DUMFRIES & GALLOWAY
PUBLIC PROTECTION COMMITTEE

Dumfries & Galloway Multi-Agency Child Protection Guidance

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1 Introduction

1.1 The safety and wellbeing of children and young people, including unborn babies is paramount. Our children and young people have the right to be protected from all forms of harm and abuse.

1.2 This guidance, which informs the development of local multi-agency child protection procedures, processes and training, will support the care and protection of children in Dumfries & Galloway.

1.3 The guidance has been developed collaboratively, by the local Child Protection Guidance Implementation Group which had representatives from social work, health, police, education, Scottish Fire & Rescue Service and Third Sector. Self-evaluation is a critical aspect of the work that we do and has informed the development of this guidance. The Public Protection Committee are extremely grateful to the members of this group for their time and expertise.

1.4 Best practice in engaging with children, young people and families has been captured and principles embedded throughout.

1.5 This guidance is for all practitioners who support children and families whether they work in health, police, third sector, local authority or education settings. The approaches set out depend on a culture and ethos which recognises that whilst there are specific responsibilities associated with certain professional roles, it is everyone's job to make sure children 'are alright'.

1.6 The integration of child protection within the GIRFEC continuum and framing responses to child protection concerns within this national practice model is a critical feature of this guidance. The guidance highlights the importance of GIRFEC in protecting children, particularly in recognising that all children must receive the right help at the right time.

1.7 In alignment with our strengths and relationships approach, there is a strengthened focus on children's rights, engagement, and collaboration with families, and on building on existing strengths. The intention is to further support more holistic approaches that reduce stressors on families and communities to reduce the risk of harm to children and young people.

1.8 This guidance recognises that physical and emotional safety provides a foundation for wellbeing and healthy development. There are collective responsibilities to work together to prevent harm from abuse or neglect from pre-birth onwards. In addition, the implementation of this guidance will support greater consistency in what children and families can expect in terms of support and protection across Dumfries & Galloway.

1.9 This guidance is based on the National Guidance for Child Protection in Scotland.

2 Principles

2.1 The most effective protection of children and young people involves early support within the family, before urgent action is needed, and purposeful use of

compulsory measures is necessary. If children do require placement away from home, real protection involves attuned, trauma-informed and sufficiently sustained support towards reunification or towards an alternative secure home base when this is not possible.

2.2 The Scottish approach to child protection is based upon the protection of children's rights. There are consistent threads running between enabling, preventative and protective work applying the GIRFEC approach. Child protection is therefore considered within a continuum of prevention and protection, with multi-agency support beginning with early intervention informed by the GIRFEC model of policy and practice. Multi-agency assessments are set in the context or rights, resilience, and relationships.

2.3 The GIRFEC National Practice Model - provides shared practice concepts within assessment and planning. Practitioners should be familiar with the core elements such as 'SHANARRI', wellbeing indicators, the My World Triangle, and the resilience matrix. Together they support holistic analysis of safety and wellbeing, dimensions of need and the interaction of strengths and concerns. The National Risk Assessment Toolkit integrates the national practice model in a generic approach to the holistic assessment of risk, resilience, and strengths.

2.4 **Rights** - Child protection is integral to the protection of human rights. United Nations Convention on the Rights of the Child (UNCRC) underpins the GIRFEC approach. The child's best interests, right to non-discrimination, and appropriate involvement in decision-making are key requirements. The Children and Young People (Scotland) Act 2014 supports implementation of the key aspects of the UNCRC.

2.5 Connections between safety and rights are further illustrated in "The Promise", the Independent Care Review. The Independent Care Review (2020) listened to over 5,500 individuals, more than half of whom had experience of the 'care system'. This Review emphasised the need to listen to children's voices.

2.6 **Voices** – of children and young people shaped the Children's Charter in 2004. The Children's Charter sets out what children and young people need and expect to help protect them and promote their welfare. Each child who can form a view on matters affecting them has a right to express those views if they so wish. Those views must be listened to, understood and respected, and should be given due weight in accordance with a child's age and maturity.

2.7 When a child is very young or has difficulty communicating, every effort must be made to understand their views and needs. Those working with babies must seek to understand the 'voices' of infants through their body language, verbalisations and gaze so that their feelings, preferences and ideas are heard, and their rights and views are upheld. The Voice of the Infant: best practice guidelines and Infant Pledge sets out what infants should expect from those around them. Infants must be supported to be active participants in all services they come into contact with.

2.8 The child's experience, views and needs are central within child protection processes. Talking with and listening to children means attention not only to

words but also to their experience, needs, wishes and feelings. Listening includes attention to non-verbal communication and to physical and behavioural responses to their care environment.

2.9 **Relationships** – protecting children involves listening to families, being clear and honest about concerns, giving choices and seeking co-operation. *"All children must be supported to continue relationships that are important to them, where it is safe to do so*."[1] The aim is to develop goals in collaboration with families on the basis of shared understanding.

2.10 In some situations, partnership may seem unrealistic due to services finding it hard to engage with families. This might be due to avoidance or aggression. Engagement requires exploration of the barriers to collaboration and of the factors that encourage motivation to change. Partnership can only evolve if processes and choices are understood within a trauma-informed approach.

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

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

2.13 **Signs of Safety** is a relationship-based practice model of child protection and family support, which is an innovative, collaborative, strengths-based, safety organised approach for practitioners working with children and families and was adopted in Dumfries & Galloway in 2018.

2.14 The model integrates respectful, open-minded, and detailed exploration of risk and strengths with step-by-step action to achieve and sustain change in order to increase safety. Plain language is fundamental to forming shared agreements in stressful and urgent circumstances.

2.15 **Safe and Together** is a model for working with families where there is domestic violence where we partner with the non-abusing parent and build on their strengths and successes. The model provides tools which support assessment and safety planning. This is also relationship-based practice and was introduced in Dumfries and Galloway in 2022.

2.16 **Cultural sensitivity** – and competence is necessary in considering the family perspective. It is essential to consider the child's experience and consider risks, stresses and protective factors in the child's world. Religion, faith and places of community and worship may be a key reference point and a source of resilience, identity and connection.

2.17 At the same time, risks and stresses are accentuated to some families by isolation, racism, food insecurity, poor housing, barriers to employment, and poverty.

[1] Independent Care Review (2020)

2.18 A **trauma-informed approach** – should be taken in all child protection work. A knowledge of child development and the impact of trauma is required in relation to undertaking Joint Investigative Interviews. These skills are key in relation to the new Scottish Child Interview Model (SCIM).

2.19 **Transitional support** – continuity of planning and support is required when supporting children through transitions. The child should remain central to this.

2.20 For vulnerable young people making their individual transitions to adult life and services, it is important to consider that transitions might involve changing worker, service and moving home, and therefore are multi-dimensional for the young person, and that risks can increase as a result of emotional and relational transitions.

2.21 Local services must ensure sufficient continuity and co-ordination of planning and support for each vulnerable young person at risk of harm as they make their individual transitions to adult life and services. 'Transitions may be considered by services to be a 'handover' between services, and yet for a young person they are multi-faceted. Phases of enhanced risk may relate to emotional and relational transitions that occur sometime after changes in service, worker or home base.

