**INTERAGENCY REFERRAL DISCUSSION (IRD)**



**Multi – Agency**

**Guidance for**

**Practitioners and Managers**

***Working together with Children’s Services, Police Scotland and NHSGGC***

[](https://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=2ahUKEwjn9Nyd7NLlAhURoRQKHb8QDrcQjRx6BAgBEAQ&url=https://www.scotland.police.uk/&psig=AOvVaw1YdQG-c9Ee5PRve14snPCc&ust=1573035509920234)[](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&ved=2ahUKEwjDm43j69LlAhUFAWMBHXXICBkQjRx6BAgBEAQ&url=/url?sa%3Di%26rct%3Dj%26q%3D%26esrc%3Ds%26source%3Dimages%26cd%3D%26ved%3D%26url%3Dhttps://www.scot.nhs.uk/ggc_2col-2/%26psig%3DAOvVaw3f4J9tHx2eGAUZwn_mKnbh%26ust%3D1573035418140049&psig=AOvVaw3f4J9tHx2eGAUZwn_mKnbh&ust=1573035418140049)

**ACKNOWLEDGEMENT**

This document has been written in partnership with partner Child Protection Committees;

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Please note that health and police colleagues should read this document in conjunction with their single agency standard operating procedures. For Social Work colleagues and others this document should be read in conjunction with their single agency child protection procedures.

