case review and / or inquiry; and
- a requirement for taking forward a child or young person towards permanence, both for presenting to the permanency panel and for the legal process.

In addition, an increasing number of adults are also requesting access to their personal case file records, in order to understand past events in their childhoods and / or lives.

Chronologies have proven to be a critical record showing when key changes or events happened in their childhood. Chronologies can enable them to explore specific details in the case file record. It is important that staff are aware of this need.

**Benefits of a Chronology**

Practice and research has shown that Chronologies can be extremely important in identifying critical events in the lives of children and young people and can assist practitioners in decision making when working together with vulnerable children and families.

When an *Integrated Chronology* is collated, it provides practitioners with a useful, holistic history of *significant events* in that child or young person’s life. It can provide a very clear timeline in terms of practitioner, service and / or agency involvement. It can also demonstrate the effectiveness, or otherwise, of previous interventions, involvements and support.

When an *Integrated Chronology* is further analysed, it can provide practitioners with a valuable tool by which to consider the immediate cumulative impact on a child or young person, both in the short term and in the longer term.
It can also allow practitioners to consider the child or young person’s holistic wellbeing in keeping with the GIRFEC Practice Model.

**Responsibility for a Chronology**

For *Single Agency Chronologies*, the **Named Person** Service should hold a completed Chronology. In education, this should be completed by the **Named Person** assisted by the Designated Child Protection Officer (CPO). Ideally, this should be held electronically, if secure systems are in place and allow this.

For *Integrated Chronologies*, the **Lead Professional**, in consultation with the **Named Person**, should collate the information from education, health, police, social work, voluntary / third sector and from any other relevant practitioner, services and / or agencies involved with the child, young person and / or family and combine them into an *Integrated Chronology*. Ideally, this should be held electronically, again if systems are in place and allow this. In practice, there will times when the **Named Person** is also the **Lead Professional**.

The roles of the **Named Person** and **Lead Professional** are key to the development of an *Integrated Chronology*. Normally the **Lead Professional** will co-ordinate the development of an *Integrated Chronology* between and across the various practitioners, services and / or agencies and / or network of practitioner support.

There is however an expectation that it is the responsibility of each practitioner service and / or agency to contribute towards an *Integrated Chronology*. Across Tayside, it is acknowledged that there are various models and approaches being taken to Chronologies. Individual services and / or agencies have in place their own practice arrangements and should have in place their own Single Agency Chronology Guidance. Individual service and / or agency IT systems may or may not be able to produce individual service and / or agency computer generated Chronologies.

At present, there is no shared electronic database and / or IT system able to pull together an *Integrated Chronology*. Practice has not been enabled by such technology.

A Generic Exemplar Template for the collation of a Chronology has been agreed within Tayside.

**Significant Events**

In terms of a Chronology, it is not possible to specify what type of *factor, concern, event, incident, milestone and / or circumstance* are considered significant enough to warrant inclusion in a Chronology. In most cases, practitioners will require to exercise their own professional judgement.

Any changes, which are considered to have a *significant impact* on the child or young person, whether they are positive or negative, or a strength or a weakness, should be considered as a possible *significant incident and / or event*. 
Impact

It is important that each factor, concern, event, incident, milestone and / or circumstance whether single or recurring, positive or negative, are considered in terms of the impact on a child or young person’s wellbeing.

Professional judgement and a common sense approach should be adopted when determining impact. Practitioners may also find it helpful to seek peer and / or line management support when trying to identify impact and may also wish to ask themselves the “so what?” question.

Generic Examples of Significant Events

The following generic list provides some guidance for all practitioners.

A significant incident and / or event could include changes in the child or young person's:

- child protection status, including protective factors, resilience factors; vulnerabilities, risks, needs;
- Child’s Plan;
- legal status;
- family circumstances including the immediate family structure and / or the presence of any significant adults;
- domestic and / or living arrangements and / or environment;
- physical health, mental ill-health and / or emotional wellbeing including acute admissions, failed and / or missed appointments;
- developmental growth and / or normal patterns of behaviour;
- educational performance including exclusion and / or removal from education and / or home education;
- parents or carers physical and / or ill-health and wellbeing;
- incidents of domestic abuse, parental substance misuse and learning difficulties;
- service and / or agency supports, including changes of Named Person, key workers, gradual or sudden withdrawal from service and / or agency support; and
- parents or carers behaviour that is seen as difficult, hostile, evasive, non-engaging, threatening, non-compliant and / or uncooperative including any criminality.

Examples of Single Agency Significant Events

The Getting it Right for Every Child: GIRFEC Briefing for Practitioners No 8: Single Agency and Integrated Chronologies (Scottish Government: 2012) provides a useful / helpful checklist and / or set of single service and / or agency factors, concerns, events, incidents, milestones and / or circumstances in a child or young person's life which could be considered significant.
Significant Events
(N.B. The events identified in this section should not be regarded as in any way definitive).

The following areas have been identified by each of the services and / or agencies as worthy of recording but not every area will be recorded for every child or young person only where it is a relevant key event.

REMEMBER – An Integrated Chronology is not a record of a practitioner, service and / or agencies involvement with a child or young person. It is a record of significant events in that child or young person’s life, these lists are only for example:

Education

- positive or negative changes in family care structure e.g. separation, divorce, bereavement, custodial sentence;
- positive or negative changes in family circumstances e.g. housing, birth of a sibling;
- physical and mental ill-health and wellbeing of child, parents or carers;
- positive or negative changes in performance, attainment or achievement;
- identification of Additional Support Needs within staged intervention process (including requests for support services involvement e.g. psychological service, intensive support team, care and learning);
- if the child has an Individual Education Plan or Co-ordinated Support Plan;
- positive or negative changes in attendance;
- positive or negative changes in parental presence, engagement or support with child’s learning;
- episodes of exclusion or re-integration;
- significant periods of absence e.g. illness, pregnancy, truancy;
- social inclusion within the school setting including evidence of bullying or positive support networks;
- decision to initiate a Child’s Plan;
- outcomes of internal assessment team or joint support meeting;
- change of teacher or other key member of staff from the child’s school;
- change of school;
- any threats or actual incidents of violence to staff by parents or carers or child;
- any other relevant concerns or positive improvements;
Health

- positive or negative changes in health related problems in relation to the child or their parents or carers, such as disability, substance related issues, mental ill-health issues etc;
- changes in family care structure e.g. through separation, divorce, bereavement, custodial sentence;
- changes to child’s physical or emotional wellbeing;
- changes in family circumstances e.g. housing, birth of a sibling, emotional wellbeing;
- referrals to Paediatric Services, Therapy Services, Other Agencies;
- attendance at Accident and Emergency, Out of Hours and NHS24;
- incidences of hospital admissions;
- childhood illnesses;
- changes in disability;
- dates of immunisations and screening (these may or may not be of significance depending on the child’s circumstances.);
- kept or missed appointments for ante-natal, post-natal appointments, immunisations, child health surveillance, hospital appointments;
- formal health assessments e.g. developmental, LAAC;
- change to the Health Visitor, Family Nurse, School Nurse or other key staff member working with the family;
- missed appointments without acceptable reasons, including refusal of entry or variation to routine appointment schedule;
- threats or actual incidents of violence to staff;
- any other relevant concerns or positive improvements;
- significant home visits;

Social Work Services

- all referrals to social work;
- information relating to health or parental lifestyles of parents or carers that significantly impact on the child or young person;
- positive or negative changes in family care structure e.g. through separation, divorce, bereavement, custodial sentence;
- positive or negative changes in family circumstances e.g. homelessness, birth of a sibling;
- referrals to Family Support Services, Home Support, Childcare or other agencies;
- dates and details of Social Work Involvement e.g. start date, closure of case and reason;
- lack of engagement;
• child concern reports or referrals;
• outcome of child protection referrals / enquiries / investigations;
• outcome of child protection related meetings e.g. case discussions, case conferences, core groups;
• dates and reason for child being looked after and accommodated;
• change of social worker or other key worker from the service;
• changes to legal status including primary and secondary statutes where applicable;
• an established pattern of missed appointments without acceptable reasons, including refusal of entry;
• dates and conditions of contact / conditions of no contact;
• change of address including foster placement and temporary accommodation;
• referrals to the Children’s Reporter and the grounds of referral;
• outcome of children’s hearings;
• details of planning meeting with outline of decisions and / or review dates including LAAC;
• any other relevant concerns or positive progress;
• any threats or actual incidents of violence to staff including verbal threats;
• date when summary statements, working agreements, risk assessments are completed;
• significant home visits;

Police

• any incident involving a child that would require notification to another agency about a child (could include child protection, bullying, SHANARRI concerns, missing persons, youth offending and ASB);
• any incident involving an adult that would impact on the wellbeing of a child (could include parent or carer’s arrest / drug or alcohol misuse, involvement in serious and organised crime groups, mental ill-health issues);
• any incident where the environment or circumstances would impact on the wellbeing of a child (could include neglect, poor living conditions, inappropriate risk taking, internet communications);
• some convictions of an adult may impact on the wellbeing of a child or young person where they are part of or become part of a family (could include Registered Sex Offenders, Domestic Abusers, Schedule 1 offenders);
• significant events where a child or young person is victim of or witness to a serious crime;
• where compulsory measures of supervision are likely to be required;
• where an officer has repeated contact for minor behavioural issues in the family or community (could include children dealt with by campus officers);
Housing

- positive or negative changes in family care structure e.g. separation, divorce, bereavement, custodial sentence;
- positive or negative changes in family and housing e.g. relocation, eviction, transfer to private tenancy;
- positive or negative changes in maintenance of tenancy agreements;
- positive or negative changes in neighbour relations or anti-social issues. Where this has led to further action being taken, for example ASBO, then this should be recorded;
- evidence of, or referrals for suspected drug dealing, drug taking or excessive alcohol use;
- reports of anti-social behaviour on the child or parents or carers;
- reports from Elected Members, members of the public or Anti-Social Behaviour Staff regarding anti-social behaviour;
- any concerns about the safety or welfare of children or young people noted directly by housing staff or passed to them by others in the community e.g. children left unattended, poor standards of household cleanliness, children wandering the streets or being out in poor weather without adequate clothing;
- any threats or actual incidents of violence to staff;
- any other relevant concerns, positive events;

Scottish Children’s Reporters Administration\(^{11}\)

- dates of referral;
- referral reason e.g. Grounds as specified per Section 67 of the Children’s Hearings (Scotland) Act 2011:
  - in this Act “section 67 ground”, in relation to a child, means any of the grounds mentioned in subsection (2);
  - the grounds are that:
    a) the child is likely to suffer unnecessarily, or the health or development of the child is likely to be seriously impaired, due to a lack of parental care;
    b) a schedule 1 offence has been committed in respect of the child;
    c) the child has, or is likely to have, a close connection with a person who has committed a schedule 1 offence;
    d) the child is, or is likely to become, a member of the same household as a child in respect of whom a schedule 1 offence has been committed;

\(^{11}\) This Section has been updated to reflect the changes introduced per the Children’s Hearing (Scotland Act) 2011
e) the child is being, or is likely to be, exposed to persons whose conduct is (or has been) such that it is likely that:
   i.  the child will be abused or harmed; or
   ii. the child’s health, safety or development will be seriously adversely affected;

f) the child has, or is likely to have, a close connection with a person who has carried out domestic abuse,

g) the child has, or is likely to have, a close connection with a person who has committed an offence under Part 1, 4 or 5 of the Sexual Offences (Scotland) Act 2009 (asp 9);

h) the child is being provided with accommodation by a local authority under section 25 of the 1995 Act and special measures are needed to support the child;

i) a permanence order is in force in respect of the child and special measures are needed to support the child;

j) the child has committed an offence;

k) the child has misused alcohol;

l) the child has misused a drug (whether or not a controlled drug);

m) 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;

n) the child is beyond the control of a relevant person;

o) the child has failed without reasonable excuse to attend regularly at school;

p) the child:
   i.  is being, or is likely to be, subjected to physical, emotional or other pressure to enter into a marriage or civil partnership; or
   ii. is, or is likely to become, a member of the same household as such a child;

- legal status and changes to legal status;
- dates of any Children’s Hearings;
- any decisions made about the child i.e. hearings, voluntary measures, compulsory measures of care.

In summary, a Chronology is:

1. a useful tool in assessment and practice;
2. not an assessment, but part of assessment;
3. not an end in itself, rather a working tool which promotes engagement with people who use services;
4. accurate and relies on good, up-to-date case recording;
5. detailed enough but does not substitute for recording in the file;
6. flexible so that detail collected may be increased if risk increases;
7. reviewed and analysed – a chronology which is not reviewed regularly is of limited relevance;
8. constructed differently according to different applications, for example current work and examining historical events;
9. recognising that single-agency and multi-agency chronologies set different demands and expectations;
10. recording what was done at the time (many chronologies list events, dates and so on but do not have a column setting out the action taken at the time - this column should also include a note when there was no action).

**Child Protection Case Conferences (CPCCs)**

**Perth and Kinross CPC Practitioner’s Guide: Child Protection Case Conferences**

**Perth and Kinross Information and Advice Leaflet: Child Protection Case Conferences (Children & Young People)**

**Perth and Kinross Information and Advice Leaflet: Child Protection Case Conferences (Parents & Carers)**

CPCCs are a core feature of inter-agency working to protect children and young people. Their primary purpose is to consider whether the child or young person (including unborn babies) is at risk of significant harm and if so, and if so, to develop a Child Protection Plan and / or to review an existing Child’s Plan to reduce / mitigate risk.

CPCCs are non-statutory multi-agency meetings and at present they have no legal status. CPCCs are formal multi-agency meetings that enable practitioners, services and agencies to share and exchange information, assessments and chronologies in circumstances where there are suspicions or reports of child abuse and neglect.

**Arranging CPCCs**

Within Perth and Kinross, although CPCCs are multi-agency meetings, they are all arranged and managed by Services for Children, Young People and Families, in partnership with the practitioner, service or agency who has requested a CPCC.

Services for Children, Young People and Families are responsible for arranging, convening and chairing all CPCCs on behalf of partner agencies and there is dedicated secretariat in place to provide administrative support and Minute Taking. All CPCCs are chaired by a Senior Officer from Services for Children, Young People and Families - normally an Improvement Officer.

Any practitioner, service and agency can request a CPCC by contacting the Service Manager (Child Protection) Services for Children, Young People and Families). Similarly, any child or young person whose name is on the Child Protection Register (CPR) (and / or their parents, carers or any other person with parental responsibilities) can ask for a CPCC to be convened at any time. However, the decision to hold a CPCC remains with Services for Children, Young
People and Families.

However, the most important consideration must be the immediate multi-agency response and action taken to ensure the protection of the child or young person. In order to avoid any unnecessary drift, timescales have been introduced for all CPCCs and these include timescales for the production of Minutes and a *Child’s Plan*. Timescales must be observed, complied with and will be monitored by the CPC.

**Purpose of CPCCs**

The purpose of all CPCCs is to share and exchange information, in order to identify risks to a child or young person and to identify the actions by which those risks can be reduced / mitigated. As a participant, you should maintain an outcome-focused approach by (this is not considered to be an exhaustive list):

- ensuring that all relevant information held by you and / or your service or agency has been shared, exchanged and analysed on an inter-agency basis;
- ensuring that you have liaised with the child or young person's *Named Person*;
- assessing the degree of existing and likely future risk to the child or young person;
- considering the views of the child or young person and their parents, carers or any other person with parental responsibilities;
- identifying the child or young person's needs and how these can be met by services and agencies;
- developing and reviewing the *Child’s Plan*;
- identifying a *Lead Professional*;
- deciding whether to place, or not to place, or to retain a child or young person's name on the CPR; and
- considering whether there might be a need for Compulsory Measures of Supervision and whether a referral should be made to the Children's Reporter (if this has not already been done).

**Types of CPCCs**

There are four types of CPCCs – *Pre-Birth Child Protection Case Conference; Initial Child Protection Case Conference; Review Child Protection Case Conference* and a *Transfer Child Protection Case Conference*. Each CPCC has a discrete and distinct purpose and it is important that all practitioners understand these differences.

**Pre-Birth Child Protection Case Conference**

The purpose of a *Pre-Birth CPCC* is to decide whether serious professional concerns exist, about the likelihood of harm through abuse or neglect, of an unborn child, when they are born. The participants need to prepare a *Child’s Plan* in advance of the child’s birth.
A pregnancy may be considered to be high risk if one of the following circumstances and / or vulnerability factors exists (this is not considered to be an exhaustive list):

- poor economic, material and social circumstances prevail;
- domestic abuse / gender based violence;
- previous child wellbeing / child care / child protection issues;
- problematic drug / alcohol misuse of parents, carers or any other person with parental responsibilities;
- mental ill-health of parents, carers or any other person with parental responsibilities;
- learning difficulties or disabilities of parents, carers or any other person with parental responsibilities;
- physical disabilities of parents, carers or any other person with parental responsibilities;
- young unsupported mother / parents;
- mother aged under 20 years;
- homelessness / housing difficulties i.e. rent arrears;
- women or partner in the criminal justice system;
- families with many changes of address and relationships i.e. transient males within the home; and
- late bookers of over 20 weeks gestation.

A Pre-Birth CPCC will also need to consider actions that may be required at birth, including (this is not considered to be an exhaustive list):

- whether it is safe for the child to go home at birth;
- whether there is a need to apply for a Child Protection Order (CPO) at birth;
- whether supervised contact is required between the parents, carers or any other person with parental responsibilities and the child and who will provide this if needed;
- whether the child’s name should be placed on the CPR. (It should be noted that the CPR is not regulated by statute and that an unborn child’s name can be placed on the CPR. Where an unborn child is felt to require a Child’s Plan to ensure their protection, their name should be placed on the CPR); and
- whether there should be a discharge meeting from hospital and a handover to community-based supports.

**Timescales** – A Pre-Birth CPCC should take place no later than at 28 weeks pregnancy or, in the case of late notification of pregnancy, as soon as possible from the concern being raised, but always within 21 calendar days of the concern being raised. However, there may be exceptions to this where the pregnancy is in the very early stages. In addition, concerns may still be sufficient to warrant an inter-agency assessment.
Initial Child Protection Case Conference

The purpose of an Initial CPCC is to allow practitioners, services and agencies to share and exchange information about a child or young person for whom there are child protection concerns, jointly assess that information and the risk to the child or young person and to determine whether there is a likelihood of significant harm through abuse or neglect that needs to be addressed through a multi-agency Child Protection Plan. The focus should always be on keeping the child or young person safe and protected.

An Initial CPCC should also consider whether a child or young person is safe to remain at home or whether a referral to the Children’s Reporter is required. An Initial CPCC normally takes place after a child protection investigation has been carried out and an assessment has been made of the situation.

Where it is agreed that a child or young person is at risk of significant harm and that their name should be placed on the CPR, those attending the Initial CPCC are responsible for developing and agreeing a Child Protection Plan and for identifying the Core Group of staff responsible for implementing, monitoring and reviewing that subsequent Child’s Plan.

The participants need to take account of all the circumstances leading to the Initial CPCC and the initial risk assessment. Due to the timescales for calling an Initial CPCC, there may, on occasions, only be time for an interim risk management plan; a more comprehensive risk assessment may still need to be carried out after the Initial CPCC. In some instances, there will already be a Child’s Plan in place and this will need to be considered in light of the concerns about the child or young person.

Timescales – An Initial CPCC should take place as soon as possible and no later than 21 calendar days from the start of the child protection investigation.

Review Child Protection Case Conference

The purpose of a Review CPCC is to review the decision to place a child or young person’s name on the CPR or where there are significant changes in the child or young person’s family circumstances. The participants will review the progress of the Child’s Plan, consider all new information available and decide whether the child or young person’s name should remain on, or be removed (de-registered) from, the CPR.

Where a child or young person is no longer considered to be at risk of significant harm and good progress has been made with the Child’s Plan, their name should be removed (de-registered) from the CPR by the Review CPCC. Only a Review CPCC can remove (de-register) a child or young person's names from the CPR. The child or young person and their parents, carers or any other person with parental responsibilities may still require ongoing support and this should be managed through the Child’s Plan. Support should continue for as long as is necessary.

The situation should be constantly reviewed for so long as the child or young person’s name remains on the CPR. A Special Review CPCC can also be arranged at the request of any
practitioner, service or agency when there has been a significant change in the circumstances of the case, or where there has been a further alleged incident of harm or abuse which requires consideration.

**Timescales – The first Review CPCC should take place within 3 months of the Initial CPCC. Thereafter, Review CPCCs should take place within a 6 month period, or earlier, if circumstances change. A Review CPCC should also take place 12 weeks after any de-registration to ensure progress has been maintained.**

**Transfer Child Protection Case Conference**

The purpose of a *Transfer CPCC* is to specifically cover the transfer of information about a child or young person where a *Child’s Plan* currently in place.

**Permanent Moves**

Where a child or young person and their family move *permanently* from one local authority area to another local authority area, the originating local authority area will notify the receiving local authority area immediately, then follow up that notification in writing.

Where the child or young person moves permanently to another local authority area, the originating local authority area needs to assess this change in circumstances. If there is felt to be a reduction in risk, the originating local authority area should arrange a *Review CPCC* to consider the need for ongoing registration, or, if appropriate, de-registration.

In such circumstances it would be best practice for an appropriate member of staff from the receiving local authority area to attend the *Review CPCC*. Where the originating local authority area considers that the risk is ongoing or even increased by the move, the receiving local authority area is responsible for convening the *Transfer CPCC*.

Where a child or young person and their family move permanently from one local authority area to another local authority area then:

- if the child or young person has a *Child’s Plan*, the case records and / or file needs to go with the child or young person; or

- if the child or young person is subject to a Supervision Requirement, the case records and / or file needs to go with the child or young person.

Where a child or young person was on the CPR previously in another local authority area, the receiving local authority area should request the child or young person’s file from the originating local authority area (if still available).

Best practice would be for the originating local authority area to copy, in full, the child or young person’s case file notes, retain the original case file notes and send the copied case file notes to the receiving local authority area.
At the *Transfer CPCC*, the minimum requirement for attendance will be the originating local authority area’s allocated social worker and the receiving local authority area’s social worker, plus the appropriate managers as well as representatives from appropriate services and agencies including health and education.

**Temporary Moves**

Where a child or young person and their family move *temporarily* from one local authority area to another local authority area, the originating local authority area will notify the receiving local authority area immediately, then follow up the notification in writing. Where the move is temporary the receiving local authority area should immediately place the child or young person’s name temporarily on the receiving local authority area CPR. Where possible, the originating local authority area should advise how long the child or young person is expected to stay in the receiving local authority area.

Both the originating and the receiving local authority areas should make each other aware if and when the temporary registration is no longer required and why this is the case, for example, because the child or young person has returned to their home address in the originating local authority area.

If a child or young person is temporarily residing in another local authority area, arrangements must be agreed for the monitoring / supervision of the child or young person while they are in that local authority area and for the implementation of the *Child’s Plan*.

Assigning responsibility for monitoring is likely to depend on a number of practical considerations, for example, distance. Consultation between the two local authority areas is essential. Where agreement cannot be reached about monitoring arrangements, the matter must be immediately passed to Senior Managers in both local authority areas for resolution. *Whatever the difficulties and however these are resolved, the protection of the child or young person is paramount and adequate monitoring arrangements must be in place.*

**Definitions**

**Originating Authority:** This is the local authority area where the child or young person was initially placed on the CPR.

