CHILD PROTECTION MEDICAL EXAMINATIONS

This guideline is required by the Royal College of Paediatrics and Child Health Child Protection Medical Standards.

Introduction

- Child protection medical examinations are an integral part of the multiagency process response to suspicions of child abuse. They are performed as part of a section 47 enquiry and are requested during a strategy meeting.
- The objectives of a child protection medical assessment are:
    - Assess the child or young person's state of health
    - Document injuries
    - Provide a paediatric opinion to Children's Social Care and the Police regarding likely causes for any injuries or abnormalities
    - Secure forensic evidence
    - Provide reassurance for the child and parent
    - Inform treatment, follow-up and review for the child regarding any injuries, infection, or new symptoms including psychological
- Torbay and South Devon NHS FT Child Health Department sees children up to the age of 18
- Assessments of children and/or infants with suspected physical abuse will normally be commenced within 24 hours of the decision to perform a child protection medical. Variation from this may be agreed within a strategy meeting.
- The timing of other medicals could be agreed with the paediatrician (for example where there are concerns of neglect).

Process 'in-hours' - Monday to Friday 09:00 to 17:00

- 'In-hours' referrals are generally made to the Multi-Agency Safeguarding Hub (MASH) by health professionals (GPs, health visitors, midwives etc), education, police and other agencies (See sections in the TSCP Procedures on Responding to Abuse & Neglect and Referrals)
- Information regarding new referrals will be collated in the Multi-Agency Safeguarding Hub (MASH) and a strategy discussion held
- MASH will consider requesting that a consultant paediatrician attend the Strategy Meeting.
- The consultant allocated for child protection, usually for a week, can be contacted on 07775403508 or if no response can be obtained from the child protection coordinator (01803 655801) or by calling the Torbay Hospital switchboard. Staff below the level of consultant will not accept referrals without discussing them with a consultant
- Children already open to Torbay Children's Services will be the subject of a strategy meeting and all relevant professionals will be invited to ensure quoracy and information sharing

- Further information will usually be obtained by CSC/Police which may include interviewing parent/s, the child and other professionals
- Clinicians should document discussions about child protection referrals in the child's health record, regardless of whether the child is then seen for a medical assessment or not.

Process - out of hours

- During the weekends and out-of-hours referrals will be received by the Emergency Duty Service (EDS).
- Information will be collated by the EDS and a strategy discussion will be held.
- Further information will then be obtained by EDS/Police which may include interviewing parent/s, the child and other professionals
- A consultant paediatrician may be available to join the strategy discussion and can be contacted via the Torbay Hospital switchboard.
- Assessments of children and/or infants with suspected physical abuse will normally be commenced within 24 hours of the decision to perform a child protection medical. Variation from this may be agreed within strategy meeting.

Strategy Meetings

- The need for a Child Protection Medical Assessment should always be considered where there has been a report or suspicion of any form of abuse to a child
- In most cases, a new suspicion/report of physical abuse will require a CP Medical
- Clinicians should record all decisions made during strategy discussions, either before or after a child protection medical assessment
- 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 – considering the best interests of the child, is a same-day medical required or 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.
    - Where – the child protection coordinator (within the Hospital) can assist in arranging this – usually Paediatric Outpatients Department, sometimes Louisa Cary Ward

Administration process following a strategy meeting

- If a consultant paediatrician has not been part of a strategy meeting that concludes that a child protection medical is required, the allocated social worker or team manager will discuss this with a consultant paediatrician.
- The consultant will contact the Hospital Child Protection Coordinator (01803 655801) to inform them that a CP medical request has been accepted giving the child's details and the contact details of the allocated social worker or team manager.
- The CP Coordinator will confirm the time, place and examiner and liaise with the allocated social worker, including confirming details of who will accompany the child.
- Hospital notes will be obtained and prepared including checking electronic records and a copy of the standard CP Medical documentation proforma will be printed with the child's details
- Outside normal hours the consultant paediatrician will be responsible for obtaining hospital notes, checking electronic records and preparing the standard CP medical documentation pro forma which is accessible through the safeguarding children intranet page. Assistance may be obtained from a ward clerk when available.