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|  | **CHILD PR**OTECTIO**N & INTERAGENCY REFERRAL DISCUSSION** |
|  | **1.1 Interagency Referral Discussion - Definition & Purpose**  An inter-agency referral discussion (IRD) is the start of the formal process of information sharing, assessment, analysis and decision-making following reported concern about abuse or neglect of a child or young person up to the age of 18 years, in relation to familial and non-familial concerns, and of siblings or other children within the same context. This includes an unborn baby that may be exposed to current or future risk.  It is the first stage in the process of **joint child protection assessment.** An IRD may constitute one or a series of discussions depending on the situation. The discussion always involves the core agencies of social work, health and police and may include education where appropriate. Others including adult services or third sector agencies may be involved depending on the circumstances. Such collaboration is a matter of professional judgement exercised by the core agencies.  Other agencies or services may contribute information to inform the decision-making. This could include the Child Interview Team Co-ordinator, voluntary organisations, addictions services, leisure, housing services and SCRA.  The National Guidance for Child Protection in Scotland (2021) states that all agencies have a responsibility to recognise and actively consider potential risks to a child, irrespective of whether the child is the main focus of their involvement.  That role will range from identifying and sharing concerns about a child or young person to making an active contribution to joint decision-making and/or in planning an investigation to support the child or young person concerned. Protecting children involves preventing harm and/or the risk of harm from abuse or neglect. Child protection investigation is triggered when the impact of harm is deemed to be significant.  Where a young person between the age of 16 and 18 requires support and protection, services will need to consider which legal framework best fits each persons' needs and circumstances. Part 1 of the new guidance offers definitions of ‘child’ and acknowledges the legal boundaries of childhood and adulthood are variously defined.  The new National Guidance for Child Protection in Scotland (2021) is available here: [www.gov.scot/publications/national-guidance-child-protection-scotland-2021](http://www.gov.scot/publications/national-guidance-child-protection-scotland-2021)  **When is an IRD initiated?**  The IRD is the first stage in the process of **joint child protection assessment** and should be undertaken in **every case** where it is suspected that a child or young person is subject to or at risk of significant harm from abuse or neglect. An IRD should take place following a request from any of the three core agencies, health, police or social work. It does not require agreement for the IRD to be convened, only that one agency is sufficiently concerned and believes that significant harm (or risk of harm) threshold has been met.  The definition of a child or young person within this context describes;   * all children and young people up to the age of 16 years * Any child subject to a Compulsory Supervision Order up to the age of 18 years * Professional judgement can be applied to including any child / young person deemed particularly vulnerable aged 16 and up to the age of 18 years     This includes unborn children at risk of abuse or neglect, trafficked children or young people, children or young people at risk of exploitation and may also include children or young people who are placing themselves at risk. IRDs can address a number of areas of concern that, while not directly linked to familial responsibility, can and do result in significant harm to children or young people and therefore also require a strategic response from local services.  An IRD should be undertaken for all familial and non-familial abuse or neglect. The key consideration for the multi-agency team is impact on the child regardless of family connections.  Any siblings of the child or young person who is the subject of an IRD and any other child or young person closely linked to the subject or circumstances of the notification of concern should also be considered as part of the IRD. Any help they might need must also be specifically recorded and planned for.   * An IRD must always be considered where there are concerns in relation to the care and protection of a child or young person – Refer to Flowchart in **Appendix 1**.   Where a child is believed to be at immediate risk of significant harm, intervention must not be delayed pending receipt of information. The gathering of information must always be balanced against the need to take immediate protective action.  **1.2 Child Protection and Information Sharing**  Child protection is closely linked to the risk of **significant harm. Significant harm** is a complex matter and subject to professional judgement based on a multi-agency assessment of the circumstances of the child or young person and their family. Where there are potential concerns about abuse or neglect, these must be shared with the relevant core agencies. Professionals should refer to their single agency procedures for guidance on identifying and sharing a potential child protection concern.  The General Data Protection Regulation (GDPR) and Data Protection Act 2018 do not prevent or limit the sharing of information for the purposes of keeping children and young people safe. The Data Protection Act 2018 includes “safeguarding of children and individuals at risk” as a condition that allows practitioners to share information without consent. Information shared should be proportionate, relevant and necessary for the protection of children and young people.  **1.3 IRD Process**  **Initiating an IRD**  An IRD may constitute one or a series of discussions depending on the situation. It is expected that IRDs will take place within 24 hours of the notification of concern being received although it is recognised that some concerns may require a more planned discussion. In the exceptional circumstances that a more planned approach is necessary, this **should not exceed 48hours** unless it is safe to do so, such cases may include allegations of historical abuse where the alleged perpetrator has no ongoing contact with the child/young person, in such instances the discussion should not take place later than 5 working days from the point of referral**.** In cases where an IRD has been delayed beyond 24 hours, clear reasons should be articulated in the IRD record (**Appendix 3**).  In the majority of circumstances IRDs will most likely take place via conference call (**see Appendix 7**). However, in cases presenting particular challenges, there may require to be face-to-face meetings. Where a case is identified as being particularly complex, local child protection guidance regarding complex cases should be followed. The members of these meetings should include, as a minimum, all core agencies of an IRD (Police, Health and Social Work) and the meeting carries equal decision making authority to the telephone conference IRD.  