University Hospitals of Leicester NHS
NHS Trust

Safeguarding Children Guideline 19:

Child protection medical

Staff relevant to:	Medical staff working within UHL Children's Hospital
Team approval date:	April 2025
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Written by:	Dr D Bronnert
Trust Ref:	D3/2023

Introduction and who guideline applies to

Child protection medical examinations are an important part of a paediatrician's role to help keep children safe. This guidance should be used by paediatricians in the children's hospital undertaking child protection medicals.

What is covered in this guidance?

This document will give guidance on:

- What a child protection medical is and when it is needed.
- Taking consent for a child protection medical.
- How to undertake child protection medical.
- Medical photography.
- Documentation of injuries and use of new clerking pro forma.
- Formulating a summary and opinion in a child protection report that is meaningful to health, social care, and the legal system.
- Discussion with social care.

CONTENTS

1. Child protection medical examinations

1.1 What is a child protection medical examination?

A child protection medical examination is carried out to look for signs that a child or young person has been abused or neglected. A child protection medical examination differs from a clinical examination, which aims to establish what is wrong with the child or young person and what treatment may be needed.

A child protection medical examination is undertaken either at the request of social care or police or when a clinician has been or is about to make a social care referral in the context of concerns for the wellbeing of a child already receiving clinical care.

1.2 Purpose of a child protection medical examination

The purpose of a child protection medical examination is:

- To diagnose any injury or harm to the child and to initiate treatment as required.
- To assess the overall health and development of the child.
- To document the findings.
- To provide a medical report on the findings, including an opinion on the probable cause of any injury or other harm reported.
- To provide reassurance for the child and parent.
- To facilitate the police investigation 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 multi-agency assessment through sharing of information.
- To arrange for follow-up and review of the child as required, noting new symptoms, including psychological effects.

1.3 When is a child protection medical needed?

A child protection medical is necessary where there has been a disclosure or there is a suspicion of any form of abuse to a child.

Before carrying out a child protection examination, you must be satisfied that it is necessary and appropriate. You should be clear about what it is designed to achieve and whether the outcome will likely affect the proposed course of action. [1]

Indications for an urgent child protection medical examination to be carried out by the Paediatric team include:

- A child <2 who has suffered a significant injury without an explanation.
- A Non-mobile child with unexplained injury/bruises
- Domestic abuse where a child was present and may have been injured.
- Parental behaviour that puts a child at immediate risk.
- Cases of severe neglect in which urgent medical review is required.
- Any inpatient who following a strategy meeting with the police and social care, it is decided that a child protection medical is deemed appropriate.
- If concerns arise during the care of a 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. If unsure, discuss this with a consultant paediatrician.
- If you are unsure whether a Child protection medical is required speak to the consultant on call.

Remember that cases of possible sexual abuse must be referred to the specialist Sexual Assault Referral Centre (SARC) team and that we are not trained to undertake sexual abuse examinations.

Please review the **Safeguarding Children Guideline 7: Management of Suspected Sexual Abuse in Children and Young People B38/2019**

- If sexual abuse is suspected following disclosure or due to physical signs / behaviour:
- A history is required to establish information, **DO NOT ask leading or probing questions**
- A general physical examination should take place to rule out any emergency health care requirements and the findings documented on body maps within the UHL Child Protection Examination Pack.
- **DO NOT carry out intimate examination on the child unless to provide emergency treatment.**
- If it is safe to do so, fully explain to the child and parent/carer the process of investigation and management.
- Clear, concise and contemporaneous documentation is vital.
- If a referral to the SARC is required, this has to be discussed with Children's Social Care. If appropriate a referral and arrangements for attending the SARC will be made by them

If you require advice on dealing with a case then contact the Safeguarding Children Team office on 15770.

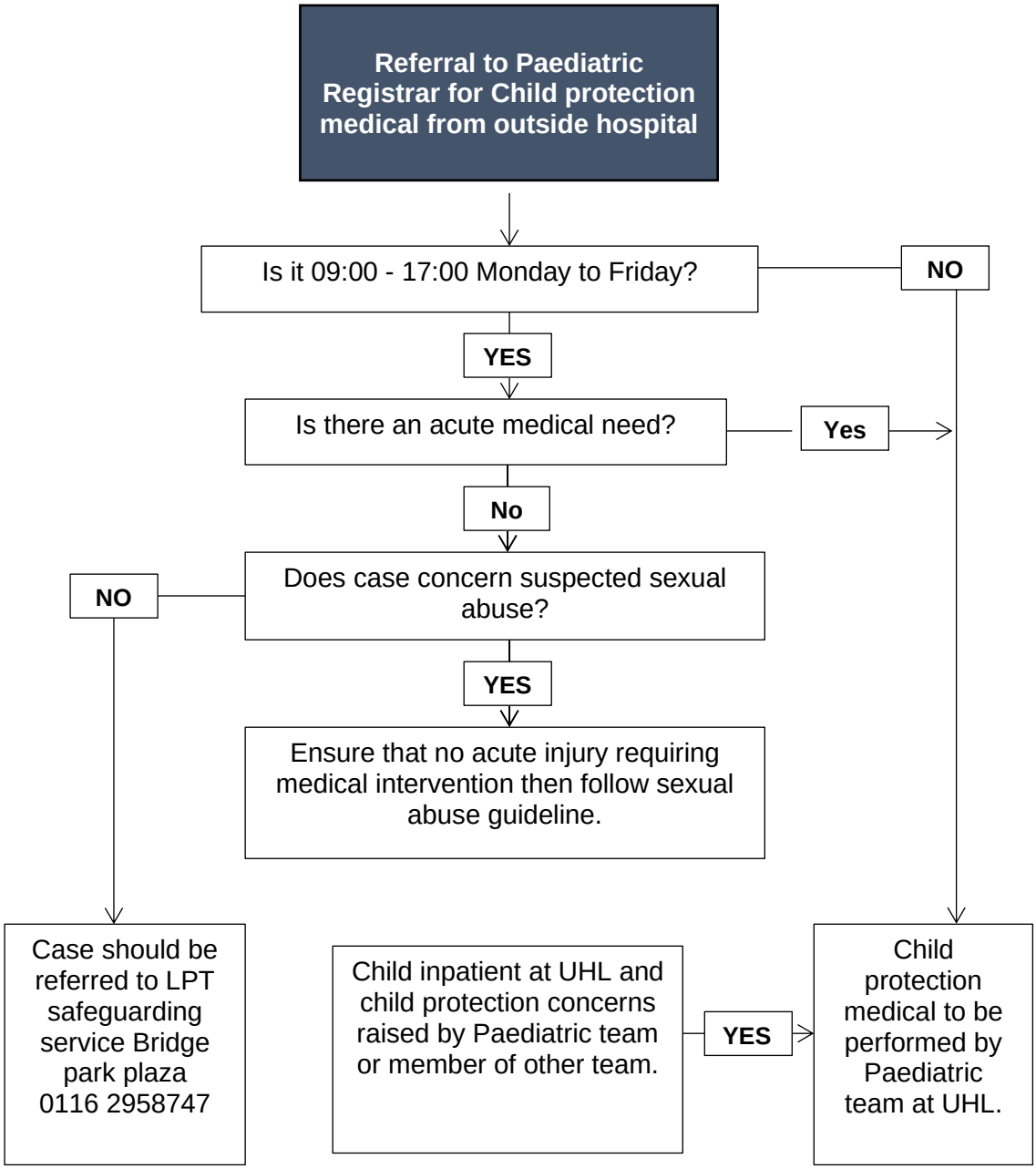
1.4 Taking referrals for Child protection medical examinations

