Safeguarding Children Guideline 19: Undertaking a Child Protection Medical Examination

University Hospitals of Leicester NHS
NHS Trust
Trust ref: B50/2019

Contents

1. Introduction and who this guideline applies to

This guideline is intended to inform the Children's Hospital medical and nursing staff when dealing with safeguarding children's referrals for a medical examination from Social Care, the Emergency Department (ED), Paediatric Intensive Care or from other areas within UHL

The LRI Paediatric Team has responsibility for performing non-accidental injury (NAI) Child Protection medical examinations for any child presenting to LRI out of hours, i.e. after 5 PM Monday to Friday, and during weekends and Bank Holidays. Referrals outside these hours should be directed to the LPT Safeguarding Service at Bridge Park Plaza in the first instance.

Child protection medical examinations are important part of a Paediatricians role to help keep children safe. This guidance should be used by Paediatricians within 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 proforma.
- Formulating a summary and opinion for a child protection report which is meaningful to health, social care, and the legal system.
- Discussion with social care

This guideline now incorporates Safeguarding Children Guidelines:

3 - Consent in Safeguarding Children Guideline

4 - Completion of Medical Reports Guideline

15 - Obtaining Photographic Evidence Guideline

2. Recommendations, Standards and Procedural Statements

2.1 Child protection medical examinations

2.2 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 is different 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 referral has been or is about to be made by a clinician to social care in the context of concerns for the wellbeing of a child already receiving clinical care.

2.3 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 clearly document the findings
- To provide a medical report on the findings, including an opinion as to the probable cause of any injury or other harm reported.
- To assess the overall health and development of the child.
- To provide reassurance for the child and parent.
- To facilitate the police investigation of a 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.

2.4 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 in the circumstances. You should be clear about what it is designed to achieve and whether the outcome is likely to affect the proposed course of action.

Indications for an urgent child protection medical examination to be carried out by 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 has put a child at immediate risk.
- Cases of severe neglect in which urgent medical review is required.
- Any inpatient whom following a strategy meeting with the police and social care a child protection medical is deemed appropriate.
- If concerns arise during the care of child in hospital, e.g. a fracture is seen on a chest x-ray taken for medical reasons; it may be difficult to be clear where standard assessment merges into a child protection medical process. If unsure, discuss 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 a sexual abuse 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.

2.5 Taking referrals for child protection medical examinations

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

When child protection concerns have been identified involving a child already in 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 referral for a child protection medical is made from outside UHL you must consult the referral pathway below to ensure that the most appropriate service carries out the medical.

