GUIDELINES ON PROCEDURES
FOR THE
IDENTIFICATION, INVESTIGATION
AND MANAGEMENT
OF NON-ACCIDENTAL INJURY
TO CHILDREN

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DEPARTMENT OF HEALTH

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FOREWORD

The Minister for Health would like to express his gratitude to all those who offered their views and suggestions in response to his Department’s request in connection with the work of reviewing the guidelines for dealing with the problem of non-accidental injury to children. He trusts that the resulting revised guidelines will further assist personnel in the difficult task entailed in coping with the problem.

Department of Health
February, 1983
CONTENTS

1. Introduction
   1.1. Purpose of the Guidelines 7
   1.2. Prevention of Non-Accidental Injury 7

2. Overall Management, Monitoring and Co-ordination of Non-Accidental Injury Cases
   2.1. Role of Director of Community Care 8
   2.2. Need for Co-operation 8

3. Identification and Investigation of Non-Accidental Injury
   3.1. Identification 9
   3.2. Investigation by a General Medical Practitioner 9
   3.3. Investigation at Hospitals 10
   3.4. Others 10

4. Management of Cases
   4.1. Initial Steps 10
   4.2. Case Conferences 11
   4.3. Long-Term Management 13

5. Exchange of Information on Non-Accidental Injury Cases
   5.1. Collection of Information 13
   5.2. Exchange of Information — Transfer of Records and Disclosure of Information from DCC’s lists of confirmed and suspected cases 15

6. The Legal Position
   6.1. General 16
   6.2. Place of Safety Order 16
   6.3. Fit Person Order 17
   6.4. Enforcement of Orders 18
   6.5. Future Changes in the Law 18
7. Next Steps Following Issue of the Guidelines

7.1. Circulation of Guidelines 18
7.2. Action at Community Care Area Level 19
7.3. Training 20

Appendices

Appendix A — Index of Suspicion 21
Appendix B — Chart Summarising Procedures for Health Board Field Workers 25
Appendix C — Section 24 of the Children Act, 1908 29
1. INTRODUCTION

1.1 Purpose of the Guidelines
While most injuries to children are accidental, some injuries can be the result of deliberate physical ill-treatment. The following guidelines are concerned with the problem of confirmed or suspected non-accidental physical injury (including injury resulting from sexual abuse) to children. The purpose is to provide guidance generally for personnel working with children, and particularly for health agencies, on the identification, investigation and management of this problem.

1.2 Prevention of Non-Accidental Injury
These guidelines do not deal specifically with prevention of non-accidental injury to children. However, health boards, hospital authorities and other statutory and voluntary agencies, which regularly come in contact with children in the course of their work, should be continually alert to the contribution they can make to the prevention of this problem. Studies have shown that the incidence of non-accidental injury to children is frequently associated with family violence, alcoholism, marital breakdown, mental illness, single parenthood, inadequate accommodation, inadequate or immature parenting and, in the light of recent experience in this country, unstable and turbulent marital relationships. Where such conditions exist, and in particular where a number of the above conditions exist together, personnel working with the families should be alert to the possibility of non-accidental injury. Greater awareness and discussion among health personnel will, it is hoped, encourage the development of alert, compassionate and balanced attitudes in dealing with the problem.
2. OVERALL MANAGEMENT, MONITORING AND CO-ORDINATION OF NON-ACCIDENTAL INJURY CASES

2.1 Role of Director of Community Care

Responsibility for monitoring and co-ordinating the management of such cases rests with the health boards as part of the child care services provided within the community care programme. The Director of Community Care and Medical Officer of Health (DCC) or, where the post is vacant, an officer designated by the Chief Executive Officer of the health board, has overall responsibility for the monitoring and co-ordination of cases of non-accidental injury occurring in his area.

