



Edinburgh and the Lothians Multi-agency Child Protection Procedures



Table of Contents

Introduction	4
Child Protection Process (from pre-birth to 18)	5
Principles Underpinning the Procedures	6
Involving Children and Families in Child Protection Processes.....	6
Working with Children and Young people	7
Working with Parents/Carers	7
16 and 17-year olds.....	7
Children’s Expectations of the Child Protection processes	8
Parents’ Expectations of the Child Protection Processes	9
What is Child Protection?	10
Definitions.....	10
What is Harm and Abuse?.....	10
Physical Abuse.....	11
Emotional Abuse	11
Child Sexual Abuse (CSA)	11
Child Sexual Exploitation (CSE)	12
Criminal Exploitation.....	12
Child Trafficking	12
Neglect	12
Agencies’ Roles and Responsibilities	13
Local Authorities	13
Children and Families Social Work Services.....	13
Education	14
Police.....	14
Health.....	14
Third Sector and Independent Organisations.....	15
Children’s Reporter	15
How Concerns May Arise	16
Concerns about Employees, Carers, Volunteers, and Service Providers	16
Information Sharing	16
Summary of Lawful Bases for Sharing Personal Information in a Child Protection Context	17
Consent when Sharing Information	17
What is Relevant Information?	18

Edinburgh and the Lothians Multi-agency Child Protection Procedures

Recording Concerns	19
Timescales for the Child Protection Process.....	19
Reporting Child Protection Concerns.....	20
Child Protection Assessment and Planning	21
Inter-agency Referral Discussion (IRD)	21
Risk Assessment	24
Interim Safety Plan.....	25
Joint Investigative Interview (JII)	25
Medical Assessment.....	26
Flowchart for Medical Assessment.....	28
Consent	30
Family Group Decision Making	32
Child Protection Planning Meeting (CPPM)	32
Types of CPPM	33
Chairing of CPPMs.....	35
Organisation and Administration of CPPMs	36
Involvement of Children and their Families.....	36
Expectations of Professionals at CPPMs	37
Provision of Reports.....	38
Restricted Access Information	39
Analysis at the CPPM	39
Reaching Decisions in the CPPM.....	40
Professional Dissent at Child Protection Planning Meetings (CPPMs)	40
Child Protection Registration	41
When Registration is Not Required	42
Parallel Processes.....	42
Child Protection Plan.....	42
Core Group.....	43
Appendices.....	45
Appendix 1 – Local Contact Details.....	45
Appendix 2 - Specific Concerns and Issues	46
Appendix 3 – Emergency Legal Measures	47
Appendix 4 – Practice Insights	50

Introduction

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

Everyone has a role in making sure children are safe, whether in private, public, or on-line spaces. The welfare of the child is the paramount consideration in action to ensure children's safety.

Child Protection is everyone's responsibility. Professionals working with children and adults must work together to share information, assess, and analyse needs and risks, and plan and deliver services jointly in a co-ordinated manner. In doing so, professionals can reduce the risk of harm to children and promote their welfare.

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

Effective use of these Procedures requires collaborative leadership from chief officers and senior managers across all services. This requires sufficient resources to deliver effective Child Protection services, supporting the workforce and ensuring they have access to high quality learning and development opportunities.

These Procedures may be complemented by individual agency Procedures or guidelines where more detail about specific processes is required. Generic terms for roles have been used throughout, as it is recognised that different areas may have designated roles with specific responsibilities.

Child Protection Process (from pre-birth to 18)

Practice Principles

Seek and consider the child's views

Protect the child's rights

Share information

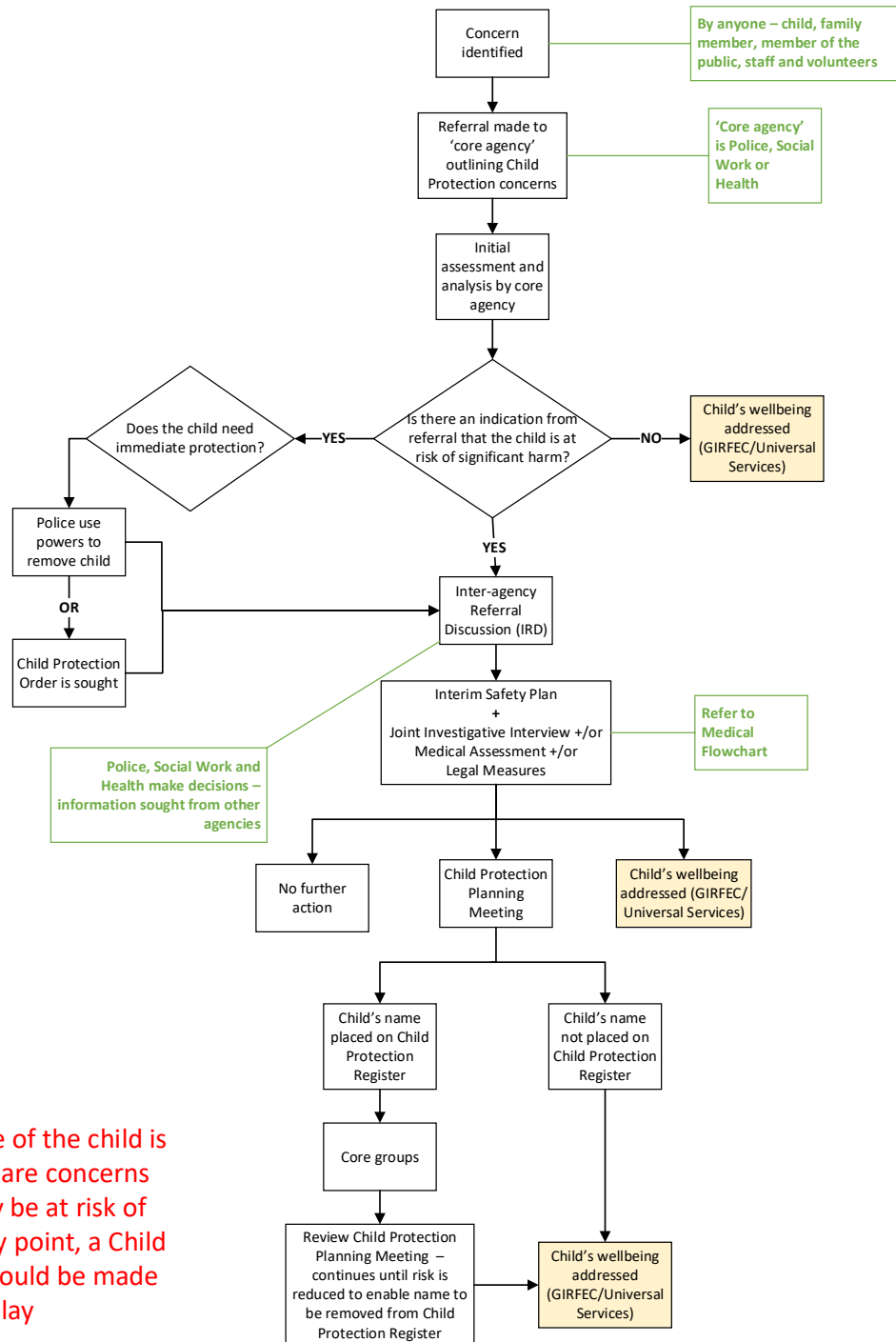
Take action at the earliest appropriate time

