Torbay Safeguarding Children Board

CHILD PROTECTION MEDICAL EXAMINATIONS

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Version 1

Keeping children safe is everyone's responsibility

Torbay Council Children's Services ■ Police ■ Health ■ Careers South West
Youth Offending Team ■ Probation ■ CAFCASS ■ Safer Communities ■ Fire Service
Schools ■ Community & Voluntary Sector

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1. Introduction

1.1. Strategy discussions/meetings must consider, in consultation with the named Doctor/ Paediatrician (if not part of the strategy discussion/meeting), the need for and the timing of a medical assessment. Medical assessments should always be considered necessary where there has been a disclosure or there is a suspicion of any form of abuse to a child.

1.2. In almost all cases a new suspicion/allegation of physical abuse will require a CP medical.

1.3. A medical assessment should demonstrate a holistic approach to the child and assess the child's well-being, including mental health, development and cognitive ability.

1.4. A medical assessment is necessary to:

- Secure forensic evidence;
- Obtain medical documentation;
- Provide reassurance for the child and parent;
- Inform treatment follow-up and review for the child (any injury, infection, new symptoms including psychological).

2. Key Questions

2.1. Within the strategy discussion and in consultation with the Paediatrician the following questions should be answered:

- Why - what will the medical add to understanding what has happened and safeguarding the child?
- When – consider best interests of child and service implications, is a same day medical required, would it be preferable to arrange an appointment the next day? If the safety plan requires information from the CP medical it becomes urgent and should occur on the same day. If not then the medical should take place within 24 hours but not necessarily the same day.
- Who – ensure the person who is going to do the medical is free of other commitments wherever possible. If the medical is performed by Middle Grade/Tier 2 Doctor – Child Protection Supervision must be sought as soon as possible (ideally while child is still present) and the report approved by a Consultant before sending.
- Where – the child protection coordinator (within the Hospital) can assist in arranging this – usually Paediatric Outpatients Department, sometimes Louisa Cary Ward

3. Who undertakes CP medicals?

3.1. Child Protection Medicals are carried out by senior TSDFT paediatric staff (consultant or middle grade) usually following request from Children's Services.

3.2. Staff below the level of consultant should not accept referrals without discussing with a consultant

3.3. See below for details about Child Sexual Abuse medicals

4. Process 'in hours' Monday to Friday 09:00 to 17:00

4.1. Most referrals are made to the Multi Agency Safeguarding Hub (MASH) by health (GPs, health visitors, midwives etc), education, police and other agencies (See sections in the TSCB Procedures on Responding to Abuse & Neglect and Referrals)

4.2. Information will be collated in the Multi-Agency Safeguarding Hub (MASH) and a strategy discussion held.

4.3. Further information will usually be obtained by CSC /Police which may include interviewing parent/s, the child and other professionals

4.4. MASH may occasionally request the consultant or one of the Named Doctors for Safeguarding Children be involved in the strategy discussion

4.5. If a decision is made that a CP medical examination is required CSC will telephone

- The Consultant of the Week (COW) on 07825 144452
- If no response the Paediatric Acute Consultant (PAC) on 07584 272641) to discuss this request:

4.6. The consultant telephones the Hospital Child Protection Coordinator (ext 55801) to inform them that a CP medical request has been accepted. The CP Coordinator will confirm time, place and examiner and liaise with CYPS, including confirming details of who will accompany child. Hospital notes will be obtained and prepared including check WINDIP, Infoflex, standard proforma etc.

5. Process - out of hours

5.1. During the weekends and out of hours referrals will be received by the Emergency Duty Service (EDS).

5.2. Information will be collated by the EDS and a strategy discussion should be held. Further information may then be obtained by EDS/Police which may include interviewing parent/s, the child and other professionals

5.3. If a decision is made that a CP medical examination is required EDS will telephone the paediatric Acute Consultant (PAC) on 07584 272641 to arrange

6. Attendance

6.1. A parent must attend if at all possible to give consent and to allow a detailed history to be taken. This should not preclude the child or young person being seen on their own.