The DCC is the person —

(a) to whom all cases are notified (see 3.3-3.5);

(b) who ensures that arrangements are made to have all the necessary information gathered concerning each case (see 4.1-4.2);

(c) who arranges for consequent case conferences (see 4.2);

(d) who oversees the general management and co-ordination of cases and ensures that such action as is decided on is carried out (see 4.2-4.4);

(e) who maintains the lists of confirmed and suspected non-accidental injury cases in his functional area (see 5).

2.2 Need for Co-operation

In carrying out these functions the DCC is heavily dependent on the senior members of his team, particularly the Senior Social Worker (SSW) and the Superintendent Public Health Nurse (SPHN). He also depends on the ready willingness and co-operation of the staffs of hospitals, schools and of many non-statutory agencies — including various day care facilities for children run on a voluntary basis — to effectively carry through his co-ordinating role.
3. IDENTIFICATION AND INVESTIGATION OF NON-ACCIDENTAL INJURY

3.1 Identification

Every injury (apart from road traffic accidents) to a child should be a cause of concern. The full history of how the injury occurred should be compared with the physical findings by doctors treating the child. When the account of the injuries is not compatible with the physical findings, the possibility of non-accidental injury must be considered and the DCC notified.

The first signs of non-accidental injury may be very slight. An index of suspicion is incorporated in Appendix A. This Appendix is neither an exhaustive list of indicators nor an index of confirmation of non-accidental injury, but should be seen as an aid to staff in their surveillance of the well-being and care of young children. The existence of any one, but particularly of a number together, of these indicators in relation to a child could justify suspicion of non-accidental injury and, therefore, further investigation.

3.2 Investigation by a General Practitioner

When a general practitioner suspects that a child has suffered non-accidental injury, he should seek explanations for the specific injuries from the parents or guardians. If these explanations are not, in his opinion, consistent with the injury, the local DCC should be informed immediately of his suspicions and, where necessary, arrangements should be made for the admission of the child to a children's hospital or to the children's unit of a general hospital. If the parent or guardian objects to the hospital admission then the doctor should discuss with the DCC the necessity of the health board seeking a Place of Safety Order in respect of the child, to facilitate removal to hospital. The procedures for applying for such an Order are outlined at paragraph 6.2 of these guidelines.

The general practitioner should be kept informed of developments in the case by the DCC and by the hospital
consultant where appropriate, and he may be required to attend at resulting case conferences.

3.3 *Investigation at Hospitals*

The hospital paediatrician, or other designated doctor familiar with the hospital’s procedures for non-accidental injury cases, should be contacted as soon as a suspected case presents itself either on referral from a general practitioner or at the casualty department. Examination and investigation should follow along the lines indicated in Paragraph 3 of Appendix A. The existence of good medical records may be vital for the successful handling of the case at a later stage. The hospital should inform the local DCC when discharging a child who is suspected to have been non-accidentally injured so that his team can confirm the home circumstances and its suitability for the child’s return.

3.4 *Others*

When the suspicion of a person, other than the general practitioner or hospital staff treating the child, is aroused the DCC should be notified immediately. The DCC should arrange with the appropriate member of his community care team to investigate further (see 4.1). The objective generally should be to create the earliest possible opportunity for the child to be medically examined.

4. MANAGEMENT OF CASES

4.1 *Initial Steps*

All cases under investigation for suspected non-accidental injury are notified to the DCC. Through regular contact with other key personnel working on the case the DCC should ensure that all the relevant information is available to them regarding children and their families and that a programme is formulated for the child’s future well being.

The community care team member initially involved with an investigation for non-accidental injury should discuss the
case with his/her respective senior colleague on the team. This discussion ought to take place on the same date that the suspicions are first aroused, or as soon as possible thereafter (generally within 24 hours). It should cover all known aspects of the case, including, if possible, the family doctor’s views, the degree of risk of further injury to the child and particularly whether the risk of leaving the child in the custody of its parents or guardians can be taken. The field worker should then contact health personnel and other relevant agencies working with the family. Having gathered together the details of the case, the worker should consult with the relevant senior personnel on the team after which the line of action to be taken in the case should be decided. This could include the holding of a case conference. (See chart at Appendix B which sets out briefly procedures to be followed by field workers.)