Assess and analyse risk

Consider referral to the Children's Reporter

Plan and intervene with an understanding of the impact of trauma

The safety and welfare of the child is paramount. If there are concerns that a child is or may be at risk of significant harm at any point, a Child Protection referral should be made without delay



Principles Underpinning the Procedures

1. The [UN Convention on the Rights of the Child](#) (UNCRC) provides the foundation for a holistic approach to ensuring children's safety and wellbeing. The Scottish approach to Child Protection is based upon the protection of children's rights. This requires a continuum of preventative and protective work.
2. The child's views should be considered at all stages of their involvement in Child Protection processes, and they should be supported to do this by any means necessary.
3. Children should get the right help, at the right time, from the right people ([GIRFEC](#)). Early interventions through Universal Services and multi-agency supports can provide proportionate responses to reduce the risk and impact of harm before a Child Protection intervention is required.
4. These Child Protection Procedures must be considered for a person up to the age of eighteen and prior to a child's birth. 'Child' is defined as a person up to 18 years of age in line with the United Nations Convention on the Rights of the Child (UNCRC) definition. These Procedures will use the term 'child' to refer to anyone from birth up to the age 18.
5. Children may experience significant harm beyond their family environment and be exposed to violence/exploitation in their school, community, or peer group. Child Protection Procedures should be considered in all situations where a child may be or is at risk of significant harm.
6. Intervention in a child and family's lives can be traumatic events in themselves, and every action taken should be underpinned by an understanding of the impact of trauma and how to minimise this. A trauma-informed approach should frame our Child Protection response and should consider the following principles: Safety, Choice, Collaborate, Empower and Trust ([Trauma-Informed Practice: A Toolkit for Scotland](#)).

Involving Children and Families in Child Protection Processes

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

Working with Children and Young people

Children and young people must:

- Have their views sought, listened to, and considered at every stage of assessment, planning and intervention. Where professionals disagree with the child's view of what action should or should not be taken, this must be explained to the child.
- Be helped to understand what the concerns are, the purpose of any intervention, and how they can contribute throughout the Child Protection process.
- Be supported to contribute to and understand their Child Protection plan and receive an accessible copy appropriate to their age, stage and understanding (any additional support needs, communication barriers and trauma experienced should also be considered).
- Have access to advocacy.

Working with Parents/Carers

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

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

16- and 17-year olds

These Procedures apply to all children up to the age of 18 years of age. Concerns about a 16- or 17-year old should be raised under these Procedures, and the process outlined in the flowchart on **page 5** followed. Where appropriate, an Inter-agency Referral Discussion (IRD) will take place to consider the risks and planning on a multi-agency basis.

For some 16- and 17-year-olds it may be appropriate to consider the use of Adult Support and Protection or other legislation to provide protection and support beyond their 18th birthday, and this should be considered at the IRD stage. Where 16- and 17-year-olds are already known to and supported by services, transition to adult services will be managed through current local arrangements.

For some other 16- and 17-year-olds, particularly those who are not known to any service, the benefits and implications of involvement in Child Protection processes beyond the IRD stage will need to be carefully planned to ensure that they are provided with the support and protection at the right time.

Children's Expectations of the Child Protection processes



Parents' Expectations of the Child Protection Processes



What is Child Protection?

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

The first stage of the Child Protection process is when a concern has been identified and a Child Protection referral is made to one of the core agencies (Police, Social Work or Health). All concerns which may indicate risk of significant harm must lead to an Inter-agency Referral Discussion (IRD). Child Protection Procedures can and should be used to address risk of significant harm in any context or setting, within and beyond the family.

‘Harm’ in this context refers to the ill-treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill-treatment of another child or adult. ‘Development’ can mean physical, intellectual, emotional, social, or behavioural development. ‘Health’ can mean physical or mental health. Forming a view on the significance of harm involves information gathering, putting a concern in context, and analysis of the facts and circumstances.

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

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

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

Definitions

What is Harm and Abuse?

Abuse or neglect may involve inflicting harm or failing to act to prevent harm. Children may be abused or neglected in any setting, and online (for example, social media and gaming forums). Children can be exposed to abuse or exploitation in their school, community, or peer group, which makes it hard for those caring for them to keep them safe. Those responsible may be previously unknown or familiar, or in positions of trust. They may be family members.

Harm may occur pre-birth, for instance by domestic abuse of a mother or through parental alcohol or drug use.

Consideration of the impact of systemic pressures (including for example, poverty or homelessness) and structural inequalities on children is a core consideration in Child Protection assessment and family support. The way in which risk to a child is impacted by their wider circumstances should always be considered as part of an assessment and plan.

The following list is not exhaustive; see **Appendix 2** for more detail about types of harm and abuse, including hyperlinks to relevant resources.

Physical Abuse is causing physical harm to a child or young person. Physical abuse may involve hitting, shaking, throwing, poisoning, burning, or scalding, drowning, or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after. All forms of physical punishment of children are against the law in Scotland regardless of personal attitudes towards reasonable discipline.

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

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

Child Sexual Abuse (CSA) is an act that involves a child in any activity for the sexual gratification of another person. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. A child under age 16 cannot consent to sexual activity at all, so it cannot be claimed that the child consented or assented to such activity. Generally, the position for children aged 16 or 17 will depend on whether there is consent or a reasonable belief of consent. Some sexual offences, such as sexual abuse of trust (section 42 of the Sexual Offences (Scotland) Act 2009) apply up to age 18 irrespective of consent.

For those who may be victims of sexual offences aged 16-17 and who are at risk of significant harm, Child Protection Procedures apply, and must be followed when there is concern about sexual exploitation or trafficking.

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

[Child Sexual Exploitation \(CSE\)](#) is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a person under 18 years of age into sexual activity in exchange for something the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact. It can also occur online.

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

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

[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, including in towns, cities, and rural areas; it does not have to be across borders. Reasons for trafficking include sexual, criminal, and financial exploitation, forced labour, removal of organs, illegal adoption, and forced or illegal marriage. The [National Referral Mechanism](#) process helps identify victims of human trafficking and exploitation.

[Neglect](#) is the persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in the serious impairment of the child's health or development. Single instances of neglectful behaviour may cause significant harm. Early signs of neglect indicate the need for support to prevent harm.

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

- Provide adequate food, clothing, and shelter (including exclusion from home or abandonment).
- Protect a child from physical and emotional harm or danger.
- Ensure adequate supervision (including the use of inadequate caregivers).
- Seek consistent access to appropriate medical care or treatment.
- Ensure the child receives education; or
- Respond to a child's essential emotional needs.

Agencies' Roles and Responsibilities

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

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

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

Where such a 'responsible person' or senior member of staff is not available for consultation, the member of staff must not delay and should contact agencies directly. If they are not satisfied with the response from the 'responsible person', the member of staff should contact one of the core agencies directly (See **Reporting Child Protection Concerns**).

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

If asked, all agencies must provide relevant information to assist any Child Protection investigation.

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

Local Authorities

Local authorities have a legal duty (Children (Scotland) Act 1995) to safeguard and promote the welfare of children in need. This responsibility extends to all children, whatever their living circumstances. The local authority must make all necessary inquiries into the child's circumstances if it appears that the child needs protection, guidance, treatment or control, or a Compulsory Supervision Order may be required. Duties and responsibilities apply to all local authority services.