**Receiving Authority:** This is the local authority area into which the child or young person has moved to, whilst placed on the CPR.

*Timescales – Where there is confirmation that a child or young person, who is on the Child Protection Register in another local authority area, is now resident in the Perth & Kinross local authority area, with an intention to remain in the Perth and Kinross local authority area, then a Transfer CPCC should take place within 21 working days (of that confirmation).*
Chairing of CPCCs

Within Perth and Kinross, all CPCCs are chaired by a Senior Officer from Services for Children, Young People and Families - normally an Improvement Officer. The role of the Chair of a CPCC is critical. Their role is to (this is not considered to be an exhaustive list):

- agree who to invite and who should be excluded from the CPCC, in discussion with the Named Person, Lead Professional and any other relevant practitioner, service or agency;
- ensure that all persons invited to the CPCC understand its purpose, function and the relevance of their particular contribution;
- read over in advance, all the written reports and/or assessments provided by individual practitioners, services or agencies, prior to the CPCC taking place;
- confirm that the Social Worker / Social Care Officer has prepared the child, young person and their parents, carers or any other person with parental responsibilities, or their representatives in advance of the CPCC meeting taking place;
- meet with the child or young person and their parents, carers or any other person with parental responsibilities, or their representatives shortly before the CPCC meeting takes place (minimum of 10 minutes before), to explain to them, the purpose of the meeting, who will be attending the meeting, how the meeting will be conducted, what the possible outcomes of the meeting will be and to answer any questions about the CPCC beforehand;
- ensure the CPCC is quorate in terms of practitioner, service and agency representation;
- outline the background and reasons for the CPCC, facilitate introductions, note any apologies and/or absences and facilitate discussions which should be recorded by a Statutory Conference Recorder (Minute Taker);
- suggest an agreed time limit for the CPCC to be held and concluded by;
- facilitate information sharing, exchange and analysis at the CPCC, making sure that each practitioner, service or agency and the child or young person and their parents, carers or any other person with parental responsibilities or their representatives have an opportunity to participate and contribute to the CPCC in a meaningful and constructive way;
- identify the risks, needs and protective factors - ensuring these are evidence-based;
- ensure that the child or young person and their parents, carers or any other person with parental responsibilities clearly understand what is being discussed;
- ensure that the child or young person and their parents, carers or any other person with parental responsibilities or their representative's views are taken into account and recorded;
- summarise clearly the discussions, highlighting any key issues;
- facilitate joint / shared decision-making;
- determine the final decision in cases where there is disagreement and attempt to resolve
that by further discussion at the CPCC;

- where a child or young person’s name is placed (registered) on the CPR, confirm the reasons why and identify the risks and vulnerability factors;
- where a child or young person’s name is not to be placed on the CPR, or is to be removed (de-registered) from the CPR, confirm the reasons why;
- where a child or young person’s name is placed on the CPR, outline the decisions that will help shape the Child’s Plan, which will be developed at the first Core Group meeting;
- ensure that immediate actions to protect the child or young person are identified and fully understood;
- identify the Lead Professional (if not already appointed);
- facilitate the identification of a Core Group of staff responsible for implementing, monitoring and reviewing the Child’s Plan;
- advise parents, carers or any other person with parental responsibilities or their representatives about the local dispute resolution processes;
- advise parents, carers or any other person with parental responsibilities or their representatives about the local complaints procedures;
- agree the review dates;
- wherever possible, chair the Review CPCC to maintain a level of consistency;
- challenge any subsequent delays in action being taken by practitioners, service or agencies;
- ensure that Timescales are adhered to, including those relating to review dates, distribution of minutes and copies of the Child’s Plan and changes to the Child’s Plan;
- ensure the minutes are accurate, published timely and circulated (confidentially) to the CPCC participants as soon as possible and in any case within the agreed timescales;
- ensure that any practitioner forming part of the Core Group, who was not present at the CPCC, is informed immediately about the outcome of the CPCC, the decisions made and that a copy of the Child’s Plan is sent to them as soon as possible and in any case within the agreed Timescales; and
- at Review CPCCs ensure full information has been provided by the Core Group to facilitate discussion and decision making.

Of particular importance is the following.

At the conclusion of all CPCCs, and on the same day of the CPCC, the Chairperson will assume personal responsibility for communicating the following key points (in writing by email) to all attendees of the CPCC as well as to those invitees who did not attend the CPCC:

1. the decision of the CPCC in relation CPR registration;
2. the reasons for that decision (and where registered, a concise summary of the risks);
3. a clear list of actions that need to be carried out, by whom and by when, in order to protect the child or young person (this is not a child's plan);  
4. set the timescale for the first Core Group meeting.

This will ensure that there is a shared understanding and clarity about decisions and what actions should be carried out at the end of every CPCC in advance of the Minutes being published. It will also allow the Core Group members to build these actions into a more comprehensive Child's Plan when they first meet.

Minute Taking at CPCCs

Written Minutes are an integral and essential part of all CPCCs and should be noted by a suitably trained Statutory Conference Recorder (Minute Taker) who should perform no other role at the CPCC.

Written Minutes should be initially agreed by the Chair of the CPCC as accurate, before being circulated to all the participants for checking and / or accuracy. Written Minutes should be marked ‘Confidential’ and ‘For the Attention Of’ prior to publication and circulation. Copies should be placed in the child or young person’s service or agency case file notes and where relevant, stored electronically on their respective service or agency electronic files.

Written Minutes should also be provided to the child or young person and their parents, carers or any other person with parental responsibilities or their representatives who attended the CPCC. Where a child or young person and their parents, carers or any other person with parental responsibilities or their representatives did not attend, or could not attend, or only attended part of a CPCC, then they should not receive a copy of the Written Minutes. In these circumstances, the Lead Professional, invariably, but not always, the Social Worker / Social Care Officer should convey the outcome of the CPCC to them verbally and ensure they fully understand.

Any participant at a CPCC, who is of the opinion the Written Minutes are inaccurate, or an incomplete record, or who are uncertain as to their meaning, should send their comments to the Chair of the CPCC as soon as possible, highlighting the issue clearly. Any agreed changes should be recorded by the Chair of the CPCC as an Addendum to the Written Minutes. The Chair of the CPCC will then sign off the Final Written Minute.

Written Minutes should, as a minimum, record the following (this is not considered to be an exhaustive list):

- time, date and place where the CPCC took place;
- who chaired the CPCC;
- those invited to attend, those who attended, those who were absent and those who were excluded;
- whether the child or young person and their parents, carers or any other person with parental responsibilities or their representatives were invited to attend, attended and / or
were absent (where appropriate);

- reasons why the child or young person and their parents, carers or any other person with parental responsibilities or their representatives were not invited to attend (where appropriate);
- written reports and assessments requested and actually received;
- a concise but accurate summary of the information shared, exchanged and discussed at the CPCC;
- the risks, needs, vulnerability and protective factors identified at the CPCC;
- the views of the child or young person and the views of their parents, carers or any other person with parental responsibilities or their representatives;
- the decisions, reasons for the decisions and a note of any disagreement and / or dissent;
- any recommendations made at the CPCC;
- any decision to place (register), not to place or to remove (de- register) the child or young person on / from the CPR;
- the outline of the Child Protection Plan agreed at the meeting, detailing the required outcomes, timescales and contingency plans (SMART);
- the name of the Named Person and the Lead Professional;
- initial membership of the Core Group; and
- suggested date and / or timescales for the Review CPCC to take place.

**Timescales – Participants should receive the CPCC Minutes within 15 calendar days of the CPCC meeting.**

To avoid any unnecessary delay in actions and tasks identified, at the conclusion of all CPCCs, and on the same day of the CPCC, the Chairperson will assume personal responsibility for communicating the following key points (in writing, by email) to all attendees of the CPCC as well as to those invitees who did not attend the CPCC:

1. **the decision of the CPCC in relation CPR registration;**
2. **the reasons for that decision (and where registered, a concise summary of the risks);** and
3. **a clear list of actions that need to be carried out, by whom and by when, in order to protect the child or young person (this is not a child’s plan).**

This will ensure that there is a shared understanding and clarity about decisions and what actions should be carried out at the end of every CPCC in advance of the Minutes being published. It will also allow the Core Group members to build these actions into a more comprehensive Child’s Plan when they first meet.

**Quorum**

It is important when practitioners, services or agencies are invited to attend a CPCC that every effort is made to attend. If a practitioner, service or agency is unable to do so, they may wish to consider sending a deputy, suitably briefed and authorised to represent them and / or their
service or agency. All CPCCs must remain quorate at all times.

As a minimum, at least three individual services, agencies and / or professional groupings should be present, before a CPCC can proceed. However, situations may arise whereby only two services, agencies and / or professional groupings are present. In these circumstances, the Chair of the CPCC has the discretion to decide whether or not the CPCC should go ahead. It should only go ahead if he or she is satisfied that all the essential information is available, particularly from the key practitioners, services and agencies involved.

**There should never be a single agency CPCC. A CPCC should never proceed if there are only representatives from one service or agency present.**

**Participants at Child Protection Case Conferences (CPCCs)**

The number of people participating in a CPCC should be limited to those with a need-to-know, or those who have a relevant contribution to make. This may include a support person or advocate for the child, young person and their parents, carers or other with parental responsibilities. It may also include the provision of Independent Advocacy.

**Timescales – Participants should be given a minimum of 7 calendar days notice of the decision to convene a Child Protection Case Conference.**

**Service / Agency Representatives at CPCCs**

CPCC participants should include (this is not considered to be an exhaustive list):

- the practitioner, service or agency who raised the concern (always present);
- local authority Social Worker(s) and / or Social Care Officers including the Lead Professional (if already appointed);
- education staff (including the Named Person) where any of the children or young people in the family are of school age and / or attending pre-five establishments;
- NHS staff (including the Named Person), including Health Visitor / Family Nurse / School Nurse / GP as appropriate, depending on the child or young person’s age and the child’s Paediatrician where applicable; and
- police where there has been involvement with the child or young person and / or their parents, carers or any other person with parental responsibilities or their representatives.

Other participants might include other health practitioners (including mental health services, speech and language etc), adult services, housing staff, addiction services, educational psychologists, local authority legal representatives, relevant third sector organisations, representatives of the Procurator Fiscal and armed services staff, where children of service personnel are involved.

There may be occasions when it is appropriate to invite foster carers, kinship carers, home carers, childminders, volunteers or others working with the child, young person or family to the
CPCC. The practitioner most closely involved with the person to be invited should brief him or her carefully beforehand. This should include providing information about the purpose of the CPCC and their contribution, the need to keep information shared confidential and advice about the primacy of the child or young person’s interests over that of the parents, carers or any other person with parental responsibilities or their representatives where these conflict.

On some very rare occasions, a Children’s 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. On some occasions, the family may request that their legal representative / solicitor should be invited. However, given that CPCCs have no current legal status in Scottish Law; legal representatives / solicitors can attend, but can only act as a supporter to the child or young person and their parents, carers or any other person with parental responsibilities or their representatives.

**Parents and Carers at CPCCs**

Parents, carers or other with parental responsibilities should, where appropriate, be invited to attend CPCCs. It is important to make the distinction between attendance and participation. It they are to attend, then they must be properly prepared, briefed and supported beforehand and empowered to participate at the CPCC. In the majority, if not all of the cases, this will be the role undertaken by the Social Worker and / or Social Care Officer prior to the CPCC taking place. They need to be provided with clear information about the concerns practitioners, services or agencies have about their child, if they are to change the behaviours which puts the child or young person at risk.

The Chair should encourage the parents, carers or any other person with parental responsibilities or their representatives to express their views, while bearing in mind that they may have negative feelings regarding the intervention in their family.

The Chair should make certain that parents, carers or any other person with parental responsibilities or their representatives are informed in advance about how the information and discussion will be presented and managed.

Parents, carers or any other person with parental responsibilities or their representatives may need to bring someone to support them when they attend a CPCC. This may be a friend or another family member, at the discretion of the Chair. This may also be an Advocacy Worker. This could also be a legal representative / solicitor. However, these persons are there solely to support the parents, carers or any other person with parental responsibilities or their representatives only and have no other role within the CPCC meeting.

**Children and Young People at CPCCs**

Consideration should be always given to inviting children and young people to CPCCs.

CPCCs can be uncomfortable for children and young people to attend and the child or young person’s age and the emotional impact of attending a CPCC must be considered beforehand. A decision not to invite the child or young person to a CPCC should be verbally communicated to them, unless there are reasons for not doing so.
Children and young people attending CPCCs should be prepared beforehand, so that they can participate in a meaningful way and thought should be given to making the CPCC meeting as child and family friendly as possible. In the majority, if not all of the cases, this will be the role undertaken by the Social Worker / Social Care Officer.

Prior to a CPCC taking place, the Chair should also meet with the child or young person to explain the process and answer any questions he / she may have.

Consideration should also be given to the use of an Advocate for the child or young person. It is crucial that the child or young person’s views are obtained, presented, considered and recorded during the CPCC, regardless of whether or not they are present.

Where the child or young person has additional support needs and / or is disabled, consideration should be given to whether they will need support to express their views.

Where English is not their first language, the use of an Interpreter should also be considered. Reasons for agreeing that older children and young people should or should not attend a CPCC meeting should be noted, along with details of the factors that led to the decision.

These should be recorded in the CPCC Minutes.

Where appropriate and agreed, the child or young person should be part of the Core Group.

**Non Invitations to CPCCs**

In exceptional circumstances, the Chair of a CPCC may determine that a parent, carer or any other person with parental responsibilities or their representatives should not be invited to attend a CPCC (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 CPCC and the Chair should identify who will notify them of the outcome and the timescale for carrying this out. This should be recorded in the CPCC Minutes.

**Exclusions at CPCCs**

A decision to exclude someone from all, or part of a CPCC, rests with the Chair of the CPCC. The reasons for deciding to exclude someone from all or part of a CPCC can include the following (this is not considered to be an exhaustive list):

- there is strong risk of violence or intimidation at, or following, the CPCC;
- the Police or the Procurator Fiscal (if criminal proceedings have begun) are concerned by an alleged perpetrator’s attendance;
- confidential information regarding another person needs to be discussed;
- the police need to provide information which is sub-judice;
- there are serious concerns about the wellbeing of the family member should they
attend;

- someone is clearly under the influence of drugs or alcohol to the extent that their participation in the CPCC would be disruptive;
- a parent, carer, or any other person with parental responsibilities or their representatives have a bail / legal restriction order in place; and
- it is not in the child or young person's best interest for another person to attend, i.e. they are the alleged perpetrator.

In every instance, where someone has been excluded, the Chair of the CPCC should record their reasons in the minutes and the exclusion should only be for as long as is necessary.

Any practitioner can request the exclusion of an individual from the CPCC. Such a request must be made directly to the Chair of the CPCC. The Chair should discuss the request with the relevant practitioner and if necessary with his / her Supervisor / Line Manager, before coming to a decision about whether to exclude.

Where a parent, carer or any other person with parental responsibilities or their representatives has been excluded from the Initial CPCC, the Chair must make arrangements to meet with them to ensure that the decisions of the CPCC are fed back to them, preferably within 24 hours of the decisions being made.

**Practitioners at CPCCs**

The following bullet points provide a useful checklist for all practitioners invited to attend at and to participate in a CPCC (this is not considered to be an exhaustive list).

Practitioners must understand the purpose and function of all types of CPCCs;

- understand why they have been invited to attend and to participate;
- confirm they will be attending or not attending the CPCC;
- make every effort to attend or send a suitably briefed deputy on their behalf, authorised to represent them, their service or agency;
- understand what is expected of them before, during and after a CPCC;
- gather all relevant information pertaining to the child and their family from their own service or agency cases files and databases;
- prepare and submit their written report or assessment, prior to the CPCC taking place and / or if requested contribute to a written report or assessment;
- ensure that their written report or assessment is shared with the child, young person and their family prior to the CPCC taking and ensure that they understand the contents of the written report or assessment and that their views are reflected in any written reports or assessment;
- ensure that the child, young person and family are supported to complete the relevant forms, i.e. What do You Think Forms etc, thus enabling them to give their views;
• ensure / provide the child, young person and their family with the following information and advice leaflets in advance of the CPCC:
  • a guide to Child Protection Case Conferences – Information and Advice for Children and Young People;
  • a guide to Child Protection Case Conferences – Information and Advice for Parents and Carers;
  • a guide to Information Sharing, Confidentiality and Consent – Information and Advice for Children and Young People;
  • a guide to Information Sharing, Confidentiality and Consent – Information and Advice for Parents and Carers;

• consider if any individual should not be invited or be excluded from the CPCC and alert the Chair of the CPCC in advance;
• identify any information that should be classed as restricted access and alert the Chair of the CPCC in advance;
• attend the CPCC timeously and be aware of the relevant Timescales;
• fully participate in the discussions and decision making at the CPCC;
• provide all relevant information to the CPCC;
• not be afraid to agree and / or disagree with the discussions and multi-agency decision making at the CPCC;
• ensure they contribute to the discussions around identifying risks, needs, vulnerability and protective factors;
• take part in the multi-agency decision to place, or not to place, or to retain or remove the child or young person’s name on / from the CPR;
• check the accuracy of the CPCC Minute, highlighting any amendments and changes;
• where appropriate, take part in developing the immediate Child Protection Plan;
• where appropriate, participate in the Core Group Meetings and the implementation and monitoring of the Child’s Plan; and
• act if they are not satisfied with the multi-agency decision making process at the CPCC, make their position known, advise the other participants and the Chair and in the first instance alert their Supervisor / Line Manager.

Provision of Written Reports at CPCCs

All practitioners, services and agencies invited to attend a CPCC will also be invited to prepare and submit relevant written reports, relating to their service or agency’s involvement with the child, young person and family. Some may also be asked to produce an assessment report and / or to contribute to an assessment report.
These written reports should also include information pertaining to significant adults in the child or young person’s life, provide a clear overview of the risks, needs, vulnerabilities, protective
factors, the views of the child or young person and that of their parents, carers or any other person with parental responsibilities views or their representatives. The view of any other siblings, children and young people in the household or extended family should also be considered. These reports should also include a chronology of significant events.

Invitees have a responsibility to share the content of their written report and assessments with the child or young person and their family in an accessible, comprehensible way and should do so prior to any CPCC taking place. This is particularly important prior to an Initial CPCC taking place.

Consideration needs to be given as to the most appropriate means of sharing reports and assessments with the child, young person and their family and to when this should be done. It is important that they understand the contents, conclusions and recommendations of these reports and assessments.

Those practitioners, services and agencies who are not able to attend a CPCC, should also prepare and submit a written report and assessment prior to the CPCC or contribute to a composite report or assessment. Written reports or composite reports or assessments should be given to the Chair of the CPCC well in advance of the CPCC meeting taking place; as a minimum no later than 24 hours before the meeting takes place. A Lead Professional may collate these composite reports or assessments together.

Best practice would be for each practitioner to arrange to explain and discuss the contents of their written report and assessment with the child, young person and their family at least 24 hours before the CPCC takes place.

**Restricted Access Information**

Restricted access information is information that, by its nature, cannot be shared freely with the child or young person, their parents, carers or any other person with parental responsibilities, or their representatives.

Anyone involved in a CPCC can make a request to speak to the Chair of the CPCC, where they have sensitive information which they may wish to share with other practitioners, outwith the presence of the child or young person, their parents, carers or any other person with parental responsibilities, or their or their representatives. This restriction of information should only be used in exceptional circumstances.

Where possible and appropriate to do so, this information should be shared with relevant parties when received. The information should also be shared with the other participants at the CPCC. However, such information may not be shared with any other person without the explicit permission of the provider. Practitioners will be required to justify why information is being classed as Restricted Access Information.

Restricted information can include (this is not considered to be an exhaustive list):
• sub-judice information that forms part of legal proceedings and which could compromise those 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 at CPCCs**

All participants at a CPCC, whose service or agency have significant involvement with the child or young person and their family have a responsibility to contribute to the multi-agency decision as to whether or not to place the child or young person’s name on the CPR, whether to retain the child or young person’s name on the CPR or whether to remove the child or young person’s name from the CPR. This is a multi-agency and shared responsibility of all those participating in the CPCC.

Where there is no clear consensus in the multi-agency discussion and decision making process, the Chair of the CPCC will use his or her professional judgement to make the final decision, based on an analysis of the evidence and the issues raised.

In these circumstances, the decision making process needs to be subjected to independent scrutiny from a senior member of staff with no involvement with the child or young person, their family, in the case or the CPCC meeting. In practice this will be a Service Manager in Services for Children, Young People and Families.

**Dispute Resolution at CPCCs**

At present CPCCs are non-statutory meetings and have no legal status. Dispute resolution is a way of managing:

• challenges about the inter-agency child protection process;
• challenges about the multi-agency decision-making and outcomes;
• challenges by children, young people or their parent, carer or any other person with parental responsibilities or their representatives about the multi-agency CPCC meeting decisions; and
• complaints about practitioner behaviour.

Pending the completion of the dispute resolution process, all protective actions should continue.

Within Perth and Kinross, all services and agencies involved in child protection work have clear complaints procedures, which should be followed where there is a complaint about an individual practitioner.

Where a member of staff wishes to raise an issue about the CPCC process or disagrees with the multi-agency decision making at the CPCC meeting, they should go through their normal
service or agency Line Management / Supervision arrangements.

If the complaint is about a specific practitioner, or their service or agency, then they should follow that service or agency’s complaints procedures, details of which will be given to them and explained.

Any child, young person, parent, carer or any other person with parental responsibilities or their representatives, who are subject of a CPCC, may request the Head of Services for Children, Young People and Families to review the multi-agency decision making process of the CPCC, where they do not accept or agree with that multi-agency decision.

Any child, young person, parent, carer or any other person with parental responsibilities or their representatives, wishing such a review should write to Head of Services for Children, Young People and Families within 14 days of the CPCC taking place and will be given support in doing so. In these circumstances it will be the Lead Professional, who will direct them to the appropriate support services.

The Head of Services for Children, Young People and Families will only review the multi-agency decision of CPCC where one or more of the following criteria apply:

- relevant information was not available to the original CPCC;
- there are reasonable grounds to suggest that inaccurate or insufficient information was presented to the CPCC; and
- there are reasonable grounds to suggest that the multi-agency decision reached by CPCC was unreasonable in light of the evidence provided to the CPCC.

A Review Panel Meeting will take place if a child, young person, parent, carer or any other person with parental responsibilities or their representatives does not accept the outcome of the review and it appears to the Head of Services for Children, Young People and Families that either:

- inaccurate or misleading information was provided to CPCC which impacted significantly upon its multi-agency decision making processes; and
- there are clear grounds for believing that the multi-agency decision making processes were not warranted by the information presented to it.

It is suggested that the Review Panel may comprise:

- the Head of Services for Children, Young People and Families;
- an experienced Paediatrician in Child Protection;
- an experienced Senior Police representative in Child Protection;
- the Child Protection Inter-Agency Coordinator; and
- the chair of the Voluntary Sector Child Protection Forum, Perth and Kinross.
Decision by Head of Services for Children, Young People and Families

The decision by the Head of Services for Children, Young People and Families, and the findings from the Review Panel will be considered final and will be reported to the Perth and Kinross Chief Social Work Officer (CSWO).