2.6 Referral pathway for Child protection medical examination

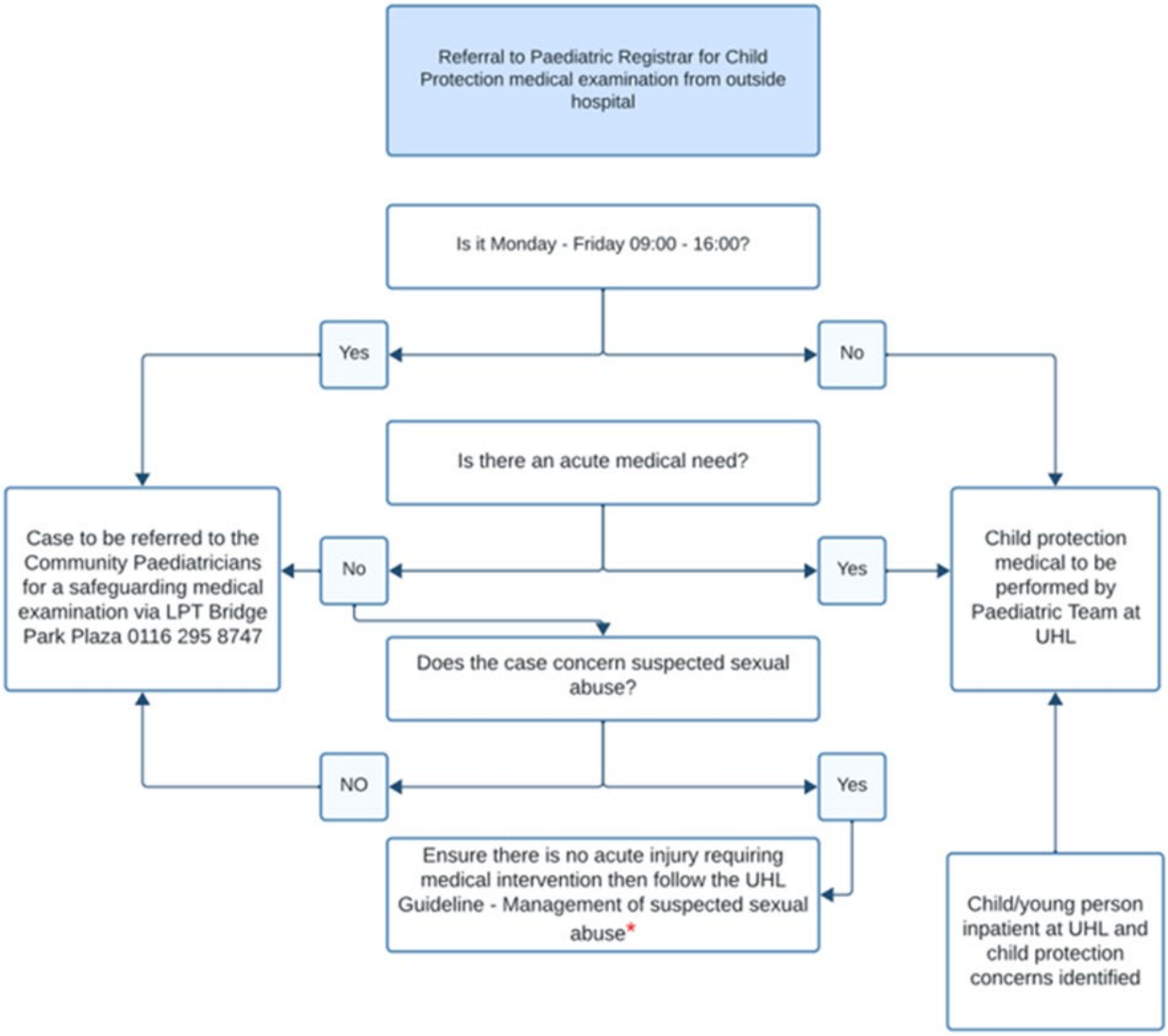
The UHL paediatric team are responsible for performing Child Protection medical examinations on children and young people in whom child protection concerns have been identified within Paediatric ED or the Children's hospital.

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

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

Consultant in charge is the consultant on call for day.

If a child or young person receives a child protection medical examination by the LPT Community Paediatricians but is admitted to UHL for investigations as part of the medical examination. The Consultant Community Paediatrician will remain lead Consultant for the child or young person, and they MUST NOT be discharged without agreement from the Community Paediatrician.



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

3.0 Discussion with Social Care

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

It is good practice prior to undertaking a child protection medical to discuss the case with social care and obtain their agreement, as it is social care who are 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 inform them of any child protection concerns regarding the child.

Remember city / county! Use postcode checker to determine whether child should be referred to 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)

Clearly document who has been spoken to, and any information / advice that has been provided.

4. 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 appendix 3).

Parents should be provided with child protection medical leaflet (Appendix 2) prior to taking consent.

Written consent is needed for radiological investigations and photography. If images are to be recorded through photography, consent must be taken and it should be made clear their definition of use, such as for diagnostic purposes and/or for education and training.

4.1 Refusal of consent for CP medical / examination

A parent or carer's refusal for a medical assessment should not be allowed to cause unnecessary delay. Where consent is withheld, this should be clearly documented, and consideration given to how this may impact on 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.