Children and Families Social Work Services

Children and Families Social Work Services play a key role in investigating Child Protection concerns and supporting children and families. Social Work is one of the three 'core agencies' in Child Protection, with Police and Health. Designated managers are responsible for

discussing Child Protection referrals with Police and Health (through the Inter-agency Referral Discussion (IRD) process) and specially trained Social Workers and Police Officers interview children who may have suffered abuse or neglect. A Social Worker is always the Lead Professional when a child's name is placed on the Child Protection Register.

Education

All staff working in education establishments, including early learning and childcare (ELC) settings, have a key role in the support and protection of children. Although not a 'core agency' in Child Protection, Education staff should be involved in key processes. Every school has a nominated person (known as the Designated Member of Staff (DMS) in East Lothian, Midlothian and West Lothian, and Child Protection Coordinator in Edinburgh) taking lead responsibility for Child Protection in their school, in liaison with the Head Teacher/head of establishment.

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

- Additional needs or factors that may impact on a child's ability to voice concern.
- Physical and emotional changes in a child that could indicate abuse or neglect.
- Family, school, cultural and community context of concerns about a child or children.
- Escalating support needs of a child and their family; and
- Risks and stresses for some children in transitional stages as they move into a new school or on to adult life and services.

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

Police

Police Officers have a statutory duty to detect and prevent crime and have a key role in Child Protection and community safety. Every policing division has a dedicated Public Protection Unit staffed by specialist officers, with investigation teams and a Divisional Concern Hub. These Officers have a key role in the assessment, investigation and planning around Child Protection. Police Scotland is one of the three core agencies involved in Inter-agency Referral Discussions (IRDs) (with Social Work and Health) and undertake the investigative interviews of children who may have been abused, alongside specially trained Social Workers. Police have a statutory duty to refer the facts to the Procurator Fiscal where a criminal offence may have been committed, and to refer children to the Scottish Children's Reporter Administration when they may be in need of compulsory supervision. Police have emergency powers to remove a child from harm or risk of harm (For more information, see **Appendix 2**).

Health

Health professionals are often the first to be alerted to cases of child abuse, particularly in suspected cases of physical abuse and neglect. Health staff have contact with children,

parents, and carers in circumstances where they may identify that a child may be at risk. Health is one of the three 'core agencies' in Child Protection, with Police and Social Work. Through the Inter-agency Referral Discussion (IRD) process, Health professionals offer children a trauma informed health assessment, which satisfies both the child's health needs and any forensic requirements.

The health service will support access to ongoing physical and psychological health care for the child.

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

Health professionals can seek advice and support about Child Protection matters from NHS Child Protection Advisors.

Third Sector and Independent Organisations

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

Further and Higher Education establishments, independent schools, private early years' providers and third sector supported accommodation services are expected to incorporate these Procedures into their own organisation's Child Protection policies, procedures, and guidance. Where a Child Protection concern arises in relation to a child who attends an independent school, college, or university out with their own area, the establishment must liaise with the local authority where the child usually lives.

Children's Reporter

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

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

How Concerns May Arise

Anyone working with children or families may become aware of a potential Child Protection concern. This may be a one-off event or an accumulation. The following is not an exhaustive list, but includes when:

- A child says something that is concerning (e.g., a young person says they are meeting up with an adult they met on-line).
- The child's presentation changes, either suddenly or over time (e.g., a child appears tired, hungry, or unkempt, or they are more withdrawn).
- A child has visible injuries, which are not explained adequately (e.g., a baby with bruising or broken bones).
- Information is shared by another person, service, or anonymous source (e.g., reports from neighbours that a young child is out alone at night).
- A child tells an adult that something has happened to them (e.g., a child tells their teacher that they have been hit by an adult).
- There is concern about staff or volunteers in your own or another organisation.
- There is concern arising out with the family - such as exploitation, peer-on-peer or online abuse.
- A sudden or unexpected event occurs in relation to another child in the same family, household, or context (e.g., a sudden or unexplained child death).

Concerns about Employees, Carers, Volunteers, and Service Providers

Concerns may arise about people who work with children either in relation to their behaviour at work or in their private life. If you have a Child Protection concern about a member of staff in your own or another organisation, this should be shared according to these Child Protection Procedures.

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

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

Information Sharing

Sharing relevant information as soon as possible is essential to protecting children from harm. All staff and volunteers should be supported by their organisation to be confident in sharing

information appropriately and be guided in working and applying the law by their organisation's policies and procedures. Information sharing should be lawful, fair, and transparent.

Each agency is responsible for maintaining accurate and secure records.

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

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

Summary of Lawful Bases for Sharing Personal Information in a Child Protection Context

Summary of Lawful Bases for Sharing Personal Information in a Child Protection Context	
Public interest or public task	Necessary for performance of a task carried out in the public interest, which is laid down by law, or in the exercise of an official authority, for example, a public body's tasks, functions, duties or powers.
Vital interests	Necessary to protect someone's life or, for example, if a child is deemed to be at risk of significant harm.
Legal obligation	Necessary to comply with a common law or statutory obligation.

Reference: Lawful basis for processing | ICO

It is the role of designated Police, Social Work and Health staff to consider whether there may be a risk of significant harm, and if so, to progress Child Protection Procedures (see **Child Protection Assessment and Planning**). If asked for information as part of a Child Protection investigation by one of the core agencies, organisations must comply.

For more information refer to the [10 step guide to sharing information to safeguard children](#) published by the Information Commissioner's Office.

Consent when Sharing Information

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

Consent requires people to have real choice and control about the sharing of their personal data. In most situations where there is a Child Protection concern, parents will not have real choice or control – the welfare of the child is the paramount consideration and overrides all

other duties. Seeking consent may place the child at increased risk. However, where appropriate, agreement and understanding about the sharing of information may be helpful in engaging individuals in the process.

Parents and carers should be told what information about them is being shared, with whom and why this is necessary, unless they cannot be found, or to do so would be detrimental to the:

- Best interests of the child.
- Health and safety of a child or another person.
- Prevention or detection of crime (e.g., creating a risk of harm to a child); and/or
- Apprehension or prosecution of offenders.

What is Relevant Information?

Information shared must only be that which is necessary for Child Protection purposes. Where there is a Child Protection concern, relevant information should be shared with Police or Social Work without delay, provided it is necessary, proportionate, and lawful to do so. Professional judgement must always be applied to the available evidence about each specific emerging concern, and about what is relevant, proportionate, and necessary to share.

Information gathering is an essential part of the Child Protection process, enabling robust risk assessment and planning.

Examples of relevant information include:

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

If in doubt about information sharing, seek advice from line managers, or those in the organisation with responsibility for Child Protection or information governance.

When a child shares a concern:

- They must be taken seriously and supported.

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

Further detailed guidance on information sharing can be found in the [GIRFEC Practice Guidance](#).

Recording Concerns

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

All practitioners should ensure that they adhere to their own agency’s recording protocols. Information should be recorded as soon as possible after the event.

Recording should be concise, factual, and accurate.

Clear reasons for decisions should be stated.