Where it is decided that an IRD should take place, the core agencies will initiate a process of information gathering and sharing (as described under heading, Roles and Responsibilities within the IRD below).  Having received a notification of a possible child protection concern, an IRD will take place between social work, police, and health. Where another service requires to be involved this should happen at the earliest opportunity. Where they have an involvement with the family, education and other health professionals (such as health visitors or school nurses) **must be consulted** in relation to their statutory responsibilities and the key information they hold. Depending on the circumstances, it may be appropriate for education to be directly involved in the IRD decision making.  An IRD will take place **before** any agency proceeds with an investigation, **including** a Joint Investigative Interview (JII), medical examination or other single or joint enquiry, **except** where emergency child protection measures are required.  While it is desirable to have complete information on which to base joint decisions, there may be occasions where core agencies (police, social work and health) need to make decisions on the information available to them at the time. Any immediate child protection action should be undertaken without delay. In these instances, depending on the circumstances, it may be necessary to reconvene an IRD to consider any subsequent new or revised information.  **Protecting Vulnerable Groups**  When an IRD considers a risk or potential risk caused by a person who is in employment subject to Protecting Vulnerable Groups (PVG) registration, the lead professional involved in the IRD must notify the relevant senior manager in their organisation. Details of the referral and the IRD’s assessment of potential risk of further harm should be provided to the senior manager, allowing them to make a formal decision on whether or not to report the concern to the person’s employer.  **Re-convening the IRD**  It may be necessary to reconvene an IRD several times as enquiries progress to review strategies and evaluate outcomes. In particular this would apply where further information is received by any of the core agencies which would require the initial agreed response strategy to be reconsidered. Additionally, in situations where there isn’t enough information to competently make a decision as to the need for future action, it may be necessary to stop and subsequently reconvene the IRD to allow for single agency enquiries to take place to better inform decision making.  **Roles and Responsibilities within the IRD**  Those responsible for joint decision making within the IRD will be the **core agency** representatives: a Social Work Manager, a Detective Sergeant or Detective Inspector from Police Scotland, the identified Child Protection Advisor, Child Protection Service, NHSGGC and where appropriate a relevant Education Manager. The exact persons may change in subsequent reconvened IRDs however will be of the same or a higher supervisory grade and with the appropriate training and experience. **All participating agencies** will take responsibility for seeking information from within their agency (including their adult facing services as necessary) unless otherwise agreed and bringing it to the multi-agency discussion within agreed timescales. Where it is identified that another agency requires to be consulted and/or provide information, agreement should be reached between the core agencies as to who will make the request.  It is the responsibility of the core agency receiving the notification of concern to convene the IRD process. The Lead Professional for the IRD should be agreed at the start of the IRD discussion. Ordinarily, this would be the representative of the core agency responsible for convening the IRD process. The Lead Professional should act as the co-ordinator for the IRD process and be responsible for recording. All participants are responsible for contributing to the decision making and the collation and analysis of the information they are presenting to the IRD. This should include a professional view of the relevance of this information in consideration of any risk to the child or young person. All IRD participants will be responsible for recording all the agreed decisions made and outcomes within their own agency systems.  **All core agencies** are responsible for agreeing on how to proceed within **24 hours**.  **The IRD Meeting & IRD Record**  To support the assessment of risk, details of the circumstances which led to the notification of concern and relevant chronological information relating to significant events for the child or young person who is the subject of the IRD and any other relevant person involved in the concern, should be shared as part of the IRD.  The information sought, gathered and shared should relate to:   * The child or young person about whom there is a concern; * Any relevant information about siblings of that child; * Other children connected to that child where relevant; * Any relevant information about key and/or significant adults who are involved and/or associated with the child in question; * Any relevant information about other children in the household of the suspected perpetrator and any other children the suspected perpetrator has access to.   The source of information can be extensive and may vary on a case by case basis.  Refer to **Appendix 6** for a list of minimum checks to be carried out.  The participants within the IRD will consider and make decisions on relevant issues including:   * Any immediate protective action necessary (if not already addressed); * Identifying further information required as necessary; * Identifying possible risks/ protective factors for the child or young person and any other child or young person as necessary; * Identifying any further action as necessary (including the need for any health action and consideration of the need for a child protection investigation), responsibilities and next steps; * Where necessary the planning of any subsequent child protection investigation; * Where appropriate feedback to other agencies/ services and the referrer.   The IRD Record (**see Appendix 3**) must be used to record the relevant information shared; a summary of the discussion, agreed decisions and immediate plan of action for the child, including the development of an investigation plan as necessary. Every stage of the IRD will be recorded within the IRD Record. Such a record is essential to enable core agency participants to explain their decision making rationale at a later date.  