Child protection medical examinations are undertaken in the community and at UHL.

When child protection concerns have been identified involving a child already in the Paediatric ED or the Children's hospital, the Paediatric team under the Paediatric consultant on call will be responsible for undertaking the child protection medical examination.

When a child protection medical referral is made from outside UHL, you must consult the referral pathway below to ensure that the most appropriate service carries out the medical.

1.5 Referral pathway for Child protection medical examination



Referral pathway notes:

The paediatric Team are responsible for performing Child Protection medical examinations on children with child protection concerns identified within the Paediatric ED or the Children's hospital.

The paediatric team also has a responsibility to respond to concerns raised by other medical teams (e.g. Paediatric ENT, Orthopaedics, surgery, PICU)

All Paediatric SpRs should be competent in undertaking a safeguarding medical.

The consultant in charge is the consultant on call for the day.

2. Discussion with social care

All children who undergo a child protection medical examination must be discussed with social care.

It is good practice before undertaking a child protection medical to discuss the case with social care and obtain their agreement, as social care is responsible for leading section 47 enquiries.

It is the responsibility of whoever undertakes the child protection medical to contact Children's duty/child's allocated social worker and discuss/inform them of any child protection concerns regarding the child.

Remember city/county! Use the postcode checker to determine whether the child should be referred to the city or county social services team; access it here: Postcode checker

- Leicester City: **0116 454 1004**
- Leicestershire: **0116 305 0005**
- Rutland **01572 758407** (out of office hours/weekend contact Leicestershire)

Document who has been spoken to and any information/advice provided.

3. Consent for child protection examinations (see flow chart)

Informed Consent is required for all Child Protection Medical Examinations. This should be taken from someone with parental responsibility (see who has parental responsibility in Appendix 3).

Parents should receive a child protection medical leaflet (Appendix 2) **before** consenting.

Written consent is needed for the medical, radiological investigations and photography. If photographic images are planned, consent must be obtained, and it should be clear what these images may be used for, e.g., diagnostic purposes and/or education and training.

3.1 Refusal of consent for CP medical / examination

A parent or carer's refusal of a medical assessment should not be allowed to cause unnecessary delay. Where consent is withheld, this should be documented, and consideration should be given to how this may impact the child and whether escalation of the concern is required. Legal advice should be sought urgently from the UHL Safeguarding Children Team (x15770) or the UHL Legal Affairs Team (x18960). Out of office hours, the Duty Manager for UHL can be contacted for advice.

The Medical Practitioner may assess some children under sixteen years old to be Gillick Competent to give informed consent. Legal advice should nevertheless be sought if this is against the parent's wishes.

Children must not be medically examined against their wishes unless there is a need for emergency medical treatment. In this instance, the Consultant Paediatrician should be contacted as the first point of advice, and the case can be escalated to the Trust Legal Affairs Team (x18960) if required.

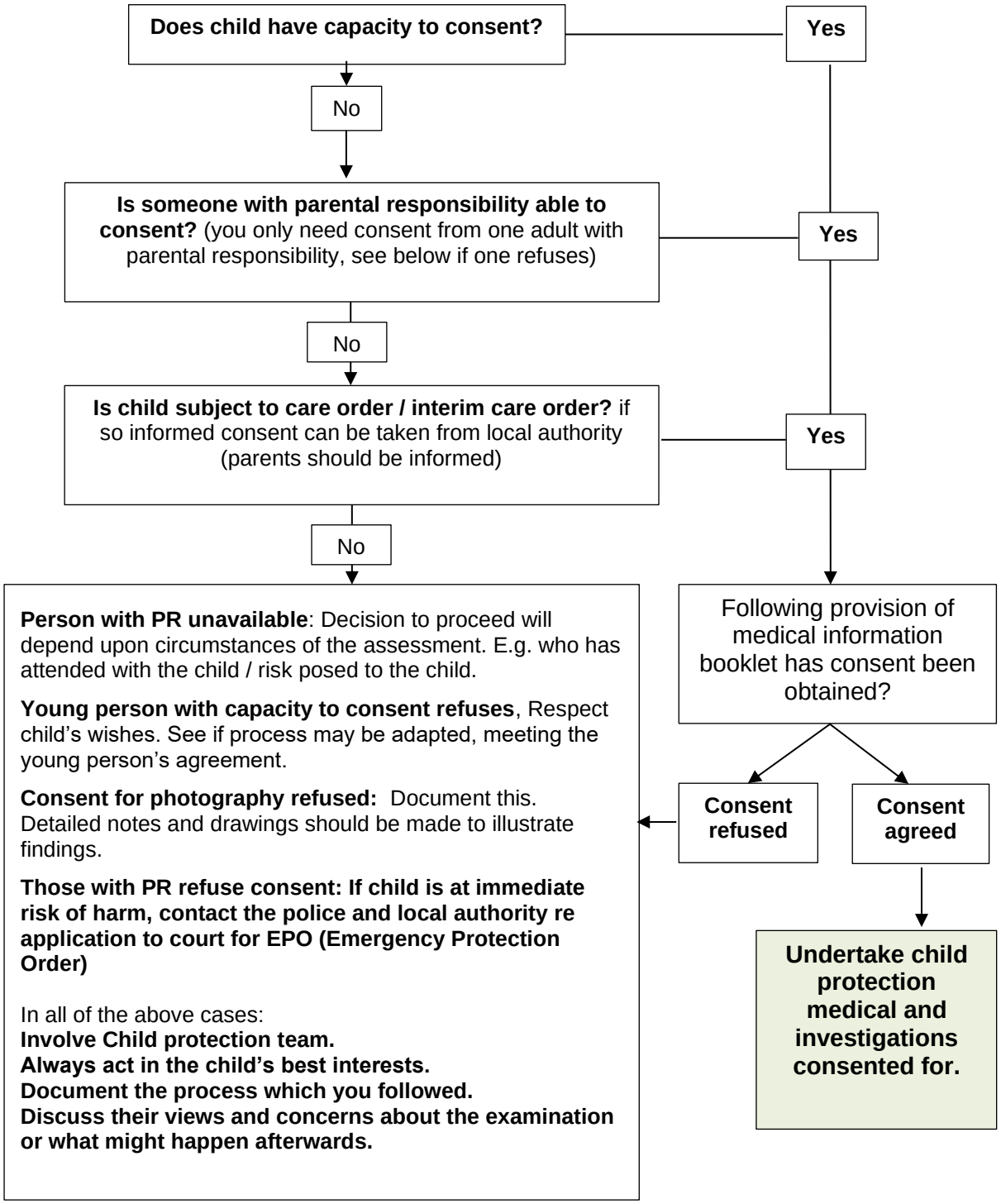
Additional information can be found on the Trust Policy for Consent to Examination or Treatment (V9)

