Manchester University
NHS Foundation Trust

## DOCUMENT CONTROL PAGE

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| **Title:** | Child Protection Medicals – Service Delivery Standards |
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| **Application:** | Royal Manchester Children's Hospital, Wythenshawe Hospital and North Manchester General Hospital – areas where child protection medicals are completed |

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| **Originated / Modified By:** | Dr Clare Wilkins, Dr Louise O'Connor, Dr Mercedes Osuagwu |
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| **Ratified by:** | Safeguarding Quality and learning Group (approved 18th December 2024)<br>RMCH safeguarding Committee (approved 22nd November 2024)<br>RMCH Policies and Guidelines Group |
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| **Responsibility of:** | Dr Clare Wilkins, Dr Louise O'Connor, Dr Mercedes Osuagwu |

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## 1 Introduction

Child Protection medical assessments are completed by paediatricians when there are child protection concerns related to physical abuse and neglect. If the Child Protection Medical is requested by Children's Social Care and is part of a S47 investigation this may be referred to as a 'S47 Medical'. In 2020 the Royal College of Paediatrics and Child Health (RCPCH) and the Child Protection Special Interest Group (CPSIG) published a set of standards about the service delivery aspects of child protection medical assessments. This guideline is to ensure that these standards are met when a child protection medical assessment is completed in the acute units at Manchester Foundation Trust (Royal Manchester Children's Hospital, Wythenshawe Hospital and North Manchester General Hospital).

## 2 Purpose

The purpose of this guideline is to ensure that Child Protection medicals are completed to the standard outlined by the RCPCH. The guideline also gives advice about how to complete a child protection medical report.

## 3 Detail of Trust approved procedural document.

**Standards for Child Protection Medical Assessment**
(Based on RCPCH Good practice service delivery standards for the management of children referred for child protection medical assessment, October 2020)

### 3.1 Timing of medicals:

- Clinician should respond to a request for a child protection medical within a timely fashion.
- The child or infant must receive a full, and fully documented, physical examination within 24 hours of recognition of the concern, except when doing so would, in the opinion of the examining doctor, compromise the child's care or the child's physical or emotional wellbeing. If an examination is not carried out or certain areas are not examined, then the reason is to be documented in the child's case notes.
- Our service enables assessment of children and/or infants with suspected physical abuse to normally be commenced within 24 hours.
- A clinician with appropriate expertise will be available during normal working hours to engage with partner agencies in a strategy discussion.

### 3.2 Consent

- Written consent for a child protection medical should be taken from a person with parental responsibility whenever possible.
- If a child or young person is Gillick competent they can provide consent for a child protection medical.

- Written consent for the child protection medical should be taken on the consent form that is part of the trust child protection proforma.
- Specific consent should be taken for medical photography (use consent form 2, panel 1), if the photos are to be used for teaching and/or publication that should be specified on the consent form.
- Specific consent should be taken for skeletal surveys, CT or MRI scans completed as part of the child protection assessment.

### 3.3 Competencies

Clinicians completing child protection medicals should:

- be working at ST4 level or equivalent or above.
- have level 3 child protection competencies.
- be actively engaged in relevant continued professional development or supervised by doctor actively engaged in relevant CPD.
- be attending safeguarding peer review meetings or supervised by doctor who attends peer review and have regular supervision.
- appropriate supervision or regulatory measures would be put in place, in line with GMC guidance, if there were recurrent or significant concerns regarding a clinician's ability to produce clear, balanced, and reasonable opinions and actions within the context of child protection medical assessments.

### 3.4 Supervision

- When child protection medical assessments are carried out by clinicians in training, associate speciality doctor or clinical fellow, the supervising senior clinician, as a minimum, sees the visible findings or injuries that have raised concern and reviews and co-signs the report.
- Children seen for a child protection medical assessment should have a documented, named supervising senior clinician responsible for the child protection opinion.

### 3.5 Chaperone

- During child protection medical assessments, a named chaperone should be present as a witness, and to support the child and clinician.
- For Child Protection Medicals the chaperone should be a qualified health professional, not a student or HCA (ie the chaperone needs to be registered with a professional body) – *see MFT 'Chaperone Policy', 2023 for additional information*
- It is not appropriate for the Social Worker to act as the chaperone.
- Document the name and role of the chaperone on the child protection proforma.

### 3.6 Child and Family support

- An independent interpreter should be offered if English is not the family's first language. Telephone interpretation is not appropriate unless there is no other option. Offer a sign language interpreter for people with a hearing disability.