The Lead Professional is responsible for recording the discussion and agreed decisions and actions in the IRD Record. This must be completed within **2 working days** of the completion of the IRD process. The Lead Professional is responsible for sharing the IRD Record with the other participants in the IRD. IRD participants are responsible for ensuring the accuracy of their information and agreed actions, responding to the Lead Professional **within 5 working days** of receipt of the IRD Record. Unless there are exceptional circumstances, if no feedback has been received then the IRD Record will be considered a true and accurate reflection of the discussion. IRD participants are responsible for ensuring that they retain a copy of the IRD Record in the appropriate location within their agency system in line with data protection requirements.   * The IRD Record is **NOT** intended to record findings of any subsequent investigation. The key purpose of the Record is to record the **joint decisions** **and action** taken by participants in the IRD process; * Joint decisions must **always** be recorded by the **Lead Professional** in the **IRD Record** referred to in **Appendix 3**; * The completed **IRD Record must be issued to all IRD participants**. This will be the responsibility of the **Lead Professional**; * It is the responsibility of **all** **IRD participants** to ensure the accuracy of the information within the IRD Record and highlight any required amendments without delay   **Joint Investigative Interviews (JII)**  Whether or not a JII is required is a decision made at **every** IRD meeting. The IRD must consider if the child has been or may have been the victim of abuse, and if it is necessary to consider criminal charges against an individual accused of causing the harm. In such cases, the IRD should nominate the relevant DS or SSW/TM to make contact with the North Strathclyde Child Interview Team Coordinator who will plan and carry out this interview. It is essential that the IRD consider the reason for the JII, any safety concerns and any known needs of the child that require consideration by the interviewers, noting this detail on the IRD record (**Appendix 3**).  The IRD must also consider if the child has been witness to harm, which may not have directly been inflicted on them, for instance domestic abuse or online exploitation. In such cases, the IRD must consider if a JII is required in order to obtain a witness statement from the child. In making this judgement the IRD should consider; the likely impact of the incident on the child and the likelihood of the child having to attend court in respect of the incident. Where it is recognised that the child is required to make a witness statement, the nominated DS or SSW/TM should contact the Child Interview Team Coordinator with the same relevant details.  Whilst in the majority of cases, a decision to proceed to JII, will be accompanied with a decision to proceed to a full Child Protection Investigation, it may be the case, particularly in non-familial cases of abuse that the child / young person is required to be interviewed but they have no ongoing contact with the alleged perpetrator. As such, where the IRD agrees, clear justification for proceeding with the JII without a full assessment under the auspices of Child Protection can be written into the IRD record.  The Child Interview Team Coordinator will consider referrals for child witnesses, when it is agreed the case is sufficiently complex and/or the child or young person is assessed to require additional levels of support.  Where there are no welfare or protection concerns surrounding the witness and therefore the threshold for initiating an IRD is unmet, a referral to the Child Interview Team can progress without scheduling an IRD. Consideration should be given as to the lead agency who will determine that necessary checks/discussion have taken place with relevant individual(s) and/or partner agencies to ensure child or young person is able to proceed with a JII. Each lead agency should determine their method of recording and decision-making in these circumstances.  Referral criteria document in respect of the Child Interview Team must be referred to under these circumstances and in relation to Procurator Fiscal requests.  **1.4 Quality Assurance**  Each of the core agencies will have in place single agency managerial and scrutiny processes and retain responsibility for the quality of their agency’s contribution to the IRD.  Additionally, the IRD process will be reviewed on a multi-agency basis to ensure robust decision making is consistently taking place.  Each local authority area will undertake partnership reviews of a sample of completed IRDs on at least a quarterly basis subject to local policy and procedures. Where this occurs, feedback should be given to the participants of the IRD reviewed and any thematic learning highlighted to the relevant strategic grouping responsible for practice development.  **1.5 Medical Examination / Assessment**  A thorough assessment of the child’s health needs is an essential element of child protection investigations. A comprehensive assessment of a child and family’s medical history and the child’s health can inform the risk assessment and help determine whether further investigation is necessary.  The IRD supports discussion to ensure that consideration is given to the need for a medical examination. Although a medical examination is not a requirement in every case where it is subsequently determined that a child protection investigation is necessary, it needs to be considered in **all** cases regardless of whether the child has any apparent or visible injuries or appears neglected. A medical examination should take place when an appropriate health professional determines that the child’s health/welfare may be at risk The reasons for proceeding with or not proceeding with a medical examination/assessment should be clearly recorded in the IRD Record. **The health core agency representative (usually Child Protection Advisor, Child Protection Service, NHSGGC) will lead on discussions which relate to the medical and health needs of the child.**    During the IRD, an agreement will be reached on the following:   * Whether a Joint Paediatric/Forensic Examination for suspected child sexual abuse is required; * Whether a Joint Paediatric for suspected inflicted (non-accidental) injury is required; * Whether a Comprehensive Medical Assessment (CMA) is required and whether this is required urgently (e.g. cases of acute neglect) by the child protection paediatrician or to be undertaken by a community paediatrician (e.g. chronic neglect). Regardless of who will undertake the CMA, the Child Protection Service will arrange this. * Whether further information/examination should be sought from a Health Professional already involved in the child’s care (GP/HV/hospital specialist)   In all cases the IRD should consider;   * What the medical is likely to achieve; * Who should conduct the medical assessment; * Urgency of the medical; * Where and when it should be conducted.   