3.2 Consent flow chart

Separate informed written consent is required for:

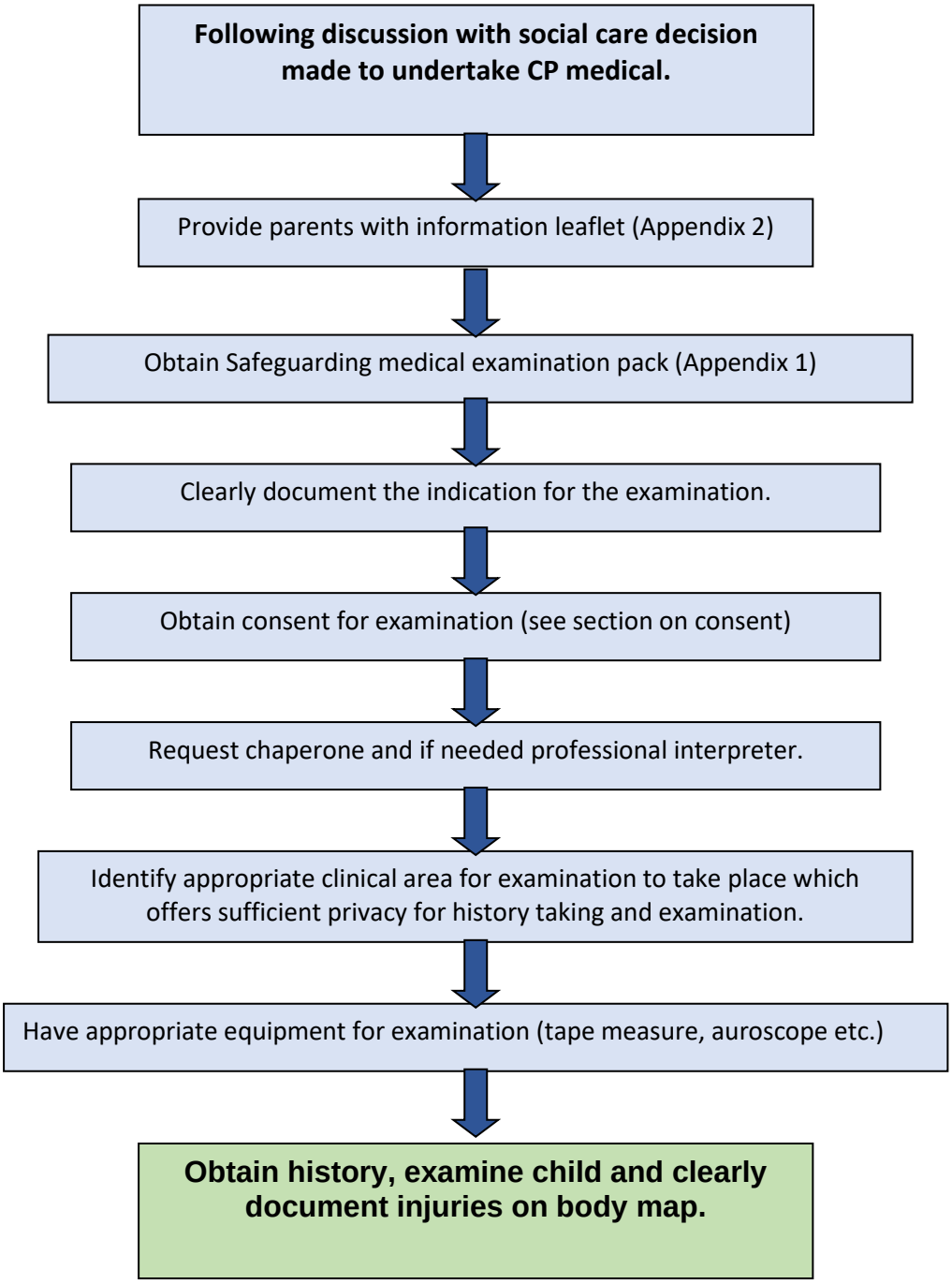
- **CP medical**
- **Medical photography (clearly define use of photos in consent)**
- **Radiological investigations**

Child protection medical information booklet should be provided to those providing consent



4. Preparation for Child protection medical examination

When the decision has been made to undertake a child protection medical, the following should take place:



4.1 Chaperone

Child protection medical assessments should be carried out in the presence of a chaperone. The chaperone should be a qualified health professional there as a witness and to support the child and clinician. Their name should be recorded on the Safeguarding medical examination pack and in the medical report.

5. Undertaking child protection medical

To take a complete and detailed history the Safeguarding medical examination pack should be used and worked through systematically (Appendix 1).

By completing the safeguarding medical examination pack fully, you will be able to obtain a detailed history and examination of all children undergoing a child protection medical.

5.1 Taking history regarding injuries

Ensure you have the name of the person giving history and their relationship to the child.

Use open questions

- e.g. How did xxxx get the bruise?
- **Not,** Was the bruise caused by xxxx falling?

