FIFE MULTI-AGENCY CHILD PROTECTION INTER-AGENCY REFERRAL DISCUSSION PROTOCOL (IRD)

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Contents

Introduction

This Inter-Agency Referral Discussion (IRD) protocol is underpinned by relevant legislative context, and the National Guidance for Child Protection in Scotland 2021 (amended 2023).

In terms of child protection safety is the priority. Every child or young person has the right to feel and be safe and protected from all forms of harm and abuse, including:

- Any form of physical, sexual or emotional abuse, sexual or criminal exploitation, child trafficking, forced marriage, female genital mutilation, or internet enabled offending.
- Neglect, faltering growth, fabricated or induced illness.

Abuse or neglect are both maltreatment and could involve the actual infliction of harm but equally could involve failing to act to prevent harm.

Anyone could identify a concern that a child may be at risk of significant harm, and such concerns should be reported without delay to Social Work or where the risk is immediate to Police Scotland.

Where such concerns arise, Health, Police or Social Work practitioners should initiate an IRD, to start child protection processes. Child protection refers to the processes involved in consideration, assessment and planning of required action, together with the actions themselves (National Guidance for Child Protection in Scotland 2021 – updated, 2023).

If the risk of harm is assessed to be significant and immediate Police Scotland and Social Work have statutory responsibilities and must consider the immediate action necessary to secure the safety of the child, other children, others in the family or the wider community.

Definition and Thresholds

An IRD starts the formal process of information sharing, assessment, analysis and decision-making when concerns arise about abuse or neglect of a child or young person up to the age of 18 years, or an unborn baby. An IRD provides a strategic basis for critical risk assessment and agreed response and therefore is distinct from other multi-agency meetings such as Team Around the Child meetings, Child Protection Planning Meetings, or Professionals meetings.

Child protection procedures may be considered for any person up to the age of 18 years, but there are overlaps between the legal boundaries of childhood and adulthood. Fife Vulnerable Young Person Protocol provides practitioners with further guidance when considering those young people aged over 16 years.

Person(s) in a Position of Trust

Concerns which relate to children under 18 years who may be at risk of **harm** through abuse, neglect or exploitation from a person in a position of trust over them should always be considered for IRD. Note that this refers to harm, and not to significant harm.

Where Police, Social Work or Health receive information that a child may have been abused or neglected and/or is suffering or is likely to suffer significant harm an IRD must be initiated without any undue delay. There is no statutory definition or defining criteria for significant harm, however it does relate to serious interruption, change or damage to a child's physical, emotional, intellectual or behavioural health and development. Thresholds around significant harm are difficult to define, and professional judgement is needed about the severity and immediacy of harm or the risk of harm. This will be reviewed as relevant information is shared. To assist practitioners' detail around the circumstances when an IRD is required and when an IRD should be considered is included at Appendix 1. This is a guide, and in no way an exhaustive list. Practitioners should seek supervision when unsure.

Sexual Assault Response Coordination Service (SARCS)

Children aged 16-18 who have experienced rape or sexual assault can access the National Self-Referral Service. This service provides support and collects potential evidence, even if the young person is not ready to report the sexual offending to the Police. This is in accordance with the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021 and the Forensic Medical Services (Self-Referral Evidence Retention Period) (Scotland) Regulations 2022.

When to Involve the Police:

An Interagency Referral Discussion (IRD) may be considered if there are signs of vulnerability in the young person. In some cases, the police must be involved regardless of the young person's wishes, such as:

- **Public Interest:** When information suggests an immediate risk to the safety of the young person or others.

- **Immediate Risk:** If there is a threat to life, serious harm, use of weapons or firearms, abuse, exploitation, or any other significant threat that requires immediate police response.

In these situations, the welfare and safety of the individual and the public take priority over the self-referral process. Please see Forensic Medical Service Self-Referral Protocol for full guidance.

Child Protection vs. Adult Support and Protection:

For vulnerable young persons, child protection should be considered first. However, a multi-agency discussion may determine that adult support and protection is more appropriate.

An IRD is also relevant for children under the age of 12 who may have caused or risk causing serious harm to another, as defined in the Age of Criminal Responsibility (Scotland) Act 2019. For more information, please see ACRA operational guidance for Police and Social Work

An IRD is also the referral for children aged 12 - 17 years who may require formal Care and Risk Management (CARM), those children who present as a serious risk of harm to others as defined in the Scottish Government Framework for Risk Management and Evaluation (FRAME) for children aged 12-17 years. For more information, please see CARM Protocol.

On receipt of an IRD each agency will assess the circumstances and consider whether the threshold is met. Agencies' assessment of circumstances may on occasion differ, and multi-agency discussion may be required to come to an agreed position. Where a decision is made not to progress an IRD, this must be recorded in writing on the IRD document with a robust rationale and a note of the agencies and practitioners involved in that decision. Each agency should save the IRD in line with their own processes.

An IRD is not a single event, but rather a co-ordinated process. The IRD process is closed when a reasoned interagency decision is made and recorded around single or multi-agency assessment and action until the point of a Child Protection Planning Meeting (CPPM), that a CPPM is not required, or that no further action is required. An IRD will remain open until a decision is reached around CPPM, although it is acknowledged that in some cases a competent decision not to proceed to CPPM may be made, but further information comes to light during assessment or investigation suggesting a CPPM may be required. In those cases, the IRD is subject to review to finalise that decision around CPPM (see section Review IRD's).

Complex investigations involve one or more abusers and a number of abused children or young people. Such investigations require a multi-agency response at both strategic and operational levels, but IRD remains the starting point for multi-agency planning. An outcome from IRD may be the need for a Strategic Meeting, which will be chaired and attended by Senior Managers from Police and Social Work, as well as relevant representatives from other agencies. The remit would include setting the terms of reference for investigation, provide strategic leadership, agree resourcing and protocols as required.

Inter-Agency Referral Discussion (IRD) Process

Core Participation

In Fife the core IRD participants are:

- NHS Fife/Health and Social Care Partnership
- Police Scotland Fife Division Child Abuse Investigation Team
- Fife Council Social Work

Education is a key contributor to the IRD process, though not a core participant. A representative from Education may attend IRD meetings when deemed appropriate.

All partners work in accordance with agreed single agency roles and responsibilities, outlined in Appendix 2 - Health, Police, Social Work and Education.

Responsibility for chairing an IRD is shared across all three core partners. This may be the agency that initiated the IRD but that will not necessarily always be the case, where agreement is reached between the participants as to another agency or representative being most appropriate. Where a Lead Professional is already allocated, it is likely that they are the most appropriate representative to take the role of Chair.

Where appropriate, representation can be sought from other agencies or specialisms with relevant information or contribution, for example Barnardo's, Family Support Services, CAMHS.