2.22 **Family Support** – should be provided early whenever possible. Third Sector have a vital role here, providing collaborative and flexible support which is wide ranging. Preventative, protective and reparative assessment and action should be co-ordinated and streamlined as appropriate in each situation. Support can be provided in the family home or Family Centre settings.

3 Definitions

3.1 Definitions of "Child"

3.1.1 The protection of children and young people in Dumfries and Galloway includes unborn babies, and children and young people up to their eighteenth birthday.

3.1.2 While child protection procedures may be considered for a person up to the age of 18, the legal boundaries of childhood and adulthood are variously defined and there are overlaps.

3.1.3 In Part 1 of the Children (Scotland) Act 1995 a child is generally defined as someone under the age of 18 but, most of the provisions which deal with parental rights and responsibilities apply only to children under the age of 16.

3.1.4 Part 2 of the Children (Scotland) Act 1995 deals with support for children and families and includes local authorities' duties in respect of looked after children and children 'in need'. For those purposes a child is also defined as someone under the age of 18.

3.1.5 The Mental Health (Care and Treatment) (Scotland) Act 2003 follows the Children (Scotland) Act 1995 in defining a child as a person who is under the age of 18. This does not affect a young person's ability to consent to medical treatment, but this legislation ensures that additional safeguards are in place

when a person aged under 18 needs compulsory care and treatment in relation to their mental health.

3.1.6 The Adults with Incapacity (Scotland) Act 2000 safeguards people who do not have capacity in relation to making decisions about their welfare and/ or finances. This legislation defines 'adults' as those who have attained the age of 16.

3.1.7 The Adult Support and Protection (Scotland) Act 2007 also applies to those aged 16 and over, as 'adult' is defined as an individual aged 16 or over.

3.1.8 Where a young person between the age of 16 and 18 requires support and protection, **services will need to consider which legal framework best fits each person's needs and circumstances.** In Dumfries and Galloway, all protection issues for 16 and 17-year-olds are considered within Child MASH (Multi-Agency Safeguarding Hub). Therefore, all referrals to Social Work for young people in this age category should be a child referral using a Request for Assistance Form.

3.1.9 Universal services should seek to identify pregnant women who will require additional support. There must be local assessment and support processes for high-risk pregnancies[2].

3.2 Definitions of Parents and Carers

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

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

3.2.3 Same-sex couples can adopt a child together and have the same PRRs. A same-sex partner has no automatic parental responsibilities and rights for their partner's children. If a child is conceived by donor insemination or fertility treatment on or after 6 April 2009, a same-sex partner can be the second legal parent. The second parent may hold parental responsibilities and rights if they were married or in a civil partnership with the mother at the time of insemination/ fertility treatment, or if the person is named as the other parent on the child's birth certificate and the birth was registered post 4 May 2006, or if the person completes and registers a Parental Responsibilities and Rights agreement with the mother. It is possible for a

[2] Dumfries and Galloway Pre-Birth Guidance and Processes for Vulnerable Pregnant Parents and Babies

same sex partner to apply for parental responsibilities if none of these conditions apply.

3.2.4 A 'carer' is someone other than a parent who is looking after a child. A carer may be a 'relevant person' within the children's hearing system. 'Relevant persons' have extensive rights within the children's hearing system, including the right to attend children's hearings, receive documents relating to hearings, and appeal decisions taken within those proceedings.

3.2.5 A 'kinship carer' is a carer for a child looked after by the local authority, where the child is placed with the kinship carer in accordance with Regulation 10 of the Looked After Children (Scotland) Regulations 2009. To be approved as a kinship carer, the carer must be related to the child or a person who is known to the child and with whom the child has a pre-existing relationship ('related' means related to the child either by blood, marriage or civil partnership).

3.2.6 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.

3.3 Definition of Named Person

3.3.1 The Named Person is the person that children, young people and families can contact when they need access to relevant support for their own or their child or young person's wellbeing.

3.4 Definition of Lead Professional

3.4.1 The Lead Professional is an agreed, identified person within the network of practitioners who are working alongside the child or young person and their family. In most cases, the professional who has the greatest responsibility in co-ordinating and reviewing the child's plan will undertake this role.

3.5 What is Child Abuse and Child Neglect?

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

3.6 Physical Abuse

3.6.1 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. This is known as Fabricated and Induced Illness and includes Perplexing Presentations, which is when fabrication is not confirmed but is identified as a potential diagnosis.

3.6.2 There may be some variation in family, community or cultural attitudes to parenting,for example, in relation to reasonable discipline. Cultural sensitivity must not deflect practitioners from a focus on a child's essential needs for care and protection from harm,or a focus on the need of a family for support to reduce stress and associated risk.

3.6.3 The Child (Equal Protection from Assault) (Scotland) Act 2019 came into force in November 2020, meaning that children in Scotland now have the same protections against assault as adults. The Act removes the previous defence of "reasonable chastisement". All forms of physical chastisement, punishment and/ or discipline of children and young people are against the law. Dumfries and Galloway Public Protection Committee: Multi-Agency Children (Equal Protection from Assault) (Scotland) Act 2019 Guidance

3.7 Emotional Abuse

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

- conveying to a child that they are worthless or unloved, inadequate or valued only in so far as they meet the needs of another person.
- exploitation or corruption of a child, or imposition of demand inappropriate for their age or stage of development.
- repeated silencing, ridiculing or intimidation.
- demands that so exceed a child's capability that they may be harmful.
- extreme overprotection, such that a child is harmed by prevention of learning, exploration, or social development.
- seeing or hearing the abuse of another.

3.8 Sexual Abuse

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

3.8.2 For those who may be victims of sexual offences aged 16-17, child protection procedures should be considered. These procedures must be applied when there is concern about the sexual exploitation or trafficking of a child.

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

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

3.8.5 **Harmful Sexualised Behaviour** is defined as 'sexual behaviour(s) expressed by children and young people under the age of 18 years that are developmentally inappropriate, may be harmful towards self or others and/or may be abusive towards another child or young person or adult' (Hackett, 2014).

3.8.6 Practitioners' ability to determine if a child's sexual behaviour is harmful will be based on an understanding of what constitutes healthy sexual behaviour in childhood, as well as issues of informed consent, power imbalance and exploitation.

3.9 Criminal Exploitation

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

3.10 Child Trafficking

3.10.1 Child trafficking involves the recruitment, transportation, transfer, harbouring or receipt, exchange, or transfer of control of a child under the age of 18 years

for the purposes of exploitation. Transfer or movement can be within an area and does not have to be across borders. Transfer can take place over the internet without someone leaving their home. Examples of and reasons for trafficking can include sexual, criminal and financial exploitation, forced labour, removal of organs, illegal adoption, and forced or illegal marriage.