Examining Paediatrician

- Torbay and South Devon NHS Foundation Trust has a consultant allocated to child protection every week. Although the allocated consultant does have other responsibilities they are usually available to attend strategy meetings and conduct/oversee CP medicals. They carry a service mobile 07775 403 508. The allocated consultant can arrange for another senior paediatrician to cover if they are unable to attend.
- When child protection medical assessments are carried out by clinicians in training, the supervising senior clinician, as a minimum, must see the visible findings or injuries that have raised concern and reviews and must co-sign the report.
- Child protection medical assessments should be carried out by clinicians working at 'middle grade' level or equivalent or above, with relevant level 3 child protection competencies.
- It is expected that all doctors who perform Child protection medical assessments actively engage in relevant continuing professional development and attend peer review meetings. The Child Health Department holds peer review meetings every month.

The Child Protection Medical Assessment

- 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.
- A person with parental responsibility or delegated responsibility must attend if at all possible to give consent.
- Ideally parents/carers should be present to allow a detailed history (past medical and of events leading up to the current concern) to be taken. If avoidance of contact between child/young person and parent is in the child/young person's best interest then seeing the parent separately or having a telephone conversation with them should be facilitated.
- This should not preclude the child or young person from being seen on their own if they wish and if they are competent to provide their own consent.
- A social worker should usually attend with the child.
- A police officer may attend if appropriate
- Children and young people will be given a choice about who accompanies them in a child protection medical assessment, including not having a relative or social worker present.
- Children, young people, and families who have a disability should be provided with appropriate support.
- Written information for families, in most of the languages spoken by families accessing the service of the local area, explaining the child protection medical assessment process is under development.
- Written information for children explaining the child protection medical assessment process in age-appropriate language is under development.

Consent

- Where possible, written consent for the child protection medical assessment should be taken from a person with parental responsibility or delegated responsibility. If children's services or the police decide that it is unsafe or inappropriate for any of those people with parental responsibility to attend to provide consent in person this should be arranged by telephone.
- Separate consent is required for a skeletal survey, blood investigations, photography and use of images
- A Gillick competent child or young person can provide their own consent
- The standard medical documentation facilitates the recording of discussions and any subsequent actions where consent is withheld for any part of the assessment.

Chaperones

- During child protection medical assessments, a named chaperone should be present as a witness, and to support the child and clinician.
- Chaperones should be trained in that role.
- Chaperones should be qualified health professionals or Healthcare assistants who are considered eligible to act as chaperones in our service. Chaperones should not be students.

Interpreters

- Doctors should obtain a qualified medical interpreter if the parents and/or child/young person are unable to freely converse in English. This should be arranged through Language Line. Hospital switchboard can provide access.
- When an interpreter is used, their identifying details should be recorded on the child protection medical assessment proforma.

Provisional findings

- The examiner will provide verbal feedback to professionals who accompanied the child once the medical is completed before the child leaves the hospital and will inform the child/young person and parent/guardian of broad conclusions as appropriate.
- The examiner will provide attending social workers and/or police officers with a written provisional report at the time of the child protection medical assessment, containing the professional medical opinion regarding the likelihood of abuse based on the history and clinical findings.

Final opinion

- A final plan and outcome will be documented in the hospital notes.
- A comprehensive type-written report with a full professional opinion should be dispatched securely to social care (and police if involved), usually within 48 hours and always within 10 working days of a child protection medical assessment.
- A copy of the assessment (standard proforma), provisional report and final typed report will be kept in the child's health record.
- The report will also be securely shared with relevant health professionals (e.g., gp, health visitor or school nurse).

Photography

- Clinicians taking photographs should be offered training in relevant photography skills and the photographs taken subject to peer review (subject to consent)
- Photographs should be taken of all significant visible findings.
- Photographs taken should be of a standard that is suitable to be used in court.
- Photographs of significant visible findings should always be taken at the time of the child protection medical assessment.
- Photographs taken as part of child protection medical assessments should be stored securely in line with RCPCH guidance and FFLM guidelines on photography.
- Photography involving intimate images should comply with the intimate images guidance written by the FFLM and RCPCH.
- Clinical photographs should not be routinely sent with the report.
- Clinical photographs are to be made available in a secure and timely manner to social care, police or a court on request via TSDFT legal department.