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

Timescales for the Child Protection Process

What	When
A Child Protection concern should be shared with a core agency	Without delay (both in and out of office hours)
The Inter-agency referral discussion (IRD) should be held	As soon as possible.
A Child Protection Planning Meeting (CPPM) should be held	Within 28 calendar days of the start of the IRD
A pre-birth CPPM should be held	Wherever possible by the 28th week of gestation but not before 22 weeks gestation
Notice of a CPPM	At least 20 calendar days
Provision of a report for a CPPM	10 calendar days before the CPPM
Reconvening a CPPM if inquorate	Within 10 working days
Participants should receive the CP Plan	Within 5 working days
Participants should receive the minute of the CPPM	Within 10 working days
The Core Group should be held	Within 15 working days of the Initial or Pre-birth CPPM, and at least every 4 to 6 weeks

Review CPPMs should be held	Within 3 months of a pre-birth CPPM. Within 6 months of an Initial CPPM and then every 6 months or earlier if agreed.
Referral to the Children’s Reporter can be made	At any stage when a compulsory supervision order appears necessary.

Reporting Child Protection Concerns

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

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

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

1. Informing, or seeking advice from, a designated person (in Health, this is the Child Protection Advisor/Health Child Protection Team” or “responsible person”) in the agency or organisation (See **Agencies’ Roles and Responsibilities**).
 - i. The designated person will listen to concerns and give advice on what action needs to be taken. If appropriate they will make, or recommend making, a Child Protection Referral.
 - ii. Where a member of staff or volunteer is unable to contact their designated person or they are not satisfied that the response is not adequate to address the risk of harm to the child, they should make a Child Protection Referral without delay.
2. Making a Child Protection Referral directly to one of the core agencies. Staff may believe that it is more appropriate to contact one of the specific core agencies, dependent on the nature of the concerns, for example immediate concerns for the child’s safety, their own safety, or a concern relating to an adult.

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

Making a Child Protection Referral

A Child Protection Referral is when information is shared with designated people in one of the core agencies (Police, Social Work or Health) if the referrer knows or suspects that a child is at risk of significant harm. The key contacts for each area can be found at **Appendix 1**.

This should be done without delay. A Child Protection Referral should include all relevant information known by the referrer.

Where Health Staff suspect that a child is at risk of significant harm, they must act on those concerns, by referring to the local Child Health Protection Team or out-of-hours Paediatrician on-call for Child Protection. Whilst it may be appropriate to discuss concerns with line

managers, individual practitioners are responsible for ensuring that their concerns are shared with the local Health Child Protection Team (or Police or Social Work, who may initiate an Inter-agency Referral Discussion (IRD)).

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

- Where the information indicates a **low level of risk**, the matter may be diverted to universal services for support.
- Where the information indicates a **risk of significant harm**, the receiving core agency should initiate an Inter-agency Referral Discussion (IRD).
- Where the information indicates that the child is at **immediate risk of significant harm**, emergency legal measures to remove the child to a place of safety may be used. These may be used at any time. Parents must be supported to understand the reasons why these measures are required and be made aware they can seek legal advice. See **Appendix 2**.

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

Escalation

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

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

For Child Protection Planning Meetings, see **Professional Dissent at CPPM**.

Child Protection Assessment and Planning

Inter-agency Referral Discussion (IRD)

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

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

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

All concerns which may indicate risk of significant harm must lead to consideration of an IRD. Where information is received by Police, Health, or Social Work that a child may have experienced or may be at risk of significant harm, an IRD must be convened without undue delay.

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

An IRD will continue until the point that a decision is made to hold a Child Protection Planning Meeting (CPPM) or that alternative (or no further) action is appropriate.

IRD Participants

Police, Social Work and Health must always be part of an IRD. Information must always be sought from other agencies and services working with the child and their family to support a comprehensive understanding of the circumstances. Where a child is in an early years', or school setting, Education must be consulted as part of the IRD.

Where an IRD considers a child aged 16 or 17, adult Social Work Services should be consulted and may be involved in the IRD for the purpose of supporting analysis and decision making about whether the risks are better addressed by Adult Support and Protection Procedures or other legal frameworks and whether appropriate support would be better provided by Adult Services.

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

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

Initiating an IRD

Any one of the core agencies can initiate an IRD where they believe that a child is at risk of significant harm, and inter-agency discussion, assessment and decision-making are required. The initiating agency must directly contact the other agency IRD participants and open a record on the electronic IRD system, known as eIRD. For IRDs that are initiated overnight, consideration should be given to whether Health is immediately essential to the decision-making i.e. where the child (or any sister or brother) is thought to require an immediate Joint Paediatric Forensic Medical, or is at risk regarding immediate health issues, or the extent of sexual assault is unclear.

Undertaking an IRD

At any point during the IRD process it may become apparent that emergency measures are required to protect the child.

IRD participants should share relevant information about:

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

IRD participants should analyse the information to understand the impact on the individual child and the child's lived experience.

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

Decisions and planning

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

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

- Joint investigative interview; and/or
- Medical assessment.

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

If not, the IRD should decide whether:

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

The IRD participants should clearly identify who is responsible for progressing the follow-on actions and feeding this back to relevant staff. Where a CPPM is going to take place, IRD participants should inform their staff of this decision, to allow as much time as possible for professionals to prepare a report.

The IRD should clearly identify:

- Who will inform the child/parent/carer of the outcome of the IRD; and
- What feedback to the referrer is appropriate, and who is going to provide this.

Interface with Other Processes

Children and young people who are believed to have harmed others may also require co-ordinated information sharing and decision-making (for example, when a child under 12 has caused serious harm which requires investigation, or when a child is at risk of being drawn into extremism). Whilst alternative processes may be considered, (such as a referral under the Prevent Strategy (See number 31, Appendix 2) or Investigative Interview under the Age of Criminal Responsibility (Scotland) Act 2019 (See number 30, Appendix 2)), if there are also concerns that the child is at risk of significant harm, an IRD will provide the opportunity for effective information sharing and co-ordination of actions.

IRD Record

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

IRD Review and Sign-off

Every IRD record will be reviewed and signed off within locally agreed timescales by the local area's IRD Review Group.

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

Risk Assessment

Risk Assessment is not a one-off event but an ongoing, dynamic process as the risk of harm can become more or less severe. It is used to inform the plan at all stages. The risk assessment is used to update and adapt the plan as new information comes to light and the effectiveness of interventions is reviewed.

Risk assessment involves:

- Keeping a focus on the child and understanding their lived experiences.
- Gaining a picture of the child and family circumstances to understand what needs to happen in order to maximise safety, minimise harm and protect the child.
- Gathering single and multi-agency information/evidence from relevant sources - case records; family; chronology; previous interventions.
- Analysis of the gathered information (i.e., making sense of the information) in order to identify the risk factors, vulnerabilities, protective factors and strengths and how these impact or may impact on the safety and wellbeing of the child now and in the future; and
- Identifying barriers to reducing risk, including 'disguised compliance'

Practitioners should use the range of tools available to them to provide clear rationale for their assessment. They may be multi-agency (including the [National Risk Assessment](#)

[Framework](#), [GIRFEC National Practice Model](#) or specialist (such as DASH-RIC, Neglect Toolkit). A robust assessment is the basis for sound decision making and planning.

A [chronology](#) is an essential tool to support risk assessment. It may highlight patterns of behaviour, previous interventions that have been unsuccessful or worked well which can inform the risk assessment, decision making and planning when analysed along with all the other gathered information. Single agency or a multi-agency chronology must be provided for a Child Protection Planning Meeting. See number 2, **Appendix 4**.

The child and the parents/carers must be supported to understand the risk assessment and the purpose of agency interventions to maximise their potential to keep the child safe.

Interim Safety Plan

A multi-agency interim safety plan should be in operation throughout an IRD, proportionate to the current assessment of risk. The plan must be agreed by the IRD participants and followed until conclusion of the IRD or until the CPPM takes place. The interim safety plan must be shared with the people who are responsible for implementing it, and the child and family as appropriate.