3.11 Contextual Safeguarding and Extra-Familial Harm

3.11.1 An ecological approach, contextual safeguarding looks to understand and respond to the risks and harm young people encounter beyond the home – extra-familial harm. This includes exploring the different dynamics of family, school, peers, and the community where the young person spends time. Recognising the 'weight of influence' of peer relationships and other extra-familial factors and shifting focus towards the contexts in which young people make 'choices' or 'behave' are of primary consideration. Rather than focussing on changing young people's behaviour, planning and interventions look towards creating social conditions and environmental drivers that enable safer choices. Collaboration between key agencies is paramount to interrupting patterns of harm.

3.12 Neglect

3.12.1 Neglect consists of persistent failure to meet a child's basic physical and/ or psychological needs which is likely to result in the serious impairment of the child's health or development. "Persistent" means there is a pattern which may be continuous or intermittent which has caused or is likely to cause significant harm. However, there can also be single instances of neglectful behaviour by a person in a position of responsibility that can be significantly harmful.

3.12.2 Neglect is complex area of work. Practitioners must be aware of the multi-facetted nature of neglect and the many factors that could lead to the neglect of a child. Early signs of neglect indicate the need for support to prevent harm.

3.12.3 The GIRFEC SHANARRI indicators set out the essential wellbeing needs. Neglect of any of these can impact on healthy development. Once a child is born, neglect may involve a parent or carer failing to provide adequate food, clothing and shelter (including exclusion from home or abandonment); to protect a child from physical and emotional harm or danger; to ensure adequate supervision (including the use of inadequate caregivers); to seek consistent access to appropriate medical care or treatment; to ensure the child receives education, or to respond to a child's essential emotional needs. The identification of chronic neglect and/ or cyclical neglect can be aided by the use of chronologies which can help identify concerning patterns and behaviours.

3.13 Faltering Growth

3.13.1 Faltering growth refers to an inability to reach or maintain normal weight and growth in the absence of medically discernible physical and/ or genetic reasons. This condition requires further assessment and may be

associated with chronic neglect. However, there may be occasions where no medical cause can be identified for child having a small stature. If they are growing adequately despite their small stature, that would not suggest neglect. If there is concern that a child may be underweight or failing to grow, medical assessment is indicated.

3.13.2 Malnutrition, lack of nurturing and lack of stimulation can lead to serious long-term effects such as a greater susceptibility to serious childhood illnesses and reduction in potential stature. For very young children the impact could quickly become life-threatening. Chronic physical and emotional neglect may also have a significant impact on teenagers[3].

3.14 Female Genital Mutilation (FGM)

3.14.1 This extreme form of physical, sexual and emotional assault upon girls and women involves partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Such procedures are usually conducted on children and are a criminal offence in Scotland. FGM can be fatal and is associated with long-term physical and emotional harm. As part of the National Action Plan to Prevent and Eradicate FGM, the Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 was enacted. The Act's requirements include FGM Protection Orders and Statutory Guidance.

3.15 Male Circumcision

3.15.1 Circumcision is a procedure that removes the foreskin from the penis. The Scottish Government recognises non-therapeutic male infant circumcision on religious grounds. However, this procedure should be carried out in a hospital by trained paediatric surgeons under general anaesthesia, when the male child is between 6 and 9 months old, and a part of a regulated NHS system.

3.16 Forced Marriage and Honour Based Abuse

3.16.1 A forced marriage is a marriage conducted without the full and free consent of both parties and where duress is a factor. Duress can include physical, psychological, financial, sexual, and emotional abuse. Forced marriage is both a child protection and adult protection matter. Child protection processes will be considered up to the age of 18 years.

3.16.2 Forced marriage may be a risk alongside other forms of so called 'honour-based' abuse (HBA). HBA includes practices used to control behaviour within families, communities, or other social groups, to protect perceived cultural and religious beliefs and/ or 'honour'.

3.17 Online Child Abuse

3.17.1 Online child abuse is any type of abuse that occurs in the digital environment and the internet, facilitated through technology and devices such as

[3] https://childprotection.rcpch.ac.uk/child-protection-evidence/teenage-neglect-systematic-review/

computers, tablets, mobile phones, gaming devices and other online-enabled devices. If abusive content is recorded, uploaded, or shared by others online, there is a risk of the continued experience of abuse.

3.17.2 Online abuse can include online bullying; emotional abuse and blackmail; sharing of intimate images; grooming behaviour; coercion and preparatory behaviour for abuse including radicalisation; child sexual abuse and child sexual exploitation.

3.18 Radicalisation

3.18.1 Radicalisation refers to the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups. Online activity can lead to isolation which can increase the risk to a child of becoming exposed and influenced by extremist values and behaviours.

3.18.2 Within Scotland "Prevent" is a multi-agency strategy to support and divert children and young people away from terrorism related activity.

3.19 Age of Criminal Responsibility

3.19.1 The Age of Criminal Responsibility (Scotland) Act 2019 raised the age of criminal responsibility so that children under the age of 12 years cannot be held criminally responsible for their actions. The Act makes provision for referral to a Children's Hearing on welfare or care and protection grounds rather than having committed an offence. As well as applying to less concerning behaviours, this also applies to violent or dangerous behaviours which have caused or could have caused significant harm to others.

3.19.2 In Dumfries and Galloway, we would consider any dangerous or violent behaviours by a child under 12 years as requiring a response under our child protection processes on the basis that we understand such extreme behaviours are likely to be indicative of trauma or unmet need. There is specific national and statutory guidance to be followed when undertaking IRDs and Joint Investigative Interviews (JIIs) when this is the cause for concern, taking into account the potential reasons behind such behaviours and the need for a trauma informed approach.

4 Roles and Responsibilities

4.1 All agencies have a responsibility to recognise and actively consider potential risks to a child, irrespective of whether the child is the main focus of their involvement.

4.2 All agencies working primarily with adults as their main client group should always consider if any adult vulnerabilities or behaviours, for example mental health, drug and alcohol use, may impact on the adult's ability to safely parent their child or any children who may be in their care. Within health services, a 'Think Family' approach to assessment and planning is adopted in order to improve outcomes for children and their families.

4.3 All services and professional bodies should have clear, single agency, policies in place for identifying, sharing and acting upon concerns about risk of harm

to a child or children. There must be consideration of the needs, rights and mutual significance of siblings in any process that has a focus on a child.

4.4 Each practitioner remains accountable for their own practice and must adhere to their own professional guidelines, standards and codes of professional conduct, including undertaking training relevant to their role and responsibilities.

4.5 Third Sector, private sector and faith organisations should have information, advice and training to make them aware of the potential risks to children and to support their knowledge and confidence about steps they might take to keep children safe.

4.6 Professional curiosity is an essential skill for practitioners to use in the protection of children and young people. Practitioners need to explore and understand what is happening for a child or within a family, rather than making assumptions or accepting things at face value. Professional challenge is part of good child protection practice. Reflective practice and regular supervision are ways to support practitioners to adopt professional curiosity as a non-judgemental and holistic approach to protecting children at risk of harm.

4.7 Children and young people should get the help they need, when they need it, for as long as they need it, and their wellbeing is always paramount - practitioners should always consider the needs of the child or young person and any impact on them.