4.2 Case Conferences
Requests for arrangement of case conferences on non-accidental injury cases should be made to the DCC. If the DCC agrees that the holding of a case conference is called for, he should set the date and make arrangements for the relevant people to attend. It may be appropriate to mention at this point that consideration should be given to involving the Gardaí (including, where appropriate, officers of the Juvenile Liaison Service and the Welfare and Probation Service) prior to or in the case conference, having regard to the circumstances of the individual case.

It is recommended that community care teams review and standardise case conference procedures so that:

(a) every effort is made to have in attendance at conferences all workers involved with a case;

(b) written summaries are prepared by all relevant workers of their involvement in and views on the case and submitted for consideration at the conference. Copies of these summaries should be retained by the DCC who
may, in cases of extreme urgency, request verbal reports from workers who are unable to attend the conference. The DCC should arrange for the presentation at the conference of such verbal reports, which should be subsequently confirmed in writing by the workers concerned;

(c) the non-accidental nature of the injury in question is fully discussed at the conference, the available information processed, the family problems identified and the extent to which relationships in the family could represent a serious danger to the physical well-being of the child assessed. On the basis of this discussion an agreed programme of intervention should be planned and the key worker identified;

(d) the key worker is the person with responsibility for ensuring that the programme is implemented and through whom all subsequent relevant information on the family should be processed;

(e) the programme of action specifies the visiting routine, the purpose of such visits and when the next joint review of the case should take place; it should also make specific recommendations as to the use of support facilities such as day care and home helps where such facilities can be made available to the family;

(f) the DCC arranges to have conferences recorded and these records should incorporate the important points made in the course of the discussion, the decisions reached and the agreed programme of action to alleviate the family's problems;

(g) the case conference also decides the listing of the case and whether it is confirmed or suspected non-accidental injury (see 5.1);

(h) the DCC arranges for the record mentioned at (d) above.
to be circulated to all workers who have a continued involvement with the case concerned.

The Gardaí must be notified as quickly as possible where a breach of the law is indicated.

It is important to have the case conference called as quickly as possible and to have all those involved in it kept informed of the progress of the child and the family, particularly during the critical stages. The DCC, SSW and SPHN should especially keep themselves informed of developments and, in all cases of serious injury or neglect, conferences to review the situation should be held from time to time. Parents/guardians should be made aware of the general approach being adopted in the case. In cases where it is decided to seek a Fit Person Order in respect of the child the concurrence of the DCC should be obtained.

Senior members of the community care team should ensure that field workers have adequate supervision and support when working with difficult families and that as far as possible these workers should be experienced in dealing with families at risk.

4.3 Long-term Management
Programmes for the long-term management of a non-accidentally injured child must be considered at an early stage and kept under periodic review. Where a child has been removed for treatment for his own safety, particular care must be taken when deciding the stage at which the child can return home. Support work for the family should be provided for the family while the child is away and on his return home.

5. EXCHANGE OF INFORMATION ON NON-ACCIDENTAL INJURY CASES
5.1 Collection of Information
It is important that full and accurate information on all non-accidental injury cases is maintained at local community care area level. The essential information to be collected by
the DCC about non-accidental injuries should serve two basic purposes—

(i) to help assess the extent of the problem and

(ii) to provide information to other workers on whether a child has previously suffered from suspected or confirmed non-accidental injury.

Each DCC should supervise (either personally or through a designated officer) the maintenance of lists of suspected and of confirmed cases of non-accidental injury in his area. The information contained in the lists will be available from the cases notified to him and should consist of the following details:

(a) date of notification and source of referral;
(b) full name, date of birth and sex of the child;
(c) any other name by which child is known;
(d) name(s) (and if relevant, alias(s)) of parent(s) or guardian(s);
(e) present address of parents or guardians and previous addresses, if known;
(f) name(s) and age(s) (approx.) of other children and adults in the household;
(g) a short description of the injuries to the child;
(h) present location of the child and the name of the key worker in the case.