Should the child, young person, parent, carer or any other person with parental responsibilities or their representatives still not accept the outcome of this review process, it will be open to them to pursue the formal statutory complaints procedure (social work complaints procedure).

Child Protection Register (CPR)

All local authorities, including Perth and Kinross, are responsible for maintaining a central register of all children and young people – including unborn babies – who are the subject of a Child’s Plan. This is called the Child Protection Register (CPR).

At present, the CPR has no legal status, but provides an administrative system for alerting practitioners that there is sufficient professional concern about a child or young person to warrant a Child’s Plan.

Local authority social work services are responsible for maintaining the CPR of all children and young people in their area who are subject to a Child’s Plan, though the decision to put a child or young person on the CPR will be based on a multi-agency assessment. The CPR provides a central resource for practitioners concerned about a child or young person’s safety or care.

Within Perth and Kinross, Services for Children, Young People and Families maintain the CPR on behalf of all services and agencies.

Placing a Child on the Child Protection Register (CPR)

The decision to place a child or young person’s name on the CPR should be taken following a CPCC, where there are reasonable grounds to believe, or suspect, that a child or young person has suffered or will suffer significant harm from abuse or neglect, and that a Child’s Plan is needed to protect and support that child or young person. This is always a multi-agency decision.

The local authority should inform the child or young person's parent, carer or any other person with parental responsibilities or their representatives about the information held on the CPR and who has access to it. Where the child or young person has sufficient age and understanding, the child or young person should similarly be informed.

When a child or young person’s name is placed on the CPR, they are registered against one or more of the following areas of concern:

- domestic abuse;
- parental alcohol misuse;
- parental drug misuse;
- non-engaging family;
- parental mental ill-health problems;
- children placing themselves at risk;
- sexual abuse;
- child sexual exploitation;
- physical abuse;
- emotional abuse;
- neglect;
- forced or dangerous labour; and
- other concern(s).

Removing a Child from the Child Protection Register (CPR)

If and when the practitioners who are working with the child or young person and family decide that the risk of significant harm to the child or young person has been sufficiently reduced and the child or young person is no longer in need of a Child’s Plan, the local authority should remove the child from the CPR.

The decision to remove a child or young person’s name from the CPR will be made by a Review CPCC, at which all the relevant practitioners, services and agencies are represented, as well as the child, young person and their family. When a child or young person’s name is removed from the CPR, the child or young person and their family must be informed. This is always a multi-agency decision.

Removal of a child or young person’s name from the CPR should not necessarily lead to a reduction or withdrawal of services or support to the child or young person and family by any or all of the services or agencies. The risk of significant harm to the child or young person may have receded, but the child or young person may continue to require a range of support; this will form part of the single planning process for the child or young person.

At the point of de-registration, consideration should be given to whether a different Lead Professional should be appointed and if so, arrangements made for the transfer to be agreed.

Making Use of the Child Protection Register (CPR)

Within Perth and Kinross, the Keeper of the Child Protection Register is the Team Leader, Perth and Kinross Child Protection and Duty Team.
Contact Number – 01738 476768 (24 hours).

The CPR is held separately from service or agency records or case files and is secure. There is 24-hour access to the CPR for all practitioners, services / agencies who need to make an enquiry about a child or young person.
Core Groups

The purpose of a Core Group is for a small group of identified individuals, including the Named Person, Lead Professional, the child or young person, their parents, carers or any other person with parental responsibilities or their representatives, who have a crucial role to play to implement, monitor and review the Child’s Plan.

The Core Group is responsible for ensuring that the Child’s Plan remains focused on achieving better outcomes for the child or young person by reducing the known risks.

The functions of a Core Group include (this is not considered to be an exhaustive list):

- ensuring the ongoing assessment of the needs of, and risks to a child or young person who has a Child’s Plan;
- implementing, monitoring and reviewing the Child’s Plan so that the focus remains on improving outcomes for the child or young person. This will include evaluating the impact of work done and / or changes within the family in order to decide whether the risks have increased or decreased;
- maintaining effective communication between all practitioners, services, agencies involved with the child or young person and their parents, carers or any other person with parental responsibilities or their representatives;
- activating contingency plans promptly when progress is not made or circumstances deteriorate;
- discussing re-registration and / or de-registration prior to a Review CPCC taking place;
- reporting to the Review CPCC on progress; and
- referring any significant changes in the Child’s Plan, including non-engagement of the family to the CPCC Chair.

Where appropriate and agreed, the child or young person should be part of the Core Group. Consideration of the involvement of the child or young person should take cognisance of their age, capacity and the emotional impact of attending a meeting to discuss the risks they have been placed at. Children and young people attending must be prepared beforehand to allow them to participate in a meaningful way. It is crucial that their views are obtained, presented and considered during the meeting.

The Core Group should provide a less formal way for children, young people and their parents, carers or any other person with parental responsibilities or their representatives to interact with practitioners, service and agency providers. Where they are unable or unwilling to attend the meetings, their views should be sought and represented within the meeting, either in written form or through their views being presented verbally. These views should be recorded within the minutes of the Core Group meeting.

Members of the Core Group should be kept to a minimum, without compromising the planning or protective process. Too many practitioners in the Core Group can limit child and family
attendance and contribution. Only relevant people should be invited.

In addition, during the work period of the Core Group, the child or young person will be physically seen by practitioners on a frequent / regular basis and as a minimum at least once per fortnight.

Timescales – The Initial Core Group meeting should be held within 10 working days of the Initial CPCC; meetings thereafter should take place every four weeks or more frequently where deemed necessary. Where a Core Group identifies a need to make significant changes to the Child’s Plan, they should notify the CPCC Chair within 3 calendar days. A decision to postpone a Core Group meeting may be taken, but the meeting should be convened within two weeks.

Child’s Plan

Tayside Child’s Plan Template

The Tayside Child’s Plan Template has been adopted as the single planning framework for all children and young people who need coordinated support and is for use by all staff working in Perth and Kinross. Staff in education, health, social work, third sector and the independent sector use the Tayside Child’s Plan Template to coordinate the actions required to meet the individual needs of children and young people.

The Tayside Child’s Plan Template is for children under 12 years and for young people over 12 years. This format is also to be used as the Child Protection Plan for all children and young people who are at risk of harm, abuse and exploitation and whose names have been placed on the Child Protection Register (CPR). All children and young people whose names are included on the CPR will have a Child Protection Plan.

What’s in a Child’s Plan?

Every Child’s Plan should include and record:

- information about the child’s wellbeing needs including the views of the child and their parent(s);
- details of the action to be taken;
- the service(s) that will provide the support;
- the way in which the support is to be provided;
- the outcome that the Child’s Plan aims to achieve;
- information about why the Child’s Plan has been created, what it is aiming to achieve, and the actions to be taken to improve the child’s safety and other aspects of their wellbeing; and
- when the Child’s Plan should be reviewed.

Note: Across Tayside and within Perth and Kinross the Tayside Child’s Plan Template is used as the Child’s Plan for all children and young people. It also acts as the Child Protection Plan. Throughout these guidelines the term Child’s Plan is used consistently and links to the Scottish Government’s GIRFEC webpages for Child Plans where more detailed national generic guidance can be found.
Plan Partners and the Lead Professional for children whose names are included on the CPR?

A Child’s Plan will also record who will coordinate the support. This person is known as the Lead Professional for the Child’s Plan who will coordinate the work of all of the Plan Partners and work with the child, young person and their parent (s) to keep them informed. The Plan also sets out who are the Plan Partners and their role in delivering the actions set out within it. For children and young people whose names are included on the CPR, the Lead Professional will always be a Social Worker working in Services for Children, Young People and Families and the Named Person will always be a named Plan Partner.

Reviewing the Child’s Plan

For children and young people whose names are included on the CPR, the Child’s Plan (Child Protection Plan) will be reviewed monthly by Plan Partners at meetings of the Core Group. Progress will be overseen at agreed intervals by the Review Child Protection Case Conference.
Part IV
Child Protection in Specific Circumstances
In this part of the guidelines, practitioners will find additional information and advice on dealing with a range of specific circumstances, which may impact adversely on a child or young person, albeit these are not necessarily stand alone and / or mutually exclusive issues from each other. Whilst individually and / or collectively they may impact on a child or young person, their mere presence alone should not necessarily lead to any immediate child protection assumptions being made.

The National Guidance for Child Protection in Scotland 2014 provides further information and advice on an even wider range of complex child protection issues which practitioners may also find helpful.

**Child Protection**

*If you are worried or concerned about the welfare or protection of a child or young person, you should, in the first instance, share that worry or concern with your Line Manager / Supervisor / Designated Child Protection Officer. Thereafter, child protection procedures should be followed without any unnecessary delay.*

*You should contact the Perth and Kinross Child Protection and Duty Team or Police Scotland:*

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<tr>
<td>Perth and Kinross Child Protection and Duty Team - (24 hours)</td>
<td>01738 476768</td>
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<tr>
<td>Police Scotland Non - Emergency Number</td>
<td>101</td>
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<td>In an Emergency</td>
<td>Call 999</td>
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*Perth and Kinross Information and Advice Leaflet: Child Protection and Duty Team*

**Whistleblowing and Child Protection**

Within Perth and Kinross single services / agencies should have in place their own complaints, grievance and / or escalation procedures.

All staff must ensure they are familiar with them and know how to access them at all times.

In terms of *child welfare and child protection* all staff are encouraged to report any worry or concern that have a about a child or young person's wellbeing. This includes their care and protection.

Staff are encouraged to escalate any worry or concern they have in relation to single service and / or multi-agency service provision; delivery and / or decision making (or lack of it) to their Line Manager / Supervisor. Staff can also escalate their worry or concern to their Head of Service. Staff Associations and Representative Bodies are also in a position to help if necessary.
Message from Scottish Government Minister for Children and Early Years 18 December 2008:

"In the wake of the Baby P case in Haringey, there has been increased public scrutiny of child protection services, and it is vital that we do all that we can to prevent a similar tragedy occurring in Scotland.

I would therefore like to take this opportunity to highlight the whistle-blowing and internal complaints procedures which I know that every Council, Police Force and NHS Board has in place. Every child protection practitioner should be aware of what they can do, and should do, to report any concerns they may have that cases are being mismanaged, or that capacity problems are preventing them from giving at-risk children the support that they need. They should also be confident that any such concerns will be taken seriously and acted on appropriately.

I am asking that you bring the policies you have to the attention of your area's relevant workforce, and remind them of their responsibilities in this area. It can be difficult to speak out about these kinds of problems, but we must encourage a culture of openness and transparency, where the priority is on improving services to vulnerable children by naming and addressing problems, rather than apportioning blame.

I place great value on the work of Child Protection Committees in co-ordinating multi-agency child protection service priorities, and I enjoyed meeting with you last week. I know that Scotland's front-line practitioners are doing a difficult job very well, and I hope that you will help empower them to report any concerns that they have, to help us protect Scotland's children”.

Unseen and / or Hidden Children

All practitioners and managers across the public, private and third sector within Perth and Kinross, must be aware that children and young people can become unseen and / or hidden from services and agencies.

Most children and young people are registered with universal services – health and education and are easy to reach, to engage with and to see. However, some children and young people, who have never been registered with universal services; or who move into the area from another area and do not register with universal services, are more difficult to reach, to engage with and to see.

Children and young people living at home, or in households where there is a professional and / or service or agency involvement, are normally seen on a weekly and / or frequent basis. Children and young people known to universal services – health and education, are seen regularly as they continue to grow and develop. If they are in local authority schooling, they will be seen on a daily basis and robust absence management procedures are in place to follow-up on any unexplained absences.

Describing all the circumstances where a child or young person could become unseen and / or hidden is complex and there are many reasons why this could happen. Children and young people can become unseen and / or hidden for many reasons, including:
run away from home and gone missing;
forgotten or missed key appointments;
unsuccessful pre-planned and / or unplanned visits;
exclusion from school;
being withdrawn from school;
unregistered with Education and Health (including a GP);
absent through truancy; and
ill and / or unwell – the reasons are many.

It is important that all practitioners and managers have an understanding of these issues and know what to do, if and when, they are worried or concerned that a child or young person has become unseen and / or hidden to them or to their service or agency. This responsibility applies equally to all practitioners and managers working in children’s services and in adult services, who may be working with the parents or carers.

If they form a view that a child or young person is becoming unseen and / or hidden, accidentally, deliberately or otherwise; they must take action to ensure that child or young person is seen. There may be a perfectly reasonable explanation for this, but these must be explored with the parents or carers and with Line Managers / Supervisors.

It may be that such a worry or concern is identified over a period of time because of a number of failed visits and / or appointments. It may be that the family have moved away. It may be that the child or young person is simply not being seen on visits. It may be that access to the home is being prevented. It may also be that the parents or carers themselves are starting to become more hostile and / or non-engaging.

It is generally accepted that children and young people, who are unseen and / or hidden, may be at a greater risk of harm and abuse. Irrespective, it is important that the child or young person is seen to be safe and well. Their care and welfare remains paramount.

If any practitioner or manager is worried or concerned that a child or young person has or is becoming unseen and / or hidden they must take action immediately.

Make every effort to see the child or young person is safe and well.

Inform your Line Manager / Supervisor immediately.
Hostile / Non-Engaging (Including Disguised Compliance) Parents and Carers


Perth and Kinross Child Protection Committee has produced the above Practitioner's Guide to assist all practitioners and managers working with hostile and / or non-engaging parents and carers, especially when there are child protection concerns.

This guidance is for all practitioners and managers working with children and families across the public, private and third sectors in Perth and Kinross. It aims to support, protect and empower all staff. This guidance may also be particularly helpful to managers who manage and / or supervise practitioners who may, as part of their work, encounter hostile and / or non-engaging behaviours from time to time. This guidance should assist staff to identify how these behaviours can impact on their own welfare and on their ability to undertake required tasks. This includes a number of Practice Notes and Appendices / Checklists which practitioners and managers may find helpful.

Given the number of unknown variables (types of concern, levels of risk, previous behaviours, timescales etc) it is not possible, within the confines of this guidance to identify and / or predict every type of situation which many arise. Nevertheless, there will always be a need for professional judgment and common sense to be exercised by the case worker and / or Line Manager / Supervisor.

Definition of Hostile

This involves any behaviour which has a damaging effect, physically and / or emotionally on a third party. This could include a range of behaviours such as actual physical violence, being verbally abusive and / or emotionally abusive. It could also include behaviour which is confrontational, hostile, threatening and / or intimidatory. Intimidation can also extend to making inappropriate use of the complaints system against staff members. The impact of such behaviours on individual staff will vary, but the fear of violence and / or aggression is widely recognised as impacting on judgments, interpretation and intervention.

Definition of Non-Engaging

This involves any behaviour which proactively sabotages efforts put in place by practitioners to effect change. This could include a range of ambivalent behaviours aimed at undermining processes, such as being deliberately non-compliant and / or evasive, paying lip service to agreements, failing to keep agreed appointments, being late for appointments and / or frequently changing appointments, cutting visits short, refusing to allow access to the child and / or the home, putting little effort into making the changes work or simply being passive to the involvement of practitioners.
Recognition, Response and Impact

All practitioners and managers should be alert to a parent or carer who is, or is becoming, hostile and / or non-engaging. They should also know how to respond effectively.

Practitioners and managers must recognise that working with a parent or carer who is, or is becoming hostile and / or non-engaging is very challenging. In many cases practitioners will find this very difficult and intimidating. This will, without doubt, have an impact on the practitioners directly involved with the child, young person and family. In these circumstances, support from Line Managers / Supervisors is vitally important, as is robust supervision of staff.

Practitioners and managers must consider all the potential factors which may, or may not be having an impact on practitioners working with a parent or carer who is, or is becoming, hostile and / or non-engaging and help to clarify the source of the hostility.

Avoiding people who are hostile and / or non-engaging is a normal human response. In many cases practitioners will find these behaviours very difficult and / or intimidating. Whilst this is a perfectly natural feeling and reaction it can, in some circumstances, lead to potential drift in terms of service provision and support. It is important, therefore, that all practitioners can identify and be alert to these behaviours, share and exchange relevant information with others, and seek further support and guidance from their Line Manager / Supervisor.

Practitioners should also be aware of the impact hostile and / or non-engaging behaviour could have on them personally. Some practitioners are able to respond to hostile and / or non-engaging families in a positive way which indicates that they are untroubled by such conflict, whilst other practitioners simply cannot. It is important that practitioners understand that this is not unusual and they should not be embarrassed in any way by their reaction and / or response to hostile and / or non-engaging behaviours.

The impact on practitioners may be felt and expressed in a number of different ways which could include:

- surprise and / or embarrassment;
- numbness and / or denial;
- distress and / or fear;
- avoidance;
- self-doubt and / or guilt;
- shock and / or anger;
- loss of self-esteem and of personal and / or professional confidence;
- a sense of loss and / or helplessness;
- sleep and dream disturbance; and
- hyper vigilance.
In more serious cases practitioners may be impacted as follows:

- preoccupation with the event or related events;
- repetitive stressful thoughts, images and emotions;
- illness;
- post traumatic stress; and
- loss of objectivity in similar and / or future situations.

**Planning Work**

When planning necessary work with hostile and / or non-engaging parents or carers it is important that Line Managers / Supervisors acknowledge the impact, or likely impact, on practitioners of such work.

All practitioners have a responsibility to consider their own health and safety just as their Line Manager / Supervisor and their service and / or agency has a responsibility for ensuring the health and safety of all staff. It is essential that a plan is formulated between the Line Manager / Supervisor and the practitioner prior to working with parents or carers known to be, or likely to be, hostile and / or non-engaging.

Line Managers / Supervisors have many responsibilities, including briefing / debriefing and learning and development, for ensuring the health and safety of their staff and for their general day to day supervision and support. This includes monitoring, reviewing and supporting staff via supervision. By far the greatest responsibility is the requirement for supportive and robust supervision and clear planning around managing contact. All incidents of hostile and / or non-engagement must be recorded.

**keep alert to any behaviour considered to be hostile and / or non - engaging**

**be aware that hostile and / or non - engagement can lead to unnecessary drift**

**doing nothing is not an option**

**do not be afraid or embarrassed if you feel intimidated in any way – this is normal**

**seek and share information quickly and effectively;**

**seek support from your peers and your Line Manager / Supervisor;**

**always consider your own safety, the safety of others and the safety of the child or young person – that is paramount**

**always ensure that a plan is in place for working with hostile and / or non-engaging parents or carers**

**If any practitioner or manager is worried or concerned that a parent or carer is becoming hostile and non-engaging they must take action immediately.**

**Make every effort to see the child or young person is safe and well.**

**Inform your Line Manager / Supervisor immediately.**
Bullying

What is Bullying?

*Bullying a child or young person is child abuse.*

Bullying behaviour can include name-calling; teasing; putting down or threatening; ignoring; leaving out or spreading rumours; physical assault; stealing and damaging belongings; sending abusive text, email or instant messages; making people feel like they are being bullied or fearful of being bullied and targeting someone because of who they are or are perceived to be.

Bullying behaviour can leave people feeling helpless, frightened, anxious, depressed or humiliated and can have a devastating and lifelong impact. It can take place in schools; at home; in the community; at youth groups and out-of-school care. It can be perpetrated by both children and adults alike. It is also increasingly associated with the use of the internet and mobile phone technologies, especially via social networking sites. In essence, the behaviour is the same and requires similar prevention methods.

Bullying behaviour may be related to perceived or actual difference and involve the expression of prejudices regarding, for example, race, gender, disability and sexual orientation. It may be just one manifestation of the prejudice experienced by the child or young person, and / or may compound other difficulties in their life. With this in mind vulnerable children and young people may be at particular risk.

What is Online Bullying?

*Online bullying a child or young person is child abuse.*

Online bullying (or Cyber Bullying) is a relatively new type of bullying, one that harnesses the modern technologies all teenagers use: mobile phones; e-mail; social networking sites and web-based chat rooms.

Bullying is purposeful, repeated behaviour designed to cause physical and emotional distress. Cyberbullying (or online bullying) is defined by [Childnet International](http://www.childnet-international.org) as the use of technologies by an individual or by a group of people to deliberately and repeatedly upset someone else.

Technology can be used to carry out a wide range of unacceptable or illegal behaviours. Cyberbullying can include:

- intimidation and threats;
- harassment and stalking;
- vilification / defamation;
- exclusion or peer rejection;
- impersonation;
• unauthorised publication of personal information or images; and
• manipulation.

Practitioners can find further information, advice and resources on bullying and cyberbullying at the following websites:

Respect Me which supports schools, local authorities and communities to prevent and tackle bullying effective through training, support for policy development and awareness raising information provision and includes advice on cyber-bullying.

Childnet International which works with young people to support them to stay safe online. It also works with parents, carers and professionals to provide resources, guidance and policy advice to help them to protect children and young people from online issues and risks.

**Trafficking and Exploitation**


The Human Trafficking and Exploitation (Scotland) Act 2015 was passed by the Scottish Parliament in October 2015 and received Royal Assent in November 2015. The first provisions of the Act came into force on 31 May 2016 and implementation of the rest of the Act is ongoing. The Act:

• makes it simpler to take action by introducing a single offence for all kinds of trafficking for the first time, consolidating and strengthening existing law. The new offences of human trafficking and of slavery, servitude and forced or compulsory labour now have the maximum penalty of life imprisonment attached to them for anyone who is convicted of these new offences;
• gives courts new powers and measures to prevent and punish trafficking;
• requires the Lord Advocate to issue instructions to prosecutors about how trafficking victims should be treated if they are alleged to have committed an offence; and
• provides clear rights to adult victims to access support and assistance, and places a duty on the Scottish Ministers to ensure that guardians are available for all children who reasonably appear to have been trafficked or to be vulnerable to being trafficked, where no one in the UK holds parental rights and responsibilities in relation to such a child.

Scottish Government: Human Trafficking Webpage

Scottish Government (2017): Trafficking and Exploitation Strategy

Human trafficking and exploitation are complex and hidden crimes, as well as an abuse of human rights and dignity. **Human trafficking and exploitation of a child or young person is child abuse.** Tackling trafficking and exploitation requires a multi-agency approach at all levels.

The many purposes for which people are used – including commercial sexual exploitation, labour exploitation, criminal exploitation (for example, benefit fraud and forced drugs cultivation), domestic servitude, sham marriages and organ trafficking – are continually evolving. Victims can be
subjected to more than one form of exploitation, e.g. commercial sexual exploitation and criminal exploitation in the form of shoplifting.

Human trafficking and exploitation are not only international issues. It happens here and is not confined to our cities. There is also a perception that trafficking is about people from outwith the UK, however adults and children, including UK citizens, are trafficked and exploited within and between communities in Scotland and the wider UK.

**Human Trafficking** is a criminal offence. There are two parts to this offence - a **relevant action** and an **intention to exploit or knowledge of likely exploitation**. Both parts are needed for an offence to be committed.

**Relevant Action** means carrying out a relevant action with regard to another person. It does not matter whether the other person consents to that action being taken. A relevant action is any of the following:

- recruiting another person;
- transporting or transferring another person;
- harbouring or receiving another person; and
- exchanging control over, or transferring control over another person;
- arranging or facilitating (without necessarily doing), any of the actions above.

