Suffolk Safeguarding Partnership

Child Protection Medical Assessments Guidance

Policy Version History

Version	Date	Review Date	Author/Reviewer	Date of PPE/ LIG Approval
1	July 2012	July 2015	Dr Nikki Rycroft, Designated Doctor *West Suffolk, Ipswich and East Suffolk CCGs*	
2	18/10/2018	18/10/2021	Cindie Dunkling, Designated Safeguarding Nurse *West Suffolk, Ipswich and East Suffolk CCGs*	October 2018
3	08/12/2020	08/12/2023	Rachel Furley, Paediatric Consultant, *West Suffolk Hospital* and Designated Doctor for Safeguarding Children, *West Suffolk Ipswich and East Suffolk CCG.*	December 2020
4	10/03/2021	08/12/2023	Addition of James Paget Pathway.	February 2021

1. Introduction

A paediatric medical assessment should always be considered when there is a suspicion of, or a disclosure that indicates a child is at risk of significant harm (sec 47 Children Act 1989). This includes child abuse and/or neglect involving injury, suspected sexual abuse or serious neglect. For the purpose of this guidance, the term 'medical assessment' will be used.

A specialist paediatric medical opinion is required to:

- Perform medical evaluation and documentation of signs of abuse or neglect to provide evidence in the child protection investigation and in some cases for subsequent legal proceedings.
- Identify unmet medical or developmental needs.
- Analyse known medical or developmental concerns, implement interventions in the context of abuse and neglect and to advise on their significance.
- Contribute to a multi-agency management plan.

Although cases can present with a variety of features, bruising is the most frequent presentation (either as suspected physical abuse or mixed forms of abuse or neglect).

Please refer to the non-mobile baby guidance and documents on the Suffolk Safeguarding Partnership website: https://www.suffolksp.org.uk/

The purpose of a medical assessment is:

- To assess the health and wellbeing of the child to establish whether there is any medical evidence of abuse or neglect, and to initiate further investigation and treatment as required.

The expected outcomes of a medical assessment are:

- An assessment of the child's general health and development.
- Advice regarding investigation, treatment or intervention.
- Guidance to the child and carers about any medical findings and any future implications.
- A record of any physical findings, including written notes, drawings, photographs, video recordings or samples.
- To establish whether the account given for any observed injury or harm is consistent with the injury or harm sustained.
- Reports and statements as required to the investigation team, using the RCPCH Child Protection Companion as a basis for evidence, give an opinion regarding the presenting concern.
- Information sharing with the child's GP and other relevant health professionals.
- Providing continuing medical care or making referrals to relevant health service colleagues. If the examination and report is completed by a paediatric registrar, a supervising consultant **must** be identified within the documentation and report.

- An immediate verbal feedback for the attending social worker.
- A typed medical report, usually within 3 working days.

A medical assessment can be stressful for all involved and ensuring that they are seen by the correct people at the correct time in a caring and supported manner is essential in managing this.

2. Referral Procedure for Child Protection Medical Assessment

Where the child requires urgent medical attention (e.g. suspected fractures, bleeding, loss of consciousness), they should be taken to the nearest hospital emergency department and the police should be informed.

The referral guidelines for the different regions of Suffolk are below.