- When an interpreter is used, their identifying details should be recorded on the child protection medical assessment proforma.
- Only interpreters from organisations approved by the health provider organisation, social care department, or police are to be used. **A family member should never be used as an interpreter.**
- All reasonable adjustments should be made for parents/guardians with disabilities (learning, hearing or sensory) or mental health concerns in giving and receiving information.
- Children and young people are given a choice about who accompanies them in a child protection medical assessment, including not having a relative or social worker present.
- Children, young people, and families who have a disability or mental health concern should be provided with appropriate support.
- **The child protection medical assessment and associated discussions should take place in a private space, such that discussions are unlikely to be overheard by other children and families.**

### 3.7 Communication

- Clinicians should record all decisions made during strategy discussions, either before or after a child protection medical assessment.
- Clinicians should review the child's health record.
- **The child protection assessment is completed on the trust child protection proforma which includes body maps**. Trust proforma is available on the intranet, and on HIVE ('drop down list' Child Protection Medical)
- A comprehensive history should be taken (using the pro forma will help with this.) The examining doctor should consider whether taking a history directly from the child is in that child's best interests. This should always be the option of choice. Any important statements from the child or parent should be documented verbatim.
- Information should be given to the child and family about the child protection assessment and what this involves (information available as part of CP proforma and additional information booklet found on intranet, 'Child Protection Investigations Explained').
- Clinicians should provide attending social workers and/or police officers with a written provisional report at the time of the child protection medical assessment, containing the professional medical opinion regarding the likelihood of abuse based on the history and clinical findings. This is found at the end of the child protection proforma.
- A copy of the assessment (standard proforma), provisional report and final typed report should be kept in the child's health record.
- Feedback, including results of investigations, is given as appropriate to children, young people, and carers.
- A comprehensive type-written report with a full professional opinion should be dispatched to social care (and police if involved), within 10 working days of a child protection medical assessment. (see guidance on writing a Child Protection Medical Report in section 4, example of report format in Appendix C)

- Child protection reports will be sent by secure e mail to the Social Worker, Police and Health Visitor and to the GP, safeguarding nursing team and Named Doctor by secure electronic transfer in the HIVE patient electronic records.
- If the child protection medical is completed by the community paediatric team and further investigations or admission is required, this can be arranged following a discussion between the community paediatric consultant and acute hospital consultant (for the area the child lives in). The hospital will organise the investigations and inform the community team of the results from the investigations, but it is the responsibility of the person who completed the child protection medical to write the report and give the opinion. In very exceptional circumstances, with consultant to consultant, agreement the acute hospital consultant may write an additional report.
- For all hospital child protection medicals Inform the local Safeguarding Children Nursing Team within working hours. Complete a Safeguarding order on HIVE.

**Multiagency discussion/Strategy meetings**:

- Most children which have undergone a Child Protection medical assessment require a discussion with Children's Social Care. This does not always mean that the outcome of the assessment is non-accidental injury, some cases require discussion as further support for the family may be indicated.
- Multi-agency involvement may differ depending on the individual case. Some cases may have been referred by or already known to social care and so already have an allocated social worker, others, for example those referred internally, may require a new referral to social care.
- Dependent on how the case has been referred, a strategy meeting may have already taken place prior to your assessment and a follow up meeting will be required, or if a new referral has been made then the decision to hold an initial strategy meeting will be made.
- Strategy meetings are arranged and chaired by social care. There are representatives from social care, health, school, police, and the GP if felt to be required.
- Strategy meetings should be arranged within normal working hours (if an emergency, out of hours strategy meeting has taken place, it would be expected there to be a review strategy meeting within normal working hours)
- **ALL strategy meetings should be attended by the General Paediatric Consultant** who is lead for the case.
- ALL outcomes from strategy meetings should be clearly documented in the patient's notes.

### 3.8 Photography

- Photographs should be taken of all significant visible findings and these photographs should be of a standard that is suitable to be used in court.
- Consent should be obtained for medical photography.
- Photographs should be taken of significant visible findings at the time of the child protection medical assessment or the next working day.

- ‘Out of hours’ photographs can be taken on Rover device which directly uploads to the patients HIVE electronic records. Written consent to take the photographs should be obtained.

  **Medical illustration:**
  Working hours Mon- Fri 08.30 – 16.30.
  Telephone:
  RMCH: 0161 276 4139
  Wythenshawe Hospital: 0161 291 5832
  NMGH: 0161 720 2373

- Clinical photographs should not be routinely sent with the report.
- Photographs can be made available to social care, police or a court by asking them to contact the Subject Access Team on e mail: SAR.MFT@mft.nhs.uk.