However, travel from one place to another is not a required action for there to be an offence of human trafficking in Scotland. Trafficking can take place within a building, room to room.

**Exploitation** means the person doing the **relevant action** must either be doing so with the **intention of exploiting the other person or, in the knowledge that the person is likely to be exploited**. The word **exploitation** is given a defined meaning in **Section 3 of the Act**. The **exploitation** must fall within that meaning for there to be a criminal offence.

There are four types of **exploitation** defined in **Section 3 of the Act**, they are:

1. slavery, servitude and forced or compulsory labour;
2. prostitution or sexual exploitation;
3. removal of organs; and
4. securing services and benefits.

**Slavery, Servitude and Forced or Compulsory Labour** is where a person is a victim of conduct, which is an offence under **Section 4 of the Act**.

**Prostitution or Sexual Exploitation** is the exercise of control, direction or influence over prostitution by another person, which shows that the person is aiding, abetting or compelling the prostitution, falls within the meaning of exploitation. Involving a person in the making or production of materials which are classified as obscene under **The Civic Government (Scotland) Act 1982** is
also exploitation. Finally, where the person has been the victim of certain sexual offences listed in Section 3 (5) then that is exploitation.

**Removal of Organs** is where a person is encouraged, required or expected to do anything which would be an offence related to the removal of organs or human tissue. This includes things done outside Scotland which would amount to such an offence if they happened inside Scotland.

**Securing Benefits and Services** is a general category, and brings two sets of circumstances within exploitation. First are cases where any person is subjected to force, threats or deception designed to induce that person to provides services of any kind, provide another person with benefits of any kind, or to enable another person to acquire benefits of any kind.

Second are cases where a child, young person or vulnerable adult is used to provide services of any kind, provide another person with benefits of any kind or to enable another person to acquire benefits of any kind without the use of force, threats or deception, but in circumstances where a person who was not a child or vulnerable adult would be likely to refuse to be used for that purpose. **Benefits** in this section is a general word and has a meaning wider that social security benefits.

**Trafficking of Children and Young People**

**Human trafficking and exploitation of a child or young person is child abuse.**

Children and young people are by default more vulnerable to coercion and abuse than adults due to their age and dependency on others for their care and are therefore at greater risk of becoming victims. Children and young people’s vulnerability can be increased where they experience a physical disability or learning disability or any other particular set of characteristics or experiences which would increase their reliance on adult care. It does not matter whether or not there has been any coercion or deception; children and young people are not considered capable of informed consent to such abusive activity.

The risks to children and young people can be even greater when they are moved to another location, where they have no associations or shared language. How child victims will experience trafficking and exploitation will differ and may be impacted on by their gender. Figures indicate for example that many more female than male victims will experience sexual exploitation.

The range of situations in which children and young people could be subject to trafficking and exploitation is complex and not always obvious, particularly in situations such as domestic servitude where the child or young person is kept unseen. Circumstances could include what appear to be legally acceptable arrangements such as private fostering and inter-country adoption. Forced marriage and other forms of child abuse may be linked to trafficking and exploitation.

It is also crucial to recognise that trafficking and exploitation does not only affect children and young people from other countries; there have been cases of domestic trafficking and exploitation of children and young people who have been born and brought up in Scotland. The growth of the internet and use of social media has only added to the complexity in identifying both victims and
perpetrators. It is important that appropriate investigations, sensitive to the cultural norms of each child or young person, take place depending on the individual circumstances.

Currently, where a child victim or suspected child victim arrives in Scotland, unaccompanied and separated from their family, they will receive additional support from the Scottish Guardianship Service. Funded by the Scottish Government, this project is a partnership between Aberlour Scotland’s Children’s Charity and the Scottish Refugee Council. Working alongside local authority supports, Guardians support children and young people by helping them navigate the immigration and welfare processes, help them feel supported and empowered throughout the asylum process, assist them to access the help they need when they need it, and make informed decisions about their future. Any eligible child or young person can be referred, recognising that a trafficking episode won’t always be immediately apparent or disclosed.

**Recognition and Response to Child Trafficking**

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

There are no validated risk assessment tools that can predict the risk of trafficking or definitively identify those who have been trafficked. However, **Scottish Government (2013): Inter-Agency Guidance for Child Trafficking** provides information and guidance to all practitioners to help them identify trafficked children and young people and make appropriate referrals so that victims can receive protection and support. This guidance includes an indicator matrix for child trafficking; based on the best available information about factors in a child or young person’s circumstances which may lead to the belief that a child or young person has been trafficked.

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

This approach to addressing child trafficking and exploitation is underpinned by the principle of the best interests of the child; enshrined in **The Children (Scotland) Act 1995** and built upon in the **Getting it right for every child (GIRFEC)** framework. This is also in line with **Article 3 of the UN Convention on the Rights of the Child (UNCRC)**. Support and protection for child victims in Scotland is provided within the context of the child protection system and the GIRFEC approach to improving outcomes for children and young people.

*It is essential that practitioners take timely and decisive action where child trafficking is suspected because of the high risk of the child or young person being moved. Action should not be postponed until a child or young person realises, agrees or divulges that they have been trafficked.*
Often, children and young people are threatened with punishment if they speak. Also, they may not be aware that they are victims of trafficking. In all cases where it is suspected that a child or young person may be a victim of human trafficking or exploitation, the child or young person’s safety is paramount and child protection procedures must be activated quickly.

If any practitioner, service or agency believes that a child or young person they are in contact with is, or may have been, trafficked they should initially consult the indicator matrix and contact social services and / or the police immediately. The child or young person’s safety remains the principal consideration and all necessary actions and inter-agency child protection procedures should be followed to ensure that they are protected.

In cases where a child or young person may have been trafficked, their carer may be involved in the trafficking or exploitation. Seeking their consent could put the child or young person at further risk or lead to their being moved elsewhere. Unless there is clear evidence that seeking consent would in no way harm the child or young person; referring agencies should not seek the carer’s consent for children or young people under 16.

The responsibility for coordinating services for child victims of human trafficking and exploitation lies primarily with the relevant Local Authority. A range of support will be provided depending on the assessed needs and specific circumstances of the child or young person.

**National Referral Mechanism (NRM)**

The [National Referral Mechanism (NRM)](https://www.gov.uk) is a framework for identifying victims of human trafficking, exploitation or modern slavery and ensuring they receive the appropriate protection and support. The NRM is also the mechanism through which the [Modern Slavery Human Trafficking Unit (MSHTU)](https://www.gov.uk) collect data about victims. This information contributes to building a clearer picture about the scope of human trafficking and modern slavery in the UK.

To be referred to the National Referral Mechanism (NRM) potential victims of trafficking must initially be referred to one of the UK’s two Competent Authorities (CA) - the Modern Slavery Human Trafficking Unit (MSHTU) or the [UK Visas and Immigration](https://www.gov.uk). This initial referral will generally be handled by an authorised referring agency, such as the police or social services. The authorised referring authority is known as the First Responder. The First Responder completes a referral form which is then passed to the Modern Slavery Human Trafficking Unit (MSHTU) who will then determine which CA will deal with the case and will forward the papers if needed.

Completed forms should be sent to the Modern Slavery Human Trafficking Unit (MSHTU) via e-mail at [nrm@nca.x.gsi.gov.uk](mailto:nrm@nca.x.gsi.gov.uk) or by fax to 0870 496 5534. Up-to-date information on the [Modern Slavery Human Trafficking Unit (MSHTU)](https://www.gov.uk) and National Referral Mechanism (NRM) is available [here](https://www.gov.uk).

Referral to a CA is voluntary and can happen only if the potential victim gives their permission by signing the referral form. In the case of children their consent is not required. To download an adult or child referral form go to the [gov.uk website](https://www.gov.uk).
Child Sexual Exploitation (CSE)


Child Sexual Exploitation (CSE) is Child Sexual Abuse. CSE has two distinctive characteristics - exploitation and exchange.

Child sexual exploitation 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. As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act. (Note: This is not necessarily considered to be an all-inclusive or exhaustive list of possibilities).

CSE is a complex issue and can affect any child or young person; male or female; anytime; anywhere - regardless of their social; economic or ethnic background.

CSE should not be seen in isolation, but in the wider context of vulnerability and risk. CSE is often hidden and can involve features of violence, coercion and intimidation. Involvement in exploitative relationships are characterised in the main by the child or young person's limited availability of choice, resulting from their social; situational; psychological; physical; economic and / or emotional vulnerability.

CSE can also occur through the use of technology and without the child's immediate recognition, e.g. being persuaded to post sexual images of themselves on the internet / mobile phones without any immediate payment or gain.

CSE perpetrators have power over their victims by virtue of their age; gender; intellect; physical strength; and / or economic or other resource. The gain for those perpetrating or facilitating CSE can include financial benefit; sexual gratification; status or control.

Victims of CSE rarely disclose their abuse. This may be due to fear or even them not recognising they are a victim of CSE, or they may consider themselves to be in a loving adult relationship with the abuser. The sophisticated grooming and priming processes conducted by the perpetrators and the exchange element can also act as additional inhibitors and / or barriers to disclosure.

In some CSE cases, the sexual abuse may take place between the victim and the perpetrator; in other CSE cases the victim may be passed between two or more perpetrators and in some CSE cases this may be organised by criminal gangs or organised groups.

Remember, CSE is abuse and a child protection concern. No child or young person can consent to their own abuse. SEE BEYOND.
CSE Vulnerability Factors

There are aspects in every child or young person's historical or current circumstances which may make them more vulnerable to being targeted and / or groomed for CSE.

The following is a list of CSE vulnerability factors (situational / environmental), albeit these are not necessarily considered to be an all-inclusive or exhaustive list of possibilities:

- a history of abuse (including familial sexual abuse and emotional abuse);
- a history of neglect;
- being looked after, or formerly looked after;
- disrupted family life, including family breakdown, separation; divorce;
- historic / ongoing domestic violence and / or problematic parenting;
- living in a chaotic / dysfunctional households;
- disengagement from education and isolation from other support mechanisms;
- going missing from home or care environments - regularly / frequently;
- problematic parental alcohol and / or drug use;
- parental mental ill-health and / or parental learning disabilities;
- homelessness; living in hostel, bed and breakfast or homeless accommodation (especially longer term);
- poor health and wellbeing, social exclusion; social isolation;
- low self-esteem; low self-confidence; poor self-image; eating disorders;
- recent bereavement or loss;
- being in a state of poverty; financial hardship; unemployment;
- having a disability - particularly autistic spectrum disorder or a learning disability;
- experiencing bullying in and / or out of school;
- involvement in crime / offending;
- online vulnerability and lack of recognition of risk in the online world;
- uncertainty of sexual orientation / or unable to disclose to family and friends;
- risk of forced marriage / honour based violence / female genital mutilation; and
- links with other young people who are sexually exploited.

CSE Signs and Risk Indicators

There are a number of signs, symptoms and indicators (behavioural) which may alert you that a child or young person is at risk of CSE. The following is a list of CSE signs and symptoms, albeit these are not necessarily considered to be an all-inclusive or exhaustive list of possibilities:
- staying out late or regular episodes of being missing overnight or longer without permission;
- reduced contact with family and friends and / or other support networks;
- multiple callers to home (unknown adults / older young people);
- evidence of / suspicion of physical or sexual assault; disclosure of assault followed by withdrawal of an allegation;
- unplanned pregnancy; repeat sexually transmitted infections (STIs); terminations; high number of sexual partners;
- peers involved in sexual exploitation;
- exclusion, truancy or unexplained absences from school or college;
- relationships with controlling adults;
- entering / leaving vehicles driven by unknown adults or taxicabs;
- frequenting areas known for known on / off street sexual exploitation (prostitution);
- children under 13 years asking for sexual health advice;
- concerning use of the internet / mobile phone;
- acquisition of money, clothes, mobile phone etc without plausible explanation;
- receiving lots of texts / phone calls prior to leaving;
- agitated / stressed prior to leaving home / care;
- returning distraught / disheveled or under the influence of substances;
- requesting emergency hormonal contraception (the morning after pill) upon return from an unexplained absence;
- inappropriate sexualised behaviour for age and development;
- physical signs of bruising or bite marks;
- new peer groups;
- significantly older ‘boyfriend’ or ‘girlfriend’;
- increasing secretiveness around behaviours;
- change in personal hygiene (greater attention or less attention;
- overtly sexualised dressing;
- self-harm and other expressions of despair;
- evidence or suspicion of substance misuse / alcohol and drug use;
- gang member or association;
- risks associated with the Internet:
  - grooming children or young people on-line for sexual abuse offline;
children viewing abusive images of children / pornographic images;
- selling children or young people on-line for abuse offline;
- making abusive images of children or young people;
- viewing abusive images of children or young people;
- access to contact sites; chat lines via the internet or mobile phones and
- sexting.

CSE Non-Disclosure

The reasons why a child or young person may not disclose CSE are complex and numerous. In many cases they do not recognise that they are a victim of CSE.

The following is a list of reasons why children and young people do not always disclose CSE, albeit these are not necessarily considered to be an all-inclusive or exhaustive list of possibilities:

- fear that perceived benefits of exploitation may outweigh the risks e.g. loss of or supply of alcohol; drugs; the relationship and associated love and attention;
- fear of retribution on self or family or that situation could get worse;
- fear of violence within exploitative relationship;
- Shame;
- fear of not being believed;
- fear of labelling e.g. being a prostitute or being gay;
- fear of separation from family and / or threat of being placed in secure accommodation;
- loss of control; fear of Police involvement and court proceedings; and
- don’t recognise they are being exploited.

CSE Other Factors

The following additional points are known about CSE, albeit these are not necessarily considered to be an all-inclusive or exhaustive list of additional points: the key factor that distinguishes CSE from other forms of child sexual abuse is the concept of exchange - the victim is enticed; coerced; manipulated; forced or deceived into engaging in the sexual abuse in return for something;

- practitioners can misinterpret CSE as consensual and can fail to recognise the element of exploitation;
- CSE is typified by a power imbalance in favour of the perpetrator;
- children and young people in care (particularly those in residential care) have a disproportionate risk of CSE;
- the majority of CSE victims are living at home;
- most CSE concerns are reported by practitioners; friends or family; or by proactive
investigations rather than by self-disclosure by the victim; and

- no single agency can, or should, address the challenge of preventing and responding to CSE in isolation - a multi-agency approach is much more effective.

What to do if you are concerned that a child or young person is at risk of CSE:

ASK

Ask yourself the following questions:

1. What have I seen?
2. What have I heard?
3. What do I feel is unusual or different?
4. What has actually happened?
5. What is my concern?
6. What is this telling me?
7. What should I do now?

ACT

Remember:

1. Protecting children and young people and keeping them safe is everyone’s job!
2. Keep your focus on the child or young person - their safety is paramount!
3. Doing nothing is not an option!
4. Do not assume someone else will do something!
5. Do not delay unnecessarily - act quickly!
6. Look, Listen and Record your Concern!
7. Look Further and See Beyond!
8. If you are a practitioner - Follow your agency child protection procedures
9. If you are a practitioner - Tell your Line Manager or Child Protection Officer immediately!
10. If you are a member of the public:
11. Contact the Child Protection and Duty Team (24 hours) on 01738 476768
12. In an Emergency - Dial 999
13. Police (Non-Emergency) - Dial 101
14. ChildLine - Dial 0800 1111
15. Crimestoppers - Dial 0808 555 111
OnLine and Mobile Phone Child Safety

New technologies, digital media and the internet are an integral part of children and young people’s lives. Whether on a computer at school or at home, a games console or mobile phone, children and young people are increasingly accessing the internet whenever they can and wherever they are. This has enabled entirely new forms of social interaction to emerge, for example, through social networking websites and online gaming.

These new technologies also bring a variety of risks such as:

- exposure to obscene, violent, illegal or distressing material;
- bullying or intimidation through online platforms;
- identity theft and abuse of personal information; and
- exploitation by online predators – for example, sexual grooming – often through social networking sites.

It is important that children and young people understand the risks and can make sensible and informed choices on-line. In a constantly changing technological landscape it is difficult to keep pace with change and criminal activity. Practitioners need to support children and young people to use the internet and mobile technology responsibly and know how to respond when something goes wrong.

If a child or young person in your care discloses something to you, related to the internet and the use of technology, then the same reporting procedures used for incidents offline can and should be followed. Where there are concerns that a child or young person may be at risk of harm, or that they may have engaged in online behaviours which might affect their own safety, or the safety of others, then please refer your concerns immediately to the Designated Child Protection Officer within your own service or agency. In an emergency, direct contact should be made with Police Scotland.

Perth and Kinross Child Protection Website contains more comprehensive information and advice on Internet and Mobile Phone Child Safety and includes a number of useful links/downloads which practitioners may find helpful.

CEOP (Child Exploitation and On-line Protection Centre)

The Child Exploitation and On-line Protection Centre (CEOP) is dedicated to eradicating the sexual abuse and exploitation of children. CEOP is part of the UK policing community and tracks and brings offenders to account, either directly or in partnership with local and international police forces.

CEOP also works with children, young people, parents, carers and practitioners to deliver their unique Thinkuknow internet safety programme. This resource includes films, presentations, games, lesson plans, publications and posters covering a range of issues from grooming by child sex offenders to cyber bullying. These can be accessed and downloaded from the Thinkuknow website.
Further information and advice can also be found at the [Scottish Government's National Action Plan on Internet Safety for Children and Young People](https://www.gov.scot/publications/national-action-plan-internet-safety-children-and-young-people/) (April 2017) and at the [IWF - Internet Watch Foundation](https://www.iwf.uk/).

**Missing Persons**


The Scottish Government has published the above Framework. It is the first of its kind in Scotland. It does not propose to change the policy or practice direction or create new systems alongside those that already exist.

Going missing is a clear sign that something is wrong in a person's life. The overwhelming majority of people who go missing are children, young people and vulnerable adults. Going missing exposes people to unnecessary risks; it impacts negatively on their health and wellbeing; and, in a small number of cases, it can lead to death. For many, they are having problems at home, at school or at work. The evidence tells us that anyone can become vulnerable.

The decision to go missing is not one that people take lightly and it is often an act of last resort in response to abuse, distress or desperation. The impact of someone going missing can be devastating for families and friends who are often left in limbo, desperately waiting for news of their missing loved one.

Often the problems which lead to someone going missing can lead to a dangerous cycle of repeat incidents. It is important, therefore, that all services, agencies and other organisations join together to understand, and try to deal with, the issues which may be lying behind any individual case. All practitioners have a duty to look out for the most vulnerable in our communities.

**Definition of Missing Person**

A missing person is anyone whose whereabouts are unknown and:

- where the circumstances are out of character; or
- the context suggests the person may be subject to crime; or
- the person is at risk of harm to themselves or another.

**Risk Assessment**

When a person is reported missing, a risk assessment will be undertaken by Police Scotland and thereafter categorised as *high, medium or low*. This risk assessment will be carried out jointly with partners, when they are involved, to capture all information that will assist in determining the correct category of risk. Police Officers have been issued with an aide memoire consisting of 21 questions to assist in determining the most appropriate risk category - the questions are produced below.
Missing Person - Low Risk Status

Low Risk is deemed as any person that goes missing where there is low risk of harm to that person or others.

Missing Person - Medium Risk Status

Medium Risk is a missing person that is likely to place themselves in danger or they are a threat to themselves or others.

Missing Person - High Risk Status

High Risk is a missing person where the risk posed is immediate and there are substantial grounds for believing that the Missing Person:

1. Is in danger through their own vulnerability; and / or
2. May have been the victim of a serious crime; and / or
3. The risk posed is immediate and there are substantial grounds for believing that the public is in danger.

Risk Assessment Determination

Vulnerability

1. Is there any identified risk of suicide?
2. What are these vulnerabilities?
3. What are the effects of failure to take medication that is not available to them?
4. Does the missing person have medical or mental ill-health conditions, physical illnesses or disabilities?
5. Can the person interact safely with others when finding themselves in unfamiliar circumstances?
6. Is there a dependency on drugs, alcohol, medication or other substances?
7. Do the current/previous weather conditions present additional risk? Consider all circumstances including age & clothing.

Influences

8. Are there family/relationship problems or recent history of family conflict and/or abuse?
9. Are they the victim or perpetrator of domestic violence?
10. Is there an on-going personal issue linked to racial, sexual or any cultural issues?
11. Were they involved in a violent and/or hate crime incident prior to disappearance?
12. Are there any employment or financial problems?
13. Is forced marriage or ‘honour’ based violence an issue?
14. Are they the victim of sexual exploitation, human trafficking or prostitution? If so, is going missing likely to place them at risk of considerable harm.
Past Behaviour

Behaviour that is out of character is often a strong indicator of risk.

14. Are the circumstances of going missing different from normal behaviour patterns?
15. Is there a reason for the person to go missing?
16. Are there any indications that preparations have been made for absence?
17. What was the person intending to do when last seen? Did they fail to complete their intentions?
18. Has the person disappeared previously and were they exposed to harm on such occasions?
19. Is the missing person a risk to others? And in what way?
20. Are there other unlisted factors which the officer or supervisor considers relevant in the assessment of risk?

Return Discussions

A return discussion can help to support a person following their return, provide a platform to identify underlying issues and obtain information that could prevent future missing episodes.

The purpose of a return discussion is to:

- support the individual who has gone missing and identify the underlying causes so that these can be addressed;
- provide an opportunity for them to talk about the circumstances that prompted them to go missing;
- provide an opportunity for them to talk about their experience when missing and their feelings following their return;
- use relevant information gathered to help prevent further missing episodes by:
  - determining any on-going risk of harm and relevant local risk information;
  - referring the individual to appropriate support services.

There is no set time for the discussion to occur but, when possible, first contact should be made within 72 hours, with the discussion taking place within one week, at a suitable time for the individual. The discussion should take place in a safe environment with a trained practitioner of their choice when possible. It is important that a person who has been missing is given the opportunity to speak about it as soon as they are ready to do so.

Speaking and listening to people after they return is an important way of understanding the reasons they went missing and any harm they may have come to, or could still be at risk of. The most appropriate support can then be offered to the person. The information obtained can also help to inform the necessary steps or actions required to prevent a repeat incident.
The discussion may not be practical at the point of return; it can often be more useful for Police Scotland to conduct a brief ‘safe and well’ check and allow a return discussion to be followed up in the coming days when circumstances may be more appropriate for the individual. This should be seen as a process rather than a one off event. The person who has been missing may well be vulnerable and it’s important that they have time and the opportunity to talk to a skilled professional.

Discussions should generally respect the confidentiality of the child, young person or adult who has been missing. However, information gathered during the discussion which could help safeguard the child, young person or adult from any harm should be shared with the relevant agencies.

Appropriate information sharing between partners may be necessary (sometimes required by law) to adequately support the individual, understand risk and prevent the person going missing in the future. This point should be discussed with the person at the beginning of any return discussion to ensure they understand why confidentiality may be broken and can give informed consent to sharing of relevant information. By having this conversation the practitioner allows the returned person to build trust.

