What is Child Abuse and Neglect?  

Information for Children and Young People

Outer Hebrides Inter-Agency Child Protection Procedures 2015

Children should be...

• Show me love...  
  ...don’t hurt me

• Make sure I am well looked after...  
  ...don’t neglect me

• Talk to me...  
  ...don’t shout at me

...protected not neglected

Drawing by Caron aged 11.
What to do if you are worried about a child or young person?

If you are worried or concerned about a child or young person you should contact the Comhairle nan Eilean Siar Social Work Departments or Stornoway Police Office

<table>
<thead>
<tr>
<th>CnES Social Work</th>
<th>Stornoway Balivanich Castlebay</th>
<th>01851 822749 01870 604880 01871 817217</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police in the Western Isles</td>
<td>All Police Offices can be contacted via 101</td>
<td></td>
</tr>
<tr>
<td>In an Emergency</td>
<td>Call 999</td>
<td></td>
</tr>
<tr>
<td>Out of Hours Social Work</td>
<td>01851 701702</td>
<td></td>
</tr>
</tbody>
</table>

Document Control

<table>
<thead>
<tr>
<th>Outer Hebrides Child Protection Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardian/Keeper:</td>
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</tr>
<tr>
<td>FOI Compliant:</td>
</tr>
<tr>
<td>Health &amp; Safety Compliant:</td>
</tr>
</tbody>
</table>
Foreword

The protection of children and young people is everyone’s job and everyone’s responsibility.

In the Western Isles this is a shared responsibility and is promoted through the work of the multi-agency Chief Officers Group (COG) and the Child Protection Committee (CPC). The Chief Officers Group provides leadership, direction, scrutiny and support to child protection services across the Western Isles. The Child Protection Committee is responsible for the design, development, publication, distribution, dissemination, implementation, evaluation and review of all inter-agency child protection policy and practice. Both partnerships are responsible for ensuring that child protection services remain compliant with existing and emerging national standards, meet local needs and expectations and ultimately provide better outcomes for children and young people.

These inter-agency child protection procedures have been reviewed to take account of a number of recent legislative, policy and practice developments. Online safety, child trafficking and the protection of children affected by parental alcohol and/or drug misuse are only some of the specific issues that have become the focus of attention in recent times. One of the more fundamental developments, however, has been the move towards children’s services that put the interests of the child at the centre of every process and decision, building up from universal services: the Getting it Right for Every Child (GIRFEC) approach has been instrumental in this. These inter-agency child protection procedures also take account of messages from research, outcomes from public enquiries, multi-agency inspections and the findings and recommendations from Significant Case Reviews.

These inter-agency child protection procedures have been produced to advise and support practitioners from all services/agencies and help inform the general public of our business arrangements. They complement, but do not replace, existing operational child protection guidelines/procedures held within individual services/agencies and to which staff must refer when responding to child protection concerns. The need for early identification, intervention and support, comprehensive and robust assessments, good communication and information sharing, sound decision making and outcome focused planning remain vital and these inter-agency child protection procedures support that approach.

These inter-agency child protection procedures reflect our personal and shared commitment to child protection across the Western Isles and demonstrate our individual and collective commitment to providing better outcomes for vulnerable children, young people and their families.

Malcolm Burr
Chief Executive
Comhairle nan Eilean Siar
Gordon Jamieson
Chief Executive
NHS Western Isles

Gordon MacLeod
Chief Inspector
Area Commander
Police Scotland
Tom Boyd
Locality Reporter Manager
Scottish Children’s Reporter Administration
Introduction

These inter-agency child protection procedures are aimed at practitioners and managers from all services/agencies who are responsible for the protection of children and young people across the Western Isles and also the members of the public who wish to be better informed of the nature of child protection work. They contain the core information required by all services/agencies and complement, but do not replace, existing single service/agency child protection procedures.

The overall aim of these inter-agency child protection procedures is to ensure that services/agencies providing services and support to children, young people and their families have an appreciation and understanding of other service/agency roles, responsibilities and legal powers. They also highlight the importance of, and encourage services/agencies to, communicate and share information about the circumstances and needs of children and families where necessary. This will result in the optimum use of experience and expertise in protecting children and young people. They seek to ensure that in acting to protect children and young people, services/agencies avoid causing them undue stress or adding unnecessarily to any harm already suffered by them.

One agency acting on its own cannot protect children and neither can procedures in isolation. These procedures are primarily to ensure effective inter-agency communication, collaborative working and to provide a consistent framework for practice. Professional judgement based on thorough assessment and critical analysis is also required to ensure these procedures are applied appropriately to individual situations and specific needs of the child.

Staff require to be supported to develop skills and knowledge to make them confident and competent practitioners. Improving these attributes will allow complex and difficult decisions to be made which will increase the likelihood of better outcomes for children and young people.

The Children and Young People (Scotland) Act 2014 has just completed its passage through Parliament and guidance will be developed over the coming year to prepare for commencement of the provisions. The Scottish Government is working with Community Planning Partnerships to encourage the necessary changes in procedure and process to ensure readiness for the new duties. This guidance reflects National Guidelines for Child Protection in Scotland 2014, references the anticipated new ways of working and procedures which some Community Planning Partnership areas are already implementing.

This will help to minimise any update ahead of commencement once the guidance to support implementation of the Children and Young People (Scotland) Act 2014 is completed it sets out duties on a range of public bodies to report on how they are taking forward children’s rights as set out in the UN Convention. Moreover, ratified by the UK Government in 2009, the UN Convention on the Rights of Persons with Disabilities stipulates that in order for disabled children to be able to realise the rights mentioned above, they need to be provided with disability and age-appropriate assistance. Local training for both practitioners and managers will be undertaken to better inform staff and improve practice.
These inter-agency child protection procedures have been revised and produced in accordance with recent child protection policy, practice and legislative developments, particularly the recent National Guidance for Child Protection in Scotland 2014 and take cognisance of other emerging national child protection policy, practice and legislative developments.

They aim to ensure an informed and appropriate response for children and young people about whom practitioners, in key services/agencies, in the public, private and third sectors across the Western Isles, may have child care and/or protection concerns.
How to Use these Guidelines

These procedures have been produced to support, reflect and translate the National Guidance for Child Protection in Scotland 2014 into the local Outer Hebrides child protection working context/arrangements.

These procedures do not replace the National Guidance for Child Protection in Scotland 2014, nor do they replace any existing single service/agency child protection policies, procedures and/or guidelines. On the contrary, they aim to support them and provide the over-arching policy framework, within which all other child protection policies, procedures and/or guidelines should fall.

These guidelines are divided into five parts.

Part I describes the policy and legislative framework which underpins child protection policy and practice in Scotland and in the Western Isles;

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

Part III describes in detail, the key component processes for all child care and/or protection concerns including what to do if you are worried about a child; investigation and response; information sharing; risk assessment; interviewing; medical examinations; child protection case conferences and the child protection register;

Part IV provides further information on advice on a range of other key child protection issues which practitioners may identify and/or become involved in, keeping in mind this is not an all inclusive and/or exhaustive list of issues;

Part V lists all relevant policy and legislation pertaining to the child protection landscape.

Detailed information on the roles and remits of all private, public and independent sector agencies can be found by accessing the following web pages.

Throughout these guidelines, practitioners will find many electronic and/or intelligent links for quick and easy reference to other key documents etc. Viewers may find these links helpful. These guidelines should now be regarded as both dynamic and iterative and they will be published and maintained as an online electronic resource on the Outer Hebrides child protection website.

Thereafter, they will be kept under continuous review by the Child Protection Co-ordinator who can be contacted on 01851 822764.
# Table of Contents

<table>
<thead>
<tr>
<th>Part I</th>
<th>Child Protection in Context</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Policy Statement</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part II</th>
<th>Child Protection Definitions, Signs and Symptoms</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Definitions</td>
<td>13</td>
</tr>
<tr>
<td>3.</td>
<td>What is Child Abuse and Child Neglect</td>
<td>18 – 19</td>
</tr>
<tr>
<td>4.</td>
<td>What is Child Protection</td>
<td>20 – 22</td>
</tr>
<tr>
<td>5.</td>
<td>Signs and Symptoms</td>
<td>22 – 26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part III</th>
<th>Child Protection Responses</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>What to do if you are worried about a child or young person</td>
<td>28</td>
</tr>
<tr>
<td>7.</td>
<td>Responding to Concerns about Children or Young People</td>
<td>28 – 29</td>
</tr>
<tr>
<td>8.</td>
<td>Initial Risk Assessment and Inter-Agency Referral Discussions (IRD)</td>
<td>30 – 33</td>
</tr>
<tr>
<td>10.</td>
<td>Identifying and Managing Risk Including Chronologies</td>
<td>39 – 40</td>
</tr>
<tr>
<td>11.</td>
<td>Joint Investigation</td>
<td>41 – 42</td>
</tr>
<tr>
<td>12.</td>
<td>Health Assessments and Medical Examinations</td>
<td>43 – 48</td>
</tr>
<tr>
<td>13.</td>
<td>Child Protection Case Conferences (CPCCs)</td>
<td>49 – 63</td>
</tr>
<tr>
<td>14.</td>
<td>Child Protection Register (CPR)</td>
<td>64 – 65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part IV</th>
<th>Child Protection in Specific Circumstances</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td>Child Protection in Specific Circumstances</td>
<td>66</td>
</tr>
<tr>
<td>16.</td>
<td>Domestic Abuse</td>
<td>67 – 68</td>
</tr>
<tr>
<td>17.</td>
<td>Children Affected by Parental Substance Misuse (CAPSM)</td>
<td>69</td>
</tr>
<tr>
<td>18.</td>
<td>Children and Young People Affected by Parental Mental Health Difficulties</td>
<td>70</td>
</tr>
<tr>
<td>19.</td>
<td>Children with Mental Health Difficulties</td>
<td>71</td>
</tr>
<tr>
<td>21.</td>
<td>Children Affected by Disability</td>
<td>73 – 75</td>
</tr>
<tr>
<td>22.</td>
<td>Children and Young People at Risk of Self Harm and/or Suicide</td>
<td>76 – 78</td>
</tr>
<tr>
<td>23.</td>
<td>Under-Age Sexual Activity</td>
<td>79 – 81</td>
</tr>
<tr>
<td>24.</td>
<td>Children and Young People who are Missing and/or Young Runaways</td>
<td>82 – 84</td>
</tr>
<tr>
<td>25.</td>
<td>Child Trafficking</td>
<td>85</td>
</tr>
<tr>
<td>27.</td>
<td>Female Genital Mutilation</td>
<td>89</td>
</tr>
<tr>
<td>29.</td>
<td>Bullying</td>
<td>92 – 93</td>
</tr>
<tr>
<td>30.</td>
<td>Online and Mobile Phone Child Safety</td>
<td>94 – 96</td>
</tr>
<tr>
<td>31.</td>
<td>Lesbian, Gay, Bisexual and Transgender Young People (LGBT)</td>
<td>97</td>
</tr>
<tr>
<td>32.</td>
<td>Hostile and Non-Engaging Parents and Carers</td>
<td>98</td>
</tr>
<tr>
<td>33.</td>
<td>Complex Child Abuse Investigations</td>
<td>99 – 100</td>
</tr>
<tr>
<td>34.</td>
<td>Transition</td>
<td>101 – 102</td>
</tr>
<tr>
<td>35.</td>
<td>Criminal Injuries: Compensation for Victims of Child Abuse</td>
<td>103</td>
</tr>
<tr>
<td>36.</td>
<td>Going to Court: Supporting Child Witnesses</td>
<td>103 – 104</td>
</tr>
<tr>
<td>37.</td>
<td>Children in Residential Care</td>
<td>104</td>
</tr>
<tr>
<td>38.</td>
<td>Children Looked After in an Out of Region Placement</td>
<td>104</td>
</tr>
<tr>
<td>40.</td>
<td>Very Young Children</td>
<td>105</td>
</tr>
<tr>
<td>41.</td>
<td>Sudden Unexpected Death of Infants ( SUDI)</td>
<td>105 – 106</td>
</tr>
<tr>
<td>42.</td>
<td>Young Carers</td>
<td>106</td>
</tr>
<tr>
<td>43.</td>
<td>Ethnicity</td>
<td>106 – 107</td>
</tr>
<tr>
<td>44.</td>
<td>When the Child's First Language is not English</td>
<td>107</td>
</tr>
<tr>
<td>45.</td>
<td>Supporting Staff involved in Child Protection Issues</td>
<td>108</td>
</tr>
<tr>
<td>Part V</td>
<td>Policy Context, Legislation, Useful Websites and Contact Numbers</td>
<td>109</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Appendix I</td>
<td>Policy Context</td>
<td>110 – 111</td>
</tr>
<tr>
<td>Appendix II</td>
<td>Legislative Context</td>
<td>112</td>
</tr>
<tr>
<td>Appendix III</td>
<td>Useful Web Links</td>
<td>113 – 114</td>
</tr>
<tr>
<td>Appendix IV</td>
<td>Contact Details</td>
<td>115 – 116</td>
</tr>
<tr>
<td>Appendix V</td>
<td>Key Legislation and Explanatory Notes</td>
<td>117 – 125</td>
</tr>
<tr>
<td>Appendix VI</td>
<td>Research and Resources</td>
<td>126 – 129</td>
</tr>
</tbody>
</table>
Part I

Child Protection in Context
1. Policy Statement

Child Protection has to be seen in the context of the wider *Getting it Right for Every Child* (GIRFEC) approach, the *Early Years Framework* and the *UN Convention on the Rights of the Child*. Underpinning this wider approach are two key child protection policy developments, namely the *Children's Charter* and the *Framework for Standards*.

The *Children's Charter* describes, in child-friendly language, the views and expectations of children and young people. It also confirms what makes them feel safe. The thirteen key messages for practitioners, services/agencies are:-

- Get to know us;
- Speak with us;
- Listen to us;
- Take us seriously;
- Involve us;
- Respect our privacy;
- Be responsible to us;
- Think about our lives as a whole;
- Think carefully about how you use information about us;
- Put us in touch with the right people;
- Use your power to help;
- Make things happen when they should; and
- Help us to be safe.

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

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

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

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

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

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

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

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

**Standard 8:** Agencies, individually and collectively, demonstrate leadership and accountability for their work and its effectiveness.
Getting it Right for Every Child (GIRFEC)

All children and young people have the right to be cared for and protected from harm and abuse and to grow up in a safe environment in which their rights are respected and their needs are met. Children and young people should get the help they need, when they need it and their welfare is always paramount.

The Scottish Government has set out a vision that all Scotland's children and young people will be successful learners; confident individuals; effective contributors; and responsible citizens. This depends very much on how well they have been supported to develop their well-being. All services/agencies in contact with children and young people must play their part in making sure that children and young people are safe, healthy, achieving, nurtured, active, respected, responsible and included.

A recent acclaimed piece of work by University of Edinburgh on GIRFEC Wellbeing Definitions and Indicator Examples offers a valuable reference tool to enable practitioners and concerned others to accurately and meaningfully measure and assess a child’s well-being. This mechanism can be located at GIRFEC Wellbeing Definitions and Indicator Examples

GIRFEC has a number of key components:-

- a focus on improving outcomes for children, young people and their families based on a shared understanding of well-being;
- a common approach to gaining consent and sharing information where appropriate;
- an integral role for children, young people and families in assessment, planning and intervention;
- a co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the well-being indicators;
- streamlined planning, assessment and decision-making processes that result in children, young people and their families getting the right help at the right time;
- consistent high standards of co-operation, joint working and communication, locally and across Scotland;
- a Named Person in universal services for each child and a Lead Professional to co-ordinate and monitor multi-agency activity where necessary;
- maximising the skilled workforce within universal services to address needs and risks as early as possible;
- a confident and competent workforce across all services for children, young people and their families; and
- the capacity to share demographic, assessment and planning information electronically within and across agency boundaries.
GIRFEC advises that at each stage of an intervention, practitioners should ask themselves the following five questions:-

- **What is getting in the way of this child or young person’s well-being?**
- **Do I have all the information I need to help this child or young person?**
- **What can I do now to help this child or young person?**
- **What can my agency do to help this child or young person? And**
- **What additional help, if any, may be needed from others?**

Within the Western Isles, the GIRFEC Implementation Group has published a number of key documents, aimed at translating the *Getting it Right for Every Child (GIRFEC) Practice Model and Approach* seamlessly across existing practices in education and children’s services. In doing so they have published the following key information and guidance papers which all practitioners may find helpful in their day-to-day child protection work:-

- **Parents and young people’s views;**
- **The Named Person;**
- **The Lead Professional;**
- **The Child’s Plan;**
- **Chronologies:**
- **Getting It Right for Children and Young People in the Western Isles:**

The full roles and responsibilities of multi agency services / single agencies can be accessed via the following link: [Roles and Responsibilities](#)

The role of the Named Person, as defined by the *Children and Young People (Scotland) Act 2014*, is key to information sharing and the management of concerns about children. Where the role is in place the Named Person will be a single point of contact with responsibility for promoting, supporting and safeguarding children’s wellbeing. **The Act also introduces a legal duty to share information that is likely to be relevant to the Named Person functions.** Guidance on the exercise of the Named Person functions and on information sharing will be issued in advance of these provisions coming into force.

Chief Officers and senior managers have a clear responsibility to deliver robust, co-ordinated strategies and services for protecting children and to provide an agreed framework to help practitioners and managers achieve the common objective of keeping children safe. Additionally, when the provisions within Part 3 of the *Children and Young People (Scotland) Act 2014* come into force, the Comhairle and the local health board will be required to jointly produce Children’s Services Plans that identify how children’s and related services will be provided in a way that best safeguards, supports and promotes the wellbeing of all children in their locality. Currently only local authorities are under a duty to publish plans for services for children under section 19 of the Children (Scotland) Act 1995 which will replaced by the provisions in Part 3 of the 2014 Act when they come into force.
Part II

Child Protection Definitions, Signs and Symptoms
2. Definitions

What exactly are Child Care and/or Protection Concerns?

Child care and/or protection concerns are defined and interpreted widely and can include:

- Parent or carer incapable or unable to adequately look after their child;
- Domestic abuse where a child or young person is affected, or lives in the same household where incidents of domestic abuse occur;
- Child or young person under the influence of alcohol;
- Children left unattended in a household, where to do so is leaving them at risk of harm;
- A child or young person who is outwith parental control;
- Drugs search at home address where children/young people are in the household;
- Adult arrested for committing an offence whilst having care of a child or young person;
- Child or young person is the victim of a crime or offence;
- Child or young person living in neglectful circumstances;
- Adult in an unfit state to care for a child; and
- Any other situations where a child or young person may be at risk.

Action to support and protect children must be informed and effective. To achieve this all stakeholders must have a clear and consistent understanding of what is meant by terms such as child, parent, carer, child abuse, neglect, child protection, harm, and significant harm. The following section provides definitions and further explanations about key terms used within child protection.

Child

A child can be defined differently in different legal contexts:

In terms of Part 1 of the Children (Scotland) Act 1995 (which deals with matters including parental rights and responsibilities), a child is generally defined as someone under the age of 18. In terms of Chapter 1 of Part 2 (which deals with support for children and families and includes local authorities’ duties in respect of looked after children and children “in need”), a child is also defined as someone under the age of 18.

In terms of Chapters 2 and 3 of Part 2 (which dealt with matters including children’s hearings and child protection orders), a child means someone who has not attained the age of sixteen years; a child over the age of sixteen years who has not attained the age of eighteen years and in respect of whom a supervision requirement is in force; or a child whose case has been referred to a children’s hearing by virtue of section 33 of this Act (Effect of orders etc. made in others parts of the United Kingdom). However, Chapters 2 and 3 of Part 2 have been largely repealed by the Children’s Hearings (Scotland) Act 2011, except in relation to certain ongoing cases which are still proceeding under the 1995 Act.
The Children’s Hearings (Scotland) Act 2011 now contains the current provisions relating to the operation of the Children’s Hearings system and child protection orders. Section 199 states that, for the purposes of this Act, a child means a person under 16 years of age. However, this section also provides some exceptions to that general rule. Subsection (2) provides that for the purposes of referrals under section 67(2)(o) (failure to attend school), references in the Act to a child include references to a person who is school age. “School age” has the meaning given in section 31 of the Education (Scotland) Act 1980.

Additionally, children who turn 16 during the period between when they are referred to the Reporter and a decision being taken in respect of the referral, are also regarded as “children” under the Act. Children who are subject to compulsory measures of supervision under the Act on or after their 16th birthday are also treated as children until they reach the age of 18, or the order is terminated (whichever event occurs first). Where a sheriff remits a case to the Principal Reporter under section 49(7)(b) of the Criminal Procedure (Scotland) Act 1995, then the person is treated as a child until the referral is discharged, any compulsory supervision order made is terminated, or the child turns 18.

The United Nations Convention on the Rights of the Child applies to anyone under the age of 18. However, Article 1 states that this is the case unless majority is attained earlier under the law applicable to the child. The meaning of a child is extended to cover any person under the age of 18 in cases concerning: Human Trafficking; sexual abuse while in a position of trust (Sexual Offences (Scotland) Act 2009) and the sexual exploitation of children under the age of 18 through prostitution or pornography (Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005).

When the Children and Young People (Scotland) Act 2014 comes into force, a “child” will be defined for the purposes of all Parts of that Act, as someone who has not attained the age of 18.

The individual young person’s circumstances and age will dictate what legal measures can be applied. For example, the Adult Support and Protection (Scotland) Act 2007 can be applied to over-16s where the criteria are met. This further heightens the need for the Comhairle to establish very clear links between the Child and Adult Protection Committees and to put clear guidelines in place for the transition from child to adult services. Young people aged between 16 and 18 are potentially vulnerable to falling “between the gaps” and our local services must ensure that processes are in place to enable staff to offer ongoing support and protection as needed, via continuous single planning for the young person. The GIRFEC framework and provision of the Named Person service for 16-18 year olds will be key to ensuring that wellbeing needs can be identified and addressed.

Where a young person between the age of 16 and 18 requires protection, services will need to consider which legislation or policy, if any, can be applied. This will depend on the young person’s individual circumstances as well as on the particular legislation or policy framework. On commencement of the Children and Young People (Scotland) Act 2014, similar to child protection interventions, all adult protection interventions for 16 and 17 year olds will be managed through the statutory single Child’s Plan.
Special consideration will need to be given to the issue of consent and whether an intervention can be undertaken where a young person has withheld their consent. The priority is to ensure that a vulnerable young person who is, or may be, at risk of significant harm is offered support and protection.

This guidance is designed to include children and young people up to the age of 18. However, as noted above, the protective interventions that can be taken will depend on the circumstances and legislation relevant to that child or young person. It is also important to identify and support vulnerable pregnant women and give consideration to high-risk pregnancies within child protection processes.

**Parent**

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

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

**Carer**

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

**Kinship Carer**

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

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

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

**Informal kinship care** refers to care arrangements made by parents and/or carers or those with parental responsibilities with close relatives or, in the case of orphaned or abandoned children, by those relatives providing care. A child cared for by **informal kinship carers** is not **Looked After**. The carer in such circumstances is not a foster carer, nor is assessment of such a carer by the local authority a legal requirement.

**Private Fostering**

**Private Fostering** refers to children placed by private arrangement with persons who are not close relatives. **Close relative** in this context means mother, father, brother, sister, uncle, aunt, grandparent, of full blood or half blood or by marriage. Where the child’s parents and/or carers have never married, the term will include the birth father and any person who would have been defined as a relative had the parents and/or carers been married. The onus is on that person or persons who are providing the private fostering to notify the Comhairle that such an arrangement has been set in place.
3. What is Child Abuse and Child Neglect?

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

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

**Physical Abuse**

Physical abuse is the causing of physical harm to a child or young person. It 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.

A further category of neglect can be identified in the form of fictitious illness syndrome. If it is suspected that there may be a diagnosis of fabricated illness, it should be managed by the team manager by working closely with health colleagues and the police. It is important to carefully plan any decision to tell the parents about a diagnosis of fabricated illness.

The research available shows that the abusing parent is particularly dangerous at the time of diagnosis. When fabricated illness or diagnosed or suspected, particular consideration needs to be given to whether parents should be invited to the child protection case conference.

**Emotional Abuse**

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

**Sexual Abuse**

Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts.

They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways (see also section on child sexual exploitation)
Neglect

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

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

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

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

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

There are also circumstances where, although abuse has taken place, formal child protection procedures are not required. For example, the child’s family may take protective action by removing the child from the source of risk. Children who are abused by strangers would not necessarily require a Child/Young Person’s Protection Plan unless the abuse occurred in circumstances resulting from a failure in familial responsibility.

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

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

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

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

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

Harm means the ill-treatment or the impairment of the health or development of the child, including, for example, impairment suffered as a result of seeing or hearing the ill-treatment of another. In this context, development can mean physical, intellectual, emotional, social or behavioural development and health can mean physical or mental health. Whether the harm suffered, or likely to be suffered, by a child or young person is significant harm is determined by comparing the child’s health and development with what might be reasonably expected of a similar/unaffected child.
There are no absolute criteria for judging what constitutes significant harm. In assessing the severity of ill treatment or future ill treatment, it may be important to take account of: the degree and extent of physical harm; the duration and frequency of abuse and neglect; the extent of premeditation; and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.

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

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

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

The reactions, perceptions, wishes and feelings of the child must also be considered, with account taken of their age and level of understanding. This will depend on effective communication, including with those children and young people who find communication difficult because of their age, impairment or particular psychological or social situation.

It is important to observe what children do as well as what they say, and to bear in mind that children may experience a strong desire to be loyal to their parents and/or carers (who may also hold some power over the child).

Steps should be taken to ensure that any accounts of adverse experiences given by children are accurate and complete, and that they are recorded fully.
Who is a Child in Need?

The concept of need as defined in the Section 93 (4) of *The Children (Scotland) Act 1995* relates to a child being in need of care and attention because:-

- He/she is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining a reasonable standard of health or development unless they are provided for him/her under or by virtue of that Part of the Act by services provided by a local authority;
- His/her health or development is likely to be significantly impaired or further impaired unless such services are provided;
- He or she is disabled; or
- He/she is adversely affected by the disability of any other person in his/her family; and

Children with particular vulnerabilities or disabilities aged between 16 and 18 are potentially at risk of falling between services and local authorities must ensure that staff offer ongoing support and protection as required.

5. Signs and Symptoms

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

General Presentations

Conflicting explanations or inconsistent reports of:-

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

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

Bruises

Black eyes are particularly suspicious if:-

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

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

The following are uncommon areas for accidental bruising:-

- back;
- back of legs;
- buttocks (except occasionally along the bony protuberance of the spine);
- neck;
- mouth;
- cheeks;
- behind the ear;
- stomach;
- chest;
- under arm; and
- genital and rectal areas.

Bites

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

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

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

**Scars**

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

**Fractures**

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

**Genital/Anal Area**

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

**Shaken Baby Syndrome**

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

**Poisoning**

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

**Emotional Abuse**

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

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

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

Child’s Behaviour

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

Sexual Abuse

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

Physical Indicators

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

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

Neglect

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

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

Child Protection Responses
6. What to do if you are worried about a child or young person?

*If you are worried or concerned about a child or young person you should contact the Comhairle nan Eilean Siar Social Work or local Police:*

<table>
<thead>
<tr>
<th>CnES Social Work</th>
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<tbody>
<tr>
<td>Stornoway</td>
<td>01851 822749</td>
</tr>
<tr>
<td>Balivanich</td>
<td>01870 604880</td>
</tr>
<tr>
<td>Castlebay</td>
<td>01871 817217</td>
</tr>
</tbody>
</table>

| Police in the Western Isles | 101               |
| In an Emergency             | Call 999          |

| Social Work Out of Hours    | 01851 701702      |

7. Responding to Concerns about Children or Young People

*All Practitioners should ensure they understand their own service/agency child protection procedures, know how, where and when to access them and know who their designated Lead Child Protection Officer is.*

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

If a child or a young person provides information that suggests that he or she is being exposed to abuse or neglect you should:-

- remain calm, no matter how difficult it is to listen to the child;
- listen to the child and take them seriously;
- reassure them they were right to tell you;
- ensure the child is safe from harm;
- keep any questions to a minimum, for clarification purposes and never interrupt;
- tell the child what you are going to do next and tell them that you are going to have to speak to someone who can help;
- as soon as is practical write down everything that the child has told you using the child’s exact words if possible;
- make a note of the date, time, place and people who were present; and
- act promptly and immediately, report your concerns to your Line Manager, Supervisor or designated Child Protection Officer.
Child Protection Investigation

A child protection investigation is defined as a joint investigation, between Police and Social Work where a crime or offence has or may have been committed against a child or young person. Further assessment is necessary in order to decide the risks and needs of a child or young person and what action should be taken.

Once a Child Protection Investigation has been concluded a CF2 form must be completed and submitted by social work staff to the designated officer within 5 working days and the CareFirst system updated accordingly.
8. Initial Risk Assessment and Initial Referral Discussion

An Initial Referral Discussion (IRD) is a discussion between two or more services/agencies, where it has been suspected that a child has suffered, is suffering or may be at risk of harm or abuse. In practice an IRD is not a single event, but rather a series of ongoing events and discussions.

Whenever necessary, practical and possible, these discussions will take place at organised meetings of the relevant practitioners. Where this is not always practical or possible, discussions will take place by phone and the sharing and exchanging of information can be virtual/electronic (phone, e-mail, fax etc).

For each child or young person discussed in the IRD, the participating services/agencies/practitioners will agree upon the following:-

- What child care or protection concerns are raised by the information contained within the Child Protection Referral?
- What needs are identified?
- Whether immediate legal measures to protect the child – child protection orders / assessments or exclusions are necessary
- Which service/agency is already involved in providing a support to the child/young person and/or their family?
- What risks factors, protective factors and/or strengths have been identified for that child and other siblings?
- Whether an initial Children & Families enquiry is appropriate, the outcome of which must be discussed fully with the police immediately thereafter
- Whether an initial police enquiry is appropriate, the outcome of which must be discussed fully with the team leader in Education and Children Services?
- Is there a need for a joint investigative interview by Police and Social Work?
- Do the circumstances justify a need for a Health Assessment?
- Do the circumstances justify a need for a Medical Examination? If so, the Police or Social Work must contact and speak with the Designated Consultant in NHS Western Isles.
- What are the timescales, roles, responsibilities and agreed sequence of actions/events?
- Whether a referral should be made to the Reporter as compulsory measures of care may be required.

The initial referral discussion should also consider the need for:

- Establishing who holds parental rights and responsibilities for the child
- Ensuring in cases where the child is looked after that the parents are notified and;
- Providing immediate support to the child and family.

The decisions taken following the initial discussion must be clearly recorded by the team leader, Children & Families Service, on Form CPR6 identifying the actions to be taken, by whom, and within the previously agreed specified timescales.
This must be undertaken as soon as practicable and not later than three working days after the discussion/meeting and distribute to relevant agencies as well as recorded onto the CareFirst system.

Depending on the nature of the case further planning discussions may be required following the initial discussion but in the event of a joint or single agency investigation a further discussion meeting should be convened in order to:

- Review the factual information received to date and identifying any information required that is outstanding;
- Review the outcome of any investigations that may have taken place as a result of the initial planning discussion;
- Review the need for any further action;
- Consider the need for consultation with Procurator Fiscal and the Children’s Reporter if this has not already taken place;
- Consider the need to convene an Initial Child Protection Case Conference.

Any decisions taken at subsequent planning meetings must be recorded on Form CPR6

At all stages following a referral being received, ongoing consideration must be given to the needs and welfare of the child, including their need to be accommodated outwith the family home or any care needs that may arise in the event of a parent or carer having to be removed from the household. Parents should be kept fully informed throughout the process unless there are circumstances which prohibit this. If parents are not to be informed of any aspect of an investigation then the reasons for this must be clearly recorded.

In the Western Isles, separate and distinct from these initial referral discussions, there will also be weekly meetings which will take place in Stornoway and Balivanich between the police designated officer, children and families social work colleagues, health staff and where appropriate education personnel to address childcare concerns or issues.

**IRD Outcomes**

The IRD must agree on one or more of the following options for action:-

- No further action following an IRD;
- Direct referral to a single service/agency - in which case the service/agency should be prepared to accept the referral and identify a Lead Professional;
- Child Protection Investigation/Assessment to take place. Immediate actions taken when there are concerns that the information provided suggests that a child or young person may be at risk of immediate and/or significant harm or abuse, and emergency procedures may be necessary to remove a child or young person from their home;
- The Consultant will decide if a medical examination is required as per the NHS Western Isles Protocol; and
- Referral to the Children's Reporter where the IRD participants believe that compulsory measures of care may be required. Details of any previous child concern reports shall be included with any referral made to the Reporter at this time or subsequently by any service/agency.
IRD Sharing and Recording

There will be an expectation on the part of those practitioners who participate in an IRD that each service/agency will thoroughly research their own information and recording systems, including all electronic databases and/or paper systems to enable effective decision making to take place. Those practitioners who take part in an IRD will be responsible for recording all the agreed decisions made and outcomes within their own service/agency systems (eg in Social Work, the duty Social Worker, will ensure the outcomes are recorded within the profile notes on CareFirst).

IRD participants will also be responsible for sharing relevant information and decisions with staff in their own services/agencies who ‘need to know’ and where it is in the best interests of a child or young person to do so.

Wherever possible, all IRD decisions should be made on the basis of agreement and consensus between all participants and will be noted. However, where agreement and consensus cannot be achieved, then the views of the majority will be taken and noted. Any disagreements/dissent which cannot be resolved will be noted and discussed with the participants’ respective Line Managers/Supervisors.

Where there are any issues/concerns raised during the collation of information from services/agencies relating to concerning behaviour, threats or violence to staff members, this information must be shared across all the services/agencies to allow them to assess the level of risk and to safeguard staff members.

If a service/agency is unable to engage with the child and/or family for any reason, and there is evidence that the family's circumstances are either not improving or indeed deteriorating, they should consider making an immediate referral to the Children's Reporter, similarly if a child protection investigation takes place an automatic referral will be passed to SCRA.

IRD Feedback

Throughout the IRD process, feedback will be provided to the person and/or the service/agency that raised the child care and/or protection concern in the first place. Such notification will be in accordance with data protection and confidentiality guidelines Those providing feedback will ensure that it is recorded in the relevant case files/notes.
9. Information Sharing, Recording, Confidentiality and Consent

Information sharing

Where it is considered that a child or young person is at risk of harm, information must be shared between agencies to enable an assessment to be undertaken. In such circumstances, consent from the child or parent is not required and should not be sought.

It is nevertheless, often good practice to inform the child and parent of any actions you are going to take. There can however be circumstances where it is considered that this could place a child or others at risk, or compromise any investigative enquiry, so advice should normally be sought first from social work or police.

An exchange of relevant information between professionals is therefore essential in order to protect children. To secure the best outcomes for children practitioners need to understand when it is appropriate to seek or share information, how much information to share and what to do with that information. Practitioners also need to consider from and with whom information can and should be sought and/or shared. This applies not only between different agencies but also within agencies. Although those providing services to adults and children may be concerned about the need to balance their duties to protect children from harm and their general duties of confidentiality towards their patient or service user, the overriding concern must always be the welfare of the child.

Where agencies are acting in fulfillment of their statutory duties, it is not necessary or appropriate to seek consent – for example, where a referral is made to the Reporter under the ‘Children Scotland Act 1995’ or where a report is provided by the Local Authority in the course of an investigation by the Reporter under the Act. In such instances, the consent of a child and/or parents need not be sought prior to the submission of a report.

If a child’s wellbeing is considered to be at risk, relevant information must always be shared.

The application of this principle can be highly sensitive, particularly where children and young people make use of a service on the basis of its confidentiality. Good examples of this are helplines set up to support children and young people, such as ChildLine. Many young people need the time and space that such confidential services can offer to talk about their problems with someone who can listen and advise without necessarily having to refer. However, on some occasions, this contract of confidentiality can be suspended if the information received concerns risks to a child or another person.

The Children and Young People (Scotland) Act 2014 contains provisions which, when enacted, will introduce a duty to share concerns about a child’s wellbeing with the Named Person. In such cases the Act allows for the disclosure of information obtained through confidential service contact, where the requirements set out in the Act have been met.
General Principles

The [National Guidance for Child Protection in Scotland 2014](#) also provides further guidance in relation to this matter and the following high level general principles are relevant:

<table>
<thead>
<tr>
<th>Principle</th>
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<tr>
<td>The safety, welfare and well-being of a child are of central importance when making decisions to lawfully share information with or about them;</td>
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<tr>
<td>Children have a right to express their views and have them taken into account when decisions are made about what should happen to them;</td>
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<tr>
<td>The reasons why information needs to be shared and particular actions taken should be communicated openly and honestly with children and where appropriate, their families;</td>
</tr>
<tr>
<td>In general, information will normally only be shared with the consent of the child (depending on age and maturity). However, where there are concerns that seeking consent would increase the risk to a child or others or prejudice any subsequent investigation, information may need to be shared <strong>without consent</strong>;</td>
</tr>
<tr>
<td>At all times, information shared should be relevant, necessary and proportionate to the circumstances of the child, and limited to those who need to know;</td>
</tr>
<tr>
<td>When gathering information about possible risks to a child, information should be sought from all relevant sources, including services/agencies that may be involved with other family members. Relevant historical information should also be taken into account;</td>
</tr>
<tr>
<td>When information is shared, a record should be made of when it was shared, with whom, for what purpose, in what form and whether it was disclosed with or without informed consent. Similarly, any decision <strong>not</strong> to share information should also be recorded; and</td>
</tr>
<tr>
<td>Services/Agencies should provide clear guidance for practitioners on sharing information. This should include advice on sharing information about adults who may pose a risk to children, dealing with disputes over information-sharing and clear policies on whistle-blowing.</td>
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</table>
Policy/Legal Context – National

The following provisions provide the policy and/or legislative context for the sharing of information for child care and/or protection concerns. These provisions also provide for the sharing of information for other purposes including public protection, crime investigation and crime detection. They also govern issues of privacy and confidentiality. These provisions are:-

- UN Convention on the Rights of the Child;
- Children's Charter;
- Framework for Standards;
- Getting it Right for Every Child;
- National Guidance for Child Protection in Scotland 2014;
- The Children (Scotland) Act 1995;
- The Human Rights Act 1998;
- The Data Protection Act 1998; and;
- Other Professional Codes of Conduct.