It is important to note that, If the child requires urgent medical treatment, this can be sought in the usual way through Emergency Department or General Practitioner, the Accident and Emergency Department is NOT the appropriate service to undertake a planned medical assessment and provide a child protection opinion.  A full comprehensive report will be available for each medical within 4 weeks of the medical. Immediate verbal feedback will be given to Police/Social work at the time of the appointment.  Please note that where the outcome of an IRD is not to seek a medical examination, subsequent information at the investigation or case conference stage may prompt a review of this decision. Where this occurs, the identified Child Protection Advisor, Child Protection Service, NHSGGC should lead on discussions which relate to the medical and health needs of the child.  \*\*NHSGCC will confirm their position in light of the National Guidance for Child Protection in Scotland (2021) for 16-18 year olds where a medical is required (with respect to suspected sexual abuse, the current measures will remain – 12 years of age and under will have their medical undertaken at Glasgow Children’s Hospital and 13 years of age and above, the medical will be undertaken at Archway.  Further Information in Respect of Medical Examination  Appendix 3: Flow chart of who to contact during and out-with office hours  Appendix 4: NHSGGC Child Protection Service Medical Guidance.  Appendix 5: National Guidance for Child Protection in Scotland Definitions  Further information on the National Standards for Health Care and Forensic Medical Standards can be accessed here: [National Standards for Health Care and Forensic Medical Standards](http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/sexual_assault_services.aspx)  **1.6 IRD Outcomes & Action Plan**  The IRD Record should clearly identify any action being taken to protect and support the child.  During the IRD process the following options should be considered for action:   * **Emergency Legal Measures**: The information shared may require that agencies take immediate action to ensure a child’s safety by removing them from their home or current residence i.e Child Protection Order, Exclusion Order, Police Emergency Powers, Child Protection Assessment Order; * **Child Protection Investigation** – Undertaken when there are concerns that the information provided suggests that it is likely that a child or young person is suffering or at risk of significant harm from abuse or neglect, and there is a need to investigate further.   A child protection investigation can be undertaken **jointly** between two services or as a **single** agency. Where it is agreed that it is necessary to establish the facts regarding a potential crime or offence against a child, a Joint Investigative Interview (JII) between social work and police should be arranged. Local procedures should be followed in these instances.   1. For further information, the National Child Protection Guidance can be accessed here:   [National guidance for child protection in Scotland 2021 - gov.scot (www.gov.scot)](https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021/documents/)   1. Further information on Joint investigative interviews can be accessed here: <https://www.gov.scot/Publications/2011/12/16102728/0> 2. Further information on Scottish Child Interview Model can be accessed here: <https://www.cosla.gov.uk/about-cosla/our-teams/children-and-young-people/joint-investigative-interviews-of-child-victims-and-witnesses>  * **Other action**Where the IRD determines that there is no need for any further child protection measures at this time but the child may still be in need, there could still be a requirement for action such as undertaking a multi-agency needs assessment. Local procedures should be followed in these instances. Further information on the national practice model can be accessed here:  1. [National Practice Model](https://www.gov.scot/Topics/People/Young-People/gettingitright/national-practice-model/)      * **No further action required**– Sufficient information may be available to decide that no further action is required at this time by any of the IRD participants. Relevant information should then be recorded on the relevant child/ren’s records and shared with universal services as necessary and lead professional (where in place). * **Referral to Vulnerable Young Persons Operations Group** (Inverclyde and Renfrewshire) - Where there are concerns around frequent missing episodes and/or risk of child sexual exploitation, a referral should be made to the Vulnerable Young Person’s Operations Group. Local procedures should be followed in these instances. * **Referral to the Children’s Reporter:** should **always** be considered. Where it is thought that compulsory measures of care may be required, details of the referral should be sent to the Children’s Reporter and the responsibility for undertaking this action should be agreed and recorded within the IRD Record.   **Completing an IRD**  The IRD process will not be considered completed until a decision is made as to the need for a child protection investigation which is reflected in the IRD Record along with any other outcomes and agreement as to feedback to other agencies and referrer as appropriate. If the IRD agrees that a child protection investigation is necessary, regardless of this being single or joint, it must agree on how to proceed with identified individual tasks and timescales to protect the child or young person during the investigation and up to the time of any Child Protection Case Conference that may be arranged. The IRD can be re-convened at any stage, regardless of the decision of the initial IRD.  The three core agencies must agree the completion of the IRD process.  **1.7 Resolving Disagreements**  If any agency involved in the IRD disagrees with the decision of any party and where a compromise cannot be reached, consultation with senior managers from Social Work Service, Police Scotland and Child Protection Service NHSGGC should take place in order to reach a decision. The points of disagreement and resolution must be recorded on the IRD Record (refer to Appendix 2). There should be no delays in protective action as a result of the disagreement and the majority decision will apply to **avoid delay beyond 24 hours**.  Appendix 1  **National Guidance for Child Protection in Scotland (2021) Flowchart**  **Concern about harm or risk of harm to a child, or children, from abuse or neglect** (familial and non-familial).  **Notification of nature and location of concern to police or social work** (referral to police if risk of harm is immediate).  **Wellbeing concern** |
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**Consideration of inter-agency referral discussion (IRD).** If there is likelihood of significant harm IRD process will commence. (Emergency protection considered if risk is immediate).