Initiating an IRD

An IRD should identify the subject child or children. Subject children are those identified as having been abused or neglected or having suffered or are likely to suffer significant harm. For ACRA and CARM IRD's the subject children are those who have caused or present as a risk of causing serious harm to others. It is

expected that the IRD will consider and make decisions in respect of each of these children.

The IRD may also detail other related or relevant children, who may for example be related to subject child(ren) but not to the person who may have caused harm; or related to the person who may have caused harm but have no current contact. These children would not be considered subject children.

Police and Health have specific child protection teams who will assess and disseminate IRDs originating from within their agencies. All Police and Health practitioners initiating an IRD should initially share the document with their respective child protection teams.

Police - FifeIRD@scotland.police.uk
Health - Fife.initialreferraldiscussion@nhs.scot

An IRD within the Social Work service will be initiated and managed by either the Child Protection Team or the allocated Social Work Children and Families Team, should the child or young person be open to the service.

The initiating agency will disseminate the IRD document to core partners:

Police - FifeIRD@scotland.police.uk
Health - Fife.initialreferraldiscussion@nhs.scot
Social Work - SocialWork.IRD@fife.gov.uk

In both Police and Health, child protection teams will assess and allocate the IRD. Within Social Work, the child protection team, supported by Business Support, will identify which team is responsible for the IRD.

Where the child is of nursery or school age and in Education, the initiating agency should also share the IRD with Education with a request for information.

Where the subject child is not of nursery/school age but there are relevant sibling(s) of nursery/school age and in Education, the IRD document will not be shared in full but a request for information from Education should be made. It may be appropriate to share some information to assist Education to support the sibling(s) in school, and that is a matter of professional judgement. Education has business support resources in place to assist with information gathering to support the IRD process, contactable via education.ird@fife.gov.uk

Where safe to do so, the child and/or family should be informed of the IRD and the reason for this. The views and wishes of the child and family should be sought, considered and recorded on the IRD document.

Immediate Safety/Safety Planning

Where dynamic assessment indicates there is a likelihood of immediate risk of significant harm, intervention should not be delayed pending information gathering or sharing, completion or receipt of an IRD document. In these circumstances the immediate priority should be on what will keep the child safe now, and Police and Social Work have a responsibility to decide whether immediate protective action is required.

Emergency Measures to protect the child and any other identified relevant child(ren) can be considered when information supports a child is at immediate risk of harm and that the harm cannot be reduced by a range of interventions or safely managed by a protective adult.

Any immediate protective actions taken, or emergency measures put in place, must be recorded as an Interim Safety Plan on the IRD document.

Inter-agency Referral Discussions can take place out of hours in such circumstances (see section Out of Hours).

Information Gathering/Information Sharing

Agency representatives will timeously gather relevant and proportionate information within their own agency.

Relevant information should include that which allows for the assessment and analysis of the risk of harm or actual harm caused to a child, the level of that risk of harm or actual harm, and to allow for safeguarding of the child. Professional judgement must be exercised to assess the concern and the information that is relevant, proportionate and necessary to share.

The IRD process is fully cognisant of the Data Protection Act 2018 and the lawful basis for processing information is based on the following:

- Processing is necessary for compliance with a **legal obligation** to which the data controller is subject, or
- Processing is necessary in order to protect the **vital interests** of the data subject,
- Processing is necessary for the performance of a task carried out in the **public interest** or in the exercise of official authority vested in the data controller.

Practitioners can refer to single agency guidance, and the multi-agency Information Sharing guidance for further direction.

For the purposes of an IRD, as the concern is assessed to amount to child protection, it is not appropriate to seek or gain consent for the sharing of information among statutory agencies. In these circumstances information must be shared to protect the child, so seeking consent is not appropriate, as consent is only appropriate when an individual has real choice.

Each agency will share their information with the core agencies.

Where it would support the assessment of risk and safety planning, information held by Health around the adults involved with the subject child(ren) can be sought. When the Health Child Protection Team identifies a risk of intra-familial harm and a parent/carer/adult resides in the family home and where parent/carer or adult information is considered pertinent to the IRD process, Caldicott approval can be assumed. If a parent's current partner resides in the family home and is identified as posing risk it may also be appropriate to undertake relevant and proportionate health information gathering and sharing to support IRD process and decision making, Caldicott approval will be sought in these cases. Caldicott approval can be actioned by the Health Child Protection Team.

Health and Education will identify and notify the Named Person Service for the child via agreed internal processes within each agency.

Scheduling

The IRD document will be shared by the initiating agency with an initial assessment as to an appropriate timescale for scheduling.

The timescales for scheduling of IRDs are:

- Same Working Day
- Next Working Day
- Within 3 Working Days
- Within 5 Working Days

This allows for attendance by the most appropriate agency representatives, but the timescale scheduled must be appropriate to the assessed risk and immediacy of any required actions.

When assessing the immediacy of required actions practitioners will consider any forensic opportunities, which could be adversely impacted by any delay. Considerations around forensic opportunities are considered further in Appendix 4.

The scheduled time and date can be amended at any time if assessment of the risk changes in the interim period.

Once an IRD is initiated and scheduled, if a need to gather further information to aid the discussion or to inform the decision is identified, a pre-discussion can take place between agencies - for example, where a third-party account has led to the IRD, it may be deemed appropriate to approach the child to gain a first-hand initial account, and this could be agreed between agencies. Any pre-agreed tasks should be recorded on the IRD document and updated with the outcome prior to or during the IRD meeting.

IRD Meeting

At a minimum the IRD should involve representation from the three core agencies - Health, Police and Social Work.

The nature of concern and the information gathered within each agency will be available to all agency representatives in advance of the scheduled appointment.

Each participant should attend the scheduled appointment prepared, having read and considered the available concern summary and agency information, and analysed the risks to the child, as well as the protective factors to build on.

Considerations and Outcomes

All IRDs will consider as a priority:

- Identification of subject child and any other relevant child(ren).
- The requirement for any other IRD.
- Any safety considerations.
- The level of risk identified.
- Evidence that a crime may have been committed or may be committed against the child/children involved.
- Any time critical actions.
- Medical intervention, including immediate medical assistance and requirement for medical examination.
- Forensic opportunities, including medical examinations, examination of where the incident occurred, seizure of potential evidential items.

- Risk person causing/risking causing harm would pose to others and the wider community impact.
- Notifiable occupations (persons in a position of trust)
- Both recent and non-recent abuse.

All IRD's should consider and record who will feedback outcomes to the child and family.

As previously mentioned, the child and/or family should be informed of the IRD if it is safe to do so. Where an IRD proceeds without the child or family being aware, this should be clearly recorded on the IRD document along with a defensible rationale.

