

CHILD PROTECTION MEDICAL GUIDANCE FOR SOCIAL CARE, POLICE AND MEDICAL PROFESSIONALS

1. Police and Social Care Referral

If the child appears seriously ill or injured, seek emergency treatment at the local Emergency Department (ED). Where possible, contact the Paediatric ED consultant to inform them of the attendance in advance.

In all other situations, when a decision has been agreed between Social Care, Police and Health that a Child Protection medical is required, the following guidance needs to be followed:

Suspected Non Accidental Injury:

For bruising in Non mobile infants, please refer to SSCB protocol for the management of actual or suspected bruising in Infants who are Not Independently [Mobile](#)

i. For out of hours/bank holidays/weekends

The emergency duty team and police officer should contact the nearest Emergency Department (ED) to the child's home address and ask to speak to the Paediatric Consultant on call.

ii. During working hours (Monday to Friday, 9am-5pm)

The social worker should contact the relevant Community Paediatric Office (listed at appendix 1). The relevant office is dictated by the child's address. The safeguarding administrator will take the contact information from the social worker. The social worker should provide details of the child including name, address, details of any injury and the name of the social worker who will accompany the child to the medical. Where possible, written information highlighting the concerns about the child and family should be sent in advance (via secure email)

For all sexual abuse allegations (acute and non-recent),

During working hours (Monday to Friday) please contact the Solace Centre, Sexual Assault Referral Centre (SARC) directly and discuss with Paediatric Consultant On Call for the SARC (see Appendix). Out of hours please call the Police via 999, who will liaise with the On call crisis worker at the Solace Centre.

2. Timing of the medical

A mutually agreed time for the medical examination will be arranged. Where possible, child protection medicals will be undertaken during working hours.

If there are concerns in respect of the timing of the medical, an Assistant Team Manager/Manager from Children's Services should request to speak to the Community Paediatrician On Call for Safeguarding. Should there be no appropriately trained Paediatrician available to undertake the examination in a time frame deemed appropriate to the Police and social worker, a discussion needs to take place between the On Call Community Paediatrician and Assistant Team Manager and action agreed to secure a medical as soon as possible given the needs of the child and the investigation. If the On Call Community Paediatrician is not available then this should be escalated to the Community Named Doctor for Safeguarding and if not resolved, then the Surrey wide Designated Doctor for Safeguarding should be contacted.

If the Community Paediatrician is unable to undertake the medical examination and the only alternative is to take the child to an ED department, it is the responsibility of the Community Paediatrician On Call to arrange for the examination to take place with a hospital based Paediatrician and to tell the social worker who will be undertaking the medical. The decision for a child protection medical to be conducted out of hours should be through a multiagency discussion with Police, Children's Services and the Paediatrician On Call. It is not appropriate for Children's Services to just arrive at the Emergency department with a child without prior discussion unless the child is seriously ill or injured.

If the social worker or police officer subsequently decide a medical is no longer needed they must make the examining Paediatrician aware at the earliest opportunity.

Should the estimated time of arrival of the child and professionals at the agreed medical centre/hospital change, the social worker or police officer must inform the Paediatrician at the earliest opportunity.

3. The Medical

It is essential that a social worker who knows the history of the concerns attends with the child and carer for the medical examination. The Paediatrician has the right to decline the medical examination, if no clear history is available.

Where possible, the child should be seen within 30 minutes of arrival for the medical. If the child is seen in the Emergency department (ED) out of hours, then this will depend on the clinical need in the ED at that time.

It is imperative that the parent/guardian who is providing consent is present at the medical examination. If this person is unavailable (see section on Consent) the attending social worker should have obtained written consent from the parent/guardian before bringing the child to the medical examination. The Paediatrician should be satisfied that the young person/parent has understood the purpose of the examination, what it will involve and how the results might be used.

The child will not be examined and the appointment cancelled if appropriate consent is unavailable.

The social worker should provide as much information about the need to undertake an examination and the circumstances that have lead to the decision to seek medical examination to the examining Paediatrician prior to the medical examination.

If the child is seen in the ED out of hours, the child should not be discharged until the case has been discussed with the Paediatric Consultant On Call or the Paediatric ED Consultant.