* Investigative principles apply at every step
* Information sharing principles apply at every step
* Referral to Reporter may occur at any stage
* Timescales for key steps in assessment and planning apply
* Professionals must consider the understanding, experience and engagement of child and family/significant others at every step
* Assessment of risks and strengths is dynamic. Steps may need to be revisited

\*interim safety plan applied when needed

Concerns about neglect or abuse of a child believed to be involved in serious harmful behaviour, child protection investigation will be necessary for care and protection of all children involved must be planned and co-ordinated.

Assessment and support, which is co-ordinated when a multi-agency plan is required. Re-referral to police or social work can occur if risk assessment changes.

Child Protection Planning Meeting reviews Child Protection Plan and Registration.

Child Protection Core Group Meetings work with child and family to implement plan.

**Child Protection Planning Meeting** (if multi-agency Child Protection Plan is required to prevent significant harm). Consideration of adding child’s name to child protection register, and referral to Reporter. Child Protection Core Group identified.

**Child protection investigation.** A multi-agency assessment, co-ordinated by a lead professional, is required when IRD decides there is risk of significant harm. (If not, assessment and support may still be offered).

**IRD process.** The start of the formal process of information sharing assessment, analysis and decision-making following reported concern. If likelihood of significant harm, initial plans are made eg about: investigation; JII; health assessment; needs of this child and others involved in this context; and any immediate protective action. \*

Appendix 2

**Child Protection Flowchart – Interagency Referral Discussion (IRD)**

**Concern Raised**

**Yes** – Refer to Reporter

Partners across services working with children and families

Might compulsory measures of supervision be necessary?

Public

**Child Protection Investigation**

Information gathering and the decision to launch an investigation is done jointly, and in consultation with **Education** services and other appropriate agencies through IRD. **Relevant professionals with a significant involvement in a child’s life** must be informed and/or involved.

**Social Work** seek Child Protection Order

**Police** use their powers to remove the child

No further action

Need for support identified

**No requirement for further child protection procedures**

**Interagency Referral Discussion (IRD)**

**Police, Social Work and Health**

Does the situation require an immediate response to protect the child?

**Initial Information Gathering**

**Appendix 3**

**Interagency Referral Discussion (IRD) Record**

*This document provides a record of decisions made at an IRD. The professional leading the IRD is responsible for completing the record and distributing it the other participants within 2 working days. Each agency must ensure a copy of this record is retained in the appropriate location within their agency system in line with data protection requirements.*

**Part A**

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| **Referral Details** | | | |
| Referrer name / agency: | |  | |
| Primary Concern: | | Additional Concern(s): | |
|  | |  | |
| Date and time referral received: | Date and time IRD commenced: | Date and Time IRD Completed | Role/ relationship of Referrer to child |
|  |  |  |  |
| **Provide any reason for delay :** | | | |

| **Child/ young person(s) involved:** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Name | DOB / EDD | Address | School/Nursery | Care First ID | CHI | Gender |
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|  | | **Discussion Participants:** | | | |
| Agency | IRD Lead (X) | | Name | Designation | Involved /Consulted |
| Social Work |  | |  |  |  |
| Police |  | |  |  |  |
| Health |  | |  |  |  |
| Education |  | |  |  |  |
| Other (Please State) |  | |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Parents / Carers & Other Significant Peron(s):** | | | | | | |
| Name | Dob | Relationship to Child | PR  *Yes/No* | Address | Care First ID | CHI |
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| **Referral summary:** |
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| **Agency System Checks – Information Shared** | | | |
| --- | --- | --- | --- |
| IRD (last 2 years) |  | CPR (last 2 years) |  |
| Social Work | Allocated Case: Y / N | Legislation: | |
|  | | |
| Police |  | | |
| Health |  | | |
| Education |  | | |
| Other (Please state) |  | | |