In IRDs held in respect of unborn babies who may be at risk of significant harm, these considerations will lead to agreed outcomes such as:

- Requirement for a joint multi-agency assessment.
- Requirement for single agency response(s).
- What action must be taken around the safety of the unborn baby, and contingency plans in the event the safety actions cannot be completed.
- Requirement for a Child Protection Planning Meeting (CPPM).
- Requirement for early referral to the Principal Reporter - at the time of birth is there a likelihood that the child involved will be in need of protection.

In IRDs held in respect of children who may have been abused or neglected, or may be at risk of significant harm these considerations will lead to agreed outcomes such as:

- What action must be taken around the immediate safety and wellbeing of the child/children involved?
- Requirement for an interagency child protection investigation?
- Requirement for single agency response(s) or investigation(s)?
- Requirement for a joint investigative interview (JII).
- Requirement for a medical examination – see Appendix 5 for full details around the different options for medical examination.
- Joint Paediatric Forensic Examination (JPFE)
- Specialist Child Protection Paediatric/Single Doctor/Comprehensive Medical Assessment.
- Requirement for a Child Protection Planning Meeting (CPPM).
- Requirement for early referral to the Principal Reporter - is the child/children involved in need of protection, guidance, treatment and/or control, is there a need for a Compulsory Supervision Order to be considered.

In IRDs held in respect of children under the age of criminal responsibility (under 12 years), these considerations will lead to agreed outcomes such as:

- Requirement for an ACRA investigation.
- Requirement for the child to be removed to a place of safety and identifying that place of safety.
- Requirement for an ACRA search.
- Requirement for forensic data or samples - if so, is a Sheriff's Order required?
- Requirement for an ACRA investigative interview - if so, is a Sheriff's Order required?
- Requirement for a Community Impact Assessment.

Practitioners can refer to ACRA operational guidance for Police and Social Work for further information on the Age of Criminal Responsibility (Scotland) Act 2019.

In IRD's held in respect of children aged 12-17 years who present a serious risk to others and may require formal Care and Risk Management (CARM) processes, these considerations will lead to agreed outcomes such as:

- Requirement for a Care and Risk Management meeting.
- Requirement for a single agency response or investigation.
- Requirement for a Community Impact Assessment.

Interim Safety Plan

Every IRD must consider an Interim Safety Plan for the subject child and siblings impacted. Any other children considered at risk of significant harm immediate safety planning and/or IRD should be considered.

Any protective actions taken, or emergency measures put in place, to address and mitigate immediate risk will be recorded by the initiating practitioner as an Interim Safety Plan on the IRD document.

The purpose of an ISP is to ensure the safety of the child/children now and if a Child Protection Planning Meeting (CPPM) is to be held, to ensure safety up to that point. An ISP should clearly define the risk of harm, the action required to minimise those risks, who or which service is responsible for the identified actions and the frequency of action.

All agencies involved in the IRD should contribute to the ISP, agreeing all actions and taking responsibility for allocation of the actions for which their agency is responsible.

The ISP should be updated as necessary either until the closure of the IRD or, if an Initial Child Protection Planning Meeting is to be held, up until that point.

The ISP should be clear and practical, in plain, easily understood language, avoiding jargon, acronyms and professional language.

Any participants named in the plan must be aware of, understand and agree their part in ensuring the child's safety. As such the plan must be shared as appropriate within agencies with responsibility outlined in the plan.

The child and family must also be involved in the safety plan. They must be fully aware of, and understand, the content. It is particularly important therefore that language is appropriate and easily understood. The IRD should record who is responsible for presenting the agreed ISP to the child and family.

The ISP is a live safety plan and will be updated when circumstances change, new information comes to light or assessment of risk changes. Relevant agencies and practitioners with responsibility outlined in the plan, and the child and family, must be kept updated of amendments.

Child Protection Planning Meeting

A decision around whether a Child Protection Planning Meeting is required is the final decision of an IRD.

Where an IRD decision is made that a child protection investigation is required, a CPPM must follow within 28 calendar days of the concern being raised, unless an IRD decision has been made that a CPPM is not required. In Fife, it is agreed that the date of 'concern being raised' will be taken to be the date the IRD is shared among partner agencies, and the CPPM should therefore follow within 28 calendar days of that date.

The National Guidance for Child Protection (Scotland) 2021 (updated 2023) provides that a CPPM is a formal multi-disciplinary meeting, which must include representation from the core agencies (Health, Police and Social Work) as well as any other agencies currently working with the child and their family, including Education. The child and relevant family members should be invited and supported to participate, as appropriate in each situation.

The purpose of the meeting is to ensure relevant, proportionate information is shared to allow for a shared assessment of risk, and to agree a plan to minimise risk of harm to the child. The CPPM must decide whether the child is at risk of significant harm and requires a co-ordinated, multi-agency Child Protection Plan.

Closure

An IRD is considered closed once a decision has been reached and recorded to hold a CPPM, and about assessment and action required until a CPPM is held, or a decision is reached and recorded that a CPPM is not required.

A decision that no further immediate action is required may also close the IRD.

If any action(s) remain incomplete at the point of closure of the IRD, once it has been completed the responsible agency must notify all core agencies (Health, Police and Social Work) of the outcome.

Review IRD's

A Review IRD should be raised when new information comes to light or circumstances change, which may require reconsideration of a decision from IRD. A Review IRD is not a new concern about the same child, that would be a new IRD.

The initial IRD document should be updated to reflect that this is a Review IRD, and detail around the additional information or change in circumstances should be added in the appropriate section of the document. The initiating agency should document any safety measures already in place and assess an appropriate timescale for the IRD. The Review IRD should be shared with core agencies, and Education where appropriate. All agencies should review the information previously gathered and shared in respect of the initial IRD, and update that with any new relevant and proportionate information, then share with the core agencies. The Review IRD will be scheduled within the appropriate timescale.

Out of Hours

Out of Hours IRD's are for urgent cases only.

Where an assessment suggests the likelihood of risk of significant harm is immediate, where immediate action is required or where evidential opportunities may be lost without action, IRDs can take place out of hours. The threshold for IRD as outlined previously is still relevant to out of hours IRDs.

The initiating agency should contact the other core agencies to inform of the need for an IRD. Out of Hours details for each core agency are as follows:

Health	Contact Victoria Hospital, Kirkcaldy on 01592 643355 and ask for the On Call Paediatrician.

Police	Call 101 or 999 if an emergency. Details of the concern will be passed to the most appropriate officer/team for action. Email FifeIRD@scotland.police.uk (only monitored 0800 to 2000 hours)
Social Work	Call Emergency out of Hours on 03451 55 00 99 (available anytime out of office hours), email socialwork.EOOHS@fife.gov.uk (only monitored until 0030 hours).

An Out of Hours IRD should still be facilitated and attended by representatives from all three core agencies.

Each core agency representative should endeavour to gather relevant and proportionate background information to support the process. It is acknowledged that out of hours not all information may be available or accessible, and the information may be shared verbally rather than in a written format.

