West Lothian Child Protection Committee

INTER-AGENCY REFERRAL DISCUSSION (IRD) PARTICIPANTS' GUIDANCE

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Contents

Introduction

An IRD is the start of the formal process of information sharing, assessment, analysis and decision making where one or more of the core agencies assess that there is a risk of significant harm to a child[1] up to the age of 18 years. This may be in relation to familial and non-familial concerns, concerns about siblings, other children in the same context and unborn babies.

All concerns which indicate risk of significant harm must lead to consideration of an IRD. When information is received by Police, Health, or Social Work they should consider their agency's information and discuss with others if required. If it is concluded that a child may have experienced or may be at risk of significant harm, an IRD must be convened.

IRDs should, wherever possible, happen during normal office hours. Out of office hours professionals should focus on immediate actions to protect a child and interim safety planning until the IRD can take place.

When should there be an IRD?

This list is not exhaustive. The Child Protection procedures apply to children from before birth to the age of 18)

IRD should **always** be considered:

- Child presenting with unexplained injuries, allegations of physical assault
- Bruising to a child who is not mobile
- Concerns that an unborn baby will be at risk of significant harm as soon as it is born
- Under 13 years – sexual activity.
- Sexual activity with a child where one person is in a position of trust
- Chronic neglect
- Parental alcohol or drug use/mental ill health/learning disability that presents a risk to the child
- Domestic abuse incident where child is injured/involved.
- Child who has committed a serious sexual or violent offence against another person (CaRM)
- Child experiencing/at risk of child exploitation (including online) – sexual / criminal / sextortion
- Allegations of sexual assault/rape
- Concerns about FGM/forced marriage/honour-based abuse
- Following drug raids on properties where children live/frequent
- Sudden and unexplained death of a child
- If a disclosure is required about the risks presented by a Registered Sex Offender
- Medical neglect (teeth, failure or delay seeking medical attention, failure or delay following medical advice). Concerns that a parent is deliberately making a child ill or is withholding or maladministering required medication

IRD **may** be considered:

- Child self-harm/suicide attempt
- Child presenting a risk to others/displaying harmful sexual behaviour
- Child (over 13 years of age) engaging in sexual activity. (Considerations: ages of those involved, consensual or coercive, alcohol or drugs a factor, payment/bribery/threats)
- Parental death from murder or suicide, parental self-harm/suicide attempt
- Domestic abuse
- Accumulation of concerns (A pattern/history of concerns should be considered in the overall context of the child's safety / wellbeing / development.)
- Threats of serious violence to parents/carers by a third party

[1] The term child is used throughout to mean someone up to the age of 18

Which professionals should be involved?

Police, Social Work and Health must always be part of an IRD. Information must always be sought from other agencies and services working with the child and their family. If a child is attending nursery or school, Education must be consulted as part of the IRD. Best practice would see a Designated Member of Staff for Child Protection (DMS) from the school or nursery being involved in the IRD. Consideration should be given to inviting ASP SW to the IRD if consideration of whether CP or ASP procedures would best provide a route to protect a 16 or 17-year-old is required. Wherever possible IRDs should involve three (or four-way) conversations rather than telephone calls between two agencies.

Information should always be gathered from those involved with the child or family (this includes professionals whose focus is on working with adults). Information should be gathered from previous local authority areas where a child or the family has lived and from other police forces outside Scotland if appropriate.

Duration of IRD

Completing IRDs should be a priority for all participants. CPPMs should be arranged within 28 days of an IRD starting and professionals and family members invited to CPPMs should get at least 20 days' notice of the meeting. In effect this means that the majority of IRDs should be completed **within 8 calendar days**. An IRD is completed when a decision has been made about the need for a CPPM.

In exceptional circumstances IRDs may take longer to conclude than 8 working days. For example, an interview with the child may be delayed, the outcome of medical assessments may take some time. If this is the case then consideration should be given to extending the timescale to holding a CPPM to ensure that those invited have time to prepare a report, receive and read reports for the meeting and that parents are adequately prepared for the meeting.

Who should be considered for an IRD?

Familial abuse

The need for an IRD should be considered for all children in the household and children in the extended family who visit the household/ have contact with or are sometimes cared for by the alleged perpetrator. The risks to **each** child and any actions required should be considered. Where children live in separate households it may make more sense to initiate more than one IRD

Extra-familial abuse

- The need for an IRD should be considered when the alleged perpetrator is not a member of the child's family but the child is at risk of significant harm. The source of the risk may be criminal gangs, a peer, an online threat, a single or group of sexual predators, a person in a position of trust (e.g. priest, teacher, youth club leader).
- In addition to the Child Protection procedures, if more than one child is identified as being at risk of CSE, the Organised/largescale CSE Procedure should be considered.
- Children who present a risk of serious harm to others (including those under the age of criminal responsibility)
- Children who are at risk of significant harm due to self-harm (including suicide attempts)
- It is important to remember that children who are accommodated or subject to a supervision order may still be at risk of significant harm

16- and 17-year-olds

CP Procedures apply to all children up to the age of 18 years of age. Concerns about a 16- or 17-year old should be raised under CP Procedures. Where appropriate, an IRD will be initiated.
For some 16- and 17-year-olds it may be appropriate to consider the use of Adult Support and Protection or other legislation to provide protection and support beyond their 18th birthday, and ASP SW Manager should be included in the IRD.