Local Context

Within Western Isles, a number of single and inter-agency policies, procedures, protocols etc have been established to facilitate the sharing and exchange of information in specific child protection circumstances and they include:-

- Western Isles Health Board Child Protection Guidance for Working with ‘under age’ Young People who are Sexually Active
- Western Isles ADAT and CPC Inter Agency Guidelines for Children affected by Parental Drug and Alcohol Related Problems
- Multi-Agency Public Protection Arrangements (MAPPA); Memorandum of Understanding
- Western Isles Health Board Child Protection: The Unborn Child and other

Practitioners in all services/agencies should inform service users how information about them will be held, stored and shared. Children and their families have a right to know when information about them is being shared, where possible their consent should be sought unless doing so would increase the risk to a child or others, or prejudice any subsequent investigation.

Practitioners should record all requests for consent, whether agreed or otherwise in case file notes. Where applicable, reasons for refusal should also be recorded. Where it is decided not to seek consent, the reasons for not having done so should also be recorded. All services/agencies have in place their own arrangements for the retention and retrieval of such information, in keeping with The Data Protection Act 1998 and The Freedom of Information (Scotland) Act 2002.
The following eight Working Principles of The Data Protection Act 1998 must always be considered:

- Data must be processed fairly and lawfully;
- Data must be processed for one or more specified or lawful purpose;
- Data must be adequate, relevant and not excessive;
- Data must be accurate and kept up to date;
- Data must not be kept for longer than is necessary;
- Data must be processed in accordance with the rights of data subjects;
- Data must be protected from unlawful/unauthorised processing and from damage or loss;
- Data must not be transferred outside the European Economic Area without adequate protection.

Dr Ken Macdonald, Assistant Commissioner Scotland & Northern Ireland Information Commissioner’s Office offers this directive in March 2013.

“Whilst it is acknowledged that practitioners need to be sure their actions comply with all legal and professional obligations, fear that sharing genuine concerns about a child’s or young person’s wellbeing will breach the Act is misplaced. Rather, the Act promotes lawful and proportionate information sharing, while also protecting the right of the individual to have their personal information fairly processed.

Most practitioners are confident about appropriate and necessary sharing where there is a child protection risk. The problem can be where the circumstances do not yet reach the child protection trigger yet professional concerns exist, albeit at a lower level. In many cases, a risk to wellbeing can be a strong indication that the child or young person could be at risk of harm if the immediate matter is not addressed.

As GIRFEC is about early intervention and prevention it is very likely that information may need to be shared before a situation reaches crisis. In the GIRFEC approach, a child’s Named Person may have concerns about the child’s wellbeing, or other individuals or agencies may have concerns that they wish to share with the Named Person. Whilst it is important to protect the rights of individuals, it is equally important to ensure that children are protected from risk of harm.

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

It is very important that the practitioner uses all available information before they decide whether or not to share. Experience, professional instinct and other available information will all help with the decision making process as will anonymised discussions with colleagues about the case. If there is any doubt about the wellbeing of the child and the decision is to share, the Data Protection Act should not be viewed as a barrier to proportionate sharing.”
Sharing of information across areas when a child moves

Where there is a change in a child’s circumstances and they move to another local authority, the originating area is responsible for forwarding information, including details of any increased levels of risk resulting from the move, to the receiving local area. The Children and Young People (Scotland) Act 2014 contains provisions which, when enacted, introduces a legal duty for the Named Person Service Provider to inform the new service provider of that move, and to share information that they consider necessary to promote, support or safeguard a child’s wellbeing. Where a Child’s Plan is in place, the legislation is specific that, with few exceptions, the area into which the child moves is responsible for the management of the Plan.

10. Identifying and Managing Risk

What is Risk in a Child Protection Context?

Understanding the concept of risk is critical to child protection. For further information, see the section on Identifying and managing risk. This is supplemented by a National Risk Assessment Toolkit to support the assessment of children and young people.

Working with risk is at the heart of child protection. For this reason, the importance of good, accurate risk assessment within child protection cannot be overstated. Understanding the concept of risk is critical to child protection.

In the context of these guidelines, risk is the likelihood or probability of a particular outcome given the presence of factors in a child or young person’s life.

Risk is part and parcel of everyday life: a toddler learning to walk is likely to be at risk from some stumbles and scrapes but this does not mean the child should not be encouraged to walk. Risks may be deemed acceptable; they may also be reduced by parents and/or carers or through the early intervention of universal services. Only where risks cause, or are likely to cause, significant harm to a child would a response under child protection be required.

Failure to properly identify risk can lead to serious, and even fatal, outcomes for children. The National Risk Framework to Support the Assessment of Children and Young People (2012) aims to support and assist practitioners at all levels, in every agency, in these tasks.

There are no absolute criteria for judging what constitutes significant harm: sometimes, it can be a single traumatic event, such as a violent assault or poisoning; often, it is a combination of significant events which can interrupt, change or damage the child’s physical and psychological development.
These tools are the:

- Well-Being Indicators;
- My World Triangle; and
- Resilience Matrix.

The Resilience Matrix provides a framework for weighing up particular risks against protective factors for the individual child. By helping practitioners make sense of the relationship between the child’s levels of vulnerability or resilience and the world around them, the Resilience Matrix will help highlight areas of risk that need more comprehensive or specialist assessment and analysis. As the diagram below shows, the Resilience Matrix can be used to examine factors in relation to:

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

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

- resilience within a protective environment (low risk); 
- resilience within adverse circumstances (medium risk); 
- vulnerable within a protective environment (medium risk); and 
- vulnerable within adverse circumstances (high risk).
Assessing Risk

Risk assessment is not static, nor can it be separated from risk management. Risk factors can reduce over time, or conversely, increase. Equally, changes in a child or family's circumstances can strengthen or limit protective factors.

The process of identifying and managing risk must therefore also be dynamic, taking account of both current circumstances and previous experiences, and must consider the immediate impact as well as longer-term outcomes for children. Risk assessment must also consider both the immediate and longer terms needs of a child.

Guidance on the Compilation of Chronologies & the process of Integrated Chronologies

A chronology seeks to provide a clear account of all significant events in a child’s life to date, drawing on the knowledge and information held by agencies involved with the child and family.

A significant event is anything that has a significantly positive or negative impact on the child. It does not have to happen to the child, but could result in a change of their circumstances, which has positive or negative consequences for them. It is important to note that what might be a key event in one child’s life, such as a period of good health or good school attendance after a long period of absence or exclusion, will not even be relevant to another child. In this respect agencies are asked to use their professional judgement in completing the chronologies.

A chronology is important because it records the circumstances and experience of the child and milestones in their life. For example those positive events celebrated by a family which are usually easily remembered. Some significant experiences may be less positive but are an important influence on the life of the child. This needs to be recorded as a chronology to identify at a glance, the key patterns indicating needs, risks, evidence of resilience and the family’s potential to support its own needs or progress with minimal intervention.

The key purpose of the chronology of significant events, therefore, is early indication of an emerging pattern of risk and concern. This may be evident by gradual and persistent withdrawal from protective factors such as non-attendance at health appointments and non-attendance at nursery/school alongside a frequent attendance at A&E or GP on-call service. Events such as domestic abuse referrals, referrals to the Children’s Reporter and referrals of concern should also be recorded. In most circumstances the child’s chronology should start with their birth however in some cases particularly in that of a baby it will be relevant to start the chronology pre-birth. This will show emerging patterns of risk before the baby is born.

The full guidance protocol can be viewed below
11. Joint Investigation

Every child has a right to protection from harm, abuse and exploitation. Where a child may have suffered such treatment, and agencies involved in child protection are called to intervene, the child’s welfare should be of paramount importance. Under GIRFEC, the interests of other children should also be considered. From the outset, every decision made about interviewing the child must be made on the basis the paramount consideration is the best interests of the child.

Care must be taken that children do not suffer any undue distress during the investigations into allegations or reported information. Agencies should also endeavour to treat children as individuals, and where possible, involve them in making decisions. These principles are founded on the United Nations Convention on the Rights of the Child 1989, and the Children (Scotland) Act 1995.

The National Child Protection Guidance 2014 makes clear that any notification of concern must result in the consideration of relevant information and indicate a need to make decisions on a number of issues. One of these is whether a joint investigative interview is required and, if so, the arrangements that need to be put in place.

The purpose of joint investigations is to establish the facts regarding a potential crime or offence against a child, and to gather and share information to inform the assessment of risk and need for that child, and the need for any protective action. The joint investigation can also provide evidence in court proceedings, such as a criminal trial or a Children’s Hearing proof.

A joint investigation may normally be undertaken in cases:

- involving familial abuse;
- where the child is looked after by the local authority;
- where there are particular difficulties in communicating and it is considered that social workers or other staff could contribute effectively to the investigation; or
- in any other circumstances, where it is agreed jointly by police and social work, that a joint approach would be beneficial to the enquiry.

On receipt of information indicating that a child has suffered or may be at risk of abuse or neglect, information should be gathered from all relevant agencies who know the child and/or the child’s parents or carers, including any relevant health or education information and information from any adult services involved. Where it is decided by police and social work that a child protection response is required health colleagues must be involved in any decisions about the health needs of the child. Managers with designated responsibility will be responsible for planning, co-ordinating and liaising on any joint investigation and interview. There may be occasions an immediate risk is identified and there will be a need to make dynamic and quick time decisions based on the information available.

The investigative interview is a formal, planned interview with a child, carried out by a core team trained and competent to conduct it, for the purposes of eliciting the child’s account of events (if any) which require investigation. This group should include other staff from relevant agencies including the Named Person and the Lead Professional. This interview is child-
centred and sensitive to the child’s needs and capacity.

The main purposes of the investigative interview are to:

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

In the Western Isles, these interviews are normally carried out by trained police and social work staff, who have completed the Joint Investigative Interviewing Training (JIIT) approved by the Association of Chief Police Officers in Scotland (ACPO(S)) and the Association of Directors of Social Work (ADSW). Within Western Isles Joint Investigative Interviews may be digitally and visually recorded. Interviews can also be carried out at remote locations.

The Scottish Government has published Guidance on Joint Investigative Interviewing of Child Witnesses in Scotland which provides further information and advice on planning and conducting Joint Investigative Interviews which practitioners may find helpful.

Emergency legal measures to protect children at risk

In some cases urgent action may be required to protect a child from actual or likely significant harm or until compulsory measures of supervision can be put in place by the Children’s Hearing System. At times, a child’s parents or carers may agree to local authority social work services providing the child with accommodation and looking after them until concerns about the child’s safety, or reports or suspicions of abuse or neglect, can be clarified. Social work services might also consider whether others in the child’s extended family or social network could look after the child while agencies carry out further inquiries or assessment. There will, however, be cases where the risk of significant harm, or the possibility of the parents or carers removing the child without notice, makes it necessary for agencies to take legal action for their protection.

Any person may apply to a Sheriff for a Child Protection Order, or the local authority may apply for an Exclusion Order. The Child Protection Order authorises the applicant to remove a child from circumstances in which he or she is at risk, or retain him or her in a place of safety, while the Exclusion Order requires the removal of a person suspected of harming the child from the family home.

In exceptional circumstances, where a Sheriff is not available to grant a Child Protection Order or a child requires to be immediately removed from a source of danger, any person may apply to a Justice of the Peace for authorisation to remove or keep a child in a place of safety. In addition, a police constable may immediately remove a child to a place of safety where he or she has reasonable cause to believe that the conditions for making a Child Protection Order are satisfied, that it is not practicable to apply to a Sheriff for such an order and that the child requires to be removed to a place of safety to protect them from significant harm. In both cases, the child can only be kept in a place of safety for a period of 24 hours.
and further protective measures may have to be sought.

The Children’s Hearing Scotland Act 2011 (s35 and s36) also makes provision for the local authority to apply for a Child Assessment Order if it has reasonable cause to suspect that a child may be suffering or is likely to suffer significant harm and that it is unlikely that an assessment to establish this could be carried out without obtaining the order (for example, where those with parental responsibility are preventing an assessment of the child being undertaken to confirm or refute the concern).

The Child Assessment Order can require the parents or carers to produce the child and allow any assessment needed to take place so that practitioners can decide whether they should act to safeguard the child’s welfare. The authority may ask, or the Sheriff may direct, someone such as a GP, paediatrician or psychiatrist to carry out all or any part of the assessment. The order may also authorise the taking of the child to a specified place, and keeping them there, for the purpose of carrying out the assessment and may make directions as to contact if it does so. Practitioners need to assist in carrying out these assessments when asked to do so and local procedures should make provision for this. Where the child is of sufficient age and understanding, they may refuse consent to a medical examination or treatment whether or not a Child Assessment Order is made.

12. Health Assessments and Medical Examinations

The Need for a Comprehensive Health Assessment and Medical Examination

Following the initial screening of all child care and/or protection concerns and in keeping with the Initial Referral Discussions (IRD) a joint investigation may determine the need for a health assessment and/or a medical examination to be carried out on a child or young person.

A comprehensive medical assessment should be considered in all cases of child abuse and neglect, even when information from other services/agencies show little or no obvious health needs. Accurate and comprehensive entries made in the health records are essential. In some cases of child abuse and neglect, there will be no obvious signs or symptoms and some children or young people will require diagnostic procedures only available in a well-equipped hospital or clinical environment.
The comprehensive medical assessment has five purposes:-

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

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

The decision on whether an actual comprehensive health assessment and/or medical examination is appropriate should be made during the planning and investigation stage with social work, police and with the involvement of relevant health professionals.

Medical examinations will only be carried out where this is deemed to be necessary and in the best interests of the child. Agencies should be clear about what it is designed to achieve and whether the outcome is likely to affect the proposed course of action. It is recognised that medical examinations may be traumatic for the child or young person and/or their parents and/or carers. Therefore it is important that practitioners inform and consult the child or young person and their parents and/or carers about the need for the medical examination and the process.

**Consent to Medical Treatment and Examination**

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

For children and young people not deemed to have the capacity to consent, parental consent will be required unless other steps have been taken (such as by direction of a Child Assessment Order granted by a Sheriff) to obtain legal authority to dispense with parental consent. Parental consent should be sought if the parents have parental rights and responsibilities and the child or young person is under 16, unless this is clearly contrary to the safety and best interests of the child or young person (for example, in urgent circumstances).
If the local authority believes that a medical examination is required to find out whether concerns about a child or young person’s safety or welfare are justified and the parents refuse consent, the local authority may apply to a Sheriff for a Child Assessment Order or a Child Protection Order with a condition of medical examination. A child or young person subject to a Child Assessment Order or a Child Protection Order may still withhold their consent to examination or assessment if they are deemed to have legal capacity.

**In practice no child will be made to undergo a medical examination where they refuse to give consent either by word or actions.**

**Paediatric Assessments for Child Abuse and Neglect**

If the first examining doctor suspects child abuse or neglect they should discuss this with their senior clinician and consult local child protection procedures. If it is deemed appropriate, their concerns should be shared immediately with social work before referral for paediatric assessment in order to initiate a child protection investigation. All details should be carefully recorded in the child or young person’s medical record. If the doctor is not clear whether injuries or clinical features are suggestive of abuse, but considers abuse in his differential diagnosis, he may refer the child or young person for a general paediatric examination and opinion. It is important that an appropriate professional gives an opinion about the probability of abuse. In most cases this will be a consultant paediatrician. However it is important to note there are a number of different types of paediatric examinations:

**General Paediatric Assessment**

This acute medical assessment is appropriate if there is a differential diagnosis which includes abuse (e.g. multiple bruising, seizures, failure to thrive, or fractures). This would only be appropriate if the child has no other concerning features in the history including social history. It is important that any paediatric examination provides the following:

- Clinical care decisions for the child or young person
- Interpretation of evidence to support a diagnosis of abuse
- An opinion about the probability of abuse
- Identification of a child or young person’s health needs and interventions

More detailed information about the roles and responsibilities of medical practitioners and child protection can be found in [*Child Protection Guidance for Health Professionals*, Protecting Children and Young People: The responsibilities of all doctors] or the *Suicide Prevention Strategy*
Comprehensive Medical Assessment

This planned medical examination is done by a paediatrician usually as an outpatient. This specialist paediatric assessment would be indicated if there are concerns about neglect or chronic abuse over a period of time. It is usually carried out as part of a social work investigation. It requires a number of additional tasks to be completed usually by the Lead Professional (e.g. collation of all previous medical records from PHN/HV, family nurse, school nurse, GP, hospital and Emergency Department records, community child health and child psychiatry records). A chronology would be expected prior to examination, and any social work reports should be made available. A full typewritten medical report and opinion will be given to social work and copies sent to the Reporter to the Children’s Panel and GP.

Specialist Child Protection Paediatric Assessment

This will usually be urgently requested after social work involvement (and after a joint investigation), if there are acute signs and symptoms suggestive of physical abuse. It is a single doctor examination and should be carried out by an experienced trained paediatrician, who has additional skills in child protection. There should be a proforma document for recording clinical assessment including history, examination (using body maps) and any investigations planned. It is imperative that clear and detailed notes are kept. Photographs will usually be taken, and a medical report completed with an opinion stated, for social work (and police) as part of the investigation. The child or young person may need admission to the paediatric ward for further tests (e.g. x-rays, blood investigations).

Joint Paediatric/Forensic Assessment

The need for a joint paediatric/forensic assessment is indicated if there are serious injuries or illness (e.g. complex fractures, head injuries, burns, or the result of preliminary assessment is inconclusive and a specialist’s opinion is required to establish the diagnosis).

This two doctor examination is the most specialised type of examination and only undertaken after a joint discussion with social work, police and health. It is usually arranged during working hours with the appropriate skilled personnel and facilities available.

This specialist examination provides a high standard of forensic evidence to sustain any criminal or care proceedings, provide treatment and ongoing care, and offers reassurance and advice to the child and carer. It is always done for Child Sexual Abuse. It is usually carried out by a paediatrician and forensic physician, but can be carried out by paediatric and any other appropriately trained doctor.

There may be the need for appropriate specimens for trace evidence including semen, blood, fibres etc. The forensic physician takes responsibility for the gathering of any samples for forensic analysis while the paediatrician takes responsibility for arranging other investigations (e.g. X-rays, MRI, blood clotting tests).
The presence of two doctors in the joint paediatric forensic assessment is not only important for the corroboration of medical evidence in any subsequent criminal proceedings but is regarded as good practice. Following assessment the two doctors should confer immediately, and give an immediate statement to the police officers who may be in attendance.

**Medical Report**

If doctors are asked by social work or police for a report they should provide a type written report detailing the referral pathway to them, the time and place of examination, the names of those present, details of history and examination and specific details of any injuries or abnormalities. The report should summarise significant positive and negative findings as this will be considered evidence.

Most doctors will be recording their involvement as witnesses “to fact”. Some specialists such as consultant paediatricians will be expected to also give an opinion (as courts consider them ‘experts’) based on their findings and will have to clearly state the probability of abuse.

It is imperative that all specialist paediatric medical examinations result in a clear report. This should also contain details of the doctor’s role, experience and status. It should contain statements of fact (evidence found on history and examination), then an opinion about whether abuse may be possible or probable. It must be sufficiently detailed to meet the Reporter’s requirement as well as the Procurator Fiscal, if necessary, in criminal cases. This is called a Stage 1 report.

A Stage 2 report may be completed after further investigations and results are available, and may have additional evidence from research to support the diagnosis of abuse. This is usually written by a specialist consultant in child protection.

**Arranging a Medical Examination**

The number of examinations to which a child or young person is subjected must be kept to a minimum. Careful planning of the medical component of the examination by experienced medical staff will facilitate this.

In planning the medical investigation, it is important to remember that it is the duty of the police to provide best evidence, including medical evidence, to the Procurator Fiscal and the Children's Reporter in appropriate cases.

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

Where there is a medical urgency any immediate needs of the child such as injuries requiring treatment should be dealt with as appropriate by A&E and/ or the attending health professionals(s).

In all circumstances the welfare of the child must take precedence over the forensic requirements of a police investigation.
The timing and location of the medical examination should be agreed jointly by the medical examiners and the other agencies involved. It may not be in the child’s best interests to rush to an immediate examinations thus to allow the child time to rest and prepare or for more information to become available. However it is expected in the majority of cases medical examinations will be carried out locally and quickly by a doctor who is competent to carry out such an examination and assessment.

Enquiry Officers and/or Child Protection Officers as well as the social worker involved in the case, should attend the location of the examination with the child concerned and person giving consent for the examination, if required. Examinations should take place in an appropriate healthcare facility and under no circumstances a police station.

In cases of alleged sexual abuse where the incident has taken place sometime previously, the examination must be carefully planned to take place at a location and time when skilled personnel and specialist staff are available. In cases of pre-pubertal sexual abuse this examination may be a mainland facility. Where the incident is believed to have taken place more recently, care must be taken to ensure that forensic trace evidence is not lost. Particular care should be taken to retain clothing and bedding, and to avoid bathing.
PROCEDURE FOR ARRANGING MEDICAL EXAMINATION IN CASES OF ALLEGED CHILD ABUSE

Child in need of medical care e.g. appears ill, bleeding or in pain.

NO

Tripartite Discussion

Police, Children’s Services and Health (Lead Clinician or deputy) jointly consider nature and timing of examinations required with reference to:

- Illness or injury
- Timing of forensic samples
- Presence or absence of signs
- Safety of child/ sibling
- Historical nature of any allegations
- Consent and legal issues

Non Sexual Abuse

Sexual Abuse

Doctor (Lead Clinician or deputy) arranges Medical examination*

Depending on the location and nature of the examination required this may involve:

**Paediatric/ Forensic Medical Examination**
(Single of joint examination)
Lead Clinician/Police Surgeon (single or joint examination) or jointly with Consultant Paediatrician / other relevant Consultant e.g. gynaecology, orthopaedics.

**Comprehensive Medical Assessment**
Lead Clinician Child Protection, Paediatrician or GP.

*The Lead Clinician Child Protection and Consultant Paediatrician may be contacted at any stage in this process through the switchboard Western Isles Hospital 01851 704704.

Doctor (Lead Clinician or deputy) facilitates arrangements for medical examinations.

**Contact NHS Highland**
Consultant on-call for Child Protection
Raigmore Hospital, Inverness
01463 70 4000

**Contact NHS Greater Glasgow & Clyde**
Consultant on-call for Child Protection
Yorkhill, Glasgow
0141 201 0000

**Contact Patient Travel**
01851 702997 or air ambulance transport if scheduled flights clinically inappropriate e.g. urgent or OOH transfer

Travel and accommodation arrangements should be for the whole party.
13. Child Protection Case Conferences (CPCCs)

Within Western Isles, arrangements for all Child Protection Case Conferences are managed via Education and Children’s Services (Children and Families Service).

The National Guidance for Child Protection in Scotland 2014 suggests specific timescales, within which, the various types of Child Protection Case Conferences should take place. However, whilst specifying same, it does recognise the complexity and challenge in doing so in some cases, concluding this may not always be possible. In such cases it suggests the reasons for not complying with these timescales should be recorded.

Child Protection Case Conferences (CPCCs) are a core component of the inter-agency child protection process.

Purpose of CPCCs

A core component of GIRFEC and the Children and Young People (Scotland) Act 2014 is the Child’s Plan (Part 5 of the Act contains the relevant provisions). Within the context of child protection activity, where this plan includes action to address the risk of significant harm, it will incorporate a Child Protection Plan and any meeting to consider such a plan is known as a Child Protection Case Conference (CPCC).

The primary purpose of CPCCs is to consider whether the child or young person – including an unborn child – is at risk of significant harm and if so, to review any existing Child’s Plan and/or consider a multi-agency Child Plan to reduce the risk of significant harm.

CPCCs are formal multi-agency meetings that enable practitioners, services/agencies to share and exchange information, assessments and chronologies in circumstances where there are suspicions or allegations of child abuse and/or neglect.

The need for a CPCC should be discussed with other practitioners, services/agencies at an early stage in any child protection investigation. Any practitioner, service and agency can request a CPCC.
Functions of CPCCs

The function of all CPCCs is to share and exchange information in order to identify risks to the child or young person collectively and the actions by which those risks can be reduced. The participants should maintain an outcome-focused approach:

- ensuring that all relevant information held by the Named Person and each service or agency has been shared and analysed on an inter-agency basis
- assessing the degree of existing and likely future risk to the child;
- considering the views of the child/young person/parents/carers;
- identifying the child or young person’s needs and how these can be met by services and agencies;
- developing and reviewing the Child/Young Person’s Protection Plan;
- identifying a Lead Professional;
- deciding whether to place or retain a child or young person’s name on the Child Protection Register; and
- considering whether there might be a need for Compulsory Measures of Supervision and whether a referral should be made to the Children’s Reporter if this has not already been done.

There are four types of CPCC: Pre-Birth; Initial; Review; and Transfer.

Pre-Birth CPCCs

The purpose of a Pre-Birth CPCC is to decide whether serious professional concerns exist about the likelihood of harm through abuse or neglect of an unborn child when they are born. The participants need to prepare an inter-agency plan in advance of the child’s birth.

They will also need to consider actions that may be required at birth, including:

- whether it is safe for the child to go home at birth;
- whether supervised access is required between the parents and the child and who will provide this if needed;
- whether there is a need to apply for a Child Protection Order at birth;
- whether the child’s name should be placed on the Child Protection Register. (It should be noted that as the Register is not regulated by statute, an unborn child can be placed on the Register. Where an unborn child is felt to require a Child/Young Person’s Protection Plan, their name should be placed on the Register); and
- whether there should be a discharge meeting and a handover to community-based supports.

The National Guidance for Child Protection in Scotland 2014 suggests that where possible, a Pre-Birth CPCC should take place no later than at 28 weeks pregnancy or, in the case of late notification of pregnancy, as soon as possible from the concern being raised but always within 21 calendar days of the concern being raised. There may be exceptions to this where the pregnancy is in the very early stages. However, concerns may still be sufficient to warrant an inter-agency assessment.
Within Western Isles concerns regarding unborn babies are managed via the Western Isles Health Board Child Protection: The Unborn Child. The Senior Nurse - Child Protection, manages this process and practitioners who have concerns about unborn babies should report their concern directly to the Senior Nurse Child Protection or alternatively the Duty Social Worker and/or local police office.

Initial CPCCs

The purpose of an Initial CPCC is to allow practitioners, services/agencies to share and exchange information about a child or young person for whom there are child protection concerns, jointly assess that information and the risk to the child or young person and to determine whether there is a likelihood of significant harm through abuse or neglect that needs to be addressed through a multi-agency Child/Young Person’s Protection Plan. The initial CPCC should also consider whether the child is safe to remain at home or a referral to the Children’s Reporter is required.

Where it is agreed that a child or young person is at risk of significant harm and that their name should be placed on the Child Protection Register, those attending the Initial CPCC are responsible for developing and agreeing a Child/Young Person’s Protection Plan and identifying the Core Group of staff responsible for implementing, monitoring and reviewing that Plan. The participants need to take account of the circumstances leading to the Initial CPCC and the initial risk assessment. Due to the timescales for calling an initial CPCC, there may only be time for an interim risk management plan; a more comprehensive risk assessment may still need to be carried out after the Initial CPCC.

In some instances, there will already be a multi-agency Child’s Plan in place and this will need to be considered in light of the concerns about the child or young person.

The National Guidance for Child Protection in Scotland 2014 suggests that where possible the Initial CPCC should take place as soon as possible and no later than 21 calendar days from the notification of concern being received. Where possible, participants should be given a minimum of five days notice of the decision to convene an Initial CPCC.

Review CPCCs

The purpose of a Review CPCC is to review the decision to place a child or young person’s name on the Child Protection Register or where there are significant changes in the child or young person’s family circumstances. The participants will review the progress of the Child/Young Person’s Protection Plan, consider all new information available and decide whether the child or young person’s name should remain on the Child Protection Register.

The National Guidance for Child Protection in Scotland 2014 suggests that where possible the first Review CPCC should take place within three months of the Initial CPCC. Thereafter, Reviews should take place six-monthly, or earlier if circumstances change.
Where a child or young person is no longer considered to be at risk of significant harm and good progress has been made with the Child/Young Person’s Protection Plan, their name should be removed from the Child Protection Register by the Review CPCC. The child or young person and their parents and/or carers may still require ongoing support and this should be managed through the Child/Young Person’s Protection Plan.

Transfer CPCCs

Transfer CPCCs specifically cover the transfer of information about a child where a Child/Young Person’s Protection Plan is currently in place. Only a Review CPCC can de-register a child from the Child Protection Register. Where a child or young person and their family move permanently to another local authority area, the original local authority will notify the receiving local authority immediately, then follow up that notification in writing.

Where the child moves to another authority, the originating authority needs to assess this change in circumstances. If there is felt to be a reduction in risk, the originating authority should arrange a Review CPCC to consider the need for ongoing registration, or, if appropriate, de-registration. In such circumstances it would be best practice for an appropriate member of staff from the receiving authority to attend the Review CPCC.

Where the original authority considers that the risk is ongoing or even increased by the move, the receiving local authority is responsible for convening the Transfer CPCC.

The National Guidance for Child Protection in Scotland 2014 suggests that where possible this Transfer CPCC should be held within the timescales of the receiving local authority’s Initial CPCC arrangements but within a maximum of 21 calendar days.

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

- if the child or young person has a Child/Young Person’s Protection Plan, the case records and/or file needs to go with the child or young person; or
- if the child or young person is subject to a Supervision Requirement, the case records and/or file needs to go with the child or young person.

Where a child was on the Child Protection Register previously in another local authority area, the receiving local authority should request the child’s file from the previous local authority area (if still available).

Participants at CPCCs

The people involved in a CPCC should be limited to those with a need to know or those who have a relevant contribution to make. All persons invited to a CPCC need to understand its purpose, functions and the relevance of their particular contribution. This may include a support person or advocate for the child, young people and their parents and/or carers.

Consideration should be given to how to respond to a situation when a parent or carer refuses to allow a child or young person access to information and advocacy services in relation to child protection processes and particularly in situations where there are issues relating to the age and development of the child or young person.
Chair of CPCCs

Within Western Isles, all CPCC’s are chaired by senior members of staff who are experienced child protection practitioners; they have a sufficient level of seniority and/or authority to do so.

CPCCs will be chaired by senior staff members, experienced in child protection, who are competent, confident and capable. It is critical that the chair has a sufficient level of seniority within their own organisation and is suitably skilled and qualified to carry out the functions of the chair. The chair, wherever possible, should not have any direct involvement with or supervisory function in relation to any practitioner who is involved in the case.

They should be sufficiently objective to challenge contributing services on the lack of progress of any agreed action, including their own. While the chair will in the majority of instances be from Social work services, where an individual could fulfill the required criteria, it is possible for a senior staff member from a different agency or service to undertake the role. The chair should be able to access suitable training and peer support.

In their capacity as Chair their role is to:-

- agree who to invite, who cannot be invited and who should be excluded in discussion with the Named Person, Lead Professional and any other relevant agency;
- meet with parents and/or carers and explain the nature of the meeting and possible outcomes;
- facilitate information sharing and analysis;
- identify the risks and protective factors;
- ensure that the parents and/or carers and child or young person’s views are taken into account;
- facilitate decision-making;
- determine the final decision in cases where there is disagreement;
- wherever possible, chair Review CPCCs to maintain a level of consistency;
- where a child or young person’s name is placed on the Child Protection Register, outline decisions that will help;
- shape the Initial Child/Young Person’s Protection Plan (to be developed at the first Core Group meeting);
- identify the Lead Professional;
- advise parents and/or carers about local dispute resolution processes;
- facilitate the identification of risks, needs and protective factors;
- facilitate the identification of a Core Group of staff responsible for implementing and monitoring the Child/Young Person’s Protection Plan;
- agree review dates;
- challenge any delays in action being taken by staff or agencies;
- ensure that wherever possible, the national timescales are adhered to, including review dates, distribution of minutes and copies of the Child/Young Person’s Protection Plan and changes to Plans; and
• ensure that any member of staff forming part of the Core Group who was not present at the Child Protection Case Conference is informed immediately about the outcome of the Child Protection Case Conference and the decisions made and that a copy of the Child/Young Person’s Protection Plan is sent to them.
• ensure that appropriate multi-agency consideration is given to whether compulsory measures of supervision may be required to address the assessed risks or needs for the child.
• ensure referral to the Reporter if compulsory measures may be required.

Minute-Taker for CPCCs

Minutes are an integral and essential part of CPCCs. They should be noted by a suitably trained clerical worker and agreed by the chair before being circulated to the participants.

The National Guidance for Child Protection in Scotland 2014 suggests that where possible participants should receive the minutes within 15 calendar days of the CPCC. To avoid any unnecessary delay in actions and tasks identified, the chair should produce a record of key decisions and agreed tasks for circulation within one day of the meeting. This should be distributed to invitees who were unable to attend and members of the core group, as well as CPCC attendees.

Minutes need to be clearly laid out and should as a minimum record the following:-

• those invited, attendees and absentees;
• reasons for child/young person/parents/carers non-attendance (where appropriate);
• reports received;
• a summary of the information shared;
• the risks and protective factors identified;
• the views of the child/young person and parents and/or carers;
• the decisions, reasons for the decisions and note of any dissent;
• the outline of the Child/Young Person’s Protection Plan agreed at the meeting, detailing the required outcomes, timescales and contingency plans;
• the name of the Lead Professional; and
• membership of the Core Group.

Service/Agency Representatives at CPCCs

CPCC participants need to include:-

local authority social worker(s);
education staff where any of the children or young people in the family are of school age or attending pre-five establishments;
NHS staff, including Health Visitor/School Nurse/GP as appropriate, depending on the child or young person’s age and the child’s Paediatrician where applicable; and police where there has been involvement with the child or young person and/or their parents and/or carers.
Other participants might include other health practitioners (including mental health services), adult services, housing staff, addiction services, educational psychologists, relevant third sector organisations, representatives of the Procurator Fiscal and armed services staff where children of service personnel are involved.

On occasion, a Children’s Reporter may be invited to attend although their legal position means they can only act as an observer and cannot be involved in the decision-making.

Participants attending are there to represent their service/agency and to share information to ensure that risks and needs can be identified and addressed. They have a responsibility to share and exchange information and clarify other information shared as necessary.

There may be occasions when it is appropriate to invite foster carers, home carers, childminders, volunteers or others working with the child or family to the CPCC. The practitioner most closely involved with the person to be invited should brief him or her carefully beforehand.

This should include providing information about the purpose of the CPCC and their contribution, the need to keep information shared confidential and advice about the primacy of the child or young person’s interests over that of the parents and/or carers where these conflict. **The Chair must recognise the need to keep the number in attendance proportionate for effective decision making**

**Parents/Carers at CPCCs**

Parents, carers or others with parental responsibilities should, where appropriate, be invited to CPCCs. They need clear information about practitioner’s concerns if they are to change the behaviour which puts their child at risk.

In exceptional circumstances, the Chair of a CPCC may determine that a parent/carer should not be invited to, or be excluded from attending a CPCC (for example, where bail conditions preclude contact or there are concerns that they present a significant risk to others attending, including the child or young person). The reasons for such a decision need to be clearly documented. Where children and/or parents/carers are not invited to attend they must be informed and given reasons for the decision in writing by the Chair at least seven calendar days before the date of the conference.

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 recorded in the Minutes.

The Chair should encourage the parent/carer to express their views, while bearing in mind that they may have negative feelings regarding the intervention in their family. The Chair should make certain that parents and/or carers are informed in advance about how information and discussion will be presented and managed. Parents/carers may need to bring someone to support them when they attend a CPCC. This may be a friend or another family member, at the discretion of the Chair, or an Advocacy Worker. This person is there solely to support the parent/carer and has no other role within the CPCC.
Child/Young Person at CPCCs

Consideration should be given to inviting children and young people to CPCCs. CPCCs can be uncomfortable for children to attend and the child or young person’s age, developmental stage and the emotional impact of attending a meeting must be considered. A decision not to invite the child or young person should be verbally communicated to them, unless there are reasons not to do so.

Children and young people attending should be prepared beforehand so that they can participate in a meaningful way and thought should be given to making the meeting as child and family friendly as possible. Consideration should also be given to the use of an Advocate for the child or young person. It is crucial that the child or young person’s views are obtained, presented, considered and recorded during the CPCC, regardless of whether or not they are present. Where the child or young person is disabled, consideration should be given to whether they will need support to express their views. Where appropriate and agreed, the child or young person should be part of the Core Group.

Reasons for agreeing that older children and young people should or should not attend a CPCC or a Core Group meeting should be noted, along with details of the factors that lead to the decision. This should be recorded in the Minutes.

Provision of Reports at CPCCs

All practitioners, services/agencies invited to attend a CPCC will also be invited to prepare and submit relevant reports, relating to their involvement and support with the child, young person and family.