The considerations within the IRD and potential outcomes as outlined previously remain relevant to out of hours IRDs.

The chairing of the IRD, the recording and the sharing of the final completed document will be the responsibility of the initiating agency.

Dispute Resolution

Where there is disagreement at any stage of the IRD, the areas of disagreement must be noted on the IRD document.

Disagreement at any stage should not delay any required action to protect the child/children.

Where agreement cannot be reached, participants should escalate disagreement to their respective line managers. Any manager from the three core agencies can reconvene an IRD. Appropriate managers from each of the core agencies, senior to the agency participant, should collaboratively review the circumstances. The agreed resolution and outcome from such a managerial or independent review should be added to the IRD document, and feedback should be provided to the relevant IRD participants. Please see Fife's Multiagency dispute and escalation Protocol for further information.

Where an agreed decision has been reached within IRD, but a manager from any of the core agencies disputes the multi-agency decision, they should discuss this with

relevant managers within the other core agencies, and Fife's Multiagency dispute and escalation Protocol should be followed.

In addition to recording the resolution and outcome on the IRD document, the managers should complete the relevant IRD Escalation MS form to allow for data capture around areas of dissent and resolution.

Practitioners can refer to Fife's Multiagency dispute and escalation Protocol for further guidance.

Quality Assurance and Review

Fife has an established IRD Quality Assurance process involving senior representatives from the three core agencies.

The review process facilitates quality assurance by assessing a representative sample of pre-birth and child protection IRDs, and all ACRA and CARM IRDs, supporting consistency of standards. Good practice and areas for improvement are identified, and feedback to participants in IRD is facilitated through direct communication with individuals and regular group forums.

Where quality assurance activity identifies that further immediate action is necessary, including for example a review of the original IRD decision, additional necessary safeguarding actions or additional children identified, the quality assurance managers are responsible for ensuring appropriate progression.

When consensus cannot be reached, participants involved in the quality assurance process should escalate via single agency line management, in line with Fife's Multiagency dispute and escalation Protocol

Governance

Data around IRD is gathered as part of the national Minimum Dataset, and further to that an agreed additional local dataset is gathered. The IRD data is scrutinised via the Quality Assurance and Data CPC sub-group and reported to the Child Protection Committee on a six-monthly basis.

Appendixes

1. Inter-Agency Referral Discussion Thresholds

An IRD is relevant in respect of a child who has been abused or neglected, or a child or unborn baby who has come to significant harm/is at risk of significant harm. There is no statutory definition or defining criteria for significant harm, but it does refer to serious interruption, change or damage to a child's physical, emotional, intellectual or behavioural health and development.

As such it is difficult to be prescriptive around thresholds for IRD. Professional judgement is needed about the severity and the immediacy of the risk of harm. The following aims to provide some guidance to practitioners around circumstances where an IRD is required or should be considered. This is no way an exhaustive list and where practitioners are unsure, they should seek supervision.

Situations where there are concerns around abuse, neglect or of significant harm to a child or unborn baby which require an IRD to be raised will include:

Physical Harm

- Any child presenting with a potential non-accidental injury or where there are concerns about potential physical abuse.
- Injuries to a non-mobile baby/child - refer to the **Child Protection Protocol for the Multi Agency Bruising Guidance for Pre-Mobile Infants**.
- Concerns indicating physical assault of a child or young person.

Sexual Harm including Child Sexual Exploitation

- Evidence of sexual or potential sexual abuse.
- A younger child aged under 13 years involved in sexual activity - a younger child cannot consent therefore this is potential sexual abuse.
- An older child aged 13 years or over engaging in sexual activity where there are concerns around risk of significant harm as a result. This may include potential imbalance of power within the relationship, concerns around pressure to consent, force, or exploitation. Reference to the Underage Sexual Activity Protocol may assist considerations.
- Any child or young person who may have taken or had taken indecent images, suggesting abuse or exploitation.
- Any child or young person who has contact (direct or indirect) with a known or suspected sex offender.

- Parental relationship with a known or suspected sex offender which is potentially impacting on the safety and well-being of the child or young person.
- Any child or young person who is being groomed or where there is evidence of child sexual exploitation (refer to **Fife's Inter-agency Guidance on Child Sexual Exploitation**).

A young person who is seen under the Forensic Medical Services (victims of sexual offences) (Scotland) Act 2021 Implementation Self-Referral National Protocol who exhibits indicators of vulnerability or where professional judgement determines there is an immediate risk to their safety or the safety of another person (whether adult or child) or member of the public, the welfare and safety of the person and wider public. (Refer to Self-Referral National Protocol section 11.2 and 11.3)

Emotional Harm

- Persistent emotional abuse – continuous or intermittent pattern of persistent emotional ill treatment that has severe and persistent adverse effects on a child or young person's emotional development, which has caused, or is likely to cause, significant harm.

Neglect

- Any child or young person for whom there are cumulative concerns or significant concerns about neglect and where that pattern of caregiving is impacting significantly on the health, development or welfare of the child or young person.
- Any child or young person for whom there are significant concerns around lack of supervision that may amount to neglect.

Death of a child – unexplained

- Surviving child sibling of an unexpected and/or unexplained child death.

Parental Issues

- Parental problematic drug or alcohol use that is presenting a significant or immediate risk to the unborn baby, child or young person.
- Domestic Violence and/or Coercive Control whether a consistent pattern or not, where this has a significant impact on an unborn baby, child or young person, or where there is immediate risk to the child or young person.
- Drug/alcohol related parental deaths.

Female Genital Mutilation

- Any unborn baby, child or young person subjected to/at risk of Female Genital Mutilation (refer to Fife's Inter-agency Guidance on Female Genital Mutilation).

Forced Marriage

- Any child or young person subjected to/at risk of Forced Marriage (refer to Scottish Government - Multi Agency Guidelines: preventing and responding to forced marriage).

Human Trafficking

- Any child or young person who is a suspected or actual victim of human trafficking.

Medical Needs

- Any unborn baby, child or young person with a medical condition who is at risk of significant harm due to lack of adherence to medical requirements.
- Any child or young person where there are concerns about the management of a medical condition by the child or their carer, which is leading to risk of significant harm**.**
- Any child or young person where there are concerns regarding fabricated or induced illness.

Missing Person

Where it is determined that a child is at risk of 'significant harm' or that their behaviour presents a 'serious risk of harm to others' they should be referred to Police or Social Work to raise an IRD under Child Protection Guidance or Care and Risk Management Guidance (CARM).

Extremist/Terrorist Behaviour

- Any child or young person where there are concerns that the child may be engaging in extremist or terrorist behaviour or may have a close connection with another person who may be engaging in extremist or terrorist behaviour. (Refer to Prevent Multi-Agency Panel Duty Guidance: Protecting people vulnerable to being drawn into terrorism (publishing.service.gov.uk)).