The lists should be reviewed at least annually by the DCC in consultation with the relevant senior personnel on his team. Where initial suspicion has proved to be unfounded, details should be deleted from the list. A case should be listed as confirmed non-accidental injury only if there is:

(i) medical opinion to support this view; or

(ii) an admission of this by the person who inflicted the injury; or
(iii) a successful prosecution against the assailant.
All other cases should be listed as suspected.

5.2 Exchange of Information on Cases

Transfer of Records
When families with children who are considered at risk of non-accidental injury change residence and move to another community care area, the DCC should arrange for transfer of all the appropriate records to the DCC of the family's new area. (It is suggested that the DCC might keep a short summary of the salient points of the case when transferring these records.) If the new address of the family is unknown, every effort must be made to ascertain it. This might best be done with the co-operation of the Gardai, the Department of Social Welfare, the housing authorities or other agencies likely to have this information. Health board personnel who come in contact with a problem family who have recently moved into their area should ascertain their previous location and confirm that the relevant records of the family have been transmitted.

Disclosure of Information from Lists
The information to be given from the DCC’s lists or, indeed, in respect of other suspected cases known to him but not yet listed, is at his discretion. However, the fullest possible information should be given having regard to the circumstances of the case, particularly where the information is needed for a case conference. Generally speaking, information should only be given in response to a written request. Where the urgency of the situation dictates, information may be given on the telephone but there should be suitable safeguards to ensure that the person requesting the information is acting in good faith; e.g. by asking for a telephone number and ringing back with the information required.

It is essential that all the information obtained on specific cases, either from lists or through access to the case record,
is treated with the utmost confidentiality by the staff involved and by those obtaining information. Where there is difficulty about the exchange of information between persons in different disciplines or persons in the same discipline, the DCC must make every effort to achieve working arrangements which will give the maximum access to relevant information consistent with maintenance of confidentiality.

6. THE LEGAL POSITION

6.1 General
The most relevant legislation is Part II of the Children Act, 1908. There are two sections of this Act which deal with getting custody quickly of children at risk — Sections 20 and 24. Section 20 is concerned with cases where prosecutable offences have been committed against the child and the offenders are to be brought to Court. However, in most cases of non-accidental injury, the DCC will not be concerned with bringing prosecutions. The child at risk is usually a symptom of a family with problems, requiring help and guidance rather than the invocation of the criminal law. The most useful section for the purpose of these guidelines is Section 24.

6.2 Place of Safety Order
A copy of Section 24 of the 1908 Act is attached at Appendix C. This section provides a means whereby a child can be quickly removed to a place of safety if there is reasonable cause to suspect that he/she has been or is being ill-treated in a manner likely to cause him/her harm. Any person may approach a District Justice and, on oath, give information as to the serious risk to the child. It is most desirable that persons, including health personnel, taking this action should first discuss the matter with the local DCC and also inform him of the outcome. The Justice, acting on the evidence presented, may authorise a Garda, under warrant, to take the child in question to a place of
safety. A place of safety includes any garda station, hospital, surgery or other suitable place, the occupier of which is willing to receive the child. The warrant authorises the Garda, who should be accompanied by the person applying for it, to enter a house (by force if necessary) to remove the child. The Garda may also be accompanied, if so directed by the Justice, by a doctor. A warrant is normally addressed to the Garda Superintendent of the district in which the child lives and he is then responsible for ensuring that the child is taken to a place of safety. The removal is a temporary one until the child can be brought before the Court, at which stage the Court may commit the child to the care of a relative or other fit person. A District Justice may issue a warrant for a Place of Safety Order outside normal court hours. The procedure for securing a Place of Safety Order is governed by the Summary Jurisdiction Rules 1909 (SRO 1909 No. 952).

In extreme urgency; i.e. when the parents will not agree to have the child admitted to hospital and are likely to remove the child before a Place of Safety Order can be obtained, the Gardai must be informed. It is worth noting that in cases where a prosecutable offence has been committed against the child the Gardai have powers under the above mentioned Section 20 to remove and detain the child immediately.

