



Child Protection Medical Guidance for Medical professionals, Childrens services and Police.

If the child appears seriously ill or injured, seek emergency treatment at the local Emergency Department (ED). Where possible, contact the Paediatric ED or On call Paediatric consultant to inform them of the attendance in advance. Children should not be brought unannounced to the ED unless urgent medical treatment is required.

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 must be adhered to.

1. When a Medical Assessment is Necessary

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.

Additional considerations are the need to:

- Secure forensic evidence;
- Obtain medical documentation.

Only paediatricians with appropriate paediatric and child protection training should physically examine the whole child for the purposes of a safeguarding medical assessment. This should be a Paediatric Registrar (ST4 or above/ Middle grade) and any examination should be discussed with a Consultant Paediatrician before the child is discharged.

It is not appropriate to send a child to their GP for a safeguarding medical.

Other health staff should note any visible marks or injuries on a body map and document details in the child's records.

2. Purpose of Medical Assessment

A paediatric medical assessment is an essential component of a child protection investigation. It is a comprehensive holistic assessment that includes clinical history and examination. It should include a developmental assessment (particularly below the age of 5 years). The assessment should include obtaining any relevant investigations, arranging aftercare and writing a report with an opinion.

The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease. [*The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming 2003.*](#)

The purpose of a medical assessment is to:

- Identify the child's health needs, initiate treatment and arrange any necessary follow up as required;
- To help to reduce the physical and psychological sequelae of such abuse;
- To determine the likelihood of child abuse on the balance of probability;
- To facilitate the police investigations of a possible crime by documentation of clinical findings, including injuries and taking samples that may be used as forensic evidence in a police investigation relevant to all types of abuse;
- To contribute to the multiagency assessment through sharing of information.

3. Strategy meetings

Strategy meetings should be called for all children where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. They should be held in line with SSCP guidance (Procedure 4.8 strategy discussions section 47 enquiries) and as specified in Working Together 2018; this should include a local authority social worker, Named Nurse (and Named Doctor where appropriate) and Police as a minimum. The need for a planned medical assessment with appropriate consent should be considered as part of this meeting.

Where a child has presented to a health professional which has then led to a referral to Children's services, the consultant paediatrician should be part of the strategy meeting so that the medical findings can be correctly interpreted. If the child is an inpatient in an acute Trust the strategy meeting should be held within the acute trust to ensure the Paediatric Consultant can attend and ensure access to all relevant health information. Where there is a need for further strategy meetings, it is essential that a paediatric consultant contributes to these.

As stated in Working Together 2018, health practitioners are responsible for securing additional expert advice and support from Named or Designated professionals for more complex cases following preliminary Strategy discussions.

If the allegation raises concerns about child sexual abuse, the on call paediatrician at the SARC should be involved in the strategy meeting. The paediatrician will assist in planning an appropriate holistic medical examination and ensure the health needs of the child or young person are met.

Children's services will chair the meeting and should ensure typed minutes are circulated in a timely fashion to all who have contributed to the strategy meeting.

See **SSCP Procedures** Section 4.8 [Strategy Discussions and Section 47 Enquiries](#)

4. Arranging the Medical Assessment for Police and Childrens services

When a decision has been that a child protection medical assessment is required, this guidance needs to be followed:

For bruising in non mobile infants, please refer to SSCP protocol for the management of [Bruising in Infants who are Not Independently Mobile](#).

Where possible the child should be seen by a social worker prior to a referral.

Child protection medicals should only be completed by an appropriately trained Paediatrician and children should not be taken to their GP for a child protection medical.

Where unexpected safeguarding concerns are identified by health that may require a child protection medical and urgent medical care is not required, a referral should be made to Childrens Services who will arrange the medical in the community by the Community Paediatricians (unless they are under 6 months and there is concern about physical abuse)

I. For out of hours/bank holidays/weekends

The emergency duty team or 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 to arrange a mutually convenient time. If they are unable to speak to anyone in the ED, they should ask to speak to the Paediatric Registrar on call who should liaise with the consultant on call.