The Social worker should remain with the child or family until the medical has been completed and a joint plan made for the safety of the child.

4. Admission and Supervision

Most children with safeguarding concerns do not require admission to hospital, unless they require treatment or necessary investigations. As a last resort admission may be required when there is an immediate need for a temporary and safe environment while other arrangements are being put in place.

If a child is admitted and there are child protection concerns, it is essential that supervision arrangements for carers or parents are clarified between the Consultant in charge and Children's Services if they wish to stay with the child. Nursing staff are rarely able to provide one to one supervision at all times.

5. Documentation and communication

The examining Paediatrician will provide verbal feedback together with a completed summary report on the day of the examination (if this is required by agency partners).

The 'Gold' Standard for producing a fully typed report is 3 working days from the examination. However, these time scales may not be achievable under certain circumstances and if so, the reason for this needs to be made clear to the referring agency.

The examining Paediatrician will be responsible for the distribution of the report to other appropriate agencies e.g., GP, Children's Services, Named Doctor for Safeguarding and Police.

Where there is a need for on-going medical investigations, it is the responsibility of the Paediatric Consultant in charge of the case to ensure that multi-agency partners are kept informed of the results.

6. Strategy meetings

Any strategy meetings should involve Health as stated in Working Together 2015. This should be convened in liaison with the Paediatric Team and if the child is an inpatient in an acute Trust, where possible this should be held within the acute Trust to ensure the Paediatric Consultant can attend. Children's services are responsible for ensuring typed minutes of the meeting are circulated to all.

If the allegation involves child sexual abuse, consideration should be given to including the On-call paediatrician for the SARC, who can assist in planning an appropriate holistic medical examination and ensure the health needs of the child or young person are met. See appendix for contact details.

7. Professional Differences:

If the paediatrician does not agree with the outcome of the child protection investigation, it is the doctor's responsibility to escalate their concerns to the multiagency team, aiming for resolution. The SSCB escalation procedure should be followed if ongoing concerns remain and communicated to the Named Doctor.

8. Who Can Give Consent for the Medical

Wherever possible, any person with parental responsibility should be asked for their permission for the Paediatrician to undertake a Child Protection medical. However there are occasions when other options need to be considered. These are listed below and in accordance with Surrey Safeguarding Children Board procedures:

- A person with parental responsibility (PR) (it is usually sufficient to have consent from one such person)
- If the young person is 16 and over and has given their permission and has capacity.
- If a child is under 16 but a Paediatrician considers s/he has sufficient understanding to give informed consent and they have given their consent.
- The Local Authority when the child is the subject of a Care Order (interim or full care order). The local authority can consent if they have joint parental responsibility, although where possible the parent / carer should also be informed.
- A Court as part of a direction attached to an Emergency Protection Order (EPO), a full Care Order or an Interim Care order (ICO) or a Child Assessment Order.
- The Local Authority when the child is accommodated and the parent / carers have abandoned the child or are physically or mentally unable to give such authority.
- The High Court when the child is a Ward of Court.

ii. Situations where consent is withheld or not available:

Whilst these circumstances are not common, they do present important and at times difficult clinical decisions:

- a) If a person with parental responsibility is unavailable to give consent, then the decision to proceed will depend upon the circumstances of the assessment, such as who has attended with the child and the risk posed to the child. You should consider involving others and seek advice, obtain consent from their local authority and always act in the child's best interests. Document the process which you followed.
- b) A young person with capacity to consent, who refuses, should be respected. The young person may agree to a limited examination and the process may be adapted, meeting the young person's agreement. The clinician should offer information about the consequences of refusal and offer a further opportunity. Any risks to the child should be discussed with experienced colleagues, including named professionals and clearly documented in the notes.
- c) Refused consent for photography should be respected and documented. Detailed notes should be accompanied by careful line drawings to illustrate the findings.
- d) If a person with parental responsibility refuses consent and you believe the child is at immediate risk of harm, contact the police and local authority who will decide whether to apply for an EPO. Note that an EPO confers parental responsibility but a Police Protection Order (PPO) does not.