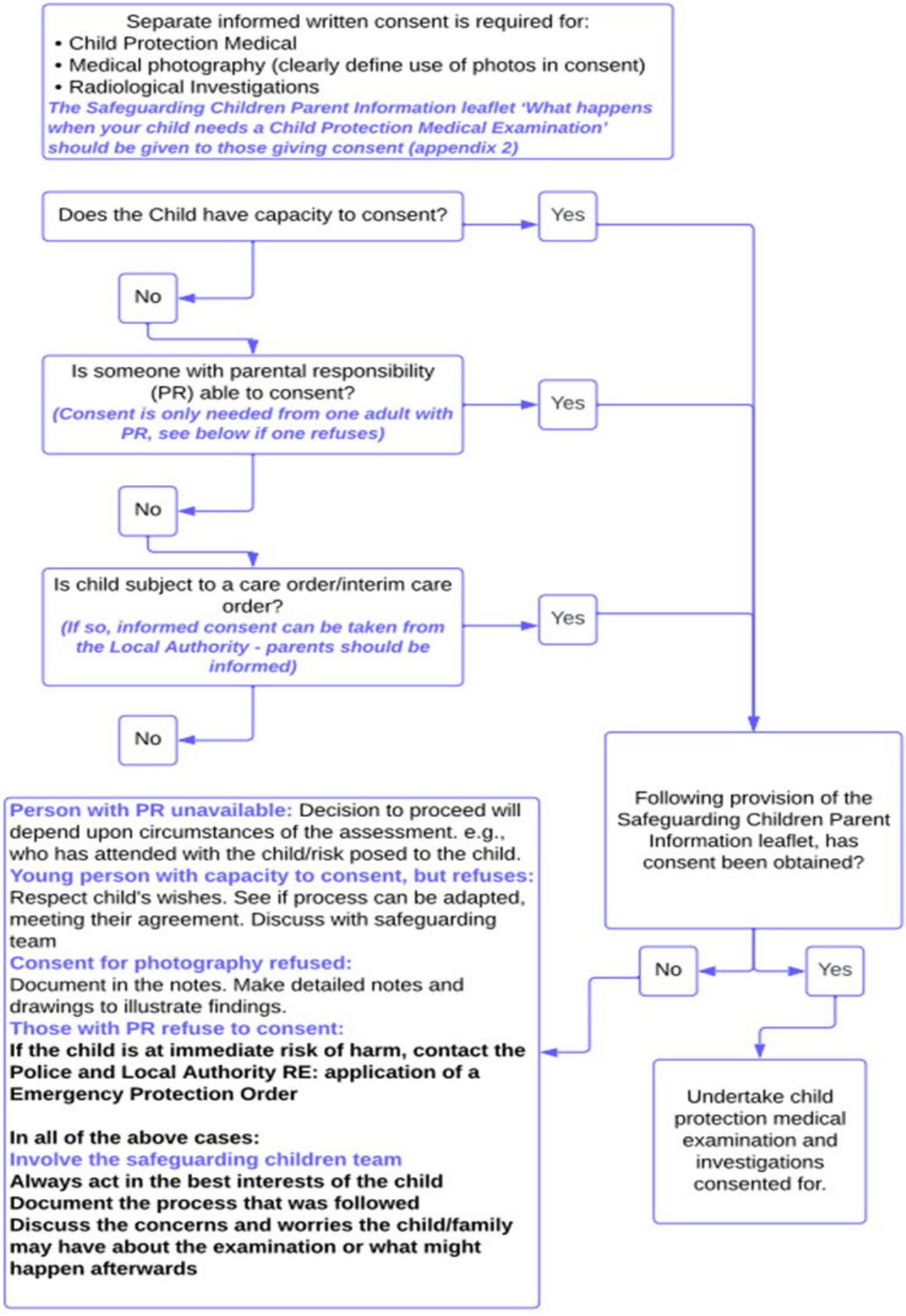
Some children under sixteen years old may be assessed by the Medical Practitioner to be

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 escalated to the Trust Legal Affairs Team (x18960) if required.