When assessing an injury, always try to establish:

- **Who** is providing information
- **What** the injury is
- **When** (date and time) did the injury occur?
- **Where** did the injury occur?
- Were there any **witnesses**?
- **What happened afterwards?**
    - How was child?
    - was a medical review sought, and if not, why?

5.2 Documentation:

Medical notes, including all diagrams, must always be dated, timed and signed. Your name and job title should be printed beside your signature.

Each page should include three identifiers for the child, e.g. name, date of birth, and S number.

Documentation must:

- **Be clear and contemporaneous.**
- **Include telephone conversations and discussions with the multiagency team.**
- **Use a safeguarding medical examination pack (see appendix).**
- **Include both positive and negative findings.**
- **Ensure no discrepancies between notes, reports and statements.**
- **Include who and where information came from and who was present at each stage of the consultation.**

Any deviations from standard practice or difficulties must be documented.

5.3 Voice of the child

Listening to and capturing the voice of the child is essential for effective safeguarding practice. It helps professionals to understand children's lived experiences, hear their views about their lives and circumstances, and take effective action to support or safeguard them.

If old enough, always take a separate history from the child themselves with parents out of the room. Ensure that the child's allegations are documented verbatim, using quotation marks. Additionally, where appropriate, record your questions exactly as they were asked.

Children may try to communicate their worries and needs through their behaviour, and doctors should be aware of this. Document any behaviour exhibited by the child, for example, if they are fearful or happy and contented when with a specific carer.

5.4 Documenting injuries

A **body map** and **tape measure** must be used.

Document:

- Location of injury by drawing on a body map and measuring the distance from bony prominence.
- identify the type of injury, e.g. bruise, cut, scab, burn, soft tissue swelling, etc.
- To measure the size of the injury, you need to measure both length and width. More measurements may be required if irregular shape.
- Colour.
- Any pattern, e.g. linear, in the shape of a hand, etc.
- Whether skin intact.
- Whether tender.
- Document the explanation offered for each injury.

Remember that your history may be requested as evidence; it is therefore essential that it is accurate, legible, references the patient, and both dated and signed.

Your documentation must make sense to both you and others. You may need to go through your notes in court in the future; you should, therefore, not use abbreviations and avoid paraphrasing.

6. Photographing injuries

While the taking of photographic images of external injuries in cases of suspected child abuse is considered good practice by the RCPCH, **it must be remembered that:**

- Images must be of good quality.
- Those taking the images must have had adequate training.
- Images should be taken using specialist equipment.
- Inappropriately stored images can breach patient confidentiality.
- Written consent must be obtained for child protection images. The consent must clearly outline what the images may be used for. If consent is refused, images cannot be taken.

When it is suspected that images will be required for evidential purposes, they should be taken by Medical illustration or the police.

There will be situations where Medical illustration / the police photographer are unavailable. In these situations, consideration should be made to whether it is in the child's best interests for the images to be obtained by the doctor undertaking the child protection medical. Examples of these situations include:

- Out of hours, child presenting with significant bruising to the arm and a fracture. Cast needs to be applied to the arm.
- Out of hours, a child presenting with swelling/erythema thought secondary to trauma and concerns that this may have resolved by morning.
- Out of hours, a child with a laceration which needs stitches/dressing.

If taking images yourself, use the following guidance to ensure that images are of the best quality possible.

NEVER take intimate images of a child (genitals, anus, and breast). These must only be taken by medical illustration / SARC. For additional information and how to refer to the SARC, please review the Safeguarding Children Guideline 7: Management of Suspected Sexual Abuse in Children and Young People B38/2019

NEVER use your own phone to take images; images should only be taken using on-call Phone and stored using Nervecentre. No images should be stored in the phone's memory bank.

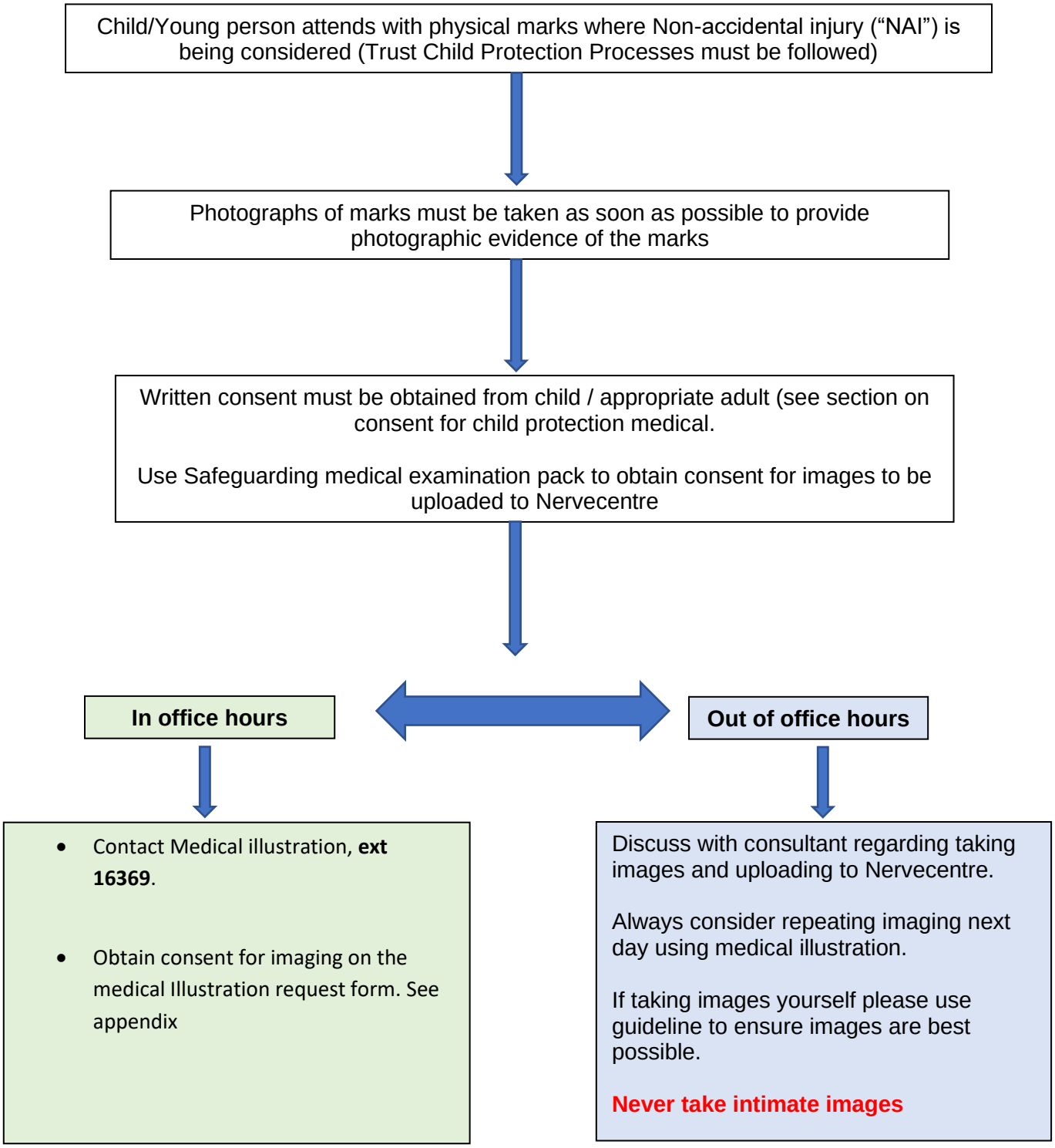
Any image taken for child protection purposes forms part of the child's electronic patient record.