**3.9 Investigations** – Please cee Appendix A ‘Guidance on arranging investigations for child protection medicals’

- All investigations to be discussed with the paediatric consultant leading on the safeguarding management of the child.
- All investigations are arranged in line with guidance from RCPCH.
- If a dental assessment is required, when there is concern about potential dental neglect, contact the school nurse and ask for the child to be referred to local dentistry service.
  For Manchester Children a referral could also be made to the Manchester community dental service via Mft.mcds-referrals@nhs.net. Referral form attached in Appendix D.

**3.10 Peer Review**

- Safeguarding peer review meetings are carried out regularly in line with the need from the department.
- There is an attendance record with minutes of the meeting.
- At peer review meetings there is access to the line drawings and/or photographs of visible findings or injuries being discussed
- At peer review meetings, there is access to the medical reports relating to the assessments being discussed, to review the wording of the opinions given.
- Terms of reference for peer review are in Appendix B.

**3.11 Service QI**

- Regular (minimum annual) monitoring and audit of aspects of the child protection medical assessment service are undertaken by our service.
- There are processes in place to collect feedback from service users to inform our regular monitoring.

- There are regular meetings with Children's Social Care and MFT Safeguarding nurses.

### 3.12 Clinician Support

- Child protection work by its very nature is often stressful for all concerned, including clinicians and allied health staff. Failure to recognise and address the emotional toll on staff who are exposed to this work can contribute to poor staff wellbeing and possibly contribute to staff avoiding this difficult area of work.
- Reflective supervision is available from named professionals in the organization.
- MFT also have an Employee Health and Wellbeing service which offers a range of services to their employees including psychological support. More information about this can be found on the MFT intranet (search employee emotional support) or use this link https://peopleplace.mft.nhs.uk/our-services/employee-health-and-wellbeing-service/psychological-wellbeing-mental-health-service/
- Support can also be found at the Employee Assistance Programme. This is a 24 hour help line, telephone 0800 028 2047
- In each area in MFT there are 'Mental Health First Aiders'. Information can be found on the MFT intranet or use this link https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/mental-health-first-aid

## 4 Child Protection Medical Report

- ALL Child Protection medical assessments should be followed up with a medical report, even if the conclusion is that the injury is accidental and there are no child protection concerns.
- The report will be the responsibility of the assessing doctor, with supervision from the lead consultant and should be checked and co-signed by the supervising consultant.
- The report should be completed and sent out within 10 working days.
- All medical reports should be completed on HIVE and the forwarded to the secretary of the lead consultant, who will disseminate out to relevant professionals.

**Reports should include:**

*See Appendix C for example of Child Protection report format*

- Author's name, status, and nature of involvement in the case along with their qualifications and experience.
- Name and date of birth of the child
- Date, time, and place of the examination.
- The reason for the assessment
- Who made the request
- Who was present (include the chaperone)
- Who gave consent

- Use non-medical language (or explain terms in brackets).

- Include positives and negatives in the report to avoid selective extraction of negative information
- Separate sections for history, examination, results, summary of assessment and opinion.

- **History**
  - Succinct details of circumstances of injury and the source of that information.
  - Include times and dates – try and show the timeline of events.
  - Highlight the current concerns/complaints/allegations.
  - Indicate the origin of any third-party information.
  - Use the child's own words where possible.
  - Relevant background of paediatric and social history.

- **Examination**
  - General overview of how the child presented including their physical appearance (clothing, hygiene), their behaviour (quiet and withdrawn/uncontrollable) and interaction with parent/carer and professional.
  - Include the child's height, weight, and head circumference (for infants)
  - General systems examination
  - A list of injuries – these should be numbered and described.

- **Investigations**
  - Summary of results and their interpretation.
  - Document if photographs were taken.

  - If there are outstanding investigations these should be stated. A supplemental report should be issued when the results are available along with a statement as to whether they have changed the opinion.

- **Interpretation**
  - Consider differential diagnosis.
  - This section can be used to describe any evidence from the literature which has helped you form your opinion – such as information from the Child Protection Companion or RCPCH systematic reviews.
  - Also to include information from other professionals that you may have discussed the case with, such as radiologists, haematology, orthopaedics etc
  - Link the information from your assessment, so it is clear to anyone reading the report why you have come to the opinion that you have.

- **Opinion**
  - <u>This is very important</u>. A statement should be made as to the likelihood of the injury being accidental or non-accidental.