Significant harm to self

- On occasions the significant harm may arise from the child or young person's own actions, and in these circumstances, consideration can be given to whether child protection processes are appropriate. This approach allows professionals to assess situations where a child's self-risk behaviours - such as self-harm, eating disorder, attempted suicide or suicidal ideations, running away or absconding, or the use of substances (drugs/alcohol) - may reach the threshold of significant harm. It is important to note that this does not imply that every instance of these behaviours should trigger a child protection pathway. Many children and young people may be more appropriately supported by alternative pathways or services, such as the Child Wellbeing Pathway, referral to the Children's Reporter and/or appropriate mental health pathways and legislation.

Situations which merit consideration be given to an IRD include:

- A child or young person participating in any form of harmful communication - consider who is involved, the age of people involved, any vulnerabilities, power imbalances and recipients of the message(s).
- Third party disclosure of abuse.
- Where parental mental health may be significantly impacting on the health, development or welfare of the child or young person.
- Violence or threats of violence within the home environment between family members or associates of the family.
- An unexplained death in the child's home, irrespective of whether the child was present or not.

2. Single Agency Roles & Responsibilities - Health

The National Guidance for Child Protection in Scotland (2021, updated 2023) describes some of the essential health roles within a wide spectrum of services and the overarching responsibilities for all health practitioners. Boards will have variations however all will have designated lead roles for child protection.

The **Lead Nurse for Child Protection** is the most senior nurse responsible for child protection and holds a strategic role. They must support the Board in delivering high-quality, safe and effective services that promote wellbeing, early intervention and support for children and their families. The Lead Nurse has operational oversight of the child protection team's 4 core functions; IRDs, child protection advice, supervision and training and leads quality improvement work.

The **Lead Paediatrician for Child Protection** is a senior clinician, usually a paediatrician, who must have child protection expertise and experience in order to advise the health board on strategic child protection matters, provide clinical leadership to medical staff, and other clinicians delivering child protection services.

The **Lead Nurse for Child Protection** and the **Lead Paediatrician for Child Protection** contribute to the work of the Child Protection Committee and subgroups, the development of child protection strategic planning arrangements, standards and guidelines on a single and an inter-agency basis, advise and support child protection health professionals and service providers. The NHS public protection accountability and assurance framework (2022) and associated toolkit guides health boards in assessing the adequacy and effectiveness of their child protection arrangements at both strategic and operational levels and informs existing health board and shared multi-agency governance and assurance arrangements.

The **Child Protection Team Leader (CP TL)** supports and deputises for the Lead Nurse for Child Protection, provides management support to the Child Protection team and partner agencies, has operational management responsibility of the teams 4 core functions; IRDs, child protection advice, supervision and training and supports the quality improvement work of the Child Protection team. The Child Protection Team Leader is responsible for supporting multiagency IRD review quality assurance processes.

Senior Child Protection Nurse Advisors (SCPNA) are registered nurses or midwives who have undertaken specialist further education in child protection and

support the Lead Nurse and the Team Leader in delivering the child protection service across the Board area.

Paediatricians with a Special Interest in Child Protection (PwSICP) support the clinical child protection service and the Lead Doctor for child protection. Providing operational child protection services, undertaking child protection related medical examinations, support for peer review and advice for colleagues in the clinical assessment where there are child protection concerns, liaison between hospital and community staff for child protection.

Midwives (MW) have a significant role in early identification and prevention of risk factors and in the anticipation of additional care needs that may impact the unborn child during pregnancy, these may be physical, psychological, social or cultural. NHS Fife have a Vulnerable In Pregnancy (VIP) MW team.

Health Visitors (HV) are registered nurses or midwives who have undertaken additional education at masters' level. They offer a core or additional home visiting programme to all families with children under five years of age, the core programme consisting of eleven home visits. The health visitor has a named person role, supporting the development of children in the first five years of a child's life, early identification of need, parental support by providing information, advice, and help to access other services.

Family Nurses (FN) are specially trained nurses who offer a licensed Family Nurse Partnership Socio-Educative Programme, working with young first-time mothers and their families, from pregnancy until their child is two years old. In addition to the schedule of home visits, the family nurse fulfils the requirements of the Universal Health Visiting Pathway and the named person role.

School Nurses are registered nurses or midwives who have undertaken additional education, in order to support school-aged children in attaining their health potential. School nurses deliver proportionate universal services to school-age children, based on their professional assessment of need.

General Practitioners (GPs) and practice staff are well placed to detect early or developing concerns about children and families. Their roles encompass prevention, recognition and early response, and out of hours GP services.

All NHS Fife practitioners have a role in protecting the public, and all regulated staff in NHS Boards and services have duties to protect the public.

All NHS Fife staff have a responsibility to act on any concerns they have identified for unborn babies, children and young people in accordance with Inter-agency and single agency policies and procedures.

Sharing relevant information is an essential part of protecting children from harm. Practitioners should all understand when and how they may share information in accordance with inter-agency and single agency policies and procedures.

Interagency Referral Discussions (IRDs) Roles and Responsibilities - Health

The Child Protection team administration staff are responsible for the timely completion of the health administrative processes relating to IRDs, including IRD scheduling.

When professional judgement determines the threshold for significant harm/risk of significant harm has been met in-hours (0830 - 1600 hours), NHS Fife health practitioners are responsible for initiating an IRD following local procedures. The Child Protection Team will be the gatekeeper for health raised IRDs in-hours.

When professional judgement determines the threshold for significant harm/risk of significant harm has been met out-of-hours (after 1600 hours), the Health Practitioner should report and discuss the child protection concern with the Social Work Contact Centre (03451 551 503) to ensure adequate safety planning and the progression of an out of hours IRD if required.

Where any immediate actions have already been taken to ensure the safeguarding of the subject child or children, this should be clearly outlined in the IRD, within the Interim Safety Plan.

If safe to do so, health care practitioners should discuss their concerns with the child/young person and/or parent/carer and should explain the need for information sharing. During any discussions practitioners should be mindful of any ongoing police investigations. Discussions and any views from child/young person and/or parent/carer should be documented on the health electronic record.

NHS Fife are responsible for ensuring appropriate health representation and participation in IRDs. The SCPNA/VIP MW will identify the appropriate health professional to attend the IRD.

The Senior Child Protection Nurse Advisor (SCPNA) will attend for specific criteria as below, this may be in addition to the frontline practitioner:

- Child death (IRD for any surviving siblings)
- Suspected Non-Accidental Injury (NAI)
- Sexual Assault
- Complex Child Sexual Exploitation (CSE) cases i.e. multiple subjects

- Trafficking
- When professional judgement of SCPNA indicates a requirement to attend e.g. out of area IRDs
- Young person not meeting the School Nursing criteria/not in education.