The **person taking the images is responsible for** ensuring:

- Appropriate **consent** has been obtained.
- Images of the correct patient are being taken and stored in the **correct Nervecentre record.**

Ensure that any **images clearly identify where** on the body the **bruise/injury is**. For example, if a child has bruising to their left forearm, it is best to photograph the whole arm and then take closer pictures of the bruise so it is clear where it is.

6.1 Photography flow chart



6.1 Guide to taking images using hospital phone and uploading to Nervecentre

1. Ensure that consent has been obtained.
2. Identify appropriate place to take images, ensuring sufficient privacy and proper lighting.
3. Ensure you have a chaperone and appropriate equipment (phone/tablet, measuring tape / right-angled linear scale.
4. Open Nervecentre on hospital phone/tablet. The person obtaining images must be one logged in.
5. Search for patient.
6. Ensure that the correct patient has been identified by matching the patient's name, date of birth and S number to those on the patient's wristband.
7. ensure a plain background, e.g. get the child to lie on a white sheet.
8. Take an image showing the location of the injury. For example, if there is an injury on the right forearm, start by taking a picture of the whole right arm.
9. Take close-ups of injury both with and without measuring apparatus.
10. Upload all images directly to Nervecentre. Do not store images on phone/tablet.
11. Use Smartphone medical photography quick reference guide below to get the best images.

6.3 Quick reference guide to using a smartphone to take photographs of Injuries

7. Investigations as part of child protection medical examination.

As per RCPCH guidance, Radiological imaging, Ophthalmology review and blood tests should be carried out as part of the child protection medical on all children less than two years of age in whom abusive injury is suspected. In older children, investigations should be chosen on a case-by-case basis and should be appropriate to any suspected injury.

If, following obtaining a complete history and carrying out a detailed clinical examination, no concerns about possible abuse arise (e.g. child referred with concerns regarding multiple bruises, on examination all felt to be congenital dermal melanocytosis), then these investigations may not be necessary.

7.1 Radiological Imaging

As per Royal College of Radiologists Guidance (The radiological investigation of physical abuse in children), the following investigations, based on the child's age, should be undertaken in all cases of suspected physical abuse:

18.2

<table>
<tr><th></th><th colspan="3">Age</th></tr>
<tr><th></th><th>Less than 1 year</th><th>1 – 2 years</th><th>Over 2 years</th></tr>
<tr><td>CT head</td><td>Yes</td><td>If evidence of head trauma or abnormal neurology.</td><td rowspan="2">Imaging should be considered on a case-by-case basis. In some situations, a skeletal survey will be required over 2 years. The Paediatric consultant will need to discuss this with Radiology.</td></tr>
<tr><td>Skeletal survey</td><td>Yes</td><td>Yes</td></tr>
<tr><td>MRI Head +/- whole spine</td><td colspan="3">MRI head should be performed on day 2 – 5:
On all children when CT head has demonstrated intracranial haemorrhage and/or parenchymal brain injury and/or skull fracture.
For children with ongoing abnormal neurological symptoms or signs irrespective of a normal initial CT. Any child who has had an MRI of the head in this context should also have an MRI of the whole spine at the same time.</td></tr>
</table>

Cases where a skeletal survey may be considered over 2 years:

- Children with communication or learning difficulties who may be unable to give a history of physical abuse.
- Children where there is a clinical suspicion of skeletal injury.

Requesting Radiological imaging
A skeletal survey and CT head are requested on ICE / Nervecentre ensure that the child's injuries are clearly documented in the request.

Follow-up imaging:
A skeletal survey is not complete until follow-up imaging has been completed. This should occur within 11 to 14 days and no later than 28 days after the initial skeletal survey. This is part of the skeletal survey and does not need to be separately requested.

Consent for Radiological Imaging:
Written consent is required for all radiological imaging when undertaken as part of a child protection medical. Please see the consent section for child protection medical for those who can give consent.

7.2 Taking written consent for radiological investigations

Consent can be taken via:

- Concentric (electronic consent form)
- Safeguarding medical examination pack (consent for imaging, page 4).
- A consent form for minors will be required:

Clearly document:

- **Procedure**: e.g. Skeletal survey under oral sedation.
- **Intended benefits:** Identify possible injuries, assess bone health and allow appropriate treatment if required.
- **Risks:** Radiation risks: radiation exposure can increase lifetime cancer risk. Risks of sedation: may be slow to wake or rarely need respiratory support.

If taking consent for an MRI, risks will be of sedation / general anaesthetic.

When taking consent for a skeletal survey, **ensure that parents understand that a skeletal survey requires two separate sets of images** and, therefore, two visits to the radiology department. The initial images will be undertaken during their admission, but they must return to the radiology department for follow-up imaging 11 – 14 days after.

Knowing that a skeletal survey is equivalent to 4 – 8 months of background radiation and a CT head is equivalent to 18 months is helpful if parents need reassurance. Background radiation is the radiation we are all exposed to daily through contact with the sun's rays, Radon gas from the ground, food and drink, etc.

Sedation makes the process as comfortable as possible for the child. While x-rays / CTs do not hurt, the child will have to remain still, and this may require holding the child, which can cause distress.

7.3 Sedation for Radiological imaging in child protection medical examinations

Please refer to the Sedation for Painless Imaging UHL Children's Guideline. Before sedation, children must not eat or drink: '2 hours for water, 4 hours breast milk, 6 hours for food. Essential medication may be given with a sip of water.' This information must be conveyed to parents.