6.3 **Fit Person Order**

Where it is considered necessary to take a child into care as a compulsory measure, proceedings to secure a Fit Person Order on the child should be taken as quickly as possible and especially so after the Place of Safety Order, if one has been sought, has been carried out. A ‘fit person’ includes any society or body corporate established for the reception or protection of children. The Department has been advised that a health board (or any officer of a health board acting on its behalf) can be nominated as a fit person under a Fit Person Order. The practice of making such orders on this
basis has been well established. A Fit Person Order gives the person named in the order 'like control over the child or young person as if he were his parent' (Children Act 1908, Section 22 (1)) and, in effect, gives him responsibility for the welfare of the child.

When a health board decides to apply for a Fit Person Order, the key worker in the case should compile all the relevant information, including medical reports, and then discuss it with the SSW or SPHN, whichever is appropriate, and the health board solicitor. If it is decided to go ahead with the application, the solicitor will present the case in Court. Normally, evidence must be given by the person or persons who have first-hand knowledge of the circumstances of the family.

6.4 Enforcement of Orders
Constant vigilance is required of those responsible for a child on a Place of Safety or Fit Person Order to ensure that there is no improper interference with the terms of the Order by anybody claiming custody of the child. The support and goodwill of the local Gardai is invaluable in achieving this.

6.5 Future Changes in the Law
The need for greater certainty in several aspects of the law relating to children at risk is recognised. This is being provided for as part of wider legislation dealing with the care of children in the proposed new Children Bill which the Minister for Health hopes to place before the Oireachtas shortly.

7. NEXT STEPS FOLLOWING ISSUE OF THE GUIDELINES

7.1 Circulation of the Guidelines
Health boards and hospitals should bring these guidelines to the attention of all staff likely to come in contact with cases of non-accidental injury to children. Arrangements should
be made to give all the staff concerned an opportunity to clarify and discuss such aspects of the guidelines as they consider necessary and special care should be taken to ensure that relevant newly appointed staff are fully familiar with the guidelines and with local procedures. The Minister expects and hopes that all other agencies working with children will continue to accept the need for co-operation and co-ordination with health boards in dealing with the problem of non-accidental injury. Health boards could seek this co-operation through regular contact with relevant bodies and possibly through joint participation at seminars on non-accidental injury. Health board staff should facilitate staff of other agencies in every way possible and should arrange for the circulation of these guidelines to all the agencies and bodies concerned including hospitals, general practitioners, schools, day care facilities for pre-school, mentally handicapped and physically handicapped children, children’s residential homes and local authority welfare services. Boards should also notify them of the arrangements for contacting the DCC and other appropriate officers of the Board where non-accidental injury to a child is suspected. Appendix A of these guidelines in the form of a short pamphlet should be issued to all hospitals every six months to coincide with the changes in resident medical staff.

7.2 Community Care Area Level
Each DCC should arrange periodic meetings of the key staff involved in the management of cases to enable them to exchange views and experiences in relation to effective procedures and ensure that those newly involved are fully informed and aware of the support available to them. He should also, in consultation with the senior members of his team, review from time to time procedures in his area for co-ordinating support services generally in cases where different disciplines and different agencies are providing support on a regular basis for families with young children. This would facilitate the early detection of vulnerable
families as well as increase the overall effectiveness of support measures for them. In this way stresses which give rise to situations associated with the incidence of non-accidental injury can be identified early on and steps taken to alleviate them. All staff dealing with the welfare of children have a responsibility in this area and should develop a greater awareness of child abuse and of the circumstances of the families with which they are dealing.

7.3 Training
Health boards and hospital authorities should continue to assess the key training needs of their senior staff and staff who may initially come in contact with the problem during the course of their work. The Department will co-operate with health boards and hospital authorities in arranging any suitable training programmes.
APPENDIX A

NON-ACCIDENTAL INJURY TO CHILDREN
Checklist to help identification, investigation and Initial Action.