4.8 Ensure the child or young person is seen and is safe – and remember all children who may be impacted upon and consider their needs and safety, not only the child who is at the centre of concerns. This would include siblings/ stepchildren, etc, who may have contact with a parent/ carer.

4.9 When there is significant need or risk to a child or young person, child protection procedures must be followed immediately - do not delay. Likewise, a medical/ police response may be needed urgently and should be sought without delay.

4.10 Prevention, early identification, intervention and support is critical – to prevent further escalation, harm and/ or difficulties later.

4.11 Compulsory measures of supervision and early intervention are not mutually exclusive of each other – consideration should be given to compulsory measures of supervision to ensure effective intervention and/ or compliance. The most effective protection of children involves early support within the family before urgent action is needed and purposeful use of compulsory measures is necessary. However, preventative and protective work may be needed at the same time. Preventative, restorative, supportive, collaborative and therapeutic approaches do not stop because compulsory measures or urgent protective legal steps are taken. If a Compulsory Supervision Order is likely to be required to meet the child's needs for protection, guidance, treatment or control, or to ensure compliance, then a referral must be made to the Principal Reporter, Scottish Children's Reporters Administration (SCRA) to allow consideration as to whether a children's hearing should be arranged. A referral to SCRA should usually be made following agreement at a Child's

Plan Meeting.

4.12 In keeping with the GIRFEC National Practice Model– always involve the practitioner who is fulfilling the role of the Named Person. The Named Person for the child or young person will play a critical role in deciding whether a child or young person needs help, and in accessing such help promptly.

Age of Child/ Timeframe	Named Person
birth – start school	health visitor (or family nurse up to 2 years if child is on Family Nurse Programme)
Attending school	head teacher, depute head teacher in a primary school or a pupil support teacher in a secondary school
Home schooled	No designated Named Person at this time however, this should be the most suitable person who knows the child.
16-17 left school	No designated Named Person at this time, however, this should be the most suitable person who knows the child.

4.13 Where there is a child's plan in place, always involve the practitioner who is carrying out the role of the Lead Professional,

- The **Lead Professional** is the practitioner best placed to co-ordinate multi-agency activity supporting the child or young person and their family. They do this alongside the **Named Person.** The Lead Professional may also be the Named Person. For Child Protection and Looked-after Children the Lead Professional is always a Children and Families Social Worker.
- The **Named Person** is a professional point of contact in universal services, both to support children and their parents/ carers when there is a wellbeing need for the child, and to act as a point of contact for other practitioners who may have a concern about the child's safety and wellbeing. **In areas where there is no Named Person it may be necessary to identify someone known or trusted to the child or family, or someone who can be a point of contact for other practitioners.**
- The **Child's Plan** is the single agency, or multi agency action plan agreed by all involved services.

4.14 Always consider the wider factors in assessment– the family's strengths; vulnerabilities; challenges; protective factors; resilience; ability to recover and the impact on the child or young person. Using strengths and relationships-based practice will encourage good working relationships.

4.15 A multi-agency **Chronology** must be considered to ensure all relevant

information is available. This will help families and agencies identify patterns over time. Remember that no one agency will have all the history of the child/ family that will enable the best support to be provided. Together we can make a difference and make better decisions. **Single agency Chronologies** are crucial to this process.

4.16 Ensure you have read and understood your own service and/ or agency child protection procedures and adult protection procedures – know where and how to access them.

4.17 If in any doubt, seek help and support from your line manager and/ or the designated person within your own agency with responsibility for child protection.

4.18 In Dumfries and Galloway, a central register is held and maintained within Children and Families Social Work. This register contains the names of all the children and young people whose names have been placed on the Child Protection Register. The Keeper of the Register is the Chief Social Work Officer.

4.19 In matters where practitioners encounter obstacles/ disagreements that they are unable to resolve, reference should be made to the Children's Services Resolution and Escalation Framework (in development).

4.20 Information Sharing

4.20.1 Sharing relevant information is an essential part of protecting children from harm. Practitioners should understand when and how they share information. Individual agencies should have systems and procedures in place to ensure lawful, fair and transparent information sharing. Where there is a child protection concern, relevant information should be shared with police or social work without delay, provided it is necessary, proportionate, and lawful to do so.

5 Identifying and Responding to Concerns About Children

5.1 Child protection procedures are initiated when police, social work or health determine that a child may have been significantly harmed or may be at risk of significant harm.

5.2 Concerns about harm from abuse, neglect or exploitation may arise in a number of ways including:

- because of what a child has said
- over a period of time
- in response to a particular incident
- as a result of direct observations
- through reports from family, from a third party, or from an anonymous source
- if children are known to social work or have an existing child's plan
- through notification that a child may become a member of the same household as a child in respect of whom any of the offences mentioned

in Schedule 1 of the Criminal Procedure (Scotland) Act 1995 has been committed, or as a person who has committed any of the offences mentioned in Schedule 1.

5.3 All **Referrals for born and unborn children** **-** are received through the **Single Access Point (SAP[4])** who assess the referral and decide whether this should go to the MASH for consideration of an Inter-agency Referral Discussion (IRD). If there is an accumulation of concerns or crisis, the allocated worker/ SSW can request an IRD. Police and Health professionals can bring their own information to request an IRD. All requests for an IRD are recorded on an Inter-agency Referral Discussion Notification Form (IRDNF) which are then considered in a tripartite discussion (Police, Health and Social Work). This involves initial screening and then a decision is made regarding whether an IRD will be held. If agreed this should take place within 24 hours

5.4 Social Work will gather background information from education (Named Person when available or the Education Safeguarding Manager during holiday periods) to inform the IRD. Relevant persons who have important information will be included within the IRD as necessary. Consideration should be given to whether a joint child and adult IRD is required if there are concerns of an adult support and protection nature as well as child protection. All 16–17-year-olds should be considered within child protection processes unless there are exceptional circumstances. This decision will be made within MASH alongside adult colleagues to ensure the best support and protection is received using the most appropriate legislation.

5.5 **Pre-Birth** - To assess if an unborn child is at risk of harm or exposed to parental behaviours which could have a significant impact on their health, safety and development, consideration needs to be given to the seriousness of the behaviours, the impact (on the unborn child) and likelihood of the harmful behaviours happening in the future.

5.6 Concerns for unborn children may include, but not exclusively, domestic abuse, parental substance use, parental mental health issues and criminality, where these would impact on the child's health, care and safety. Parents themselves may be vulnerable adults who require support and/ or protection. Certain risk factor are specific to pregnancy and include late presentation/ booking and concealed pregnancy.

5.7 Confirmation of an ongoing viable pregnancy should be sought with the specialist midwife if this is unclear prior to the IRD. If an IRD is being held for an unborn child, the specialist midwife should be advised by either health or social work representative from MASH and updated of the outcome and recommendations the same working day. If the decision is not to progress under child protection processes, a recommendation should be made as to whether or not a Pre-Birth assessment and plan are required.