These reports should also include information pertaining to significant adults in the child or young person’s life and provide a clear overview of the risks, needs, vulnerabilities, protective factors and the child or young person’s views. Other siblings, children and young people in the household or extended family should also be considered. Invites have a responsibility to share the content of their reports with the child or young person and their family in an accessible, comprehensible way. Particularly prior to an Initial CPCC, consideration needs to be given as to the most appropriate means of sharing reports with the child, young person and their family and to when this should be done.

Restricted Access Information

Restricted access information is information that, by its nature, cannot be shared freely with the child, young person, parent/carer and anyone supporting them. The information will be shared with the other participants at the CPCC within a protected period. Such information may not be shared with any other person without the explicit permission of the provider.
Restricted information includes:-

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

**Reaching Decisions at CPCCs**

All participants at a CPCC with significant involvement with the child or young person and family have a responsibility to contribute to the decision as to whether or not to place the child or young person’s name on the Child Protection Register.

Where there is no clear consensus in the discussion, the Chair will use his or her professional judgement to make the final decision, based on an analysis of the issues raised. In these circumstances, the decision making needs to be subjected to independent scrutiny from a senior member of staff with no involvement in the case.

**Dispute Resolution at CPCCs**

*How are disputes to be handled arising from a Child Protection Investigation and other aspects of Child Protection processes?*

Please be aware that CPCCs are non-statutory meetings and as such have no legal status.

Dispute resolution is a way of managing:-

- challenges about the inter-agency child protection process;
- challenges about the decision-making and outcomes;
- challenges by children/young people or their parents/carers and/or guardians and/or representatives about the CPCC meeting decisions; and
- complaints about practitioner behaviour.

*What if a practitioner wishes to make a complaint about any part of the Child Protection process, including elements of the investigation, the decision making or the behaviour of another practitioner?*

Across the Western Isles all services and/or agencies involved in child protection work have clear complaints procedures, these should be followed where there is a complaint about an individual practitioner or a decision taken by a single agency.

Where a member of staff wishes to raise an issue or disagrees with any multi-agency decision making including at the CPCC meeting, they should go through their normal service and/or agency Line Management/Supervision arrangements. The matter can then be given attention by senior officers in the concerned agencies and move toward satisfactory resolution as outlined in the following escalation procedures.
What if a child/young person or their parents/carers and/or guardians and/or representatives wish to make a complaint about the Child Protection process, decision making or the behaviour of another practitioner, service and/or agency?

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

Children and young people and their parents/carers and/or guardians and/or young people themselves who are unhappy about any aspect of the Child Protection process may request the respective designated officers of the key agencies namely the Police Scotland Area Commander, The Head of Children’s Services or a Chairperson of the Case Conference to meet with the complainant, if they have not already done so, learn of their grievance and thereafter review practice and the decision making process. Where there remains dissatisfaction, then a review of any decision can be requested.

Any child, young person, parent, carer, guardian and/or representative, wishing such a review should write to the Head of Service (Children and Families’) and will be given support in doing so. In these circumstances, the Lead Professional or Named Person will direct them to the appropriate support services.

The Head of Service will only review the decision of any CPCC where one or more of the following criteria apply:-

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

**Review Stage 1**

Where it appears to the Head of Service that the complainant is unclear about the basis of the decision making of the CPCC, he/she may request the Chair of the CPCC to meet with the complainant in order to clarify the reason for the decision and attempt to seek a resolution.

Where information is presented to the Head of Service which was apparently not available to the original CPCC, or, where inaccurate information appears to have been presented, the Head of Service will:-

- confirm whether this was in fact the case;
- assess the potential impact of this information against the decision making taken at the CPCC and liaise with the Chair of the CPCC; and
- determine whether, in light of the above, it may be appropriate to refer the matter back to a CPCC for a further review.

Only where the decision/recommendations of the CPCC do not appear to have been informed by key information presented to CPCC, may the Head of Service remit the matter back to the Chair of the CPCC for their comments and, exceptionally, may thereafter ask them to convene another CPCC and ask it to review its decision.
Whichever route is followed, the Head of Service will write to the complainant within 14 days of receipt of their request for review of the CPCC decision and will advise them of their proposed course of action. Where the Head of Service remits back to the Chair of the CPCC with their comments, they shall advise the child, young person, parent, carer, guardian and/or representative within 14 days, in writing, of the outcome of the review process.

**Review Stage 2**

Where the child, young person, parent/carer/guardian and/or representative do not accept the outcome of the review process undertaken by the Head of Service at Stage 1, it shall be open to the Head of Service to call a Review Panel Meeting in order to consider the decisions/recommendations reached by CPCC.

This will only take place if a child, young person, parent/carer/guardian and/or representative does not accept the outcome of Stage 1 of the review process and it appears to the Head of Service that either:

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

It is suggested that the Review Panel may comprise:

- *the Head of Service for Children and Families’*;
- *an experienced Paediatrician or other Health colleague in Child Protection*;
- *an experienced Senior Police representative in Child Protection*;

**Decision by Head of Service**

The decision by the Head of Service, whether at Stage 1 or Stage 2 of the review process will be final and will be reported to the Western Isles Chief Social Work Officer.

Should the child, young person, parent/carer/guardian and/or representative still not accept the outcome of this review process, it will be open to them to pursue the formal statutory complaints procedure (social work complaints procedure).

**Escalation Procedures for Professionals with Child Protection or Child Wellbeing Concerns**

This policy has been developed to outline quick and straightforward means of resolving professional differences of view in specific cases in order to safeguard the welfare of children and young people.

Effective working together depends on resolving professional disagreements/differences to the satisfaction of workers and agencies and a belief in genuine partnership working.

The process of resolution should be kept as simple as possible and the aim should be to resolve difficulties at a professional practitioner level wherever possible.
Contents:

1. Potential areas of disagreement.
2. Resolving disagreements.
3. Where professional disagreements remain.
4. Following the use of the escalation policy.
5. Flowchart.

1. Potential areas of disagreement
Problem resolution is an integral part of professional co-operation and joint working to safeguard children and only becomes detrimental if not resolved in a constructive and timely fashion. Professional disagreement must not detract from ensuring that the child or young person is safeguarded. The child or young person’s wellbeing and safety are of paramount consideration throughout the process of resolution of differences between professionals.

Disagreements can arise in a number of areas but are most likely to arise around thresholds, roles and responsibilities, the need for action and communication. Examples are given below although this list is not exhaustive.

- A referral is not considered to meet the eligibility criteria for assessment by any service for example; several low level concerns or a poorly framed or constructed referral.
- Any Services determine that further information should be sought by the referrer before a referral is progressed.
- There is disagreement as to whether child protection procedures should be followed.
- There is disagreement about the need to convene an Initial Case Conference.
- There is disagreement over the sharing of information and/or provision of services.
- Disagreements over the outcome of an assessment and whether the appropriate plan is in place to safeguard and promote the wellbeing of the child.
- Disagreement over whether something is a Child Concern or Child Protection.
- A service not in agreement with a case closure.

At all times the aim should be to resolve difficulties at practitioner/fieldworker level. Where attempts at problem resolution leaves a worker or service believing that the child or young person remains at risk of significant harm, this worker or service has responsibility for communicating such concerns through agreed channels.

2. Resolving disagreements
Initial attempts should be taken to resolve the problem, and this should normally be between the people who disagree unless the child or young person is at immediate risk. Where differences in status and/or experience may affect the confidence of some workers to pursue this unsupported, a third party should be consulted. If unresolved (within 48 hours), the problem should be referred to the worker’s own line manager, who will advise the worker how to proceed. This may involve the worker re-engaging with the person with whom the disagreement has taken place or the line manager discussing the difficulties with their respective colleague in the other service. It may also be considered appropriate to convene a professional worker’s meeting chaired by a worker not directly involved in the dispute. Where the problem remains unresolved the line manager will refer to senior colleagues. (See flowchart.)

A clear record should be kept at all stages, by all parties. In particular, this must include written confirmation between the parties about an agreed outcome of the disagreement and how any outstanding issues will be pursued.

3. Where professional disagreements remain
If professional disagreements remain unsolved the matter must be referred to Service Managers in respective services.
4. Following use of escalation policy
It may be useful for individuals to debrief following some disputes in order to promote continuing good working relationships. Further, when the issue is resolved, any general issues should be identified and referred to the service’s representative on the Child Protection Committee for consideration by the relevant subgroup to inform future learning.

**Escalation Policy for Professionals with Child Protection or Child Wellbeing Concerns**

A professional disagrees with a decision or response from any service regarding a child protection or child concern and initial attempts to resolve the problem have failed. Records noted.

Professional discusses (within 24 hours) with Team Leader/Child Protection Officer (CPO) in his/her own service, and action agreed. Records noted.

Team Leader/CPO – Referring service discusses concern/response with the opposite number in the service within 48 hours. Records noted.

If concern continues the Team Leader/CPO – Referring Service discusses concern/response with the next tier of management, e.g. Service Manager/Head Teacher within 48 hours. Records noted.

If issue remains a discussion will take place at a Senior Management level as appropriate and action agreed. Records noted.

If senior managers are unable to agree a decision they will inform Directors/Heads of Service in order that the matter can be reviewed and agreement reached. Records noted.

General issues to be identified and referred to the Child Protection Committee to inform future learning.

In schools
The professional will refer to the Child Protection Officer.

Referrer advised of outcome at this stage.

Referrer advised of outcome at this stage.

At all stages consideration can be given by any person to a referral to the Children’s Reporter.
Child/Young Person’s Protection Plan

When a Child’s Plan incorporates a Child Protection Plan this should set out in detail:-

- the perceived risks and needs;
- what is required to reduce these risks and meet those needs; and
- who is expected to take tasks forward including parents and/carers and the child or young person themselves.

In addition, a Child/Young Person’s Protection Plan needs to clearly identify:-

- key people involved and their roles and responsibilities, including the Lead Professional and other named practitioners;
- timescales;
- supports and resources required (in particular, access to specialist assistance);
- the agreed outcomes for the child or young person;
- the longer terms needs of the child and young person;
- the process of monitoring and review; and
- any contingency plans.

Responsibility is shared for the Child/Young Person’s Protection Plan. Each person involved should be clearly identified, and their role and responsibilities set out. To preserve continuity for the child or young person and their parents and/or carers, arrangements should be made to cover the absence through sickness or holidays of key people. All Child/Young Person’s Protection Plans where there are current risks should have specific cover arrangements built in to make sure that work continues to protect the child. Plans should also clearly identify whether there might be a need for Compulsory Measures of Supervision. Progress can only be meaningfully measured if the action or activity has had a positive impact on the child or young person.

The National Guidance for Child Protection in Scotland 2014 suggests that where possible participants should receive a copy of the agreed Child/Young Person’s Protection Plan within five calendar days of the CPCC. It is recognised that a full comprehensive risk assessment may not be achievable within the timescales of the Initial CPCC or the first Core Group. Therefore, it should be recognised that the early Child/Young Person’s Protection Plan may need to be provisional until a fuller assessment can be undertaken.

Core Groups

A Core Group is a group of identified individuals, including the Lead Professional, the child or young person and their parents and/or carers, who have a crucial role to play in implementing and reviewing the Child/Young Person’s Protection Plan. The Core Group is responsible for ensuring that the Child/Young Person’s Protection Plan remains focused on achieving better outcomes for the child or young person by reducing the known risks. The National Guidance for Child Protection in Scotland 2014 suggests that where possible the initial Core Group meeting should be held within 15 calendar days of the Initial CPCC.
The functions of a Core Group include:-

- ensuring ongoing assessment of the needs of and risks to a child or young person who has a Child/Young Person’s Protection Plan;
- implementing, monitoring and reviewing the Child/Young Person’s Protection Plan so that the focus remains on improving outcomes for the child or young person. This will include evaluating the impact of work done and/or changes within the family in order to decide whether risks have increased or decreased;
- maintaining effective communication between all practitioners, services/agencies involved with the child or young person and parents and/or carers;
- activating contingency plans promptly when progress is not made or circumstances deteriorate;
- ensuring that all school age children on the register will be seen by the Lead Professional at least monthly and the outcome of such visits recorded in the Child/Young Persons Protection Plan.
- reporting to the Review CPCCs on progress; and
- referring any significant changes in the Child/Young Person’s Protection Plan, including non-engagement of the family to the CPCC Chair.

Consideration of the involvement of the child or young person should take cognisance of their age and the emotional impact of attending a meeting to discuss the risks they have been placed at. Children and young people attending must be prepared beforehand to allow them to participate in a meaningful way. It is crucial that their views are obtained, presented and considered during the meeting. The Core Group should provide a less formal way for children, young people, parents and/or carers to interact with service and agency providers.

The Core Group will report back to the CPCC on progress on the Child/Young Person’s Protection Plan. The National Guidance for Child Protection in Scotland 2014 suggests that where a Core Group identifies a need to make significant changes to the Child/Young Person’s Protection Plan, they should notify the CPCC Chair within three calendar days.
14. Child Protection Register (CPR)

What is the Child Protection Register?

All local authorities are responsible for maintaining a central register of all children and young people – including unborn children – who are the subject of an inter-agency Child/Young Person’s Protection Plan. This is called the Child Protection Register.

The Child Protection Register has no legal status but provides an administrative system for alerting practitioners that there is sufficient professional concern about a child to warrant an inter-agency Child/Young Person’s Protection Plan.

Local authority social work services are responsible for maintaining a register of all children in their area who are subject to a Child/Young Person’s Protection Plan, though the decision to put a child on the Child Protection Register will be based on a multi-agency assessment.

Placing a Child on the Child Protection Register

The decision to place a child or young person’s name on the Child Protection Register should be taken following a Child Protection Case Conference where there are reasonable grounds to believe or suspect that a child or young person has suffered or will suffer significant harm from abuse or neglect and that a Child/Young Person’s Protection Plan is needed to protect and support that child or young person.

When placing a child or young person on the Child Protection Register, it is no longer necessary to identify a category of registration relating to the primary type of abuse and neglect. Instead, the local authority should ensure the child or young person's name and details are entered on the Child Protection Register, as well as a record of the key areas of risk to the child.

The local authority should inform the child or young person’s parents and/or carers about the information held on the Child Protection Register and who has access to it. Where the child or young person has sufficient age and understanding, the child or young person should similarly be informed.

Removing a Child’s Name from the Child Protection Register

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

The decision to remove a child or young person’s name from the Child Protection Register will be made by a Review CPCC at which all the relevant practitioners, services/agencies are represented, as well as the child, young person and their family. When a child or young person’s name is removed from the Child Protection Register, the child or young person and their family must be informed.
Removal of a child or young person’s name from the Child Protection Register should not necessarily lead to a reduction or withdrawal of services or support to the child or young person and family by any or all of the services/agencies. The risk of significant harm to the child or young person may have receded, but the child or young person may continue to require a range of support; this will form part of the single planning process for the child or young person. At the point of de-registration, consideration should be given to whether a different Lead Professional should be appointed and if so, arrangements made for the transfer to be agreed. The Child/Young Person’s Protection Plan will, following de-registration, become a Child/Young Person’s Plan.

Making Use of the Register

Within the Western Isles, the keeper of the Child Protection Register is the Chief Social Work Officer. The depute keeper is the Depute Chief Social Worker

The Child Protection Register provides a central resource for practitioners concerned about a child or young person’s safety or care. It assists in the identification and management of cases of child abuse, in the pooling of fragmented information, which when viewed as a whole may confirm or dispel suspicion of child abuse/neglect, and in the provision of statistical data to aid planning, training and research

It is held separately from service/agency records or case files and is secure. There is 24-hour access to the Child Protection Register for all practitioners who need to make an enquiry about a child or young person.

| FAIRE | 01851 701702 |

The Scottish Government also maintains a list of current Keepers of Child Protection Registers in Scotland and contact points for Child Protection Registers in other parts of the UK. All practitioners should notify the Keepers of local Child Protection Registers of any changes to details relating to children named on the register.
Part IV

Child Protection in Specific Circumstances
15. Child Protection in Specific Circumstances

In this part of the guidelines, practitioners will find further information and advice on a range of specific circumstances, which could impact adversely on a child or young person, albeit these are not necessarily stand alone and/or mutually exclusive issues from each other. Whilst individually and/or collectively they could impact on a child or young person, their mere presence alone should not necessarily lead to any immediate child care and/or protection assumptions being made.

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

However, if you are worried or concerned about a child or young person you should contact the local social work or Police Office:-

<table>
<thead>
<tr>
<th>CnES Social Work</th>
<th>01851 822749</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stornoway</td>
<td>01870 604880</td>
</tr>
<tr>
<td>Balivanich</td>
<td>01871 817217</td>
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<tr>
<td>Castlebay</td>
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<table>
<thead>
<tr>
<th>Police in the Western Isles</th>
<th>All Police Offices can be contacted via 101</th>
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</table>

| In an Emergency                      | Call 999                                   |

16. Domestic Abuse

Domestic Abuse describes any behaviour that involves exerting control over a partner or ex-partner’s life choices and that undermines their personal autonomy. Although most victims are women, men can also suffer domestic abuse, and it can also occur in same-sex relationships.

The Criminal Justice and Licensing (Scotland) Act 2010, provides for a statutory offence of ‘stalking’ specifically criminalising stalking. Conduct which might be described as harassment or stalking can be prosecuted under Scots law as a breach of the peace. This common law offence covers all behaviour (including single incidents) which is severe enough to cause alarm to ordinary people and threaten serious disturbance to the community. Section 38 provides for an offence of ‘threatening and abusive behaviour; it is an offence for a person to behave in a threatening or abusive manner towards someone if that behaviour would be such as to be likely to cause a reasonable person to feel fear or alarm.
Children and young people living with domestic abuse are at increased risk of significant harm, both as a result of witnessing the abuse and/or by being abused themselves. Children and young people living with domestic abuse may suffer from stress-related illnesses and conditions and experience feelings of guilt, shame, anger, fear and/or helplessness. Children and young people can also be affected by abuse even when they are not witnessing it or being subjected to abuse themselves. Domestic abuse can profoundly disrupt a child or young person’s environment, undermining their stability and damaging their physical, mental and emotional health and well-being.

The impact of domestic abuse on a child or young person will vary, depending on factors including the frequency, severity and length of exposure to the abuse and the ability of others in the household (particularly the non-abusive parent/carer) to provide parenting support under such adverse conditions. If the non-abusive parent/carer is not safe, it is unlikely that the children will be safe either. The best way for practitioners to keep children, young people and non-abusive parents and/or carers safe is to focus on early identification, intervention, assessment and support.

When undertaking any assessment or planning for any child or young person affected by domestic abuse, it is crucial that practitioners recognise that domestic abuse involves both an adult and a child victim. Intervention and support should be ongoing and should not cease if and when the abuser and the non-abusing parent/carer separate. Indeed, separation may trigger an escalation of violence, increasing the risk to the child or young person and their non-abusing parent/carer.

For more information, see the following.

- National Domestic Abuse Delivery Plan for Children and Young People.
- Criminal Justice and Licensing (Scotland) Act 2010 (Section 39, relevant to the offence of stalking)

Within Western Isles the Domestic Abuse Forum has developed a range of further information, advice and tools on domestic abuse which practitioners may find helpful.
17. Children Affected by Parental Substance Misuse (CAPSM)

Problematic parental substance use can involve alcohol and/or drug misuse and can include prescription as well as illegal drugs.

Parents and/or carers who are problematic alcohol and/or drug users are not necessarily bad parents and/or carers. However, it is important to acknowledge the strong evidence-base on the impact of problematic alcohol and/or drug misuse on children and young people.

Practitioners working with parents and/or carers who are problematic alcohol and/or drug users must understand the potential impact of that misuse on children and young people. Children and young people whose parents and/or carers are problematic alcohol and/or drug users may experience harm physically, mentally and/or emotionally. One of the challenges is that problem alcohol use and/or drug misuse are often associated with a range of other circumstances that affect the family’s life and the health and well-being of children and young people. These could include poverty, deprivation, poor physical and mental health, poor housing, debt, offending and unemployment. Any or all of these factors are likely to have an impact on the parent/carer and the child/young person.

Getting our Priorities Right 2012 notes that all services have a part to play in helping to identify children that may be at risk from their parent's problem alcohol and/or drug use and at an early stage. Services need to respond in a co-ordinated way with other services to any emerging problems. This information should also take account of any wider factors that may affect the family's ability to manage and parent effectively. It should also take account of any strengths within the family that may be utilised.

Within Western Isles the Alcohol and Drug Partnership (ADP) supports the Child Protection Committee and has developed a range of further information, advice and tools on alcohol and/or drug misuse which practitioners may find helpful. This has been collated under the collective Inter Agency Guidelines: Children affected by Parental Drug or Alcohol Related Problems.

Further information can also be found at:-

- Scottish Government (2008) The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem; and
18. Children and Young People Affected by Parental Mental Health Difficulties

Many parents and/or carers who have a mental health difficulty can parent effectively. However, there is evidence to suggest that children and young people can be affected by parental mental health difficulties and this can in some cases, impact on their care and protection from harm and/or abuse.

There are a number of features which can contribute to the risk experienced by a child or young person living with a parent or carer affected by mental health difficulties. Whilst this is not an exhaustive list, it can include:-

- the parent/carer being unable to anticipate the needs of their child or young person or put them before their own;
- the child or young person becoming involved in the parent/carer’s mental health behaviour;
- the child or young person becoming the focus for parental aggression or rejection;
- the child or young person witnessing disturbing behaviour arising from the mental illness (often with little or no explanation);
- the child or young person being separated from a mentally ill parent, for example because the latter is hospitalised; and
- the child or young person taking on caring responsibilities which are inappropriate for his/her age.

A number of other factors may also need to be considered, including the attachment relationship and any instances of domestic abuse. Where parents and/or carers experience mental health problems, their needs, may at times, conflict with the needs of their child or young person.

Practitioners involved with the parent/carer should consider the impact of these factors on the child or young person’s needs. Where concerns are identified, these should be shared with child protection practitioners. Practitioners should bear in mind the importance of putting the child or young person’s interests first.

Further information can also be found at:-

- See Me (Scotland’s national campaign to end stigma and discrimination associated with mental ill health).
- Scottish Good Practice Guidelines for Supporting Parents With Learning Disabilities

Back to Contents
19. Children with Mental Health Difficulties

In some instances the fact that a child has significant mental health difficulties will be obvious by virtue of the fact that they have contact with services. Other children will have significant mental health difficulties without being in contact with mental health services.

Children who suffer mental health difficulties may present with a range of symptoms and behaviours. At times, these difficulties have their origins in abusive experiences, and the child’s behaviours may be their means of managing their distress or keeping themselves safe. Children who have suffered abuse may also experience flashbacks or dissociative experiences which can be triggered during discussion of their abuse, and which can be extremely distressing to the child. Children in this state are extremely vulnerable and may present with inexplicable or challenging behaviours.

Professionals involved in making investigations and decisions pertaining to a child with mental health difficulties, may not have the in depth knowledge of the child’s mental health issues needed to understand some of these behaviours. When a child who is thought to have significant mental health difficulties and who is receiving support for these, is the subject of child protection concerns, contact should be made with the relevant specialist mental health professional involved in the child’s care. Specialist mental health advice on potential difficulties or risks in relation to interviews etc. should be considered at each decision making stage.
20. Children and Young People Who Display Harmful or Problematic Sexual Behaviour

Any incident or concerns about such behaviour by children or young people must be taken very seriously and referred to Social Work, Authority Reporter or Police.

When there are allegations that a child has been harmed by another child or young person, enquiries should be carried out as detailed within these guidelines and individual agency child protection procedures. In such a situation it is essential that the needs and welfare of the child victim and the child perpetrator be considered separately.

Any child or young person alleged to have harmed another child should be referred to the Authority Reporter to assess the need for compulsory measures of supervision.

Where the child or young person themselves may be at risk of harm the appropriate social work service manager should make a decision on the need to convene a Child Protection Case Conference in respect of the child or young person. Where a case conference is convened this should be separate from any Case Conference in respect of his or her victim.

Such a Case Conference in respect of the alleged abuser should consider:

- Information about the young person;
- The family and household composition, and social history;
- Details of the abusive behaviour and relevant information about the child victim including age and gender;
- The child or young person's level of understanding and acceptance of the abuse;
- The need for compulsory measures of supervision;
- The potential impact of criminal prosecution (noting that a sheriff may refer a young person found guilty in a criminal court to a Children's Hearing for disposal);
- Whether the child or young person may have harmed in the past or currently;
- The child or young person's need for services and support to address their offending behaviour; and
- If the child or young person themselves is at risk of being harmed and whether there is a need for his or her name to be placed on the Child Protection Register and an interagency child protection plan drawn up.

The reasons for a decision taken not to convene a Child Protection Case Conference in respect of an alleged abuser must be carefully recorded in the child or young person's case file.

In all cases where a child or young person is involved in, or is reasonably suspected of involvement in the harm of another young person, the social worker with case responsibility for the alleged perpetrator must compile a brief assessment in consultation with other appropriate professionals within 7 days of the instigation of the child protection investigation or incident that gave rise to the concerns.
This assessment must include consideration of risk in particular situations i.e. risks presented at school, placement, or to other children in the community and how these will be managed.

A referral must be made to the Reporter. The risk assessment must be explicit in terms of identifying actions, responsible persons and plans to review and update the assessment.

Where a decision is taken not to convene a Case Conference in respect of a child or young person alleged to have harmed another child, a multi-agency planning meeting must be convened in order to consider the risk assessment and risk management plan and any ongoing risk the child or young person may present to any other child.

This multi-agency planning meeting should consider the issues identified for consideration by a Child Protection Case Conference (excluding the need for the child’s name to be placed on the Child Protection Register) and review the decision as to whether or not a formal Child Protection Case Conference is necessary.

Consideration must also be given to the possible need for therapeutic services for any child or young person who is alleged to have abused. Particular consideration should be paid to children with additional support needs who are involved in the harm of other children.

21. Children Affected by Disability

The definition of disabled children includes children and young people with a comprehensive range of physical, emotional, developmental, learning, communication and health care needs. Disabled children are defined as a child in need under section 93(4) of the Children (Scotland) Act 1995.

Disabled children are vulnerable to the same types of abuse as their able-bodied peers. Children with behavioural disorders, learning disabilities and/or sensory impairments are particularly at risk. Neglect is the most frequently reported form of abuse, followed by emotional abuse.

Abuse of disabled children is significantly under-reported. Local services need to ensure their systems for collecting information about disabled children are sufficiently robust. Where a child has a disability, the type and, if relevant, the severity of that disability should be recorded, along with the implications for the child’s support and communication needs.

Disabled children are more likely to be dependent on support for communication, mobility, manual handling, intimate care, feeding and/or invasive procedures. There may be increased parental stress, multiple carers and care in different settings (including residential); there may also be reluctance among adults, including practitioners, to believe that disabled children are abused. Disabled children are likely to be less able to protect themselves from abuse. Limited mobility can add to their vulnerability. In addition, the network of carers around the child is likely to be larger than for a non-disabled child, which can be a risk factor in itself. While the majority of parents/carers provide the highest standard of care for their child, it must be acknowledged that in some cases they themselves will be perpetrators of abuse.
Children looked after by parents/carers in the community can have complex health care needs which include life-threatening conditions. Caring responsibilities, which may involve complex clinical procedures, can lead to considerable pressure on families. Reliance on physical, mechanical and chemical interventions to manage health and behaviour can leave these children particularly vulnerable to harm. Disabled children’s dependence on medication may leave them exposed to further abuse, for example where medication is wrongly - or simply not administered - either deliberately or through lack of knowledge and understanding.

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

When responding to concerns about a disabled child, expertise in child protection and disability should be brought together to ensure the child receives the same standard of service as a non-disabled child. It may be helpful to involve practitioners with experience of working with disabled children, such as speech and language therapists or residential workers. Local guidance should set out processes and available support and be sensitive to the particular needs of disabled children during child protection investigations, for example when they need to be examined, give consent or communicate evidence.

Where a disabled child is deaf or hard of hearing or has learning disabilities, special attention should be paid to the child’s communication support needs, ascertaining the child’s perception of events, and understanding their wishes and feelings. Practitioners should be aware of non-verbal communication systems, when they might be useful and how to access them, and should know how to contact suitable interpreters or facilitators. Assumptions should not be made about the inability of a disabled child to give credible evidence or withstand the rigours of the court process. Each child should be assessed carefully and supported to participate in the process where this is in their best interests.

Local services need to provide training for those involved in child protection work on the particular vulnerability of disabled children. Local guidelines should encourage practitioners to make contact with key workers as early as possible, for advice on the child’s impairment, how it is likely to impact on the investigation and the support needed for the child.

Specialist advice should be sought at an early stage. Investigation planning should include: providing support to the child, including with communication; identifying a suitable location including, where needed, any communication boards/loop system; and allowing additional time for the investigation, including time to brief the support staff and time for breaks in line with the child’s needs.

Disabled children can progress into adult protection. The Protection of Vulnerable Groups (Scotland) Act 2007 recognises the vulnerability of disabled adults. Transition to adult services can be a traumatic time for disabled children and their families. Local services should consider the development of transition plans that reflect the complexity of transition from child to adult services.
Children can also be affected by the disability of those caring for them. Disabled parents/carers/siblings may have additional support needs relating to physical and or sensory impairments, mental illness, learning disabilities, serious or terminal illness, or degenerative conditions. These may impact on the safety and wellbeing of their children, affecting their education, physical and emotional development. A full assessment of parents’ needs, and of the support they need in order to fulfil their parenting responsibilities, should be carried out as well as an assessment of the needs of the child. Joint working between specialist disability and child protection services will be needed. For further information, see the section on mental health.

For more information, see the following:

- **Safeguarding Disabled Children: Practice Guidance**. The guidance covers England and Wales, but is nevertheless valuable for practitioners working in Scotland.
- **Triangle** is an independent organisation that works directly with children and their families but also offers training and consultancy to practitioners and agencies.
- **Capability Scotland** is a third sector agency providing education, employment opportunities and support for disabled people.
- **Child Protection and The Needs and Rights of Disabled Children and Young People: A Scoping Study**.
- **Scottish Good Practice Guidelines for Supporting Parents with Learning Disabilities**, which provides practical guidance to agencies that support people with learning disabilities who become parents.
22. Children and Young People at Risk of Self Harm and/or Suicide

Western Isles Child and Adolescent Mental Health Services (CAMHS) team supports children and young people who are self harming or at risk of suicide. They also risk assess and can offer advice and support to carers and practitioners in a wide range of services to better understand how best to respond in an appropriate manner to a very sensitive, and often stigmatising, issue.

Self-Harm

Self-harm is generally a way of coping with overwhelming emotional distress. Many children and young people self-harm where there is no suicidal intent. However, research shows that young people who self-harm can be at a higher risk of suicide.

Why do some children and young people self-harm?

There are many reasons why they may do this and whilst the following may be influencing and/or deciding factors, they are also symptoms of normal adolescent development.

Influencing Factors; family problems feeling stressed; having boy/girlfriend problems; exams/school work; self-esteem issues; bereavement; feeling lonely; feeling guilty; not having someone close to talk to; bullying; difficulties associated with sexuality; feelings of being rejected; mental health issues; reaction to trauma or abuse; peer pressure; poor body image; and substance misuse (drugs and alcohol).

Types of self-harm; cutting; biting; self-burning, scalding, branding; picking at skin, reopening old wounds; breaking bones, punching; hair pulling; head banging; ingesting objects or toxic substances; overdosing with a medicine; eating disorders; drug and alcohol misuse; risk taking such as dangerous driving; extreme sports; and unsafe sex and/or multiple sexual partners.

Warning Signs for self harm; wearing long sleeves at inappropriate times; spending more time in the bathroom; unexplained cuts or bruises, burns or other injuries; razor blades, scissors, knives, plasters have disappeared; unexplained smell of Dettol, TCP etc; low mood - seems to be depressed or unhappy; any mood changes - anger, sadness; negative life events that could have prompted these feelings - bereavement, abuse, exam stress, parental divorce, etc; low self-esteem; feelings of worthlessness; changes in eating or sleeping patterns; losing friendships; withdrawal from activities that used to be enjoyed; abuse of alcohol and or drugs; spending more time by themselves and becoming more private or defensive.
Suicide

Suicide is an act of deliberate self-harm, which results in death

Why do some children and young people attempt or commit suicide?

Suicide attempts in children and young people nearly always follow a stressful event or life crises: inter-personal loss such as relationship problems, bereavement or traumatic grief, family break-up; or issues relating to sexual orientation. However, sometimes the child or young person will have shown no previous signs of mental health problems.

Sometimes, the child or young person has had serious problems (e.g. with the police, their family or school) for a long time. These are the children or young people who are most at risk of further attempts. Some will already be seeing a Counsellor, Psychiatrist or Social Worker. Others have refused normal forms of help, and appear to be trying to run away from their problems.

Warning Signs for risk of suicide: Previous deliberate self-harm or suicide attempt; talking about methods of suicide; dwelling on insolvable problems; giving away possessions; hints that “I won’t be around” or “I won’t cause you any more trouble”; change in eating or sleeping habits; withdrawal from friends, family and usual interests; violent or rebellious behaviour, or running away; drinking to excess or misusing drugs; feelings of boredom, restlessness, self-hatred; failing to take care of personal appearance; becoming over-cheerful after a time of depression; and unresolved feelings of guilt following the loss of an important person or pet (including pop or sports idols).

You can help; Let them talk about their feelings, listen carefully to what they have to say. Let them know you care, ask if they are thinking about suicide. Persuade them to talk further to family, friends, a GP, a counsellor or someone they can trust or Breathing Space or Samaritans.

If it is something you cannot assess, seek further advice. This could include contacting NHS 24 on 08454 24 24 24 or through a nurse or doctor locally or calling 999 if they have immediate suicide plans.

Practitioners who discover a child or young person to have self-harmed should seek medical assistance where necessary. Where the injury is serious or life-threatening, then call 999.

Practitioners who discover a child or young person to have attempted suicide should:

- Keep safe and do not endanger your own life
- If the person’s life is in danger, phone 999 immediately or take the person directly to A&E
- Perform first aid if it is necessary and only if it is safe to do so
- Remove the means if possible, if the person is drinking alcohol or taking drugs, try to get them to stop and encourage the person to talk
- Listen non-judgementally
For further information please see:

*The Mental Health of Children and Young People: A framework for promotion, prevention and care;*
*COMPASS mental health team* is dedicated to asylum seekers and refugees.
*Working with Children and Adults Who May be at Risk of Self-harm: Practice Guidance on Information Sharing, Protection and Confidentiality*
23. Under-Age Sexual Activity

Any information given directly to the police will automatically result in a child concern report being made and any instance of sexual activity involving children under the age of 13 must be reported to the police / social work services for immediate discussion.

Scots Law

Within Scotland, the law is clear that society does not encourage sexual intercourse in young people under 16. However, it does not follow that every case presents child care and/or protection concerns and it is important that a proportionate response is made. If there are no child care and/or protection concerns, there may still be needs to be addressed either on a single agency or multi-agency basis.

However, child care and/or protection measures must be instigated if:-

- the child is, or is believed to be, sexually active and is 12 years of age or under;
- the young person is currently 13 years of age or over, but sexual activity took place when they were 12 years of age or under;
- if there is evidence or indication that the young person is involved in pornography or prostitution;
- if the young person is perceived to be at immediate risk and
- where the other person is in a position of trust in relation to the young person.

Practitioners Assessment

When a practitioner becomes aware that a young person is sexually active or is likely to become sexually active the practitioner has a duty of care and any other responsible adult has a moral responsibility to ensure that a young person’s health and emotional needs are addressed and to assess whether the sexual activity is of an abusive or exploitive nature.

It is essential that the practitioner considers whether this activity is something that needs to be referred on for further consideration. The facts surrounding the actual relationship and the wider needs of the young person should be taken account of. Crucial elements of this assessment relate to issues of consent, the ages of those involved; the circumstances of the sexual activity and the perceived vulnerability of the young person.

The following guidance is offered to help determine whether there is a need to refer a young person for under age unlawful sexual activity and child protection measures. Sufficient information should be obtained and recorded to enable a properly informed judgement to be made. This also will assist should a decision be called into question at a later date.
Consider

- Characteristics of the young person; age, development and level of maturity.
- Level of emotional development
- Vulnerability
- Self esteem and self image
- Isolation
- Cognitive capacity
- Knowledge and level of understanding, appropriate / inappropriate sexual knowledge
- Pre-existing sexualised behaviour

Social Factors

- Parenting
- Family background
- Previous contact with social work services, health service and involvement with the police
- Characteristics of the partner
- Age difference
- How they met
- Level of sexual knowledge
- Potential for exploitation
- Known to agencies/police

Consent Issues

- How was consent given?
- Does the young person understand he/she has a choice?
- Was consent expressly sought?
- Is it active consent or just passive acceptance, does the young person understand that not saying no is not the same as consenting?
- Was consent freely given or was the young person coerced/bribed, threatened or even assaulted?
- Was it a sufficiently informed consent i.e. with knowledge of possible consequences?
- Did the young person have control of the situation or understand potential consequences?
- Was alcohol or drugs involved?

Context of the Sexual Activity

- Ongoing relationship
- Is it a one off or on-going risk taking activity?
- Influence of social/peer group pressure
- Was consideration given to contraception / sexual health issues.
It is recognised that information about sexual behaviour involving a young person can come from a variety of sources e.g. rumour, directly from the young person, from a third party or from direct observation. The source and the nature of the information will determine the timing and who is best placed to seek clarification from the young person. In addition the skills, confidence and the level of responsibility of the practitioner involved and their level of knowledge of the young person will indicate who is best to speak with the young person.