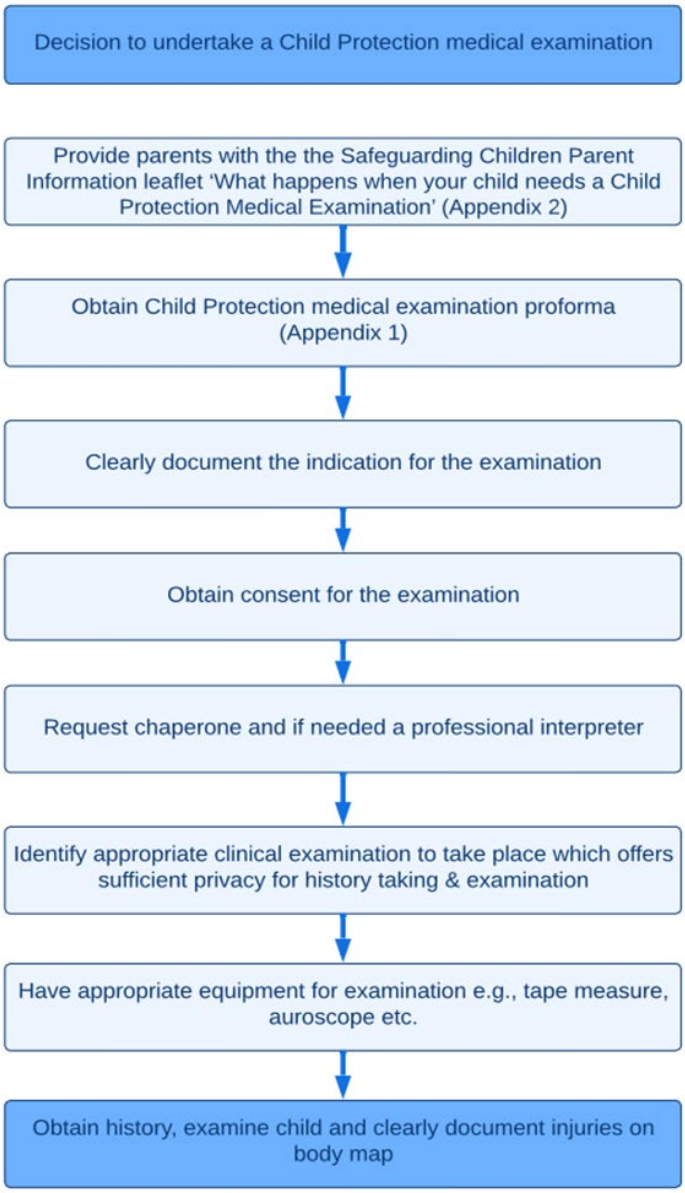
Additional information can be found on the Trust Policy for Consent to Examination or Treatment

4.2 Consent flow chart



5. Preparation for Child protection medical examination

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



5.1 Chaperone

Child protection medical assessments should be carried out in the presence of a named chaperone. The chaperone should be a qualified health professional, who is there as a witness and to support the child and clinician. Their name should be recorded on the child protection medical assessment proforma and in the medical report.

6. Undertaking child protection medical

To take a full and detailed history the child protection medical examination proforma should be used and worked through systematically (Appendix 1).

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

6.1 Taking history regarding injuries

Ensure that you have the name of the person giving history and their relationship to 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)?
- **Where** did the injury occur?
- Were there any **witnesses**?
- **What happened afterwards?**
    - How was the child?
    - Was medical attention sought? if not why not?

6.2 Documentation:

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

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

Documentation must:

- **Be clear and contemporaneous.**
- **Include telephone conversations and discussions with the multiagency team.**
- **Use safeguarding medical proforma (see appendix 1).**
- **Include both positive and negative findings.**
- **Ensure no discrepancies between notes, reports, and statements.**
- **Include who and where information has come from, and who was present at each stage of the consultation.**

Any deviations from standard practice or difficulties must be documented.