5.8 If child protection concerns arise at any stage of a pre-birth assessment for an unborn child, these should be referred to the Single Access Point/ MASH. If an assessment is in the process of being completed this can be updated to

[4] Dumfries and Galloway Social Work call handling team (030 33 33 3001)

include a risk assessment in place of a child protection inquiry.

5.9 If child protection concerns are identified for an unborn child and there are older children in the care of the parent, the older children's needs and vulnerabilities should also be considered within the risk assessment.

6 Disabled Children

6.1 Each disabled child has their own unique needs and strengths. The support required should, therefore, be considered holistically, with assessments that clearly show the intersections between their strengths and their needs.

6.2 Disability can have an impact on children's physical, emotional, developmental, learning, communication, and health care needs. These have a profound and long-lasting impact on the child's ability to engage fully in normal day-to-day activities.

6.3 Most parents of disabled children provide a safe and loving home. Their expertise, commitment, and willingness to work in partnership are potential strong protective factors.

6.4 However, children with communication impairments, behavioural disorders, learning disabilities and sensory impairments may be additionally vulnerable to abuse and neglect. Within child protection processes additional preparation and consideration will be taken of the impact of any disability for a child to ensure effective protection. Where the child or young person is non-mobile due to disability, reference should be made to the Multi-Agency Protocol for Injuries to Non-Mobile Children.

6.5 Children with disabilities have an equal right to be safe, and gaining understanding of their views is of significant importance. Their voice and feelings must be heard when people make decisions that involve them.

6.6 Harm may be accentuated by various intersecting contextual factors, such as the impact of poverty, lack of support for parents, parental mental health or domestic abuse.

6.7 Barriers to protection can occur at any point during support or child protection processes:

- when nobody listens to the child and those who know the child best.
- if the child's communications and reactions are not understood.
- when there is a lack of curiosity, competence and confidence in exploring reasons for distress or signs of maltreatment.
- when there is a lack of practitioner awareness of the impact of neglect.
- when there are delays or fragmentation in the assessment and sharing of information, or the co-ordination and planning of assessment and support.

6.8 Protecting disabled children is a combined responsibility. Close partnering is required between health and education, other specialist practitioners, third sector, social workers leading child protection investigations and parents/

carers and advocates as necessary. Transitions for disabled children are extremely important and require careful planning and assessment as changes within services and life stages are times of increased and predictable vulnerabilities. Where possible, it is crucial that children and young adults are supported to keep themselves safe.

7 Migrant Families

7.1 From a safeguarding perspective, local authorities have duties to support migrant families with No Recourse to Public Funds. These families face a high risk of poverty and destitution. COSLA's online platform Migration Scotland has supplementary guidance for local authorities and other professionals on migrant rights and entitlements. This guidance must be followed when assessing a child's needs.

7.2 **Unaccompanied Asylum-Seeking Children and Trafficked Children** – An IRD is held for all unaccompanied asylum-seeking children and trafficked children coming into the area. The full rights of the UNCRC are principal to all actions taken and every child is provided with the safety and care given to any UK national. Home Office processes are followed. Trauma informed support to help understanding and healing is paramount for children.

7.3 Contextual safeguarding needs to be considered in managing the risks posed to and from the child and other children who may be involved. A traditional focus on child and family and which does not consider the relevance of wider relationships and the location of harm, may not suffice in managing presenting behaviours or reducing contextual risks. In these situations, it may be necessary to consider an MDT meeting to consider the wider contextual safeguarding concerns.

8 Initiating CP Procedures

8.1 IRD

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

8.1.2 **Purpose** - IRDs are required to analyse multi-agency information and decide if the threshold for significant harm has been met and to agree a co-ordinated inter-agency interim safety plan up until the point a Child Protection Planning Meeting (CPPM) is held, or until a decision is made that a CPPM is not required/ that alternative action is required.

8.1.3 All concerns which may indicate risk of significant harm must lead to an IRD. **Where there is a Named Person or person in an equivalent role, they should be notified.** Agency records will be checked for relevant information that may assist in placing a concern in context, and that may inform next steps.

8.1.4 The IRD will share all relevant information from **police, social work, health and education** to form a shared analysis, to include the nature and significance of the risk of harm, the likelihood of it happening and the impact.

8.1.5 **Professional judgement** is key, alongside the information shared to inform the analysis and come to a decision regarding whether or not the child has experienced or is likely to experience **significant harm.**

8.1.6 '***Significant harm refers to serious interruption, change or damage to a child's physical, emotional, intellectual or behavioural health and development'*** **(National CP Guidance 2021).**

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

- The child's experience.
- The child's development in context.
- What has happened.
- Parent or carers responses to concern as far as they are known.
- Past occurrence.
- Immediate risk of harm and cause of this risk.
- Impact/ potential impact on the child's health and development.

8.1.8 The IRD will create an interim safety plan which identifies any unmet needs for the child and should make recommendations, clearly linked to identified needs and risks, regarding the next actions to be taken which will include notifying the Named Person of the outcome.

8.1.9 An IRD will give priority consideration to:

- the safety and needs of the child/ children involved.
- level of risk faced by child/ children and by others in this context.
- evidence that a crime or offence may have been committed or may be committed against a child.

8.1.10 Where a child is at risk of harm from neglect, abuse or exploitation, consideration should always be given to the needs and potential risks to other children in the same household or family network, and to children who are likely to become members of the same household or family network.

8.1.11 Where the decision of the IRD is that the child is not at risk of significant harm, but there are welfare concerns and unmet need has been identified, the IRD will identify next actions and pass back to the relevant professional for further assessment and in order that a child's plan can be developed to support the child/ family.

8.1.12 Where the outcome of the IRD is that the child is not at risk of significant harm and there are no welfare concerns or unmet needs, the content of the discussion will be shared with the Named Person.

8.1.13 Children and young people who are believed to have harmed others may also require co-ordinated information sharing and decision-making. They may also have experienced abuse. Investigative processes must safeguard and protect

their wellbeing as a primary consideration. IRDs are the lynchpin of effective processes when concerns arise about children who have caused serious harm to others.

8.1.14 Care and Risk Management (CARM) processes may be applied when a child (aged 12-17 years) has been involved in an incident of a serious nature (irrespective of the legal status of the incident) or where a pattern of significant escalation of lesser behaviours suggests that an incident of a serious nature may be imminent.

8.2 Joint Investigative Interviews (JII) - Stepwise (5 Day) and Scottish Child Interview Model (SCIM)

8.2.1 A JII will take place if a child is victim of or witness to a crime. The child's welfare will always be considered within the JII, will be trauma informed and consider the child's specific needs including any communication issues. Effective interview planning is essential, and must consider practicalities such as location, transport, timing, breaks and communication between interviewers during interview.

8.2.2 A JII can be an outcome at either the IRDNF or IRD stage. When a JII is the outcome of an IRD, discussion will take place regarding the best model to use according to the child's circumstances and needs.

8.2.3 Dumfries and Galloway currently use both interview models but are moving towards using the SCIM Model for most interviews with children.