For situations where the need for child protection measures is not realised there is an expectation that practitioners will explore with the young person the circumstances surrounding the sexual activity. The young person’s views should always be sought and listened to.

Any practitioner with concerns should discuss these with their line manager at an early stage and prior to the referral to the police or social work services should this become necessary.

Depending on the source, the clarity and the immediate seriousness of the information where the initial information is clearly indicating that child protection measures may be in required, it may be appropriate to speak immediately with the police and/or social work services prior to speaking with the young person. This is a matter for professional judgement and if required advice can be sought by contacting children and families social work services.

**Referral Outcomes**

After a referral is made discussions should take place between investigatory officers from police and social work to consider whether to instigate a child protection investigation or arrange for a getting it right for every child planning meeting to provide support and services to the young persons who are involved.

While each agency and each practitioner has got particular responsibilities, sometimes detailed in codes of conduct or legislation, all will need to ensure that the wellbeing of any child is paramount. Practitioners should also be aware of the risks presented to other children by any male or female who has been involved in under age sexual activity.

**Additionally, NHS Western Isles together with its partners on the C.P.C. has developed a web-based ethical decision making tool to ensure that the needs of children are addressed. This can be located at www.wiusp.org.uk**
24. Children and Young People who are Missing and/or Young Runaways

This guidance is not intended to replace existing single agency policies, procedures and/or protocols in place for children and/or young people who are missing and/or are young runaways and should therefore be read in conjunction with same.

Practitioners should be clear that where they are concerned that a child or young person is missing or has runaway, significant concerns about the welfare of a child should be acted on and that existing data protection legislation permits information-sharing within the context of child care and/or protection.

Missing Children and Young People

Describing a child or young person as missing can cover a wide range of circumstances. A child, young person and/or family (including unborn children) can be considered as missing in the following circumstances:-

Children and Young People – Missing to Statutory Services

Children who are ‘missing’ from statutory services

This can include a child or family’s loss of contact with, or their ‘invisibility’ to, a statutory service, such as education, health, social services or third sector (for example, home educated children, Gypsy/Traveller community). The parent may have repeated explanations for the child’s absence such as playing outside or with friends and relatives; the parent may withdraw the child from services; or there is no response when calls are made to the child’s home.

Children who are ‘missing’ from home or care.

This can involve a child or young person who has run away from their home or care placement, who has been forced to leave or whose whereabouts are unknown. This may be because they have been the victim of an accident, crime and/or because they have actively left or chosen not to return to the place where they are expected.

Children and Young People – Missing from Education (CME)

Children and young people can be missing from education for a variety of reasons including:-

- Families who simply move and do not tell anyone;
- Long term truants/young offenders;
- Families involved with fraud;
- Families that do not return from holiday;
- Families fleeing from domestic violence/abuse;
- Families involved in witness protection; and
- Children whose families become homeless.
Young Runaways

A child or young person who has run away and cases where a child or young person has been thrown out by their parents and/or carers are both covered by the term young runaway.

All children and young people who go missing and/or run away remain vulnerable to the factors that led to them going missing or running away as well to the risks associated with being missing or having run away.

The reasons for a child’s absence may not always be apparent. A number of circumstances in which children or young people may be termed as missing and/or having run away are listed below:-

**Parental/Carer Abduction** – A parent/carer may fail to return or remove a child or young person from contact with another parent/carer, in contravention of a court order or without the consent of the other parent/carer (or person who has parental rights). This can occur within national boundaries as well as across borders;

**Stranger Abduction** – Whilst extremely rare, a child or young person may fail to return because they have been the victim of a crime;

**Forced Marriage** – A child or young person may go missing due to being forced into marriage abroad or within the UK;

**Trafficked Children and Young People** – A child or young person may go missing due to being trafficked and later being removed from a placement. Asylum-seeking children are particularly vulnerable to vanishing. Their substitute care may feel unsafe and many do not have a trusted adult to advocate for them;

**Sexual Exploitation** – A child or young person may go missing due to sexual exploitation;

**Vulnerable Young People** – Such young people are identifiable by their criminal or risk-taking behaviour, poverty, disengagement with education, being looked after, self-harming, mental health issues and/or experience of abuse. They may take steps to escape from their situation;

**Transition** – A young person moving from children to adult services need processes in place to manage this experience, maximising support and minimising risk. Transition can be a difficult time for young people and their parent/carer, or carer or staff in residential care. Some express their negative emotions through high risk and sometimes offending behaviour; they may also be vulnerable to alcohol and/or drug misuse and sexual predators. These cases are very challenging to manage effectively and call for a collaborative approach that includes offender management services a fuller explanation is provided at topic 31; and;

**Home-Educated Children** – A child or young person may be unknown to services as a result of their removal from mainstream education or never having been enrolled within an education authority. Where this is the result of a decision being made to educate them at home this should not, in itself, be regarded as a child care and/or protection concern.
If you are worried or concerned about a child or young person you should contact the Comhairle nan Eilean Siar Social Work Departments or Stornoway Police

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<th>CnES Social Work</th>
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<td>Stornoway</td>
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<td>Castlebay</td>
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| Police in the Western Isles | 101 |

| In an Emergency             | Call 999 |

Further information can also be found at:-

- [National Guidance for Child Protection in Scotland 2014](#)
- [Vulnerable Children and Young People – Guidance Pack](#)
- [Vulnerable Children and Young People Young Runaways](#)
- [Vulnerable Children and Young People Sexual Exploitation through Prostitution](#)
- [Scottish Government – Home Education Guidance](#)
- [Private Fostering – Responsibilities of Local Authorities](#)
- [Included, engaged and involved part 1: attendance in scottish schools](#)
- [Included, engaged and involved part 2: a positive approach to managing school exclusions](#)
- [Missing Out. Young Runaways in Scotland](#)
25. Child Trafficking

What is Child Trafficking?

Within Western Isles, we have taken a broad definition to describe Child Trafficking.

Child Trafficking is the term given to the movement of any child or young person up to the age of eighteen, into and within a country with the intent to exploit them generally, but not exclusively, for financial gain. It is a serious, organised crime and is usually linked to prostitution rings and money laundering activities.

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

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

- child labour, for example, on cannabis farms;
- debt bondage;
- domestic servitude;
- begging;
- benefit fraud;
- drug trafficking/decoys;
- illegal adoptions;
- forced/illegal marriage (for further information, see the section on Honour- based violence and forced marriage);
- sexual abuse; and
- sexual exploitation.

Tackling child trafficking requires a multi-agency response at all levels. All agencies and practitioners must be aware of the issues pertaining to child trafficking and of the potential indicators of concern.

For further information please see:

- Child Trafficking Referral Form.
- Referral Form Guidance.
- Child Trafficking Assessment.
- The NSPCC National Child Trafficking Advice and Information Line (CTAIL) is a service for anyone with concerns about human trafficking. The number (during office hours) is 0800 107 7057.
- The Scottish Guardianship Service provide support to trafficked children who are also seeking asylum.
26. Child Sexual Exploitation

The sexual exploitation of children and young people is an often hidden form of children sexual abuse, with distinctive elements of exploitation and exchange. In practice, the sexual exploitation of children and young people under 18 might involve young people being coerced, manipulated, forced or deceived into performing and/or others performing on them, sexual activities in exchange for receiving some form of material goods or other entity (for example, food, accommodation, drugs, alcohol, cigarettes, gifts, affection). Sexual exploitation can occur through the use of technology and without the child’s immediate recognition.

In all cases those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are often common features; involvement in exploitative relationships being characterised in the main by the child/young person’s limited availability of choice resulting from their social, economic and/or emotional vulnerability.

In some cases, the sexual activity may just take place between one young person and the perpetrator (whether an adult or peer). In other situations a young person may be passed for sex between two or more perpetrators or this may be organised exploitation (often by criminal gangs or organised groups).

Sexual exploitation is abuse and should be treated accordingly. Practitioners should be mindful that a dual approach is key in tackling CSE; whilst a young person must be both engaged with and supported, there must also be a focus on proactive investigation and prosecution of those involved in sexually exploiting the young person.

Vulnerabilities

In a high proportion of cases, victims of Child Sexual Exploitation will have one or more social, situational, psychological or physical vulnerabilities. Vulnerabilities can include:

- A history of abuse, neglect and/or disadvantage; Being looked after, or formerly looked after;
- Disrupted family life, including family breakdown, domestic violence and/or problematic parenting;
- Disengagement from education and isolation from other support mechanisms; Going missing from home or care environments;
- Drug and alcohol misuse;
- Homelessness
- Poor health and wellbeing, social isolation, bullying or low self-esteem.
Indicators

Possible indicators of sexual exploitation, which workers should be aware of in any assessment of a child or young person, are as follows:

- Staying out late or episodes of being missing overnight or longer; Multiple callers (unknown adults/older young people);
- Evidence of/ suspicion of physical or sexual assault; disclosure of assault followed by withdrawal of an allegation;
- Unplanned pregnancy and/or Sexually Transmitted Infections (STIs); Peers involved in sexual exploitation;
- Drugs/alcohol misuse;
- Isolation from peers/social networks;
- Exclusion or unexplained absences from school or college; Relationships with controlling adults;
- Entering/leaving vehicles driven by unknown adults;
- Unexplained amounts of money, expensive clothing or other items; Frequenting areas known for adult prostitution.

Children under 13 years asking for sexual health advice; Concerning use of the internet/mobile phone.

Risks associated with the Internet

There are specific risks associated with the internet in terms of child sexual exploitation, including:

- Grooming children on-line for sexual abuse offline;
- Children viewing abusive images of children/pornographic images; Selling children on-line for abuse offline;
- Making abusive images of children; Viewing abusive images of children;
- Access to chat lines via the internet or mobile phones; Sexting.

Therefore when undertaking an assessment around child sexual exploitation practitioners should consider what risks are posed to the child or young person through the internet, and those that are posed by the child or young person to other children or young people.

Non-disclosure

It is important that practitioners are aware that young people who are victims of CSE rarely directly disclose because they often do not recognise their own exploitation. For example, a young person may believe themselves to be in an “adult relationship” with their abuser. Disclosure of sexual exploitation can be particularly difficult for young people; the sophisticated grooming and priming processes conducted by perpetrators and the exchange element of this form of abuse can act as additional barriers to disclosure.
Examples of other reasons for non-disclosure include:

- Fear that perceived benefits of exploitation may outweigh the risks e.g. loss of: supply of alcohol, drugs; the “relationship” and associated “love” and attention; Fear of retribution or that situation could get worse;
- Fear of violence within exploitative relationship; Shame;
- Fear of not being believed;
- Fear of labelling e.g. as a prostitute or gay;
- Fear of separation from family and/or threat of secure;
- Loss of control; fear of Police involvement and court proceedings.

**Referral**

Anyone who works with children and families and has concerns that a child is at risk of abuse through sexual exploitation must make a referral in accordance with child protection procedures set out in Part 3 of this guidance. This includes circumstances where there is a lack of evidence or where there may be concerns which cannot be substantiated. Referrals can help to build up a picture that a child may be suffering harm through sexual exploitation. It is important that practitioners do not wait for a disclosure from a young person or the accumulation of hard evidence, prior to making a referral.
27. Female Genital Mutilation

Female genital mutilation is a culture-specific abusive practice affecting some communities. It should always trigger child protection concerns. The legal definition includes all procedures which involve the total or partial removal of the external female genital organs for non-medical reasons. There are four types of female genital mutilation ranging from a symbolic jab to the vagina to the partial or total removal of the external female genitalia.

The Prohibition of Female Genital Mutilation (Scotland) Act 2005 makes it illegal to perform or arrange to have female genital mutilation carried out in Scotland or abroad. A sentence of 14 years” imprisonment can be imposed. There are also several options that should be considered to protect children and prevent female genital mutilation occurring including Child Protection Orders.

The procedure performed at various ages including babies and adolescents, but more commonly carried out on children aged between four and ten years. It is a deeply rooted cultural practice in certain African, Asian and Middle Eastern communities. Justifications for female genital mutilation may include:

- tradition;
- family honour;
- religion
- increased male sexual pleasure;
- hygiene; and
- fear of exclusion from communities.

For further information, see the following.

- Prohibition of Female Genital Mutilation (Scotland) Act 2005.
- FORWARD.
- List of UK hospitals and clinics offering specialist female genital mutilation services.
- UNICEF website for female genital mutilation HM Government (2011)
- Multi-agency Practice Guidelines: Female Genital Mutilation.; and
- National Guidelines 2014 (Item 513)
28. Honour- Based Violence and Forced Marriage

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

- inappropriate make-up or dress;
- having a boyfriend/girlfriend;
- forming an inter-faith relationship;
- kissing or intimacy in a public place;
- pregnancy outside marriage; and
- rejecting a forced marriage.

A forced marriage is defined as a marriage conducted without the full and free consent of both parties and where duress is a factor. Duress can include physical, psychological, financial, sexual and emotional pressure. A clear distinction must be made between a forced marriage and an arranged marriage. An arranged marriage is one in which the families of both spouses are primarily responsible for choosing a marriage partner for their child or relative, but the final decision as to whether or not to accept the arrangement lies with the potential spouses. Both spouses give their full and free consent. The tradition of arranged marriage has operated successfully within many communities for generations.

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

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

Education

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

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

Police

- Reports of domestic abuse, harassment or breaches of the peace at the family home.
- Threats to kill and attempts to kill or harm.
- Truancy or persistent absence from school

For more information, see the following.

- Forced marriage: A wrong not a right.
- Forced Marriage (Protection and Jurisdiction) (Scotland) Act 2011
- Forced Marriage Scotland
29. Bullying

What is Bullying?

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

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

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

What is Cyber Bullying?

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

Cyber bullying is defined by [Childnet International](http://www.childnetinternational.org) as the sending or posting of harmful or cruel text or images using the internet or other digital communication devices. Cyber bullying is an intentional activity and can be carried out by an individual or group using electronic forms of contact repeatedly over time against a victim who cannot easily defend themselves.

This can include the taking of a picture or video clip of a child or young person and sending this to others to make them feel threatened and or embarrassed. It can also include the filming of physical attacks and sharing these images with others.

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

- [Respect Me](http://www.respectme.co.uk) which supports schools, local authorities and communities to prevent and tackle bullying effective through training, support for policy development and awareness raising information provision and includes advice on cyber-bullying.

- [The Anti-Bullying Network](http://www.theanti-bullying-network.org) which is an independent operation with the following objectives - to support anti-bullying work in schools; to provide a free website and to offer an anti-bullying service which will include the provision of training, publications and consultancy services.
Childline provides help and support for children and young people.

Parentline (www.children1st.org.uk/parentline) a national, confidential helpline providing advice and support to anyone caring for or concerned about a child. Cyberbullying – Safe to Learn: Embedding anti-bullying work in schools.
30. Online and Mobile Phone Child Safety

Technology

New technologies, digital media and the internet are an integral part of children's lives. Whether on a computer at school or at home, a games console or mobile phone, children and young people are increasingly accessing the internet whenever they can and wherever they are. This has enabled entirely new forms of social interaction to emerge, for example, through social networking websites and online gaming.

However, these new technologies make children and young people far more accessible to those who may wish to abuse them. It is more anonymous and it may act as a vehicle for groups of abusers to communicate with one another and provide mutual legitimisation. Secondly, these new technologies introduce new methods to the way in which abusers organise can their abuse.

Risks

These new technologies also bring a variety of risks such as:-

- exposure to obscene, violent or distressing material;
- bullying or intimidation through email and online (cyber-bullying);
- identity theft and abuse of personal information;
- pro-eating disorder, self harm or suicide sites; and
- exploitation by online predators – for example, sexual grooming – often through social networking sites.

Practitioners need to support children and young people to use the internet and mobile technology responsibly and know how to respond when something goes wrong.

Advice for Practitioners

It is important that children, young people, parents, carers and practitioners understand the risks and can make sensible and informed choices on-line. In a constantly changing technological landscape it is difficult to keep pace with change and criminal activity.

Practitioners may find the following lists of some Do’s and Don’ts helpful:-

**DO’s**

- Do try and get up to speed with new technologies through self-learning;
- Do encourage children and young people to keep personal details to a minimum when on-line and only allow trusted friends access to social network pages;
- Do reassure a child or young person that they are not to blame if they have had unwanted sexual contact whilst on-line;
- Do take possession of the device, computer, mobile phone etc to prevent further activity and preserve evidence; and
- Do refer to your designated child protection officer within your own service/agency if an internet issue occurs.
**DON'Ts**

- Don't challenge any on-line abuser, you may alert them and compromise a criminal investigation;
- Don't try and interrogate computers, mobile phones or other devices; you may contaminate or destroy evidence;
- Don't try and initiate an investigation but instead contact the police as soon as possible and explain the circumstances; and
- Don't ignore the issue; children or young people elsewhere may still be at risk.

**How to Preserve Evidence**

All practitioners and those involved in the care and/or protection of children and young people should be aware of the value of digital evidence contained on computers, mobile phones and other media (this includes media used by the victim as well as any suspect).

If there is a suspicion that such equipment might be of evidential value the following procedures should be adopted:-

- Prevent further use of the computer or other equipment;
- Prevent access to the computer, or other equipment or associated media;
- Do not disconnect the power unless there is a reason to believe that the computer is carrying out a task that would delete any evidence. In which case remove the power lead from the rear of the computer, do not shut the computer down in the normal manner and do not switch off at the wall, (both these actions may cause files to be deleted); and
- Do not allow anyone (no matter how computer literate they may be) to interrogate the computer. This should only be done by Police Scotland police officers. If you follow these guidelines the evidential value of the data will then be preserved.

**CEOP (Child Exploitation and On-line Protection Centre)**

The [Child Exploitation and On-line Protection Centre](https://www.ceop.police.uk) (CEOP) is dedicated to eradicating the sexual abuse of children. CEOP is part of the UK policing community and tracks and brings offenders to account, either directly or in partnership with local and international police forces.

CEOP also works with children, young people, parents, carers and practitioners to deliver their unique [Thinkuknow](https://www.thinkuknow.org) internet safety programme. This resource includes films, presentations, games, lesson plans, publications and posters covering a range of issues from grooming by child sex offenders to cyber bullying. These can be accessed and downloaded from their [Website](https://www.ceop.police.uk).
For more information, see the following.

- The Scottish Government [Internet safety page](#).
- The Child Exploitation and Online Protection Centre (CEOP) provides information and resources on child internet safety and runs a well-established education programme, ThinkuKnow.
- Where a child comes across potentially illegal content online, a report can be submitted to the [Internet Watch Foundation](#).
- WithScotland’s [Keeping Children and Young People Safe Online: Balancing Risk and Opportunity](#)
- [respectme](#)
31. Lesbian, Gay, Bisexual and Transgender Young People (LGBT)

All practitioners, working with and/or caring for young people, must recognise the rights, needs, and aspirations of lesbian, gay, bisexual and/or transgender (LGBT) young people. This duty is best articulated by The Equality Act 2010.

This Act has two main purposes – to harmonise discrimination law and to strengthen the law to support progress on equality and diversity.

For many LGBT young people, the fear of being *outed* and stigmatised is real and for many, very fearful. Sharing information relating to an LGBT young persons’ sexual orientation and/or gender identity with another practitioner, service and/or agency can potentially place that young person at a greater risk and should be treated with sensitivity.

There is often a perception within mainstream services that a young person’s LGBT identity in and by itself, may constitute a child care and protection concern. **This perception is wrong.** Practitioners must therefore be aware and sensitive to these considerations.

[LGBT Youth Scotland](https://www.lgbtyouthscotland.org.uk) is Scotland’s largest youth and community-based lesbian, gay, bisexual and transgender (LGBT) organisation who strive to improve the health and wellbeing of LGBT youth and LGBT communities in Scotland. They seek to ensure:-

LGBT young people can enjoy a safe and supportive upbringing and reach their full potential;
LGBT young people are empowered to make positive choices about their lives;
An end to homophobia and transphobia in Scottish schools, colleges and youth groups;
Better health and wellbeing for LGBT young people and the wider LGBT community; and
LGBT young people are successful learners, confident individuals, effective contributors and responsible citizens.

Their website contains a wide range of information, advice and factsheets which practitioners may find helpful.

Also of interest may be the more locally relevant LGBT Western Isles [Facebook Page](https://www.facebook.com/LGBTWesternIsles).
32. Hostile and Non-Engaging Parents and Carers

On occasion, because of the nature of child care and/or protection work, some parents and/or carers may feel angry and can react in a way that is deemed either hostile and/or non-engaging. This type of behaviour can impact on practitioners in a variety of ways.

Practitioners should therefore be able to identify this type of emerging behaviour at an early stage and whilst adopting a firm but positive and non-discriminatory approach, be mindful of their own safety, the safety of their colleagues and the safety of the child or young person. Line Managers should be made aware of any hostile and/or non-engaging behaviour and this information should be recorded and shared with other practitioners, services/agencies working with the child and family in question.

Practitioners working with Hostile and/or Non-Engaging Parents and/or Carers can also benefit from peer support and/or supervision from Line Managers, both of which is critical when dealing with these types of situations.

The following key practice notes may be helpful:

- Practitioners should recognise and know what action to take quickly and effectively in response to this type of behaviour;
- Practitioners should acknowledge that they may feel intimiated by this behaviour and that this is not an unusual response;
- Practitioners should consider their own health and safety and the health and safety of their colleagues;
- Practitioners should see and/or attempt to see the child is safe and should at the earliest opportunity, inform their line manager of such developments;
- Practitioners should where possible, continue to work with the child, parent and/or carer;
- Practitioners should re-affirm their professional and/or legal authority to work with the child and family;
- Practitioners should also take into account the parenting capacity of the parent and/or carer, together with their race, ethnicity, language, cultural and religious backgrounds and
- Practitioners should share, exchange and record this information quickly, appropriately and effectively.

Practitioners should note that the National Guidance for Child Protection in Scotland 2014 provides additional information and advice on more specialist child protection matters including:

- Children and Young People who Display Harmful or Problematic Sexual Behaviour;
- Complex Child Abuse and Investigation;
- Historic Allegations of Child Abuse; and
- Allegations against Foster Carers and Residential Social Workers.
33. Complex Child Abuse Investigations

Each investigation of complex abuse will be different, depending on the characteristics of the situation, its scale and complexity. Although complex abuse in residential settings has been widely reported in recent years, complex abuse can occur within family networks, day care and other provision such as youth services, sports clubs and voluntary groups, and via the internet. Complex abuse investigations require thorough planning, effective inter-agency working and attention to the welfare needs of both child victims and adult survivors. This section aims to provide advice and guidance to practitioners who are faced with these difficult situations.

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

Ritual abuse

Ritual abuse can be defined as organised sexual, physical, psychological abuse, which can be systematic and sustained over a long period of time. It involves the use of rituals, which may or may not be underpinned by a belief system, and often involves more than one abuser. Ritual abuse usually starts in early childhood and uses patterns of learning and development to sustain the abuse and silence the abused. The abusers concerned may be acting in concert or using an institutional framework or position of authority to abuse children. Ritual abuse may occur within a family or community, or within institutions such as residential homes and schools. Such abuse is profoundly traumatic for the children involved.

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

Abuse by Organised Networks or Multiple Abusers

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

Networks Based on Family or Community Links.

Abuse can involve groups of adults within a family or a group of families, friends, neighbours and/or other social networks who act together to abuse children either on- or offline.

Abduction

Child abduction may involve internal or external child trafficking and may happen for a number of reasons. Children cannot consent to abduction or trafficking.

Institutional Setting

Abuse can involve children in an institutional setting (for example, youth organisations, educational establishments and residential homes) or looked after children living away from home being abused by one or more perpetrators, including other young people.
Commercial Sexual Exploitation

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

- Survivor Scotland is a Scottish Government-run website for victims of childhood sexual abuse.
- Safeguarding Children from Abuse Linked to a Belief in Spirit Possession provides more detail regarding the circumstances around child victims of spirit possession accusations.
- The Office of the Children's Commissioner two-year Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG).
34. Transition

Dealing with Concerns and Allegations that Relate to Young People Aged 16 -18 Years of Age.

For young people aged between 16 – 18 years of age it may be the case that these Outer Hebrides Child Protection Inter Agency Guidelines would apply whenever concerns or allegations are being made. It is therefore important to ensure that there is a consistency of approach and ease of transition between child protection and adult support and protection especially for young people who have a disability.

The guidelines are appropriate for two separate groups.

1) Young people who are not known or subject to child protection measures. In such cases:

At the point of referral the relevant area community care manager and the children’s services manager, in consultation with colleagues in health and police will agree which guidance would be most appropriate to manage the case.

Whichever guidance is followed the initiation of the procedure should also be flagged in the other system.

2) Those who are on the Child Protection Register at their 16th birthday. In such cases:

At the next child protection planning meeting, where it is determined that the young person should continue to be registered, consideration should be given to which guidance would be most appropriate to manage the case (i.e. child protection or adult support and protection).

If there is consensus that the adult protection processes should apply, responsibility can only be transferred if formal agreement of the children’s services manager and the area community care manager can be confirmed at the meeting or the subsequent core group meeting – these meetings also have the responsibility for agreeing and documenting the necessary transfer arrangements in processes.

WHICHEVER GUIDANCE IS FOLLOWED THE INITIATION OF THE PROCEDURE SHOULD ALSO BE FLAGGED IN THE OTHER SYSTEM.

Transition planning

The move from child to adult services presents significant risks. Young people at this transition stage can drop out of services altogether, losing their safety net of support. The risk is exacerbated by the fact that different agencies have different criteria for defining when someone becomes an adult, or can access particular services. The importance of ensuring appropriate planning to support these transitions is vital. Named Persons and Lead Professionals should consider how best to manage transition, follow clear planning processes, taking steps to identify the needs of individual young people and looking at the interventions they might need to support and, if necessary, protect them in adulthood.

No child or young person from the age of 15 is on a Compulsory Supervision Order should be without a clear transition plan set in place where the recommendation is to discharge the Order.
Agencies should be clear about the collective responsibility to manage this transition effectively and Chief Officers should ensure this understanding is reflected in single forum objectives. There needs to be agreement with those responsible for areas such as MAPPA, adult protection, Violence Against Women and Alcohol and Drug Partnerships to ensure that mutual responsibilities are properly reflected in each agency’s guidance.

The Named Person for the child or young person must ensure a careful and planned transfer of responsibility when another practitioner becomes the Named Person. Similarly, the transition from one Lead Professional to another will need to be planned carefully, particularly when another service becomes the lead agency.

Key strategic transition planning arrangements

- Particular areas where The Child Protection Committee and other public protection fora will need to work together include the development of policies and procedures and training plans and provision. Here in the Outer Hebrides we have established arrangements in order that other relevant public protection services are properly represented in those areas where their remits overlap. There may also be opportunities for public protection fora to share learning and development in relation to quality assurance (particularly multi-agency case file audits and significant case reviews).

- We have ensured that there are appropriate operational links between adult and children's services to address protection issues. These links ensure good communication, fostering a good understanding of risk and safety issues for all age groups. There will inevitably be overlap between child and adult protection. Assessment and planning processes may need to be aligned and some investigations or assessments may be best undertaken jointly, for example when child and adult protection issues are identified within the same family. The aim should be to maximise the safety and welfare of children and at-risk adults while minimising the impact of the investigation on those involved.

- A key inter-agency procedure and practitioner guidance protocol has been developed, specifically; **Vulnerable Children and Young People at Risk of Significant Harm**
  These procedures will be invoked when workers and those with knowledge of the child identify an escalation/pattern of behaviour resulting in increased risk either to an individual or to others. They are not intended to be used when children or young people come to attention of agencies for the first time whilst engaging in risk-taking behaviours (i.e. using drugs/alcohol absconding, etc).

- These procedures will also be applied in relation to children and young people aged 16 – 18 years who have not been looked after and children and young people aged 16 – 21 years who have been looked after previously.
35. Criminal Injuries: Compensation for Victims of Child Abuse

The Criminal Injuries Compensation Scheme provides payments to compensate victims of violent crime and is managed by the Criminal Injuries Compensation Board.

The ‘Tariff Scheme’, managed by the Criminal Injuries Compensation Authority (CICA) was introduced on 1 April 1994. This is based on a tariff or scale of awards, which are grouped together into 25 bands of severity which can be compared.

Local authority social work services have a ‘duty of reasonable care’ towards any child with whom they are involved. This clearly would include all children whose cases are considered by child protection case conferences.

The duty of reasonable care includes taking steps to protect the child’s estate and to take any steps to increase the child’s estate. Social work services will probably be involved with most, if not all, of the known or suspected victims of child abuse.

Part of the duty of reasonable care held by social work services is to advise victims and their carers of the existence and relevance of the CICA and give them guidance on how a claim to the CICA is made.

Any child or adult not given this advice may have a claim against the social work service for loss suffered as a result of the service’s professional negligence at any time. Team leaders are responsible for considering the relevance of an application to the CICA for every eligible child a member of their team is working with.

This may include some children not placed on the child protection register because the abuse was carried out by a stranger or by someone who no longer has contact with the child leading to the conclusion that the child is not ‘at risk’.

36. Going to Court: Supporting Child Witnesses

At the beginning of a child protection investigation it is always possible that a child may be called upon to give evidence at either a proof hearing or a criminal trial. It is important, therefore, that staff are honest about this possibility with children and parents and carers and reassure them about the process.

If a statement is taken from a child, no matter whether the child is a victim or witness, the parent/carer and child should be given the leaflet ‘Children who are Witnesses’.

The aim of the leaflet is to help the parent or carer until more formal proceedings begin, and copies are available from all police stations, social work offices, children’s reporter offices, and procurator fiscal offices.

The Procurator Fiscal office in Stornoway sends out letters designed to keep parents and carers fully informed of the progress of any criminal proceedings.
Once either the Procurator Fiscal or the Children’s Reporter formally cites a child, they will also be given a booklet giving details of the process ahead more fully.

A series of publications provide guidance on how to provide support to vulnerable witnesses before, during and after any court proceedings.

These include:

- Special Measures for Vulnerable Adult and Child Witnesses, a guidance pack;
- Code of Practice to facilitate the provision of therapeutic support to child witnesses in court proceedings;
- Information about Child, Young and Vulnerable Witnesses to inform decision making in the legal process.

37. Children in Residential Care

All children, wherever or whatever their circumstances, have a right to protection from abusive situations. Any information that a child living in residential care has been, is, or may be at risk of abuse/neglect should be reported in line with the internal guidance relating to the residential establishment. It is necessary that the Head of Children’s Services/Chief Social Work Officer be notified immediately.

Any such allegation will be investigated in a similar way to an allegation relating to abuse of a child living in the community. The Head of Children’s Services/Chief Social Work Officer and the Care Inspectorate will be immediately notified of any such allegation.

38. Children Looked After in an Out of Region Placement

When an allegation of abuse/neglect of a child, looked after by Comhairle nan Eilean Siar, and accommodated in a mainland placement, comes to the attention of the children & families service, it is the responsibility of the children & families service/police personnel to investigate such allegations in accordance with their relevant child protection procedures. The designated officer in police and children & families service should discuss any allegation coming to their attention and refer the matter on to their counterparts in the relevant authority where the child is accommodated. The team leader must notify the Care Commission and the Chief Social Work Officer.

39. Foetal and Peri-Natal Vulnerability

Some children are placed at risk before or shortly after birth. Children and families services should be notified if health professionals or other agencies anticipate there may be risk after birth, for a child still in utero, even if it means breaching the confidentiality owed either to mother or father.
In addition to following the protocols in such NHS documents as the NHS Western Isles Child Protection: Unborn Child Policy consideration should be given to the use of pre birth child protection conference in the following situations:

- Where either prospective parent is a schedule 1 offender;
- Where there is a history of previous action to protect the children of either parent;
- Where parental behaviour places the normal development of the foetus at risk;
- Where there has been a previous, unexplained, cot death;
- Where this is a first pregnancy, particularly where the parent(s) are very young, for a woman and/or partner who has a history of having been abused or looked after.

The aim of such meetings is to assess parenting capacity and pre/post-natal support needs; and to consider whether the unborn child needs to be placed on the child protection register. It will also discuss if it is safe for the child to go home following birth and consider if there is a need to apply for a child protection order.

Care should be taken to encourage positive engagement and to minimise stigmatisation. Early intervention to prepare for the birth is recommended.

Multi-agency meetings should be planned for no later than at 28 weeks pregnancy to ensure a child’s plan is in place in sufficient time for possible early delivery. Should late notification of a request for a meeting be made the meeting should take place as soon as possible and within 21 calendar days. Transition plans should be in place from midwife to health visitor, and a review child’s plan meeting or core meeting date planned.

40. Very Young Children

Many of the points that apply to children with additional needs may be relevant when interviewing very young children. Additional considerations for this group include the fact that very young children can be very attached to familiar figures such as a parent. They can be distrustful of strangers and become distressed or avoid contact when left alone in rooms with unfamiliar adults. Unfamiliar surroundings can heighten their distress.

Furthermore, pre-schoolers are more used to interacting with adults in play situations rather than serious formal sessions so, again, building rapport will be essential and more time may be needed when explaining the conventions of the investigative interview.

41. Sudden Unexpected Death in Infancy (SUDI)

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

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

During such an investigation, the Senior Investigating Officer should consider using suitably trained officers from the local policing division’s Public Protection Unit for more specialist tasks during, such as:

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

There are occasions where the cause of death cannot be established. In such cases pathologists may classify the death as unascertained, pending investigations or as a Sudden Unexplained Death in Infancy (SUDI).

Alternatively, they may choose to record the cause of death as Sudden Infant Death Syndrome (by definition a death due to natural causes which have not been determined).

For further information, see the following:

Healthcare Improvement Scotland (HIS) has delivered a programme of work on SUDI: SUDI Scotland Toolkit - For Professionals

42. Young Carers

Children and young people may become the primary carer in a family as a result of a parental illness (physical or mental) or addiction. As a result of inappropriate responsibility, the young carer’s own health and development may be seriously impaired.

Where practitioners come across a child who they believe to be a young carer, they should consider the impact this is having on the child’s development and whether there is a need to provide them with additional support.

43. Ethnicity

There may be certain barriers to communication other than language. Some children from asylum-seeking families, for example, may have had negative experiences with the authorities dealing with their application (e.g. discrimination, racism, etc.) and may therefore be mistrustful of professional interviewers. Such issues should be treated with due care and consideration.
When interviewing children from different backgrounds and heritage, interviewers might encounter beliefs and values that are different to their own. However, interviewers should never impose any ethnocentric attitudes during an interview. The child’s culture and customs must always be respected. The following are some points to consider:

Certain rituals or customs might affect the scheduling of the interview (e.g. prayer times, holy days, fasting).

Behaviour towards authority figures can vary from culture to culture. In some cultures it is inappropriate for a child to question anything an authority figure says. In this situation, it is essential that the interviewer makes clear the ground rules described earlier (e.g. where the child should correct the interviewer if they make a mistake).

Beliefs and practices regarding child rearing can also vary from culture to culture. Interviewers should respect that and avoid passing judgement.

The issue of shame can be a major determinant of how co-operative the child and their family are with regards the investigation (a child disclosing allegations of abuse might fear retribution from their family and the community).

**44. When the child’s first language is not English**

A child should, wherever possible, be interviewed in their first language (or, if bilingual, the one of their preference). Only in special circumstances, i.e. where an interpreter is not available and there is an immediate need to talk to the child, should an exception be made.

Interviewers should be aware that some children who use English everyday, for example at school, may revert to using their native language for certain terms, e.g. parts of the body.

If an interpreter is required, then they should be someone independent of the child’s family and community.

They should be fully briefed as to their role and remit during the interview and to the principles of the phased interview. The interpreter should also have an understanding of the child’s cultural context as well as being able to speak the language.

The interpreter should be fully aware that they must translate exactly the interviewer’s questions and the child’s responses.

They should avoid making inferences. Moreover, interpreters should not add in or omit anything; just report what has been said.

If the child has any preferences regarding the interpreter’s gender or ethnicity, these should be respected and accommodated wherever possible. This applies for all interview personnel (and also any forensic medical examinations).
45. Staff involved in Child Protection Issues

Staff who become closely involved in child protection procedures contribute to decisions that make a profound impact on the lives of children and whole families. Accordingly, at times, staff may feel a strong emotional response including frustration, anger, or even guilt about these issues. Agencies have a duty of care towards their staff, and welfare and support systems should be in place to help staff cope with these issues.

Children can’t always tell someone if they are being abused or neglected.

But you can.

Visit www.childprotectionscotland.org to find out how.