The return discussion should:

- **be available for all people (children, young people and adults) who return from being missing in Scotland**;
- **be conducted in person, where possible, by a trained practitioner who is trusted by the person who has been missing**;
- **happen at the most suitable and appropriate time in a safe and comfortable environment (ideally within one week with initial conduct occurring within 72 hours) for the individual after they have returned from going missing**;
- **sensitively address confidentiality and what information may need to be passed on**.

Aim to obtain:

- how the person is feeling;
- what he or she thought about their experience when missing;
- the reasons for going missing;
- what happened, including where they went, and who with;
- whether any harm was experienced;
- what the person feels could help prevent them going missing again.

And inform:

- additional help or support that may be helpful;
- assessment of vulnerability;
- care plan, if applicable;
- local intelligence of potential risk factors.
Appropriate provision should be provided for all children, young people and adults. Support should be provided, for example, through the attendance of a caregiver or communication aids where appropriate, and a discussion held when the person is available to do so.

In many circumstances, the discussion can be done informally as a conversation between the person who has returned and a service provider they may already be engaged with, such as a social worker, a key worker in a care facility or a support worker from a third sector organisation. However in some instances the person may prefer to speak with someone else and should wherever possible be given this option as this is likely to increase the value of the discussion.

In the absence of another service provider local provision for return discussions has been provided by Police Scotland, as the main responders to a reported missing person. Although, it is recognised that in some circumstances Police Scotland are not the ideal body to have responsibility for a return discussion, it is important that a missing person, when they return, has the opportunity to speak about their experience. The lead agency for a return discussion should be agreed locally between local authority, Police Scotland, Education, NHS and the Third Sector to identify local responsibility and ensure provision is available for all missing people.

A return discussion should be treated as essential following the return of a missing person. It is intended to identify support that may be required, understand the issues and reduce risk of future episodes. Those leading the return discussion should be trained and aware of the purpose and importance of the discussion and not approach it as a tick box exercise.

Appropriate and proportionate information gathered should be shared with the agencies concerned, including Police Scotland and the local authority, as agreed with the interviewee, and in line with information sharing protocols. Disclosures that are made about criminality or harm should be actioned accordingly and the individual should be made aware of this process and why it is necessary, both before the discussion begins and again at the conclusion to ensure understanding.

Where a referral is made for the person to receive further support or protection, the leading organisation, agreed locally, should follow this up to ensure action is being taken.

When a referral is not deemed necessary, the returned person should still be signposted to more general support, for example Missing People or Runaway Helpline, Childline, Samaritans or alternative Third Sector organisations. They will therefore have the opportunity to further discuss the issues they are facing, or to reach out if they're thinking about going missing again.

If a discussion is declined, any reasons given should be recorded and the leading agency should consider if any change is needed to the return discussion process itself.


- who should be invited to participate a Return Discussion?
- what is the purpose of a Return Discussion?
- why hold a Return Discussion?
• *when should a Return Discussion take place?*
• *where should the Return Discussion occur?*

**Missing Children and Young People / Runaways**

Describing a child or young person as missing can cover a wide range of circumstances. In this context, the term missing also includes children and young people who are unseen or hidden. A child, young person and / or family (including unborn children) can be considered as missing in the following circumstances:

**Children and Young People – Missing to Statutory Services**

This can include a child, young person or family’s loss of contact with, or their invisibility to, a statutory service, such as education (for example, home educated children), health, social work or a third sector service provider. In these circumstances the parent or carer may have repeated explanations for the child or young person's absence. Practitioners must investigate these explanations thoroughly.

**Children and Young People – Missing from Home or a Care Placement**

This can include a child or young person who has run away from their home or care placement, who has been forced to leave or whose whereabouts are unknown. This may be because they have been the victim of an accident, crime or offence or because they have actively left or chosen not to return to the place there they are expected. Again, practitioners must investigate these explanations thoroughly.

**Children and Young People – Missing from Education (CME) Scotland**

Children *missing from education* are children and young people of compulsory school age who are not on a school roll and are not being educated otherwise (at home, privately or in an alternative 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). Children and young people can be missing from education for a variety of reasons including:

• families who simply move and do not tell anyone;
• long term truants / young offenders;
• families involved with fraud;
• families that do not return from holiday;
• families fleeing from domestic violence/abuse;
• families involved in witness protection; and
• children whose families become homeless.

Again, practitioners must investigate these circumstances thoroughly. Within Perth and Kinross we have in place local procedures in relation to CME. Further information and advice about CME can be found at CME Scotland: [www.gov.scot/Topics/Education/Schools/cmescotland](http://www.gov.scot/Topics/Education/Schools/cmescotland).
A child or young person who has run away, and cases where children or young people have been *thrown out* by their parents or carers, are both covered by the term runaway (though the individual circumstances and needs of the child or young person may vary considerably).

Children and young people who go missing remain vulnerable to the factors that led to them going missing (for example, domestic abuse in a care environment) as well to the risks associated with being missing (for example, homelessness). Extreme cases can result in homelessness and sleeping rough, engaging in crime, drugs and vulnerability to sexual exploitation. Many cases are never reported to police and few such children ever approach agencies for help.

The reasons for a child’s absence may not always be apparent. A number of other circumstances in which children or young people may be termed as missing are listed below:

- **Parental / Carer Abduction** – a parent or carer may fail to return or remove a child or young person from contact with another parent or carer, in contravention of a court order or without the consent of the other parent or carer (or person who has parental rights). This can occur within national borders as well as across borders;
- **Stranger Abduction** – whilst extremely rare, a child or young person may fail to return because they have been the victim of a crime;
- **Forced Marriage** – a child or young person may go missing due to being forced into marriage abroad or within the UK;
- **Trafficked and Exploited Children and Young People** – a child or young person may go missing due to being trafficked and exploited later being removed from a placement. Asylum-seeking children are particularly vulnerable to vanishing. Their substitute care may feel unsafe and many do not have a trusted adult to advocate for them;
- **Sexual Exploitation** – a child or young person may go missing due to sexual exploitation;
- **Young Runaways and those forced to leave or thrown out** – this can include any child or young person under the age of 16, who is absent from their domicile without the reasonable authority of those responsible for or in charge of them, and who needs a service either to find and return them to that place (where it is safe or in the child or young person's interests to do so), or to
  
  (a) keep them safe;

  (b) ensure an appropriate and proportionate response to their needs;

  (c) meet statutory obligations.

and under the age of 18 who runs from substitute care. Children who go missing from home or care may do so because they are running away *from* a source of danger or have been forced to leave; or because they are running *to* something or someone. They can be at significant risk as they may need to find a safe alternative place to stay, often with few resources. This can result in begging or stealing or staying with a complete stranger.
• **Vulnerable Young People** – such young people are identifiable by their criminal or risk-taking behaviour, poverty, disengagement with education, being looked after, self-harming, ill-health issues and / or experience of abuse. They may take steps to escape from their situation;

• **Transition** – a young person moving from children to adult services need processes in place to manage this experience, maximising support and minimising risk. Transition can be a difficult time for young people and their parent or carer, or carer or staff in residential care. Some express their negative emotions through high risk and sometimes offending behaviour; they may also be vulnerable to alcohol and / or drug misuse and sexual predators. These cases are very challenging to manage effectively and call for a collaborative approach that includes offender management services; and

• **Home-Educated Children** – a child or young person may be unknown to services as a result of their removal from mainstream education or 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 care and / or protection concern.

**Children Affected by Disability**


National Child Protection Disability Toolkit

**Definition**

The above Guidance uses the social model of disability, which, rather than focusing on medical problems or physical deficits, explores the social and environmental barriers, cultural processes and policy frameworks that disable children and young people with an impairment.

Disabled children and young people are children and young people first and foremost and their wellbeing and protection should be considered in relation to the individual child or young person’s circumstances. Ensuring disabled children and young people's wellbeing is everybody’s responsibility and an awareness of what constitutes best practice is essential. It is critical that all practitioners are aware of the potential vulnerability of disabled children young people and of what constitutes best practice in protecting them from the risk of abuse and neglect.

The definition of disabled comes from The Equality Act 2010: a person, including a child or young person, is considered to be disabled if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. It includes children and young people with a comprehensive range of physical, emotional, developmental, learning, communication and health care needs. Disabled children and young people are defined as a child in need under Section 93(4) of the Children (Scotland) Act 1995.
Whilst disabled children and young people are likely to suffer much the same abuse as other children and young people, research suggests that disabled children and young people are 3 to 4 times more likely to be abused than non-disabled children and young people. Research has also shown that children and young people with communication impairments, behavioural disorders, learning disabilities and sensory impairments are particularly vulnerable.

The most common forms of abuse experienced by disabled children and young people are neglect and emotional abuse, although they may experience multiple abuses. Disclosing abuse can be more difficult for children and young people who have a wide range of communication styles, and this can be more problematic if a perpetrator is also in a trusted role.

**Greater Risk**

Disabled children and young people are at greater risk of harm partly from the effects of their disability and their environment; partly because of the response of practitioners. See Additional Practice Notes on Greater Risk.

The response of practitioners can also contribute to the vulnerability of disabled children and young people in respect of the risk of abuse and harm. Practitioners from all services / agencies / all disciplines must be aware of the values, attitudes and beliefs that lead to denial or minimisation of the impact of abuse and neglect in relation to a disabled child or young person, as this can lead to a failure to respond and / or report abuse or neglect. Practitioners may find it more difficult to attribute indicators of abuse or neglect, or may be reluctant to act on concerns in relation to disabled children and young people due to a number of factors which they may not be consciously aware of. See Additional Practice Notes on the Response of Practitioners.

**Recognising Indicators**

Significant harm caused by abuse and neglect may be the result of a specific incident, or more likely, an accumulation of concerns over time. Assessment must include analysis of accurate recordings, comprehensive chronologies and relevant information regarding significant events / concerns in relation to the disabled child, young person and their siblings. This along with the timeous sharing of relevant information can increase the identification of and inquiries into possible abuse and neglect.

Disabled children and young people experience the same sort of abuse as other children and young people: neglect, physical abuse, sexual abuse (including exploitation) and emotional abuse. Neglect seems particularly prevalent. It is crucial when considering whether a disabled child or young person has been / or is at risk of abuse and / or neglect, that the disability does not mask or deter appropriate investigation of child protection concerns. Any concerns for the safety and wellbeing of a disabled child or young person should be acted upon timeously and local child procedures must be followed. There should be no distinction made in acting on concerns where a child or young person is disabled. See Additional Practice Notes on Recognising Indicators.
**Barriers**

Communicating abuse is difficult for any child or young person, they may be confused, fearful, traumatised and uncertain about what has happened and what might happen in the future. The recognition of concerns in relation to the protection of children and young people from abuse and harm cannot be determined by disclosure alone. Not every child or young person will disclose abuse or harm and there should be no greater expectation that disabled children and young people will disclose more readily than any other children and young people.

For a disabled child or young person it may be especially difficult, as they may not have the means to communicate about their abuse experience(s). For some disabled children and young people with speech, language and communication needs, making known that they have been subject to abuse, neglect or ill treatment is dependent on the ability of practitioners to recognise and respond appropriately to a range of verbal and non-verbal cues. It may be necessary to seek support and advice from practitioners with specialist skills who are most familiar with the child and their means of communication.

**Working with the Family**

Most parents or carers of disabled children and young people provide safe and loving homes. However, there must be awareness that this is not always the case: some fail to offer acceptable care, overwhelmed by the pressures upon them and their family or receiving inadequate support from services and some do deliberately harm their children.

As in all cases of suspected child abuse, it is important to develop cooperative working relationships as far as possible with the families and carers of disabled children and young people. This is challenging when the parents or carers are themselves under suspicion and particularly difficult with some parents or carers who are very hostile or superficially cooperative.

Some parents or carers of disabled children and young people may exhibit similar behaviour and the possibility that threatening and hostile behaviour towards workers may indicate similar behaviour towards the child or young person must always be considered; where parents are apparently compliant, the advice to maintain healthy scepticism is just as relevant. There should also be awareness that families with disabled children or young people may also have issues about the misuse of alcohol and drugs, mental ill-health, domestic abuse just as in other families. Additionally, the parent or carer may be disabled and not receiving the support they require to meet the additional demands of being a parent or carer. See [Additional Practice Notes on Working with the Family](#).

**Reporting and Investigation**

Where a practitioner has concerns that a disabled child or young person may be being abused or neglected, they should follow their own service / agency and / or local child protection procedures for passing on a concern to statutory child protection services. Concerns should be shared at the first opportunity either with an appropriate manager or with the designated member of staff who has responsibility for child protection in the agency/service provider, so that a referral can be made promptly.
As with non-disabled children and young people, it is not always obvious from an initial referral that there is a child protection issue to be considered. Practitioners, the family, the child or young person and others may emphasise other problems or difficulties and the need for protection from harm may not always be obvious. Thus, the practitioner receiving the referral should systematically seek information about the identified needs and circumstance that have prompted the referral.

It is important that, where possible, as much accurate information is gathered, in order to fully understand the context and assess the likelihood of harm to the child or young person. It may be necessary to obtain an accurate assessment of the child or young person's understanding and language abilities from their parent, teacher, speech and language therapist or advocacy support and then take advice on communicating or working with the assistance of someone who knows the child or young person well.

Local child protection procedures must be followed where there is reasonable cause to believe that any child or young person is suffering, or is at risk of suffering, significant harm. The first responsibility, as with any investigation into allegations of abuse and/or neglect is to ensure that the child or young person is safe including when the child or young person is living away from home in foster, residential, secure or hospital care. Consideration also needs to be given to the wellbeing and protection needs of any siblings living in the family home. As with all enquiries, the need for accurate, detailed, contemporaneous recording of information is essential. See Additional Practice Notes on Reporting and Investigation.


**Getting Our Priorities Right (GOPR): Working Together with Children, Young People and Families Affected by Problematic Alcohol and / or Drug Use**


Scottish Government (2013): Getting our Priorities Right: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and / or Drug Use

Perth and Kinross Practitioner's Guide and Toolkit: Getting Our Priorities Right (GOPR): Working Together with Children, Young People and Families Affected by Problematic Alcohol and / or Drug Use

Perth and Kinross Child Protection Committee, in partnership with Perth and Kinross Alcohol and Drug Partnership (ADP), has developed the above Perth and Kinross Practitioner's Guide and
Toolkit: Getting Our Priorities Right (GOPR): Working Together with Children, Young People and Families Affected by Problematic Alcohol and / or Drug Use. It aims to:

- keep children, young people and their families safe and protected;
- translate the national policy guidance into the local practice arrangements;
- promote prevention; early identification; proportionate intervention and support to children, young people and families affected by problematic alcohol and / or drug use;
- ensure children, young people and their families get the right kind of help and support they need, when they need it, for as long as they need it;
- ensure parents or carers are provided with help and support to improve their parenting capacity;
- support and empower all practitioners and managers working with children, young people and families affected by problematic alcohol and / or drug use;
- fit with, support, complement and not replace existing single service or agency assessment and care planning processes in relation to children, young people and families affected by problematic alcohol and / or drug use; and
- provide better outcomes for children, young people and families affected by problematic alcohol and / or drug use.

The Practitioner’s Guide and Toolkit is for all practitioners and managers working with children, young people and their families within the public, private and third sectors across Perth and Kinross. It is particularly aimed at all those practitioners and managers within education and children’s services, adult services, health and / or alcohol and drugs services who are working with children, young people and families affected by problematic alcohol and / or drug use.

The Practitioner's Guide and Toolkit is divided into 3 self-explanatory parts:

- Part 1 Practitioner’s Guide: This part is divided into 5 sections (which reflects the national GOPR guidance). Each Section is presented (from a practitioner’s perspective) in a question and answer style format. Each Section contains bullet point messages and prompts (extracted from the national guidance). Each Section contains additional key practice points, references and / or electronic links.

- Part 2 Policy, Legislation, References and Electronic Links: This part contains references and electronic links to the national policy framework; legislative framework; local publications (policies, procedures, and information and advice leaflets) and useful web links (national and local).

- Part 3 Toolkit Checklists: This part contains a number of Checklists which contain various questions and prompts. Each Checklist supports early identification and proportionate intervention. They are presented as Document Templates which can be completed online, downloaded and / or printed off. They also contain text boxes and / or fields which automatically expand to allow data input. Each Checklist contains some guidance about who can use it and when to use it. Each Checklist allows the author to include information about the child, young person and / or their parent or carer; to consider what the information is telling them and to record the next steps to be taken. These Checklists do not replace professional judgment; instinct; and common sense. They do not replace any other single
service or agency screening, assessment and care planning processes and aim to support and complement existing processes.

The following key points have been extracted from the Practitioner’s Guide and Toolkit:

- alcohol is by far the most popular substance in Scotland;
- estimating the exact numbers of children and young people affected by problematic alcohol and drug use remains a complex task - there is always a level of significant under-reporting;
- problematic alcohol and / or drug use - is defined as “when the use of drugs or alcohol is having a harmful effect on a person’s life, or those around them”;
- not all alcohol and / or drug use is harmful; it does not necessarily follow that all children and young people will be adversely affected or that all users are bad parents or carers; albeit it can impair and / or affect their parenting capacity;
- alcohol and / or drug use may co-exist with mental ill-health and domestic abuse - a toxic trio; with heightened risks for children and families;
- adults can recover from problematic alcohol and / or drug use; whilst being effective parents or carers for their children;
- pregnancy and pre-conception stages are the most critical stages - sexual health, family planning and maternity services have an important role to play;
- unborn baby - pre-conception and pregnancy - some babies are born dependent on alcohol and drugs and can develop severe withdrawal symptoms - Neonatal Abstinence Syndrome (NAS) and Fetal Alcohol Spectrum Disorder (FASD);
- Neonatal Abstinence Syndrome (NAS) - has serious impact on attachment; inter-actions; longer-term growth and development;
- Fetal Alcohol Spectrum Disorder (FASD) - has serious impact on health and development; effects are lifelong and include learning disability; behavioural problems; impaired emotional development; hyperactivity and attention disorders - this is not an exhaustive list;
- Recovery - is defined as "a process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society";
- Recovery Timescales - for adults may differ from child protection timescales - there is a need to be aware of the risks;
- Recovery Timescales - the start and end points are variable; it is a sustained journey over a given period of time; it can last for several years or for a lifetime - outcomes are better if a whole system and whole family approach is taken; and
- stigma remains one of the biggest issues - it can result in reluctance to seek help; create a fear of being judged; a fear of repercussions; and can present a significant barrier.
- Recovery Timescales - contingency and supportive measures are necessary; consider the impact if services are withdrawn too quickly - keep your focus on the child or young person.
It is generally accepted that children and young people affected by parental problematic alcohol and / or drug use; by domestic abuse and by parental mental ill-health – sometimes referred to as the toxic trio – are at a significantly disproportionate risk of harm and abuse. Practitioners involved with the parent or carer should consider the impact of these factors on the child or young person’s wellbeing. Where concerns are identified, these should be shared with other practitioners in children's services.

Children and Young People Affected by Parental Mental Health Difficulties

Perth and Kinross Council Mental Health and Wellbeing Webpages
Perth and Kinross Young People's Mental Health and Wellbeing Webpages

The majority of parents or carers who have an ill-health difficulty can parent effectively. It is not inevitable that living with a parent or carer who has a mental ill-health issue will necessarily have a detrimental impact on a child or young person's development and wellbeing. However, there is evidence to suggest that many children and young people living with parental mental ill-health are more vulnerable.

There are a number of features which can contribute to the risk experienced by a child or young person living with a parent or carer affected by mental ill-health difficulties. Whilst this is not an exhaustive list, these can include:

- the parent or carer being unable to anticipate the needs of their child or young person or put the needs of their child or young person before their own;
- the child or young person becoming involved in the parent or carer's ill-health behaviour;
- the child or young person becoming the focus for parental aggression or rejection;
- the child or young person witnessing disturbing behaviour arising from the parental mental illness (often with little or no explanation);
- the child or young person may experience stigma arising from being associated with their parent or carer's mental ill-health;
- the child or young person being separated from a mentally ill parent or carer, for example because the parent or carer is hospitalised; and the anxieties and fears a child or young person may have of being separated by their parent or carer; and
- the child or young person taking on parental caring responsibilities which are inappropriate for the child or young person's age and / or development.

There are also a number of other factors which may impact on parenting capacity and these can include problematic parental alcohol and / or drug use; instances of domestic abuse; resilience and attachment difficulties; ill-informed parental coping strategies and a lack of insight into the impact of the illness on both the child or young person and the parent or carer themselves.
It is generally accepted that children and young people affected by parental mental ill-health; by domestic abuse and by parental problematic alcohol and/or drug use – sometimes referred to as the toxic trio – are at a significantly disproportionate risk of harm and abuse. Practitioners involved with the parent or carer should consider the impact of these factors on the child or young person’s wellbeing. Where concerns are identified, these should be shared with other practitioners in children's services.

The stigma associated with mental ill-health problems means that many families are reluctant to access services because of a fear about what will happen next. Parents or carers may worry about being judged and that they will be deemed incapable of caring for their children. Many will therefore view asking for services or support as a high-risk strategy.

Where parents experience mental ill-health problems, their needs may at times conflict with the needs of their child. Staff should bear in mind the importance of putting the child or young person’s interests first.

Effective partnership working across all services is needed to ensure that children and young people are protected and their short and longer-term needs met appropriately. A holistic approach to assessment is fundamental to providing appropriate services to both parents and carers and children and young people in families dealing with mental health problems. In particular, Young Carers’ Groups may be an important source of support.

However, it needs to be recognised that this work is not limited to specialist services. Universal services must also be aware of the potential impact of adult mental illness on parenting capacity and, therefore, on children and young people. Practitioners must develop a sound knowledge of, and relationship with, other services to facilitate joint working and shared case management.

The Mental Health Foundation suggests some practical measures for helping children and young people, summarised as follows:

- give clear, factual information about their parent or carer’s mental ill-health;
- assist in preparing children and young people for times when their parent or carer may be absent;
- parents or carers should share what they find helpful and unhelpful when they are unwell;
- share the parent or carer’s support needs with a trusted adult; and
- prepare the child or young person on what to expect if they are going to visit their parent or carer in an inpatient unit.

Practitioners may also find the following helpful: Scottish Association for Mental Health (SAMH) and See Me.
Children and Young People at Risk of Self Harm

**Tayside Multi-Agency Guidance: Supporting Children and Young People at Risk of Self-Harm and Suicide**

**Tayside Self Harm and Suicide Quick Reference Guide**

**Perth and Kinross Young People's Mental Health and Wellbeing Webpages**

This above Tayside Guidance can provide support for individuals and practitioners supporting children and young people who are either self-harming or at risk of self-harming. It supports practitioners working in a wide range of services and agencies to better understand how best to respond in an appropriate manner to a very sensitive, and often stigmatising, issue. It also supports practitioners working in a wide range of services or agencies to better understand how best to respond, in an appropriate manner, to a very sensitive and often stigmatising issue.

**Link between Self Harm and Suicide**

**Self-Harm** can be 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 children and young people self-harm where there is no suicidal intent. However, research shows that children and young people who self-harm can be at a higher risk of suicide.

**Why do some Children and Young People Self-Harm?**

Anyone can self-harm. This behaviour is not limited by gender, race, education, age, sexual orientation, socio-economics or religion. Self-harm is a coping mechanism which enables a person to express difficult emotions.