Where a child has been admitted to a hospital and who is subject to an IRD, a discharge planning meeting must take place.

The plan should include:

- Detail who will see and speak to the child and how often.
- Details of who is doing what to ensure a child's immediate safety; and
- The name of the person with lead responsibility for monitoring the plan.

Joint Investigative Interview (JII)

An IRD will decide whether a Joint Investigative Interview (JII) is needed. Joint Investigative Interviews are carried out by Social Workers and Police who are specifically trained to interview children and vulnerable witnesses. JIIs are conducted using the Scottish Child Interview Model (SCIM). The Joint Interview process will be co-ordinated and supervised as determined by local structures.

The purpose of a JII is to:

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

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

- Experience before the interview and the context of the interview.
- Motivation to share/participate.
- Strengths and resources.
- Interests (to aid rapport building).
- Complex needs and level of understanding.
- Experience of trauma and adversity.
- Speech, language/interpreting, and communication support needs.
- Relationships, including sources of reassurance and anxiety; and
- Accompanying support, transport, and care arrangements.

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

Medical Assessment

In all cases where there is suspected risk of significant harm, the need for a medical assessment must be discussed during the IRD. The decision to undertake a medical examination or health assessment, the nature and timing of that examination and any decision not to examine the child must be made by the Health Child Protection Team or out of hours the Paediatrician on-call for Child Protection in discussion with other core agencies and clearly documented.

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

The purpose of the examination is to:

- Secure any immediate medical treatment the child may need.
- Provide a specialist medical opinion on whether or not child abuse or neglect is a likely cause of the child's presentation.
- 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.
- Listen to and reassure the child.
- Listen and reassure the family as far as possible in relation to the longer-term health needs; and
- Support multi-agency planning and decision-making.

The examination must be trauma informed, comprehensive, gathering information about the child's overall wellbeing, growth, and development, including documentation and interpretation of injuries.

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

The decision to carry out a medical assessment and the decision about the type of medical examination is made by a Paediatrician, informed by the IRD. The number of examinations will be kept to a minimum. For the purposes of the Procedures the person carrying out the medical examination will be termed the examining medical practitioner.

The main types of medical examination are:

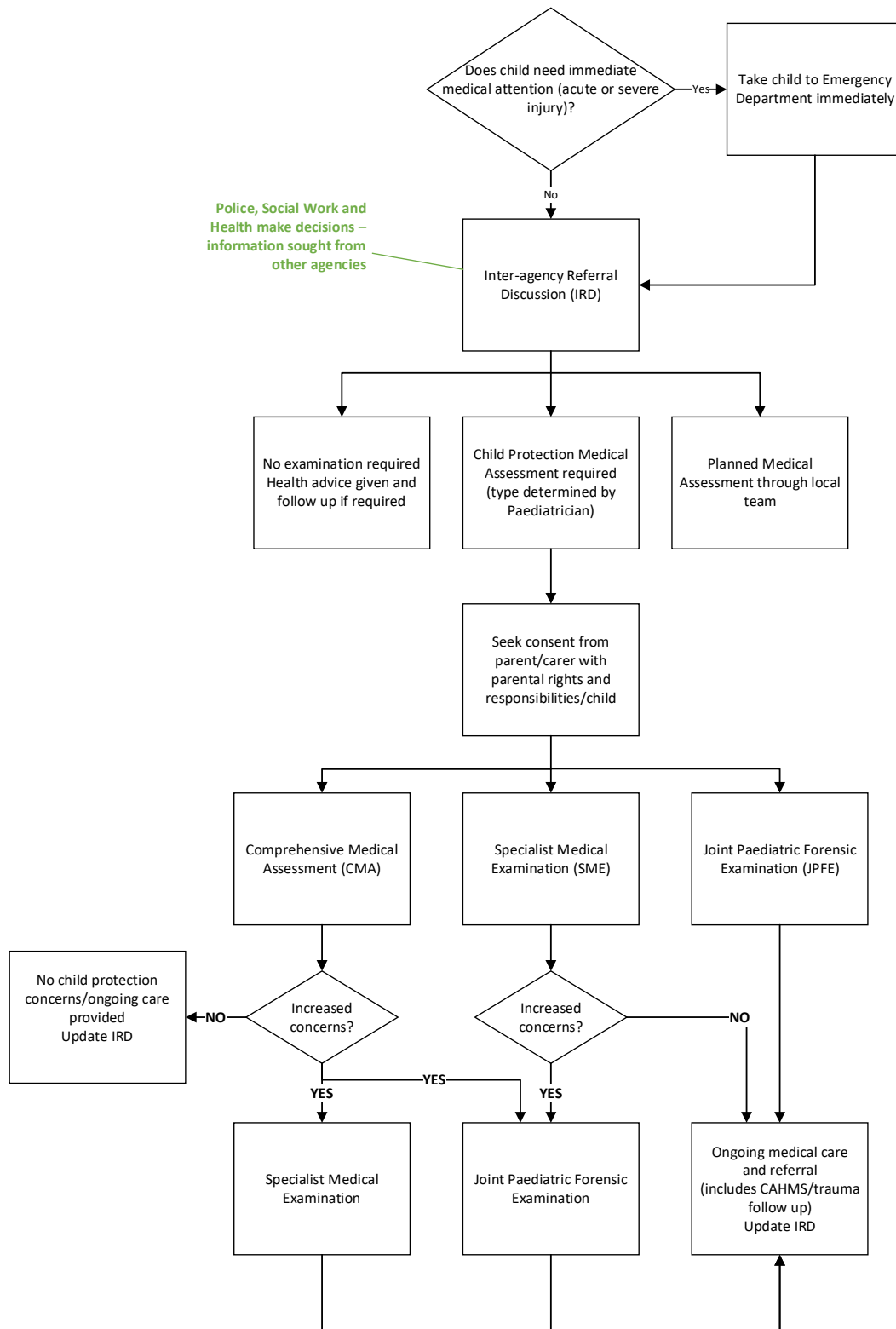
Comprehensive Medical Assessment (CMA) Comprehensive medical assessments are carried out in situations where it is unclear from the initial information whether abuse or neglect has occurred, and alternative accidental or medical explanations may be forthcoming. These examinations are carried out by doctors trained in child health, General Practitioners, or hospital based paediatric staff where the child has presented directly to primary care, Emergency Departments or hospital paediatric departments. A comprehensive medical assessment may also be carried out if neglect, particularly medical neglect is suspected. This will allow a holistic assessment of the child's health and development to provide an opinion on likelihood of neglect and initiate ongoing follow up.

Joint Paediatric Forensic Examination (JPFE) or Specialist Medical Examinations. These examinations are carried out where clear evidence of serious injury is reported at the inter-agency referral discussion, e.g., non-accidental head injury in an infant, severe injury in an older child or a disclosure of sexual abuse, significant potential harm or a requirement for forensic medical opinion. They are carried out by specialist Paediatricians working with Forensic Physicians (FP). They may include the expert opinion of other medical colleagues for example plastic surgeons or radiologists. Their aim is to provide an opinion of the likelihood of physical or sexual abuse or neglect where other corroborating evidence exists.

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

- All relevant information about the cause for concern.
- Information on previous concerns about abuse or neglect.
- The inter-agency plan to meet the child's needs at this stage.
- Relevant known background of the family or other relevant adults; and
- Information from the Joint Investigative Interview if available.