If you need to report a concern about a child in
Comhairle nan Eilean Siar
you can call Stornoway: 01851 822 749 (during office hours) 01870 604 880 (during office hours)
Barra:
01871 810 431 (during office hours)
Social Work Emergency Out of Hours 01851 701 702
Part V

Policy Context, Legislation, Useful Web Links and Contact Numbers
**Policy Context**

The following schedule provides the historic and contemporary child protection policy context for the Outer Hebrides Inter-Agency Child Protection Procedures:-

**Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation**
(Scottish Office 1998):

**Scottish Executive (2001) For Scotland’s Children: Better Integrated Children’s Services**;


**Scottish Executive’s Audit and Review Report (2002) entitled “It’s everyone’s job to make sure I’m alright”**;

**Scottish Executive (2003) Getting Our Priorities Right: Good Practice Guidance for Working with Children and Families Affected by Substance Misuse**;


**Scottish Executive (2005) Protecting Children and Young People: Child Protection Committees**;


**HMIe Services for Children Unit (2006): Self Evaluation and Quality Indicators Framework: “How well are children and young people protected and their needs met?”**;

**Getting it Right for Every Child**;


**HMIe Services for Children Unit (2009): How good are we now? How well do we protect children and meet their needs? How good can we be? Self Evaluation Using Quality Indicators**;


Scottish Government (2009) The Early Years Framework Part II;

Scottish Government (2010) National Guidance: Under-Age Sexual Activity: Meeting the Needs of Children and Young People and Identifying Child Protection Concerns; and

Legislative Context

The following schedule provides the historic and contemporary child protection legislative context and explanatory notes where appropriate for the Outer Hebrides Inter-Agency Child Protection Procedures:

The Police (Scotland) Act 1967;
The Social Work (Scotland) Act 1968;
The Health and Safety at Work etc Act 1974;
The Sex Discrimination Act 1975;
The Race Relations Act 1976;
The National Health Service (Scotland) Act 1978;
The Education (Scotland) Act 1980;
The Sex Discrimination Act 1986;
The Age of Legal Capacity (Scotland) Act 1991;
The Children (Scotland) Act 1995;
The Human Rights Act 1998;
The Data Protection Act 1998;
The Race Relations (Amendment) Act 2000;
The Sexual Offences (Procedure and Evidence) (Scotland) Act 2002;
The Freedom of Information (Scotland) Act 2002;
The Protection of Children (Scotland) Act 2003;
The Criminal Justice (Scotland) Act 2003;
The Education (Additional Support for Learning) (Scotland) Act 2004;
The Vulnerable Witnesses (Scotland) Act 2004;
The Asylum and Immigration (Treatment of Claimants, etc.) Act 2004;
The Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005;
The Management of Offenders etc (Scotland) Act 2005;
The Prohibition of Female Genital Mutilation (Scotland) Act 2005;
The Disability Discrimination Acts 1995 and 2005;
The Equality Act 2006;
The Protection of Vulnerable Groups (Scotland) Act 2007;
The Sexual Offences (Scotland) Act 2009;
The Equality Act 2010;
The Criminal Justice and Licensing (Scotland) Act 2010;
and
UN Convention on the Rights of the Child.
Useful Web Links

Aberlour  www.aberlour.org.uk/
Action for Children  www.actionforchildren.org.uk/
ADP Western Isles  Alcohol Drug Partnership
Anti Bullying Network  www.antibullying.net/
Association of Chief Police Officer in Scotland  http://acpos.police.uk/
Association of Directors of Education in Scotland  www.adescotland.org.uk/
Association of Directors of Social Work  www.adsw.org.uk/
Barnardo's  www.barnardos.org.uk/scotland
Child Exploitation and Online Protection Centre  www.ceop.police.uk/
Centre for Learning in Child Protection  www.clicp.ed.ac.uk/
Child Net (Know it All)  www.childnet-int.org/kia/
Child Protection in Sport  www.childprotectioninsport.org.uk/index.html
Child Trafficking  http://www.nspcc.org.uk
Childline  www.childline.org.uk
Children 1st  www.children1st.org.uk/
Children's Hearing's  www.chscotland.gov.uk/
Children in Scotland  www.childreninscotland.org.uk/
Comhairle Nan Eilean Siar  www.cne-siar.gov.uk
Confederation of Scottish Local Authorities  www.cosla.gov.uk/
Crimestoppers  www.crimestoppers-uk.org
Institute of Research & Innovation in Social Services (IRISS)  www.iriss.org.uk/
Internet Watch Foundation  www.iwf.org.uk
Legislation  www.opsi.gov.uk/index.htm
NHS Western Isles  http://www.wihb.scot.nhs.uk
NHS 24  www.nhs24.com/
Police Scotland  http://www.northern.police.uk/Territories/western-isles.html
Royal College of Paediatrics and Child Health  http://www.rcpch.ac.uk/
Scottish Child Law Centre  www.sclc.org.uk/
Scottish Children’s Reporter Administration  www.scra.gov.uk/
Scottish Government  www.scotland.gov.uk/Home
Scottish Government Publications  www.scotland.gov.uk/Publications/
Scottish Parliament  www.scottish.parliament.uk/
Scottish Refugee Council  http://www.scottishrefugeecouncil.org.uk/
Scottish Social Services Council  www.sssc.uk.com/
Social Care and Social Work Improvement Scotland  www.scswis.com
Social Care Institute For Excellence  www.scie.org.uk/
Stop it Now  www.stopitnow.org.uk/
ThinkUknow  www.thinkuknow.co.uk/
UK Human Trafficking Centre  www.ukhtc.org
UNICEF  www.unicef.org/
Who Cares? Scotland  www.whocaresscotland.org/
WithScotland  www.withscotland.org/

Return to Contents
Contact Details for Reference and Information

To report child care concerns and to seek advice and guidance:

Social Work Department, Comhairle nan Eilean Siar
Sandwick Road, Stornoway, Isle of Lewis 01851 822749

Social Work Department, Comhairle nan Eilean Siar
Balivanich Isle of Benbecula 01870 604880

Social Work Department, Comhairle nan Eilean Siar
Castlebay Isle of Barra 01871 817217

Western Isles Out of Hours Social Work 01851 701702

Stornoway Police, Police Station, Church Street, Stornoway 01851 702222

NHS Western Isles, 37 South Beach Street, Stornoway 01851 702997

Child Protection Co-ordinator and Development officer 01851 822737

Education and Children's Services (Education and Social Work)

Each school in Western Isles has a Child Protection Designated Officer.

This person or the Head Teacher is the first point of contact within each school.

SCRA. Reporter to the Children’s Panel 0300 200 2236
10 Harbour View
Cromwell Quay
Stornoway

Procurator Fiscal Service, Procurator Fiscal’s Office 01851 703439
Sheriff Court Buildings
Lewis Street
Stornoway

Action for Children 01851 705080
30 Bayhead Street
Stornoway

Western Isles Child Care Partnership 01851 822280
7 Harbourview Development
Cromwell Quay
Stornoway

Alcohol and Drug Partnership 01851 708923
1 Bank Street
Key Legislation and Explanatory Notes

The Children (Scotland) Act 1995
This is the primary legislation for the protection of children and young people. It includes actions that are relatively rare but which can be instigated in emergencies; situations where it is necessary to plan assessment and longer term legal measures to protect or supervise children and young people.

The Act provides for 3 main types of Emergency Protection: the Child Assessment Order (CAO), the Child Protection Order (CPO) and the Exclusion Order (EO).

**Child Assessment Orders (CAO)**

The conditions which are required to be met to satisfy the Sheriff are set out in Section 55 (1) of the Children (Scotland) Act 1995. A Child Assessment Order is obtained by a local authority from a Sheriff. It enables an assessment of a child’s health or development to be made. It is designed for instances where the situation is not as urgent as that required in the case of a Child Protection Order but there is a concern about a child’s safety or welfare.

A Child Assessment Order can last for up to seven days from the date specified in the Order and can include such directions and conditions as the Sheriff considers appropriate for the proper assessment of the child including provision for the child’s residency and any medical examinations deemed necessary.

The Child Assessment Order (not any other Order under this Act) does not reduce the child’s rights to refuse medical treatment or procedures as determined by **The Age of Legal Capacity (Scotland) Act 1991**. An application for this Order requires formal notice to the relevant parties. Should a Sheriff consider it more appropriate, he or she must issue a Child Protection Order rather than a Child Assessment Order.

**Child Protection Orders (CPO)**

There are occasions when urgent action is required to protect a child from significant harm. Any person, including the local authority, can apply to the Sheriff for a Child Protection Order under Section 57 (1) of the Children (Scotland) Act 1995.

Specifically when a local authority suspects that a child is suffering or will suffer significant harm or any person who has reasonable grounds to believe the above may apply to a Sheriff for a Child Protection Order (CPO). Such an Order ceases to have effect where no attempt has been made to implement it within 24 hours of it being granted.

It can do one or more of the following:-

- Require the child to be produced;
- Authorise removal to, and retention of, the child in a place of safety;
- Prevent the removal of the child; and
• Instruct that the child’s location be kept secret
• The local authority can also apply for an Order under Section 57 (2) of the aforesaid Act if its enquiries are being frustrated by being denied access to the child. The Sheriff may make decisions regarding contact with the child and whether medical and psychiatric examinations, assessments or treatments are required.

The duration of the Order is limited to 24 hours/2 working days from implementation until an initial Children’s Hearing. Following the initial hearing the Children’s Reporter must arrange a second hearing on the 8th working day after implementation of the order when the grounds for referral and statements of the facts of the case will be put to the child and parents/relevant persons.

Exclusion Orders (EO)

Under Section 76 of the Act, a local authority may apply to a Sheriff for an Exclusion Order to exclude a ‘named person’ from the house of a particular child or children. An Exclusion Order has the effect of suspending a person’s occupancy rights (if any) to the child’s family home and of preventing that person from entering the home without the express permission of the local authority. The local authority can apply to the Sheriff to attach a power of arrest to any interdict granted, prohibiting the named person from entering or remaining in a specified area in the vicinity of the home.

A full Hearing must take place not later than 3 working days after the Interim Order is granted when a Sheriff may grant an Exclusion Order for up to 6 months with conditions attached including the aforesaid power of arrest.

Emergency Protection Procedures

When the conditions for the granting of a Child Protection Order are met but a Sheriff is not available, application can be made to a Justice of the Peace for an Order to produce a child and/or the removal or detention of a child in a place of safety.

This particular Order ceases to have effect if it has not been implemented within 12 hours of being granted. Application must be made to a Sheriff within 24 hours if the child needs to remain in a place of safety. A Police Constable may remove a child to a place of safety if he or she considers the grounds for a Child Protection Order are met.

In the Western isles the availability of a sheriff/honorary sheriff varies from area to area consequently all cases will be referred to Education and Children Services in Stornoway for advice and subsequent action.

Children Seeking Refuge

In term of Section 38 of The Children (Scotland) Act 1995 Local Authorities and persons running residential establishments have the power to provide refuge in designated or approved establishments and households for children and young people who appear to be at risk of harm and who request refuge.
A child or young person must request refuge;
- There is no requirement on the child or young person to disclose information about his or her circumstances as a condition of access to refuge;
- Provision of refuge is not an alternative to the local authority using its other responsibilities and power under the Act;
- Households may include designated foster families; and
- A designated police officer has to be advised that the child or young person is being given refuge and is safe;

A child or young person’s parents and/or carers retain their responsibilities and rights in respect of the child or young person and should be advised that the child or young person is being provided with refuge. However they cannot demand the return of the child or young person nor is it necessary to provide parents and/or carers with other details unless the child or young person wishes them to be told. Parents and/or carers would not normally be advised of the location of the refuge but should have a contact number of a person through whom they can be re-assured of a child or young person’s wellbeing.

The Children & Young Persons (Scotland) Act 1937


The Act sets out a number of criminal offences:-

**Section 12** – Cruelty to persons under 16.

If any person who has attained the age of 16 years and has the custody, charge or care of any child or young person under that age, wilfully ill-treats, neglects, abandons, or exposes him or cause or procures him to be ill-treated, neglected, abandoned or exposed in a manner likely to cause him unnecessary suffering or injury to health (including injury to or loss of sight, or hearing, or limb, or organ of the body and any mental derangement) that person shall be guilty of an offence.

**Section 15** – Causing or allowing person under 16 to be used for begging.

**Section 33** – Prostitution or persons under 16 taking part in performances endangering life or limb.

**The Human Rights Act 1998**

All legislation passed by either the UK or Scottish Parliament should adhere to the principles of the European Convention on Human Rights. Insofar as it is possible, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention. Sometimes there may be a potential conflict of interest between children and adults and a balancing of competing rights will be required. For further information, see the chapter on Principles and standards. UN Convention on the Rights of the Child
The Age of Legal Capacity (Scotland) Act 1991

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

Part V of The Police Act 1997

This Act introduced a system of disclosures, criminal history information, to individuals and organisation for employment and other purposes. This service is known as Disclosure Scotland. The aim of the service is to enhance public safety and to help employers and voluntary organisations make safer recruitment decisions.

The Sex Offenders Act 1997

This Act requires certain persons convicted of certain sexual offences (almost all related to offences committed against children and young people) to register their names and addresses with the Police for a given period which varies depending on the crime and the length of sentence. Police must be notified of an intended change of address.

Local authorities have a clear role to play in the Act’s implementation. The exchange of information with local Police and the undertaking of such assessment is vital in order that offenders who present a risk are identified and monitored. Public safety and child protection are paramount in this respect.

The Crime and Disorder Act 1998

This Act permits a Chief Constable to apply for a Sex Offender Order when a person of 16 years or over, who is a convicted sex offender, has acted in such a way as to give reasonable cause to believe that an Order under this section is necessary to protect the public from serious harm. The local authority where the offender lives and the Police must consult prior to making an application.

The Sheriff may impose certain conditions on the Order and should the offender be in breach of these conditions, a police constable can arrest, without warrant, a person whom he or she reasonably suspects of committing a prohibited act in contravention of the Sex Offender Order.

The Female Genital Mutilation Act 2003 and The Prohibition of Female Genital Mutilation (Scotland) Act 2005

These Acts make it an offence for UK nationals or permanent United Kingdom residents to carry out female genital mutilation (FGM) abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.
The Protection of Children (Scotland) Act 2003

This legislation requires that Scottish Ministers keep a list of individuals whom they consider to be unsuitable to work with children and young people, to prohibit individuals included on the list, and the individuals who are similarly regarded in other jurisdictions, from doing certain work relating to children and young people, to make further provision in relation to that list and for connected purposes.

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

This Act creates the offence of sexual grooming. It also makes provision for Risk of Sexual Harm Orders to be granted by the court to protect children and young people from sexual behaviour. It also creates further offences in relation to child prostitution and exposure to pornography.

The Management of Offenders etc (Scotland) Act 2005

This relates to the arrangements for assessing and managing risks posed by certain offenders. The responsible authorities for the area of a local authority must jointly establish such arrangements.

The Protection of Vulnerable Groups (Scotland) Act 2007

This Act allows for the establishment of a new Vetting and Barring Scheme which will replace the current Disclosure System. All individuals who work with children and young people or adults at risk of harm (whether paid staff or volunteers) will be required to register to become a scheme member. This arose from the Bichard Inquiry, undertaken following the Soham murders in 2002. The Inquiry called for a registration system for all those who work with children and adults at risk of harm. The Vetting and Barring Scheme will deliver this recommendation ensuring that those who have a history of behaviour which indicates they are unsuitable to work with children or adults at risk of harm are prevented from doing so.

The Sexual Offences (Scotland) Act 2009

This Act has translated a number of common law offences – including rape – into statutory offences which criminalise sexual conduct which takes place without consent. It defines consent as “free agreement” and makes clear that consent may be withdrawn at any time.

The Act:-

- provides for the first time a statutory definition of consent as “free agreement” enshrined in the law;
- replaces the common-law offence of rape with a broader statutory offence (which includes male rape);
introduces new statutory crimes, including specific offences of sexual assault by penetration and of voyeurism, and others targeting coercive sexual conduct such as the sending of sexually offensive emails or texts, and sexual exposure; and

includes ‘protective offences’ to safeguard those with limited or no capacity to consent due to their age or mental disorder. This includes equalising at 16 the age of consent for boys and girls.

The Act introduced in Sections 42-45 a new offence relating to a breach of a position of trust in respect of a child. The Act provides clear guidance as to what constitutes a position of trust in these circumstances. It updated and amended the provisions of the UK Sexual Offences (Amendment) Act 2000. Section 55 also allows for a Scottish resident to be convicted of an offence committed abroad if it would be deemed a criminal offence in Scotland. It is no longer necessary for the behaviour to be illegal in the country where it occurs. Unlawful sexual intercourse with a 12-year-old somewhere in Asia, for example, would be able to be prosecuted in Scotland.

Criminal Justice and Licensing (Scotland) Act 2010

The Criminal Justice and Licensing (Scotland) Act 2010, provides for a new statutory offence of ‘stalking’ specifically criminalising stalking. Conduct constituting stalking may, depending on the circumstances, be prosecuted using a number of common law and statutory offences. Some of the offences most relevant to stalking, including breach of the peace, threatening and abusive behaviour, the law on threats and offences under the Sexual Offences (Scotland) Act 2009, are described above. Conduct which might be described as harassment or stalking can be prosecuted under Scots law as a breach of the peace. This common law offence covers all behaviour (including single incidents) which is severe enough to cause alarm to ordinary people and threaten serious disturbance to the community. As a common law offence, the scope of the offence is ultimately a matter for the courts to determine but it is a wide-ranging offence and the courts recognise that it can be serious. The maximum penalty for common law offences such as breach of the peace is limited only by the court in which the case is tried. In the High Court, a life sentence is theoretically possible.

Section 38 of the Criminal Justice and Licensing (Scotland) Act 2010 provides for an offence of ‘threatening and abusive behaviour”. It provides that it is an offence for a person to behave in a threatening or abusive manner towards someone if that behaviour would be such as to be likely to cause a reasonable person to feel fear or alarm. This offence is intended to allow for the prosecution of threatening or abusive behaviour that could previously have been prosecuted as a breach of the peace, prior to the Appeal Court’s decision in the case of Harris v HMA in 2010, which ruled that the crime of breach of the peace requires a public element.

The Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011

The Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act was passed by the Scottish Parliament on 22 March 2011 and came into force on 28 November 2011, to provide a specific civil remedy for those threatened with forced marriage and those already in such a marriage.
A Forced Marriage is a marriage in which one or both parties do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress includes both physical and emotional pressure. It is very different from arranged marriage, where both parties give their full and free consent to the marriage.

The Scottish Government believes that all people in Scotland who are eligible to marry or enter into a civil partnership have a right to do so freely and without coercion.

**Sex Offender Community Disclosure Scheme**

Keeping Children Safe or the Sex Offender Community Disclosure Scheme is a process that allows any member of the public to make an application to Police Scotland if they have a concern about a person’s access to a child. It is a slow time information sharing process.

Any disclosure will only be made to the parent, guardian or carer of that child. The Sex Offender Community Disclosure Scheme does NOT change how Police Scotland will deal with child protection incidents, which will continue to be dealt with as a matter of operational priority. Disclosure will only take place after careful consideration and where children are deemed to be at risk. The scheme is not about disclosing general information on sex offenders.

**Children's Hearings (Scotland) Act 2011**

The Children’s Hearings (Scotland) Act 2011 sets out the framework for the care and protection of children by the imposition of Compulsory Measure of Supervision. The Act sets out when referrals must be made to the Children’s Reporter, the mechanisms for the provision of Compulsory Measures of Supervision and the forms such measures may take. This Act also sets out the legislation governing emergency measures for the protection of children, including child protection and child assessment orders, emergency applications to justices of the peace and the powers of a constable to remove a child to a place of safety.

**National Guidance for Child Protection in Scotland: Guidance for Health Professionals 2012**

This guidance is intended to act as a practical reference point for all healthcare staff working within an adult and child service context. It includes all children and young people up to the age of 18. It also highlights the specific roles and responsibilities of specialist staff working in particular settings wherever children and young people will usually be seen and it sets out the framework to aid practitioners in their role in dealing with child protection concerns.

For further information on the existing and emerging national child protection policy/legislative context please contact the Western Isles Child Protection Co-ordinator at Comhairle Nan Eilean Siar, Stornoway on 01851 822764.

**Police and Fire Reform (Scotland) Act 2012**

The Police and Fire Reform (Scotland) Act 2012 lays down the duty of a Constable and the overarching policing priorities. The main purpose of policing is to improve the safety and
wellbeing of persons, localities and communities in Scotland and, as such, the duty of a Constable includes:

Prevent and detect crime
Maintain order
Protect life and property
To take such lawful measures and make such reports to the appropriate prosecutor as maybe needed to bring offenders with all due speed to justice

**Children and Young People (Scotland) Act 2014**

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

- the rights of children and young people;
- investigations by the Commissioner for Children and Young People in Scotland;
- the provision of services and support for, or in relation to, children and young people;
- the statutory operation of the Named Person and Child’s Plan;
- the extension of early learning and childcare;
- the role of corporate parent;
- the extension of aftercare support to young people leaving care (up to and including the age of 25);
- entitling 16 year olds in foster, kinship or residential care the right to stay in care until they are 21;
- support for kinship care;
- the creation of an adoption register;
- consultation on certain school closure proposals;
- some amendments to children’s hearings legislation;
- appeals against detention in secure accommodation; and provision of free school lunches.

There are different implementation dates for different parts of the Act, and practitioners working in children’s rights and services should ensure they keep up to date with the changes being made as the different parts of the Act are brought into force. Guidance will be produced by the Scottish Government to support the implementation of the Act.
Guidance on the Compilation of Chronologies & the process of Integrated Chronologies

Introduction

The Western Isles is committed to the underpinning principles of ‘Getting it right for every child’. This practice guide incorporates the key aspects of the SWIA ‘Practice Guide for Chronologies’ which was published in January 2010.

The chronology seeks to provide a clear account of all significant events in a child’s life to date, drawing on the knowledge and information held by agencies involved with the child and family.

A significant event is anything that has a significantly positive or negative impact on the child. It does not have to happen to the child, but could result in a change of their circumstances, which has positive or negative consequences for them. It is important to note that what might be a key event in one child’s life, such as a period of good health or good school attendance after a long period of absence or exclusion, will not even be relevant to another child. In this respect agencies are asked to use their professional judgement in completing the chronologies.

This brief and summarised account of events provides accumulative evidence of emerging needs and risks and flags up when a multi-agency response might be necessary. The chronology should be factually based and it should be clear what the source of the information is. The chronology should not replace existing case notes or records which will include much more detailed and sensitive information which is owned by the child and or family and a clear distinction must be made between the two. The chronology should be succinctly recorded and child-focused. Each event should have an action or an outcome that has had a significant impact on the child. It is not appropriate to only record dates of meetings, visits etc without the outcome that therefore details the significant event. When reading a chronology there should be no apparent gaps in information.

A chronology is important because it records the circumstances and experience of the child and milestones in their life. For example those positive events celebrated by a family which are usually easily remembered. Some significant experiences may be less positive but are an important influence on the life of the child. This needs to be recorded as a chronology to identify at a glance, the key patterns indicating needs, risks, evidence of resilience and the family’s potential to support its own needs or progress with minimal intervention.

The key purpose of the chronology of significant events is early indication of an emerging pattern of risk and concern. This may be evident by gradual and persistent withdrawal from protective factors such as non-attendance at health appointments and non-attendance at nursery/school alongside a frequent attendance at A&E or GP on-call service. Events such as domestic abuse referrals, referrals to the Children’s Reporter and referrals of concern should also be recorded. In most circumstances the child’s chronology should start with their birth however in some cases particularly in that of a baby it will be relevant to start the chronology pre-birth. This will show emerging patterns of risk before the baby is born.

Review and analysis of a chronology is essential to an effective assessment. A chronology which is not reviewed and analysed serves little if any purpose.
Guidance on the Chronology of Significant Events

The following areas have been identified by each of the agencies as worthy of recording but not every area will be recorded for every child only where it is a relevant key event. What becomes significant can change over time. It is important to avoid the chronology becoming overly extensive by adding events that are of no real significance:

**Education**

- Positive or negative changes in family care structure e.g. separation, divorce, bereavement, custodial sentence
- Positive or negative changes in family circumstances e.g. housing, birth of a sibling
- Physical and mental health and wellbeing of child, parents/carers
- Positive or negative changes in performance, attainment or achievement
- Physical or emotional presentation of child, parents/carers
- Identification of Additional Support Needs within staged intervention process (including requests for support services involvement e.g. psychological service, intensive support team, care and learning)
- If the child has an Individual Education Plan or Co-ordinated Support Plan
- Positive or negative changes in attendance or punctuality
- Positive or negative changes in parental presence, engagement or support with child's learning
- Episodes of exclusion or re-integration
- Significant periods of absence e.g. illness, pregnancy, truancy
- Social inclusion within the school setting including evidence of bullying or positive support networks
- Decision to initiate a Multi-Agency Assessment.
- Outcomes of internal assessment team or meetings
- Change of teacher or other key member of staff from the child’s school
- Change of school
- Any threats or actual incidents of violence to staff by parents or child
- Any other relevant concerns or positive improvements

**Social Work Services**

- All referrals to social work
- Information relating to health or parental lifestyles of parents/carers that significantly impact on the child
- Positive or negative changes in family care structure e.g. through separation, divorce, bereavement, custodial sentence
- Positive or negative changes in family circumstances e.g. homelessness, birth of a sibling
- Referrals for family support, home support, Childcare or other agencies
- Dates and details of Social Work Involvement e.g. start date, closure of case and reason
- Lack of engagement
- VPD referrals for child, parent/ carers and outcomes.
- Outcome of child protection referrals/enquiries/investigations
- Significant changes/outcome of child protection related meetings e.g. case discussions, case conferences, core groups
- Dates and reason for child being looked after and accommodated
- Change of social worker or other key worker from the service
- Changes to legal status including primary and secondary statutes where applicable
- An established pattern of missed appointments without acceptable reasons, including refusal of entry
- Dates and conditions of contact/conditions of no contact
• Change of address including foster placement and temporary accommodation
• Referrals to the Children’s Reporter and the grounds of referral
• Outcome of children’s hearings
• Details of planning meeting and/or review dates including LAAC
• Any other relevant concerns or positive progress
• Any threats or actual incidents of violence to staff including verbal threats
• Date when summary statements, working agreements, risk assessments are completed
• Significant home visits

Education and Social Work staff may also want to consider the following information from partner agencies.

Health

• Positive or negative changes in health related problems in relation to the child or their parents/carers, such as disability, substance related issues, mental health issues etc
• Changes in family care structure e.g. through separation, divorce, bereavement, custodial sentence
• Changes to child’s physical or emotional wellbeing
• Changes in family circumstances e.g. housing, birth of a sibling, emotional well-being
• Referrals to Paediatric Services, Therapy Services, Other Agencies
• Attendance at Accident and Emergency, Out of Hours and NHS24
• Incidences of hospital admissions
• Childhood illnesses
• Changes in disability
• Dates of immunisations and screening
• Kept or missed appointments for ante-natal, post-natal appointments, immunisations, child health surveillance, hospital appointments
• Formal health assessments e.g. developmental, LAAC
• Change to the Health Visitor, School Nurse or other key staff member working with the family
• Missed appointments without acceptable reasons, including refusal of entry or variation to routine appointment schedule
• Threats or actual incidents of violence to staff
• Any other relevant concerns or positive improvements
• Significant home visits

Housing

• Positive or negative changes in family care structure e.g. separation, divorce, bereavement, custodial sentence
• Positive or negative changes in family and housing e.g. relocation, eviction, transfer to private tenancy
• Positive or negative changes in maintenance of tenancy agreements
• Positive or negative changes in neighbour relations or anti-social issues. Where this has led to further action being taken, for example ASBO, then this should be recorded
• Evidence of, or referrals for suspected drug dealing, drug taking or excessive alcohol use
• Reports of anti-social behaviour on the child or parents
• Any concerns about the safety or welfare of children or young people noted directly by housing staff or passed to them by others in the community e.g. children left unattended, poor standards of household cleanliness, children wandering the streets or being out in poor weather without adequate clothing
• Any threats or actual incidents of violence to staff
• Any other relevant concerns, positive events
Scottish Children’s Reporters Administration

- Dates of referral
- Referral reason e.g. care and protection, youth justice, domestic abuse, school attendance.

Co-ordination of the Integrated Chronology

Practice and research has shown that integrated chronologies can be extremely important in identifying critical events in the lives of children and can assist professionals in decision-making when working together with vulnerable children and families. A single incident, no matter how significant or insignificant it may appear in itself, often takes on a far greater importance in the life of a child when placed in the context of a proper, time-lined integrated chronology. The integrated chronology, therefore, requires careful co-ordination and close working between the agencies involved, and requires individuals to carefully note all matters which may constitute a significant event.

The Named Person and/or Lead Professional is responsible for collating the integrated chronology and all agencies involved in the integrated assessment are expected to contribute to the chronology. The process will work best when there is a shared sense of responsibility by all for gathering, recording, and passing the information to the lead professional who will take overall responsibility for collating and distributing the integrated chronology.

Parents, carers, young people and children can be given a copy of the integrated chronology, providing this does not place the young person or child at further risk and any restricted information is removed. Parents or carers should be encouraged to reflect on the content of the integrated chronology with the help of their Named Person, Lead Professional or any other agency representative with whom they are involved. Some parents/carers or young people may wish to correct details or make a contribution to the integrated chronology and this should be considered by the Lead Professional. The views of the child and parents/carers should be recorded within the assessment. Where it is discovered there are inaccuracies in the content of an individual agency’s chronology, the Lead Professional will discuss this with the agency representative to seek clarity and resolution.

Compilation of the Integrated Chronology

1. On invitation to an Initial Child Protection Case Conference, LAAC Review, CSP Meeting or any other type of integrated assessment meeting or where a Child’s Plan is being compiled, each agency should review their own single agency chronology on the child and up-date it where necessary. Where, for any reason, this does not exist the agency should review their records on the child and select significant events as per the guidance above.

2. Where possible, each agency should bring their own chronology to the initial meeting for submission to the Lead Professional or Named Person

3. The Lead Professional or Named Person will collate the individual chronologies received and produce the integrated chronology as part of the child’s integrated assessment.

4. The time scales for integrated chronologies will be those applicable to the purpose of the assessment and the forum in which it should be discussed e.g. Child Protection Case Conference, Co-ordinated Support Plan Meeting, LAAC Review.
5. During the span of the child or young person’s plan, the Lead Professional shall have responsibility for the ongoing co-ordination of the integrated chronology and the assessment team should review on a regular basis.

6. Each agency representative should continue to add to his or her individual agency chronology, which may have a specific focus on the main role of that particular agency, for example, the child’s education. They should also advise the Lead Professional of the events they are including, at the date they learn of them, so that these significant events are also included in the integrated chronology where they fit the criteria.

**Child Protection Cases**

1. For children on the child protection register, the forum for reviewing and analysing chronologies will be the Child Protection Core Group Meeting. The Assessment Team should meet immediately prior to the Core Group Meeting to agree on the information that is to be contained within the integrated chronology. In the absence of an I.T. solution for sharing and integrating chronologies, the process has to be conducted manually. Therefore each agency should bring its own chronology to the meeting.

2. The chair of the Core Group should define the period of time from where the significant events are relevant to the child’s current situation if it is not appropriate for the chronology to start with the birth of the child. Each child on the register should have a separate chronology.

3. In the case of Child Protection Registration, during the life of the core group, each member of the core group should continue to compile their own agency’s chronology and report all significant events to the allocated social worker or team leader at the time they occur, as per good practice.

4. The Lead Professional will continue to up-date the Integrated Chronology and ensure these are with the Child Protection Administrator 5 working days before the date of the review and e-mailed to the appropriate forum members 2 days prior to the meeting.

5. Any disagreements over the content of the integrated chronology, which cannot be resolved by the core group chair, shall be referred to the relevant Social Work Manager who will advise on the final content.

6. Any member of the core group who is aware of a significant event that for any reason was not included in the chronology, should bring this to the attention of the core group chair as soon as possible.

7. Each agency representative should continue to add to their individual chronology which may have a specific focus on the main role of that particular agency, for example, the health of the child.
**Conclusion**

Chronologies have an important role in providing data to examine patterns and identify actual or potential risks. In line with national guidance, The Western Isles uses the Girfec Practice Model and Integrated Assessment Framework as its main working tool for children and families services. Single agency chronologies and multi-agency integrated chronologies are recognised as key tools in the process of assessment and review. SWIA's practice guide for chronologies, January 2010, states that:-

"Chronologies, as part of a skilled and focused approach, can be an essential tool in caring for and protecting children and adults by:

- Bringing together issues identified by different agencies and presenting them coherently.
- Contributing precise data which can help practitioners identify patterns of behaviour which will contribute to an assessment.
- Recognising chronology is relevant in criminal justice work for assessing and managing people who constitute a high risk to themselves and/or others
- Using their findings as an integral part of supervision and peer reviews.
- Strengthening the partnership between practitioners and people who use services”.

**Format**

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<th>Date of Entry</th>
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Research and Resources

Learning communities

Learning communities or networks can support the training and development of practitioners working with children in child protection and care. Broadly speaking, they bring together groups of people who share common goals, take responsibility for their own learning and support the learning of others in the community. Participants need to be motivated, active and willing to communicate with each other either face-to-face or in a virtual interactive environment.

Often, communities and networks will adopt an inter-disciplinary approach, based on an educational or 'pedagogical' design. They may also develop a shared repertoire of resources, including experiences, stories, tools and ways of addressing recurring problems. This takes time and sustained interaction. It is the combination of these elements that constitutes a community of practice.

Such communities share certain defining features or characteristics:

- a sense of belonging and shared ownership;
- loyalty to the community, its members and the groups that they represent;
- constructive, honest and helpful interaction that builds trust and reinforces a sense of peer support;
- openness and willingness to share, including lessons learned, challenges and interests;
- active involvement and commitment to helping the learning community achieve its aims, including by providing input into its long-term development and review;
- seeking knowledge and solutions wherever possible; and
- a willingness to share learning, as appropriate, outwith the learning community in pursuit of common aims.

The variety of communities allows agencies to access a range of knowledge and support that can help inform policy and practice across child welfare. Together, these communities aim to foster collaboration between the practitioners, managers, academics and consultants that make up the child protection community in order to contribute to better outcomes for children and young people and disseminate evidence of best practice. These are important resources for local agencies and the Outer Hebrides Child Protection Committee.

All agencies working in child protection and care should identify and clarify the resources available locally and nationally to support practitioners and managers and identify the means of sharing learning across the workforce. This should be managed through local strategic bodies including the Outer Hebrides Child Protection Committee.
More information can be found at:

- WithScotland is based at University of Stirling and offers expert advice and support for all staff in Scotland working with child protection issues. It is also developing links between child protection and adult protection across Scotland. WithScotland's aims are to:
  - co-ordinate the exchange of knowledge across agencies, and disseminate policy and practice messages from existing national and international research evidence;
  - broker and facilitate links across both adult protection and child protection sectors in Scotland, the UK and internationally;
  - establish research partnerships to obtain funding to undertake new research to an international standard;
  - identify gaps in service provision or training needs to inform local and national policy developments; and
  - contribute to the development and promotion of a national strategic training and continuing professional development framework.

The posts of National Child Protection Committee Co-ordinator and Adult Protection Coordinator were established to support the National Child Protection Committee Chairs Forum and Adult Protection Policy Forum respectively to take forward national priorities and to help both Child and Adult Protection Committees increase consistency and reduce duplication of effort. Both posts sit within WithScotland, in order to promote partnership working across both communities.

The University of Edinburgh/NSPCC’s Child Protection Research Centre was set up to conduct research and provide analysis and commentary on child protection developments across the UK. Based at the University of Edinburgh, the Centre is mainly funded by the NSPCC. The work of the Centre falls under the following broad strands:

- tracking, monitoring and providing an overview of child protection policy across the UK;
- conducting detailed comparative policy analysis into specific aspects of child protection; and research into gaps in child protection knowledge.

The Centre for Youth and Criminal Justice supports improvement in youth justice, contributing to the realisation of better lives for individuals and communities. The Centre’s role is to strengthen the creation, sharing and use of knowledge and expertise and it works in collaboration with practitioners, managers, policy-makers, researchers and those whose lives have been affected by youth justice. This includes the interface between youth offending and child protection. The work centres on three key activities:

**Practice development:** Supporting youth justice practitioners and organisations to create, share and use knowledge

**Research:** Supporting the creation of new knowledge through doing, and supporting others to do, research

**Knowledge Exchange:** Supporting the dissemination of knowledge and facilitating dialogue between those with different perspectives or forms of knowledge

The NSPCC has developed resources for anyone working to protect Scotland’s children. These include research and statistical briefings and resources on Scottish guidance, legislation, Significant Case Reviews and training.
Resources developed since 2010

**National Framework for Child Protection Learning and Development in Scotland 2012**

The purpose of the framework is to set out a common set of skills and standards for workers to ensure the delivery of a consistently high standard of support to children and young people across the country. The main aim is to strengthen the skills and training of professionals and improve the advice and tools available to them in assessing, managing and minimising risks faced by some of our most vulnerable children and young people.

**National Risk Framework to Support the Assessment of Children and Young People**

This Guidance aims to support and assist practitioners at all levels, in every agency, to be able to approach the task of risk identification, assessment, analysis and management with more confidence and competence. It seeks to provide tools that, if used, support methodical and systematic approaches to not only better understanding risk and its presentation with children and families, but also enhance interventions and potential outcomes.

The Guidance should not be viewed as prescriptive in character; it requires practitioners to consider the use and application of the tools with each individual set of circumstances they are faced with. The expectation is not to follow slavishly each element but to apply these proportionately when focusing upon the child’s needs, their wellbeing and the strengths and pressures within their life circumstances. This Framework, the Guidance and Tools it contains, seek to support and complement existing assessment processes. Risk is an element of all assessment, it does not stand alone. Children and young people’s needs and emerging risks require to be considered along the continuum of their lifespan.

**National Guidance for Child Protection in Scotland: Guidance for Health Professionals in Scotland**

This guidance is intended to act as a practical reference point for all healthcare staff working within an adult and child service context. It highlights the specific roles and responsibilities of specialist staff working in particular settings wherever children and young people will usually be seen. It sets out the framework to aid practitioners in their role in dealing with child protection concerns.

