GSCP MULTI-AGENCY CHILD PROTECTION MEDICAL ASSESSMENT PROTOCOL

This protocol ensures that when a child or young person is alleged or suspected to have suffered or be at risk of significant harm and where a Strategy Discussion decides that a Child Protection Medical Assessment or Forensic Medical Examination is necessary, the child will be assessed by a doctor with appropriate skills and expertise

It has been co-produced by Safeguarding Children professionals across the Gloucestershire Safeguarding Children's Partnership, and has been peer-reviewed by health professionals including Paediatricians and Forensic Medical Examiners.

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Gloucestershire Safeguarding Children Partnership

MULTI-AGENCY CHILD PROTECTION MEDICAL ASSESSMENT PROTOCOL

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Version Control

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1.0	October 18th, 2023	Final Version approved for publication
1.1	December 4th, 2023	Draft review
2.0	December 19th, 2023	Final Version 2.0
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1 What is a Child Protection Medical Assessment?

A Child Protection (CP) Medical Assessment is conducted to identify signs that a child or young person has been abused or neglected (GMC 2018)[1]. It is part of the process to safeguard a child. If sexual abuse*, physical abuse*, emotional abuse, or neglect is suspected[2], where there is the potential risk of significant harm or death, a CP Medical Assessment will likely be required. Ordinarily this will be when a decision has been taken to undertake an enquiry under section 47 of the Children Act 1989, or potentially under section 17 with parental consent. 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 a potentially fatal disease[3].

The CP Medical Assessment should demonstrate a holistic approach to the child. As well as assessing for evidence of abuse and assessing the current physical health of the child and any unmet health needs, it should also include screening of their mental health, a developmental assessment, and if appropriate, screening for sexually transmitted infections[4]. Other investigations may be needed, including identification of any unmet medical needs that come to light in the examination. Support should be organised to help minimise any potential physical or psychological sequelae of the suspected abuse, regardless of type.

A CP Medical Assessment is therefore more comprehensive and different to a clinical assessment; the latter aims to establish a diagnosis and determine what treatment may be needed[1]. It may be that the child requires clinical assessment for a medical condition in addition to a CP Medical Assessment; these various clinical assessments and scenarios, which sit outside the CP Medical Assessment process, are described in Appendix 1.

2 Process

2.1 Making the decision as to whether a CP Medical Assessment is required:

2.11 The decision as to whether a child or their siblings need a CP Medical Assessment will be made in a Strategy Discussion (SD), by a consensus decision of the members of the Strategy Discussion and based upon the information in section 1. Health practitioners should advise about the appropriateness or otherwise of medical assessments[5]. A CP Medical Assessment will only be deemed appropriate if it is in the child's best interests, and where it will make a difference to the outcomes for the child or for the safeguarding process[6]. The child's wishes should be sought where possible (see section 3, Consent).

2.12 CP Medical Assessments will only be undertaken following a SD; the timing of a CP Medical Assessment will be decided within the SD. Please see the Gloucestershire Safeguarding Children's Partnership (GSCP) Strategy Discussion Policy for further information about Strategy Discussions.

2.13 The Strategy Discussion will also ascertain whether any other clinical assessments for diagnosis and treatment are required; this is described in more detail within Appendix 1.

2.14 A Gloucestershire Health & Care NHS Foundation Trust (GHC) MASH nurse representative will ascertain which health representatives should attend the SD. If these health representatives are then unable to attend the SD, the MASH nurses will attend the Strategy Discussion to ensure that "health" is present to contribute to the decision making as to whether a CP Medical Assessment is required.