Flowchart for Medical Assessment



Chaperones

A chaperone is an impartial observer who would be present when an intimate examination is being carried out on a child. A chaperone should usually be a health professional who is not involved in the examination of the child. A relative or friend would not usually be considered to be a suitable chaperone, but the examining medical practitioner should comply with a reasonable request from the child to have someone else present, as well as the chaperone (GMC Guidelines).

The wishes of children should be considered and supported wherever possible. In respect of choice of the gender of examinee ([Supporting children and young people who may have experienced sexual abuse – Clinical Pathways NHS Scotland 2020](#)). Where medical on-call arrangements do not support this position, a Police Officer of the same gender as the victim may be asked to be a chaperone.

Timing of medical examinations

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

It is also important to ensure appropriate emotional support is available for the child and a child friendly environment is created. This must be balanced against the need for forensically clean setting.

Where the involvement of a Forensic Physician is required, the Police will contact the on-call Forensic Physician, through locally arranged Procedures.

Following examination

At the end of the examination, the examining medical practitioner will share their initial conclusions with the attending Police and Social Worker, including any plans for further investigation (e.g., x-ray, haematology) and the implications of those. The examining medical practitioner will also contribute to the immediate safety planning for the child and any other children who are potentially at risk.

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

Recording and Reports

Examinations are documented on the national standardised Child Protection Paediatric Examination Form (which includes body charts to record all injuries).

An immediate opinion (subject to revision) will be provided after the examination to Police and Social Work. The appropriate report (single Doctor letter or soul and conscience report) providing an opinion of the likelihood of abuse will be made available within four weeks and shared with participants of the IRD.

Consent

Joint Investigative Interviews (JII)

- The child must be helped to understand the purpose and process of the interview as part of preparation in order to support willing engagement and informed consent.
- The JII will not proceed without the child's informed consent.
- It is good practice to always discuss the reason for a Joint Investigative Interview with a parent or guardian, but their consent is not required. Parents/carers should be made aware that the interview is taking place unless there is a good reason not to, for example, where there are strong grounds to suspect that they are involved in the abuse.
- Separate consent must be obtained for a medical examination to take place.

Medical Assessments

Written parental consent will be required prior to any Child Protection medical examination, unless the child or young person is considered, by the examining medical practitioner, to have capacity to give consent on their own behalf.

The written consent must be taken by the examining medical practitioner. In exceptional circumstances witnessed telephone consent may be taken from the parent or individual with parental rights and responsibilities, by the examining medical practitioner.

Consent must be obtained in one of the following ways:

- From a parent or carer with parental rights.
- From a child assessed to have capacity; or
- Through a court order (for a child who does not have capacity to give consent).

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

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

In order to ensure that children and their families give properly informed consent to medical examinations, it is the role of the examining medical practitioner, assisted if necessary by the

Social Worker or Police officer, to provide information about all aspects of the procedure and how the results may be used; and to ensure informed consent has been obtained.

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

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

Issue	Consent of Parent	Consent of Child
Joint Investigative Interview.	Not required.	Required.
Medical examination, where the examining medical practitioner decides that the child does not to have capacity to consent to examination, and of understanding the consequences of consenting.	Consent is essential prior to any Child Protection medical examination and must be obtained by the examining medical practitioner. Consent should usually be written, and provided by the parent or legal guardian, unless a young person is considered by the Doctor to have capacity to give consent on their own behalf. In certain circumstances, it might not be possible for the parent to attend the examination to provide written consent. Discussion must then take place with health, prior to the appointment, to agree how consent will be provided. The examining medical practitioner might obtain verbal consent, over the phone, with a parent. This should be witnessed by another professional who will counter-sign that consent has been provided. In the absence of consent being able to be provided by any person with the examining medical practitioner will proceed in the best interests of the child.	Examining medical practitioner will only proceed if in the child's best interests.

<p>Medical examination, where the examining medical practitioner decides that the child does have capacity to consent to examination, and of understanding the consequences of consenting.</p>	<p>Not required.</p>	<p>Required, even where a measure or an interim order or supervision requirement is for the child to submit to a medical examination or treatment.</p> <p>Where a child is looked after and accommodated and consent for medical treatment has previously been given, specific consent to a medical examination for Child Protection purposes will be required.</p>
---	----------------------	---

Family Group Decision Making

The Family Group Decision Making (FGDM) approach brings family and friends together to strengthen the support around the child. Consideration should be given to using this approach at any point. It is not an alternative to Child Protection Procedures but can enhance the planning for the child. Refer to local guidance for further information.

Child Protection Planning Meeting (CPPM)

A Child Protection Planning Meeting (CPPM) is a formal multi-disciplinary meeting to decide whether the child is at risk of significant harm and devise a plan to reduce the risk. This is achieved by ensuring all relevant information is shared and analysed.

The child and their parents/carers should be invited and supported to participate in the CPPM. Where they are unable to participate in person their views must be sought and represented at the meeting.

CPPMs must include representation from the core agencies (Social Work, Health, and Police) and any other agencies currently working with the child and their family. This includes any early years, school, or other education setting, which the child attends.

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

Where the CPPM has identified immediate risk of significant harm to the child, action should be taken without delay, using emergency measures.

In addition, CPPMs must always consider whether a referral to the Children's Reporter is required. This should be based on consideration of the possible Grounds of Referral. If a referral is to be made, the CPPM should agree who will do this and by when. A referral to the

Reporter is not a suitable contingency plan to manage or mitigate risk; bringing the child into another system or process will not in itself make them safer.

Types of CPPM

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

- Initial/Pre-birth
- Review
- Transfer

Initial CPPM (ICPPM)

The purpose of an Initial Child Protection Planning Meeting (ICPPM) is to share the information held by each agency, including initial assessments, to carry out a multi-agency analysis of risk and reach a decision about whether a child is at risk of significant harm. An ICPPM must take place within 28 calendar days of the start of the IRD.

Pre-birth Child Protection Planning Meetings (PBCPPM)

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

PBCPPMs should take place wherever possible by the 28th week of gestation but not before 22 weeks gestation, as this is the edge of viability of an unborn baby. This should not prevent early assessment and supportive interventions for the family.

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

Where a Child Protection Plan is in place prior to a child's birth, the child must not be discharged from hospital until a discharge planning meeting has been considered. This would be required if there were any changes to the family circumstances that would necessitate a review of the Child Protection Plan prior to discharge. This meeting should include the Core Group members and the child's relevant family members, as well as hospital-based maternity ward staff.

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

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

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

A Review CPPM must be held no later than three months after the child's birth. This review should not remove the child's name from the Child Protection Register unless there are exceptional circumstances.

Review CPPM

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

A Core Group can request an early review by referring the case to the CPPM Chair. An early review should be considered only where there is a significant change in the child's circumstances that indicate a change to the child's registration status may be required. The Lead Professional is responsible for contacting the CPPM Chair to discuss the need for an early review.

Where a child is no longer considered to be at risk of significant harm, their name should be removed from the Child Protection Register (referred to as de-registration). Removal of a child's name from the Register can only happen at a Review CPPM. The child and their family may still require ongoing support, and the child's wellbeing should be addressed and managed by Universal Services or by a multi-agency child's plan (GIRFEC).