Always record in quotes verbatim any allegations from the child and record your questions verbatim where appropriate.

6.3 Documenting injuries

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

Document:

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

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

Your documentation must make sense to both you and others. It is possible that you will need to go through your notes in court in the future; you should therefore not use abbreviations and avoid paraphrasing.

7. 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 good quality.
- Those taking the images must have had adequate training.
- Images should be taken using specialist equipment.
- Inappropriately stored images can breech patient confidentiality.
- Written consent must be obtained for child protection images, and it must be clearly outlined in the consent 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 these images should be taken by medical illustration or the police.

There will be situations in which medical illustration / the police photographer is 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 arm and with fracture. Cast needs to be applied to arm.
- Out of hours, child presenting with swelling / erythema thought secondary to trauma and concerns that this may have resolved by morning.
- Out of hours, child with 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

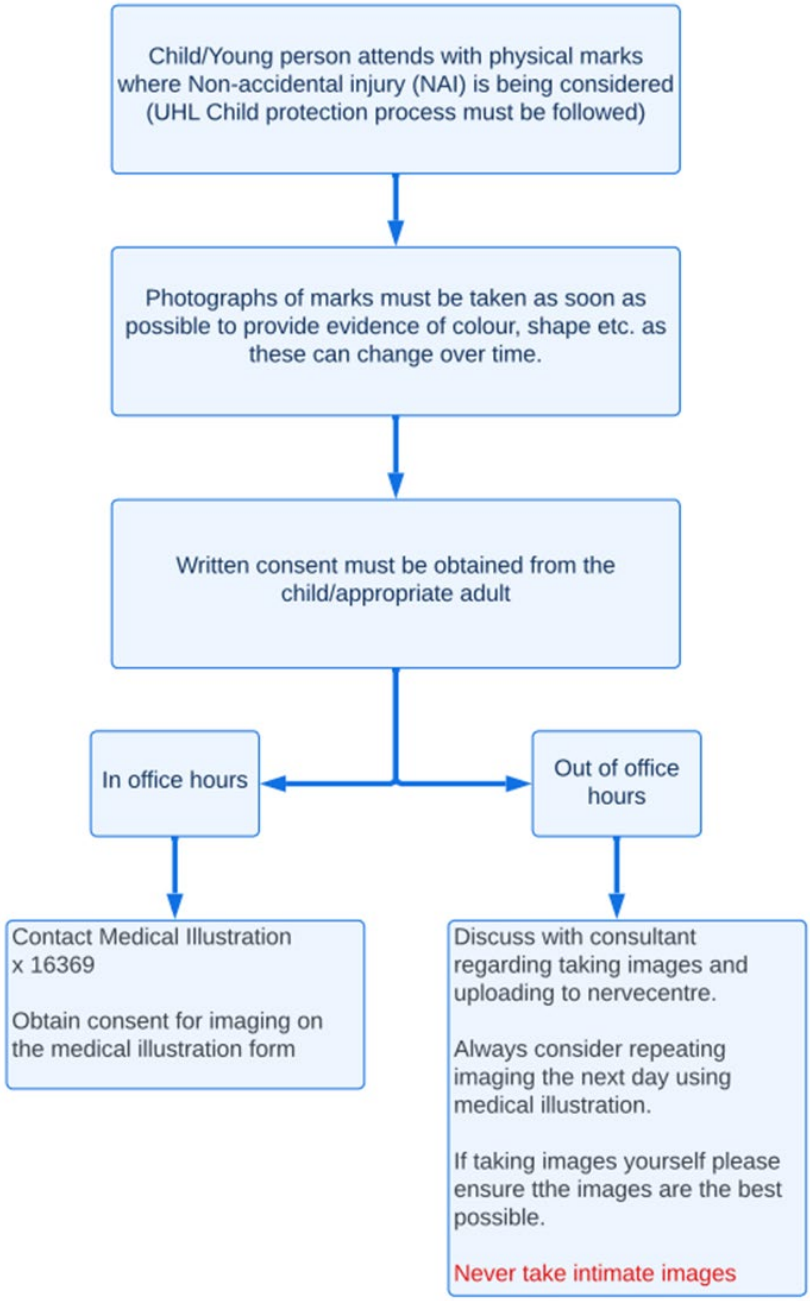
NEVER use your own phone to take images; they should only be taken using on-call phone and stored using nerve centre. No images should be stored in a phone's memory bank.