2.15 The paediatric team will be invited to all SDs where it is likely that a CP Medical Assessment will be required, to enable them to have the opportunity to hear all of the information about the child in advance of completing the CP Medical Assessment. The paediatric team will also be invited to all SDs where it is equivocal as to whether a CP medical will be required, to enable them to hear all of the information about the child and to join the decision-making process about whether or not a CP Medical Assessment is required[7]. The paediatric team will not be invited to the SDs where it is unlikely that a CP Medical Assessment will be required. The email address to send the invites to is the generic safeguarding children email for Gloucester Hospitals NHS Foundation Trust (GHT): ghn-tr.safeguarding.children@nhs.net. When a paediatric opinion is likely to be beneficial to the decision making, e.g., for those cases where it will be difficult to determine whether a CP Medical Assessment will be required, the SD should where possible be arranged at a time when the GHT paediatric doctor can attend.

2.16 Additional health representatives may attend the SD (e.g., the GP) and they will then also contribute to this decision-making process about whether a CP Medical Assessment is required.

2.17 Where there is a concern about sexual abuse*, or the presentation includes sexual abuse as a possible differential diagnosis, a doctor from The Bridge Sexual Assault Referral Centre (SARC) should be invited to attend the SD by emailing TheBridge@uhbw.nhs.uk or if it is urgent, by phoning 0117 342 6999. This is in addition to the local health representatives, not as a replacement for them.

2.2 Timescales

All Child Protection Medical Assessments should be carried out within timescales appropriate to their medical needs, the type of abuse and the requirement for collection of evidential samples[8-10]:

- Physical injury: within 24 hours[10].
- Acute sexual assault: The timing of cases must be carefully triaged depending on the urgency of the needs, both medical and forensic, to obtain forensic evidence, document fresh healing and healed injury and prevent pregnancy and sexually transmitted infection[9-10]. If there are allegations that indicate forensic swabs are required, then the examination must be undertaken as soon as possible as DNA evidence wanes very quickly. The definition of an acute case is up to 21 days, in order to capture all possible forensic evidence including healing injuries[8]. See also section 2.17. All children suspected of being sexually abused* should be offered a full Forensic Medical Examination, regardless of time since the abuse happened.
- Historic sexual abuse, neglect, or emotional abuse: the referral should be assessed according to clinical need and requirement of the child protection process; children should not be kept waiting for more than 10 working days from the point of referral, unless there are clear mitigating factors agreed by all parties[10-11].
- Where police investigation or protection from harm is required: within 24 hours[9] (excluding historic sexual abuse).

2.3 How to book a CP Medical Assessment:

2.31 Once a decision has been jointly agreed at the Strategy Discussion that a CP Medical Assessment is required, the Social Worker will need to contact the medical team as below. The Social Worker must request the CP Medical Assessment, and share details about the child and any relevant information from the Strategy Discussion.

2.32 To access a CP Medical Assessment, the next step will depend upon the type of abuse, the day of the week and the time:

2.321 **Sexual abuse*:** All referrals for sexual abuse Forensic Medical Examinations, whether acute or historic, should be made by **telephoning the Sexual Assault Referral Centre (SARC) in Bristol, The Bridge on 0117 342 6999.**

In cases of recent sexual abuse, when children are aged 16-17, after referral to The Bridge, The Bridge may assess that the child can be seen at the local Gloucestershire SARC, Hope House. Children aged 13-17 may self-refer to The Bridge. Children under the age of 13 cannot be seen as self-referrals. Information is shared with children's social care for all children aged 17 and under that attend the Bridge for a Forensic Medical Examination.

2.322 **All other types of abuse: Working hours:** All other Child Protection Medical Assessments will be undertaken by GHT. In hours, (Mon – Fri, 9am – 5pm) the social worker (SW) will **telephone the GHT Child Protection Administrator on 0300 422 5701** to request the CP Medical Assessment. During these working hours there is a rota of paediatricians who undertake CP Medical Assessments. Wherever possible the CP Medical Assessment should take place within working hours.