Children and young people who hurt themselves often feel that physical pain is easier to deal with than the emotional pain they are experiencing, because it is tangible. But the behaviour only provides temporary relief and fails to deal with the underlying issues that a child or young person is facing. For some people, self-harm may last for a short time, for others, it can become a long-term problem. Some people self-harm, stop for a while, and return to it months, even years, later, in times of distress.

**Influencing Factors** – family problems; feeling stressed; having boy / girlfriend problems; exams / school work; self-esteem issues; bereavement; feeling lonely; feeling guilty; not having someone close to talk to; bullying; difficulties associated with sexuality; feelings of being rejected; mental ill-health issues; reaction to trauma or abuse; peer pressure; poor body image and substance misuse (drugs and alcohol).

**Types of Self-Harm** – cutting; biting self; burning; scalding; branding; picking at skin; reopening old wounds; breaking bones; punching; hair pulling; head banging; ingesting objects or toxic substances; overdosing with a medicine; eating disorders; drug and alcohol misuse; dangerous driving / sports and unsafe sex / multiple sexual partners.
Warning Signs – wearing long sleeves at inappropriate times; spending more time in the bathroom; unexplained cuts or bruises; burns or other injuries; razor blades, scissors, knives, and plasters have disappeared; unexplained smell of Dettol, TCP etc; low mood - seems to be depressed or unhappy; any mood changes - anger; sadness; negative life events that could have prompted these feelings - bereavement; abuse; exam stress; parental divorce etc; low self-esteem; feelings of worthlessness; changes in eating or sleeping patterns; losing friendships; withdrawal from activities that used to be enjoyed; abuse of alcohol and / or drugs; spending more time by themselves and becoming more private or defensive.

Taking Action - Self-Harm

Practitioners who discover a child or young person to have self-harmed should not panic; make sure the child or young person is safe and should seek medical assistance where necessary.

Where the injury is serious or life threatening, then call an ambulance immediately, or go straight to A&E. If it is something a practitioner cannot assess, seek further advice. This could include contacting NHS 24 on 111 or through a nurse or doctor locally.

If the child or young person discloses that they self-harm, it is important to listen non-judgementally. Enable the child or young person to retain some control of their situation. Remember self-harm is a coping mechanism, so stopping self-harm may not be best thing to aim for immediately. Safety and understanding are more important.

Children and Young People at Risk of Suicide

Tayside Multi-Agency Guidance: Supporting Children and Young People at Risk of Self-Harm and Suicide
Tayside Self Harm and Suicide Quick Reference Guide
Suicide Help App
Perth and Kinross Young People's Mental Health and Wellbeing Webpages

The Suicide Help App can be a source of support for someone with thoughts of suicide no matter where they are. It contains contact details for organisations that can support people in distress; information about suicide; guidance on how to help and a Safety Plan Template to help individuals think through what helps them at times of crisis. The above Tayside Guidance gives further information on how to respond to children and young people with thoughts of suicide, and the links between suicide and self-harm.

Why do some Children and Young People have thoughts of Suicide?

Suicide is defined as an act of deliberate self-harm which results in death. Anyone is at risk of suicide. Suicide attempts in children and young people nearly always follow a stressful event or life crises: inter-personal loss such as relationship problems; bereavement; traumatic grief; family
break-up or issues relating to sexual orientation. However, sometimes the child or young person will have shown no previous signs of prior mental ill-health problems.

Sometimes, the child or young person has had serious problems (e.g. with the police, their family or school) for a long time. These are the children young people who are most at risk of further attempts. Some will already be seeing a Counsellor, Psychiatrist or Social Worker. Others have refused normal forms of help, and appear to be trying to run away from their problems.

**Warning Signs** – previous deliberate self-harm or suicide attempt; talking about methods of suicide; dwelling on insolvable problems; giving away possessions; hints that “I won’t be around” or “I won’t cause you any more trouble”; change in eating or sleeping habits; withdrawal from friends, family and usual interests; violent or rebellious behaviour, or running away drinking to excess or misusing drugs; feelings of boredom, restlessness, self-hatred; failing to take care of personal appearance; becoming over-cheerful after a time of depression and unresolved feelings of guilt following the loss of an important person or pet (including pop or sports idols).

**Taking Action - High Risk**

If a child or young person has attempted suicide and is injured:

- dial 999 and ask for an ambulance or take the person to A&E;
- keep the child or young person safe and do not leave them alone unless it is safe to do so;
- if the child or young person is drinking or taking drugs, try to get them to stop;
- keep yourself safe. move to a safe distance if necessary; and
- perform First Aid if needed and it is safe to do so.

**Taking Action - Suicidal Thoughts**

If a child or young person has suicidal thoughts:

- take all signs of distress seriously, even if the child or young person seems to be leading a normal life;
- ask the child or young person what is troubling them;
- let them know you care;
- encourage the child or young person to talk; and listen to them without being judgemental;
- contact the child or young person's GP (if known) or NHS24 on 111; and
- call [Breathing Space](0800 83 85 87) or [Samaritans](116 123) or [ChildLine](0800 1111).

If a child or young person is at risk of self-harm or suicide then practitioners must follow their own service or agency child protraction procedures immediately.
Domestic Abuse (DA) and Violence Against Women and Girls (VAWG)

Scottish Government Violence Against Women Webpages

The terms Domestic Abuse (DA) and Violence Against Women and Girls (VAWG) are inextricably linked.

Definition - Domestic Abuse (DA)

Domestic Abuse, as gendered based violence, can be perpetrated by partners or ex partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family and friends. It can be characterised by a pattern of coercive control often escalating in frequency and severity over time. Women are far more likely to be victims than men. Many women never report the abuse to police.

Definition - Violence Against Women and Girls (VAWG)

Violence against women and girls encompasses (but is not limited to):

- physical, sexual and psychological violence occurring in the family (including children and young people), within the general community or in institutions, including domestic abuse, rape, and incest;
- sexual harassment, bullying and intimidation in any public or private space, including work;
- commercial sexual exploitation, including prostitution, lap dancing, stripping, pornography and trafficking;
- child sexual abuse, including familial sexual abuse, child sexual exploitation and online abuse;
- so called ‘honour based’ violence, including dowry related violence, female genital mutilation, forced and child marriages, and ‘honour’ crimes.

Gender Based

These actions are mainly carried out by men against women and children. The different forms of violence have their roots in gender inequality and in the different power relations between men and women in society. They are therefore understood as gender-based violence and are interlinked. This does not mean that women do not use violence or carry out the actions described above. Nor does it mean that men are not the victims of these actions. It merely recognises that statistically men are commonly the perpetrators and women and children the victims.
Context of Violence

In the context of violence against women, violence has a broader meaning than the normal dictionary definition of violence, which generally requires some form of exertion of physical force. The range of behaviours described above can be physical, but they also include emotional, psychological and sexual abuse, and behaviour which is coercive and controlling in nature.

Key Facts about VAWG

- violence against women and girls is widespread, affecting women and girls of any age, class, race, religion, sexuality or ability;
- women and girls are most at risk from men they know;
- women and girls are often at an increased risk when they leave a relationship;
- factors which may increase women and girl’s vulnerability to some types of violence include age, disability, poverty, pregnancy and childbirth;
- when asked, significant numbers of women and girls describe patterns of abusive behaviour and repeat victimisation, rather than discrete assaults; and
- women and girls experience violence at different points in their lives, and significant numbers of women and girls experience more than one type of violence.

Impact of Domestic Abuse and Child Protection

Children and young people living with domestic abuse are at an increased risk of significant harm, both as a result of witnessing the abuse and being abused themselves. Children and young people can be affected by abuse even when they are not witnessing it or being directly subjected to abuse themselves.

The impact of living in a household where there is a regime of intimidation, control and violence differs by children’s developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development. It also affects their likelihood of experiencing or becoming a perpetrator of domestic violence and abuse as an adult, as well as exposing them directly to physical harm.

The impact of domestic abuse on a child and young person will vary, depending on factors including the frequency, severity and length of exposure to the abuse and the ability of others in the household (particularly the non-abusing parent or carer) to provide parenting support under such adverse conditions. If the non-abusing parent or carer is not safe, it is unlikely the children will be.

Children frequently come to the attention of practitioners when the severity and length of exposure to abuse has compromised the non-abusing parent or carer’s current capacity to nurture and care for them. The best way to keep both children and the non-abusing parent or carer safe is to focus on early identification, assessment and intervention. Managers and practitioners need to be aware of the signs of domestic abuse and routinely make appropriate enquiries.
For children and young people living with domestic abuse, witnessing violence and other abusive behaviours towards a non-abusing parent or carer can have a detrimental impact on a child or young person’s emotional and physical development and overall wellbeing.

It is important to find out what children and young people have experienced as a consequence of the perpetrator’s actions in order to gain some understanding of the possible impact of these experiences. Children and young people will have been told, or from experience, know not to talk about the abuse as this can result in the abuse escalating.

Children and young people react in different ways and the relationship between the abuse and the effect it has on them can be complex and multifaceted. If the non-abusing parent or carer is not safe then it is unlikely that the children will be.

The non-abusing parent or carer may appear to professionals as inadequate and be using alcohol and /or drugs as a coping mechanism. It is important to acknowledge that it is the behaviour of the abuser that may create or exacerbate issues around mental health and /or substance abuse of the non-abusing parent or carer.

**Children & Young People - Coping Strategies**

Children and young people develop complex strategies of survival in order to deal with the stress and adversity they are experiencing. They are not passive victims of domestic abuse but develop their own coping mechanisms. The survival strategies adopted by children and young people living with domestic abuse are diverse. Factors which contribute to a child or young person’s resilience include the strength and stability of support through their networks of family and friends, from sources in their wider community and from their non-abusive parent or carer.

Some children and young people’s coping strategies will change over time and can include opposite behaviours at different times, for example, from being clingy and withdrawn to having difficulty regulating their emotions and behaviour. Some children and young people feel so concerned for their mother’s safety that they want to protect her all the time and may refuse to go to school or feign illness so that they can stay at home with their mother. Some children and young people have poor social skills and some have highly developed social skills.

Some children and young people take on responsibilities in the home, such as child care for younger siblings and household chores in the hope that this will help to keep the peace. Other children and young people, especially older children, may adopt strategies aimed at self-protection including presenting an external front of courage in order to hide the fear and anxiety that lies beneath the surface.

As they lack a proper understanding of what is happening, children and young people are likely to believe that they are somehow responsible for the abuse. They are aware that violence can stem from arguments over child care, children’s behaviour or discipline or from resentment about the amount of tie the non-abusing parent or carer devotes to their children. This sense that they have in some way caused the abuse can lead children and young people to attempt to modify their behaviour, by being quiet or perfect in the hope that this will prevent an episode of abuse.
Many children and young people living with domestic abuse learn from an early age that it must be kept secret. The pressure of secrecy makes disclosure difficult for children and young people, who may go to great lengths to hide the reality of what is happening. Some children and young people may be being sexually or physically abused by the same abuser and the presence of domestic abuse contributes to silencing them about their own or their sibling’s abuse.

*It is generally accepted that children and young people affected by domestic abuse; by parental problematic alcohol and / or drug use and by parental mental ill-health – sometimes referred to as the toxic trio – are at a significantly disproportionate risk of harm and abuse.* Practitioners involved with the parent or carer should consider the impact of these factors on the child or young person’s wellbeing. Where concerns are identified, these should be shared with other practitioners in children's services.

**Honour-Based Violence (HBV)**

*Honour Based Violence (HBV) is a breach of Human Rights and if the victim is a child or young person under 16 years of age HBV is Child Abuse. Elements of HBV also constitute crimes and offences.*

HBV is a term used to describe violence committed within the context of the extended family which is motivated by a perceived need to restore standing within the community, which is presumed to have been lost through the behaviour of the victim. Most victims of HBV are women or girls; although men may also be at risk.

Women and girls may lose honour through expressions of autonomy, particularly if this autonomy occurs within the area of sexuality. Men may be targeted either by the family of a woman who they are believed to have dishonoured, in which case both parties may be at risk, or by their own family if they are believed to be homosexual.

Common triggers for HBV include:

- perceived inappropriate make-up or dress;
- refusing an arranged / forced marriage;
- having a relationship outside the approved group;
- kissing or intimacy in a public place;
- loss of virginity;
- pregnancy outside marriage;
- spending time without the supervision of a family member;
- reporting domestic violence;
- attempting to divorce;
- pushing for custody of children after divorce; and
- refusing to divorce when ordered to do so by family members.
However, some families may resolve to abuse or kill a member on what would appear to be very trivial grounds. It is important to take fears of HBV seriously, even when it seems unlikely. Victims of HBV are more likely to underestimate the risks to their safety than overstate them and even if the offence seems trivial to you, this does not mean it is trivial to his or her family.

People at risk of HBV may have had negative experiences and expectations of authority. It is important to reassure potential victims, to be culturally sensitive and empathic without making assumptions about her or his culture and background. Try to establish a means of making secure and confidential contact at the earliest opportunity, as a client may not be able to make a second attempt to ask for help.

As HBV is a collective crime, the potential assailants and their networking capacity multiply the risk. Assessments of risk that assume a single perpetrator are inadequate. It is not unknown for family to pay a hit man or agency to deal with a fugitive from the family. Families that are widely spread across the country may make many areas unsafe for people at risk of HBV. Families may also deploy their professional networks to locate an individual. In arranging protection, it is important to carry out a thorough assessment of the ability and potential of the family to locate and harm the victim.

HBV tends to be committed in communities that are high-context; i.e. those in which the family or community is considered pre-eminent rather than the individual. As a result of this, victims of HBV may lack self-confidence and self-reliance, and suffer profoundly from the isolation from their families. In this instance it is important to arrange support systems to help empower victims of HBV to rebuild their lives and to form social networks.

Many survivors of HBV are psychologically affected by their experiences, and may need counselling for depression or post-traumatic stress disorder from a culturally appropriate provider. Practitioners may also find the following helpful: Honour Base Violence Awareness Network and EngageME.

**Forced Marriage (FM)**

*Forced Marriage (FM) is a breach of Human Rights and if the victim is a child or young person under 16 years of age FM is Child Abuse. FM is also a criminal offence across the UK.*

FM is a marriage in which one or both spouses do not (or, in the case of children / young people / adults at risk, cannot) consent to the marriage and coercion is involved. Coercion can include physical, psychological, financial, sexual and emotional pressure, threatening conduct, harassment, threat of blackmail, use of deception and other means. It is also force to knowingly take advantage of a person’s incapacity to consent to marriage or to understand the nature of the marriage. Coercion may be from parents, other family members and the wider community. It is often associated with other forms of domestic abuse and Honour Based Violence (HBV). FM can also be associated with Human Trafficking.

FM is different to arranged marriage in which the families of both spouses take a leading role in arranging the marriage but the prospective spouses have the choice whether or not to accept the
arrangement. This tradition has existed successfully in many communities and countries for a very long time. But if the spouse changes their mind and is forced to go ahead with the marriage, it is considered a FM.

Women are usually the victims of FM but men can be victims too. People with physical and learning disabilities may be forced into marriage by families wanting to ensure their long-term care. Victims are under enormous cultural pressure to conform to the wishes of family and community. This is often accompanied by severe physical, emotional and sexual abuse. It is not uncommon for victims to be killed (so-called Honour Based Killings) or to commit suicide.

FM is an abuse of children’s rights under the UN Convention on the Rights of the Child (UNCRC). It is also an abuse of the basic human rights of children, young people and adults, as set out in the European Convention on Human Rights (ECHR) and is directly contrary to the domestic laws of Scotland and the other UK countries. Forcing someone to marry or taking advantage of their lack of understanding to trick them into taking part in a marriage is against the law in Scotland; so too is taking someone away from Scotland, against their will, to be married elsewhere. There may be associated criminal activities such as abduction; physical abuse; and threats.

Forced Marriage Protection Orders (FMPO), which came into force in Scotland on 28 November 2011 under The Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011, aim to protect people who are threatened with, or who are already in a FM. This Act provides Scottish Courts the power to grant a FMPO to help prevent people being forced into marriage. An FMPO can require a person to:

- take the person who is to be protected to a place of safety;
- bring the protected person to a court at a certain time and place;
- refrain from violent, threatening or intimidating conduct;
- appear in court;
- disclose the whereabouts of a relevant person;
- refrain from taking the protected person abroad;
- enable another person to return to the UK within a specified period;
- submit passports, birth certificates or other documents as required; and
- provide the court with other information as it requires.

Applications for a FMPO can be made by a local authority on behalf of a victim, or by an individual themselves. Urgent Interim Orders can also be made in situations where, for example, someone is in immediate danger, or at risk of being taken abroad for a FM.

In addition to FMPOs, an additional layer of protection, which makes FM a criminal offence in Scotland, is contained in Section 122 of the Anti-Social Behaviour, Crime and Policing Act 2014 which came into effect in Scotland on 30 September 2014.
Responding to HBV and FM

Practitioners who are worried, concerned or suspect that a child or young person is the victim of, or at risk of HBV or FM should respond as they would to any other child care and / or protection concern. In addition, practitioners should also consider the following:

Do:

- see the victim on his / her own – even if they are accompanied by others;
- see the victim immediately in a secure / private place where they cannot be overheard;
- reassure the victim and explain that you will not give information to family, friends or to members of their community;
- believe and accept what the victim is saying;
- listen to the victim’s wishes;
- recognise and respect his / her wishes;
- do everything possible you can to keep the victim safe;
- establish a way to keep in contact with them discreetly;
- consider the need for immediate police / social work involvement; and
- get immediate professional advice if you are not sure what to do.

Do Not:

- approach or contact the family or attempt any kind of mediation;
- assume it is merely a cultural issue;
- send the victim back to their family;
- assume the women in the family will protect the victim;
- use a family or community member as an interpreter – always use an independent and impartial interpreter;
- turn the victim away as you may be their only chance to get help; and
- undertake an assessment - seek professional help, advice and assistance.

Practitioners may also find the following helpful: UK Government Home Office: Forced Marriage Unit
Scottish Government: Forced Marriage Website which contains up-to-date definitive guidance; legislation; information and advice leaflets; resources and case studies.
Female Genital Mutilation (FGM)

*Female Genital Mutilation (FGM) is a breach of Human Rights and if the victim is a female child or young person under 16 years of age FGM is Child Abuse. FGM is also a criminal offence across the UK.*

The World Health Organisation (WHO) defines FGM as *all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.*

Globally the practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and this trend is increasing.

FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children and young people. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

**Reasons for FGM**

In most societies, FGM is considered a cultural tradition and this is often used as an argument for its continuation. The main reason now given for carrying out FGM is social acceptance or, conversely, fear of exclusion.

Amongst ethnic groups and communities where FGM has become the social norm, parents or carers are likely to regard having their daughters cut as part of their duty as parents or carers. Whatever the origins of practice, or the stated reasons for continuing it, FGM serves to control women’s bodies and sexuality. FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls’ and women's bodies.

**Communities at Risk**

The majority of cases of FGM are carried out in 29 countries in Africa and the Middle East.

FGM is a deeply rooted tradition, widely practised mainly among specific ethnic populations in Africa and in other parts of the world including Bahrain, Iran, Iraq, Jordan, Kuwait, Oman, Palestinian territories, Qatar, Saudi-Arabia, Syria, Turkey, United Arab Emirates, Yemen, Afghanistan, Maldives, Pakistan, India, Malaysia, Indonesia, Philippines, Tajikistan, which serves as a complex form of social control of women’s sexual and reproductive rights. Practitioners should be aware that this list is not exhaustive, and that not every community or family within these countries practice FGM.
It is known that the number of potentially affected communities is growing and with increased migration from the countries where FGM is practised, more girls in the UK are at risk of FGM. It is more accurate to view FGM as being practised by specific ethnic groups, rather than a whole country.

**Legislation**

**FGM has been unlawful in Scotland since 1985** by virtue of The Prohibition of Female Circumcision Act 1985. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 re-enacts the existing offences in the 1985 Act, and extends protection by giving those offences extra-territorial effect in order to protect those being sent abroad to have FGM carried out.

Under the terms of the Act it is criminal to:

- excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person;
- aid, abet, counsel or procure a girl to mutilate her own genitalia; or,
- aid, abet, counsel of procure another person who is not a UK national to mutilate a girl’s genitalia outside the UK.

An amendment to The Prohibition of Female Genital Mutilation (Scotland) Act 2005 was passed by the UK Parliament within The Serious Crime Act 2015. This change came into effect in 2015 and replaced the term permanent resident with habitually resident. This now ensures that a person who is not legally termed a permanent UK resident will still be able to be tried in the Scottish Courts.

**Responding to FGM**

Practitioners who are worried, concerned or suspect that a girl or young woman is the victim of, or at risk of FGM should respond as they would to any other child care and / or protection concern. In addition, practitioners should also consider the following:

**Do:**

- see the victim on her own – even if she is accompanied by others;
- see the victim immediately in a secure / private place where she cannot be overheard;
- reassure the victim and explain that you will not give information to her family, friends or to members of her community;
- believe and accept what the victim is saying;
- listen to the victim’s wishes;
- recognise and respect her wishes;
- do everything possible you can to keep the victim safe;
- establish a way to keep in contact with her discreetly;
- consider the need for immediate police / social work involvement; and
- get immediate professional advice if you are not sure what to do.
Do Not:

- approach or contact the family or attempt any kind of mediation;
- assume it is merely a cultural issue;
- send the victim back to their family;
- assume the women in the family will protect the victim;
- use a family or community member as an interpreter – always use an independent and impartial interpreter;
- turn the victim away as you may be their only chance to get help; and
- undertake an assessment - seek professional help, advice and assistance.

Practitioners may also find the following helpful: Scottish Government Website: Female Genital Mutilation and Edinburgh and Lothians Inter-Agency Procedures for the Protection of Girls and Women at Risk of Female Genital Mutilation (FGM) which contains more generic information on FGM.
Part V
Appendices
Roles and Responsibilities

Part II of the *National Guidance for Child Protection in Scotland 2014* sets out, in considerable detail, the roles and responsibilities of Chief Officer Groups, Child Protection Committees, other partnerships and single service and / or agencies.

Within this part of the guidelines, practitioners will find further information on the roles, responsibilities and membership of local partnerships, services and agencies working within the Perth and Kinross context.

Partnerships

**Children, Young People and Families Partnership (CYPFP)**

*Elected Members and Chief Officers* of the public, private and third sectors discharge their individual and collective responsibility for children's services, in particular, child protection services, through the Perth and Kinross Children, Young People and Families Partnership (CYPFP).

The Vision of the CYPFP is *to enable children and young people to be the best they can be.*

The CYPFP provides the CPC with a clear governance, accountability and reporting framework for its work and is committed to continuous improvement through self-evaluation. The CYPFP also provides strong leadership; direction; support; challenge and scrutiny of child protection services across Perth and Kinross. The CYPFP meets quarterly and all meetings are minuted.

**Child Protection Committee (CPC)**

The CPC is the strategic, multi-agency child protection partnership which oversees the development; dissemination; implementation and evaluation of child protection policy and practice developments across Perth and Kinross. *Membership of the CPC* is reviewed regularly to ensure it represents fully local children’s services.

The CPC operates in terms of a *CPC Partnership Agreement and Constitution* and is supported by a public facing, *Child Protection Website*, which provides a transparent overview of the work of the CPC.