If one person with PR consents but another person who holds PR refuses consent, you should consider the case in its entirety and if you decide the examination is in the child's best interest and/or there is a public interest then you should refer to the local authority to obtain consent by court order. Advice can be taken from Named and Designated Professionals. However, consent from one party with PR is usually sufficient.

- e) If the local authority wishes an examination to take place, but the person with PR refuses to give consent, you should consider the case in its entirety and if you decide the examination is in the child's best interest and/or there is a public interest then you should refer to the local authority to obtain consent by court order. Advice can be taken from Named and Designated professionals. The local authority would need a court order to override the refusal of the party with PR.

9. Paediatricians

I. Timescales for safeguarding medical examinations

- Suspected non-accidental injury – within 24 hours
- Chronic neglect – within 7 days of referral.
- For all sexual abuse allegations, please contact the Solace Centre, Sexual Abuse Referral Centre (SARC) and discuss with Paediatric Consultant On Call for the SARC. Forensic sampling is rarely productive more than 7 days after an allegation of acute sexual assault. However clinical signs may be present on examination up to 21 days after the assault and these injuries may be forensically significant. The timing of an acute case should follow the recommendations set out in Sexual Offences: pre pubertal complainants

and post pubertal complainants (see references). It is envisaged that non acute or historical cases should be seen at the Solace Centre within 2 weeks of a decision being made that an assessment is required, usually following the Achieving Best Evidence Interview.

If there are concerns in respect of the timing of the medical, this should be appropriately escalated as (see section 2-Timing of the medical)

If there is difficulty in arranging a medical examination within 'Gold Standard' timescales, the On Call Community Paediatrician is responsible for liaising with their hospital/community counterpart for the medical to be carried out within prescribed timescales and according to guidelines. It should not be left to the referring agency to rearrange the medical.

II. The Assessment and Consent

The Paediatrician should check that all relevant information is available before conducting the examination:

- a. Social Worker / Police information in relation to the circumstances of the injury or need for examination.
- b. Outcome of any strategy discussions.
- c. HV / School Nurse / GP/ CAMHS information (where available).
- d. Past attendances to hospital.

Where possible, the child should be seen within 30 minutes of arrival for the medical. If the child is seen in the ED out of hours, then this will depend on the clinical need in the ED at that time.

An appropriate chaperone must be present for the examination. A chaperone is needed to safeguard the child, ensure the child is at ease, assist the doctor and also to safeguard the doctor from any allegations.

The examination should be carried out by a paediatrician with Level 3 competencies as per the *Safeguarding Children and Young people: roles and competencies for health care staff April 2014*. If a trainee conducts the assessment they should be supervised by a consultant or senior paediatrician.

Record who was present and what was said. Use open questions and write directly what was said and do not paraphrase. Document both positive and negative findings.

Children should be given the opportunity of speaking alone where appropriate for their age and development.

If there is a language or communication difficulty, an appropriate interpreter must be used.

Appropriate consent must be obtained prior to examining, investigating, or treating a child or young person (see consent section 8). The Paediatrician must be satisfied that the person giving the consent understands the purpose of the examination and what it will involve; how the results of the examination may be used and that they have the right to refuse consent, and the possible consequences in doing this. You must get specific consent to take photographs or other images. All photos or images taken should be stored appropriately according to local and national policy.

If the consent is via a third party, for example Children's Services, the Paediatrician should be satisfied that the parent has understood the purpose of the examination and how the results might be used. You should usually get consent in writing, but oral consent can be relied upon if waiting for written consent would delay examination or treatment of a child or young person. You must record the conversation in the child's medical record.

Surrey Safeguarding Children's Board Safeguarding Medical and Examination Record form (Cp1) **must** be used to record history / examination findings / opinion and recommendation. The name of the responsible consultant should be clearly documented. Body maps must be used and completed by dating, writing examiners name and signature.

The social history should include a genogram.

Records of the assessment should be contemporaneous and comprehensive.

Record any difficulties or limitations with either the history or examination.

When summarising your findings, discuss the differential diagnoses, base your opinion on the balance of probability supported with the evidence base.

If the medical examination is performed by a Paediatric Registrar, the findings of the examination **must** be discussed with the Consultant Paediatrician responsible before opinion and recommendation is given to Social Care / Police Safeguarding Teams. Where possible, all paediatricians should discuss each case with a fellow paediatrician before discharge.

