NCPG028 - the Royal College of Paediatrics and Child Health (Scotland)
The Child Protection Committee of the Royal College of Paediatrics and Child Health (Scotland) would like to respond to this consultation as follows.

CONSULTATION QUESTIONS

General Questions

1. What are your views on the usefulness and accessibility of the guidance for your sector?

RCPCH in Scotland is very concerned that from the viewpoint of widening the understanding and responsibilities of front-line health staff to be able to identify and respond to concerns at an early stage the guidance as currently drafted is unhelpful. The document is unnecessarily wordy and not clearly ordered despite the sections. There are contradictions between different parts of the guidance. The language used to describe levels of concern and potential risk of harm is inconsistent, the terms are not always defined e.g. ‘persistent neglect’ leaving the threshold for action unclear particularly for front line staff in universal services who do not have specialist child protection knowledge.

Are the suggested processes and terminology used relevant to your service/agency/profession?

The guidance appears heavily based in police and social work process with very little process guidance for health.

There are many suggestions which are not clearly evidenced e.g. Para 145 states – Very often referrals concerning a child at risk of significant harm come from the public. What is meant by “very often”, and what is the evidence for this statement?

How could they be improved?

In our view a complete rewrite is required focusing on key messages for frontline workers and processes required to protect children in 21st century Scotland.

2. The guidance seeks to strike a balance between acknowledging the Getting it right for every child approach as the future direction for children’s services, and the current stage of its development and implementation across Scotland.

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What are your views on how GIRFEC has been incorporated into the document?

Highly specialised children’s services and adult services will be unfamiliar with GIRFEC, whilst we acknowledge the importance in the wider context of children’s services we would have some concern that too much emphasis on GIRFEC might detract from a clear focus on meeting the needs of children at risk of harm.

In section 3 the presentation of the material is haphazard switching between different concepts around the assessment of risk. As a result in para 302 & 303 the text is misleading implying that a ‘detailed risk assessment’ should only be undertaken when a child has already been identified as ‘high risk’, meaning he/she is very vulnerable and living in a situation in a high level of adversity. This in turn implies practitioners may conclude the risk level to be medium or low where a detailed risk assessment has not been carried out. This appears to be a dangerous message.

3. Are there any equality or diversity issues that should be more fully reflected in the guidance?

No – they seem well addressed.

Specific Questions

4. Part 1: Key Definitions and Concepts: The guidance suggests that there should no longer be a requirement to identify a category of registration when registering a child on the Child Protection Register. This is to encourage a move towards a focus on the needs and risks to the individual child, rather than on categorisation.

a) Do you agree with this change in process?

Yes

Please provide additional comments.

The abolition of registration categories is welcome, as our experience is that a focus on the category of registration has been the cause of much debate and dissent amongst practitioners at case conferences, and also resulted in disagreement and anxiety from parents. It will however be vital to capture the nature of the abuse and/or neglect for service planning, audit and research as noted below.

b) We are aware that removal of categories of registration will have an impact on management information availability, and a separate project is underway to consider information requirements at a local and national level.

What are the child protection management information requirements in your area of expertise?

How is this information currently collected?

Paediatricians and in some areas centralised Board Units currently gather the following information about their involvement in child protection cases through health systems within their department and through inter-agency processes through their child protection committees.

Examples are: -

- Interagency referral discussions / tripartite discussions
- Children on the Child Protection Register
- Looked After Children

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• Attendance by professional groups at case conferences
• Children identified by public health nurses (health visitors or school nurses) as a cause for concern and those requiring intensive support
• Child protection medical examinations (specified Joint Paediatric Forensic Examinations, Specialist Paediatric Examinations, Comprehensive Medical Assessment)
• Health Assessments on Looked After and Accommodated children completed within 28 days and 42 days

5. Part 3: Risk Assessment: While the guidance discusses risk assessment and indicators of risk, it should be noted that the intention is to develop a separate risk assessment toolkit. The toolkit will be based on the general principles and framework set out within the guidance, and in particular link with the GIRFEC model.

On this basis, are you content with the principles set out in the guidance around risk assessment?

Please refer to our comments above.

Please provide additional comments.

The development of a risk assessment toolkit has been long in gestation and we recognise the challenges of delivering an effective tool. Careful thought needs to be given to the nature of risk assessment pertinent to health colleagues working in different settings e.g. Emergency departments, psychiatric units and diverse community settings, as distinct from risk assessments carried out by specialist child protection practitioners.