National Guidance on Joint Investigative Interviewing

8.2.4 Current guidance on Joint Investigative Interviewing of Child Witnesses in Scotland (2011) is under revision in line with the Scottish Child Interview Model (SCIM).

8.2.5 The Scottish Child Interview Model (SCIM) is a new approach to JII and has been implemented in Scotland. It is designed to minimise re-traumatisation and keep the needs and rights of child victims and witnesses at the centre of the process and in so doing, achieve pre-recorded evidence from the child that is of high quality. This can be used as Evidence in Chief in court for criminal and children's hearings processes. The SCIM has five connected components: strategy, planning, action, outcomes and support and evaluation. Interviewers are trained in forensic interviews of children.

8.2.6 **Purposes are to:**

- learn the child's account of the circumstances that prompted the enquiry.
- gather information to enable decision-making on whether the child, or any other child, is in need of protection.
- gather sufficient evidence to advise whether a crime may have been committed against the child or anyone else.
- secure best evidence as may be needed for court proceedings, such as a criminal trial, or for a children's hearing proof.

Approach

Taking a child-centred approach to planning interviews is vital in securing best evidence and providing the necessary support for the child before, during and after the interview. The analysis of interviews will help lead professionals to co-ordinate planning for the support, protection and recovery of the child. The analysis of interviews will also aid decision-making in respect of any crime committed.

8.2.7 A pre-interview briefing identifies the aims and objectives of the interview. The JII is planned in detail and undertaken by a police officer and a social worker, one of whom takes the lead role in the interview. Roles will be agreed in pre-interview planning, after due consideration of all relevant factors. Teamwork and flexibility are essential. In some instances, the needs and responses of the child require the second interviewer to take on the lead role. Wherever possible, there should only be one interviewer in the room with the child. The second interviewer would participate in the interview from a separate room, observing and contributing to the conduct of the interview. The lead interviewer has primary responsibility for leading the interview, asking questions and gathering information.

8.2.8 A child has a right to specify gender of the interviewer if the child is believed to have been the victim of particular offences as defined by the terms of section 8 of the Victims and Witnesses (Scotland) Act 2014; and this should be granted wherever possible.

8.2.9 For detailed roles and responsibilities see guidance on Joint Investigative Interviewing of Child Witnesses in Scotland (2011)

8.2.10 Whilst the child's consent is not explicitly required, the child must be helped to understand the purpose and process of the interview as part of preparation and support for willing engagement. Social workers and police officers have a duty to investigate as detailed in section 60 of the Children's Hearings (Scotland) Act 2011 and section 20 of the Police and Fire Reform (Scotland) Act 2012.

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

Recording

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

Authority and expertise

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

8.3 Health Assessment and Medical Examination

8.3.1 The IRD will consider the need for a medical examination and take appropriate action.

8.3.2 The National Guidance for Child Protection in Scotland (2021) notes that medical assessments and medical examinations may be undertaken for the following purposes:

- To establish what immediate treatment the child may need.
- To provide a specialist medical opinion on whether child abuse or neglect may be a likely or unlikely cause of the child's presentation.
- To support multi-agency planning and decision-making.
- To establish if there are unmet health needs, and to secure any on-going health care (including mental health), investigations, monitoring and treatment that the child may require.
- To listen to and to reassure the child.
- To listen to and reassure the family as far as possible in relation to longer-term health needs.

8.3.3 **The decision to carry out a medical examination** and the decision about the type of medical examination is made by a paediatrician; informed by multi-agency discussion with police, social work and other relevant health staff. Through careful planning, the number of examinations should be kept to a minimum.

8.3.4 Types of examination include Comprehensive Medical Examinations for Neglect, a Single Doctor examination, or Joint Paediatric Forensic Examination. The location where examinations take place following sexual assault, including forensic examinations, vary depending on age. Local multi-agency guidance on Medical Examinations and Health Assessments should be followed.

8.4 Inter-agency Investigation/ CPI

8.4.1 The IRD will decide whether the child protection investigation will be an inter-agency investigation (police/ social work) or a single investigation by social work and note the reasons why.

8.4.2 The Child Protection Inquiry will be completed by a social worker within the MASH team who will speak to the child/ children involved, relevant family members and professionals and document their responses and any planning within the investigation. An Interim-Safety plan will be put in place/ updated from the IRD to address the identified risks, appropriate action must be taken to ensure the child's immediate safety. A safety network will be explored as part of the plan to support safety, including exploration of family network ideas and solutions. Where appropriate the plan should be explained to the child.

8.4.3 CPI decision-making should take the information and analysis presented fully into account and be proportionate to the harm identified. A debrief should take place with staff about action required; trauma-informed practice to support staff with vicarious trauma should be a priority within the debrief.

Clear direction should be provided on what needs to happen next to ensure the correct plan is in place for the child. This can be child protection (in which case, an Initial or Review Child Protection Planning Meeting is required). Child in Need with a co-ordinated multi-agency support plan or passed back to the Named Person for relevant support.

8.5 Legal Measures Considerations

8.5.1 It is essential that a referral to the Children's Reporter is considered at all stages of the child protection process, including the IRD, investigation and CPPM. Reasons for the decision to refer or not should be recorded on Mosaic, the Social Work recording system.

8.6 Child Protection Assessment and Planning

8.6.1 **Completion of the Child Protection Investigation (CPI)** – The social worker needs to complete their report, with management approval, within 5 working days of the IRD. When the decision is that a Child Protection Planning Meeting is to be held, the meeting will be arranged to take place within 28 days of the IRD.

8.6.2 **Preparation for the Initial Child Protection Planning Meeting** – Once it is agreed by the social work managers that an Initial Child Protection Planning meeting will take place, a chair and CP administrator will be identified, and the social worker will provide a list of family members and professionals who should be invited to the meeting. A suitable venue will be agreed, and practical arrangements put in place to allow the family to attend. Invitations and report requests will be issued as soon as possible.

8.6.3 All children aged 5 and over for whom a Child Protection Planning Meeting is to be held should be referred by the social worker to Barnardos Hear 4U Advocacy Service to help us understand how they are feeling about their situation and what they would like to happen to keep them safe. Parents should be made aware of Dumfries and Galloway's Advocacy Service, - it is good practice to offer to make a referral on their behalf.

8.6.4 Following completion of the Child Protection Investigation report, the social worker will map the information considering existing strengths and safety, harm and complicating factors. The mapping exercise works best when completed alongside the family or partner agencies. There needs to be a Danger Statement that makes clear the harm and the impact of this and a Safety Goal that is clear what would need to be seen for the harm to reduce and a scaling question will be developed that will enable everyone to consider the current level of harm. The social worker will add to the chronology, including events shared by partner agencies. The social worker will support the family to develop their network who will be crucial in the success of the Safety Plan. The social worker will coordinate communication between everyone, it is essential that all involved are aware of any incidents or changes in circumstances makes the social worker aware.