7.4 Bloods

Blood tests should be considered for all children undergoing a child protection medical.

All children who have presented with suspected non-accidental bruising or fractures should have the following bloods done:

- Full blood count (FBC);
- liver function tests (LFT);
- Bone profile;
- Vitamin D;
- **Parathyroid hormone (PTH)**;
- Coagulation screen (coag);
- Consideration given to performing an extended clotting screen (Consultant decision).

Consider whether other tests are Indicated (e.g. (U&E, CRP, amylase, urine and blood toxicology).

In children presenting with bruising/bleeds/retinal haemorrhages abnormal clotting results should be discussed with a consultant Haematologist. The Haematologist should be asked whether the result could account for the clinical signs and whether any further tests are needed. This discussion and the name of the haematologist should be recorded in the child's notes.

7.5 Toxicology

If there are concerns that a child may have been poisoned/is under the influence of drugs, a toxicology sample will be required.

If there are safeguarding concerns, a chain of evidence form will be required (Appendix 5).

The chain of evidence is a legal concept which requires that the origin and history of any exhibit presented as evidence in a court of law must be demonstrated to have followed an unbroken chain from its source to the court.

All persons handling the sample must be documented, with a note of the time, date and place, with signatures where appropriate.

Separate forms are needed for each sample, even if being taken for the same test.

Samples must be hand delivered to the lab.

7.6 Ophthalmology

In children under 2 years of age, ophthalmic screening should occur as part of the acute medical assessment.

The ophthalmology registrar should be contacted, and an ophthalmology assessment should be requested.

8. Writing / Dictating safeguarding medical report

Child protection reports should be dictated on DiT3.

Reports should be completed within 3 days of the medical examination taking place.

While not all information may be available (Radiological investigations, Ophthalmology etc.) You should start your report as soon as possible; this information can always be added later.

Following dictation of your report, inform the safeguarding team (ext. 15770, chsafeguardingmedics@uhl-tr.nhs.uk) so that the report can be typed as soon as possible.

Ensure that you log into DiT3 and review it once typed, as your consultant cannot complete it until this has been done.

8.1 Child Protection Report pro forma

Child's name, Date of birth, s number.

Place of examination:
e.g. Paediatric Emergency Department, Leicester Royal Infirmary

Date and time of Examination:

Examining Doctor:
Record your name and grade

Consultant Paediatrician:
Record the consultant on-call.

Persons present:
Record the full names of all persons present. For family members also record their relationship to the child.
The **Chaperone** and their professional position/grade should also be recorded.

Consent:
Document who has provided consent for examination and, whether written or verbal.
Clearly document what consent has been provided, e.g., consent was provided for child protection medical (history and examination), medical images, blood tests, Ophthalmology review and radiological investigations.

Reason for examination:
Clearly document why the examination has taken place and if appropriate, who has requested it.

Paragraph outlining who you are, your professional qualifications, your grade and the length of time you have been working in paediatrics.

Paragraph outlining background information.

History:
Document the histories provided by all involved in full. Clearly indicate who has provided the history.
Suppose history has been obtained from multiple sources (e.g. mother, child, social worker). In that case, it is best to split history into different sections, documenting who provided the history at the start.
Both positives and negatives should be documented.
Remember who, what, when, where, witnesses and what happened afterwards.
Try to document verbatim if possible.

Medical history:
The child's past medical history including:

- Birth history.
- Medication history, including allergies and immunisation status.

Social and family history:
Clearly document:

- Who the child lives with.
- The names and occupations of parents.
- Names and ages of siblings.
- Whether family are known to social care.
- Whether there is any history of alcohol or drug use.
- Whether there is any history of mental health problems.
- Whether there is any history of domestic violence.
- The name of any school or nursery that the child attends.

Document any family history, in particular, any bleeding disorders etc.

Developmental history:
A clear developmental history indicating what the child can or cannot do. (**simply documenting No developmental concerns is not sufficient**)

Examination:
Start by describing the child's general appearance and dress.
Comment on child interaction with family and staff.
Document Cardiovascular, respiratory, abdominal examination and whether any abnormal neurology.
Document observations.
Document growth parameters and centiles (weight, length and head circumference).

Injuries: Document all injuries (including size, location, colour) and any explanations offered.
Comment on whether you feel that the mechanism provided explains the injury.

Investigations:

Bloods: Blood tests and whether normal**.**
Radiology: Summary of results of radiological investigations. It is best to include the full radiological report and document the radiologist providing a report in the appendix.
Ophthalmology: Document the result of the Ophthalmology examination, who performed it and their grade.

Summary:
Summarise history, examination and investigation findings. Include explanations offered for injuries by parents and whether you feel they are plausible. Include any other important information from history, e.g. history of domestic violence, parental alcohol/drug use, etc.

Example
Steven is a six-month-old who presented to the emergency department on the 1st April 2023 with bruising and swelling to his right thigh. An x-ray of his leg demonstrated a metaphyseal fracture of

his right distal femur. Examination revealed a 15 by 10 cm area of dark purple bruising to his right thigh; there was also soft tissue swelling of his right knee and thigh. The history provided by Steven's mother was that Steven slipped out of her arms on the 30th March 2023, and fell approximately 20cm onto her bed, landing on his right foot and falling backwards onto his back. Steven's mother advised that she had not presented with Steven earlier as she did not feel there was a problem. She had presented today as Steven's leg appeared swollen. Steven is developmentally normal; he can sit without support but is not yet crawling or standing. Steven's skeletal survey did not demonstrate any other fractures on initial imaging; however will need to be completed with follow-up imaging in ten days. Stevens's bloods and x-rays were not suggestive of any bony dysplasia or metabolic bone disease. Steven's clotting was normal and not suggestive of any bleeding disorder. Steven's ophthalmology review was also normal. Steven's clothing was noted to be dirty, and his mother admitted to using both cannabis and cocaine. The family are known to social services due to previous concerns regarding domestic violence.

Opinion:
Provide an opinion as to whether the explanations offered explain the injuries and as to whether you feel the child has suffered non-accidental injury.
Finish your opinion with an impact statement that reflects your level of concern regarding the child's safety and well-being, as well as any important positive (protective) and negative factors contributing to the child's safety. A recommendation should be given as to any further follow up.