**Getting our Priorities Right**

The purpose of the guidance is to provide an updated good practice framework for all child and adult service practitioners working with vulnerable children and families affected by problematic parental alcohol and/or drug use. It has been updated in the particular context of the national GIRFEC approach and the Recovery Agendas, both of which have a focus on “whole family” recovery. Another key theme is the importance of services focusing on early intervention activity. That is, working together effectively at the earliest stages to help children and families and not waiting for crises – or tragedies – to occur.
**Protecting children and young people**

The guidance published by the General Medical Council came into effect on 3 September 2012 and gives advice to doctors on:

- their duty to identify children and young people at risk of abuse and neglect, even when only treating adults
- the boundary between parental freedoms and child protection concerns
- good communication with children, parents and families when there are child protection concern
- respecting confidentiality and when to share information
- good record keeping practice
- seeking consent to examination or investigation
- understanding how other professionals involved in child protection work
- consider and act on child protection concerns
- training and skills development; and
- giving evidence in court as a witness of fact and as an expert witness.

**Core Competencies for Children’s Services Workforce**

The Common Core Competencies describes the skills, knowledge and understanding, and values that everyone should have if they work with children, young people and their families, whether they are paid or unpaid. They are also explicitly cross-referenced to the guiding principles of the United Nations Convention on the Rights of the Child (UNCRC). The values are taken from the *Getting It Right For Every Child* approach.

[Return to Contents](#)
Additional Information

Parent’s and Young People’s Views

“All children and young people should have the opportunity to make their views known about decisions which affect them. They should have the opportunity to express their opinions and have these opinions taken seriously. They should be encouraged to contribute to decision-making processes, the setting of educational objectives, the preparation of learning plans, reviews and transition planning.”

(Supporting children’s learning: code of practice, SEED, 2005, Para. 6.2)

Children and young people must be enabled and empowered in decision-making processes, and they need to know that what they have to say will be respected, listened to and, where appropriate, acted upon. We must, therefore, seek to address any barriers or potential barriers to their participation in decision making. Parents must also have the opportunity and be enabled to be involved fully in discussions and decisions regarding their child’s learning. This is crucial to understanding their child’s additional support needs.

Parents have unique knowledge and experience to contribute and a key role to play in their child’s education. Account should therefore be taken of their wishes and the perspectives they bring. In seeking to meet the needs of children and young people partnership with parents is vital and we must seek to address any barriers to their participation in discussion and decision making.

In order to express views, children and young people need to have experience of being asked for their views, being listened to, making choices and having some influence over what they do and what is provided for them. It is important that schools and early years’ settings create a climate where seeking children’s views and encouraging participation in decision-making are part of everyday activities.

While some children and young people with additional support needs will be able to express themselves clearly, others may need support with communication or confidence to express their views. For example, specific arrangements will have to be made to seek out the views of children with complex communication support needs; those who require an interpreter; or whose first language is not English; or who have behavioural difficulties and find it difficult to co-operate.

A range of approaches will need to be used to determine their views, including the use of alternative or augmentative communication systems, or engaging the views of others such as family members, foster carers, social workers and other professionals who know the child or young person. It must be stressed that no matter how complex the needs it is just as important and relevant for these children and young people to have their views listened to as it is for those who can more easily express views.
Once the child’s or young person’s views have been sought and recorded it is important to consider what is realistic and appropriate to provide, and to balance this against what a child or young person may want. However, where a child’s or young person’s views are unable to be acted on, the reasons for this should be explained to them. The views of children and young people should never be disregarded without due consideration.
Good Practice in Communicating with Children and Young People

A child or young person may benefit from:

- being given enough time to prepare and to go over the ideas and material to be discussed
- being given information in a form which is readily understood
- assistance from a teacher or other helper to understand the meaning of key terms and concepts
- a supportive communication facilitator to tease out the full meaning of all of the issues
- specialised or new vocabulary (perhaps in sign or symbol form) in order to discuss a particular topic
- support to go over ideas, perhaps on several occasions
- help to understand outcomes and agreements
- issues related to language should also be considered, for example:
  - if spoken English is not the child’s or young person’s first language, consider using an interpreter
  - consider using a facilitator for those with language or speech difficulties
  - use appropriate alternative or augmentative communication systems such as visual aids
  - and/or sign language for deaf and/or communication impaired children or young people
  - take account of any cultural preferences
  - take time to explain what decision has to be made, why it is important and how the child or young person can influence it

(Supporting children’s learning: code of practice, SEED, 2005, chapter 6)

Good practice in communicating with parents

“All professionals, schools, education authorities and other appropriate agencies should seek actively to involve parents in their work with children. They should value parents’ contribution and regard them as partners in their children’s learning.”

(Supporting children’s learning: code of practice, SEED, 2005, Para.6.22) 17

In establishing good practice agencies must:

- ensure that parents are fully aware of the processes for assessing, planning and providing for children’s needs
- ensure that parents are familiar with the support services available from the school, the education authority and from other agencies, including voluntary organisations
- extend the partnership approach to include older children and young people

When working with parents professionals must:

- acknowledge and draw on parental knowledge and expertise in relation to their child
- consider the child’s strengths as well as pressures
• recognise the personal and emotional investment of parents and be aware of their feelings
• ensure that parents understand procedures, are aware of how to access support and are given documents to be discussed well in advance of meetings
• respect the validity of differing perspectives and seek constructive ways of reconciling different viewpoints
• cater for the differing needs parents may have, such as those arising from a disability, or communication and linguistic barriers
The Named Person Role

Every child in The Western Isles will have a named person either from the primary health team or from education, according to their age. The named person will remain associated with the child, even if additional help is offered. The named person will be able to coordinate any help from within their own agency and will help families request the involvement of other agencies and services as appropriate. The role of the named person is:

- to be the first point of contact for the child, young person or family
- to seek consent and facilitate requests for involvement
- to work with the child or young person and their family to prepare and monitor any plans that are drawn up
- to establish the child’s and parent’s views
- to lead the review of impact

The named person may also be the Lead Professional when two or more agencies are working together
The Lead Professional Role

When two or more agencies need to work together to provide help to a child or young person and family, there will be a Lead Professional to co-ordinate that help. The Lead Professional would normally be drawn from the health team, education team or social work team working with the child, young person or family. The role of the Lead Professional is:

- to make sure that the child or young person and family understand what is happening at each point so that they can participate in the decisions that affect them
- to be the main point of contact for children, young people, practitioners and family members, bringing help to them and minimising the need for them to tell their story several times
- to establish the child's and parent's views
- to promote teamwork between agencies and with the child or young person and family
- to ensure the child's plan is implemented and reviewed
- to be familiar with the working practices of other agencies
- to support other staff who have specific roles or who are carrying out direct work or specialist assessments
- to ensure the child or young person is supported through key transition points, particularly any transfer to a new lead professional
- to ensure the information contained in the Child's Plan is accurate and up-to-date.

The Child's Plan

Practitioners will analyse the information regarding the strengths and pressures from the My World Triangle along with any specialist assessments and to identify the areas where help should be focused. The Well-being Indicators may also be used when a plan is being constructed or reviewed, to summarise the child or young person's needs that will be addressed in the child's plan.

Every Child's plan should include and record:

- reasons for the plan
- partners to the plan
- the views of the child or young person and their parents or carers
- an analysis of the child or young person's needs, including a summary of strengths (My World Assessment)
- what is to be done to improve a child or young person's circumstances
- details of action to be taken
- resources to be provided
- timescales for action and for change
- contingency plans
- arrangements for reviewing the plan and recording any unmet needs
- lead professional arrangements where they are appropriate
- details of any compulsory measures if required.
Plan Meeting Agenda

The five questions practitioners need to ask themselves when they are concerned about a child or young person form the **agenda for the meeting** that produces a Child’s Plan:

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

Reviewing the plan

It is important to look at whether the actions taken have achieved the outcomes specified in the plan and what changes or further action, if any, are required. In reviewing the outcome of the plan with the child or young person and family, there are six essential questions practitioners need to ask which will form the **agenda for the meeting**:

1. What has improved in the child or young person’s circumstances?
2. What if anything has got worse?
3. Have the outcomes in the plan been achieved?
4. If not, is there anything in the plan that needs to be changed?
5. Are there any unmet needs?
6. Can we continue to manage the plan within the current environment?

If the plan has been successful and the outcomes achieved, the question needs to be asked - is there a need for an ongoing multi-agency involvement, or can the needs now be met through a single agency response?
Chronologies


A chronology should:

- be a useful tool in assessment and practice
- not an assessment – but part of assessment
- not an end in itself – a working tool which promotes engagement with people who use services
- be accurate – rely on good, up-to-date case recording
- contain sufficient detail but not substitute for recording in the file
- be flexible – detail collected may be increased if risk increases
- be reviewed and analysed – a chronology which is not reviewed regularly is of limited relevance
- recognise that different constructions of a chronology are needed for different reasons e.g. current work and examining historical events
- recognise that single agency and multi-agency chronologies set different demands and expectations
- record what was done at the time

A chronology should also incorporate the following key elements:

- key dates of birth, life events, moves
- facts e.g. child’s name placed on the child protection register, MAPPA (multi-agency public protection arrangements) meeting, adult who is subject to adult protection procedures
- transitions, life changes
- key professional interventions e.g. reviews, hearings, tribunals, prison sentences
- not opinion – these may be for the record but the strength of chronologies lies in their reporting of facts/times/dates
- a very brief note of an event e.g. a fall down stairs, coming to school with a bruise, a registered sex offender whose car keeps breaking down outside a primary school
- the actions which were taken. Many chronologies list events and dates but do not have a column which enables actions taken, or not taken to be recorded
CHILD TRAFFICKING.

Why are children trafficked?

The majority of children and young people who arrive in Scotland in this way have been falsely promised a good job, and for education, sometimes their parents and/or carers have been persuaded to entrust them to others for a better quality of life. The reality is that they are trafficked for many reasons, including:

- Sexual exploitation;
- Forced labour, such as agricultural work, fishing, sweatshop, restaurant and other catering work;
- Domestic work;
- Drug trafficking - drug mules, drug dealing or decoys for adult drug traffickers;
- Petty criminal activity - begging, pick pocketing;
- Benefit fraud;
- Forced marriages;
- Illegal inter-country adoption; and
- Other criminal activities

What are the signs of Child Trafficking?

Practitioners need to be able to recognise when children and young people have been trafficked. There are some indicators which may suggest that a child or young person have been trafficked into or within the UK and may conceivably be under control of the trafficker or receiving adults.

There are no validated risk assessment tools that can predict the risk of trafficking or definitively identify those who have been trafficked. While the presence of any of the following factors does not provide definitive evidence, they should raise suspicion about the possibility of trafficking. These can include circumstances such as:

- Child or young person has entered the country illegally;
- Child or young person has no passport or other means of identification;
- Child or young person possesses money and goods not able to account for;
- Child or young person does not appear to have money but has a mobile phone;
- Child or young person is unable to confirm name and address of person meeting them on arrival;
- Child or young person is accompanied by an adult who insists on staying with the child or young person at all times;
- Child or young person has prepared a story very similar to that given by other children and young people; and
- Child or young person appears malnourished.
What other things do you need to consider?

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

Identification

Firstly, child trafficking can be difficult to identify. By its very nature, the activity is hidden from view, so practitioners need to be sensitive to the indicators of trafficking when investigating concerns about particular children and young people. There are no validated risk assessment tools that can predict the risk of trafficking or definitively identify those who have been trafficked. However, an indicator matrix has been developed which sets out a list of factors often associated with children who have been trafficked or who are at risk. While the presence of any factor does not provide definitive evidence, the indicators do point to the possibility of trafficking, particularly when more than one is present at the same time.

The indicators may apply to UK nationals and/or migrant children and young people and to both boys and girls. Practitioners should keep them in mind when working with children and young people and making an initial assessment. The indicators do not replace child protection investigations and the presence, or otherwise, of trafficking suspicions should not preclude the standard child protection procedure being implemented.

Legal Issues

Secondly, child trafficking raises important legal issues that require the involvement of specific agencies within the UK. As a signatory to The Council of Europe Convention on Action Against Trafficking in Human Beings, the UK has a responsibility to implement a specific mechanism for identifying and recording cases of child trafficking.

This formal procedure, known as the National Referral Mechanism and Child Trafficking Referral Form, became operational on 1 April 2009. This is further supported by the Child Trafficking Assessment Form and Guidance for Completion. From that date, new arrangements came into force to allow all cases of human trafficking to be referred by frontline services/agencies for assessment by designated competent authorities. In the UK the competent authorities are the United Kingdom Human Trafficking Centre (UKHTC) and a linked authority within the UK Border Agency that handles cases of immigration and asylum.

What to do if you believe that a child may have been trafficked?

First of all, doing nothing is not an option! It is essential that practitioners take timely and decisive action where child trafficking is suspected because of the high risk of the child or young person being moved. Action should not be postponed until a child or young person realises, agrees or divulges that they have been trafficked. Often, children and young people are threatened with punishment if they speak. Also they may not be aware that they are victims of child trafficking.
Any practitioner who believes that a child or young person they are in contact with is or may have been trafficked they should, in the first instance, contact the social work department or Stornoway police

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<td>Stornoway Police</td>
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They will be able to advise you on what further action should be taken. Do not seek consent from the child or young person's parents and/or carers, given the attendant level of risk for trafficked children. If after enquiry it is considered that the child has been trafficked there will be a referral made to the Competent Authority (the UK Human Trafficking Centre or UK Border Agency). If not, further discussion will decide if there are any child care and/or protection concerns be addressed under existing child care and/or protection procedures.
Honour-Based Violence and Forced Marriage

A Forced Marriage is defined as a marriage conducted without the full and free consent of both parties and where duress is a factor. Duress can include physical, psychological, financial, sexual and emotional pressure. A clear distinction must be made between a forced marriage and an arranged marriage.

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

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

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

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

**Health Indicators**
- Self-harm;
- Attempted suicide;
- Eating Disorders;
- Depression;
- Accompanied to doctors or clinics and prevented from speaking to health practitioner in confidence; and
- Female genital mutilation.

**Police Related Indicators**
- Reports of domestic abuse, harassment or Breaches of the Peace at the family home;
- Threats to kill and attempts to kill or harm; and
• Truancy or persistent absence from school.

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

Cases of forced marriage may initially be reported to social work services as cases of domestic abuse. Spouses forced into marriage may suffer domestic abuse but feel unable to leave due to a lack of family support, economic pressures and other social circumstances. In some cases, they may fear having their own children taken away from them.

In all cases, practitioners should discuss the range of options available to the child or young person and the possible consequences. A spouse who is the victim of a forced marriage can initiate nullity or divorce proceedings to end the marriage, but should be made aware that a religious divorce will not end the marriage under UK law.

Further information can also be found at:-

Home Office/Foreign and Commonwealth Office Force Marriage Unit

Forced Marriage (Civil Protection) Act 2007

Forced Marriage: A Wrong not a Right

Forced Marriage: A Civil Remedy
Communications Strategy

The Outer Hebrides Child Protection Committee (CPC) is the primary strategic planning mechanism for inter-agency child protection work in the Western Isles. It is a forum for senior managers and professionals from social work, police, health, education, scottish children’s reporters administration (SCRA), children’s panel, procurator fiscal service and the voluntary sector to achieve the task of developing, monitoring and reviewing child protection policies and practice throughout the Western Isles. It has devised a communication strategy in order to most effectively discharge its responsibilities.

It includes the following elements:

- Raising awareness of child protection issues within communities, including children and young people;
- Promoting the work of agencies in protecting children to the public at large; and
- Providing information on where the public will go if they have concerns about a child, and what could happen.

The strategy is for everyone, as it is everyone’s responsibility to ensure that children are protected from harm. In particular it is aimed at:

- **Public** – parents and carers; children and young people; community groups; general public; media.
- **Agencies** – health; police; social work; education; housing; children’s panel; legal services; voluntary service; independent education providers; childcare providers; elected members of the local authority.
- **Service users** – currently involved and those previously involved.
- **National links** – other CPC’s, Scottish Government; partner local authorities.

The main objectives of this communication strategy are to:

- Communicate relevant, clear, accurate and timely information.
- Develop and maintain the awareness and understanding of the role and functions of the Western Isles CPC.
- Ensure that customers are involved in the implementation process and that communication is a two way process.

**CPC Key Messages**

1. To raise awareness of the CPC in the community and to improve understanding of child protection work.
2. To provide clear and relevant information, where appropriate, on child protection processes.
3. To ensure that children, young people and adults have information on how to access support relating to child protection matters.
4. To enhance communication processes relating to child protection between partner agencies as represented on the CPC.
5. To ensure the CPC maintains effective links with both national and local developments relating to child protection.
Roles and Responsibilities

Part II of the National Guidance for Child Protection in Scotland 2014 sets out, in considerable detail, the roles and responsibilities of Chief Officer Groups, Child Protection Committees, other partnerships and single service and/or agencies.

Within this part of the guidelines, practitioners will find key information on the roles, responsibilities and membership of local child protection partnerships and services within the Western Isles context.

Partnerships

Chief Officers Group (COG)

The Chief Officers of the public, private and third sectors discharge their individual and collective responsibility for child protection services by way of the Chief Officers Group (COG). The partnership provides strong leadership, direction and scrutiny of child protection services and promotes the need for continuous improvement.

The COG meets regularly and continues to scrutinise, support and challenge the work of the CPC, calling for regular reports, inputs and updates. Membership of the COG includes senior representation from Comhairle nan Eilean Siar, NHS Western Isles and Western Isles CHP, Police Scotland, Crown Office and Procurators Fiscal Service, SCRA and the Third Sector. Comhairle nan Eilean Siar representation includes senior managers from the wider children’s services, adult services, housing and community care services and from cultural and community services. The COG meets at least quarterly.

Child Protection Committee (CPC)

The Child Protection Committee oversees the design, development, publication, distribution, implementation, embedding and evaluation of all child protection policy and practice developments across Western Isles. The CPC is fully compliant with the policy requirements specified in Part II of the National Guidance for Child Protection in Scotland 2014. The CPC meets every two months and its Membership is fully representative of the public, private, third sector and independent sectors across Western Isles.

Alcohol and Drug Partnership (ADP)

The Alcohol and Drug Partnership (ADP) supports the work of the Child Protection Committee and other partner organisations which are involved in child protection. Part of the Community Planning Partnership, its membership includes representation from the public, private and third sectors. The ADP meets every two months.
**Adult Protection Committee (APC)**

The Adult Protection Committee (APC) supports the work of the Child Protection Committee and is committed to ensuring that adults at risk in Western Isles are protected from harm. It has a significant role in ensuring co-operation and communication within and between agencies to promote appropriate support and protection as set out in section 42 (2) of the Adult Support and Protection (Scotland) Act 2007.

Its membership includes representation from the public, private and third sectors across Western Isles. The APC meets every two months.

**Domestic Abuse Forum**

The Domestic Abuse Forum is a multi-agency partnership which includes membership from key partners from the public, private and third sectors across Western Isles. The partnership supports the work of the Child Protection Committee and works at a local level to promote and coordinate a range of activity, aimed at raising awareness and addressing the many issues arising from violence against women. The partnership works to implement Scottish Government strategies and initiatives at a local level.

**Comhairle nan Eilean Siar**

*Comhairle nan Eilean Siar* is responsible for the delivery of public services across the 150 mile long island chain lying to the north west of Scotland’s mainland. The population is around 26,000 with 20% under the age of 18 years. Most of the population live on Lewis with around 12,000 living in the Stornoway area. The main islands are Lewis and Harris in the north and Uist and Barra in the south.

*Comhairle nan Eilean Siar Headquarters* is located in Stornoway.

**Children and Families**

Most families experience difficulties and stress at some point in their lives. For some, help and support given at the right time can make all the difference. We provide a range of services to support children, young people and their families. The Children and Families Team for Lewis and Harris is based in the Council Offices, Sandwick Road, Stornoway. The Children and Families Team for Uist and Barra is based in the Council Offices, Balivanich, Benbecula.

Teams provide a service to the Children Hearing System. They provide a service to vulnerable children and their families. Staff also offer a preventative service and crisis support to children and families.

The Family Placement Team offers respite care, fostering and adoption services throughout the Western isles. This service offers assessment for potential carers and adopters and ongoing support for approved Foster Parents and in certain circumstances, adoptive carers.
If you would like a leaflet on ‘How to Become a Foster Carer’, please contact the Team on 01851 822742.

The Children and Families Team is responsible for Child Protection enquiries and investigation and follow up involvement as required. All the Social Workers within the Children and Families Team work together with other professionals to protect children who are or may be at risk of harm. Concerns can also be reported anonymously to CRIMESTOPPERS on 0800 555 111.

Anyone wishing further information or initial advice and assistance can contact Children’s Services at the Council Offices and speak to the Duty Social Worker at any time between 9.00am and 5.00pm, Monday to Friday. Guidance and assistance can be sought either in person or by phone. No appointment is necessary.

**Education and Children’s Services** delivers an integrated approach to Children and Families’ Services across Western Isles. **Education and Children’s Services** aims to provide improved outcomes for communities in Western Isles by way of the following five main areas:-

- education;
- social work services for children and families;
- community, cultural and active recreation services;
- support services across Western Isles; and
- IT services for ECS and across the organisation.

Children, young people and their families, communities and children and families in need receive services directly in different ways for example through schools, community centres, residential homes and library and museum facilities. They also work with other providers, agencies and services to meet the needs of those who use these services.

The service works to keep people safe and protected, to improve their health and wellbeing, to develop the range and quality of learning experiences for everyone, to raise standards of performance and achievement, and to develop both active and responsible citizens along with caring and confident communities.

**Education Service**

Teachers and all other education staff have a crucial role to play in the care and welfare of children and young people, along with the promotion of their personal safety and well being. Teachers and staff in all educational establishments have a key role in creating physically and emotionally safe environments where children and young people can feel safe and secure.

Teachers are likely to have the greatest level of day-to-day contact with children and young people, so are well placed to observe physical and psychological changes in a child or young person that could indicate abuse and to contribute to the assessment of vulnerable children. Children and young people often see teachers as a trusted source of help and support.
Across Western Isles, each school has a designated Child Protection Officer, who has undergone specific child protection training in relation to this role. This person is responsible for giving child protection advise/support to staff, pupils and parents and/or carers within the school. They have a crucial role in liaising with other service/agencies when appropriate.

Through the Curriculum for Excellence, education practitioners have an important role in equipping children with the knowledge, skills and understanding they need to keep themselves and others safe. This could include offering advice and guidance on issues such as drugs, alcohol, using e-technology and bullying.

The service is committed to the principle of protecting a child’s right to be brought up in the safety and security by his/her birth family. However the welfare and safety of the child is always the paramount consideration, therefore, in certain circumstances the child or young person may be removed from their parent’s care.

Under The Children (Scotland) Act 1995, Children’s & Families Social Work Services have a statutory responsibility to enquire into the circumstances of children and young people who may require compulsory measures of supervision, who may have been abused or at risk of being abused and to take appropriate measures to protect them from further harm. Social Work will also act as the lead service for the Local Authority in the application for and implementation of the Orders introduced by The Children (Scotland) Act 1995 relating to child protection. Social Work also provides therapeutic services to children, young people and families affected by trauma or abuse.

**Early Years Services**

Early Years Service Staff within Comhairle Nan Eilean Siar’s, Education and Children’s Services Department take forward the targets set within the Western Isles Early Years and Early Intervention Strategy and support the work of the Early Years Partnership. In addition, early year’s staff supports pre-school and childcare providers throughout the islands.

The range of support includes:

- Childcare Information Service.
- Early Years, Childcare and Sure Start Grant.
- Pre-school Education.
- Training.
- Early Intervention.
- Support for Children with ASN.

**Community Care and Criminal Justice**

Scottish local authorities have a legal duty to provide criminal justice social work services. The Scottish Government funds these services through a specific grant annually awarded to local authorities who must work to specific National Standards and Objectives.
The criminal justice team works with offenders to reduce re-offending by:

- Assessing and managing the risk that a person might pose to the community
- Addressing their offending behaviour
- Working on problems that might be connected to offending behaviour

Services available to people involved with Criminal Justice are:

- Advice, information & assistance to courts, offenders & families
- Diversion from Prosecution Scheme
- Probation Order supervision
- Community Service supervision
- Attendance Order supervision
- Fine supervision
- Services to prisoners & families
- Parole supervision
- Risk assessment
- Victim support

Comhairle nan Eilean Siar criminal justice service works in partnership with other local authorities, statutory services and voluntary organisations as a member of Northern Community Justice Authority (CJA).

Community Justice Authorities were set up by the Scottish Government to ensure that a range of statutory and voluntary agencies work together to provide services that are aimed at reducing re-offending rates. The work done by the criminal justice team is set out in the law, in government guidelines and in the National Objectives and Standards for Social Work Services in the Criminal Justice System.

Criminal Justice Services also have responsibilities for the supervision and management of risk relating to adults who have committed offences against children and young people, as well as other high-risk offences. Criminal Justice staff may be directly involved in risk assessment, supervision and intervention with adult offenders against children and young people. Alternatively, through the course of their involvement with other service users, concerns about a child’s welfare may come to light – for example, in cases of domestic abuse or alcohol and/or drug misuse.

**Housing Service**

The Local Authority and Registered Social Landlords (RSLs – Housing Associations) can make an important contribution to meeting the health and welfare needs of children and young people, particularly those who need safeguarding from harm. The Housing (Scotland) Act 1987 (as amended) sets out the local authority’s statutory duties as they apply to the housing of homeless families with children and to young people. Legislation governing the allocation of housing is found in The Housing (Scotland) Act 2001 which applies equally to both the Local Authority Council and RSLs.
The Comhairle’s Housing Services Team are responsible for production of the Local Housing Strategy; Private Sector Housing Scheme of Assistance; Homelessness; and general information and advice about housing issues.

Comhairle nan Eilean Siar no longer has council houses. Following a successful tenants ballot, all council housing stock was transferred in September 2006 to a local housing association, namely the Hebridean Housing Partnership.

**Police Scotland**

The Western Isles Area Command comprises a group of islands off the West Coast of Scotland, stretching from the Butt of Lewis in the North, to Vatersay in the South. The area command supports a population of approximately 26,500 residents.

The Western Isles has the reputation of being a relatively crime-free community, enjoying one of the highest detection rates and the lowest crime rates in Scotland. However, there are challenges in policing the islands - evident in the geographical layout of the area, which is scattered and made up of a large percentage of isolated rural townships.

The Area Command Headquarters is based in Stornoway – the largest settlement and administrative capital of the islands – with other police offices located at Tarbert, Lochmaddy, Balivanich, Lochboisdale and Castlebay.

Police Scotland is committed to a policy of co-operation with other agencies involved in the care and protection of children and young people to ensure that all investigations are carried out in a sensitive, sympathetic and child-centred manner. The responsibility to ensure the care and protection of children and young people lies with all police officers. A co-ordinated response will be based on consultation and information sharing and, where necessary, will involve joint investigative interviews by a specially trained Police Officer and a Social Worker, as part of a multi-disciplinary assessment approach. In an emergency, initial attendance may involve Uniformed and/or Detective Officers.

The primary role of the police in relation to responding to information which highlights that a child or young person may be at harm, is to ascertain whether a criminal act has been committed and if so to investigate and report the matter to the Procurator Fiscal.

There is a clear distinction between the investigative role of the Police and any decision to prosecute individuals, which is the remit of the Procurator Fiscal. Police involvement does not automatically result in an alleged offender being prosecuted. Similarly, the police are obliged, where they have reasonable cause to believe that compulsory measures of supervision may be necessary, to refer a child to the Children’s Reporter.

Whenever there is a suspicion that a crime or offence has been committed against a child or young person, the Police should be informed immediately so that if appropriate, an investigation can be commenced, witnesses interviewed and evidence secured without delay. Delays in the forensic recovery of potential evidence could be critical, as could any delay in photographing injuries.
In consultation with other key staff involved in the child’s welfare the investigating Police Officers will ensure that any medical examination which may be required for evidential purposes is properly co-ordinated to coincide as far as possible with examinations by a specialist paediatrician. In some instances it may be necessary to arrange a joint paediatric/forensic examination.

In an emergency the police have the specific power under the Children’s Hearings (Scotland) 2011 to ensure the immediate protection of children believed to be suffering from, or at risk of, significant harm, commonly referred to as ‘Police Emergency Powers’.

When a Child Protection Case Conference is called in respect of a child who has been the subject of investigation the Police Officer or a Police representative will attend to contribute to the decision making process. The Police have emergency powers under section 61(5) of The Children (Scotland) Act 1995 to ensure the immediate protection of children and young people believed to suffering from, or at risk, of significant harm.

In order to fulfil their responsibilities the police may:-

- assist in education and awareness programmes;
- liaise with partner agencies;
- investigate allegations of crime;
- gather evidence;
- attend case discussions and/or case conferences;
- carry out joint investigative interviews;
- make joint enquiries with social work services;
- discuss the need to arrange medical examinations as necessary;
- interview suspects;
- detect offenders;
- utilise emergency powers where appropriate and necessary; and
- attend court or children’s hearings to give evidence.

Specialist public protection units

Every local policing division across Scotland has a dedicated Public Protection Unit staffed by specialist officers. The police are responsible for investigation and for gathering evidence in criminal investigations. This task may be carried out in conjunction with other agencies, including social work services and medical practitioners, but the police are ultimately accountable for conducting criminal enquiries.

The police hold important information about children who may be at risk of harm or significant harm, as well as about those who cause such harm. They will share this information and intelligence with other organisations when required to protect children or help other agencies carry out early intervention in response to concerns about wellbeing. Where appropriate, the police should attend and contribute to Child Protection Case Conferences. However, police are unlikely to play an active role in the core group responsible for developing the ‘Child Protection Plan’, unless their involvement is crucial to the successful implementation of the plan.
Police also liaise with a number of adult services where investigations dealing with adults may impact on children. For example, they may liaise with social services on issues such as youth justice, adult protection, children affected by parental problematic alcohol and/or drug use, anti-social behaviour, domestic abuse and offender management.

Following a risk assessment, there is a range of circumstances in which the police may consider that the need to protect children and vulnerable adults will not be met by disclosing such information to the local authority or other agencies alone. Any decision to disclose to further third parties is made carefully on a case-by-case basis, in consultation with any other relevant agencies and taking into account a wide range of factors.

**MAPPA (Multi – Agency Public Protection Arrangements)**

The Management of Offenders etc (Scotland) Act 2005, sections 10 and 11, place a statutory duty on Local Authorities, Police, Health and the Scottish Prison Service (known as the Responsible Authorities) to jointly establish arrangements for the assessment and management of risk to the public posed by sex offenders, violent offenders and those whose conviction leads the Responsible Authority to believe that they pose a significant risk of harm.

The MAPPA guidance provides the framework under which MAPPA operate, identifying three separate but connected levels at which risk is assessed and managed. This structure of risk management is intended to enable resources to be deployed so that identified risk can be managed in the most efficient and effective manner.

The levels are:-

1. **Level 1** - Routine Risk Management;
2. **Level 2** - Multi-Agency Risk Management; and
3. **Level 3** - MAPPP – Multi-Agency Public Protection Panels

Whilst there may be a correlation between level of risk and level of MAPPA management (the higher the risk the higher the level), the levels of risk do not equate exactly to the levels of MAPPA management. MAPPA acknowledges the complexity of significant re-offending behaviour and provides a mechanism for the responsible authorities to work together to develop and implement a co-ordinated risk management plan.

The current version of the MAPPA guidance can be found on the Scottish Government website

[http://www.scotland.gov.uk/publications/2012/01/12094716/1](http://www.scotland.gov.uk/publications/2012/01/12094716/1)

The multi-agency approach to assessing and managing offenders who may pose a risk of harm to the community is well established within Western Isles. A key success of the Western Isles MAPPA is the continued joint working of the Criminal Justice Services, Child Care Services, Public Protection Teams and the Offender Management Teams of Police Scotland.
This allows for all initial information to be exchanged in all cases, identifying those that can be effectively managed at Level 1 (which is the vast majority of the offenders) and also identifying those requiring either Level 2 or Level 3 management. The majority of these offenders pose a risk to children and young people and as part of risk assessment procedures, the MAPPA will regularly instigate measures to safeguard children. Members of MAPPA also attend the CPC to strengthen links.

**NHS Western Isles**

NHS Western Isles provides health services for children throughout the Western Isles area and places child protection as a high priority throughout the organisation and all staff are expected to be aware of their responsibilities in identifying and sharing concerns about a child's care or protection.

All NHS staff are expected to complete mandatory child protection training and act in accordance with current Outer Hebrides Child Protection Committee Inter-agency Guidelines.

NHS Western Isles has a Lead Clinician Child Protection and full time Senior Nurse Child Protection who are able to offer support and advice to all staff.

Further information with additional resources is available on the NHS Western Isles Intranet or [www.childprotectionsupport.org](http://www.childprotectionsupport.org)
Maternity Services

Maternity services, and midwives in particular, have a significant role in identifying risk factors to a child during pregnancy, birth and in the post-natal period, both in the hospital and the community.

Midwives, obstetricians and maternity services staff should be alert to risk factors for the mother and the infant including, but not limited to, alcohol and/or drug misuse, domestic abuse and mental health problems such as post-natal depression.

Midwives can assess the attachment of infants to their carers and offer early intervention and support to expectant and new parents.

They have a crucial role in pre-birth case conferences and planning meetings.
See NHS Western Isles Child Protection: Unborn Child Policy.

Community Nursing Services for Children (Health Visitors / Public Health Nurses)

Health visitors and public health nurses play a key role in the prevention and early identification of child protection and care concerns. After the midwife’s post-natal care ends, a health visitor/public health nurse will become a child's Named Person (or, in some cases, their Lead Professional), normally until the child starts full-time primary education.

Health visitors and public health nurses provide a consistent, knowledgeable and skilled point of contact for families, assessing children’s development and planning with parents and carers to ensure their needs are met.

As a universal service, they are often the first to be aware that families are experiencing difficulties in looking after their children and can play a crucial role in providing support.

The public health nurses for schools can contribute to prevention and early detection of child abuse through a range of health promotion activities. These include: working with teachers on personal, social and health education; monitoring the health of the school population; liaising effectively with teachers and other practitioners; and profiling the health of the school population so that nursing services can be targeted where they are needed most. They should always be alerted and, where appropriate, involved to ensure the child's health needs are fully identified and met.

Health Visitor / public health nurse for the child would be expected to participate fully in any interagency planning or case conferences.

General Practitioners and the Primary Care Team

The role of the general practitioner (GP) and the practice team in child protection can be critical in detecting potential concerns being in a unique position caring both for an adult who may pose a risk to the child and for the child who is at risk, and have a duty of care to both. As the primary care provider, a GP may also be able to give valuable insights into a child or
young person’s family as part of child protection procedures.

Their role includes prevention, early recognition and detection of concerns, assessment and ongoing care and treatment. Surgery consultations, home visits, treatment room sessions, child health clinic attendance, drop-in centres and information from staff such as health visitors/public health nurses, midwives, school nurses and practice nurses will all help to build up a picture of the child's situation and highlight any areas of concern.

GPs can provide direct support to children and their families and contribute to the Child's Plan and specifically, the Child Protection Case Conference and/or the Child Protection Plan. GPs and practices must have protocols in place for engaging with other services where child protection concerns arise.

The GMC has produced specific guidance Protecting children and young people: responsibilities for all doctors which is also available as a Short Guide for GPs including advice on identifying children and young people at risk of, or suffering, abuse or neglect, communication and support, information sharing and confidentiality and advice on working together including a need to understand the roles of other agencies.

If asked to take part in child protection procedures a GP must co-operate fully. This should include going to child protection conferences, strategy meetings and case reviews to provide information and an opinion.

**Paediatricians**

Paediatricians working in hospitals or in the community will come into contact with child abuse in the course of their work. All paediatricians have a duty to identify child abuse and neglect and must therefore maintain their skills in this area and make sure they are familiar with the procedures to be followed where abuse or neglect is suspected.

Consultant paediatricians, in particular, will be involved in difficult diagnostic situations, where they must differentiate abnormalities resulting from abuse from those with a medical cause. Along with forensic medical examiners, paediatricians with further training will be involved in specialist examinations of children suspected of abuse or neglect.

**Allied Health Professionals and Staff Working Directly with Children**

AHPs frequently provide specialised care for children many of whom are vulnerable or at risk and have an active role in both identifying concerns and monitoring progress. Any concerns must be passed on appropriately and/or discussed with lead professionals.

**Dental Care Practitioners**

Dental care practitioners will often come into contact with vulnerable children and are in a position to identify possible child abuse or neglect from examinations of injuries or oral hygiene.

The dental team should have the knowledge and skills to identify concerns regarding a child's welfare and know how and with whom to share that information.
Community Pharmacy Services

Community pharmacists, pharmacy technicians and pharmacy support staff regularly deal with children and parents/carers including those in 'at risk' groups such as children of drug misusers in the course of their day to day practice. As such, they have an important role to play in identifying whether a child is at risk of abuse.

Accident and Emergency Services

Accident and emergency staff may be the first point of contact in cases of suspected or actual child abuse and neglect. This may include scenarios where adult carers are presenting with an injury/health problem.

Carers may seek medical care from a number of sources in order to conceal the fact that a child is being injured regularly. Similarly, staff may notice a child or young person presenting themselves repeatedly, even with slight injuries, in a way that they find worrying. This may include signs of self-harming or of alcohol and/or drug misuse.

All staff should be aware of arrangements for reporting concerns and how to access advice where required from designated professionals.

Adult Healthcare Providers

All health staff, including those providing services to adults, have a duty of care to children and young people.

When you care for an adult patient, that patient may be your first concern, but you must also consider whether your patient poses a risk to children or young people.

You should look out for signs that a family may need extra support, and provide such support if that is part of your role, or refer the family to other health or local authority children's services so they can get appropriate help.

You must act on any concerns you have about a child or young person who may be at risk of, or suffering, abuse or neglect. If in doubt, you should ask for advice from the senior nurse child protection or the lead clinician.