For some 16- and 17-year-olds, particularly those who are not known to any service, the benefits and implications of involvement in Child Protection processes beyond the IRD stage will need to be carefully thought about and it may be more appropriate to ensure that they are provided with or sign-posted to support.

Risk Analysis

Analysis is the "so what?" of risk assessment.

Analysis involves making sense of the information - Sift out the irrelevant, focus on what's important.

What is the information telling you about:

- The child's lived experience;
- The family's strengths;
- The risk to the child;
- The factors that increase the risk (e.g. parent's mental ill-health, substance misuse, learning disability);
- Who or what presents the risk, and;
- Protective factors that mitigate the risk?

What does your professional training / knowledge / experience and research tell you?
The analysis and the decisions made as a result of the analysis are a multi-agency responsibility and should be undertaken together.

Recording

The analysis and decisions made as a result should be recorded in the "Decisions/Actions Required" tab of the eIRD form in the boxes titled "Summary of risks identified" and "Protective factors". Factors are only protective if they mitigate the identified risk.

The analysis of risk is ongoing throughout the IRD as more information comes to light e.g. the outcome of a medical assessment or joint investigative interview.

Example

(Referral: Jenny is 5, started school 6 months ago, referred by school because of concerns about presentation – ill clothed, grubby, head lice, tired, hungry and parents' lack of engagement when school has raised concerns with them)

RISK ANALYSIS

Following discussion of the information gathered
Susan Green (PPU), Helen Plum (SW), Lisa Scarlett (NHS Advisor) and Paul Mustard (DHT) agreed that Jenny is at risk of significant harm: Neglect by both parents.
The risk is increased by:
Both parents' substance use (alcohol)
Father's gambling addiction
Poverty (jobless household)

Poor housing
Mother's diagnosis of severe depression (spends large parts of the day sleeping)
Previous poor engagement with health visitor and current poor engagement with the school.

Maternal grandmother lives in the next street. Whether she is a protective factor is unknown at this point but should be explored further.

AGREED:
Medical assessment (suspicion of untreated head lice and impetigo, possibly underweight)
CPPM

Decision making, IRD outcome and communication with others

Decisions and Outcomes

Decisions and the outcome of the IRD are the responsibility of the core agencies (& Education if involved). Decisions and actions should be made together. Where the decision is made to arrange a CPPM or CaRM meeting an Interim Safety Plan (ISP) should also be agreed.

The outcome of an IRD may be:

- No further CP action (return to Universal Services' support)
- CPM (further multi-agency assessment and possible multi-agency support required)
- CPPM - ISP (alongside use of the Organised/largescale CSE Procedure if appropriate)
- CaRM meeting - ISP
- ASP procedure

A referral to the Reporter or use of emergency legal powers can be considered at any stage of the IRD

Communication

IRD participants must agree who is responsible for:

- feeding back to the referrer
- informing the named person and any other services that may be involved with child and/or family. Early sharing of the decision to hold a CPPM means that professionals have the opportunity to begin gathering information, producing reports and speaking to the family before a formal invite is issued.

IRD participants should also consider whether discussion/investigation has highlighted any safety issues for staff meeting with the family or visiting the home. If there are any, IRD participants must agree who will warn staff/services involved.

Interim Safety Plan (ISP)

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

The Interim Safety Plan should be recorded on the "Decisions/Actions Required" tab in the specific section for this purpose at the bottom of the page.

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

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

Supervised contact

If a child's contact with parents or the alleged perpetrator is to be supervised until the CPPM takes place, before deciding that the non-abusing parent or another family member can supervise contact the following should be considered:

- The length and frequency of the contact;
- The nature of the supervision required e.g. someone around, eyes on at all times, whether physical contact is allowed;
- Whether the supervision is for further assessment purposes;
- The risk to the non-abusing parent or family member from the perpetrator;
- Whether the non-abusing parent or family member understands the reasons for supervision and is likely to, or able to comply.

Recording

1. Child(ren):
2. Incident/Trigger for IRD:
3. Risks:
4. Interim Safety Plan: cut & paste from the box in the Decisions/Actions tab
5. Main outcome:
6. Is the case proceeding to Initial Child Protection Planning Meeting or CaRM meeting?
7. If not, should a CPM be arranged?
8. The view of the child/YP regarding risks investigated and outcome of IRD:

There may be a different conclusion for different children involved in the IRD and differences should be specified.

Bairns' Hoose

The IRD should consider making a referral to Children 1st for a Recovery Worker to support the child(ren) and their family/carers through the child protection investigation as an alternative or additional support to professionals already involved.

IRD Flowchart