Children should only be referred to the Hospital for a child protection medical if they are

- under 6 months and there are concerns about physical abuse
- or urgent medical attention is required
- or it is over a bank holiday/ weekend and there are concerns about physical abuse and the child cannot be seen by the community paediatricians within 24 hours
- or further investigations are required following a community safeguarding medical.

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).

If the child is under 6 months and there are concerns about physical abuse then the child should be referred by Childrens Services to the local Acute Hospital to be seen by the Paediatric team (see Appendix 1 for contact details).

III. For all sexual abuse allegations (acute and non-recent) and for examinations for female genital mutilation (FGM)

During working hours (Monday to Friday) please contact the Solace Centre, Surrey Sexual Assault Referral Centre (SARC) directly and discuss with Paediatric Consultant On Call for the SARC (see Appendix 1).

Out of hours please call the Police via 999, who will liaise with Surrey Solace Centre.

5. 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 by the community paediatric team.

The following are taken as a guide but each case should be considered individually.

- Suspected physical injury – within 24 hours of referral.
- 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 for DNA is rarely useful 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 expected that non recent cases should be seen at the Solace Centre within 2 weeks of a decision being made that a medical assessment is required and after the Achieving Best Evidence (ABE) Interview has been completed. A copy or a summary of the ABE interview should be provided to the SARC. All children with whom there are concerns about child sexual abuse should be referred to the SARC, so that a holistic examination can be offered and any necessary support can be provided to the child and family.

If there are concerns in respect of the timing of the medical, a Manager from Children's Services should speak directly to the Community Paediatrician on Call for Safeguarding. If there is no appropriately trained community 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 Children's Services Team Manager and action agreed to secure a medical as soon as possible, given the needs of the child and the investigation. If this is not resolved, it 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 a 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 inform 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. If required the [SSCP Interagency Escalation Policy](#) should be used.

It is not appropriate for a social worker to arrive at the Emergency department with a child without prior discussion unless the child is seriously ill or injured.

A busy paediatric ward is not a place of safety. Alternative accommodation must be sought by Childrens services.

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.

6. Consent for the Medical Examination

Appropriate consent must be obtained prior to examining, investigating, or treating a child or young person.

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.

The paediatrician 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.

Consent to share information must also be sought, stating what information you will share, who you will share it with and how the information will be used. Parents should be advised where they can go for independent advice and support. (See [Sources of independent advice and support for parents and families](#) for examples of organisation's available, GMC guidance, *Protecting Children and young people*).

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. Consent should usually be 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. The conversation should be recorded in the child's medical record.

Wherever possible, any carer 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 are in accordance with Surrey Safeguarding Children Partnership procedures:

- 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.
- A person with parental responsibility (PR) (it is usually sufficient to have consent from one such person).
- 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.

I. Situations where consent is withheld or not available:

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

For a child subjected to Police Protection, the Local Authority would need to have sought one of the above orders before the child undergoes a child protection medical assessment if the parent has not consented or is unavailable to give consent, unless the child is competent to give their own consent.

In emergency situations where the child needs urgent medical treatment and there is insufficient time to obtain parental consent, the medical practitioner:

- May decide to proceed without consent; and/or
- May regard the child to be of an age and level of understanding to give her/his own consent.

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. This should be fully documented in the medical notes.

In these circumstances, parents must be informed as soon as possible. In non-emergency situations, when parental permission is not obtained, the Social Worker and manager must seek legal advice through the local authority.

A child with capacity to consent, who refuses an examination, should be respected. The child may agree to a limited examination and the process may be adapted. The paediatrician 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.

Refused consent for photography should be respected and documented. Detailed notes should be accompanied by careful line drawings to illustrate the findings.

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

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

Children should not be seen for an assessment while under the influence of drugs or alcohol; unless there is a clinical indication such as excessive vaginal bleeding as this affects their ability to give informed consent. Police officers can take samples with early evidence kits at presentation if needed.

7. The Paediatric Medical Assessment

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)/ or Paediatric Assessment Unit out of hours, then this will depend on the clinical need in the department at that time and this may not always be possible.

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

The Paediatrician should check that all relevant information is available before conducting the examination. This should include, where possible, Health visitor/ School Nurse / GP/ CAMHS information and past attendances to hospital.