6. Part 3: Responding to Concerns about Children: The guidance states:
‘There are a number of tasks and roles that specific agencies have a particular responsibility for – for example, the decision to undertake a child protection enquiry (police and social work), planning a joint investigation, including the need for a medical examination (police, social work and health), and co-ordination of child protection case conferences and the child protection plan (social work).’

Do you agree with these roles and responsibilities?

No.

Please provide additional comments.

The decision to undertake a child protection enquiry or indeed not to, should be a joint decision between social work services, police and health, in addition to the decision making about the need for and nature of the medical examination.

This section is confusing – while the practice of joint working is encouraged, para 328 suggests that social work services are solely responsible for the decision that “further enquiries are not required….. Where social work services believe that a response under child protection is required, they must discuss the matter with the police…..”

No mention is made of any inter-agency referral discussions / tripartite discussions / strategy discussions. This guidance therefore ignores existing national guidance to Health professionals and also the report from inspections of services to protect children and young people across Scotland and our experience of good practice in front line children’s
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services. Relevant information known only to health about the child and or family may be crucial in confirming child protection concerns.

Para 333, second sentence implies that Health services are party to decisions only when social services deem it necessary – “Where it is decided (by whom??) that further enquiries under child protection are necessary, relevant health services must be consulted about the possible health needs of the child and be part of any decisions about the need for a medical examination or assessment”. Whilst we accept that health has no statutory responsibility to lead child protection enquiries we do have a statutory responsibility through the Children (Scotland) Act 1995* to cooperate with social work and police colleagues in carrying out their assessments/investigations.

There is a danger that unless Health services are involved early on, decisions made by social workers and police officers about medical assessments might focus on forensic needs and ignore the welfare component of the medical assessment.

We suggest adding –

“Local systems must be in place to facilitate early discussions between key agencies. Relevant health services must be consulted about any information they may hold on the child and family which might affect the child protection investigation, such as learning difficulties in the child and the need for augmented and alternative forms of communication, and significant mental health issues in a parent / carer. The fullest health information possible is required to inform risk assessment as well as Police and social work investigations and enquiries.

In planning a medical assessment, discussion with paediatric or forensic colleagues is essential in order that the welfare needs of the child / young person are considered together with the need to collect forensic evidence”.

The diagram on Page 107 also needs to be amended –. The involvement of Health at every stage in the process, which we believe is critical should be clearly identified in this flow chart. The second section of introduction text should be removed.


Where significant concerns are apparent these early inter-agency discussions should lead into a planning discussion between senior experienced colleagues in the health, social work and police sectors. Close co-operation between professionals at the beginning of the investigation is crucial to the success of any subsequent intervention, ensuring that all available information and evidence is gathered timeously and its significance interpreted carefully by appropriately trained and experienced staff. Failure to work together in this way may lead to the loss of forensic evidence particularly in cases of sexual abuse and to the potential risk of delaying medical treatment in a physically injured child with unsuspected internal abdominal injuries or intracranial bleeding.

Extract from summary of child protection inspections - How well do we protect Scotland’s children? A report on the findings of the joint inspections of services to protect children 2005-2009. This gives us an opportunity to write something into the guidance about tripartite discussions!

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In most areas, where there was a child protection concern, staff made an initial assessment of the situation and generally acted promptly by sharing their concerns. In a few areas there were variations in thresholds between social work teams or between social workers and other staff, which contributed to an ineffective response. Individually and together, police and social work staff were usually effective at assessing risks and needs of children at an early stage. However, in many areas health staff were not involved well by police and social workers in making an early assessment. The decisions by police officers and social workers were often taken without access to all relevant information held by health professionals. The involvement of health staff in initial planning to investigate child protection concerns was inconsistent.

The practice of interagency referral discussions as a first stage involving health, police and social work in any child protection investigation has been identified as an example of excellence and placed on the HMIE website.

7. Part 3: Child Protection Case Conferences and Appendix 1: The guidance introduces national timescales, in particular that initial Child Protection Case Conferences should be held as soon as practically possible and no later than 21 calendar days from the notification of concern. Also, it suggests that participants should receive the agreed child protection plan within 5 calendar days of the conference; and the minutes no later than 15 calendar days after the conference.
   Do you agree with these timescales? If not, what is the best standard that could be reasonably expected?