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| **Summary of discussion and list of concerns / risks identified:**  *Key Considerations:*  *\*Are there indicators of a crime or offence being committed towards the/any child that would warrant further investigation? If so, detail offence type*  *\*Are there indicators of risk of significant harm that would warrant further investigation?*  *\*Are there indicators of risk to the child’s health that would warrant further investigation? Including the need for a medical?*  *\*Is more information required which may require the re-convening of the IRD?* |
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| **Details of any immediate safety plan required to safeguard the safety, health or wellbeing of the child/ others** |
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| **Does the child present a risk to themselves or others and is any immediate action required to mitigate this risk?** |
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| **Are there any other children potentially at risk within the household, within the wider community or linked to the perpetrator? What action is suggested in respect of these children?** |
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| **Detail any dissent by professionals and what action if any was taken to resolve this** |
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| **Decisions/ Actions Required:**  ***(please mark X as appropriate)*** | **Child 1** | **Child 2** | **Child 3** | **Child 4** |
| --- | --- | --- | --- | --- |
| **Child Protection Investigation** |  |  |  |  |
| Child Protection Single Agency Investigation |  |  |  |  |
| Child Protection Joint Investigation |  |  |  |  |
| No requirement for Child Protection Investigation |  |  |  |  |
| **Decisions** |  |  |  |  |
| Joint Investigative Interview (Forensic) |  |  |  |  |
| Progress to Child Protection Case Discussion |  |  |  |  |
| Emergency legal measures – please specify |  |  |  |  |
| Referral to Children’s Reporter |  |  |  |  |
| Other action -please specify |  |  |  |  |
| No further action |  |  |  |  |
| Medical Action | | | | |
| Forensic medical |  |  |  |  |
| Comprehensive medical (acute) |  |  |  |  |
| Comprehensive medical (via Community Paediatrician) |  |  |  |  |
| Other health action -please specify |  |  |  |  |
| No medical action required at this stage |  |  |  |  |

| **Joint Investigative interview (JII) Referral Details** | |
| --- | --- |
| DS or SSW/TM who will make referral to North Strathclyde Cadre |  |
| DS or SSW/ TM undertaking Briefing and De-briefing (If known) |  |
| Date / Time of Referral to Cadre |  |
| Point of contact for Interview feedback (Name, Contact Number and Email) |  |
| **Please detail below any specific details (if known) for Cadre to consider** (i.e. who is best to support the child to and from interview, desired timescale for interview, gender of interviewer, any request for interpreter and any known learning needs) | |
|  | |
| Direct contact by nominated DS or SSW/TM should be made to the cadre (**0141 305 4635 or 0141 305 4637)** who will record all necessary details, link in directly with the relevant DS or SSW/TM undertaking the Briefing and Debriefing. Feedback will be provided directly to the investigating social worker. A copy of the completed IRD should be forwarded to the cadre to assist in the planning of the interview. | |

| **Reason(s) for decision(s)**  *\*Please record if it is appropriate to feedback to the referrer and who will be responsible for this* |
| --- |
|  |
| **Relevant consent information (NB required for medical examination):** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency:** | **Name** | **Designation** | **Outcome Agreed/Not agreed *(delete as appropriate)*** |
| Social Work |  |  | Agreed/Not agreed |
| Health |  |  | Agreed/Not agreed |
| Police |  |  | Agreed/Not agreed |
| Education |  |  | Agreed/Not agreed |
| Other |  |  | Agreed/Not agreed |

|  |
| --- |
| **Reconvened IRD**  *\* If the IRD re-convened please provide dates of re-convened discussion, changes to discussion participants, new information gathered, changed to risk assessment along with any other relevant detail* |
|  |

|  |  |
| --- | --- |
| *Police use only: IVPD No linked to this IRD record* |  |

Appendix 4

**Medical Assessments in Child Protection**

**FLOW CHART**

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Appendix 5

**NHSGGC Child Protection Service Medical Guidance**

Medical Examination

The primary purpose of the medical examination is to address the health and emotional needs of the child in a holistic manner. A secondary purpose is to collect forensic evidence for police and court proceedings including ideally video documentation of the examination and appropriate forensic swabs in a timely way. These purposes can conflict and need to be carefully managed.