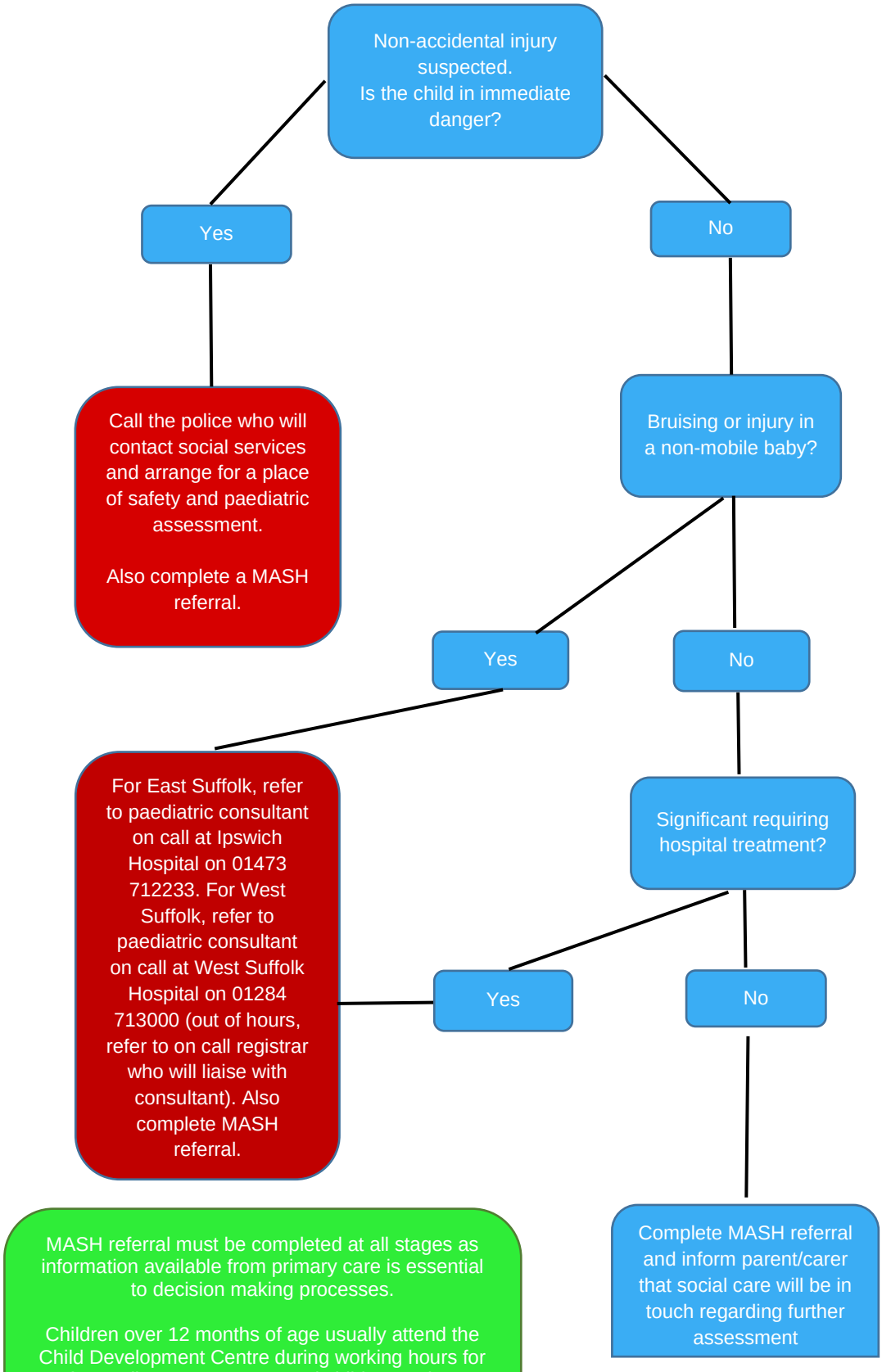
When there is a disclosure or suspicion of Sexual Abuse, the flowchart ***Referral Process for the Suffolk Paediatric SARC Service*** must be followed. Please see the link below to the SARC referral process on the Suffolk Safeguarding website.

SARC Referral Process

Waveney Area

During weekday working hours, contact the safeguarding office via the James Paget Hospital switchboard (01493 452452), except in emergency situations. Out of hours, contact the on call paediatric consultant via the same telephone number to refer the child for assessment.

The East and West Suffolk Pathway



MASH referral must be completed at all stages as information available from primary care is essential to decision making processes.

Children over 12 months of age usually attend the Child Development Centre during working hours for safeguarding assessments and children under 12 months will be seen in the hospital but the MASH will arrange this. Out of hours, children will be assessed at the hospital as emergency cases. For sexual abuse, please see the specific pathway.

INJURIES IN NON-MOBILE CHILDREN

Advice for Suffolk County Council Health Staff referring to James Paget Hospital Lowestoft for any injury or unexplained mark, any isolated or oral bleeding in the absence of a clear cause.

On identifying a mark / bruise SCC CYP Health to Telephone James Paget Hospital **Safeguarding team (01493) 452452 bleep 1096 or (01493) 4523964**

Whilst with the baby / family, contact the Safeguarding Team at James Paget Hospital. Advise them of the injury providing client's details, give details of the unexplained mark / bleeding and any relevant background. Provide a brief overview of any safeguarding concerns. Safeguarding Team will liaise with the Consultant Paediatrician on Call. At the time of the consultation, establish who will take responsibility for contacting the family post discussion.

Following telephone consultation complete referral form and send to James Paget Hospital safeguarding@jpaget.nhs.uk . Write up records and record mark or bruising on body map. Advise Named Nurse for Safeguarding Children of referral. Complete safeguarding referral to MASH if clear from the onset that injury was non accidental.

Safeguarding Medical Assessment P

Safeguarding Team at hospital to feed outcome of referral back to referrer and identified clinician to contact family to advise whether Paediatric Assessment is indicated.

Paediatrician will refer to customer first if indicated and not yet completed.

MASH will hold a strategy discussion and liaison will take place between CYPS, Police and with the Paediatrician to agree further plans.

2.1 Consent

Child protection medical assessments **will only be conducted when there is written informed consent** to do so.

Written consent should always be gained from the child/young person, if they have the capacity to do so. Where a child does not have capacity to consent, it is expected that the parent(s) or other person who holds parental responsibility (PR) will attend the assessment to give written consent. If the parent(s) or person holding PR is unable to attend or it is not in the best interest of the child for them to attend and the child/young person does not have capacity to consent, the social worker should seek to obtain written consent beforehand and ensure that the parent/guardian is available by telephone for discussion with the examining doctor. In exceptional circumstances, for example if the parent cannot be contacted or refuses consent and the examination is important to safeguard the child, the social worker or police **must** apply to the court for an order (see below). Written consent must also be sought for the use of photography and other investigations, where required.