E.g.. Steven has sustained a metaphyseal fracture of his femur and a large bruise on his thigh. Metaphyseal fractures are strongly associated with abuse (RCPCH Systematic Review on fractures, 2020). I do not feel the explanation offered by his mother explains these injuries. A short fall of 20cm onto a mattress is unlikely to cause a fracture or the large bruise to his thigh. Steven is immobile and is unlikely to have sustained these injuries himself. Steven's blood tests do not suggest a clotting problem, which would make bruising more likely. Steven's skeletal survey and bloods also do not suggest a bony dysplasia, which may make fractures more likely. With no other adequate explanation, I have significant concerns that Steven's injuries are the result of non-accidental injury.

There is a background of domestic violence and parental substance misuse, increasing the risk to Stephen's physical and emotional well-being further. I have significant concerns regarding Stephen's safety, which I have shared with Leicester City Children's Social Care

The above medical opinion has been given in the context of the information known at the time as reflected in the report. It is important to consider the above medical opinion in the context of information known by other agencies. If new information comes to light as part of the multiagency assessment that may impact the medical opinion significantly, please inform me so I can send an addendum to the report.

8.2 Provision of Written and Verbal Statements in Safeguarding Children Cases

When making a verbal or written statement, staff are acting on behalf of the University Hospitals of Leicester NHS Trust. Refer to the Safeguarding Children Guideline 10: Provision of written and verbal statements in safeguarding children cases (Trust Ref B41/2019)

Multi-agency working is essential to safeguard the well-being of children. As such, health professionals have an obligation, under Section 11 of the Children Act 2004, to assist with child protection enquiries.

Staff should only provide information within their scope of practice

Giving Statements

If staff are contacted directly by the requesting agency to arrange to give a statement in relation to a safeguarding case, the following must occur:

- The requesting agency should be directed to the Safeguarding Children Team (x15770), who will arrange a suitable date, time and venue for the statement to take place.
- All UHL staff will be supported in any case by a senior staff member. This should be either a senior member of the Safeguarding Children Team or a senior Directorate/CMG staff member as appropriate.
- Junior medical staff must have the permission of their Consultant before they are interviewed. The Safeguarding Children Team will contact the lead consultant for the case and the junior doctor to advise of the statement request. The Safeguarding Children Team members are available to support medical staff if required.
- The Safeguarding Children Team will ensure the staff member has the medical notes available when the statement is provided.
- If you provide a verbal statement, the agency will prepare a written statement. This should be read by the staff member and signed after necessary amendments have been made.
- A copy of the statement should be requested by the member of staff providing the information and provided to the Safeguarding Children Team, where it will be stored securely by the Safeguarding Children Team on their Safeguarding Electronic Notes System ("SENS").

9.0 Parental feedback

Parents must receive feedback throughout their child's stay. They should be advised regarding the examination findings and investigation results. They should also be informed of the medical team's opinion, providing this will not place the child at additional risk.
Parents should be made aware that discharge will not typically occur until the case has been discussed in a strategy meeting with social care and that the timing of these meetings is often out of our control.

10.0 Child Protection Handbook

For further information on child protection, please visit the child protection handbook. This has valuable information that can be accessed from a computer or phone.

Access the child protection handbook here.

Education and Training

Training on this guidance is provided to registrars.

Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Compliance with guideline	Review of cases where concerns raised guideline not followed	Dr D. Bronnert	Case-by-case basis	

Key Words

Child protection, child protection medical, child protection report

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Dr D Bronnert Consultant Paediatrician, Named Doctor	**Executive Lead:** **Chief Medical Officer**
Details of Changes made during review: New section (see 7.5) - Toxicology New section (see 9.0) - Parental Feedback	

Appendix 1 Safeguarding Medical Examination Pack

Please double-click on the icon for the examination pack below to open it in Adobe and print it.

new safeguarding exam pack oct24.doc

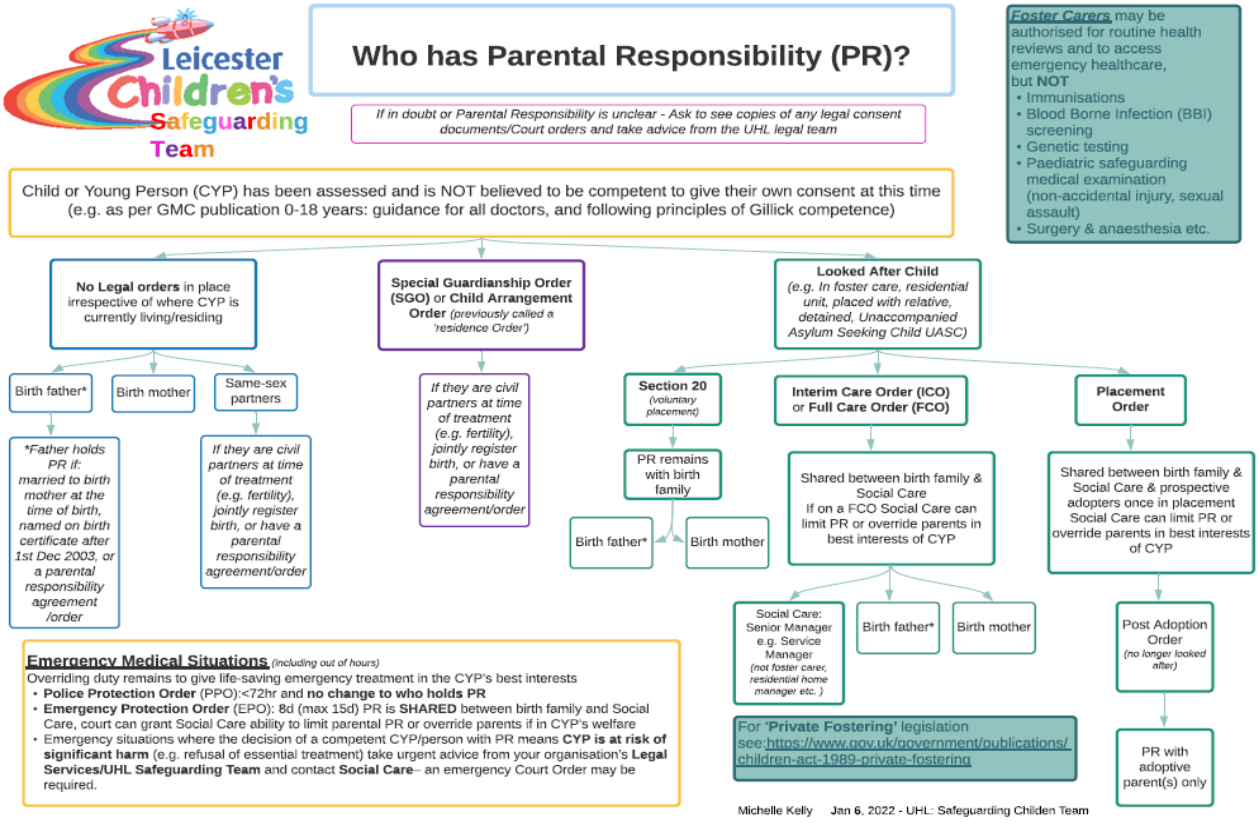
Appendix 2 Parent information leaflet

This leaflet should be provided to parents/carers of all children undergoing child protection medical.