In Part

Please provide additional comments.

This very much depends on the size of the local authority, the numbers of case conferences and availability of admin resources.

8. Part 3: Child Protection Case Conferences: The guidance suggests that pre-birth case conferences, where they identify the need for the unborn child to have a child protection plan, should also place that child on the Child Protection Register.
   Do you agree with this approach?

Yes

Is this approach already taken in your area?

Yes

What benefits do you see from pre-birth registration?

Pre-birth registration signals to the parents the seriousness with which professionals view the risks to the unborn child and allows forward planning.

What disadvantages?

Please provide additional comments.
We are aware of the need for further development and information sharing particularly facilitated by electronic systems to ensure that where concerns are identified pre birth and the decision to place the child on a register maternity services are aware of the decision and the child protection plan.

9. Part 3: Child Protection Case Conferences: The guidance states that ‘while the chair of case conferences will often be from social work services, where an individual could fulfil the required criteria, it would not be inappropriate for a practitioner from a different agency or service to undertake the role.’ The focus is therefore on the competency and impartiality of the chair, rather than their particular profession.
Do you agree with this approach?
Yes

Please provide additional comments.

Whilst agreeing with this in principle, great care would need to be taken to set down strict criteria re knowledge and experience of child protection work in this selection process.

10. Part 3: Child Protection Case Conferences: The guidance states the desire to move towards a position where only one report is considered by a case conference. However, it also recognises that this is not something all areas are capable of implementing at this stage.
However, are you content with the principle of having one composite report co-ordinated by the Lead Professional and representing the views of all services, agencies and families involved?
No

Please provide additional comments.

We have major reservations about this proposal.

There is a significant risk that this practice would limit the full debate around the issues identified by individual professionals and agencies, and dilute the full exploration of risks and strengths in reaching a decision. In making this proposal there is failure to recognise the diversities of health involvement from a wide range of child and adult specialisms.

11. Part 3: Child Protection Case Conferences: The guidance suggests that ‘all participants at a CPCC with significant involvement with the child/family have a responsibility to determine whether or not to place the child’s name on the Child Protection Register. Where there is a split decision, the Chair will determine the final decision.’
Do you agree with this approach?
Yes

Please provide additional comments.

12. Do you have any additional comments?

Section 3 page 91 Medical Examination and Assessment:

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Whilst detail is given re different types of examinations there needs to be clear reference to the contribution of health professionals. There is no reference to the added value of medical interpretation and opinion on the collected health information in addition to medical opinion subsequent to any medical examination and investigations.

There is no reference to the now well established agreed access pathways to a range of health assessments, immediate and planned.

Para 355, first line ‘the number of examinations for evidential purposes to a single examination Health may require to carry out a range of medical examinations or investigations to identify and manage health problems.

Para 352 this wording is incorrect. A comprehensive medical assessment should be considered in all cases where child protection concerns are raised.

Para 352 the second part of this paragraph deals with child sexual abuse and should follow para 358.

There is a problem with the ordering of this whole section moving between information gathering, comprehensive medical assessment and specialist examinations and would benefit from rewriting.

Para 362 at the beginning should state ‘the final decision on whether or not a joint paediatric forensic examination is required its timing and venue is the responsibility of the specialist paediatrician in discussion with the forensic physician.

Suggestions to text –

- Para 555 first sentence – When an allegation of historical child abuse is received by any agency particularly health.
- Para 192 Paediatricians working in the hospital or community ‘will’ come into contact… (not can).
- Para 338 - Whilst happy with the overall content of this paragraph what is the evidence to suggest children undergo fewer medical examinations when agencies act jointly? We would have thought the opposite would be more likely to be the case, but more importantly the medical assessments that are carried out are more timely and proportionate to the presentation.
- Para 340. Second line add ‘and together with health agree an initial ‘…
- Para 341. Second sentence. Health Boards need to designate Specialist Paediatricians and Specialist Nurses with approved training and sufficient authority to act on behalf of their agency to initiate and review joint working. (Health Boards across Scotland are working towards the model of designated and named doctors and nurses in child protection as described by the RCPCH and in place in England)

In its current form this guidance represents a wasted opportunity if not a retrograde step in the integration of children’s services. It fails to recognise the critical role of health professionals at every stage in protecting Scotland’s children.

For and on behalf of Child Protection Committee, Royal College of Paediatrics & Child Health (Scotland)

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