Paediatricians should not work in isolation and should seek advice when they have concerns.

III. Admission and Supervision

Most children with safeguarding concerns do not require admission to hospital, unless they require treatment or necessary investigations. As a last resort admission may be required when there is an immediate need for a temporary and safe environment while other arrangements are being put in place.

If a child is admitted and there are child protection concerns, it is essential that supervision arrangements for carers or parents are clarified between the Consultant in charge and Children's Services.

IV. Transfer and Discharge

If a child is transferred between hospitals and there are safeguarding concerns, this must be clearly stated prior to transfer and also documented in the written communication accompanying the child. It should be clearly stated what has happened as regards the safeguarding process.

V. Investigations

For further details please refer to the RCPCH Child Protection Companion 2013 and Appendix 2.

Relevant investigations in physical abuse may include:

Blood investigations

- Full blood count and film
- Coagulation studies (basic and extended)- see appendix
- Liver function tests
- Amylase
- Bone chemistry and Vitamin D/PTH
- Urine and blood toxicology

For skeletal survey guidance please refer to Surrey Radiological Investigations of Suspected Non-Accidental Injury.

- CT Head
- MRI Brain and spinal cord
- Ophthalmology examination

VI. Communication and Documentation

The examining Paediatrician will provide verbal feedback together with a completed handwritten summary report on the day of the examination (if requested from Children's Services).

A typed medical report should be produced within 3 working days from the examination. However, these time scales may not be achievable under certain circumstances, and if so the reason for this needs to be made clear to the referring agency. The Supervising Consultant countersigning the medical report should quality assure the report.

Where there is a need for on-going medical investigations, it is the responsibility of the Paediatric Consultant in charge of the case to ensure that multiagency partners are kept informed of the results.

Where there is a need for further strategy meetings, it is important health contributes to these. If the child is an inpatient these meetings should be held where possible in the acute Trust to enable the Paediatrician to attend.

Document all discussions regarding a child, whether face to face or on the telephone or via secure email. If you do not have the records at the time, ensure a note is written and added to the contemporaneous notes as soon as possible.

The report is written for Children's Services.

It should also be copied to:

- The GP
- Health visitor (if under 5 years of age)/ School nurse if over 5 years of age)
- Police (where there has been involvement)
- Named Doctor for the community
- Named Doctor for the local acute trust.
- The original should be filed in the hospital medical records.

All paediatricians should participate in regular safeguarding peer review.

VII. Professional Differences:

If the paediatrician does not agree with the outcome of the child protection investigation, it is the doctor's responsibility to escalate their concerns to the multiagency team, aiming for resolution. The SSCB escalation procedure should be followed if ongoing concerns remain and communicated to the Named Doctor.

Appendix 1. Medical advice:

If urgent medical care is required: contact Emergency Department (ED) of the child's nearest hospital (discuss directly with Consultant Paediatrician during working hours (09:00 to 17:00) and On Call Paediatrician out of hours)

For all other Child Protection Medical Examinations:

Monday to Friday 09:00 to 17:00 – Contact West or East Community Paediatric Team, Virgin Care (**except Epsom area which is covered by Epsom General Hospital**).

Area	Telephone number	Address
Virgin covering SW/NE/NW areas (West Team)	07717 426704 (main number) Office number if unable to access mobile): 01483 783159	Developmental Paediatricians, Jarvis Centre, 60 Stoughton Road, Guildford GU1 1LJ. Note examinations may be conducted at Goldsworth Park, Woking or the Jarvis Centre, Guildford.
Virgin covering SE area (East Team) (Tandridge, Horley, Redhill, Reigate and Dorking)	01737 768511 Ext 6863	Community Child Health, Trust Headquarters, Maple House, East Surrey Hospital, Canada Avenue, Redhill RH1 5RH.
Epsom Hospital (covers part of NE area and includes Epsom, Ewell and Banstead, Ashstead)	01372 735735 Ext 6921 Ask for Safeguarding Patient Pathway Co-ordinator.	Epsom Hospital, Dorking Rd, Epsom, Surrey KT18 7EG