Information about the medical assessment will be given to the parents/carers and child by the paediatrician completing the medical when the child and family attend the appointment. (See Appendix 3).

The following person(s) may give consent:

- A child of 16 years and over (unless lacking capacity).
- A child under 16 who is able to fully understand what is proposed and its implications (often referred to as Gillick competence). This is a judgement that needs to be taken with care by the paediatrician making the assessment of capacity and competence of the child in these circumstances.
- Any person with parental responsibility. When a child is subject to a Care Order, the person with parental responsibility will include the Local Authority.
- The Local Authority, when the child is accommodated, and the parent/carer has abandoned the child or is physically or mentally unable to give such authority.
- The court, when a child is subject to an Interim Care Order, Emergency Protection Order or Child Assessment Order. Note that consent for examination or assessment requires the court to make specific direction.
- Police Powers of Protection **do not** give parental responsibility to the Local Authority (or the police); therefore, if a person with parental responsibility or the child, if judged as Gillick competent, does not give medical consent then the medical assessment cannot proceed unless considered in the best interests of the child.

2.2 Chaperones

Child protection medical assessments **must** be conducted with an appropriate chaperone present, with their name and position recorded in the documentation. This is not only important for the child but also the examining clinician. A chaperone should be an appropriately qualified member of health staff who understands the examination which is taking place; a student should not be used as a chaperone for a medical assessment as they may be difficult to locate later if required to give feedback and might not sufficient knowledge of the clinical examination taking place.

3. Siblings

Consideration should be given to whether siblings of the subject child/young person also need a medical examination as part of the child protection enquiry, even though there are no immediate signs of injury/abuse in that child. Specific guidance should be followed in particular circumstances, e.g. in a twin SUDIC, the surviving twin should be admitted to hospital for observation, or if abusive injuries are found in a child, any other child under 2 years old in the household should have a full skeletal survey and focused medical assessments should be considered for other children in the household. The strategy meeting must consider whether these examinations also need to occur within 24 hours. Should the decision be made to postpone or not to proceed with sibling medicals, the decision and risk assessment must be clearly documented.

4. Children MUST NOT be referred to the GP for the purpose of a medical assessment

Children must be referred via the appropriate pathway to a paediatrician for a medical assessment. A child must **never** be referred to their GP for a medical assessment; a GP does not have the resources or the expertise to undertake a specialist paediatric safeguarding medical assessment and must not be asked to do so.

The majority of examinations take place on the day of referral. In cases of chronic neglect, a more planned approach may be appropriate. Examinations may be carried out by two doctors or by a doctor plus a chaperone. If the examination or report is undertaken by a paediatric registrar (ST4+) then a supervising consultant must be named in the documentation.

For sexual abuse, children will be seen in the Sexual Assault Referral Centre (SARC) by a paediatric Forensic Medical Examiner (FME) if they are under 13 years old and by a specialist nurse if over 13 years. (Please refer to separate guidance on referral and examination in cases of sexual abuse).

5. Outline of Examination

The medical and supporting staff members are trained to handle this aspect of work sensitively as it is recognised to be stressful for all involved. By following the correct referral pathways, children are seen in appropriate locations and by staff trained to support their needs.

An interpreter must be supplied if required for the child or parent/carer. Information regarding context and background information is obtained initially by the clinician from the accompanying social worker and/or police. The history of the case is obtained from the parent/carer(s) where present. Information is taken from the child in a sensitive manner, avoiding leading questions if developmentally appropriate. The assessment consists of interpretation of available historical data, observation of child and child-carer/parent interaction, an estimation of development (in younger children) and comprehensive physical

examination. If the child/young person refuses or resists examination despite reassurance, this will **not** be pursued, however examination at a later date can be considered if required/appropriate.

Every service has their own protocols, and these should be followed or the rationale documented clearly if they were deemed not to be required.

6. Photo Documentation

It may be necessary for the examining doctor to arrange for photographs of any injuries seen to be taken; the images taken will form part of the child's medical records. Local arrangements for this vary. Photographs may also be used to obtain a second opinion, for peer review and training purposes and for submission as evidence in court. Written consent must be obtained in all cases. In some cases, the examining doctor may request that photographs are taken by the police.

7. Medical Reports

Findings and provisional opinion are conveyed verbally to the social worker at the conclusion of the medical examination, followed by a written report, usually within 3 working days. In cases where findings are not clear, a second opinion or peer review may be needed before forming a final conclusion. It is therefore possible that the conclusion in the written report may differ from the initial medical opinion given at the time of assessment. All reports are also subject to peer review and subsequent amendment.