The Safeguarding Children Parent Information leaflet **'What happens when your child needs a Child Protection Medical Examination'** is available via YourHealth

Appendix 3 Parental responsibility

Parental responsibility can be complicated. If there is any doubt over who has Parental Responsibility, ask to see copies of any legal consent documents and take advice from the UHL legal team



THIS FORM TO BE USED ONLY IF MEDICAL ILLUSTRATION ARE TAKING PATIENT IMAGES

Patient addressograph

Patient surname: .....
Forename: .....
Date of birth: .....
S number: .....
NHS number: .....
Address: .....
.....
.....
.....
Sex: Female ☐ Male ☐

NHS
University Hospitals of Leicester
NHS Trust

Medical Illustration
2nd Floor Windsor Building
Leicester Royal Infirmary **0116 258 6369**

Photographer/ videographer's use only:
C number:

NHS Patient: ☐ **Private Patient:** ☐

CONSENT FOR CLINICAL PATIENT PHOTOGRAPHY ☐ OR VIDEOGRAPHY* ☐

Date: .....
Consultant (Prof/ Dr/ Mr/ Miss/ Mrs): .....
.....
Telephone: .....
Ward/ Clinic/ Theatre: .....
Department/ Specialty: .....
.....
Hospital: .....
If images are required for a specific date, state here:
.....

Clinical Diagnosis:

Clinical/visual signs to be demonstrated:

***Video must be pre-booked with photography**

TO BE COMPLETED BY PATIENT/ PARENT/ GUARDIAN

☐ I consent to photographs/ video to be taken for my medical case notes.

☐ I consent to photographs/ video to be used for printed/ online teaching and publication purposes.
The photographs/ video may be conveyed electronically within the healthcare network and also in medical textbooks, medical posters, scientific papers. They could be viewed by other patients to assess possible treatment plans and help to understand what treatments or surgeries are available.

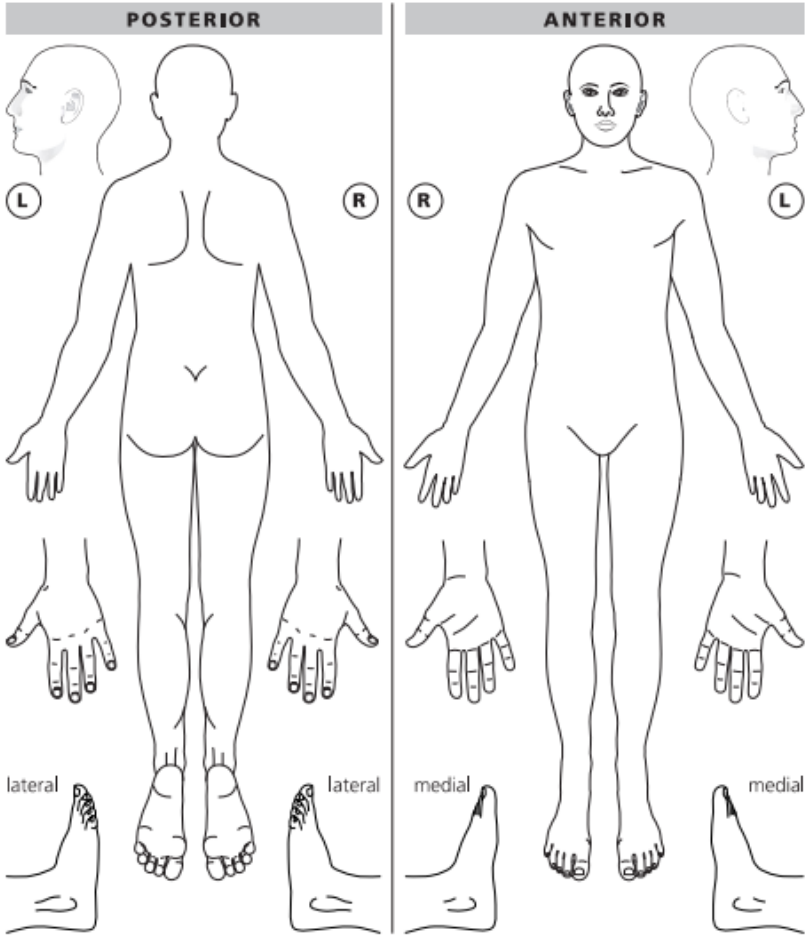
I can withdraw consent for this at any time. I can contact **photography@uhl-tr.nhs.uk** or **0116 258 6369** if I change my mind. Note: this will not apply to material already published. The Trust cannot control already published material or recall it.

CONSENT WITHDRAWN RETROSPECTIVELY ☐ **DATE** .....

PATIENT/ PARENT/ GUARDIAN/ STAFF:
Signature:
Print name:
Date:
Relationship, if not patient:
Photos to be taken in Patient's best interest:
Date:

PERSON TAKING CONSENT:
Signature: .....
Print name: .....
Date: .....
Role: .....
.....

TO BE COMPLETED BY CLINICIAN



Additional comments:

Appendix 5: Laboratory Chain of Evidence Form

Use Addressograph if possible	
Name:	
D.O.B.:	
S Number	
NHS number:	
Address:	

Consultant:	
Sample:	

Should be used when sending toxicology samples on any child where there are child protection concerns.

In suspicious circumstances there must be a clear chain of evidence from the person taking a sample to its arrival in the lab and processing.

If more than one sample is taken then each sample must be sent with its own chain of evidence form and in its own sealed bag.

Chain of evidence forms are to stay with the samples **at all times**, and to be signed by each person who handles them.

All samples are to be delivered to the laboratory **via porters only**, and not via the air tube system.

	Name	**Signature**	**Date**	**Time**
Specimen taken by:				
Witnessed by:				
Specimen taken to lab by:				
Received by lab personnel				
Senior lab personnel check at receipt:				
Senior lab personnel on completion of processing:				