Any image being 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 are being taken of the **correct patient** and stored in the **correct nerve centre 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 the bruise is positioned.

7.1 Photography flow chart



7.2 Guide to taking images using hospital phone and uploading to nerve centre

1. Ensure that consent has been obtained.
2. Identify appropriate place to take images ensuring sufficient privacy and appropriate lighting.
3. Make sure you have a chaperone and appropriate equipment (phone / tablet, measuring tape / right angled linear scale.
4. Open nerve centre on hospital phone / tablet. Person obtaining images must be one logged in.
5. Search for patient.
6. Ensure that correct patient has been identified by matching patient's name, date of birth and s number to those on patient's wrist band.

7. Try to ensure plain background e.g. get child to lie on white sheet.
8. Take image showing location of injury. E.g., if injury on right forearm start by taking image of whole right arm.
9. Take close ups of injury both with and without measuring apparatus.
10. Upload all images directly to nerve centre. Do not store images on phone / tablet.

7.3 Quick reference guide to using smartphone to take photographs of Injuries

8. 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 full history and carrying out a detailed clinical examination no concerns about 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.

8.1 Radiological Imaging

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

	Age		
	Less than 1 year	**1 – 2 years**	**Over 2 years**
CT head	Yes	If evidence of head trauma or abnormal neurology.	Imaging should be considered on case-by-case basis. There will be some situations where a skeletal survey will be required over 2 years. The Paediatric consultant will need to discuss this with Radiology.
Skeletal survey	Yes	Yes	
MRI Head +/- whole spine	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 who have ongoing abnormal neurological symptoms or signs irrespective of an apparently 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.		

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

Skeletal survey and CT head are requested on ICE / Nervecentre, ensure that child's injuries are clearly documented in request.

Follow up imaging:

A skeletal survey is not complete until follow up imaging has been completed. This should take place within 11 to 14 days and no later than 28 days after the initial skeletal survey.

Consent for Radiological imaging:

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

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

8.2 Taking written consent for radiological investigations

A consent form for minors will be required:

Clearly document:

- **Procedure**: e.g. Skeletal survey under oral sedation.

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

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

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

Sedation is used to make 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.

8.3 Sedation for Radiological imaging in child protection medical examinations

Please refer to guideline: Sedation For Painless Imaging UHL Children's Guideline.

Remember that prior to sedation children must not eat or drink: 'Starvation 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.

8.4 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 like U&E, CRP, amylase, Urine, and blood toxicology etc. are

Indicated.

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 clearly recorded in the child's notes.

8.5 Ophthalmology

In children less than 2 years of age, ophthalmic screening should take place as part of the acute medical assessment.

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

9. 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.) it is recommended to 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 will be unable to complete it until this has been done.

9.1 Child Protection Report proforma

Childs 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 name of the consultant on-call.

Persons present:
Record full names of all persons present. For family also record relationship to 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 for 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 any information.