6.2. A social worker should usually attend with the child.

6.3. A police officer may attend in circumstances where applicable.

7. Feedback

7.1. The examiner should provide verbal feedback to professionals who accompanied the child once medical completed before the child leaves the hospital and will inform the parent/guardian of broad conclusions.

7.2. A final plan and outcome will be documented in the hospital notes.

7.3. The report must be dictated and handed to the Child Protection Coordinator for typing as priority on an Infoflex CP medical proforma (Health Internal Form). **The report should reach the allocated social worker within 48 hours**.

8. Concerns occurring regarding a child already in hospital or referred by a health practitioner directly to a consultant paediatrician

8.1. It would be impossible to detail every possible variation from the above standard procedures but there are occasions when a paediatrician may be involved with providing services to a child who may have suffered abuse prior to CSC being informed.

8.2. This may involve a child seen in primary care or under the care of the Emergency Department or another specialty. It is the responsibility of professionals who believe that a child has been or is likely to be harmed to make a referral to CSC or the Police with consent of someone with parental responsibility. However in some circumstances it may be appropriate for a different course of action to be taken.

8.3. For example:

Situation	9. Action
Health professional has concerns that abuse may be part of a differential that includes other medical conditions e.g. multiple bruising - ? Non-accidental injury or haematological disorder	Paediatrician undertakes standard medical assessment. If there is concern over abuse after that assessment Paediatrician refers to MASH
Health professional has reason to believe that the child is at risk of harm if not sent directly to hospital e.g. seriously unwell or injured	Paediatrician accepts referral and advises other professional to make referral to MASH/EDS. Other professional documents reasons if referral is made without consent.
There is reason to believe that the professional, the child or other individual may be at risk of harm if concerns are raised regarding abuse in the current location	Paediatrician accepts referral and advises other professional to make referral to MASH/EDS. Other professional documents reasons if referral is made without consent.
Places staff at risk of significant harm.	Referral to MASH/EDS including reasons if referral is made without consent.
Risk destruction of evidence.	Referral to MASH/EDS including reasons if referral is made without consent.

8.4 If concerns arise during care of child in hospital, e.g. a fracture is seen on a chest x-ray taken for medical reasons, it may be difficult to be clear where standard assessment merges into a child protection medical process. It is good practice when it is clear that a thorough documented assessment for child protection purposes is required that staff consider the need to discuss with a consultant Paediatrician and complete a CP medical assessment on standard proforma with the express knowledge and consent of a person with parental responsibility.

9. Child sexual abuse medicals

9.1. Child sexual abuse medicals are not usually carried out by TSDFT staff. Children and Young People up to the age of 18 years, in whom sexual abuse has been alleged or is suspected, are usually seen during normal working hours at the Sexual Abuse Referral Centre (SARC) by members of a team of Forensic Medical Examiners and Paediatricians. Ask police or social worker to follow multi-agency flowchart and contact G4S Forensic and Medical Services (UK) Limited – For Hospital Staff see Appendix 6 & 7 Child Protection Policy).

9.2. All clinicians should bear in mind that, wherever possible, an intimate examination should only take place once for the child/ young person.

9.3. If Children's Services contact the on-call consultant to discuss a child where there are concerns about sexual abuse it is recommended that they can include the on-call doctor or specialist nurse from the SARC (as per above contact details) in the strategy discussion.