Mental Health Services

Child and adolescent mental health services (CAMHS) may become aware of children and young people who have experienced, or are at risk of, abuse and/or neglect.

CAMHS staff can help implement Child Protection Plans, providing both assessments and therapeutic support to help children recover from the impact of abuse or neglect, build resilience and develop helpful strategies for the future.
In some cases, adults and older young people may disclose abuse experienced some time ago. Even if they are no longer in the abusive situation, a crime may still have been committed and other children may still be at risk.

Health practitioners working with adults with mental health problems should always be aware of how those problems might impact on any children in the family. Where they have concerns - for example regarding domestic abuse, drug and/or alcohol misuse - they should liaise with colleagues in children's services.

If mental health practitioners are concerned that a patient’s mental state could put children at risk of immediate or significant harm, they must take action in line with local procedures.

**Addiction Services**

Addiction services have an important role to play in the protection of children including the ongoing assessment and monitoring of risk of adults' behaviour, sharing information and participating in core groups and other planning meetings.

All addiction staff should identify where children are living in the same household as and/or are being cared for by adults with alcohol and/or drug use problems.

Consideration should then be given to how the alcohol and/or drug misuse of the parent or carer impacts on the child, in conjunction with children and family services.

See Outer Hebrides CPC Interagency Guidelines on [Children affected by Parental Drug or Alcohol Related Problems](#)

**Scottish Fire and Rescue Service**

It is not the Scottish Fire and Rescue Service’s responsibility to investigate concerns regarding child protection, but to ensure that information is passed to the relevant services. If the child is in imminent risk i.e. a threat to life or where there may have been criminality, the Police will be informed without delay.

**Legal Framework**

**Scottish Children's Reporter Administration (SCRA)**

**The Children's Reporter and the Children's Hearing System**

The Children's Hearings System is the care and justice system for Scotland’s children. It is a unique system which upholds the welfare and rights of children, while ensuring that targeted assistance is provided to those in need of compulsory measures to ensure their care, protection and appropriate behaviour.
Children’s Reporters are the independent officials who act as gatekeepers to the system in each local authority, acting on the authority of the Principal Reporter of the Scottish Children’s Reporter Administration (SCRA).

Children’s Reporters receive referrals from a number of sources (such as social services, the police, and parents) as a result of a variety of serious concerns. The Reporter investigates each referral to decide if the child should be brought before a Children’s Hearing. That investigation is focussed on:

- whether the child requires compulsory measures of intervention – a supervision requirement, with or without conditions; and
- whether there is evidence to establish a formal Ground for Referral to a Children’s Hearing.

Compulsory measures are required when parents/carers or the child are unable or unwilling to engage with services sufficiently to address the risks and needs for that child, or where concerns about a child’s welfare or behaviour cannot be addressed on a voluntary basis.

The formal Grounds for Referral to a Children’s Hearing include the following - that the child:

- suffers from a lack of parental care;
- is beyond the control of their parent;
- is falling into ‘bad associations’ or is exposed to ‘moral danger’;
- has committed a criminal offence;
- has abused alcohol, solvents or drugs;
- has failed to attend school without reasonable excuse
- has been the victim of an offence such as assault, neglect, or sexual abuse
- or is in the same household as a child who has been the victim of an offence such as assault, neglect, or sexual abuse.

To assist the Reporter in reaching a decision, he or she will seek information about the child from various agencies.

If the Reporter decides that compulsory measures are necessary, and that there is evidence to establish a formal Ground for Referral, the child will be referred to a Children’s Hearing. Each Hearing comprises three Panel Members, who are all trained volunteers from the local community.

The Children’s Hearing makes the final decision about whether compulsory measures are required. It has a wide range of powers available to it, over and above imposing a supervision requirement if appropriate. Decisions can range from a placement at home with input from various services, through to a condition placing a child in secure accommodation. These powers are designed to ensure that the child is protected, that the child’s best interests are met and that any concerns about behaviour are addressed.

The Reporter drafts the Grounds for Referral for a Hearing, invites relevant parties, and makes sure that necessary information and reports have been provided so that the Hearing can make an informed decision. In cases where the Grounds for Referral are disputed by a Relevant Person (parent/carer) or a child, the Children’s Reporter is responsible for leading
the necessary evidence to establish those Grounds before a Sheriff at a Proof Hearing. The Reporter is responsible for identifying potential witnesses.

It is not SCRA practice to have children as witnesses unless absolutely necessary, so more likely that witnesses are drawn from professionals working with the child and family. Relevant Persons and children also have the right to appeal against decisions made by a Children’s Hearing, and the Reporter is responsible for conducting those appeal proceedings before the Sheriff.

Reporters can also deal with referrals in other ways that do not require referral to a Children’s Hearing, for example by referring the child to the Local Authority for Advice, Assistance and Guidance, with the child and parents/carers engaging on a voluntary basis with services.

The legal frameworks for the Reporter and the Procurator Fiscal are different in cases where there are child protection concerns. In considering a referral alleging abuse or neglect or a lack of parental care, the Reporter needs to be satisfied that there is sufficient evidence to establish it on the balance of probabilities - the standard of proof used in civil proceedings. That is the standard the Sheriff will apply in any Proof proceedings, if the Grounds for Referral put to a Children's Hearing are challenged.

The Procurator Fiscal will need a higher standard of proof in criminal proceedings against someone charged with an offence – the offence needs to be established beyond a reasonable doubt.

The Reporter is also more able to rely upon hearsay evidence (for example, a carer’s account of a conversation with a child) than is the Procurator Fiscal. Critically, the Reporter may be able to establish Grounds for Referral in Proof proceedings without having to call a vulnerable child witness. This is only likely to be the case when any interview with that child witness, and any supporting evidence, is of a high standard.

The Reporter will often take action to protect a child in cases where it is not appropriate for the Procurator Fiscal to bring criminal proceedings. It is important that practitioners are aware of these differences when they are investigating cases and providing information to the Reporter or the Procurator Fiscal. Good evidence is required in both cases, but the Reporter may be able to establish a case and protect a child with evidence that would be insufficient in criminal proceedings.

These distinctions between criminal proceedings and Children's Hearing Proof proceedings do not apply in cases where the Ground for Referral is an offence committed by the child referred. The offence needs to be established beyond a reasonable doubt in both systems.

**Procurator Fiscal**

The [Crown Office and Procurator Fiscal Service (COPFS)](https://www.cps.gov.uk) is responsible for the day-to-day prosecution of crimes/offences in Scotland. The Procurator Fiscal is the local independent public prosecutor who receives and considers reports of crimes and offences from the police, and other agencies and decides whether or not to take criminal proceedings in the public interest.
The Procurator Fiscal, as the Lord Advocate’s local representative, has the duty to investigate the circumstances of any crime/offence or suspected crime/offence brought to his or her attention. He or she acts in the public interest and decides whether to bring criminal proceedings. Where proceedings have started, the Procurator Fiscal may precognose (interview) witnesses.

Child protection encompasses effective investigation and prosecution of offences against children and young people. Decisions regarding criminal proceedings against adults or children/young people are taken by the Procurator Fiscal in the public interest, which includes, but is not restricted to, the interests of the child or young person as a witness or accused.

The gravity of the alleged offence and protection of the public are matters which required to be weighed, but in all actions concerning children/young people, the Procurator Fiscal will have regard to Article 3 of the United Nations Convention on the Rights of the Child which provides that the best interest of the child will be a primary consideration.

It is likely that a Procurator Fiscal or Precognition Officer will interview a child witness in advance of any prosecution, particularly a more serious offence which is liable to take place before a jury. This interview is known as a precognition. Its purpose is to establish what evidence the child or young person is able to give and to assess whether the child or young person is capable of giving evidence in court.

Under The Vulnerable Witnesses (Scotland) Act 2004, witnesses under the age of 16 are regarded as ‘vulnerable’ and have the right to give evidence by the use of standard special measure(s). The degree of vulnerability will determine which special measure(s) are most appropriate to use. For all children and young people under the age of 16, the party citing the witness must complete a ‘child witness notice’ notifying the court of the use of standard special measures or request to use any of the other special measure(s).

Standard special measures that child witnesses under the age of 16 have a right to use are:-

(i) a live television link where the witness is in another part of the court building;
(ii) a screen; and
(iii) a supporter in conjunction with either (i) or (ii) above

The full list of other special measures available on application (available to both child and vulnerable adult witnesses as defined in the Act) are:-

(i) a live television link from another part of the court building or other place outwith that building;
(ii) prior statement as evidence in chief (criminal cases only);
(iii) taking evidence on commission;
(iv) a screen; and
(v) use of a supporter.
The provision of these special measures aims to maximise the quality of evidence provided, in terms of its completeness, coherence and accuracy, in that vulnerable witnesses will be better supported to give their evidence with the involvement of the COPFS - VIA (Victim Information and Advice) service in all cases involving child witnesses and the SCS witness services at all Sheriff and High courts in line with local arrangements. In cases of particular delicacy or doubt the Procurator Fiscal is available for discussion with other professionals.

Third Sector

Working in Partnership

A new partnership of Third Sector intermediaries in the Western Isles has been signed and has been approved by the Outer Hebrides Community Planning Partnership. The five Partners, Voluntary Action Barra and Vatersay, Harris Voluntary Service, Volunteering Hebrides, Volunteer Centre Western Isles and Outer Hebrides Social Economy Partnership have come together as Co-cheangal Innse Gall (Linking the Outer Hebrides) to support and develop the Third Sector in the Outer Hebrides.

The Partnership will now work together strategically to deliver the four main objectives of the agreement throughout the Outer Hebrides, i.e.

- Develop volunteering
- Develop Social Enterprise
- Support and develop a strong third sector
- Build the third sector relationship with community planning

The individual partners will retain their independence and will continue to deliver the services they currently provide, but will be able to do so more efficiently, by avoiding duplication and being able to call on each other’s areas of expertise.

Every year they help many local people enjoy a better quality of life, including adults with mental ill health or limited mobility and young and adult carers. As a partnership the five organisations have to respond to changing community needs and embrace new ideas. They endeavour to promote volunteering and citizenship and aim to ensure that those that they support, particularly our young people, have every chance to succeed in life.

In communicating widely through established statutory and third sector networks, this partnership will continue to raise awareness of child protection policy and practice developments for those involved in delivering services directly to children and young people and also to those whose interest is secondary to their main role. The partnership will promote child protection training opportunities which are provided locally and render them available to the wider sector, which in turn will help develop skills and knowledge of child protection across the Western Isles.
Action for Children

Action for Children has been providing a range of child and family support services in Lewis & Harris since February 1998. They provide a residential facility for vulnerable children.

Action for Children also provide Early Years and Early Intervention parenting sessions for families affected by substance misuse and delivers the Positive Parenting Programme “Triple P” for parents of children who have, or are at risk of developing, behavioural problems.

They also provide an After Care support service and operate an Assessment and Therapy Unit. Their range of services also includes a Respite Care provision and a Saturday Club for children with special needs.

Additionally Action for Children also provides a Sure Start service offering support to parents of 0-4 yrs children and advice and practical support. A further service is offered by Children & Families Support Service (C & FSS) which offers support and advice to parents, children and young people (5yrs-21yrs) free of charge.

In the interests of protecting children and young people, each Third Sector organisation should have a clear Child Protection Policy in place. This policy should clearly state that if any concern in relation to the safety or well being of a child or young person is raised, the Social Work Service or the Police should be contacted as soon as possible.

Western Isles’ statutory services/agencies work in partnership with the voluntary sector, in order to promote good practice, share professional issues and engage in cross sector training.

GIRFEC – Wellbeing Definitions and Indicators

Safe

Every child or young person has the right to be safe and protected and to feel safe and protected from any avoidable situation or acts of commission or omission by others which might result in that child:

- being physically, sexually or emotionally harmed in any way;
- put at risk of physical, sexual or emotional harm, abuse or exploitation;
- having their basic needs neglected or experiencing that their needs are met in ways that are not appropriate to their age and stage of development;
- being denied the sustained support and care necessary for them to thrive and develop normally;
- being denied access to appropriate medical care and treatment;
- being exposed to demands and expectations which are inappropriate to their age and stage of development.
Any child or young person also needs to be helped to develop the knowledge and skills that will enable them to adopt safe practices in situations at home, at school or in the community where they may be at risk of significant harm. In other words being safe is also a positive state of being and not just the absence of harm and neglect.

Finally, being safe is also a positive state of mind. The child or young person is not only objectively safe (the risk of significant harm has been removed or considerably reduced) but also feels secure and protected within trusted relationships where adults are not only acting in the child’s best interests but also listening to the child or young person and taking account of their views, preferences and feelings.

While age and stage of development may be a factor in determining the kinds of risks to which the child or young person is likely to be exposed, the sub-domains are essentially the same for all children and young people regardless of age.

The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

<table>
<thead>
<tr>
<th>Safe</th>
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<tbody>
<tr>
<td><strong>The child or young person:</strong></td>
</tr>
<tr>
<td>• is free of exposure to physical abuse and violence within the home or the threat of it (i.e. hitting, shaking, kicking, throwing, scalding).</td>
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<tr>
<td>• is not at risk because of avoidable physical dangers and health hazards within the home.</td>
</tr>
<tr>
<td>• is not at risk because of avoidable physical dangers and health hazards outside the home.</td>
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<tr>
<td>• is free from exposure to the threat of physical or sexual abuse and violence.</td>
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<tr>
<td>• does not have a history of self harm or attempted suicide.</td>
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<td>• does not experience bullying behaviour or discrimination by peers or adults at school.</td>
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<tr>
<td>• does not experience bullying behaviour or discrimination in the local community.</td>
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<td>• is free from exposure to persistent emotional abuse within the home (i.e. is not constantly criticised, ignored, humiliated, exposed to domestic abuse within the family).</td>
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<tr>
<td>• behaves in a sexually appropriate way for their age and stage of development.</td>
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<tr>
<td>• is free from exposure to sexual abuse or exploitation (i.e. is not subjected to indecent assault, under-age or non-consensual sexual intercourse, inappropriate sexual behaviour or language, sexual grooming via the internet).</td>
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<tr>
<td>• is free from physical neglect by parents or carers (i.e. through providing adequate food, shelter and clothing, ensuring good hygiene or ensuring access to appropriate medical and dental care).</td>
</tr>
<tr>
<td>• is not left unattended when too young to properly take care of themselves.</td>
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<tr>
<td>• is not left in the care of an immature or inappropriate carer.</td>
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<tr>
<td>• emotional and developmental needs are not neglected.</td>
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<tr>
<td>• has a secure and supportive network of family members or carers and friends.</td>
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<tr>
<td>• is in regular contact with significant, supportive adults whom they trust.</td>
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• is free from exposure to serious misuse of alcohol and drugs by family members or
- others in local community.
- receives appropriate protection and guidance from parents/carers.
- is free from exposure to anti-social or criminal activity within the community.
- is not engaged in anti-social or criminal activity within the community.
- is not involved in harmful risk-taking behaviours outside the home (e.g. drugs, alcohol, inappropriate friendships).
- adopts safe practices and acts responsibly in potentially high-risk situations, *(e.g. when using tools, participating in physical contact sports and other sports involving risk of physical harm; or when confronted by substance misuse within their network of friends).*
- has good strategies for minimising risks in social situations.
- shows concern for others and is not involved in bullying or discrimination.
- feels safe at home.
- has the resilience to cope with adverse circumstances at home *(e.g. parental separation, bereavement, parent or carer with psychiatric disorder, long-term health condition or impairment).*
- feels safe when out with friends.
- does not feel pressured by others to do things which might be harmful to them or put them at risk.
- has a well-developed sense of self esteem and self respect.
- has a well-developed sense of identity and belonging.
- feels confident enough to tell a responsible adult if they have been harmed or threatened with harm.

### Healthy

Every child and young person has the right to the health care and support that will enable them to meet their developmental milestones and attain the highest possible standards of physical and mental health. Where the child or young person’s health is impaired by long-term or permanent disabilities and chronic conditions then he or she has the right to appropriate treatment, care, education, training and practical support to enable them to manage their condition, be empowered to make decisions for themselves and participate fully and effectively in school and within the community.

In the Constitution of the World Health Organisation (WHO), when it was established in 1948, health was defined as a “*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*” While the use here of the word ‘complete’ has attracted some criticism, the distinction between a positive concept of healthy well-being and the negative one of the absence of illness or impairment has become widely accepted. In 1986 the WHO reinforced this distinction with the statement that health “*is a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.*”

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Until comparatively recently health indicators for children and young people tended to focus on a limited number of sub-domains relating to health at birth and in the early years, numbers of accidental injuries, rates of suicide and self harm amongst young people, health behaviours, particularly in relation to nutrition, exercise and obesity, and risk behaviours in relation to smoking, misuse of alcohol and addictive drugs, and adolescent sexual activity. More recently a broader perspective on health has emerged. It is now increasingly common to distinguish between physical health, mental health, emotional well-being, sexual health and social health.

**Physical health:** This is when the body functions as it is meant to, and the child is free of sickness, disease, injuries, infirmities, and injuries. It is also about the child or young person having the internal defences, developed through good nutrition, exercise, hygiene and appropriate health care (e.g. immunisations), that are necessary to combat germs, bacteria and viruses and to enhance the healing process when sick or injured.

**Mental health:** The WHO defines mental health as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” As such it incorporates medical conditions as well as well-being issues relating to anxiety, low self esteem and a poorly-defined sense of identity.

**Emotional health and well-being:** children and young people who are emotionally well can manage their feelings, are motivated, are socially confident and are developing the skills for independent living.

**Sexual health:** Just as the WHO definition of health stresses the importance of positive well-being and not merely the absence of disease or infirmity so definitions of sexual health also tend to emphasize physical, emotional, mental and social well-being in relation to sexuality and not just the absence of disease, dysfunction, and risk-taking behaviour. As such, sexual health also includes a positive and respectful approach to sexuality and sexual relationships, coping with physical changes in the body and safe sexual experiences, free of coercion, discrimination and violence.

**Social health:** This aspect of health equates with being socially well-adjusted. It includes social skills, understanding social norms and mores and getting along with other children and adults. Its incorporation into consideration of children’s health partly reflects its inclusion in the World Health Organisation’s definition of health, but increasingly it also reflects the recognition by health professionals that patients who have good social functioning and are well-integrated tend to recover more quickly from illness and disease and also tend to live longer.

While these different categories of health are useful in helping to draw attention to the range of potential health outcomes for children and young people it is also clear that they are, to a large degree, inter-dependent. So, for example, the way people think and feel can cause them to be more prone to illnesses and diseases because sustained periods of stress have a negative effect on the capacity of the immune system to protect the body. Similarly,

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sustained periods of illness can lead to anxiety and depression. Recognising signs of stress and developing strategies for managing it is as important for the young person’s physical health as it is for their mental health and emotional well-being.

One of the important distinctions that needs to be made when thinking about health outcomes for children and young people, as opposed to adults, is that they are still growing. Indicators of their health need to take into account whether or not they are meeting their developmental milestones, and if not, is this a cause for concern and what might be the factors in the child’s life which may be contributing to the developmental delay? Developmental milestones are theoretical constructs reflecting statistical norms. That is, they represent the average patterns around which most children and young people will cluster. Some will reach their milestones more quickly than others. Concern only arises when the child’s development is significantly below the norm. While the sub-domains of the other Well-being Indicators are essentially the same for all children and young people regardless of age and stage of development it is clear that the health developmental milestones are age- and stage-specific.

Being healthy across these various sub-domains of children’s and young people’s health is also linked to lifestyle choices and behaviours; their hygiene practices; the exercise they take; their knowledge about the potential health risks associated with eating too much fat, salt and sugar; misuse of nicotine, alcohol and other addictive drugs, and high-risk sexual practices; and the strategies which they can employ in situations that may be potentially harmful to their health.

The child or young person needs to learn how to look after their health. As the Chief Medical Officer for Scotland has observed, “it is easier to make the effort to follow a healthy lifestyle if one sees life as worth living”. While poor social and environmental circumstances can be major contributing factors to ill-health, mental disorders and addiction, he also goes on to emphasize that if children grow up unable to make sense of their environment or find it meaningful, and have a strong sense of hopelessness and pessimism, then they will grow up with poor health.6

6 Burns, H. op.cit.
The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

**HEALTHY**

**The child or young person:**
- is not exposed as a foetus to nicotine, alcohol or drug misuse during pregnancy.
- is not exposed to other choices by the pregnant mother that might harm the foetus and newborn baby (e.g. poor diet and nutrition, excessive dieting or exercise, not taking medication, taking potentially harmful medications, preparations or supplements.).
- has a healthy birth weight (appropriate for gestational age)
- is breastfed during the first 6-8 weeks after birth.
- has strong loving attachment with primary carer(s).
- has completed immunisations by relevant ages.
- [along with parents/carers] is compliant with treatment for any illnesses, diseases, chronic conditions and impairments.
- is registered with a dentist and receives regular check-ups.
- is free of dental decay.
- is not at risk because of avoidable physical injuries in the home.
- is not at risk of avoidable physical injuries outside the home.
- is free of physical neglect by parents or carers (i.e. through providing adequate food, shelter and clothing, ensuring good hygiene or ensuring access to appropriate medical and dental care).
- attends health care services and medical screenings when necessary.
- receives appropriate care and guidance from parents/carers.
- displays age-appropriate physical development in fine and gross motor skills.
- displays age-appropriate communication, cognitive and intellectual skills and development.
- displays age-appropriate psychological development.
- displays age-appropriate social skills and development.
- has emotional and developmental needs which are not neglected.
- receives appropriate treatment, care and support to manage any disabilities or chronic conditions.
- themselves irrespective of any disabilities or chronic conditions.
- is able to cope with the normal stresses of everyday life without undue or persistent anxiety, depression, withdrawal or aggression.
- has a well-developed sense of self-esteem and self respect.
- has a well-developed sense of identity and belonging.
- feels loved and trusted.
- has the resilience to cope with traumatic events such as separation and bereavement.
- is confident and competent when faced by problems and new challenges in everyday life.
- is mostly satisfied with life, smiles and laughs a lot.
- is generally optimistic and realistic about what he or she can achieve.
- has good relationships with family and friends.
- is actively involved within his or her family, social network, school and community.
- understands the social norms customs and traditions operating in his or her network.
- has the resilience to cope with the mental health problems of one or more parents/carers.
• does not experience any bullying or discrimination in school or in the local community.
• does not have a history of self harm or attempted suicide.
• cares about and respects others.
• is able to talk to others about his or her feelings in age-appropriate ways.
• is not misusing alcohol, nicotine, drugs and other harmful substances.
• is free from pressure by others to do things which might put their health at risk.
• has a lifestyle that does not present a threat to current or future health and well-being.
• has strategies for assessing and managing avoidable risks to health.
• understands and is not unduly anxious about the physical changes taking place during puberty.
• behaves in sexually-appropriate ways for their age and stage of development.
• is aware of the risks of unprotected sex.
• adopts safe practices and acts responsibly in age-appropriate sexually-active situations.
• has a positive and respectful approach to his or her own sexuality.
• has a positive and respectful approach to other people’s sexuality.

Achieving

Every child and young person has the right to fulfil his or her potential. This is at the heart of both GIRFEC and Curriculum for Excellence.

Improving attainment and achievement go hand in hand and mean improving life chances and enabling all our young people to progress and develop the skills, ambition and know how to enable them to fulfil their potential.

The term ‘achievement’ is used broadly in the Getting it right approach. Here it is rooted in the concept of children’s rights, particularly the right of every child to fulfil his or her potential.

At one level this means being engaged, motivated to attend and actively participating in their learning and developing the knowledge and understanding, skills, capabilities and attributes needed for life and work in the 21st century.

For those with additional support needs and with special talents and abilities it involves having the opportunities and support to maximise their potential.

In the early years it involves being supported at home and in pre-school to meet or exceed the appropriate developmental milestones and be ready for primary school. But readiness for school clearly means more than just being prepared for the challenges presented by a new learning environment. It is also about developing confidence, social skills, and some level of self care and autonomy in order to cope effectively with the transition to school and a different kind of learning environment. This close correspondence between achievement and being ready for transition to new situations and new challenges runs through their schooling and on to higher or further education, training and employment.

Achievement is also about accomplishing or finishing something successfully through effort, skill, perseverance and practice. This can apply to many aspects of life and not just education. It applies to sporting achievements, art, music, dance and drama, hobbies, leisure activities and other interests.
Curriculum for Excellence recognises that attainment is an individual’s passport to personal, social, cultural and economic opportunities and is designed to raise standards and attainment levels through excellence in learning and teaching. It also recognises the vital importance of recognising and valuing wider achievements either within or out with school. This can take place in a range of ways including recognised award programmes, voluntary work or achievements such as sport or cultural activities in school or the community. I. Curriculum guidance (the 'Experiences and Outcomes' covering each subject and area of the curriculum) has such wider achievements embedded within the different subjects/areas and levels. Learner profiles, which will be developed with the learner, during the key transition points of P7 and S3, will capture young people's latest and best achievements in a range of areas, not just academic achievement.

Achievement also applies to a child’s development as a social being with a fully-formed and autonomous personality who feels they belong and can navigate their way through life with knowledge, understanding, skill and confidence in their ability to cope with new and different challenges.

Through the Curriculum for Excellence, all children and young people are entitled to experience a broad general education, with appropriate personalisation and choice, from age 3 to the end of S3. They are also entitled to opportunities for developing skills for learning, life and work. These skills are relevant from the early years right through to the senior phase of learning (S4-S6) and beyond. The development of skills is essential to learning and education to help young people to become successful learners, confident individuals, responsible citizens and effective contributors. The skills and attributes which children and young people develop should provide them with a sound basis for their development as lifelong learners in their adult, social and working lives, enabling them to reach their full potential. For all the Curriculum for Excellence entitlements see http://www.ltscotland.org.uk/understandingthecurriculum/whatcanlearnersexpect/index.asp

The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

**Achieving**

**The child or young person:**

*Is a successful learner,* confident individual, responsible citizen and effective contributor

- is developing physical and motor skills
- is developing language and cognitive skills
- is developing intellectually
- is developing psychologically and emotionally
- is developing socially
- is developing self-care and life skills
- is developing independence or autonomy
- is showing motivation and being supported to attend and participate in learning at pre-school then school.
- literacy and numeracy skills are developing
- is meeting or exceeding appropriate levels of educational attainment across curriculum.
• is progressing towards agreed learning targets with additional support.
• is responding the help offered to support enjoyment and motivation to attend school.
• is responding to the help offered to participate as fully as possible in the non-academic areas of school life
• is responding to help to develop skills for coping with and managing their disabilities and long-term conditions.
• is responding to any additional support provided.
• is learning about themselves and what they can and cannot do.
• is learning new skills and applying them to meet new challenges.
• expresses a sense of achievement from what they are learning.
• is developing aptitude in one or more cultural activities.
• is developing aptitude in one or more sporting activities.
• is developing aptitude in one or more recreational activities and hobbies.
• is working towards positive achievement in one or more non-academic activities.
• is confident and competent when faced by problems and new challenges in their everyday lives.
• aspires to go on to further or higher education and/or skilled employment (positive destinations).
• intends to stay in education or go into further education or other vocational training beyond the age of 16 (positive destinations).
• is generally optimistic and realistic about what he or she can achieve.

Demonstrates readiness for key transitions in childhood and adolescence:

All children and young people have an entitlement to a curriculum which they experience as a coherent whole, with smooth and well-paced progression through the Experiences and Outcomes, particularly across transitions

transition to primary: e.g. independent hygiene habits, well-coordinated, can sustain energy through the day, can manipulate objects, crayons, pencils, some number, letter and word recognition, can follow instructions, listens, plays and works cooperatively, eager to try new things, follows class routines, copes with change, etc.

transition to secondary: able to cope with a more subject-based curriculum, travel to school, different teachers, different peers, different rules and institutional arrangements, more independent and collaborative working, etc.

transition to adult life: has developed the independence, skills and practical knowledge needed for successful integration into adult life and transition into further/higher education or skilled employment with support where necessary

*The same applies for young people leaving care and young people with Additional Support needs who are also making the transition to support from adult services.

Nurtured

The right of every child to thrive and develop into a safe, healthy, happy, well-adjusted child and, ultimately, an independent, respected and responsible adult is fundamental. However, nurtured is one of the domains of childhood well-being that tends to be relatively overlooked in the performance and quality indicators devised and employed by most public authorities and yet tends to be a primary focus for assessing and planning for the needs of children and young people who may require additional support.
The reasons for this are two-fold. On the one hand the public authorities tend to focus on their role in corporate parenting: the nurturing of looked after children accommodated away from home. On the other hand this relative oversight may also reflect the fact that there is a clear overlap between the outcomes of nurturing and those related to being safe, healthy, achieving, respected, responsible and included. This is apparent in the list of Outcome signifiers presented below.

Nurturing begins in the womb where the unborn child is known to be positively or adversely affected by the mother’s lifestyle choices and behaviours.

The newborn child and infant needs appropriate nutrition, sleep, comfort, cleaning, cuddling, rocking and regular physical contact with the primary carer. Infants who develop a secure attachment with a parent or carer at this stage which continues through early childhood are more likely to thrive and less likely to present behavioural problems, lowered self esteem or difficulties at school in later childhood and adolescence. There is also increasing evidence that children’s early experiences can influence the way the brain develops. 

The toddler also needs to have his or her basic needs met but also by this stage nurturing involves being shown how to do things and not just having them done for them by the parent or carer, being helped to manage their emotions and behaviour in more socially appropriate ways, developing their communication and social skills, and becoming more independent within a controlled environment.

The nurturing of the older child focuses increasingly on more opportunities for independent learning and play, modelling appropriate behaviours, consistent, fair and appropriate discipline, keeping safe, developing healthy habits, developing friendship networks and being supported at home to help them with their formal education.

Nurturing continues into adolescence only here the emphasis increasingly shifts to a less directive approach to parenting based on guidance and the recognition that the young person needs to develop into an independent, respected and responsible young adult.

Where the child or young person is in residential care or with foster parents or placed with an adoptive family then the need for nurturing is precisely the same.

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The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

### Nurtured

<table>
<thead>
<tr>
<th>The child or young person:</th>
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<tbody>
<tr>
<td>is not exposed as a foetus to nicotine, alcohol, drug misuse or domestic violence and abuse during pregnancy.</td>
</tr>
<tr>
<td>is not exposed to other choices by the pregnant mother that might harm the foetus and newborn baby (e.g. poor diet and nutrition, excessive dieting or exercise, not taking</td>
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- medication).
- lives in a household where parents/carers and other family members understand the primacy of the needs of the infant or child.
- attends health care services and medical screenings when necessary.
- receives a level of physical care that ensures that the child is clean, adequately and appropriately clothed and kept warm.
- receives sufficient and appropriate nutrition.
- has strong loving attachment with primary carer(s).
- experiences consistent love and emotional warmth within the natural or placement family.
- feels loved and trusted.
- is mostly happy and satisfied with life.
- has emotional and developmental needs which are not neglected.
- is not subject to physical neglect by parents or carers (i.e. through not providing adequate food, shelter and clothing, ensuring good hygiene or ensuring access to appropriate medical and dental care).
- receives regular praise and encouragement.
- lives in an environment which promotes their cognitive and emotional development through age-appropriate stimuli.
- is not left unattended when too young to properly take care of herself or himself.
- is not left in the care of an immature or inappropriate carer.
- is free of exposure to persistent emotional abuse within the home (i.e. is not constantly criticised, ignored, humiliated, exposed to domestic abuse within the family).
- is free of exposure to the threat of physical or sexual abuse and violence.
- is free of exposure to serious misuse of alcohol and drugs by family members or others in local community.
- receives appropriate care and guidance from parents/carers.
- talks to others about his or her feelings in age-appropriate ways.
- has someone they can turn to, trust and rely on when anxious or disturbed.
- receives additional support and care when they need it.
- has a secure and supportive network of family members or carers and friends.
- has a well-developed sense of self esteem and self respect.
- has a well-developed sense of identity and belonging.
- copes with the normal stresses of everyday life without undue or persistent anxiety, depression, withdrawal or aggression.
- has the resilience to cope with adverse circumstances at home (e.g. parental separation, bereavement, parent or carer with psychiatric disorder, long-term health condition or impairment).
- is confident and competent when faced by problems and new challenges in their everyday lives.
Active

The most commonly used indicator for this particular domain of childhood well-being is the extent and frequency of physical activity by the child or young person. Scottish Government guidelines recommend a minimum of 60 minutes of physical activity per day. However, within the Getting it right approach the concept of active is used in a wider sense to incorporate play, recreation, and hobbies. It is not just about ‘doing’, although this is clearly very important; it is also about having access to and being encouraged to take up opportunities to explore their home and community environment, play with others and express themselves in a variety of different ways. It is also about developing new skills, learning how to assess and manage risks, and acting responsibly and cooperatively within teams and groups.

In other words, being active has an important role to play in developing other areas of the child’s well-being: a sense of inclusion and belonging, their physical and emotional health, their sense of achievement from facing new challenges and developing new skills, their self respect and their sense of responsibility.

At the same time it is also clear that children and young people when they are active need a safe environment (where they can take acceptable risks in a controlled way) and, in addition to opportunities, they need encouragement and early signs of emerging talent need to be nurtured. Above all, activity and play is essential to the child and young person’s sense of subjective well-being: the positive feelings about the self that come from having fun.

As Play Scotland asserts, children and young people will: “enjoy better physical, emotional and mental health; develop social skills and responsibility; appreciate the environment; understand risk and challenge; grow identity and self esteem; participate in sports, arts and culture and be less likely to offend and engage in anti-social behaviour”.

The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

<table>
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<th>Active</th>
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**The child or young person:**

- has regular time in the early years and childhood for playing and interacting with parents/carers.
- is encouraged to be curious and to explore her or his environment.
- is encouraged to play with other children.
- receives appropriate stimulus and encouragement to develop their interests.
- responds positively to physical challenges in recreational and play-related settings.
- is as physically active as his or her capacities permit.
- is actively involved within his or her family, social network, school and community.
- actively engages in sporting and recreational activities at school.
- actively engages in sporting and recreational activities within the community.
- actively participates in stimulating activities regardless of disabilities or chronic

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8 Play Scotland: [www.playscotland.org/who-we-are](http://www.playscotland.org/who-we-are)
conditions.

- is learning new skills and applying them to meet new physical and psychological challenges.
- is developing aptitude in one or more cultural activities.
- is developing aptitude in one or more sporting activities.
- is developing aptitude in one or more recreational activities and hobbies.
- is learning about themselves and what they can and cannot do.
- is learning how to assess and manage risks in recreational and play-related settings.
- expresses a sense of achievement from their activities.
- receives regular praise and encouragement.
- has a well-developed sense of self esteem and self respect.
- is confident and competent when faced by new challenges in their chosen sports or recreational activities.
- receives appropriate support and coaching in their chosen sports or activities.

Respected

As Ben-Arieh has noted, the growing focus on the child’s well-being rather than on just his or her well-becoming, along with the ratification of the United Nations Convention on the Rights of Children in 1990, has highlighted the importance of parents, carers and practitioners in children’s services recognising the child’s right to be treated with respect and dignity at all times, regardless of their age, gender or social, religious and cultural background and regardless of what they may have done or failed to do.  

Respect and being respected are multi-dimensional concepts and this is reflected in the more recent literature on child development. This contrasts with the focus in earlier socialisation theories on the processes of instilling respect in children.

Self worth and belonging

One of the main dimensions focuses on the child’s feelings of self-worth, including their sense of belonging, their self esteem, their sense of being loved and cared for and of being trusted by their friends and parents or carers. This goes with a sense of not feeling stigmatised, discriminated against or demeaned.

Respecting their views and consulting on decisions which affect them

Another dimension focuses on the right of the child or young person to express their views on matters that directly affect them and to have those views given due weight in accordance with their age and maturity by the adults who care for them or come into contact with them in a professional or personal capacity. This also links up with being consulted by their carers and key professionals about any important decisions which will directly affect their lives, and being provided with the appropriate information to make an informed judgement about these decisions and to be able to provide informed consent. An additional facet of this dimension of respect is that the child or young person is entitled to have their views, and any

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disclosures about their private lives, treated in confidence unless these disclosures raise concerns about their wellbeing.

**Informed consent**

This emphasis on consulting children and young people and seeking their informed consent for decisions and actions that will directly affect them also serves to direct us to a third dimension of respect. This goes beyond how the child or young person feels - although this is critically important. It is also about how they are objectively treated by others. Children and young people are not being respected if they are subjected to physical or emotional abuse, humiliated, exposed to abuse by their primary carer or their siblings, denied their physical and psychological integrity, denied any privacy or personal space or denied access to their loved ones or their personal possessions. They are not being respected if others ignore their vulnerability and relative dependency or their right to be treated with dignity.

**Respecting their dignity and unique individuality**

The fourth dimension of respect, which is essential to their dignity as a human being, is a predisposition to see the child or young person as an individual with a unique personality and his or her own individual needs. They are denied respect when they are labelled, defined or perceived in terms of a particular characteristic: their ethnicity, religion, language, culture, disability, condition or by the problem which may have brought them to the attention of children’s services.

Respect is fundamental to the child’s well-being. The child who is treated with respect is also more likely to be safer, emotionally and physically healthier, happier, more nurtured, more likely to feel and be included, more likely to achieve and more likely to respect themselves and others and behave in a considerate and responsible way. It is perhaps surprising, therefore, that most attempts to develop indicators of respect seem to be restricted to a few items in a questionnaire survey about how a sample of young people feel. Here Edinburgh University has tried to identify sub-domains of respected which reflect the multi-dimensional nature of the concept as it is used in the context of children’s rights.