Outside of working hours: Where a CP Medical Assessment is required outside of the working hours above due to the timeframes described in 2.7, the PAU Consultant will either undertake this CP Medical Assessment or it will be delegated by them to a suitably trained paediatric doctor. The SW will contact the Paediatric Assessment Unit (PAU) Consultant to make this request. **They can access the PAU Consultant by phoning the switchboard on 0300 422 2222 and asking for bleep 1133**, or by asking to be put through to the Paediatric Assessment Unit (PAU) Consultant. Where a CP Medical Assessment takes place at the weekend, wherever possible this should take place during the day, rather than in the evening or overnight.

2.33 During the phone call, the CP administrator/paediatrician will confirm the time and place of the CP Medical Assessment. The phone call is to also share brief details about what has happened so far. No further review of the decision as to whether the CP Medical Assessment is required should take place *at this stage*; this discussion and decision has already been taken in the SD. The clinician may not agree at this point that the assessment is necessary. Please see 2.6 for further information if there is professional disagreement about whether a CP Medical Assessment should take place.

2.34 If the person on the CP medical rota during daytime hours is unable to complete the CP Medical Assessment within the timeframe described in (5) above, this CP Medical Assessment will be undertaken by the PAU consultant or delegated to another suitably trained paediatric doctor.

2.4 Conducting the CP Medical Assessment

2.41 The CP Medical Assessment should be conducted by an appropriately trained paediatric doctor with the appropriate competencies[12]. The paediatrician will need to be satisfied that the Child Protection Medical Assessment is necessary and appropriate in the circumstances. If sexual abuse is suspected, then an suitably trained doctor must complete the assessment[8]. Doctors who are not trained to complete CP Medical Assessments (e.g., A&E doctors / GPs) must not complete these assessments[9].

2.42 The SW, along with the child/young person and usually also the parent/carer, will arrive for the CP Medical Assessment at the agreed time, not before, nor without agreement on the appointment time of the CP Medical Assessment. If there is any delay to their arrival, the SW must let the paediatrician know.

2.43 If an interpreter is required, this will be organised by the hospital.

2.44 CP Medical Assessments should be undertaken with a trained chaperone present[13], following the local chaperone policy.

2.45 The CP Medical Assessment includes[14]:

- A detailed medical, mental health and social history both from the parents/carers, as well as the medical record; these should be cross referenced. The information source needs to be clear for each section (i.e., parents, medical record etc). Both the history from the parents and the medical record would need to be included, not just one of the two. If the past medical history is not immediately available as the child has just moved area, this should be sourced from the previous area.
- Observation of the child's interactions with parents and other people present
- Full clinical examination
- A developmental assessment
- Relevant investigations to be planned
- Full detailed documentation. - Photo documentation if appropriate.

2.46 Further comprehensive information from the RCPCH Child Protection Companion detailing the full content of the CP Medical Assessment history and examination can be found in Appendix 2. The doctor should seek advice where required, and not work in isolation[14]. An evidence-based opinion should be given for the multi-agency process, based upon the analysis of the assessment to determine the likelihood of child abuse[14-15].

2.47 Forensic Medical Examinations for possible sexual abuse may need to be conducted in a setting appropriate to gather forensic evidence such as DNA evidence in the form of swabs, and toxicology evidence in the form of blood or urine, as well as the recording of fresh, healing and healed injuries[8]. It may require a forensic interpretation of the clinical findings such as injuries, to assist the police and social care to investigate the suspected abuse[8]. Medical needs may also be identified, such as consideration of HIV post-exposure prophylaxis (PEP), Hepatitis B, as well as screening for other sexually transmitted disease and assessment for appropriate care of the mental health needs[8].

2.48 The doctor should work to a locally agreed protocol to ensure adequate standards of photography, including storage of images. All significant visible findings should be photographed using an L-shaped metric scale to measure the size of injuries. It should be recorded as to whether the photo documentation represents what was seen at examination. Written consent should be obtained to take images, and for which purposes they can be used, e.g., to share images at peer review or use for teaching purposes[17]. Sexual abuse medical examinations use photo documentation and follow the guidance for the "Best Practice for the Management of Intimate Images"[18]. The police may assist by taking photographs as part of the CP assessment. The doctor will be able to access these police photographs for the purpose of report writing/peer review.