1. Index of Suspicion
   (i) Parents’ story at variance with clinical findings.
   (ii) Repeated injury.
   (iii) Visits to different hospitals or to different general medical practitioners.
   (iv) Reluctance of parents to give information.
   (v) Children brought to a hospital during evening hours.
   (vi) Children brought to a hospital for complaint other than injury — headache, fever, abdominal pain, etc.
   (vii) Lapse of time between injury and attendance at doctor’s surgery or hospital.
   (viii) Obvious familial discord, stress, etc.
   (ix) Parents’ refusal to give consent for investigation.
   (x) Nutritional deprivation.
   (xi) Retardation.
   (xii) ‘Frozen gaze’: i.e., wide-eyed immobilised expression of child who has learned not to cry because he will be subject to physical abuse.
   (xiii) Signs of general neglect.

2. Suggestive Features on Clinical Examination.
   (i) Bruises
      (a) Any bruises on a baby less than 1 year of age.
      (b) Bruising from human bites.
      (c) Black eyes.
      (d) Bruising of ear and surrounding scalp.
      (e) Petechial haemorrhages.
      (f) “Finger and thumb mark” bruises on face, trunk or limbs, especially on trunk of young baby who has been firmly held and shaken.
(ii) **Fractures**
Any fracture in the first year (unsuspected fractures of clavicle, ribs and long bones may be present even in a healthy-looking child).

(iii) **Joints**
A tender swollen joint or limb which is normal on X-ray may show calcified periosteal haemorrhage on repeat X-ray two weeks later.

(iv) **Burns and Scalds**
(a) Circular bleeds, sores or scars from cigarette burns — these are often found in clusters and may be of different ages.
(b) "Dunking" burns — buttocks, feet or hands in scalding water.

(v) **Injuries to Mouth**
(a) Small blood clot on gum or tongue.
(b) Minute tears of the frenulum.
(c) Cuts, scratches, excoriations or sores around the mouth.

(vi) **Injuries to Eyes and Brain**
(a) Retinal haemorrhages from chest compression or shaking.
(b) Subdural haematoma (when small and chronic this may present as vomiting, irritability and a failure to thrive).

(vii) **Visceral Injuries**
Injuries to a solid or hollow organ may be present without any external bruising.

(viii) **Poisoning**
Poisoning may not always be accidental or due to carelessness.

(ix) **Cot Deaths**
Some cases of "cot deaths" are non-accidental.
3. Examination and Investigation in Hospital

3.1 Examination

(i) Detailed description of all injuries e.g. site and colour of bruising.
(ii) Fundus examination — preferably by an ophthalmologist.
(iii) General nutrition.
(iv) Burns and scalds.
(v) Evidence of "poisoning."
(vi) Evidence of fracture — (skull, clavicle, ribs and long bones).
(vii) Evidence of retardation.

3.2 Investigation

(i) X-ray — skeletal survey (excluding spine or pelvis, unless clinically indicated) — immediately and in three to four weeks. The following X-ray signs are suspicious or diagnostic:-
   (a) Multiple bone injuries especially near joints.
   (b) Fractures in varying stages of healing.
   (c) Epiphyseal displacement or metaphyseal fragmentation or both.
   (d) Evulsion of parts of the provisional zone or calcification.
   (e) Cortical thickening.
   (f) Single fracture in a young baby.
   (g) Spinal fracture in a young child.

(ii) Coagulation screening if there is bruising or bleeding.
(iii) Photography.
(iv) Consultation with paediatrician and medical social worker.

3.3 Medical Records

Precise medical records may be vital to the successful management of a case of non-accidental injury at a later stage.
4. ACTION WHERE THERE IS CONFIRMATION OR REASONABLE SUSPICION

4.1 In Hospital
The paediatrician or physician responsible for the treatment of the child should inform the Director of Community Care (or the person designated by him) as soon as possible for the further overall co-ordination of the case.