History:
Document in full, the histories provided by all involved. Clearly indicate who has provided the history.
If history has been obtained from more than one source (e.g., mother, child, social worker) it is best to split history into different sections, clearly documenting at the start who has provided the history.
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:
Child's past medical history including:

- Birth history.
- Medication history including allergies and immunization 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 clearly indicating what the child can or cannot do. (**simply documenting No developmental concerns is not sufficient**)

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

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

Investigations:

Bloods: Blood tests and whether normal**.**
Radiology: Summary of results of radiological investigations, best to include full radiological report and document radiologist providing report in appendix.
Ophthalmology: Document result of 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 of 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 of 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 opinion as to whether the explanations offered explain the injuries and as to whether you feel the child has suffered non accidental injury.
Finish opinion with an impact statement, which reflects your level of concern regarding the child's safety, well-being and 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 large bruise to 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 on the medical opinion significantly, please inform me so that I can send an addendum to the report.

9.2 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.

Multi-agency working is essential to safeguard the well-being of children, and as such health professionals have an obligation, under Section11 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 member of senior staff. 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. Members of the Safeguarding Children Team are available to support medical staff if required.
- The Safeguarding Children Team will ensure that the member of staff has the medical notes available when the statement is provided.
- If you are providing a verbal statement, the agency will prepare a written statement of this. This should be read by the member of staff 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").

10. Child protection handbook

For further information on child protection please visit the child protection handbook. This has useful information which can be accessed from a computer or from your phone.

Access the child protection handbook here.

11. Education and Training

Training on this guideline is provided to Paediatric Registrars in their induction training.

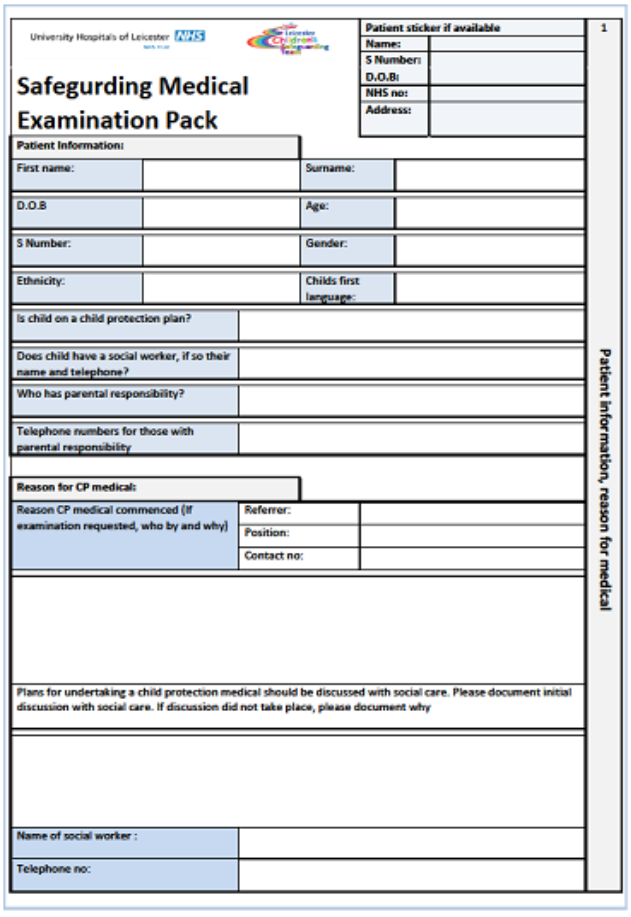
12. Monitoring and Audit Criteria

Key Performance Indicator	Method of Assessment	Frequency	Lead
Compliance with guideline	Review of cases where concerns raised that guideline was not used	Case by case basis	Dr D. Bronnert

13. Key Words

Child protection, child protection medical, child protection report, safeguarding children

Appendix 1 Safeguarding medical examination pack



University Hospitals of Leicester NHS

Safegurding Medical Examination Pack

Patient sticker if available	
Name:	
S Number:	
D.O.B:	
NHS no:	
Address:	

1

Patient Information:

First name:		Surname:	
D.O.B		Age:	
S Number:		Gender:	
Ethnicity:		Childs first language:	

Is child on a child protection plan?	
Does child have a social worker, if so their name and telephone?	
Who has parental responsibility?	
Telephone numbers for those with parental responsibility	