2.5 Documentation

Clear contemporaneous documentation of all information relating to the case should be written on a recommended proforma (see Appendix 3 for an example template). All injuries should be documented on the appropriate body maps and all documentation should be saved in the child's medical record[16]. A child protection report should then be written. **This CP report should be sent to the relevant agencies, including the children's social care team, the police, and the GP, within the requested timeframe[16], and at the latest by ten working days.** This will include any relevant information to be included in the Safeguarding Plan. The clinician should provide verbal feedback to professionals who accompanied the child once the CP Medical Assessment is completed, before the child leaves the hospital. They will also inform the parent/guardian of the broad conclusions.

2.6 Professional disagreement about the need for a CP Medical Assessment

Where a multi-agency decision has been made, if one organisation disagrees with this decision, they can challenge this through the escalation policy, as per the GSCP escalation policy. No agency should unilaterally cancel a CP Medical Assessment if the decision that it was required was made at a Strategy Discussion. If any agency disagrees with the decision of the SD about whether a CP Medical Assessment is required, then the GSCP escalation policy[19] should be followed. All such cases would benefit from being recorded so that they are available for peer review discussions and audit[5].

3 Consent

In most cases, a person with parental responsibility (PR) will be able to consent for the CP Medical Assessment. The child may have capacity to consent for themselves, however in these circumstances it is best practice to include the person with PR. A full list of those who may give consent to the CP Medical Assessment can be found at Appendix 4.

If the parent(s) does not / do not give consent to the examination and if the social worker and/or police feel an examination may be in the child's best interest, they will discuss this further with the parent(s). If consent is not obtained, then the social worker and/or the police may seek a court order which would give permission for the child/ young person to undergo a CP Medical Assessment.

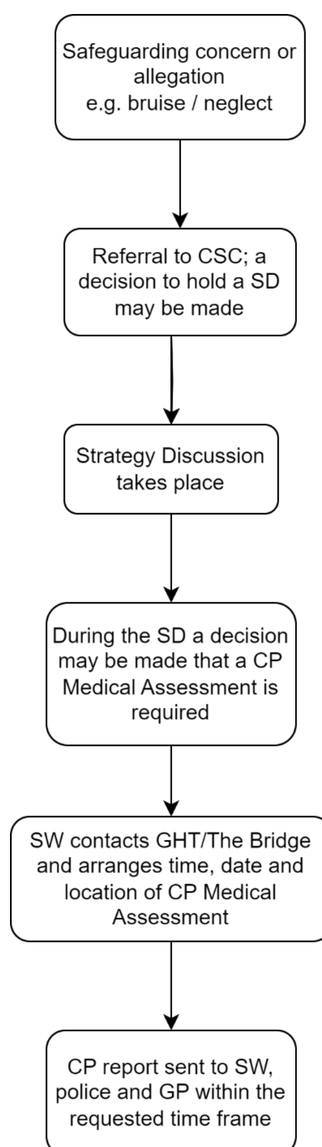
If the child has capacity to make the decision as to whether a Child Protection Medical takes place, the child's wishes should be sought and followed. If the child declines the CP Medical Assessment, then each case will be considered on its merits, documented fully, and observations recorded if possible.

4 Multi-Agency Audit

The Child Protection Medical Process will be audited against the criteria described above by the Gloucestershire Safeguarding Children's Partnership. This audit will additionally include the criteria described in the RCPCH Good Practice Service Delivery Standards for the management of children referred for Child Protection Medical Assessments 2020[20] and the Quality Standards for Clinicians undertaking Paediatric Sexual Offence Medicine (PSOM)[21]

*Where child sexual abuse is referred to it includes child sexual assault, child sexual exploitation. Physical abuse includes Fabricated and Induced Illness (FII). Female Genital Mutilation has a separate pathway from that described in this document.