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

Transfer CPPM

The purpose of a transfer CPPM is to formally place a child's name on the receiving area's Child Protection register. A transfer CPPM cannot remove a child's name from the Register. The original local authority area should consider whether the child is still at risk of significant harm before requesting a transfer CPPM. If the child is no longer at risk of significant harm, the original local authority area should remove the child's name at a Review CPPM and consider what information should be given to the new local authority area. Universal services should ensure that they receive information about any child who moves into the area.

Where a child and their family move from one authority to another and the child's name is on the Child Protection Register, a transfer CPPM will be arranged by the receiving authority and must take place within 28 calendar days from the date of request for transfer. All relevant multi-agency information must go with the child.

Chairing of CPPMs

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

CPPM chairs will:

- Be independent of the case being considered, having no supervisory or line management responsibility for any practitioner involved.
- Have the authority, skill, and experience to challenge those contributing, including agencies' assessment or the progress of the Child Protection plan.

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

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

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

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

- The discussion at the CPPM focuses on understanding and analysing the risk to the child.
- All relevant information is shared and analysed.
- All agencies contribute to the analysis and decision making.
- The Child Protection plan focuses on reducing identified risk to a child; and
- Any lack of progress in a Child Protection Plan is challenged and suitably escalated with the relevant agency.

Organisation and Administration of CPPMs

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

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

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

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

Minute of the CPPM

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

The Child Protection Plan will be circulated within five working days. A minute of the CPPM will be circulated within 10 working days.

Involvement of Children and their Families

The views of the child must always be represented and considered by the CPPM. Disability, age or where English is not a child's first language must not be a barrier to involvement.

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

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

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

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

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

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

Expectations of Professionals at CPPMs

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

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

Professionals will be expected to identify:

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

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

At a Review CPPM, professionals will be expected to evidence:

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

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

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

Quorum

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

As a minimum, for an ICPPM or PBCPPM to be quorate there must be representation from the core agencies (Social Work, NHS, and Police). Education and early learning and childcare should always be invited where the child is in an early years' service or school, are expected to attend, and should always provide information in the exceptional circumstances where they cannot attend.

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

Where a CPPM is not quorate another CPPM must take place within 10 working days. The Chair must be satisfied that there is a robust safety plan in place that safeguards the child until a further CPPM is convened.

Provision of Reports

- Each agency invited to the CPPM will submit a report, including a chronology of significant events, using the appropriate format, detailing involvement with the child and significant adults in the child's life.
- Reports will be submitted 10 calendar days prior to the scheduled date of CPPM (except where the urgent arrangement of a CPPM does not permit).
- Restricted Access Information will not be circulated in writing prior to CPPM although will be shared verbally with those professionals/agencies who need to know.
- Restricted Access Information shared or discussed during CPPM may NOT be shared with any other person, including the child and/or family, without the prior permission of the provider.

- All information, other than Restricted Access Information, contained in reports will be shared openly with the parent(s)/carer(s) and the child.
- All information shared by professionals must be used and stored appropriately by those receiving it. Where agencies cannot undertake the secure storage of information, they should not keep it.

Reports for Reviews

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

Restricted Access Information

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

Restricted information includes:

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

The information will be shared with the other participants at the CPPM, where it is proportionate to do so. Restricted access information will be discussed without the family present. The Chair will explain to the family the reasons why this will happen. Such information may not be shared after the meeting with any other person without the explicit permission of the provider.

Analysis at the CPPM

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

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

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

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

Reaching Decisions in the CPPM

All CPPMs will reach decisions by consensus.

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

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

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

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

Professional Dissent at Child Protection Planning Meetings (CPPMs)

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

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

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

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

The Chair of the meeting must advise the Lead Officer for Child Protection of the dissent immediately after the meeting, or at the latest the next working day.

The Lead Officer will ensure that a multi-agency Review Group identified by the Child Protection Committee/Public Protection Committee is advised and receives appropriate

paperwork (i.e., all reports submitted to the CPPM and a copy of the draft minutes) within 72 hours.

The Review Group will meet with the Chair of the CPPM and the professional who has dissented within 10 working days of the CPPM. The purpose of the meeting is to consider all information, explore the reasons for the decisions made, and the concerns raised.

The Review Group will produce an advisory note for the reconvened CPPM either:

- Identifying gaps or areas for further consideration; or
- Agreeing with the original assessment of risk.

A reconvened CPPM should take place within 15 working days of the Review Group meeting.

Child Protection Registration

All local authorities are responsible for maintaining a central register, known as the Child Protection Register, of all children, including unborn children, and children up to the age of 18 years, who are the subject of an inter-agency Child Protection Plan. It has no legal status but provides an administrative system to alert practitioners that the child is deemed to be at risk of significant harm.

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

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

Impact on/abuse of the child identified – Physical Abuse
Impact on/abuse of the child identified – Emotional Abuse
Impact on/abuse of the child identified – Sexual Abuse
Impact on/abuse of the child identified – Criminal Exploitation
Impact on/abuse of the child identified – Child Trafficking
Impact on/abuse of the child identified – Neglect
Impact on/abuse of the child identified – Female Genital Mutilation (FGM)
Impact on/abuse of the child identified – Honour-based Abuse and/or Forced Marriage
Impact on/abuse of the child identified – Child Sexual Exploitation
Impact on/abuse of the child identified – Internet-enabled Sexual Offending
Impact on/abuse of the child identified – Underage Sex
Vulnerability factor – Services finding it hard to engage
Vulnerability factor – Child affected by parent/carer mental ill-health
Vulnerability factor – Child experiencing mental health problems
Vulnerability factor – Domestic abuse
Vulnerability factor – Parental alcohol use
Vulnerability factor – Parental drug use
Vulnerability factor – Child displaying harmful sexual behaviour
Vulnerability factor – On-line safety
Other concern(s)

When Registration is Not Required

When a child's name is not placed on the Child Protection Register, there may still be issues that require support and assessment. In all cases where a child is not registered, the child's wellbeing should be addressed by Universal Services or a multi-agency child's plan (GIRFEC). Child Protection registration must not determine access to services or support. It is not appropriate for services to withdraw based only on the decision not to register.

Parallel Processes

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

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

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

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

Child Protection Plan

When a child is considered to be at risk of significant harm by a CPPM, their name must be added to the Child Protection Register and a multi-agency Child Protection Plan put in place. A Child Protection Plan should be focused on addressing the identified risks to the child, both immediate and longer term.

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

Actions in a Child Protection Plan should be SMARTER:

Specific	<ul style="list-style-type: none"> • Use clear everyday language. • Actions should address the identified risk - a list of referrals to services is not a plan. • Include the detail – who is going to do what by when?
Measurable	<ul style="list-style-type: none"> • Be clear about what improvement looks like and what evidence demonstrates that the plan is working. • What will it look like for the child when the plan is working? • The outcomes should reflect the impact of the actions on the child.
Achievable	<ul style="list-style-type: none"> • Consensus reached with involved professionals and the family. • Actions must be in the control or influence of the core group members. • Outcomes should not be out of reach and set the child or family up to fail.
Relevant	<ul style="list-style-type: none"> • Child Protection plans are dynamic and must address current risks and concerns. • The core group is responsible for reviewing and adapting the plan as it progresses.
Time-bound	<ul style="list-style-type: none"> • All actions need to have clear timescales (not “ongoing”). • Some timescales may be critical depending on the age of the child. these should be based on the child’s needs.
Evaluated and Re-evaluated	<ul style="list-style-type: none"> • Is the plan working/ what has been achieved/what is outstanding? • Is the plan reducing the risk of harm? • Is the plan current?