The CPC supports the ethos that *getting it right for every child is everyone’s job* and it is *everyone’s responsibility to safeguard, support and promote the wellbeing* of all children and young people; keep them *safe* and to *protect* them from harm, abuse and neglect.

The CPC meets every two months and its membership is fully representative of the public, private, third sector and independent sectors across Perth and Kinross. All meetings are minuted.

**Alcohol and Drug Partnership (ADP)**

Perth & Kinross *Alcohol and Drug Partnership (ADP)* is a strategic partnership made up of senior representatives from a wide range of partners across the area. This includes representation from Health, Social Work, Housing, Police, Scottish Prison Service and the Voluntary Sector. The ADP
is responsible for planning and joining up the various initiatives across the area strategically to address the adverse impact of alcohol and drugs use.

Perth & Kinross Alcohol & Drug Partnership (ADP) does this by:

- setting direction to strategically tackle adverse impact of drug and alcohol use in line with national and local priorities delivered by a local strategic plan;
- influencing public policy and national strategy;
- leading and coordinating joint planning and development of recovery and substance misuse services;
- commissioning needs assessments and reviewing local and national drug and alcohol profile information; and
- overseeing the delivery of the strategic objectives through the annual action plans in regards to prioritising funding through commissioning services.

The purpose of this strategy is to outline the priorities and actions needed to address the current and anticipated challenges caused by the adverse impact of both alcohol and drug use in Perth and Kinross.

**Adult Support and Protection Committee (APC)**

The **Adult Support and Protection Committee (APC)** has a significant role in ensuring co-operation and communication within and between services / agencies to promote appropriate support and protection as set out in Section 42 of **The Adult Support and Protection (Scotland) Act 2007**.

The APC supports the work of the Child Protection Committee and is committed to ensuring that adults at risk in Perth and Kinross are protected from harm. Its membership includes representation from the public, private and third sectors across Perth and Kinross. The APC meets every two months.

**Violence Against Women Partnership (VAWP)**

The **Violence Against Women Partnership (VAWP)** as a multi-agency membership, including partners from statutory and voluntary sectors across Perth and Kinross. The partnership aims to encourage an integrated response to addressing gender based violence and coordinates a range of activities aimed at raising awareness and preventing gender based violence within Perth and Kinross.

The partnership works to address the causes and consequences of violence against women via the 4 P's:

- **Prevention**: prevent, remove or diminish the risk of violence against women and its impact on children and young people;
- **Protection**: protect women from victimisation, repeat victimisation or harassment by perpetrators and protect the children and young people affected;
• **Provision**: provide adequate services to deal with the consequences of violence against women and children to help them to rebuild their lives; and

• **Participation**: ensure policy making and practice development around violence against women is shaped by the experiences, needs and views of those who use.

**Single Services / Agencies**

**Perth and Kinross Council**

*Perth and Kinross Council* is responsible for the delivery of public services across a large landward area of approximately 5,286 square kilometres to a population of approximately 145,930. Perth and Kinross Council is ranked fifth in Scotland in terms of area and thirteenth in Scotland in terms of population. A third of the overall population live in Perth City. More rural areas are clustered around Crieff, Kinross, Scone, Blairgowrie, Pitlochry and Auchterarder. The population is projected to grow by 24% by 2037, which is the third highest growth rate predicted in Scotland.

**Education and Children’s Services** delivers an integrated approach to children's services across Perth and Kinross.

**Education Service**

Teachers and all other staff working in education have a crucial role to play in the care and welfare of children and young people, along with the promotion of their personal safety. Within the Curriculum for Excellence, the health and wellbeing element is highlighted, along with literacy and numeracy, as being the responsibility of all staff and so the promotion of positive wellbeing takes a high priority within our schools and centres.

Across the school curriculum there is a focus on equipping children and young people with the knowledge, understanding and skills they need to keep themselves and others safe. This includes exploring issues such as healthy relationships; substance misuse; sexual health; exploitation; personal safety in the digital environment and developing resilience.

Teachers and staff in all schools and centres have a key role to play in creating physically and emotionally safe environments where children and young people can feel respected, cared for and secure. As a group, the staff who work in schools are likely to have the greatest level of day-to-day contact with children and young people, and so are well placed to observe, record and report physical and psychological changes in a child or young person. In our schools, children and young people often see teachers and support staff as a trusted source of help and support.

Across Perth and Kinross, each school has a designated Child Protection Officer (CPO) who has undergone specific child protection training in relation to this role. The CPO is responsible for ensuring appropriate processes are in place for recording and responding appropriately to concerns about wellbeing, for liaising as required with the Multi Agency Screening Group (MASG) and for giving child protection advice and / or support to other staff in the school, as well as supporting parents or carers or children and young people when that is required. Where there are
child protection concerns the CPO has a crucial role in passing on those concerns to social work colleagues, for investigation as appropriate and for liaising with other service / agencies.

A range of staff in schools, including those who take on the Named Person role, contribute to the assessment of vulnerable children and annual child protection update sessions in schools and centres across the authority ensure that staff are well aware of potential indicators of abuse. It is also the responsibility of senior managers to ensure appropriate support for children, young people, staff or parents or carers affected by child concern and child protection issues.

Perth and Kinross Education and Children’s Services Child Protection Procedures detail the responsibility of senior managers in schools and centres to ensure that all staff appropriately monitor, record and report any child protection concern. Practical guidance on appropriate record keeping and monitoring practices is shared in the Child Concern Paperwork Guidance.

**Services for Children, Young People and Families**

The service is committed to the principle of protecting children and young people’s right to be brought up in the safety and security of his / her own family. However the wellbeing and safety of the child and young person is always the paramount consideration. Work is undertaken with children, young people and their families within their own communities and in residential and foster placements to promote positive outcomes for all.

Under *The Children (Scotland) Act 1995*, Services for Children, Young People and Families Social Work Services has a statutory responsibility to enquire into the circumstances of children and young people who may require compulsory measures of supervision, who may have been abused or at risk of being abused and to take appropriate measures to protect them from further harm.

Services for Children, Young People and Families will also act as the lead agency for the Local Authority in the application for and implementation of the Orders introduced by *The Children (Scotland) Act 1995* relating to child protection. Social Workers also provide therapeutic services to children, young people and families affected by trauma or abuse.

**Independent Schools**

Schools in the independent education sector ensure that child protection policies and procedures meet the criteria of the recommendations set out in the Scottish Council for Independent Schools Guidelines on Child Protection and reflect Perth & Kinross Child Protection Guidelines.

*The Children (Scotland) Act 1995* placed upon the managers of independent boarding schools a duty to safeguard and promote the welfare of children resident in their schools. *The Protection of Children (Scotland) Act 2003* and *The Protection of Vulnerable Groups (Scotland) Act 2007* strengthened this duty on schools and on all persons in child care positions to protect children from harm or from being at risk of harm.

Staff are supported and enabled to respond appropriately to children and young people who have been harmed or may be at risk of harm. Training and development has been delivered to ensure that all staff are appraised of these responsibilities to promote the well-being of children and young
people. All schools in the independent education sector have a designated Child Protection Coordinator with a particular responsibility for ensuring effective links with all appropriate agencies.

**Scottish Children’s Reporter Administration (SCRA)**

Scottish Children’s Reporter Administration (SCRA) is a national body formed in 1996. Its main responsibilities are to facilitate the work of Children’s Reporters: to deploy and manage staff to carry out that work and to provide suitable accommodation for Children’s Hearings.

The Children’s Hearings System provides the operational setting in which SCRA and partner agencies work. The aim is to provide a safety net for vulnerable children and deliver tailored solutions which meet the needs of the individuals involved; while helping to build stronger families and safer communities. SCRA also works collaboratively with partners to support and facilitate the Getting it Right For Every Child (GIRFEC) agenda.

The role of the Reporter is to:

- receive referrals for children and young people who are believed to require compulsory measures of supervision;
- decide whether the child or young person needs to be referred to a Hearing, and if so draft a statement of grounds;
- provide administration to Children’s Hearings and keep a record of proceedings at Hearings;
- maintain the independence of Hearings and support fair process; and
- conduct Children’s Hearings court proceedings.

The Reporter’s primary function is to receive referrals for children and young people who are believed to require compulsory measures of supervision. The Reporter then decides whether the child or young person should be referred to a Children’s Hearing.

SCRA has nine localities, supported by a Head Office. The nine localities are: Highlands & Islands, North Strathclyde, Glasgow, Grampian, South East, Tayside & Fife, Ayrshire, Central, and Lanarkshire/Dumfries & Galloway.

The service to Perth and Kinross is provided by the Tayside Fife Locality. It is the Dundee office that provides the service to Perth & Kinross, contact details of which can be found on the SCRA website. There is a Hearing Centre in Perth and SCRA currently hold 4 Hearing session a week in this centre.

The SCRA Website provides information and resources for families and professionals. There is also information for partners and Guidance on Referral to the Reporter – Information for Partners which is a valuable resource for anyone considering whether to refer a child or young person to SCRA.
Police Scotland, Tayside (D) Division

**Tayside Division** operates within a geographical area of some 7,497 square kilometres and serves approximately 388,000 people across Tayside. Policing services are provided against a backdrop of densely populated urban areas and sparsely populated rural areas.

**Policing across Perth and Kinross** is delivered via the local policing area headquarters at Barrack Street, Perth. In 2008, Public Protection Units (PPUs) were formed within Tayside Police. The remits of the units have expanded and now includes the protection of the most vulnerable in society; namely children, victims of domestic abuse and vulnerable adults. Areas of responsibility include Child Protection, Adult Protection, Investigation of Serious Sexual Crime, Domestic Abuse, Offender Management, Youth Justice and Missing People. Based within Barrack Street, Perth is a Child / Adult Protection Investigation Team, which is supported by similar resources within Angus and Dundee and by a Divisional Risk / Concern Hub responsible primarily for information sharing.

The responsibility to ensure the care and protection of children and young people is a fundamental part of the duties of all police officers. Child Protection concerns are a priority for Police Scotland and will be handled with professionalism and sensitivity and with the best interests of the child or young person at the heart of all actions and decision.

Whilst investigations are normally undertaken by specialist officers from the Public Protection Units working jointly with the Social Work Department’s Child Protection and Duty Team and other Social Work staff, in emergencies initial attendance may involve Uniformed and / or Detective Officers. All Police officers have emergency powers under **Section 56 of The Children’s Hearings (Scotland) Act 2011** to ensure the immediate protection of children and young people believed to suffering from, or at risk, of significant harm.

Whenever there is a suspicion that a crime or offence has been committed against a child or young person, the Police should be informed immediately so that if appropriate, an investigation can be commenced and evidence secured without delay.

Specialist Officers from the local public protection unit are primarily responsible for joint child protection investigations and in conjunction with social work are trained in Joint Investigative Interviewing of Child Witnesses. They will also consult with relevant medical professionals to arrange any medical examination for the purposes of gathering evidence. The Police are ultimately responsible for investigation and gathering evidence in criminal enquiries and thereafter reporting information to the Procurator Fiscal service who decide whether a prosecution will take place. The Police may refer a child to the Children’s Reporter if they believe that they may be in need of compulsory measures of supervision.

The Police hold important information about children and young people who may be at risk of harm or significant harm and will share this information, where lawful, with other organisations to protect those children and young people and support early intervention. When a Child Protection Case Conference is called in respect of a child or young person who has been the subject of investigation, a Police representative will attend to contribute to the decision making process.
**Procurator Fiscal Services**

The **Crown Office and Procurator Fiscal Service (COPFS)** is Scotland's sole prosecuting service, independent of the police and the courts. Procurators Fiscals 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. 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. As a result, assessment of the public interest involves careful consideration of all factors.

Following careful consideration the Procurator Fiscal may decide to commence proceedings, offer an alternative to prosecution or take no action. In cases that a jury will consider, the Procurator Fiscal will gather and review all evidence before Crown Counsel makes the final decision on whether to prosecute.

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 interview witnesses and gather and review the forensic and other evidence before Crown Counsel makes the final decision on whether to prosecute.

**NHS Tayside**

**NHS Tayside** is responsible for delivering healthcare to around 400,000 people living across Tayside and North East Fife. NHS Tayside employs approximately 14,000 staff and provides a comprehensive range of primary, community-based and acute hospital services for the populations of Dundee City, Angus and Perth & Kinross. Acute services are also provided by Ninewells Hospital and Medical School to the population of North East Fife. NHS Tayside's principal health organisations are Tayside NHS Board, the Single Delivery Unit and Children Young People and Families Service NHS Tayside.

**NHS Tayside Children, Young People and Families Service** aims to establish and develop high quality local services, with health services, social services and voluntary organisations working closely together to provide services that meet local needs. It aims to make sure that the right care is delivered at the right time and in the right place. It also aims to help people in Perth and Kinross to take responsibility for their own health and wellbeing.

*All Health Staff should follow the NHS Tayside Child Protection Policy available on the NHS Staffnet website.*
Medical Staff

All Doctors

Health professionals are often the first to be alerted to situations where children or young people have been, or are at risk, of being harmed, particularly in situations where there is some uncertainty regarding the nature of concern. Doctors have a range of responsibilities when responding to concerns that a child or young person has been, or may be at risk of harm as follows:

1. To assess whether a child or young person is in need of urgent medical treatment, and make appropriate arrangements immediately;

2. To make preliminary examination of the child or young person, looking for evidence of harm to the child or young person; which would support the presenting history and / or allegation. At the same time, to look for indications of the child or young person’s overall physical and emotional care, i.e. physical growth and development and to take into account the background history. This assessment may be carried out either by the child or young person’s GP in his / her surgery or may also be following attendance at an Accident and Emergency Department or minor injury unit. It is the responsibility of the examining doctor to provide a hand-written report on his / her findings for the benefit of the relevant agencies;

3. Where medical findings support the possibility of harm to the child or young person, the doctor must inform Social Work or Police colleagues. A doctor can also seek direct advice from the On-Call Consultant Paediatrician for Child Protection. If the findings are inconclusive but the doctor is concerned abuse may have occurred, the doctor must also inform Social Work or Police colleagues. Social Work and Police should then discuss with the On-Call Paediatrician for Child Protection about the need for further medical assessments. This would take place as part of the Inter-Agency Referral Discussion (IRD);

4. Where a decision is taken to proceed with a joint paediatric / forensic medical examination, this should take place in a dedicated Child Protection facility. If the child or young person is already in hospital, the forensic medical examiner will carry out the examination in hospital with the child’s Consultant Paediatrician;

5. The findings of this joint paediatric / forensic medical examination will be shared with police and social work and a formal report is sent to the Procurator Fiscal to be used in evidence in any subsequent legal proceedings. Examination findings can also be made available to the Children’s Reporter;

6. At all stages, there will be close liaison with Social Work, Police and any other involved services / agencies through discussion at the time of referral, throughout the investigation and by the provision of a report for the subsequent Child Protection Case Conference to ensure that the child or young person’s health needs are carefully considered by the multi-disciplinary team; and

7. To ensure ongoing health surveillance and management of medical and developmental problems in children and young people who have been identified as being at risk.
**General Practitioners (GPs)**

General Practitioners (GPs) and other health care professionals are in a position to identify stress in families and to notice any indication that a child or young person has been, or is at risk of being harmed at an early stage. They therefore have a key role to play in the prevention of harm by promoting better parenting skills and referring to support agencies at an early stage when this is required. If in doubt initial guidance or advice may be sought from the Lead Clinician or Nurse Advisor Child Protection.

It is essential that whenever a GP becomes suspicious that a child or young person may be at risk of being, or has been harmed, that these concerns are discussed with colleagues experienced in working in the field of child protection and where relevant, shared with the appropriate Named Person.

*The General Medical Council (November 1987) has stated that if a doctor has reason for believing that a child or young person is being physically or sexually abused not only is it permissible for the doctor to disclose information to a third party but it is a duty of the doctor to do so.*


"if you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you should give information promptly to an appropriate responsible person or statutory agency, where you believe that the disclosure is in the patient's best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children where concerns about possible abuse need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibility about the disclosure. If for any reason you believe that disclosure is not in the best interests of an abused or neglected patient, you must still be prepared to justify your decision."

**Nursing Staff**

Nursing staff may frequently be the first contact when there is concern that a child or young person has been, or is at risk of being harmed and it is essential that staff having contact with children, young people and their parents or carers are knowledgeable about procedures to follow and the guidance available to them.

The welfare of the child or young person is paramount at all times and the child should be consulted and kept informed throughout any investigation. Even quite small children can indicate their hurt, concerns and wishes. Nurses can help provide an environment in which the child feels safe and secure. All nurses follow the NHS Tayside Child Protection Policies and Procedures.
Hospital Nursing Staff

Hospital Nursing staff will be involved in admission procedures, examinations of the child or young person and any necessary treatments. The prime responsibilities of nursing staff are to provide a caring and supportive environment appropriate to the age and needs of each particular child or young person and to observe and record the child or young person's interactions with parents or carers. Inappropriate behaviour will also be recorded and reported.

Hospital Nursing staff record their nursing interventions and actions and prepare care plans appropriate to the individual child or young person and his / her circumstances and needs. Hospital Nursing staff may on occasions prepare reports and be required to attend Child Protection Case Conferences. They communicate and co-operate with the Named Person Service and other agencies in determining child protection strategies when required.

Community Nursing

As Named Persons, Health Visitors / Family Nurses have the potential to focus in-depth knowledge of the family and may be well placed to recognise children or young people who may be vulnerable and at risk of significant harm through compromised parenting.

The Named Person will contribute to the protection of children by:

1. observing and assessing the growth, health & developmental progress of children and young people, both in and out with the context of the family situation. This enables identification of children or young people at risk and initiating appropriate child protection procedures;
2. facilitating communications with other service / agencies. The relationship between the family and the Community Nurse will aid other services / agencies in their investigations;
3. co-operating and participating in investigations by providing appropriate reports and information;
4. providing reports for and attending Child Protection Case Conferences or other meetings;
5. providing post-investigation support where there is no evidence of the child or young person being harmed by continuing contact, monitoring and recording the child or young person's health and development; and
6. undertake the role of the Named Person and facilitate assessment of risk and need through co-ordination, action and content on non-statutory Children’s Plan.

NHS 24

NHS 24 is a special health board providing national services including online, telephone, video and web-based services. NHS 24 provides access to clinical assessment, healthcare advice and information and aims to give customers the assistance and advice they require to meet their health needs.
Most calls to NHS 24 are made out-of-hours, when GP surgeries are closed, but the service is available 24 hours a day. When NHS 24 staff identify a child protection issue they will share this information with partners from other services/agencies to ensure that services are alert to the protection needs of the unborn baby, child or young person.

Accident and Emergency

These members of staff may be the first point of contact in cases of suspected or actual child abuse and neglect. This may include scenarios where adult carers are presenting with an injury / health problem. The same applies to the Ambulance Service. Emergency Dispatch Centres record and register all calls and can act as an initial hub for emergency medical responses or notifications.

Parents or carers may seek medical care from a number of sources in order to conceal the fact that a child or young person is being injured regularly. Similarly, staff may notice a child or young person presenting themselves repeatedly, even with slight injuries, in a way that they find worrying. This may include signs of self-harming or of alcohol and/or drug misuse. Arrangements for obtaining medical and nursing advice from the appropriate designated professional/team are in place locally.

Dental Care Practitioners

Dental staff will often come into contact with vulnerable children and young people and are in a position to identify possible child abuse or neglect from examinations of injuries or oral hygiene. The dental team have the knowledge and skills to identify concerns regarding a child or young person’s welfare and know how and with whom to share that information.

Community Pharmacy Services

Pharmacists, Pharmacy Technicians and Pharmacy Support staff regularly deal with children and young people and their parents or carers including those in at risk groups such as children of substance misusing parents or carers in the course of their day to day practice. As such, they have an important role to play in identifying whether a child or young person is at risk of harm and/or abuse.

NHS Tayside Child Protection Team

NHS Tayside has a dedicated Child Protection Team. Medically there is the Designated Doctor for Child Protection supported by Lead Paediatric Clinicians for each area in Tayside. There is also a Lead Nurse supported by a Team of Nurse Advisors Child Protection. The following staff are in place in NHS Tayside / Perth and Kinross with specific roles for the protection of children and young people.

Designated Doctor Child Protection

The Designated Doctor Child Protection works closely with NHS Tayside, Child Protection Committees, Lead Clinicians and Nurses in supporting all activities necessary to ensure NHS Tayside meets its responsibilities in protecting children. The Designated Doctor has an inter-agency role and also an advisory role to NHS Tayside Board both managerially and clinically.
includes advice on policy, procedure, training and communication. The Designated Doctor is also clinically active in the field of child protection and contributes to the Tayside wide Consultant led On-Call rota for child protection.

**Nurse Advisor Child Protection**

The role of the Nurse Advisor Child Protection is to:

- provide professionalism, staff support and supervision in the identification and management of child protection;
- provide effective leadership in monitoring and evaluating practice standards and work closely with service leads and managers to ensure standards are met;
- act as a resource for professionals at all levels both within and outside a specified area;
- establish and maintain professional networks within a specified area;
- co-ordinate the provision of specialist advice throughout the organisation that is both proactive and reactive;
- provide a credible, accessible and approachable service which empowers staff;
- support the identification of training needs of health staff by local managers and to deliver single agency/multi-agency child protection training;
- contribute policy development within and outwith the organisation; and
- contribute to the Multi-Agency CPC Sub Groups.

**Lead Paediatric Clinician Child Protection**

The Lead Clinician for Child Protection is a senior Paediatrician with responsibility for overseeing medical services and assessment of children and young people in Perth and Kinross who may have been abused. The Lead Clinician can be contacted for advice by medical and health staff about child protection concerns at any time. The Lead Clinician is involved in the tri-partite IRDs discussing the overall medical and health management of children and young people in non-acute cases. However the On-Call Paediatrician for child protection will provide initial advice in child protection investigations. The Lead Clinician also contributes to the Tayside-wide Consultant Led On-Call rota for child protection.

**Other Health Professionals Working Directly With Children**

This group includes many diverse health professionals, e.g. Speech and Language Therapists and Physiotherapists, all of whom may play a key role in providing therapy, treatment and care to children and young people. As with all other health professionals, this group of staff have a duty to share information with appropriate professionals to ensure the protection of children that they come into contact with.

**Health Staff Who Do Not Work Directly With Children**

Although the child or young person may not be their patient or client, health staff in this category, e.g. mental ill-health teams or substance misuse workers must proactively share any concerns
regarding a child or young person's safety, protection or welfare with an appropriate professional, either within their own service or agency or within another service or agency. It is essential that the impact of the parent or carer's condition on the welfare of the child or young person be assessed.

**Adult Social Care Services (Health and Social Care Partnership)**

The Local Authority Social Care Teams make a positive difference to meeting the health and welfare needs of children, particularly those at risk from harm. Staff work with parents who have mental health illness, substance misuse, learning and physical disabilities that can impact on the parenting role and abilities.

Adult Social Care Services includes a range of specialist provisions for particular groups, including the elderly, those with ill-health issues, people with disabilities and adults at risk and in need of support and / or protection. See: [www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection](http://www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection). Although the services are offered to support the adult, staff are alert to when they need to make relevant referrals to childcare or other agencies.