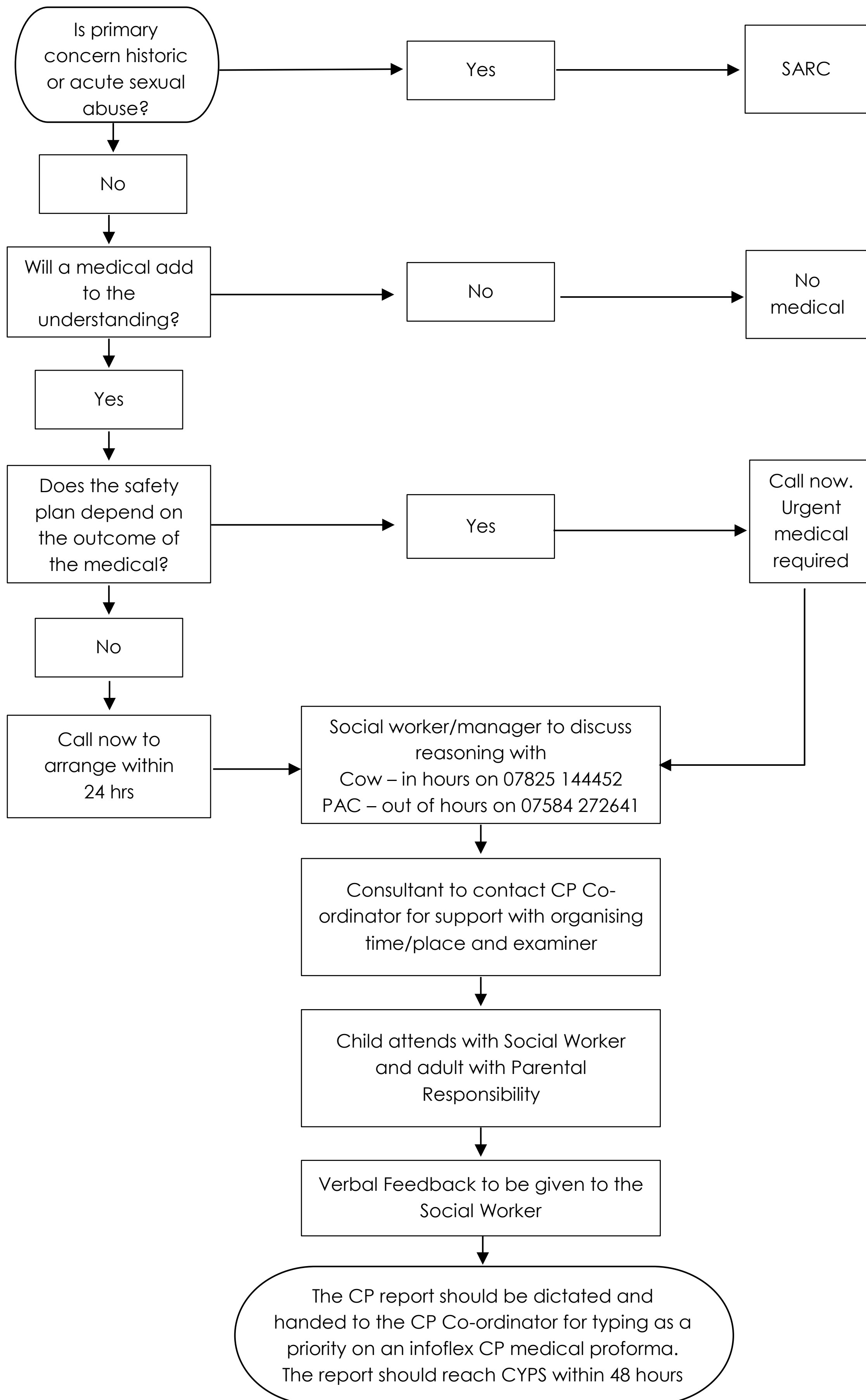
9.4. Occasionally it is appropriate for a consultant paediatrician to provide an opinion for example a child brought with an acute genital injury said to have occurred accidentally. He/she can discuss this with CSC/Police and/or the SARC (G4S): (call 0800 953 4112 and ask to speak to the on-call doctor or the specialist nurse for the Devon Sexual Abuse Assessment Service for Children and Young People.)

9.5. Also occasionally an acute sexual abuse examination is required that cannot take place at the SARC either due to urgency or the child or young person is clinically unstable needing specialist services available only in a hospital setting– list of possible situations below.

- Acute injury requiring urgent medical attention and / or the need to collect forensic samples within a specific time frame
- The child or young person admitted to Torbay Hospital for other reasons
- A general anaesthetic is required
- Doctors with other specialist skills are required at the examination e.g. from gynaecology, dermatology or genito-urinary medicine

9.6. In this situation within hours the response should be by medical staff from SARC. In situations out of hours this may require a joint examination by a Consultant Paediatrician and an FME.

10. Appendix A – When a MASH strategy discussion should seek medical advice



11. Appendix B – CP Medical Flow Chart