After working hours, weekends and Bank holidays

-contact On Call Paediatric Consultant at nearest hospital:

Hospital	Telephone number
Ashford and St Peter's NHS Foundation Trust Guildford Rd, Chertsey, Surrey KT16 0PZ	01932 872000
Royal Surrey County Hospital NHS Foundation Trust Egerton Rd, Guildford, Surrey GU2 7XX	01483 571122
Frimley Park Hospital NHS Foundation Trust Portsmouth Road, Frimley, Surrey GU16 7UJ	01276 604604
Surrey & Sussex Healthcare NHS Trust Canada Avenue, Redhill, Surrey, RH1 5RH	01737 768511
Epsom & St Helier University Hospitals NHS Trust Epsom Hospital, Dorking Rd, Epsom, Surrey KT18 7EG	01372 735735 (Epsom Hospital)

For Sexual Abuse Medicals (Acute and Non recent)

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Out of hours, call 999 and ask to speak to the police who will liaise with the Solace centre and arrange an appropriate medical.

In hours (9-5 Monday to Friday), please call the Solace Centre and ask to speak to the Paediatric consultant on call.

The Solace Centre Surrey Sexual Assault Referral Centre (SARC) The Solace Centre, Cobham Community Hospital, 168 Portsmouth Road, Cobham, Surrey KT11 1HT	01932 867581
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Appendix 2: Clotting Investigations for Bruising (as stated in RCPCH Child Protection Companion 2013)

- **First line investigations**
 - Coagulation screen:
 - Prothrombin time (PT); not International Normalised ratio (INR)
 - Activated partial thromboplastin time (aPTT)
 - Thrombin Time
 - Fibrinogen (Clauss)
 - Full blood count and film (and mean platelet volume if thrombocytopenic)
 - Assays of Factor VIIIc, Von Willebrand factor (VWF antigen and VWF activity)
- **Second line investigations**
- If there is ongoing concern about a coagulation disorder being the cause of the child's bleeding or bruising and all first line investigations are normal then rarer heritable causes of bleeding such as Factor XIII deficiency or a platelet function defect need to be considered in discussion with your local paediatric haematologist.

These would include:

- **In a child less than 2 years old:**
 - Screen for Heritable severe disorders of platelet function (either by Closure Time using PFA-100 or by Flow Cytometry quantitation of platelet glycoproteins Ia, IIa/IIIb).
 - Factor XIII screen/assay
 - **In a child 2 years or older**
 - Platelet aggregation
 - Factor XIII screen/assay
- a. Fractures or Abusive Head Trauma**
- Follow Surrey document – Radiological Investigations of Suspected Non-Accidental Injury. A Factor XIII assay (or screen) should be undertaken for a child of any age with an unexplained

References:

- FFLM & RCPCH. *Sexual offences: pre-pubertal complainants*. May 2013. <http://fflm.ac.uk/upload/documents/1369999406.pdf>
- FFLM & RCPCH. *Sexual offences: post-_pubertal complainants*. May 2013. <http://fflm.ac.uk/upload/documents/1369999423.pdf>
- GMC 2012: Protecting children and Young people: The responsibilities of All Doctors. http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
- National Collaborating Centre for Women's and Children's Health (2009) When to suspect child maltreatment. National Institute for Health and Care Excellence. <http://www.nice.org.uk/CG89>
- RCPCH. *Child Protection Companion* (<http://www.rcpch.ac.uk/child-health/standards-care/child-protection/publications/child-protection-publications>). 2nd Edition March 2013.
- RCPCH. *The physical signs of child sexual abuse: an updated evidence based review and guidance for best practice*. 2015. RCPCH London. <http://www.rcpch.ac.uk/physical-signs-child-sexual-abuse>
- Service specification for the Clinical evaluation of children and young people who may have been sexually abused. Sept 2015. RCPCH. FFLM guidance Safeguarding children and young people: roles and competences for health care staff (April 2014) <http://www.rcpch.ac.uk/child-protection-publications>
- Working Together to Safeguard Children, HM Government, 2015
Working Together to Safeguard Children 2015
- What to Do If You Are Worried a Child Is Being Abused, HM Government, 2015
<https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2>