The Adult Social Work and Social Care Service promotes child welfare by:

- ensuring children are referred for support when parental issues have been identified that could impact on parental care;
- working with parents to maximise their health and well-being to enable more positive interaction with their children;
- working closely with other services and agencies in sharing relevant information; and
- Helping manage the risk posed by offenders.

**Safer Communities Social Work Services**

Safer Communities Social Work Services have responsibilities for the supervision and management of risk relating to adults who have committed high-risk offences including those against children and young people. Criminal Justice staff may be directly involved in risk assessment, supervision and intervention with adult offenders against children and young people. Alternatively, through the course of their involvement with other service users, concerns about a child or young person's wellbeing may come to light – for example, in cases of domestic abuse or problematic alcohol and / or drug use.

**Community Safety Services**

Community Safety Services provide a range of support for a number of socially isolated and vulnerable groups including asylum seekers, domestic abuse victims and young people involved in anti-social behaviour. As many individuals involved in such situations have experienced abuse themselves and / or been in contact with children and young people who are particularly vulnerable, all staff are alert to the wellbeing of children and young people and understand their responsibilities to share any concerns with the relevant services.
MAPPA (Multi–Agency Public Protection Arrangements)

The Management of Offenders etc (Scotland) Act 2005, Sections 10 and 11, provides statutory function for Local Authorities, Police, Health and the Scottish Prison Service (known as the Responsible Authorities) to jointly establish arrangements, MAPPA, for the assessment and management of risk to the public posed by sex offenders, violent offenders and those whose conviction leads the Responsible Authority to believe that they pose a significant risk of harm.

The MAPPA guidance provides the framework under which MAPPA operates, identifying three separate but connected levels at which risk is assessed and managed. This structure of risk management is intended to enable resources to be deployed so that identified risk can be managed in the most efficient and effective manner.

The levels are:

1. Level 1 - Ordinary Risk Management;
2. Level 2 - Local Inter-Agency Risk Management; and
3. Level 3 - MAPPP – Multi-Agency Public Protection Panels.

The multi-agency approach to assessing and managing offenders who may pose a risk of harm to the community is well established within Perth and Kinross. A key to the success of the Tayside MAPPA is the continued joint working of the Criminal Justice Services, Child Care Services, Public Protection Teams and the Offender Management Teams of Police Scotland - Tayside Division.

This allows for all initial information to be exchanged in all cases, identifying those that can be effectively managed at Level 1 (which is the vast majority of the offenders) and also identifying those requiring either Level 2 or Level 3 management. The majority of these offenders pose a risk to children and young people and as part of risk assessment procedures the MAPPA will regularly instigate child protection measure and exclusion orders where necessary.

Scottish Prison Service (SPS)

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 them the best chance to reduce their reoffending when they return to the community.

The key issues in relation to children and young people with a parent or carer in the criminal justice system is to provide support to children and young people whose parent or carer is at any stage in the criminal justice system; ensure that parent-child relationships are maintained, even if the parent or carer is in long-term custody or prison and recognise that, where a child or young person is considered at risk, the response should be timely, appropriate and proportionate in line with the approach set out in Getting it right for every child.

Housing Services

The Local Authority Housing Service and Registered Social Landlords (RSLs – Housing Associations) can make an important contribution to meeting the health and welfare needs of
children and young people, particularly those who need safeguarding from harm. Housing staff come into contact with children and young people on a day-to-day basis and are well placed to identify and support a child or young person who may be experiencing risks to their wellbeing, including abuse or neglect.

The Housing (Scotland) Act 1987 (as amended) sets out the local authority’s statutory duties as they apply to the housing of homeless families with children and to young people. Legislation governing the allocation of housing is found in The Housing (Scotland) Act 2001 (as amended) which applies equally to both the Local Authority Council and RSLs.

The Housing Service promotes safeguarding by:

- identifying support needs at an early stage through an assessment of need with regard to the health and welfare of dependent children and young people;
- housing families near to their existing support networks and schools, wherever possible;
- developing multi agency arrangements; working closely with other services and agencies in sharing information; contributing to support plans and ensuring that housing staff have a good working knowledge of the local services available;
- ensuring that council housing stock meets the Scottish Housing Quality Standard and providing access to good quality and affordable temporary accommodation where this is required; and
- playing a key role in the management of risk posed by offenders.

The Housing Service also works closely with other social housing providers in delivering a wide range of housing options so as to best meet the needs of children and young people, and will cooperate with the Named Person.

Public Service Reform, Culture and Community Development Division

Staff and volunteers in this service provide a wide range of services including adult learning, Gaelic learning and cultural events, community development, community planning and policy development. The service has regular direct contact with adults of all ages, either as part of groups or as individuals. Staff are committed to ensuring the protection of children and young people is paramount and that their rights are respected. All staff receive training in helping recognise abuse and following appropriate procedures.

Community Service staff work closely with a wide range of community groups and voluntary organisations in the delivery of services. They ensure that any such groups have child protection policies and procedures in place.

Culture Perth and Kinross (CPK Trust)

Culture Perth and Kinross (CPK) is a charitable Trust, which has taken-on responsibility for the development and delivery of Museums, Galleries, Libraries, Archives and Local and Family History Services from Perth and Kinross Council.
These services are delivered across Perth and Kinross for children from birth, though activities such as Bookbug, to older people, with services delivered in residential care home and sheltered housing. We receive over 650,000 footfall visits per year.

CPK has a duty of care to safeguard all children and vulnerable adults involved in any aspect of our services from harm. All children and vulnerable adults have a right to protection, and the needs of those with disabilities, or complex needs and others who may be particularly vulnerable, must be taken into account when planning and delivering our services.

CPK will ensure the safety and protection of all children and vulnerable adults involved in services through adherence to the our Protecting Vulnerable Groups Guidelines and Procedures which reflects the National Guidance for Child Protection in Scotland 2014 the policies and procedures previously used within Perth and Kinross Council and which aim to:

- provide children, young people and vulnerable adults with appropriate safety and protection whilst in the care of CPK or using our services; and
- allow all staff / volunteers to make informed and confident responses to specific child or adult protection issues.

CPK has a Lead Officer for the Child and Adult Protection (CPKCAP) and all staff receive training on the Protection of Vulnerable Groups, as part of a rolling programme of development and awareness raising.

All staff working in planning service delivery are trained in undertaking risk assessments and where activity requires additional training, such as work within HMP Perth or HMP Castle Huntly, then staff receive additional specialist training and awareness raising sessions. The CPKCAP sits on the Perth and Kinross Child Protection Committee to ensure that best practice is being disseminated and promoted within our services at all times.

**Live Active Leisure (LAL Trust)**

Live Active Leisure have a moral and legal responsibility and duty of care towards children, young people and vulnerable adults and implement procedures to safeguard their wellbeing and protect them from harm and abuse, whilst they are using our leisure services.

Live Active Leisure has an Integrated Child Protection Policy. Through the implementation of its policies and procedures and the good practices of its members of staff, the organisation will respect and promote the rights, wishes and feelings of children, young people and vulnerable adults.

The organisation requires staff to adopt and abide by the organisation's Child Protection Policy and Procedures. Live Active Leisure, through recruitment, training and supervision of its employees will adopt best practice to safeguard, support and promote the wellbeing of children, young people and vulnerable adults and to protect them from harm and abuse.
Child Protection training is available in a wide range of formats including the induction process, annual refresher courses and online awareness training. Staff requiring more in depth knowledge can access further in-house and partner organisations training.

Live Active Leisure staff members meet hundreds of children and young people each week and are uniquely positioned to make informal assessments of changes in an individual child or young person’s behaviour and physical appearance. In this context, trained staff within the organisation can provide an early indication of abuse and may be regarded by the child or young person as a trusted adult. Live Active Leisure therefore works closely with colleagues in Education and Children’s Services to help keep children and young people safe and protected.

**Horsecross Arts (Horsecross Arts Trust)**

Horsecross Arts is committed to providing a safe and secure environment in which children and young people are able to experience the performing arts. Horsecross Arts is dedicated to ensuring that all children and young people involved in any of our activities feel comfortable and respected. Participation in the arts is an extremely enriching and rewarding experience for children and young people, developing their creative skills, encouraging self-expression, promoting open communication and heightening self-esteem.

Horsecross Arts has a robust child protection policy and set of procedures for staff and freelance practitioners working both directly (for example Perth Youth Theatre Tutors) and indirectly (for example customer facing staff in our venues) with children and young people. This includes a rigorous recruitment procedure; child protection training and regular support and supervision for roles involving regulated work with children and young people.

Horsecross Arts has two Designated Child Protection Officers (DCPOs) in place. Our policy and procedures were created in line with the National Guidance for Child Protection in Scotland 2014 and Creating Safety guidance (produced by Creative Scotland and Children in Scotland): (www.creativescotland.com/resources/professional-resources/guidance-and-toolkits/creating-safety).

It is the responsibility of all Horsecross Arts staff and freelance practitioners that the following principles underpin their actions:

- the best interests of the child or young person are a primary consideration;
- all children and young people are treated fairly, with dignity and respect;
- all children and young people have the right to express their views on matters that affect them; and
- all children and young people have the right to protection from all forms of harm, abuse, neglect and exploitation.

Furthermore, all visiting companies using our venues, that have children or young people involved in their activities / performances, or where children and young people are the primary target audience for a performance, are sent a copy of our child protection policy at the contract stage. Signature of the contract indicates acceptance of the terms laid down in our policy. If the visiting company has a Child Protection Policy of their own, a copy of this will be requested and the DCPO
must be satisfied that this policy complies with the Horsecross Arts child protection policy before the contract is agreed. In particular, the DCPO must be satisfied that adequate supervision arrangements will be in place and that adults in charge of children or young people are competent and have been properly vetted.

**Third Sector**

**Perth and Kinross Association of Voluntary Service (PKAVS)**

PKAVS is a leading charity enhancing lives and connecting communities throughout Perth & Kinross. Through its ‘one-stop-shop’ Hubs for Carers, Mental Health and Wellbeing, Minority Communities, Third Sector and Volunteering, we bring support and connections to those who need it most in our communities, whilst strengthening Perth & Kinross’s voluntary sector. As the interface for the local Third Sector, PKAVS supports, develops and connects the Third Sector. In communicating widely through established Third Sector networks, PKAVS raises awareness of child protection policy and practice developments for those involved in delivering services directly to children and young people. PKAVS also supports the administration of the Perth and Kinross Child Protection Voluntary Sector Forum (CPVSF) – which offers peer learning and practice support to third sector colleagues. The Forum is represented at the Child Protection Committee and in its various Sub-Groups. The Forum is open to all frontline practitioners and managers with an interest in developing child protection in their services / organisations. For further details see: www.vaperthshire.org/en/community-planning/children-young-people-families/practice-forums-and-networks.

**Perth and Kinross Voluntary Sector Child Protection Forum (VSCPFP)**

Perth and Kinross Voluntary Sector Forum Child Protection (VSCPFP) is a well-established, peer support (both formal and informal) and practitioner network, which allows all third sector practitioners, services and agencies the opportunity to regularly meet, discuss, share and exchange good child protection practice.

Membership includes many services and agencies that regularly contribute to, and benefit from, their training updates, peer support and resource sharing. Several of them have roles to help reduce risks of harm and neglect for children and young people, by providing a significant relationship via a worker for them and their family.

The VSCPFP is supported by Perth and Kinross Association of Voluntary Services (PKAVS) Third Sector & Volunteering Hub and has representation at the Perth and Kinross CPC and all CPC Sub Groups. These established links between VSCPFP, PKAVS, the CPC and the CPC Sub Groups help ensure that the Third Sector is working to the required child protection policy and / or legislative requirements. It also ensures that local child protection procedures and guidance, which help keep children and young people safe and promote their future wellbeing, are widely understood and complied with.

The Third Sector is a significant provider 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. Some services are provided substantially by volunteers, particularly in relation to youth work. The Third Sector includes a number of large to
medium-sized charities, providing a wide range of specialised services. These often deploy both professional staff and volunteers.

Within Perth and Kinross, the Third Sector plays an important role in supporting children and young people and families. In the interests of protecting children and young people, each Third Sector organisation should have a clear Child Protection Policy in place. If a Third Sector organisation has a concern in relation to the safety or wellbeing of a child or young person, the Social Work Service or the Police will be contacted as soon as possible.

Perth and Kinross’ statutory services / agencies work in partnership with the voluntary sector, in order to promote good practice, share professional issues and engage in cross-sector training.
Policy Context

UN Convention on the Rights of the Child (UNCRC)

European Convention on Human Rights (ECHR)

Scottish Executive (2002): Audit and Review Report “It’s everyone’s job to make sure I’m alright”


Scottish Executive (2004): Protecting Children and Young People: The Charter


HMIe Services for Children Unit (2005): How well are children and young people protected and their needs met? Self evaluation using quality indicators


Scottish Government (2008): The Early Years Framework

Scottish Government (2009): The Early Years Framework Part II


HMIe Services for Children Unit (2009): How good are we now? How well do we protect children and meet their needs? How good can we be?


Sharon Vincent (2012): Audit and Analysis of Significant Case Reviews

Scottish Government (April 2013): Getting our Priorities Right: Updated Good Practice Guidance For All Agencies and Practitioners Working With Children, Young People and Families Affected By Problematic Alcohol and / or Drug Use
Care Inspectorate (2013): Child Protection Services: Findings of Joint Inspections 2009 - 2013


Care Inspectorate (2014): How well are we improving the lives of children and young people? A guide to evaluating services using quality indicators


Care Inspectorate: 2014: A report on the effectiveness of child protection arrangements across Scotland


Barnardos Scotland (2015): Unprotected, Overprotected: Meeting the Needs of Young People with Learning Disabilities who experience, or are at risk of, Sexual Exploitation

Barnardos Scotland (2015): Unprotected, Overprotected: Meeting the Needs of Young People with Learning Disabilities who experience, or are at risk of, Sexual Exploitation: Executive Summary

Care Inspectorate (2015): Inspecting and improving care and social work in Scotland: Findings from the Care Inspectorate 2011 - 2014


Scottish Government (2017): Trafficking and Exploitation Strategy

Legislative Context

The Children and Young People (Scotland) Act 1937
The Social Work (Scotland) Act 1968
The Education (Scotland) Act 1980
The Civic Government (Scotland) Act 1982
The Housing (Scotland) Act 1987
The Age of Legal Capacity (Scotland) Act 1991
The Criminal Procedure (Scotland) Act 1995
The Children (Scotland) Act 1995
The Sex Offenders Act 1997
The Human Rights Act 1998
The Data Protection Act 1998
The Housing (Scotland) Act 2001
The Protection from Abuse (Scotland) Act 2001
The Freedom of Information (Scotland) Act 2002
Sexual Offences (Procedure and Evidence) (Scotland) Act 2002
The Protection of Children (Scotland) Act 2003
The Criminal Justice (Scotland) Act 2003
The Local Government in Scotland Act 2003
The Mental Health (Care and Treatment) (Scotland) Act 2003
The Antisocial Behaviour (Scotland) Act 2004
The Education (Additional Support for Learning) (Scotland) Act 2004
The Vulnerable Witnesses (Scotland) Act 2004
The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004
The Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005
The Management of Offenders etc (Scotland) Act 2005
The Prohibition of Female Genital Mutilation (Scotland) Act 2005
The Equality Act 2006
The Adult Support and Protection (Scotland) Act 2007
The Protection of Vulnerable Groups (Scotland) Act 2007
The Sexual Offences (Scotland) Act 2009
The Looked After Children (Scotland) Regulations 2009
The Criminal Justice and Licensing (Scotland) Act 2010
The Equality Act 2010
The Children’s Hearings (Scotland) Act 2011
The Domestic Abuse (Scotland) Act 2011
The Forced Marriage (Protection and Jurisdiction) (Scotland) Act 2011
Police and Fire Reform (Scotland) Act 2012
The Children and Young People (Scotland) Act 2014
The Human Trafficking and Exploitation (Scotland) Act 2015
The Serious Crime Act 2015
Useful Links – Perth and Kinross Local Guidance

Perth and Kinross Adult Support and Protection Guidelines

Perth and Kinross CPC Guide: Working with Hostile and Non-Engaging Parents and Carers


Perth and Kinross CPC Practitioner’s Guide: Child Protection Case Conferences


Perth and Kinross Guide: Protecting People of All Ages

Perth and Kinross Information and Advice Card: Child Protection

Perth and Kinross Information and Advice Leaflet - What is Adult Support and Protection

Perth and Kinross Information and Advice Leaflet: Change is a Must

Perth and Kinross Information and Advice Leaflet: Child Protection Case Conferences (Children & Young People)

Perth and Kinross Information and Advice Leaflet: Child Protection Case Conferences (Parents & Carers)

Perth and Kinross Information and Advice Leaflet: Fieldwork Services (Social Work)

Perth and Kinross Information and Advice Leaflet: Information Sharing, Confidentiality and Consent (Children and Young People)

Perth and Kinross Information and Advice Leaflet: Information Sharing, Confidentiality and Consent (Parents and Carers)

Perth and Kinross Practitioner's Guide: Getting Our Priorities Right (GOPR) Working Together with Children, Young People and Families Affected by Problematic Alcohol and / or Drugs Use

Perth and Kinross Information and Advice Leaflet: Child Protection and Duty Team

Tayside Practitioner's Guidance: Chronologies
### Useful Web Links

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website</th>
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<tr>
<td>Aberlour Scotland’s Children's Charity</td>
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<td>Action for Children</td>
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<td><a href="http://www.scelscotland.org.uk/blog/who-we-are/our-partners/test-partner">www.scelscotland.org.uk/blog/who-we-are/our-partners/test-partner</a></td>
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<td><strong>Getting it right for every child (GIRFEC)</strong></td>
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<td>ico.org.uk/about-the-ico/who-we-are/scotland-office/</td>
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<td>Institute for Research &amp; Innovation in Social Services (IRISS)</td>
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<td><a href="http://www.ceop.police.uk/">www.ceop.police.uk/</a></td>
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<td><a href="http://www.scottish.parliament.uk/">www.scottish.parliament.uk/</a></td>
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<td>Scottish Social Services Council (SSSC)</td>
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<td>Scottish Refuge Council</td>
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<td><a href="http://www.scotland.shelter.org.uk/">www.scotland.shelter.org.uk/</a></td>
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<td>Social Care Institute For Excellence (SCIE)</td>
<td><a href="http://www.scie.org.uk/">www.scie.org.uk/</a></td>
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<td>Social Work Scotland</td>
<td><a href="http://www.socialworkscotland.org/">www.socialworkscotland.org/</a></td>
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<td>Who Cares? Scotland</td>
<td><a href="http://www.whocaresscotland.org/">www.whocaresscotland.org/</a></td>
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<td>Young Scot</td>
<td><a href="http://www.young.scot/">www.young.scot/</a></td>
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</table>
Key Contact Details

Perth and Kinross Child Protection and Duty Team  01738 476768  24 hours, 7 days a week, 365 day a year cover

To report child care concerns and to seek advice, guidance and support.

Perth & Kinross Adult Protection Access Team  0345 3011120  24 hours, 7 days a week, 365 day a year cover

To report adult and vulnerable people concerns and seek advice, guidance and support.

Police Scotland Public Protection Unit  101 or 999 in an emergency

Specialist police unit that deals with all child protection investigations.

Additionally, a Domestic Violence Officer is located within this team, as are other officers responsible for monitoring sex offenders and attending to adult support and protection issues.

Education & Children’s Services (Schools)

Each school in Perth & Kinross has a Child Protection Designated Officer (CPO). This person or the Head Teacher is the first point of contact within each school.

Services for Children, Young People and Families (Children’s Social Work Services)

2 High Street  Council Building, 2 High Street, Perth PH1 5PH  01738 476200

Blairgowrie Social Work Team  2 Balmoral Road, Rattray, Blairgowrie. PH10 7AB  01250 871330

Strathearn & Kinross Social Work Team  Community School of Auchterarder, New School Lane, Auchterarder PH3 1BL  01764 661441

Almondbank House,  Lewis Place, Perth. PH1 3BD  01738 472260

Colonsay Resource Centre  37-39 Colonsay Street, North Muirton, Perth. PH1 3TU  01738 783450

Services for Young People  @Scott Street, 86-88 Scott Street, Perth. PH2 8JR  01738 474580
**Police Scotland (Tayside Division)**

Public Protection Unit (not staffed 24 hours)  
Perth Police Office, Barrack Street, Perth. PH1 5SF  
01738 892912 or 101

Domestic Abuse Officer  
Perth Police Office, Barrack Street, Perth. PH1 5SF  
01738 892910

Sex Offender Management  
Perth Police Office, Barrack Street, Perth. PH1 5SF  
01738 892515

Police Headquarters  
West Bell Street, Dundee. DD1 9JU  
01786 289070

**NHS Tayside**

Perth Royal Infirmary  
Taymount Terrace, Perth. PH1 1NX  
01738 623311

Ninewells Hospital  
Ninewells Road, Dundee. DD1 9SY  
01382 660111

Nurse Advisor Child Protection  
Drumhar Medical Centre, North Methven Street, Perth. PH1 5PD  
01738 564295

Lead Clinician Child Protection  
Drumhar Medical Centre, North Methven Street, Perth. PH1 5PD  
01738 564257

Paediatric Services  
Children’s Assessment Unit, Perth Royal Infirmary, Taymount Terrace, Perth. PH1 1NX  
01738 623311

Consultant Paediatrician (on call)  
Ninewells Hospital, Dundee. DD1 9SY  
01382 660111

**The Caldicott Guardians**

All NHS organisations have a Caldicott Guardian to oversee access to patient information. The Guardian is responsible for agreeing and reviewing protocols for governing the disclosure of the patient identifiable information across organisational boundaries.

The Guardians of the Information Security Officer can offer advice if you have any concerns regarding the handling of patient identifiable information.
The Caldicott Guardians for NHS Tayside are:

Medical Director
Primary Care Division, Ashludie Hospital, Monifieth, Dundee. DD5 4HQ

Medical Director
Acute Services Division, Ninewells Hospital, Dundee. DD1 9SY

Director of Public Health
Tayside NHS Board, Kings Cross Hospital, Cleppington Road, Dundee. DD3 8EA

Scottish Children's Reporter Administration

Perth & Kinross area covered from Dundee Office
6 Commercial Street, Dundee. DD1 3EH 0131 244 5700

Children’s Hearings Scotland (Perth)
Bellhaven House, Marshall Place, Perth. PH2 8NS 0300 200 1366

Procurator Fiscal's Office

Perth
82 Tay Street, Perth. PH2 8NQ 0300 020 3000
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ADP</td>
<td>Alcohol &amp; Drug Partnership</td>
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<td>ASPC</td>
<td>Adult Support and Protection Committee</td>
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<td>Children and Adolescent Mental Health Services</td>
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<td>CAO</td>
<td>Child Assessment Order</td>
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<td>CAPSM</td>
<td>Children Affected by Parental Substance Misuse</td>
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<td>Child Concern Report</td>
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<td>Criminal Justice Authority</td>
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<td>Child Sexual Exploitation</td>
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<td>CSO</td>
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<td>Domestic Violence</td>
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<td>Forced Marriage</td>
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<td>Freedom of Information</td>
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