Where the VIP Midwife, Named Person or School Nurse is identified to attend an IRD, they are responsible for arranging the attendance of a deputy should they be unable to attend.

Medical staff will be requested to join the IRD when possible, to provide medical opinion, this may also mitigate any dissent in decision making. Where medical staff are unable to attend the IRD discussion, the SCPNA or child protection admin will inform the Paediatrician on call for child protection of any decision for medical examination.

The health representative will progress and submit health information that is relevant and proportionate and meets Information Governance requirements, to the Child Protection team, in advance of the meeting.

The SCPNA will progress and submit relevant and proportionate GP checks for the purposes of the IRD.

The SCPNA will progress identified adult checks required for pre-birth, pre-school and school-aged children in accordance with the Caldicott Guardian and the Child Protection Team Memorandum of Understanding (MOU).

If the IRD is initiated by Health, the Health representative will be expected to chair the IRD meeting. However, there may be occasions when another agency may be more appropriate to chair the IRD, for example where there is already an allocated Social Worker or Lead Professional. This can be agreed between participants prior to the start of the IRD.

The health representative will attend the meeting prepared, sharing relevant and proportionate health information, participating in analysis and the IRD decision making process, including Interim Safety Planning.

The health professional in attendance will lead on the need for and nature of recommended health assessments as part of the process.

If the use of weapons is identified during an IRD, the health representative should take a health task to inform health home workers by telephone following the IRD to allow the home worker to progress appropriate risk assessment.

It is for the health representative to ensure that any actions or outcomes from IRD that are tasked to health are taken forward.

The health representative is responsible for sharing the outcome of the IRD with relevant practitioners.

The SCPNA will arrange Joint Paediatric Forensic Examinations.

The SCPNA will liaise with out of area Health Boards as required.

Should concerns which relate to children who may have been abused by or may be at risk of significant harm from a health practitioner in a position of trust be identified in during an IRD, an action must be taken by the health IRD representative to inform the Lead Nurse Child Protection/Deputy to allow the appropriate actions to be progressed.

Health practitioners are responsible for maintaining contemporaneous accurate records in accordance with local policy and Nursing & Midwifery Council (NMC) guidelines.

The appropriate line manager/Child Protection Team Leader, and/or the Lead Nurse/Lead Paediatrician Child Protection will participate in disagreement resolution processes.

It is for the health representative to report the status of their actions to the CP admin/Child Protection Clinical Effectiveness Coordinator via the circulated MS form within 5 working days for onward circulation to Police and Social Work via email, data collection and reporting.

The Child Protection Team Leader is responsible for supporting multiagency IRD quality assurance processes.

Each practitioner involved in the provision of care to children and young people is responsible for their knowledge, awareness and appropriate application in practice.

Child Protection single agency and multiagency child protection training is available to all NHS Fife staff. Staff are responsible for ensuring their individual training needs are met and all mandatory role specific child protection training is completed.

The SCPNA are responsible for providing advice and support to all healthcare professionals involved in the IRD process.

All healthcare professionals involved in the IRD process have accountability for accessing advice, support and supervision via their line manager/CP team and should record discussions according to their service procedures.

Individual practitioners are accountable for their own practice and must be fully aware and understand ethical and legal implications and adhere to Professional Guidelines.

3. Single Agency Roles & Responsibilities – Police (Fife)

Police Scotland have a statutory duty to detect and prevent crime, including offending against children, so child protection is a fundamental part of the duty of a police officer. In any child protection concern, there may be criminal offending. Police Scotland are the lead agency in respect of criminal investigations, responsible for investigation and gathering of evidence.

Police Scotland will participate in the IRD process, and will consult with partners, considering and sharing proportionate information to allow for assessment to determine whether a concern is child protection. Where that threshold is met, relevant information will be shared with the other core agencies.

Initiating an IRD

If Police receive information around a child protection concern where it is deemed that there is risk of significant harm to an unborn baby, child or young person up to the age of 18 years, they will raise an Inter-agency Referral Discussion (IRD). Similarly, if the concern relates to a child or young person under the age of 12 suspected of causing serious harm then an Age of Criminal Responsibility (Scotland) Act 2019 (ACRA) IRD should be considered, or if the concern relates to a child or young person aged 12 - 17 years suspected of or at risk of causing serious harm to others then a Care and Risk Management (CARM) IRD should be considered.

Where any immediate actions have already been taken to ensure the safeguarding of the subject child or children, this should be clearly outlined in the IRD, within the Interim Safety Plan.

All IRD's should be submitted in the first instance to the IRD Hub (FifeIRD@scotland.police.uk) within the Child Abuse Investigation Team (CAIT).

IRD Hub

The IRD Hub will assess the IRD to ensure the threshold is met and there is sufficient information available to fully assess the concern and then disseminate to partners as outlined in this guidance, with a defined timescale for discussion.

The IRD Hub will also assess IRD's received from partner agencies and consider the concern and the defined timescale, immediately highlighting any information that would change the level of associated risk.

The IRD Hub will be responsible for a comprehensive check of Police databases, including:

- Unifi (Crime recording)
- Scottish Intelligence Database (SID)
- PPU Database (Legacy Fife System)
- Interim Vulnerable Persons Database
- STORM
- Police National Computer (PNC)
- Criminal History System (CHS)
- Police National Database (PND)
- ViSOR

These system checks will be completed in respect of the subject child or children, parents or carers, the person who has caused or may cause harm and any other relevant person(s). An accurate record of relevant and proportionate information will be shared with core partner agencies and added to the completed IRD document.

IRD Meetings

In Fife (P Division), during normal working hours, the police representative at an Inter-agency Referral Discussion will be a Detective Sergeant or Detective Constable based within the Child Abuse Investigation Team.

It is Police Scotland's expectation that only officers who have successfully completed the following single agency training will undertake this role:

- Initial Investigators Development Programme
- Initial Child Protection training course and
- National Child Protection Interagency Referral Discussion training course.

If the IRD is initiated by Police, the Police representative will be expected to chair the IRD meeting. However, there may be occasions when another agency may be more appropriate to chair the IRD, for example where there is already an allocated Social Worker or Lead Professional. This can be agreed between participants prior to the start of the IRD.

Police representatives will:

- share relevant and proportionate Police information relating to the child, the parents or carers and the person who may cause or have caused harm, and any other persons deemed relevant
- attend IRD meetings prepared, having considered the concern and reviewed all agency information shared
- participate in analysis and assessment of the risks/vulnerabilities and strengths/protective factors around the child to inform appropriate safety planning and contribute to an agreed Interim Safety Plan
- contribute to robust, collective decision making around the subject child or children
- ensure the accuracy of the final IRD document.

Where Police tasks are outstanding on conclusion of the IRD, the Police participant will have responsibility for ensuring allocation and completion of the task and updating other core agencies with the outcome.