Where possible the social worker who knows the family should attend the medical examination. A comprehensive social history is essential for completion of a child protection medical examination.

This should include the outcome of any strategy discussions. **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.**

If police are not present then any relevant police information should be communicated via Childrens services.

A qualified trained health professional must be present as a chaperone for the safeguarding examination. This should be in accordance with hospital policy to ensure the child is at ease, assist the doctor, and 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 competences for healthcare staff January 2019](#). If a trainee (who should be working at ST4 level or above) conducts the assessment they should be supervised by a consultant or senior paediatrician and 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.

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

When the child is seen initially in the community and further investigations are indicated in the hospital that may necessitate admission, a direct conversation should take place where possible between the community paediatrician and the on call hospital paediatric consultant. A leaflet should be given to the parents/carers by the community explaining what investigations may be required. The decisions made by

the community team should be respected where possible unless further information comes to light and if there is a change in the clinical management, this should be communicated, where possible, to the initial referrer with an explanation as to why the decision has been changed. If a child is referred to the Hospital, a social worker should also attend the hospital with the parents.

All children should be holistically assessed in child friendly clinical environments appropriate to their age and clinical presentation with necessary equipment and access to any investigations.

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

The social history should include a genogram.

All children should have their growth parameters measured and plotted on a growth chart.

Records of the assessment should be contemporaneous and comprehensive. Any difficulties or limitations with either the history or examination should be documented.

When summarising the medical findings, discuss the differential diagnoses, base your opinion on the balance of probability supported with the relevant evidence base where this is available.

All paediatricians should participate in regular safeguarding peer review and engage in regular supervision as specified in the [Safeguarding children and young people - roles and competences for healthcare staff January 2019](#).

8. Transfer between hospitals and discharge

If a child is transferred between hospitals and there are safeguarding concerns, this must be discussed prior to transfer and also documented in the written communication accompanying the child. The safeguarding process up to the point of transfer should be clearly stated and any transfer arrangements must be agreed by police, social worker and health.

A child should not be discharged from a hospital to a home environment without agreement of the Paediatric consultant, police and children's services. It is best practice for there to be a pre discharge planning meeting to address all of the issues including appropriate follow up. A discharge letter should be written ensuring the appropriate professionals are informed, this should include the GP, health visitor and social worker, even if a more detailed medical report is to follow.

9. Documentation and communication

The examining Paediatrician should provide verbal feedback together with a handwritten completed summary report on the day of the examination (if a written summary is requested by agency partners).

Surrey Safeguarding Children's Partnership Safeguarding Medical and Examination Record form (Cp1) should be used to record history / examination findings / opinion and recommendation.

The report should document both negative and positive findings. When summarising the findings, discuss differential findings, base the opinions on the balance of probability supported with the evidence base.

There should be no discrepancies between notes, reports and police statements.

A typed medical report should be produced within 3 working days and this should be shared with all appropriate agencies (that consent has been provided for). 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 medical report. The name of the responsible Consultant should be clearly documented. Named doctors should have oversight of all medical reports for quality assurance.

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.

The medical report is written for Children's Services.

With appropriate consent, 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 report should remain in the medical records.

10. Professional Differences

If staff do not agree with the outcome of the child protection medical or investigation, concerns should be escalated to the Named Doctor and if required the Designated Doctor. It is the doctor's responsibility to escalate concerns to the multiagency team, aiming for resolution. [The Surrey FaST Resolution Process](#) should be followed.

11. Admission to Hospital and Supervision

Where possible a child should not be admitted to a paediatric ward as a place of safety as this is not an appropriate environment and the supervision required cannot be provided by nursing staff. Therefore all other avenues of alternative accommodation should be pursued where deemed necessary. 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 a child is admitted overnight to a hospital due to safeguarding concerns, after having previously been seen in the community for a child protection medical, safeguarding responsibility for the care of that child should be transferred to the Paediatric Consultant in the hospital.

Professionals should also refer to the [SSCP FaST process](#) for further clarification.