8.6.5 Partner agencies including third sector providers will complete single agency reports based on their knowledge of the child, the parents and the wider family and network. Reports should include existing strengths and safety,

past, current and possible future harm as well as complicating factors. Single agency reports should be submitted within seven days of the meeting being held.

8.6.6 A number of tools are available to support assessment - these include:

- Assessment of Care Practice Toolkit– this toolkit must be completed by the first Review CPPM for children whose names are placed on the Child Protection Register under the category of neglect.
- the National Risk Assessment Toolkit
- the GIRFEC National Practice Model
- GOPR Guidance and Toolkit for working with Children, Young People and Families Affected by Problematic Alcohol and/ or Drugs.
- Safe and Together Perpetrator Pattern Mapping Tool – a virtual practice tool which helps to identify the primary perpetrator and their pattern of coercive control, assesses the harm to children and documents protective parenting efforts.

8.6.7 Report writers (with the exception of the police report) should share and discuss their report with the family prior to submission/ attendance at the Planning Meeting. The report should be received by the Child Protection Administrator at least 7 days prior to the Planning Meeting being held.

8.6.8 **Interim Safety Planning** is an ongoing process, and the plan should be continually reviewed and updated.

8.6.9 Making a Safety Plan collaboratively with the child, family, their network is important. Professionals involved with the family need to be aware of the plan and it should be clearly recorded so that it can be accessed by Social Work Out of Hours. Plans should be tested with the family to make sure they work, and contingencies are in place. It is essential that any changes are communicated to everyone involved. It may be that extended family members have been asked to stay in the family home or have the parents and or children to stay with them. We need to be aware of the pressure this puts on families with relationships, work commitments etc and provide the support to those involved need. In some circumstances, the safety plan may require the child(ren) to stay in a kinship or foster placement. Legal processes to support this include voluntary agreement by parents under Section 25 of the Social Work (Scotland) Act 1995 or a condition of a Compulsory Supervision Order Children's Hearing (Scotland) Act 2011. In situations of actual or likely significant harm a Child Protection Order, S37 Children's Hearing (Scotland) Act 2011, can be applied for by Social Work/ Dumfries and Galloway Council. Early consultation with Dumfries and Galloway Legal Services is helpful. In an emergency the police can remove a child to a place of safety S56 Children's Hearing (Scotland) Act 2011.

8.7 Child Protection Planning Meetings

8.7.1 The Child Protection Planning Meeting (CPPM) is a formal multi-agency meeting, which must include representation from the core agencies (social

work, health and police) as well as any other agencies currently working with the child and their family, including education. Attendance at these meetings and providing information should be given priority by all agencies. Where a practitioner who has been invited is unable to attend, they must inform their line manager who should see if they can support practitioner attendance or appropriate agency/ service representation at the meeting. The child and relevant family members should be invited and supported to participate throughout the meeting, as appropriate in each situation. In exceptional circumstances where they are unable to participate in person, their views should be sought and represented at the meeting. Invitations will normally be sent 2-3 weeks prior to an ICPPM, however in urgent situations, participants should be given a minimum of five working days' notice of the decision to convene an ICPPM.

8.7.2 CPPM process: attendees will discuss the mapping, including existing safety, strengths, complicating factors and previous, current and future harm. The danger statements and safety goals will be considered and everyone, including family members will be asked the scaling questions and be expected to scale, giving reasons and what they would like to see happen in order for their score to increase. Professionals will also be asked to give their views on placing the child(ren's) name(s) on the Child Protection Register. A child may have their name placed on the register if there are reasonable grounds to believe or suspect that a child has suffered or will suffer significant harm from abuse or neglect, and that a Child Protection Plan is needed to protect and support the child.

- ICPPM held following a Child Protection Investigation (CPI) where there is a concern about significant harm where it might be necessary to have a Child Protection Plan to keep the chid(ren) safe. A decision will be made at the ICPPM whether the child's(ren's) name/s need to be placed on the Child Protection Register.
- Pre-Birth CPPM held following a CPI at an early stage or following a pre-birth assessment where harm is identified and an IRD has been subsequently held, in these situations the pre-birth assessment can be the assessment to inform the ICPPM rather than a CPI. This early discussion will allow for good planning prior to the birth of the child. If there are older children in the family either already on the Child Protection Register or being considered in a CPI the meetings may be combined.
- Review CPPM- held within 6 months from the ICPPM, following a period on the Child Protection Register. Core groups will have been held on a 4 weekly basis and will update the plan, regularly using the scaling questions to monitor progress. The core group prior to the RCPPM will make a recommendation regarding continued registration which will be based on the updated assessment and plan which the social worker has completed and circulated seven days prior to this meeting. The RCPPM will make the decision whether to remove a child's name from the Child Protection Register.

- Transfer CPPM- held when a child from another area who is subject to a Child Protection plan moves to Dumfries and Galloway. Transfer requests from another Local Authority should be sent to the MASH in the first instance for coordination and planning. On receipt of relevant assessments and plans and agreement that transfer is appropriate, a date will be set that allows for representation from the previous authority and attendance by professionals who are now working with the family in D&G. When there is a transfer CPPM the child's name will always be placed on the Child Protection Register for a minimum period of 3 months even if it is perceived that the move has reduced harm to allow for further assessment to evidence that positive changes have been sustained and that the child is settled in this area.

8.7.3 **Decision of Child Protection Planning Meetings and Dissent**

- The decision about placing a child's name on the Child Protection Register is made by the chair of the CPPM based on all the information shared prior to and at the meeting.
- All professionals will be asked to give their views about registration during the meeting and this should be informed by the analysis provided through the scaling questions.
- Parents/ Child have a right to request a review of the decision about registration.
- If a professional does not agree with the decision, they are able to register their dissent.
- Parents/ Child requests to review the decision and professional dissent are considered by a senior manager in Children and Families Social Work.

8.8 Child Protection Register

8.8.1 All local authorities are responsible for maintaining a central Child Protection Register for all children who are the subject of an inter-agency Child Protection Plan. This includes unborn babies. The register has no legal status. This is an administrative system for alerting practitioners that there is sufficient professional concern about a child to warrant an inter-agency Child Protection Plan. Local authority social work services are responsible for maintaining a register of all children in their area who are subject to a Child Protection Plan. In health, where a child's name is on the Child Protection Register, there will be a CP Alert shown on clinical Portal. This is to alert health practitioners that the child has a CP plan in place due to recognised vulnerabilities/ risks.

8.8.2 **The Child Protection Plan must:**

- be developed in collaboration and consultation with the child and their family.
- link actions to intended reduction or elimination of risk.

- be current and consider the child's short-, medium- and long-term outcomes.
- clearly state who is responsible for each action.
- include a named Lead Professional.
- include named key contributors (the Core Group).
- include detailed contingencies.
- consider the sensitive direct involvement of children and/ or their views.

8.8.3 The **Core Group** are those who have direct and ongoing involvement with the child and/ or family. They are responsible for implementing, monitoring and reviewing the Child Protection Plan, in partnership with children, parents, carers and the family network.