Reason for CP medical:

Reason CP medical commenced (If examination requested, who by and why)	Referrer:	
	Position:	
	Contact no:	

Plans for undertaking a child protection medical should be discussed with social care. Please document initial discussion with social care. If discussion did not take place, please document why

Name of social worker :	
Telephone no:	

Patient information, reason for medical

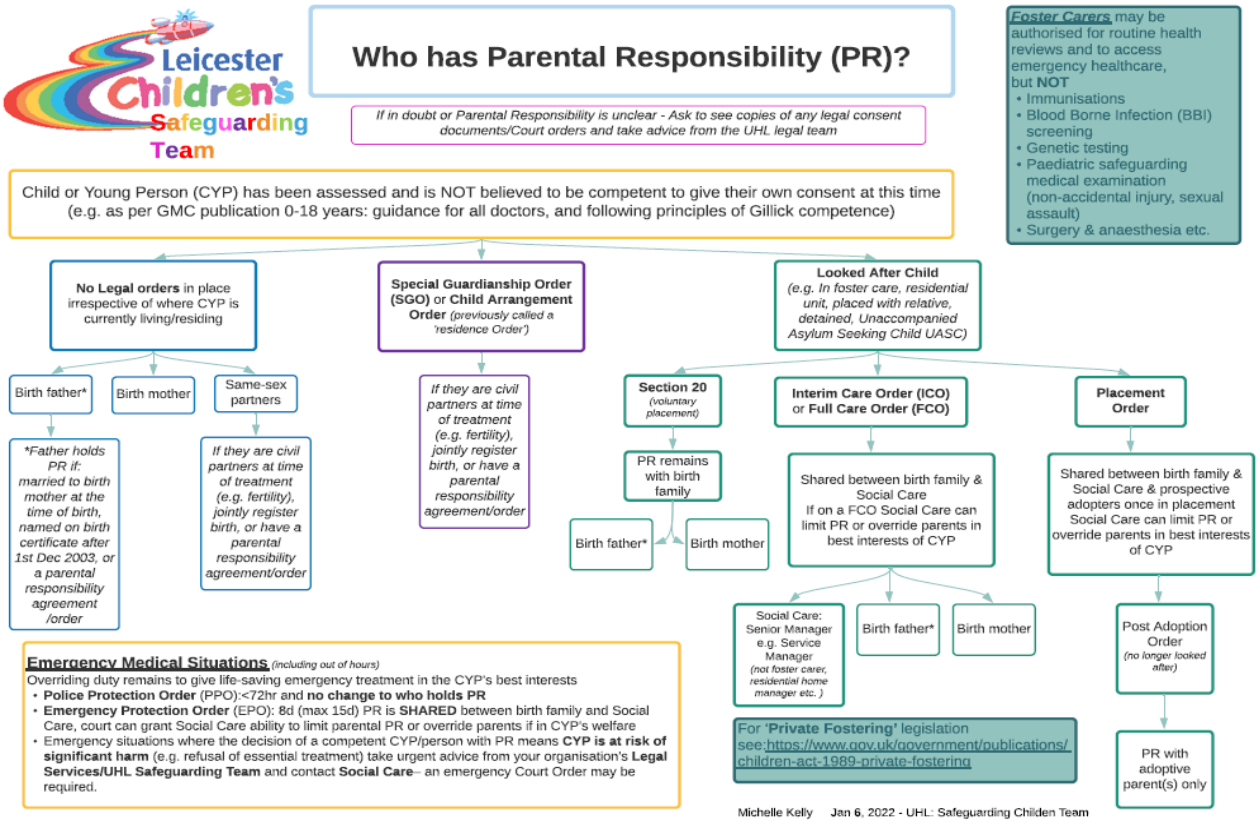
Appendix 2 Parent information leaflet

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.



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This table is used to track the development and approval and dissemination of the document, and any changes made on revised / reviewed versions

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