Out of Hours

Core hours for the IRD Hub are Monday to Friday 0800 - 1600 hours. Out with those hours, officers within the Child Abuse Investigation Team are generally on duty until 2000 hours Monday to Friday, and from 0900 - 1700 hours Saturday and Sunday.

Where there is a need for an IRD to be progressed out of hours, in line with the thresholds outlined in this guidance, if a suitably experienced CAIT officer is available, they will further IRD's out of hours. Where not available a suitably experienced Senior Investigating Officer or Local Policing supervisor will fulfil the role of the Police representative to allow for progress of an IRD.

Where a child is injured or may require an immediate Medical Examination, then contact should be made with the On Call Consultant Paediatrician at the Victoria Hospital, Kirkcaldy. Contact can be made with this professional through the usual NHS switchboard telephone number.

Where Police are the initiating agency, the Police representative will be required to populate the Inter-agency Referral Discussion document and circulate to core agencies.

4. Single Agency Roles & Responsibilities – Fife Council Social Work

Children Services Social Work

Social Work have the lead responsibility for enquiries relating to children who are experiencing or likely to experience significant harm and to carry out assessments for children in need.

Social Work can make the decision to convene an IRD, as can Health and Police.

Fife Council Social Work Service will fully participate in the IRD process as a core professional, and at times lead professional for child, young person or unborn baby. Social Work may receive requests from other agencies to consider the need for an IRD and Social Work will remain the main point of referral for child protection concerns from other Fife Council services, including Education, Housing, Third Sector Organisations and from members of the public.

If the Social Work service is the receiving agency of a child protection concern, where there is risk of significant harm to an unborn baby, a child or a young person up to the age of 18, they will be required to raise an Inter-Agency Referral Discussion (IRD). This also applies for children and young people who are suspected of causing harm via Age of Criminal Responsibility (ACRA) IRDs and Care and Risk Management (CARM) IRDs. For allocated cases this will be the responsible Area Children and Families Social Work Team, if unallocated or open to Family Support Service this will be the Child Protection Team.

The IRD document should include a concise summary of social work background information (checks). This should be completed by checking all social work recording systems for any relevant information pertaining to the child, parent/carers, the person who may cause/have caused significant harm and any other relevant person(s).

Social Work will be responsible for sharing the raised IRD with other core agencies and with Education (when the child is in school):

PPU CAIT: FifeIRD@scotland.police.uk
Health: Fife.InitialReferralDiscussion@nhs.scot
Key Contributor - Education: Education.IRD@fife.gov.uk

Social Work may have to implement an Interim Safety Plan to safeguard the child/young person or unborn baby. This plan should be included in the IRD and updated as necessary within the IRD meeting and anytime thereafter up until Child Protection Planning Meeting if one is to be convened.

The Social Work representative for an Inter-Agency Referral Discussion, during normal working hours, will be a senior practitioner or a team manager.

If the IRD is raised by Social Work, then the Social Work representative will be expected to chair the IRD meeting. There may be occasions when Social Work will chair an IRD that has been initiated by Police or Health, for example when there is a lead professional for the child or young person, or Social Work have or have had such involvement that they are best placed to chair. This can be agreed with other agencies prior to the start of the IRD.

The expectation of the Social Work representative at an IRD meeting is:

- to share relevant and necessary information relating to the child, the child's parents/carers, the person who may cause/have caused significant harm and any other relevant person(s)
- to come prepared to IRD meeting having read all IRD information and agency checks
- to share details of any editing required on IRD document
- to prepare draft strengths/protective factors and vulnerabilities/risk factors (these should be populated on IRD document for those that Social Work are chairing)
- to fully contribute to the assessment of the information shared and to the decision making in respect of the presenting referral
- to ensure that robust, evidence-based decisions are made for children, young people, and unborn babies to support their safety
- to contribute to the development of safe, achievable, coordinated plans.

All agency representatives will agree the IRD decision and outcome and will ensure the IRD document is accurate.

It is for the Social Work representative to ensure that any actions or outcomes from IRD that are tasked to Social Work are taken forward and notification of the completion and outcome of said actions are sent to Police and Health via email.

Emergency Out of Hours Social Work Service

If a child protection/ACRA/CARM concern is raised to social work out with normal working hours, this should be reported to Fife Council Social Work Emergency Out of Hours Service (EOOHS) on 03451 55 00 99.

If an IRD is required from this referral, the IRD will be generated by EOOHS. It will then be shared with core agencies (Police and Health, see emails above) and there will be an agreed time to discuss the concern, share agency information and make decisions and plans.

EOOHS IRDs should still include representatives from the 3 core agencies - Police, Health and Social Work.

The Police contact out of hours may still be the Child Abuse Investigation Team (CAIT), who can be contacted on 01592 776780. However, it may be that 101 is needed dependent on the time of concern or 999 if there are immediate concerns around safety or protection.

Where a child is injured or may require an immediate medical examination out of hours, then contact should be made with the on-call Consultant Paediatrician at Victoria Hospital. Contact can be made with this person through the NHS switchboard telephone number 01592 643355. If a Joint Paediatric Forensic Examination is required, this should be discussed and agreed with the police representative. It will be Health's (or Police's) responsibility to make arrangements for the JPFE to take place.

EOOHS will have the same responsibilities - and expectations - as set out above for a Children's Services Team Manager or Senior Practitioner who is raising and/or attending an IRD.

5. Single Agency Roles & Responsibilities – Education

IRD Process:

IRDs are initiated by Health, Social Work or Police. A child or young person who is the subject of an IRD will have information recorded on an IRD document. Once an IRD is initiated the following processes will apply:

Stage 1: Initial checks

Basic information is requested from schools.

Information should be recorded on agreed template incorporating a number of questions about the child and shared with the core agencies involved in IRD (Health, Police and Social Work) for the scheduled IRD meeting. Senior management are asked to support the person who knows the child best to complete these questions as a matter of urgency.

- The named person should assess the circumstances and determine whether attending the IRD will be beneficial. If attending IRD, the named person should alert Education IRD who will arrange for a meeting invite to be shared
- In addition, Education are likely to be asked to attend IRD meetings where safety planning is required in school
- In the event of a concern about an Education Service staff member QIO Child Protection should attend the IRD
- Where appropriate, an IRD invite should be extended to Home Education link within Education Service.

Please note that schools should ensure that the Named Person Mailbox is monitored regularly.

Stage 2: IRD Meeting

IRD Meetings are held via MS Teams and are scheduled throughout the day. Each IRD is allocated a 30-minute time slot. Information about the child protection issue and background information gathered by all agencies will be discussed at these meetings.

Stage 3: Processing

Schools will receive an abridged copy of the completed IRD document following the meeting via the appropriate Named Person Mailbox. It will contain the following information:

- Details of the child or young person and other relevant siblings
- Nature of the concern
- IRD decision/outcome.