5 CP Medical Assessment Process Flow Chart



6 References

1. GMC Ethical Guidance for doctors, "Protecting Children and Young People, the responsibilities of all doctors," Section 61, (2018)
2. RCPCH Child Protection Companion 5.1.5 (2017); also supported by the RCPCH position statement on mandatory reporting of child abuse 2023, stating that this should be for *all* forms of child abuse because there should not be a "hierarchy of abuse."
3. The Victoria Climbie enquiry 11.53 (2003) https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming; RCPCH Child Protection Companion 6.1.1 (2017)
4. RCPCH Child Protection Companion 5.1.1, 6.1.2, 6.5 (2017); RCPCH Core Syllabus for Paediatric training page 38, GPC 5,7 (August 2023) ProgressPlus-core-syllabus-2023.pdf (rcpch.ac.uk); with regards unmet health needs see also the draft Working Together to Safeguard Children guidance page 79 Working Together to Safeguard Children 2023: draft for consultation (education.gov.uk) and Safeguarding Children and Young People: Roles and Responsibilities for Healthcare Staff pages 34-37 (Intercollegiate Document)
5. Working Together to Safeguard Children; a guide to multi-agency working to help, protect and promote the welfare of children, December 2023.
6. GMC guidance, Protecting Children and Young People, Child Protection Examinations Section 62, (2018)
7. RCPCH Child Protection Companion. 2.1.3, 3.4.5 (2017); RCPCH Child Protection Standards, Standard 2e (2020) Child protection service delivery standards – RCPCH Child Protection Portal; GMC Guidance "Protecting Children and Young People." Section 26
8. FFLM/RCPCH Service specifications for the clinical evaluation of children and young people who may have been sexually abused (2015)
9. RCPCH Child Protection Companion 5.1.2 (2017)
10. FFLM Recommendations for the collection of forensic specimens from complainants and suspects (2023)
11. RCGP GP curriculum GP curriculum (rcgp.org.uk); Safeguarding Children and Young People: Roles and Responsibilities for Healthcare Staff pages 38-40 (Intercollegiate Document)
12. RCPCH Child Protection Companion 5.1.1 (2017), RCPCH Core Syllabus for Paediatric training pages 37-41 (August 2023) ProgressPlus-core-syllabus-2023.pdf (rcpch.ac.uk); RCPCH Child Protection Standards, Standard 4 (2020) Child protection service delivery standards – RCPCH Child Protection Portal
13. RCPCH Child Protection Companion 5.1.4 (2017)
14. RCPCH Child Protection Companion 5.1.5 (2017)
15. RCPCH Child Protection Companion 6.1.2 (2017)
16. RCPCH Child Protection Companion 5.1.8 (2017); Royal College of Paediatrics and Child Health Guidance on medical photography of possible physical abuse in children. 2019 www.rcpch.ac.uk/resources/guidance-medicalphotography-possible-physical-abuse-children
17. RCPCH Child Protection Companion 5.12.1-4 (2017)
18. FFLM/RCPCH Guidance for best practice for the management of intimate images which may become evidence in court (2023)
19. GSCP Escalation Policy (gloucestershire.gov.uk)
20. RCPCH Child Protection Standards 2020 Child protection service delivery standards – RCPCH Child Protection Portal

21. FFLM/RCPCH Quality Standards for Clinicians undertaking Paediatric Sexual Offence Medicine (PSOM) 2023 [Quality-Standards-for-clinicians-undertaking-PSOM-Prof-I-Wall-and-Dr-C-White-March-2021-1.pdf (fflm.ac.uk)]

Appendix 1 Clinical Assessments

It may be that a child has a medical problem that needs clinical attention. This clinical assessment, including investigation and management of any clinical problem should be organised with the appropriate clinician when it is identified, which may be at any stage; a decision as to whether a clinical assessment of a medical problem is required could be made by the parent, any professional, or during a strategy discussion.