4.2 In the Community
The person dealing with case; e.g. general medical practitioner, public health nurse, social worker, should inform the Director of Community Care (or the person designated by him) on the same date that the suspicions are first aroused, or as soon as possible thereafter (generally within 24 hours).
SUMMARY OF PROCEDURES FOR HEALTH BOARD FIELD WORKERS

Worker suspects NAI

Discuss with parent/guardian and assess situation.
Consult with Senior Colleague.
Consult with G.P. if appropriate.

If suspect unresolved, report immediately to Senior Officer and DCC and check NAI List.

Check with Community Care personnel and other agencies involved with family, e.g., school, day care centre, hospital.

With this information, consult with Senior Officer(s) and decide on immediate action if any and arrange with DCC if Case Conference is to be called.

It is the task of the Case Conference to:
Process all available information.
Agree on a plan for the care of the child/children.
Designate the Key Worker.
Set a date for case review.
Decide on Listing and category — Confirmed/Suspected.

Inform the Gardai if an offence has been committed.
Inform the parent/guardian of the outcome, if they have not been involved in the discussions.

Worker considers that the child is at immediate risk because of suspected NAI

If parents consent, arrange for immediate medical examination.

If parents are unco-operative consult Senior Colleague, contact Gardai, inform DCC and check NAI List. A Placement of Safety Order may be required.

When the child has been removed by Gardai, take the child immediately to a doctor, preferably the nearest children's hospital unit, for medical assessment.

Meanwhile, consult with all relevant personnel in conjunction with Senior Officer(s) and DCC. Case conference to be held as soon as possible.

The case conference should amongst its other tasks decide on the question of reception into care, in which event a fit Person Order may be sought.

Parents should be kept informed of decisions being made with regard to the child.

The above chart should be used in conjunction with Parts 2 to 6 of the guidelines.

Persons other than Health Board personnel who suspect that a child has been non-accidentally injured should contact the DCC immediately. The DCC should then arrange for a member of his community care team to follow up the case along the lines indicated in paragraphs 2 to 6 of the guidelines and summarised above.
24. (1) If it appears to a justice on information on oath laid by any person who, in the opinion of the justice, is acting in the interests of a child or young person, that there is reasonable cause to suspect —

(a) that the child or young person has been or is being assaulted, ill-treated, or neglected in any place within the jurisdiction of the justice, in a manner likely to cause the child or young person unnecessary suffering, or to be injurious to his health; or

(b) that an offence under this Part of this Act, or any offence mentioned in the First Schedule to this Act, has been or is being committed in respect of the child or young person,

the justice may issue a warrant authorising any constable named therein to search for such child or young person, and, if it is found that he has been or is being assaulted, ill-treated, or neglected in manner aforesaid, or that any such offence as aforesaid has been or is being committed in respect of the child or young person, to take him to and detain him in a place of safety, until he can be brought before a court of summary jurisdiction, or authorising any constable to remove the child or young person with or without search to a place of safety and detain him there until he can be brought before a court of summary jurisdiction; and the court before whom the child or young person is brought may commit him to the care of a relative or other fit person in like manner as if the person in whose care he was had been committed for trial for an offence under this Part of this Act.

(2) A justice issuing a warrant under this section may by the same warrant cause any person accused of any offence in respect of the child or young person to be apprehended and brought before a court of summary jurisdiction, and proceedings to be taken against such person according to law.

(3) Any constable authorised by warrant under this section to search for any child or young person, or to remove any child or young person with or without search, may enter (if
need be by force) any house, building, or other place specified in the warrant, and may remove the child or young person therefrom.

(4) Every warrant issued under this section shall be addressed to and executed by a constable, who shall be accompanied by the person laying the information, if such person so desire, unless the justice by whom the warrant is issued otherwise directs, and may also, if the justice by whom the warrant is issued so directs, be accompanied by a duly qualified medical practitioner.

(5) It shall not be necessary in any information or warrant under this section to name the child or young person.