IRD Process for schools:

A copy of the completed IRD document will be uploaded to the SEEMiS Wellbeing record of the subject child.

A courtesy email will direct the named person to the completed IRD, and any appropriate action(s) required.

Stage 1: Child Protection Co-Ordinator

- Ensure named person is aware of IRD and has completed any actions including feedback.
- Ensure overview of concerns is updated for child including theme of IRD.
- Liaise with named person of all children included in IRD to allow risks to be mitigated and chronologies updated. Do not share the full IRD.

Stage 2: Named Person

- Log into SEEMiS WBA and read IRD fully.
- Summarise main points of concern succinctly in relevant children's chronologies.
- Action any education tasks.
- Note actions taken in single agency chronology.
- Regularly review & analyse chronology and associated information and take appropriate action.

Record CAIT number in chronology of the subject child.

Any queries regarding IRD or this process should be directed to Gavin Waterston, QIO Child Protection (VoIP 430292) or to Sofia McGarry Development Officer for IRD/Child Protection (VoIP 430257).

6. Forensic Opportunities/Timescales

Practitioners initiating an IRD will share the IRD document with core agencies, along with an initial assessment of an appropriate timescale for scheduling. Timescales are:

- Same Working Day
- Next Working Day
- Within 3 Working Days
- Within 5 Working Days

When considering an appropriate timescale, practitioners must consider the assessed risk and immediacy of any required actions. Forensic opportunities which could be adversely impacted by any delay are one of the considerations around immediacy of any required action. This is particularly important in respect of sexual offending against a child.

In recent child sexual abuse, evidence capture from the victim will be critical. Practitioners should consider not only the need for a medical examination, but whether or not early evidence opportunities may be available. Police have a range of non-intimate Early Evidence Kits (EEKs) which can be utilised to capture any early evidence opportunities, regardless of whether a medical examination is subsequently to be carried out. It is therefore important to ensure early notification to Police Scotland of any recent child sexual abuse.

The following is a basic guide to assist in considering how long since the reported offending forensic opportunities may be available.

In respect of the victim, forensic evidence may be captured for up to seven days after the sexual offending.

Practitioners should also consider the forensic opportunities which may be available in respect of the offender, as this should also influence early notification to Police Scotland. Up to 72 hours after reported sexual offending, male suspects would be considered within the window of forensic opportunity.

Where the offending is just out-with forensic window of opportunity, it is always worth discussion with a Paediatrician or Forensic Medical Examiner.

Young People who have experienced rape or sexual assault who accessed the National Self-Referral Service will have their forensic samples taken as per Faculty of Forensic and Legal Medicine guidelines. As per the Retention Period Regulations, evidence (as described in section 17(45) of the Forensic Medical Services Act) retained from a self-referral examination will be stored by the health board for a period of 26 months (2 years, 2 months) from the day the examination starts.

7. Medical Examinations

Health Assessments and Medical Examinations

Health assessments of children, where there are child protection concerns, aim to:

- consider any immediate medical issues or treatments required,
- establish and respond to any unmet health needs, and/or
- provide a specialise medical opinion on whether or not child abuse or neglect may be the likely or unlikely cause of the child's presentation.

The outcome should support multi-agency planning and decision making and also reassure the child and family about longer-term health needs.

It is useful to have a Consultant Paediatrician attend the IRD meeting if there are suspected injuries or concerns around a child's health to capture their views. Within normal working hours, NHS Child Protection Team will bring IRDs to the Consultant's attention. Out of hours the Consultant on-Call can be contacted via Victoria Hospital switchboard. The overall decision to carry out a medical assessment and to determine the type of examination is that of a Paediatrician, however if an IRD has to take place without a Consultant Paediatrician the IRD participants can make the decision for a medical examination. Any disagreement, please refer to escalation and dispute guidance.

Main types of medical examination within Child Protection processes:

a) Joint Paediatric Forensic Examination (JPFE). Examination by a paediatrician and a forensic physician. This is the usual type of examination for sexual assault and is often undertaken for physical abuse, particularly infants with injuries or older children with complex injuries.

b) Specialist Child Protection Paediatric/Single Doctor/Comprehensive Medical Assessment. This type of examination is often undertaken when there is concern about neglect and unmet health needs but may also be used for physical abuse and non-recent sexual abuse. Comprehensive medical assessment for chronic neglect can be arranged and planned within localities when all relevant information has been collated. However, there may be extreme cases of neglect that require urgent discussion with the Child Protection Paediatrician.

There may be variations in who undertakes medical examination, and the purpose of the examination must be clear prior to the examination (usually discussed at IRD or at time of referral for the examination) to allow for a clinician with the appropriate skill set to undertake the assessment.

A Specialist Paediatric Medical Examination or Joint Paediatric Forensic Examination (JPFE) may be appropriate in the following circumstances:

- concerning injuries or condition requiring specialist assessment or further investigation
- the account of injuries and causes provided by carer does not provide an acceptable explanation for child's presentation
- specialist's opinion is required to establish diagnosis
- lack of corroboration of incident account by witness so the forensic examination may be necessary for criminal proceedings and legal child protection processes
- child sexual abuse is suspected.

Specialist imaging/assessments may be requested from medical examinations including:

- Skeletal Surveys which consist of series of radiographic images of all parts of the body in multiple views to assess the bones of a child and allow the detection of occult bony injuries in children with suspected NAI. They can also help identify underlying skeletal disorders. The Skeletal Survey will be repeated again within 10 to 14 days. The follow up survey can confirm original findings, ensure that there were no unseen fractures at the time of the initial concern and aid with dating injuries
- All infants under 1 who are having a skeletal survey will have a CT head scan. Further imaging such as CT and MRI scans are performed in line with Royal College of Radiology guidance and will provide more detail around internal injuries or concerns
- Ophthalmology assessment - to consider any injuries to eyes in cases of suspected abusive head trauma.

- Blood tests looking for medical causes/contribution to injuries or as part of developmental/nutritional assessment.

Consent

Consent must be obtained in one of the following ways:

- from a parent or carer with parental rights
- from a young person assessed to have capacity
- through a court order

Timing

- Timing of the medical examination is agreed jointly by the medical examiners and the other agencies involved.
- Child protection assessments should be carried out, in the child's interests, during the day, unless there is a forensic need or other clinical indication of urgency.

Police and Social Work Roles

The role of Police in JPFE's is to brief the medical professionals conducting the examination around the circumstances, and as part of the forensic evidence capture to collect forensic samples and swabs, ensuring the continuity of the chain of evidence.

Social Work attend medical examinations to support the child and family and to ensure they understand the process, and that consent is provided. Social Work will also ensure information is shared appropriately and consider any safety planning that may be required based on outcome.