Health practitioners should:

• advise about the appropriateness or otherwise of medical assessments, and explain the benefits that arise from assessing previously unmanaged health matters that may be further evidence of neglect or maltreatment

• provide and co-ordinate any specific information from relevant practitioners regarding family health, maternity health, school health mental health, domestic abuse and violence, and substance misuse to assist strategy and decision making

• secure additional expert advice and support from named and/or designated professionals for more complex cases following preliminary strategy discussions

• undertake appropriate examinations or observations, and further investigations or tests, to determine how the child's health or development may be impaired[20]. Information about which practitioners will complete which assessments is given below:

A GP will be able to review GP-appropriate medical problems from a medical perspective. For some emergency medical problems or injuries, the emergency department (ED) of the hospital may be more appropriate. In some instances, the health visitor, occupational therapist, physiotherapist, speech and language therapist or other medical professional would be the appropriate person for the child to see.

If during a Strategy Discussion it is determined that an assessment needs to be undertaken to decide as to whether a bruise or injury has been caused by abuse, or if an assessment of the child's unmet health needs is required where there is a concern about neglect, neither a GP nor a health visitor/school nurse can do this assessment. An appointment therefore cannot be made with the GP nor a health visitor/school nurse for this purpose. Instead, a Child Protection Medical Assessment should be organised following the process described within this document.

All professionals who have concerns about abuse or neglect of a child should make a referral to children's social care following the agreed multi-agency referral process. Please see 2.11 and 2.12 above for further information.

Appendix 2 History and Examination

Chapter 6: The Medical Assessment and Admission to Hospital – RCPCH Child Protection Portal

Appendix 3 Template for the Child Protection Medical Assessment

Chapter 20: Appendices – RCPCH Child Protection Portal Safeguarding Children Medical Proforma

Appendix 4 Consent

The following may give consent to a paediatric assessment:

- A child of any age who has sufficient understanding (generally to be assessed by the doctor with advice from others as required) to make a fully informed decision can provide lawful consent to all or part of a paediatric assessment or emergency treatment.
- A young person aged 16 or 17 has an explicit right (s8 Family Law Reform Act 1969) to provide consent to surgical, medical or dental treatment and unless grounds exist for doubting their mental health, no further consent is required.
- A child who is of sufficient age and understanding may refuse some or all of the paediatric assessment, though refusal can potentially be overridden by a court.
- Any person with parental responsibility, providing they have the capacity to do so
- The local authority when the child is the subject of a care order (though the parent should be informed)
- The local authority may seek legal advice to support obtaining a medical examination where this is in the child's best interests in cases where parental consent is deemed to be unsuitable or impossible
- The High Court when the child is a ward of court.
- A family proceedings court as part of a direction attached to an emergency protection order, an interim care order or a child assessment order.
- When a child is looked after under section 20 and a parent has given general consent authorising medical treatment for the child, legal advice must be taken about whether this provides consent for paediatric assessment for child protection purposes (the parent still has full parental responsibility for the child).

Wherever possible, the permission of a parent should be sought for children under 16 prior to any paediatric assessment and/or other medical treatment.

Where circumstances do not allow permission to be obtained and the child needs emergency medical treatment, the medical practitioner may:

- regard the child to be of an age and level of understanding to give their own consent
- decide to proceed without consent where this is deemed to be in the best interests of the child. (Where consent has not been gained, the reasons for this should be clearly documented and signed by two professionals at consultant level to say the medical examination is in the best interests of the child. Legal advice should also be sought. In these circumstances, parents must be informed by the medical practitioner as soon as possible and a full record must be made at the time.)

In non-emergency situations, when consent is not obtained, the social worker and manager must consider whether it is in the child's best interests to seek a court order.