12. Medical Investigations

For further details please refer to the RCPCH Child Protection Companion (updated On line)

Relevant investigations in physical abuse may include:

- Full blood count and film
- Coagulation studies (first line and second line investigations. For details refer to Chapter 9, Recognition of physical abuse, Child protection Companion)
- Liver function tests
- Amylase
- Bone chemistry and Vitamin D/PTH
- Urine and blood toxicology
- Skeletal Survey with follow up films. A skeletal survey is recommended for all children under 2 years of age who are being investigated for physical abuse. [The radiological investigation of suspected physical abuse in children | The Royal College of Radiologists 2017](#). Follow up imaging should be taken within 11-14 days. Skeletal surveys in children over the age of 2 may still be occasionally indicated and should be discussed on a case by case basis.
- CT Head scan is recommended for all children under 1 years of age who are being investigated for physical abuse. Children over 1 who have external evidence of head trauma and/or abnormal neurological symptoms or signs should also have a CT head.
- MRI Brain and Spinal cord.
- In children with suspected abusive abdominal injury consider a contrast abdominal CT Scan.
- Ophthalmology examination. This should be performed where possible within 24 hours if there are concerns about Non accidental Head injury and if severe physical abuse is suspected under 2 years of age.

13. Peer Review

All health services that undertake Child Protection Medical Examinations must have an effective Peer review process in place in keeping with national guidance. It is good practice that all doctors who undertake child protection medical examinations regularly attend Peer Review. This should include a mechanism to obtain feedback form local legal services or senior social workers regarding the child protection medical reports.

Appendix 1. Medical advice:

If urgent medical care is required: contact Emergency Department (ED) of the child's nearest hospital (discuss directly with Attending 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 Community Paediatric Team CFHS as below, **(except Epsom area which is covered by Epsom General Hospital- see below).**

Area	Telephone number	Address
Community Paediatric Medicals CFHS covering all of Surrey (aside from area covered by Epsom)	07717 426704 (Main number to dial to arrange all medicals) Office number if unable to access mobile: 01932 587120	Developmental Paediatrics Service, Surrey and Borders Partnership Trust, Unither House, Curfew Bell Road, Chertsey, Surrey, KT16 9FG Note examinations may be conducted at different sites across Surrey
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 Health NHS Foundation Trust Frimley Park Hospital, Portsmouth Road, Frimley, Surrey GU16 7UJ (Out of hours children are see in the Paediatric Assessment unit - PAU)	Weekdays 09:00-18:00: PAU consultant on 07881352600 Out of hours: 0300 613 5000 –On call Paediatric Consultant
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)

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, First Floor, Cobham Community Hospital, 168 Portsmouth Road, Cobham, Surrey KT11 1HT	01932 867581
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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.

If urgent medical advice is required call Mountain Healthcare 0300 130 3038

References:

- [0-18 years - GMC. Guidance for all Doctor.](#)
- [Child abuse and neglect | Guidance and guidelines | NICE 2017](#)
- [FFLM & RCPCH. Sexual offences: pre-pubertal complainants. Jan 2016](#)
- [FFLM & RCPCH. Sexual offences: post- pubertal complainants. Jan 2016.](#)
- [Information sharing advice for safeguarding practitioners, DFE 2018](#)
- [Protecting children and young people, GMC Guidance updated on line.](#)
- [The radiological investigation of suspected physical abuse in children | The Royal College of Radiologists. 2017.](#)
- [RCPCH. *Child Protection Companion*, Online RCPCH.](#)
- [RCPCH. *The physical signs of child sexual abuse: an updated evidence based review and guidance for best practice.* 2015. RCPCH London.](#)
- RCPCH [Peer review in safeguarding | RCPCH](#)
- RCPCH [Child protection service delivery standards – RCPCH Child Protection Portal 2020](#)
- [Safeguarding children and young people: roles and competences for health care staff \(Jan 2019\)](#)
- [Child maltreatment: when to suspect maltreatment in under 18s | Guidance and guidelines | NICE 2009 \(updated 2017\)](#)
- [Working together to safeguard children - GOV.UK July 2018](#)
- [What to Do If You Are Worried a Child Is Being Abused, HM Government, 2015](#)