As with most of the other well-being domains there is considerable duplication of indicators reflecting the inter-relatedness of the eight Well-being Indicators.

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<tbody>
<tr>
<td><strong>Respected</strong></td>
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<th>The child or young person:</th>
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<tr>
<td>• is free from exposure to physical abuse and violence within the home or the threat of it (i.e. hitting, shaking, kicking, throwing, and scalding).</td>
</tr>
<tr>
<td>• is free from exposure to the threat of physical or sexual abuse and violence.</td>
</tr>
<tr>
<td>• is free from exposure to persistent emotional abuse within the home (i.e. is not constantly criticised, ignored, humiliated, exposed to domestic abuse within the family).</td>
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• is free from exposure to sexual abuse or exploitation (i.e. is not subjected to indecent assault, under-age or non-consensual sexual intercourse, inappropriate sexual behaviour or language, or sexual grooming via the internet).
• has a positive and respectful approach to his or her own sexuality.
• does not have a history of self harm or attempted suicide.
• does not experience bullying by peers or adults at school.
• does not experience bullying in the local community.
• does not experience discrimination, labelling or stereotyping by peers or adults at school or in the community on the grounds of age, gender, ethnicity, religion, culture, disabilities, learning difficulties, where they come from or live.
• feels safe at home.
• feels safe when out with friends.
• feels loved and trusted.
• experiences consistent love and emotional warmth within the natural or placement family.
• receives regular praise and encouragement.
• has a well-developed sense of self esteem and self respect.
• has a well-developed sense of identity and belonging with which they feel comfortable.
• is mostly happy and satisfied with life, smiles and laughs a lot.
• feels that parents/carers, friends and the professionals with whom they come into regular contact will support them to fulfil their potential.
• is generally optimistic and realistic about what they can achieve.
• is confident and competent when faced by new challenges.
• feels that parents/carers, friends and the professionals with whom they come into regular contact will support them through challenges and difficulties.
• feels listened to and taken seriously by parents/carers.
• feels listened to and taken seriously by friends and siblings.
• feels listened to and taken seriously by the professionals with whom they come into regular contact.
• feels that parents/carers and other family members respect their privacy and personal space.
• feels that they are treated by parents/carers as individuals in their own right with their own needs, expectations and aspirations.

**when in contact with specialist or targeted children’s services the child or young person:**
• is provided with sufficient and appropriate information to make informed choices;
• is asked for their consent to information about them being shared between named agencies for a specific purpose which is explained to them and not simply as a matter of course;
• has confidence that the information is handled and stored in a secure manner;
• feels that any information they provide about themselves will be treated in confidence and that its further dissemination, handling and subsequent disposal will be appropriately controlled;
• understands that if they are at serious risk of harm any information they provide may be shared with those who can help to keep them safe;
• is made aware of the possible consequences of any decisions affecting them;
• is actively involved in any assessment, planning or review process affecting them;
• is helped to prepare for meetings where decisions will be made that directly affect them;
• has access to independent advice on how to complain about their treatment or challenge any decisions by services which they feel do not take full account of their needs and wishes.
when intimate care or supervision by professional staff is required, the child or young person:

- is treated with dignity and respect at all times;
- the level of intimate care is consistent regardless of who provides it;
- the individuality of the child or young person is respected;
- the right to personal privacy is respected;
- the right to be involved in and consulted about their intimate care to the best of their abilities is respected;
- the right to express their views on their own intimate care is respected.

Responsibility

Under Curriculum for Excellence all learning and teaching is underpinned by the four capacities\(^{10}\), one of which is to enable all children and young people to become responsible citizens, with respect for others and a commitment to participate responsibly in political, economic, social and cultural life. Responsibility is also a complex concept. Potentially, it can encompass a diversity of behaviours, values and ways of thinking and feeling. It is about accountability, but it is also about leadership and decision making and understanding the rules, norms and parameters which guide how we live alongside each other. It is about the capacity for moral judgment and taking a principled stand. It is also about showing respect and compassion for others, being honest with oneself and with others and resisting pressure to engage in inappropriate, dangerous or anti-social behaviour. It is also about self control: being patient when one’s wishes are not instantly gratified and not resorting to aggression and violence to get one’s way. It is also about learning how to negotiate with others. These are learned responses to the world about us which are never wholly mastered. They continue to be developed throughout childhood, adolescence and into adulthood as life circumstances change.

Compared with all the other domains of childhood well-being this specific domain, being responsible, appears to be of a rather different order. First it is not usually thought of as a human right, though the concepts ‘rights and responsibilities’ are often referred to jointly. The child has a fundamental right to be treated with respect but does not have a right to be responsible, although most societies have some concept of the age of responsibility when people become legally responsible for their own actions and this may be linked to specific legal and civil rights (when they can vote, get married, sit on a jury, etc). Responsibility is usually linked to the conditions which may be placed upon the exercise of rights.

Second, the child is not born with a need to be responsible in the same way that the new-born baby has a right and a fundamental need to be safe, nurtured and loved, respected, kept healthy, protected from social exclusion and all forms of discrimination, encouraged to play and be active and supported to meet the developmental milestones appropriate to their age and stage. The new-born baby is not expected to behave responsibly. Learning to take responsibility and to behave responsibly are generally regarded as being an important part of character formation and social development: the gradual development of certain habits,\(^{10}\)

\[^{10}\] http://www.ltscotland.org.uk/understandingthecurriculum/whatiscurriculumforexcellence/thepurposeofthecurriculum/index.asp
feelings, thoughts, values, attitudes and actions through parental guidance, discipline, praise, role modelling and the emergence of the capacity for self control and the cognitive ability to understand and follow moral rules and social norms and conventions.

It is perhaps not surprising, therefore, that most attempts to develop indicators of responsible behaviour have been rather narrowly conceived and tend to be focused on adolescence. Broadly speaking these indicators can be categorised into two groups:

- Indicators of the absence of responsible conduct (for example disruptive behaviour in school, being outwith parental control, exclusions from school, poor attendance, misuse of illegal drugs, binge drinking, anti-social behaviour, juvenile crime, etc);

- Output indicators focused on receipt of citizenship education and provision of opportunities for active participation at school, at home and in the local community, including opportunities for engagement in voluntary activities.

This narrow focus tends to reflect a data-driven approach to the selection of indicators. That is, at the national and local level there are well-established baselines linked to most aspects of irresponsible adolescent conduct and the need for output indicators for integrated children’s service plans and community development plans have encouraged the authorities to collect data on the provision of opportunities for youth participation at all levels.

The relative paucity of indicators of this specific domain for the early years may also reflect an assumption that indicators would not be appropriate until the young person has developed the capacity for moral reasoning. And yet, health visitors start looking for signs that the primary carer is providing the appropriate guidance and reinforcement that will not only keep the small child safe and well but will also provide a foundation for later social behaviour. Similarly, the rapidly developing work on assessing the readiness of children for pre-school and primary school focuses on a number of areas of the child’s social and emotional development which are central to responsible behaviour in any community or social grouping. For example: can the child follow simple rules and instructions, respect the property of other children, work and play cooperatively with other children, show compassion for others when they are hurt or upset, show some signs of self control, recognise when they have behaved badly and show some willingness to take responsibility for their actions.

Most of these signifiers of responsible behaviour also apply to older children and adolescents but with a greater emphasis on their understanding what is and is not appropriate behaviour in various circumstances and a greater emphasis on their understanding of their emotions and behaviour and the impact that these have on others.

It may well be that the need to work with existing databases and the need to be cost-effective and not develop a range of new local or national indicators will mean that aggregated information about the responsible behaviours of children and young people will remain relatively limited compared with the information that is collected about child safety or educational attainment. However, at the level of assessing and getting it right for the

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11 See the Chief Medical Officer for Scotland’s comments on the importance or early attachment in Burns (2007), op.cit p.7
individual child there is a potential for obtaining more – and more useful – information about this area of childhood well-being.

The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

**Responsible**

**By the time the child is due to attend primary school, he or she can:**
- follow simple rules and instructions and begin to internalise them.
- play and work cooperatively with other children.
- show concern and compassion for other children when they are hurt or upset.
- exercise some degree of age-appropriate self control over their emotions and behaviour.
- recognise when they are behaving badly and respond positively to correction.
- show some degree of age-appropriate remorse after wrongdoing, especially where this has hurt or upset others.
- show some understanding of the consequences of their actions.
- show some willingness to take responsibility for their actions.
- show respect for other children’s possessions.
- show respect for school materials and equipment.
- behave in ways that are appropriate for their age, stage of development, environment and capabilities.

**From 0 – 16 the child or young person experiences responsible care and appropriate role models to ensure they:**
- attend all appropriate health screenings and medical appointments.
- receive appropriate care and guidance from parents/carers.
- have their emotional and developmental needs addressed.
- are free from physical neglect by parents or carers (*i.e. through not providing adequate food, shelter and clothing, ensuring good hygiene or ensuring access to appropriate medical and dental care.*)
- live in an environment which promotes their cognitive and emotional development through age-appropriate stimuli.
- are not left unattended when too young to properly take care of herself or himself.
- are free from exposure to the threat of physical, emotional or sexual abuse.
- are free from exposure to serious misuse of alcohol and drugs by family members or others in local community.

**Depending upon age, maturity and any additional support needs, the school-aged child or adolescent:**
- attends school regularly.
- is aware of the school’s rules and generally abides by them.
- understands the consequences of not following school rules.
- understands the social norms and mores operating in the school.
- is generally clean and appropriately dressed when attending school.
- exercises some degree of appropriate self control over their emotions and behaviour.
- recognises when they are behaving badly and responds positively to correction.
- shows remorse after wrongdoing, especially when it has hurt or upset others.
- understands the consequences of their actions.
- takes responsibility for their actions.
- shows respect for others’ possessions.
- shows respect for school materials and equipment.
- behaves in ways that are appropriate for their age and stage of development.
Included

Inclusion, like a number of other key concepts in social policy, is a metaphor which brings some coherence to a wide range of issues, initiatives and actions aimed at transformative social change, which might otherwise seem highly diverse. This includes the equal opportunities agenda, strategies for meeting within mainstream schooling the educational needs of children with disabilities, learning difficulties and a range of social, emotional and behavioural needs; the agenda for promoting diversity and social cohesion, policies for addressing child poverty, and promoting and protecting the rights of children and young people.

As with most policy metaphors, definitions of inclusion have been varied, reflecting the priorities of different policy agendas, and open to different interpretations depending on the professional cultures of those expected to implement these agendas. Traditionally inclusion tended to be defined by its opposite, namely, exclusion. It described the policies and practices designed to address the problems and difficulties of those groups of children and families who were marginalised, disadvantaged and discriminated against and to remove the barriers that were preventing these children and families from accessing appropriate
services, exercising their rights and fully participating in their schooling, employment and local communities.

There is a strong emphasis here on removing the social, economic, cultural and personal barriers that prevent children and families from accessing services, exercising their rights and engaging with their community and society at large. But the idea of inclusion is also underpinned by social values. It is about the acceptance of all, regardless of their differences and the recognition that each, regardless of their differences, can make a valuable contribution to the community. As the Canadian educationist, Jack Pearpoint has observed: "The criterion for inclusion is breathing" rather than the individual’s IQ, family income, ethnicity, gender, age, where they come from or where they live.12 A child or young person may have a disability or be different from his or her peers in other ways but first and foremost he or she is still a child with the same basic needs for health, safety, nutrition, appropriate clothing, adequate and appropriate accommodation, a sense of belonging and the chance to develop their potential to the full.

Until relatively recently the dominant approach to inclusion within the United Kingdom has been a one-size-fits-all deficit model. Individual children and young people, groups and sub-populations with specific needs or problems become defined by those needs and problems; the extent of need is assessed to see if they are eligible for additional support and, if they are, then they are referred to the appropriate services, benefits or interventions.

However, over the last two decades there has been a growing body of research and evaluation evidence suggesting that some of these programmes and interventions have not produced the desired outcomes on the scale that had been anticipated. This is partly because symptoms have often been confused with causes, the range of potential contributory factors has been too narrow, the context in which the problems have emerged has been relatively ignored and the programmes and initiatives have not taken sufficient account of differences within their target groups. As the Chief Medical Officer for Scotland has observed: “Herculean efforts to improve health and expenditure of significant resources has, over the past decades produced steady improvements in health which has been undermined by our failure to accelerate the health status of those at the lower end of the socio-economic spectrum. If we are to produce such acceleration, perhaps we need to consider the methods we have been using to improve health. Perhaps it is time for a change.” He goes on to emphasise the importance of developing an approach to health improvement which does more to unlock the assets within individuals which create a sense of control and wellbeing.13

More recently, assets-based thinking has begun to emerge. For example, the work of Marmot and Wilkinson has indicated that the relationship between people’s health and its social determinants is highly complex.14 As the Chief Medical Officer for Scotland has observed, more emphasis needs to be placed on the personal resources that individuals require in order to create better health for themselves. This, he argues, begins with

effective and consistent parenting to enable the child to develop a sense that its environment or world is structured and relatively predictable. Then, as they grow and learn, they develop enhanced social networks through school and work, and the accompanying self esteem and resilience, which allow them to manage their lives effectively. Then they are more likely to decide that the effort of adopting a healthy lifestyle is worthwhile, possible and manageable.\textsuperscript{15}

This focus on developing the personal resources and resilience of each child and young person is at the core of what the World Health Organisation has described as an assets model.\textsuperscript{16} In the context of health provision the emphasis gives equal weight to creating health and not just to preventing disease.

The assets-based model has also begun to influence thinking on inclusion policies across other public services. In relation to the delivery of integrated children’s services the model is strongly reflected in the developmental ‘ecological’ approach underlying the \textit{Getting it right} practice model. Here the emphasis is placed on addressing the needs of the whole child and not just those of current or most urgent concern and also assessing the child’s needs within the context of his or her development and environment and identifying the strengths and pressures in that child’s world that need to be taken into account in producing a child’s plan.

The advocates of an assets-based approach do not appear, as yet, to be arguing that it must be seen as an alternative to the deficit model. The argument appears to be that a better balance needs to be struck between the two approaches when devising and implementing social policy.\textsuperscript{17}

However, on looking at the indicators that have been developed or selected for measuring inclusion there does appear to be a strong emphasis on the deficit model with:

- a preponderance of indicators on household income, benefits claimants, homelessness and access to suitable accommodation, social housing and parental employment;

- a focus on children and young people in specific groups: socio-economic, ethnic and cultural minorities, disabled, low attainers, asylum seekers, etc.

As with the indicators on being responsible, this tends to reflect a data-led approach to the selection of those indicators for which there are well-established databases. Once again, at the level of assessing and getting it right for the individual child, there is a potential for obtaining more – and more useful – information about the assets of the child as well as their vulnerability and how these may be impacting on their social, cultural, economic and educational inclusion.

\textsuperscript{15} Burns, H. (2009) op.cit p.11.
\textsuperscript{17} Morgan & Ziglio, \textit{ibid}. 
The following are suggested for discussion as the type of issues that might be taken into account by practitioners when considering the well being of a child or young person. They are not intended as an exhaustive or prescriptive checklist.

### INCLUDED

**The individual child or young person:**
- has strong loving attachment with primary carer(s).
- experiences consistent love and emotional warmth within the natural or placement family.
- feels trusted.
- is mostly satisfied with life.
- feels listened to and taken seriously by parents/carers.
- has someone they can turn to, trust and rely on when anxious or disturbed.
- has a secure and supportive network of family members or carers and friends.
- in regular contact with significant, supportive adults whom they trust.
- receives appropriate protection and guidance from parents/carers.
- has the resilience to cope with adverse circumstances at home (e.g. parental separation, bereavement, parent or carer with psychiatric disorder, long-term health condition or impairment, etc.)
- has the resilience to cope with traumatic events such as separation and bereavement.
- has well-developed sense of identity and belonging with which they feel comfortable.
- has a well-developed sense of self esteem and self respect.
- copes with the normal stresses of everyday life without undue or persistent anxiety, depression, withdrawal or aggression.
- is confident and competent when faced by problems and new challenges in everyday life.
- is generally optimistic and realistic about what they can achieve.

**To minimise the potential impact of social and economic exclusion the child’s family:**
- lives in accommodation suitable for the size and needs of the child and family.
- lives in a well-maintained, safe and secure home environment.
- has an income level adequate to meeting day-to-day needs and special needs.
- manages the household income effectively for the benefit of the whole family.
- receives all of the benefits to which they are entitled.
- is not experiencing recurring debt problems or, if they are, are being provided with advice on financial matters.
- can access appropriate training for either or both carers if unemployed.
- has access to affordable, good quality, local child care provision when both parents are working.

**The child or young person and family:**
- receive additional support and care when they need it.
- access health care when needed.
- are registered with a dentist and receives regular check-ups.
- have the child or young person’s health regularly monitored and screened.
- are receiving the appropriate treatment, care and support to enable the child or young person to manage any disability or chronic condition.
- feels empowered to express their wishes (where possible) and make decisions for themselves in relation to disability or chronic conditions.
- are receiving additional support for learning difficulties.
the child:

- is free from bullying at school
- does not experience discrimination, labelling or stereotyping by peers or adults at school on the grounds of age, gender, ethnicity, religion, culture, disabilities or learning difficulties.
- feels accepted and valued by the school
- feels accepted and valued by their peers.
- takes part in school-based, extra-curricular activities which support social contact.
- feels encouraged to participate in these extra-curricular activities.
- feels confident enough to tell a responsible adult if they have been subjected to discriminatory attitudes or actions.
- feels listened to and taken seriously by any children’s services professionals with whom they come into contact.
- feels that the school has a positive view towards his or her faith.
- feels that the school has a positive and supportive view towards his or her native language.

within the community the child or young person:

- feels accepted within the community.
- feels listened to and taken seriously by friends and neighbours.
- takes part in community activities which support social contact.
- feels encouraged to participate in these community activities.
- does not experience discrimination, labelling or stereotyping in the local community on the grounds of age, gender, ethnicity, religion, culture, disabilities or learning difficulties.
- is free from bullying by others within the local community.
- is actively involved in the life of the local community.
- can access, if needed, a faith network in order to practice his or her faith.
- feels that the local community has a positive view towards his or her faith.
- can access, if needed, a support network in order to use and further develop his or her native language.
- feels that the local community has a positive and supportive view towards his or her native language.

Overview

This paper began by observing that the eight domains or areas of a child’s life which, together, constitute the over-arching concept of childhood well-being underlying the Getting it right for every child approach are very broad. Just as well-being itself is multi-dimensional, so too are each of the eight domains. Each Well-being Indicator encompasses a wide range of needs, behaviours, attitudes, physical and mental states and conditions.

The evaluation of the development and implementation of Getting it right highlighted that practitioners across the children’s services often used the Well-being Indicators as a kind of over-arching framework when talking about the needs and concerns of the children and young people they were working with but when they carried out an assessment and developed a plan the intended outcomes were often phrased in much more specific terms and it was not always clear how the actions to be taken to address the identified needs and concerns would lead to the improved well-being of the child or young person. In some cases there were unstated assumptions about the likely outcomes of particular actions and
interventions. In other instances the stated outcomes for the child appeared, in practice, to be concerned with the delivery of outputs.\textsuperscript{18}

In these circumstances it was found to be useful to break down the eight Well-being Indicators into their more detailed constituent parts. No doubt others carrying out a similar exercise might well have included some additional signifiers or presented a more reduced set.

However, Edinburgh University suggested that a roughly similar set of well-being outcome signifiers would emerge from any systematic review of the literature on children’s well-being and any systematic review of a significant number of children’s plans (Edinburgh University looked at around 100 such plans for children and young people receiving multi-agency support and around another 50 plans for single agency support within the universal services).

Once you look at the level of detail in the sample lists of outcome signifiers for each of the eight domains, it soon becomes apparent that there is considerable overlap and duplication. This is even clearer if you look at Figure 3. This differentiates between those indicators and signifiers which appear under more than one domain and those which tend to belong exclusively to a single domain. The high degree of overlap serves to demonstrate the extent of the inter-relationships between the different domains. See, for example, the degree of overlap between outcome indicators or signifiers for being included and being respected or between the signifiers for being nurtured, healthy and safe.

Figure 3 has been designed that might be used alongside the Getting it right practice model, especially the My World Triangle and the Resilience Matrix, particularly when assessing complex cases requiring multi-agency planning and support. It is also possible to extract items from the sample in order to design smaller outcome signifiers for specific purposes such as assessing readiness for school or readiness for coping with the transition to independent adult life.

\textit{Figure 3: Some Examples} the well-being of children and young people

<table>
<thead>
<tr>
<th>Outcome signifiers</th>
<th>√ or X</th>
<th>Well-being Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not exposed as a foetus to nicotine, alcohol, drug misuse or domestic violence and abuse during pregnancy</td>
<td></td>
<td>Nurtured, Healthy</td>
</tr>
<tr>
<td>Not exposed by the pregnant mother to other lifestyle choices that might harm the foetus and newborn baby</td>
<td></td>
<td>Nurtured, Healthy</td>
</tr>
<tr>
<td>Has a healthy birth weight appropriate for gestational age</td>
<td></td>
<td>Healthy</td>
</tr>
<tr>
<td>Breastfed during the first 6-8 weeks after birth</td>
<td></td>
<td>Healthy</td>
</tr>
<tr>
<td>Strong loving attachment with primary carer(s)</td>
<td></td>
<td>Healthy, Nurtured, Included</td>
</tr>
<tr>
<td>Lives in household where parents/carers and other family members understand the primacy of the needs of the infant or child</td>
<td></td>
<td>Nurtured</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attends all appropriate health care services and medical screenings when</td>
<td>Nurtured, Healthy, Responsible, Included</td>
</tr>
<tr>
<td>necessary</td>
<td></td>
</tr>
<tr>
<td>Has completed immunisations by relevant ages</td>
<td>Healthy</td>
</tr>
<tr>
<td>[Along with parents/carers] is compliant with treatment for any illnesses,</td>
<td>Healthy</td>
</tr>
<tr>
<td>diseases, chronic conditions and impairments</td>
<td></td>
</tr>
<tr>
<td>Registered with a dentist and receives regular check-ups</td>
<td>Healthy, Included</td>
</tr>
<tr>
<td>Free of dental decay</td>
<td>Healthy</td>
</tr>
<tr>
<td>Receiving appropriate treatment, care and support to manage any disabilities</td>
<td>Healthy, Included</td>
</tr>
<tr>
<td>or chronic conditions</td>
<td></td>
</tr>
<tr>
<td>Feels empowered to express their wishes (where possible) and make</td>
<td>Healthy, Included</td>
</tr>
<tr>
<td>decisions for themselves irrespective of disabilities or chronic conditions</td>
<td></td>
</tr>
<tr>
<td>‘Receives additional support and care when they need it’</td>
<td>Included</td>
</tr>
<tr>
<td>Receives a level of physical care that ensures that the child is generally</td>
<td>Nurtured, Responsible</td>
</tr>
<tr>
<td>clean and appropriately dressed when attending school’</td>
<td></td>
</tr>
<tr>
<td>Receives adequate and appropriate nutrition</td>
<td>Nurtured</td>
</tr>
<tr>
<td>Experiences consistent love and emotional warmth within natural or</td>
<td>Nurtured, Respected, Included</td>
</tr>
<tr>
<td>placement family</td>
<td></td>
</tr>
<tr>
<td>Feels loved and trusted</td>
<td>Nurtured, Healthy, Respected, Included</td>
</tr>
<tr>
<td>Is mostly happy and satisfied with life</td>
<td>Nurtured, Healthy, Respected, Included</td>
</tr>
<tr>
<td>Emotional and developmental needs are not neglected</td>
<td>Nurtured, Respected, Included</td>
</tr>
<tr>
<td>Are free from physical neglect by parents or carers (*i.e. through not</td>
<td>Nurtured, Healthy, Safe, Responsible</td>
</tr>
<tr>
<td>providing adequate food, shelter and clothing, ensuring good hygiene or</td>
<td></td>
</tr>
<tr>
<td>ensuring access to appropriate medical and dental care.*)</td>
<td></td>
</tr>
<tr>
<td>Receives regular praise and encouragement</td>
<td>Nurtured, Respected, Active</td>
</tr>
<tr>
<td>Receives appropriate protection, care and guidance from</td>
<td>Nurtured, Healthy, Safe, Included</td>
</tr>
<tr>
<td>parents/carers</td>
<td></td>
</tr>
<tr>
<td>Not left unattended when too young to properly take care of themselves</td>
<td>Nurtured, Safe, Responsible</td>
</tr>
<tr>
<td>Not left in the care of immature or inappropriate carer</td>
<td>Nurtured, Safe</td>
</tr>
<tr>
<td>Is free from exposure to persistent emotional abuse within the home</td>
<td>Nurtured, Safe, Respected</td>
</tr>
<tr>
<td>(*i.e. is not constantly criticised, ignored, humiliated, exposed to</td>
<td></td>
</tr>
<tr>
<td>domestic abuse within the family).</td>
<td></td>
</tr>
<tr>
<td>Is free from exposure to sexual abuse or exploitation (*i.e. is not</td>
<td>Safe, Respected</td>
</tr>
<tr>
<td>subjected to indecent assault, under-age or non-consensual sexual</td>
<td></td>
</tr>
<tr>
<td>intercourse, inappropriate sexual behaviour or language, or sexual grooming</td>
<td></td>
</tr>
<tr>
<td>via the internet).</td>
<td></td>
</tr>
<tr>
<td>Free from exposure to serious misuse of alcohol and drugs by family</td>
<td>Nurtured, Safe, Responsible</td>
</tr>
<tr>
<td>members or others in local community</td>
<td></td>
</tr>
<tr>
<td>Not at risk of avoidable physical dangers and health hazards within the</td>
<td>Healthy, Safe</td>
</tr>
<tr>
<td>home or in the community</td>
<td></td>
</tr>
<tr>
<td>Lives in an environment which promotes their cognitive and emotional</td>
<td>Nurtured, Responsible</td>
</tr>
<tr>
<td>development through age-appropriate stimuli</td>
<td></td>
</tr>
<tr>
<td>Is able to talk to others about his or her feelings in age-appropriate</td>
<td>Nurtured,</td>
</tr>
<tr>
<td>ways</td>
<td></td>
</tr>
<tr>
<td>Has someone they can turn to, trust and rely on when anxious or disturbed</td>
<td>Nurtured, Included,</td>
</tr>
<tr>
<td>Receives additional support and care when they need it</td>
<td>Nurtured, Included</td>
</tr>
<tr>
<td>Has a secure and supportive network of family members or carers and friends</td>
<td>Nurtured, Safe, Included</td>
</tr>
<tr>
<td>Has a well-developed sense of self esteem and self respect</td>
<td>Nurtured, Healthy, Safe, Respected, Included</td>
</tr>
<tr>
<td>Has a well-developed sense of identity and belonging</td>
<td>Nurtured, Healthy, Safe, Respected, Included</td>
</tr>
<tr>
<td>Able to cope with the normal stresses of everyday life without undue or persistent anxiety, depression, withdrawal or aggression</td>
<td>Nurtured, Healthy, Included</td>
</tr>
<tr>
<td>Has the resilience to cope with adverse circumstances at home (e.g. parental separation, bereavement, parent or carer with psychiatric disorder, long-term health condition or impairment).</td>
<td>Nurtured, Healthy, Safe, Included</td>
</tr>
<tr>
<td>Confident and competent when faced by problems and new challenges in their everyday lives</td>
<td>Nurtured, Healthy, Respected, Achieving, Responsible, Active</td>
</tr>
<tr>
<td>Successful learner, confident individual, responsible citizen and effective contributor</td>
<td>Achieving</td>
</tr>
<tr>
<td>Generally optimistic and realistic about what he or she can achieve</td>
<td>Healthy, Respected, Included</td>
</tr>
<tr>
<td>Has good relationships with family and friends</td>
<td>Healthy</td>
</tr>
<tr>
<td>Is actively involved within his or her family, social network, school and community.</td>
<td>Healthy, Active</td>
</tr>
<tr>
<td>Understands the social norms, customs and traditions operating in his or her network</td>
<td>Healthy, Responsible</td>
</tr>
<tr>
<td>Does not experience bullying or discrimination by peers or adults at school or in the local community</td>
<td>Healthy, Safe, Respected</td>
</tr>
<tr>
<td>Does not have a history of self harm or attempted suicide</td>
<td>Healthy, Respected</td>
</tr>
<tr>
<td>Cares about and respects others</td>
<td>Healthy</td>
</tr>
<tr>
<td>Able to talk to others about his or her feelings in age-appropriate ways</td>
<td>Healthy</td>
</tr>
<tr>
<td>Not misusing alcohol, nicotine, drugs and other harmful substances</td>
<td>Healthy, Responsible</td>
</tr>
<tr>
<td>Free from pressure by others to do things which might put them at risk</td>
<td>Healthy, Safe</td>
</tr>
<tr>
<td>Lifestyle does not present threat to current or future health and well-being</td>
<td>Healthy, Responsible</td>
</tr>
<tr>
<td>Has strategies for assessing and managing avoidable risks</td>
<td>Healthy, Safe, Responsible</td>
</tr>
<tr>
<td>Understands and is not unduly anxious about the physical changes taking place during puberty</td>
<td>Healthy</td>
</tr>
<tr>
<td>Aware of the risks of unprotected sex</td>
<td>Healthy</td>
</tr>
<tr>
<td>Adopts safe practices and acts responsibly in potentially high-risk situations, (e.g. when using tools, participating in physical contact sports and other sports involving risk of physical harm; confronted by substance misuse within their network of friends).</td>
<td>Safe, Responsible</td>
</tr>
<tr>
<td>Positive and respectful approach to own and others' sexuality</td>
<td>Healthy, Respected, Responsible</td>
</tr>
<tr>
<td>Behaves in sexually appropriate ways for their age and</td>
<td>Healthy, Safe, Responsible</td>
</tr>
<tr>
<td>Stage of Development</td>
<td>Quality</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Free from exposure to anti-social/criminal activity within the community</td>
<td>Safe</td>
</tr>
<tr>
<td>Not engaged in anti-social or criminal activity within the community</td>
<td>Safe, Responsible</td>
</tr>
<tr>
<td>Shows concern and compassion for others and is not involved in bullying or discrimination</td>
<td>Safe, Responsible</td>
</tr>
<tr>
<td>Feels safe at home</td>
<td>Safe, Respected</td>
</tr>
<tr>
<td>Feels safe when out with friends</td>
<td>Safe, Respected</td>
</tr>
<tr>
<td>Feels confident enough to tell a responsible adult if they have been harmed or threatened with harm</td>
<td>Safe</td>
</tr>
<tr>
<td>Displays age-appropriate motor skills and physical development</td>
<td>Healthy</td>
</tr>
<tr>
<td>Displays age-appropriate communication, cognitive and intellectual skills and development</td>
<td>Healthy</td>
</tr>
<tr>
<td>Displays age-appropriate psychological development</td>
<td>Healthy</td>
</tr>
<tr>
<td>Displays appropriate social skills and development</td>
<td>Healthy</td>
</tr>
<tr>
<td>Motivated to attend and participate in learning at preschool and school</td>
<td>Achieving</td>
</tr>
<tr>
<td>Literacy and numeracy skills are developing</td>
<td>Achieving</td>
</tr>
<tr>
<td>( \text{Is meeting or exceeding appropriate levels of educational attainment across curriculum} )</td>
<td>Achieving</td>
</tr>
</tbody>
</table>

**Children and young people with impairments, disabilities and chronic conditions**

| \( \text{Meet or exceed appropriate learning targets with additional support} \) | Achieving |
| Enjoy and are motivated to attend school                                              | Achieving |
| Participate as fully as possible in the non-academic areas of school life             | Achieving |
| Develop skills for coping with and managing their disabilities and long-term conditions | Achieving |
| Responsive to any additional support provided                                         | Achieving |

**All children and young people**

| \( \text{Self-care and life skills appropriate to age and stage} \) | Achieving, Responsible |
| \( \text{Have a level of independence or autonomy appropriate to age and stage} \) | Achieving, Responsible |
| Learning new skills and applying them to meet new physical and psychological challenges | Achieving, Active |
| Learning about themselves and what they can and cannot do                           | Achieving, Active |
| Developing aptitude in one or more cultural activities                              | Achieving, Active |
| Developing aptitude in one or more sporting activities                              | Achieving, Active |
| Developing aptitude in one or more recreational activities and hobbies               | Achieving, Active |
| Demonstrating positive achievement in non-academic activities                        | Achieving |
| Express sense of achievement from their learning                                    | Achieving, Active |
| Aspire to go on to FE/HE and/or skilled employment                                   | Achieving, Responsible |
| Intend to stay in education or go into FE or other vocational training post-16       | Achieving, Responsible |
| Participate in age-appropriate school and voluntary activities to develop responsibility, leadership and decision making skills | Responsible |
| Engage in age-appropriate voluntary activities | Responsible |
| Play and work cooperatively with others | Responsible |
| Exercise age-appropriate self control over their emotions and behaviour | Responsible |
| Recognise when they are behaving badly and respond positively to correction | Responsible |
| Show age-appropriate remorse after wrongdoing, especially when it has hurt or upset others | Responsible |
| Generally clean and appropriately dressed for school | Responsible |
| Generally understand the consequences of their actions | Responsible |
| Generally take responsibility for their actions | Responsible |
| Show respect for others’ possessions | Responsible |
| Show respect for school materials and equipment | Responsible |
| Not engaged in activities which could lead to school exclusion | Responsible |
| Behaviour is appropriate for their age and stage of development | Responsible |
| Not considered by staff to be disruptive | Responsible |
| Considered by professional staff and parents/carers to be honest and reliable | Responsible |
| Feel accepted and valued by school and community | Included |
| Feel listened to and taken seriously by parents/carers | Respected |
| Feel listened to and taken seriously by friends | Respected, Included |
| Feel listened to and taken seriously by the professionals with whom they come into regular contact. | Respected, Included |
| Feel that parents/carers and other family members respect their privacy and personal space | Respected |
| Feel they are treated by parents/carers as an individual in their own right with their own needs, expectations and aspirations | Respected |
| Have opportunities to take part in community-based and school-based, extra-curricular activities which support social contact | Included |
| Feel encouraged to participate in these activities | Included |
| Feel confident enough to tell a responsible adult if they have been subjected to discriminatory attitudes or actions | Included |
| Feel that the school and community has a positive view towards his or her faith | Included |
| Feel that the school and community have a positive and supportive view towards his or her native language. | Included |
| Have access, if needed, to a faith network in order to practice his or her faith | Included |
| Have access, if needed, to a support network in order to use and further develop his or her native language | Included |

**When in contact with specialist or targeted children’s services the child or young person and family:**

| Has sufficient information to make informed choices | Respected |
| Feels that information they provide is treated in confidence unless there is serious risk of harm | Respected |
| Has confidence that the information they provide is handled and stored in a secure manner | Respected |
Are asked for their consent if specific information is to be shared across agencies | Respected
---|---
Are actively involved in assessment, planning and review processes | Respected
Are helped to prepare for meetings | Respected
Are informed of possible consequences of any decisions affecting them | Respected
Can seek independent advice if unhappy about the decisions taken | Respected

**When the child requires intimate care by professional staff:**

<table>
<thead>
<tr>
<th>Respected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treated consistently with dignity and respect</strong></td>
</tr>
<tr>
<td><strong>The individuality of the child or young person is respected</strong></td>
</tr>
<tr>
<td><strong>The right to personal privacy is respected</strong></td>
</tr>
<tr>
<td><strong>Involved in and consulted wherever possible about their intimate care</strong></td>
</tr>
</tbody>
</table>

**The child’s family:**

<table>
<thead>
<tr>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living in accommodation suitable for their size and needs</strong></td>
</tr>
<tr>
<td><strong>Living in a well-maintained, safe and secure home environment</strong></td>
</tr>
<tr>
<td><strong>Has income adequate for meeting day-to-day needs and special needs</strong></td>
</tr>
<tr>
<td><strong>Manages the household income effectively for benefit of whole family</strong></td>
</tr>
<tr>
<td><strong>Aware of benefits to which they are entitled</strong></td>
</tr>
<tr>
<td><strong>Not experiencing recurring debt problems or, if they are, are being provided with advice on financial matters</strong></td>
</tr>
<tr>
<td><strong>Where unemployed one or both carers can access appropriate training</strong></td>
</tr>
<tr>
<td><strong>Where both carers are working has access to affordable, good quality, local child care provision</strong></td>
</tr>
</tbody>
</table>

**The child or young person:**

<table>
<thead>
<tr>
<th>Active</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feels that parents/carers, friends and professionals want them to fulfil their potential</strong></td>
</tr>
<tr>
<td><strong>Feels that parents/carers, friends and professionals will support them through challenges and difficulties</strong></td>
</tr>
<tr>
<td><strong>Gets regular time in the early years and childhood for playing and interacting with parents/carers</strong></td>
</tr>
<tr>
<td><strong>Encouraged to be curious and to explore their environment</strong></td>
</tr>
<tr>
<td><strong>Encouraged to play with other children</strong></td>
</tr>
<tr>
<td><strong>Receives appropriate stimulus and encouragement to develop interests</strong></td>
</tr>
<tr>
<td><strong>Responds positively to physical challenges in recreational settings</strong></td>
</tr>
<tr>
<td><strong>As physically active as his or her capacities permit</strong></td>
</tr>
<tr>
<td><strong>Actively engaged in sporting and recreational activities</strong></td>
</tr>
<tr>
<td><strong>Receives appropriate support and coaching in their chosen sports or activities</strong></td>
</tr>
</tbody>
</table>