Investigations

- Haematological investigations (blood tests) should be taken as recommended in RCPCH guidance.
- Skeletal Surveys are performed in line with the RCR (Royal College of Radiologists) guideline 'The Radiological Investigation of Suspected Physical Abuse in Children'.
- Skeletal survey and other radiological investigations are requested by the consultant paediatrician contacting the radiology troubleshooter consultant
- When a fracture is suspected to be secondary to abuse, relevant biochemical blood tests are taken, in line with RCPCH guidance.

Working with other specialists

- Orthopaedic opinions can be requested by the consultant paediatrician speaking directly to the consultant orthopaedic surgeon.
- Ophthalmology opinions are requested through eye casualty
- General dental assessments for children undergoing a child protection medical assessment, e.g. where there is concern about potential dental neglect can be obtained through the maxillofacial consultant
- When a further assessment of a bite mark is needed the consultant paediatrician will discuss with the relevant police officer regarding involvement of a forensic odontologist

Peer Review

- Peer review meetings take place monthly and it is expected that senior paediatricians undertaking child protection medical assessment attend a minimum of 6 meetings a year
- Peer review meeting attendance records with minutes of the meetings are kept securely without patient-identifiable information.
- Notes are made by the examining consultant for the hospital records
- At peer review meetings there is access to the line drawings and/or photographs of visible findings

Other points

- Regular feedback is obtained from local senior social work managers regarding the clarity of child protection medical assessment medical reports.
- The TSDFT named doctors link with named doctors from other health provider organisations in the Peninsula as part of an informal clinical network to keep in touch with mainstream paediatric and child protection opinion and practice.
- Regular (minimum annual) monitoring and audit of aspects of the child protection medical assessment service are undertaken by TSDFT.
- The TSDFT Paediatric team actively seeks to remain up-to-date with research themes in children's safeguarding.
- Processes to collect feedback from service users to inform service improvement are under consideration.
- Appropriate supervision or regulatory measures would be put in place, in line with GMC guidance, if there were recurrent or significant concerns regarding a clinician's ability to produce clear, balanced, and reasonable opinions and actions within the context of child protection medical assessments.

Report clarification and professional differences

- It is expected that the Child Protection medical opinion is evidence based, balanced and understandable by non-medical professionals. Social workers and other recipients of CP reports are encouraged to seek clarification from the author of anything in the report that is not clear or they do not understand.
- Child Protection Medical processes are, like all safeguarding practices, subject to the appropriate resolving Professional differences frameworks available on the TSCP website.

Further information

- If new information becomes available after the completion of the child protection medical the examining paediatrician can be asked to consider that information and provide an updated report.

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

- 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 before CSC being informed.
- 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 MASH referral (or EDS out of hours) with the consent of someone with parental responsibility.
- However, in some circumstances, it may be appropriate for a different course of action to be taken.
- For example:

Situation	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, mark in non-mobile infant - ? Non-accidental injury or birthmark	• Paediatrician undertakes standard medical assessment. • If there is concern over abuse after that assessment Paediatrician refers to MASH or EDS out of hours.
• 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 for referral being made without consent.
• Risk destruction of evidence.	• Referral to MASH/EDS including reasons if referral is made without consent. • Consider contacting Police 999

- 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. A consultant paediatrician should be informed immediately and for consideration of MASH/EDS referral.

Child Sexual Abuse Medicals

- 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.
- The police or social worker should follow a multi-agency flowchart and contact Exeter SARC - Devon & Cornwall SARC - NHS (sarchelp.co.uk)
- All clinicians should bear in mind that, wherever possible, an intimate examination should only take place once for the child/ young person.
- 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 the above contact details) in the strategy discussion.
- 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 on-call doctor or specialist nurse
- 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. A clinician of SARC should be involved in the strategy discussion to agree on an optimum response.

Flow diagram