Specialist Paediatric Examination

The Specialist Paediatric Examination provides a comprehensive medical assessment of the child, establishing the need for immediate treatment and ongoing health care as well as providing a high standard of forensic evidence to sustain any criminal or care proceedings and offering reassurance and advice to the child and carers. The examination is intended to encompass both the child's need for medical care and the legal requirement for evidence in a single examination. It is carried out by a single doctor – usually an experienced trained paediatrician who has additional skills in child protection.

Joint Paediatric/Forensic Examination

The Joint paediatric/forensic examination combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate specimens for trace evidence including, for example, semen, blood or transferred fibres. While the paediatrician is responsible for assessing the child’s health and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up, the forensic physician is responsible for the forensic element of the examination and fulfils the legal requirements in terms of, for example, preserving the chain of evidence. The presence of two doctors in the joint paediatric/forensic examination is important for the corroboration of medical evidence in any subsequent criminal proceeding and is also good medical practice.

Both types of medical examinations should include the use of a national paediatric proforma (the clinical record of examination) and may include a colposcope to provide light and magnification when examining the genital area. Usually a contemporaneous DVD recording is also taken in case a further opinion of findings is required during legal proceedings. Written consent from an individual with parental rights (if child under 13) or child themselves must be obtained for this procedure. Pre-pubertal children are never examined internally unless the examination takes place under general anaesthetic (for example if surgical treatment required at presentation) and deemed necessary for the clinical assessment.

Comprehensive Medical Assessment

In GGC there is an established process for assessment of children at risk of ***chronic neglect***. These children are referred into the Child Protection Service in the usual manner from other agencies and triaged for Comprehensive Medical Assessment (CMA). The CMA service is delivered by Specialist Children’s Service (SCS). CMA’s are carried out by Consultant Paediatricians in a standard way with opinion given and reports written.

An immediate CMA by the child protection Paediatrician may be indicated if there are concerns about acute neglect. A discussion with the appropriate medical team is required to plan the type and timing of any medical assessment.

Appendix 6

**Definitions of Medicals from National Guidance on Child Protection for Scotland**

Comprehensive medical assessment

366. A comprehensive medical assessment should always be considered in cases

of child abuse and neglect, even when information from other agencies show little or

no obvious health needs. Accurate and comprehensive entries made in the health

records are essential. In some cases of child abuse and neglect, there will be no

obvious signs or symptoms and some children will require diagnostic procedures

only available in a well-equipped hospital or clinic.

367. 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

when taken in conjunction with other assessments, so that 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 damage or health risk has occurred.

Specialist paediatric or joint paediatric/forensic examination

371. A specialist paediatric or joint paediatric/forensic examination may need to be

carried out under the following circumstances:

* the child urgently requires more specialist assessment or treatment at a

paediatric department (for example, if they have a head injury or suspected

fractures);

* the account of the injuries provided by the carer does not provide an

acceptable explanation of the child's condition;

* the result of the initial assessment is inconclusive and a specialist's opinion is

needed to establish the diagnosis;

* lack of corroboration of the report, such as a clear statement from another

child or adult witness, indicates that forensic examination, including the taking

of photographs, may be necessary to support criminal proceedings against a

perpetrator and legal remedies to protect the child;

* the child's condition (for example, repeated episodes of unexplained bruising)

requires further investigation; and

* in cases of suspected child sexual abuse, as the medical examination has to

be carried out by medical practitioners with specialist skills using specialist

equipment.

*For further information see the National Guidance for Child Protection in Scotland (2014)*

[*https://www.gov.scot/Resource/0045/00450733.pdf*](https://www.gov.scot/Resource/0045/00450733.pdf)

Appendix 7

**Records checks to be carried out**

Social Work

* + Social Work recording system (eg SWIFT/CCM/OLM/Info@Work) for child, siblings, parents/carers, perpetrator and any other connected children.

Health

* + EMIS (Child’s Health Record) for child and siblings.
  + Portal (Hospital Record) for both child and relevant adults.

Police Scotland

* Criminal History System (CHS)
* Police National Computer (PNC)
* Scottish Intelligence Database (SID)
* Vulnerable Person Database (VPD)
* Relevant Command and Control System for Division
* Divisional Crime Recording System
* PND
* Legacy Databases

If, through the minimum checks, a subject is identified as having a record on Violent and Sex Offender Register (VISOR), full details must be obtained at the earliest opportunity.