There should only be one multi-agency plan for a child at any given time. If there is already a multi-agency child’s plan in place at the point a child’s name is placed on the Child Protection Register, this should be incorporated into the Child Protection Plan and reviewed by the core group. It is important that Child Protection Plans have measurable outcomes and that these are outcomes for the child. Interventions should be aimed at maximising safety and reducing the identified risks.

Core Group

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

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

The Core Group should:

- Be co-ordinated by the lead professional (the Social Worker).
- Meet on a regular basis, the first time within 15 days of the CPPM and at least every six weeks until the RCPPM.
- Agree who is responsible for seeing and speaking to the child on a regular basis, the frequency of which should be proportionate to the level of risk.
- Review the progress and update the Child Protection plan.
- Consider any new information and significant events, updating and analysing the multi-agency chronology.
- Communicate regularly between meetings, sharing relevant information as required.
- Review and add to the multi-agency chronology.
- Activate contingency plans promptly when progress is not made, or circumstances deteriorate.
- Request an early RCPPM if appropriate.

Appendices

Appendix 1 – Local Contact Details

Local Authority Social Work

East Lothian [Child Protection | Child Protection | East Lothian Council](#)

Edinburgh [Child Protection – The City of Edinburgh Council](#)

Midlothian [Child Protection | Report a child at risk | Midlothian Council](#)

West Lothian [Child Protection - West Lothian Child Protection](#)

Police - 101 or 999 (in an emergency)

Appendix 2 - Specific Concerns and Issues

Hyperlink - [Part 4: Specific Support Needs and Concerns - National Guidance for Child Protection in Scotland 2021 - updated 2023 - gov.scot \(www.gov.scot\)](#)

4.2: Poverty

4.8: When services find it hard to engage

4.21: Protection of disabled children

4.42: Parents with learning disabilities

4.48: Impact of mental health or health problems on children

4.56: Children and young people experiencing mental health problems

4.65: Suicide and self-harm affecting children

4.70: Responding to neglect and emotional abuse

4.93: Domestic abuse

4.122: Children and families affected by alcohol and drug use

4.136: Physical abuse, equal protection, and restraint

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

4.164: Child sexual abuse

4.184: Child sexual exploitation

4.207: Indecent images and internet-enabled sexual offending by adults

4.216: Children and young people who have displayed harmful sexual behaviour

4.234: Child Protection in the digital environment/on-line safety

4.252: Under-age sexual activity

4.266: Pre-birth assessment and support

4.282: Children who are looked after away from home

4.303: Reunification or 'return home'

4.304: Preventing the repeated removal of children

4.307: Children and young people who are missing

4.328: Protecting unaccompanied asylum-seeking and trafficked children

4.340: Child trafficking and child criminal exploitation

4.363: Protection in transitional phases

4.367: Bullying

4.377: Hate crime

4.384: Serious harmful behaviour shown by children above and below the age of criminal responsibility

4.402: Vulnerability to being drawn into terrorism

4.403: Complex investigations

4.421: Female genital mutilation

4.435: Honour-based abuse and forced marriage

4.449: Fabricated or induced illness

4.457: Death of a child

4.474: Community

4.476: Cultural and faith communities

4.491: Children and families in the defence community

4.499: Child Protection in the context of disasters and public emergencies

4.505: Historical (non-recent) reports of abuse

Appendix 3 – Emergency Legal Measures

Section 25 Children (Scotland) Act 1995

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

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

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

The Sheriff hears evidence from the applicant and decides whether there are sufficient grounds to grant the order. The Sheriff must be satisfied that certain criteria exist before making the CPO. The most frequently used criteria are that:

1. There are reasonable grounds to believe that:
 - the child has been or is being treated in such a way that the child is suffering or is likely to suffer significant harm,
 - the child has been or is being neglected and as a result of the neglect the child is suffering or is likely to suffer significant harm,
 - the child is likely to suffer significant harm if the child is not removed to and kept in a place of safety, or
 - the child is likely to suffer significant harm if the child does not remain in the place at which the child is staying (whether or not the child is resident there), and
2. The order is necessary to protect the child from that harm or from further harm.

It must be implemented within 24 hours, or it expires.

Once an order is implemented, a Children's Hearing will be held within two working days, unless the reporter terminates the order before the second day hearing, or an application to vary or terminate the order has been made to the Sheriff. The purpose of this Hearing is to consider if the Order is still required.

Where the application is made by a local authority there are alternative criteria that apply under section 38 of the 2011 Act. The sheriff may grant the order if satisfied that:

1. The local authority has reasonable grounds to suspect that:
 - the child has been or is being treated in such a way that the child is suffering or is likely to suffer significant harm,

- the child has been or is being neglected and as a result of the neglect the child is suffering or is likely to suffer significant harm, or
 - the child will be treated or neglected in such a way that is likely to cause significant harm to the child, and
2. The local authority is making enquiries to allow it to decide whether to take action to safeguard the welfare of the child, or is causing those enquiries to be made, and
 3. Those enquiries are being frustrated by access to the child being unreasonably denied, and
 4. The local authority has reasonable cause to believe that access is required as a matter of urgency.

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

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

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

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

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

An Exclusion Order (Section 76 of the Children (Scotland) Act 1995)

The Local Authority can apply to a Sheriff for an order to exclude any person named on the order from the child's family home, where the child has suffered, is suffering or is likely to suffer significant harm as a result of any conduct, or any threatened or reasonably apprehended conduct of the person named in the order. This needs to be necessary for the protection of the child and would better safeguard the child's welfare than the removal of the child from the family home. There needs to be a person named in the application who is 'capable of taking responsibility for the provision of appropriate care for the child'.

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

A child may request refuge and if the child appears to be at risk of harm may be provided with short-term refuge either by the local authority or by a person who provides a care home service. This would usually last for up to seven days or in exceptional circumstances up to

fourteen. The agency providing refuge should consider other legal measures once this period ends.

For a full list of relevant legislation, Hyperlink [Appendix C: Legislation – list of other relevant legislation - National guidance for Child Protection in Scotland 2021 - gov.scot \(www.gov.scot\)](#)

Appendix 4 – Practice Insights

Hyperlink - [practice insights](#)

1. Inter-agency referral discussion (IRD) and progression to Joint Investigative Interview (JII)
2. Joint chronologies common approach
3. Pre-birth assessment, early support, and planning
4. Early support in pre-birth child protection, using family group decision making
5. Domestic abuse informed practice in child protection
6. Contextual safeguarding
7. Safeguarding and child sexual exploitation
8. Familial child sexual abuse
9. Equal protection, child protection and cultural competence
10. Disabled children and child protection investigative interviews
11. Child protection in transitions to adult life and services for disabled children
12. Supporting parents with learning/intellectual disabilities
13. Understanding a child's journey and keeping the child at the centre of decision making
14. Assessing parental capacity to change
15. Identifying and addressing neglect: applying the Graded Care Profile
16. Addressing Neglect and Enhancing Wellbeing (ANEW)
17. Child participation: sharing a child's protection plan with a child
18. Participation and engagement

Edinburgh and the Lothians Multi-agency Child Protection Procedures

Version control	Date	Review
First version	15/11/2023	14/03/2025 – Child Protection Lead Officers for Edinburgh, East Lothian and Midlothian and West Lothian confirmed no changes required. Next review 14/03/2027.