8.8.4 The Core Group should:

- be co-ordinated by the Lead Professional and chaired by a senior social worker.
- meet in person on a regular basis (4 weekly) to carry out their functions, the first time being within 15 days of the CPPM.
- keep effective communication between all services and agencies involved with the child and parents/ carers.
- activate contingency plans promptly when progress is not made, or circumstances deteriorate.
- refer the need for any significant changes in the Child Protection Plan to the CPPM Chair within 3 calendar days, or as urgently as necessary to safeguard the child.
- be alert, individually and collectively, to escalating concerns, triggering immediate response, additional support and/ or a review CPPM as appropriate.
- Consider the need for any CP medical examination for neglect if appropriate and refer to the paediatrician accordingly.
- Make a recommendation to the RCPPM regarding the need for continued registration.

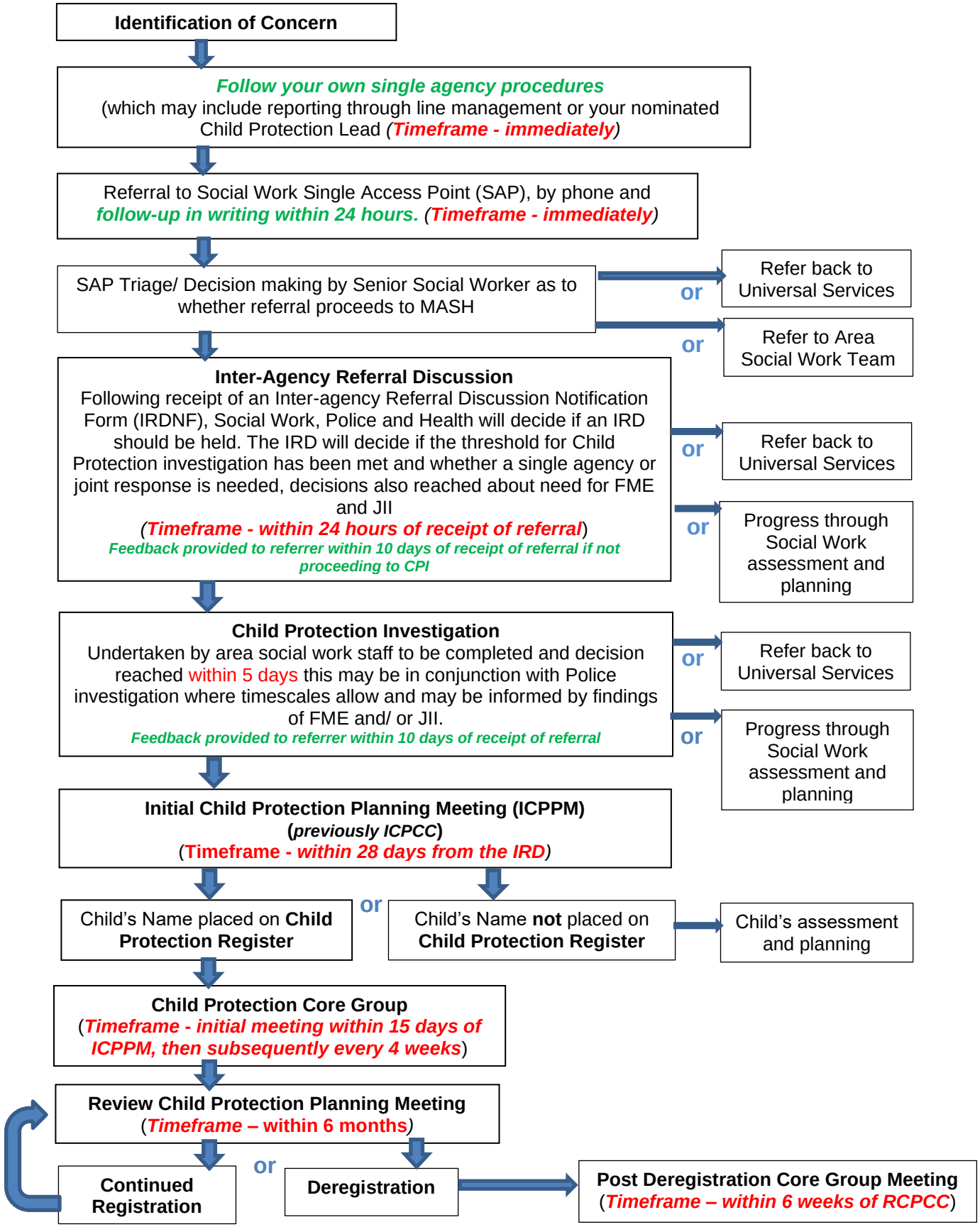
8.8.5 Following de-registration, there will be a further core group which ensure the plan has continued to work and will agree whether this is an appropriate time to pass the plan back to a Lead Professional within Health or Education.

9 Escalation

9.1 When staff are working together around a child or young person, sometimes planning for the child can run into obstacles/ disagreements that those involved are not able to resolve. In these situations, it is critical that such issues are resolved as quickly as possible to avoid potential "drift" in the delivery of the Child's Plan. This may require escalation of issues through the

line management structures. A local Resolution and Escalation Protocol is in place to provide professionals with a process to follow.

Appendix 1 - Dumfries and Galloway Child Protection Process Flowchart



Appendix 2 - Important Links and Legislation

Important Links

Voice of the Infant: Best Practice Guidelines and Infant Pledge (www.gov.scot)

Pre-Birth Assessment Protocol for Vulnerable Pregnancies (dgppp.org.uk)

Dumfries and Galloway Public Protection Partnership Assessment of Care: Practice Toolkit (www.dgppp.ork.uk)

About the Safe & Together™ Model | Safe & Together Institute (safeandtogetherinstitute.com)

Medical Examinations and Health Assessments Guidance

Information Sharing – A 10 Step Guide Safeguarding Children

Protecting Scotland's children and young people: it is still everyone's job.

Legislation and Policy Context

Policy and Legislative Framework References and Electronic Links

National Guidance Child Protection Scotland 2021-Updated 2023.pdf

Convention on the Rights of the Child | UNICEF

Getting it right for every child (GIRFEC) (www.gov.scot)

National Risk Framework to Support the Assessment of Children and Young People (www.gov.scot)

Getting Our Priorities Right: Good Practice Guidance (www.gov.scot)

Care Inspectorate Joint Inspect Quality Indicators Children & Young People.pdf (fva.org)

Quality standards | Standards and Indicators | NICE

National Trauma Training Programme - Home (transforming psychological trauma.scot)

National Legislative Framework

Children (Scotland) Act 1995 (legislation.gov.uk)

Human Rights Act 1998 (legislation.gov.uk)

Dumfries and Galloway Multi-Agency Child Protection Guidance

Children and Young People (Scotland) Act 2014 (legislation.gov.uk)

Data Protection: The Data Protection Act (www.gov.uk)

UK GDPR Guidance and Resources | ICO

Children (Scotland) Act 2020 (legislation.gov.uk)

Children's Hearings (Scotland) Act 2011 (legislation.gov.uk)

Online Safety Act (2023)

Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020