Add:
- Any medical recommendations for future management or paediatric follow up.

- **The child protection report should routinely be copied to:**
  - Allocated social Worker.
  - Police officer.
  - GP.
  - Health Visitor (child less than 5 years age).
  - School Nurse (child greater than 5 years age).
  - Named Doctor for Child Protection on your site.
  - Safeguarding Nursing Team on your site.
  - Any other consultants involved in the clinical care of the child, including referring clinician.

- **The report should be signed by the clinician who completed the medical (including their GMC number) and the supervising consultant (including their GMC number).**

## 5 Equality Impact Assessment

EqIA assessment has been completed. This guideline refers to all young people, under 18 years of age who require a Child Protection medical examination

Awaiting outcome from this

| **Equality Impact Assessment**<br>Please record the decision whether the policy, service change or other key decision was assessed as relevant to the equality duty to:<br>• Eliminate discrimination and eliminate harassment.<br>• Advance equality of opportunity<br>• Advance good relations and attitudes between people | | | |
|---|---|---|---|
| Not relevant | | Relevant | |
| Where the decision was NOT RELEVANT, please record the reason for the decision below... | | Where the decision was RELEVANT, please record details of the outcome of the full impact assessment and summarise the actions that will be taken to eliminate or mitigate adverse impact, advance equality or justification for the impact. | |
| Please enter the EqIA registration Number: | | | |

## 6 Consultation, Approval and Ratification Process

The document has been reviewed by the Named Doctors and Named Nurses for ORC, Wythenshawe and NMGH. It has been sent to the acute paediatricians who complete child protection medicals at ORC, Wythenshawe and NMGH for review.

The document has been approved by the RMCH Safeguarding Committee and The Safeguarding Quality and Learning group.

The document will be reviewed every 3 years by the acute Named Doctors.

## 7 Dissemination and Implementation

Dissemination

- The guideline will be on the trust intranet.
- The guideline has been shared with all acute paediatric consultants who complete child protection medical examinations.
- The guideline will be shared at paediatric induction of new middle grade doctors who may need to complete a child protection medical examination as part of their role.

Implementation

**Implementation of Trust approved procedural documents.**

- The guideline has been shared with all acute paediatric consultants who complete child protection medical examinations.
- The guideline will be shared at paediatric induction of new middle grade doctors who may need to complete a child protection medical examination as part of their role.

Compliance with the guideline will be monitored by repeating the RCPCH Standards for Child Protection Medicals in 1–2 year time.

## 8 References and Bibliography


1) RCPCH Good practice service delivery standards for the management of children referred for child protection medical assessment, October 2020
2) Haematological evaluation of bruising and bleeding in children undergoing child protection investigation for possible physical maltreatment: A British Society for Haematology Good Practice Paper; Tina Bliss et all, BJHaem, July 2022
3) RCPCH Child Protection Companion, Chapter 9 - Recognition of Physical abuse; Chapter 16 - Reports and Records; Chapter 17- Photo Documentation as part of the child protection medical assessments.
4) Royal College of radiologists. The radiological investigation of suspected physical abuse in children, revised first edition 2018.

## 9 Associated Trust Documents

1) Diagnostic guideline for haematological evaluation of bruising and bleeding in children undergoing child protection investigation for possible physical maltreatment, Dr J Grainger, 2024
2) Safeguarding management of Injuries in Infants, Dr Wilkins, Dr O'Connor, Dec 2022
3) MFT 'Chaperone Policy', 2023

## 10 Appendices

Appendix A: Guidance on arranging Investigations for Child Protection medicals.

Appendix B: Terms of reference for Safeguarding Peer Review.

Appendix C: Example of Child Protection Report Format

Appendix D: Manchester Dental Referral Form

**Appendix A**

## Guidance on arranging investigations for Child Protection Medicals

All investigations to be discussed with the paediatric consultant leading on the case. Written consent is required for radiological investigations, including skeletal surveys.

### 1. Blood Tests:

### 1.1 Haematological investigations:

**First line investigations**: **Full blood count, blood film, basic coagulation screen (PT, APTT, fibrinogen)**

**Second line investigations**: Paediatric consultant leading child protection assessment to discuss with paediatric haematology consultant at RMCH (For more information see Diagnostic guideline for haematological evaluation of bruising and bleeding in children undergoing child protection investigation for possible physical maltreatment, Dr J Grainger, 2024)

**Consider laboratory investigations when**:

- *There is bruising in a pre-mobile child*
- *There is unusual bruising pattern and/or bleeding that is out of proportion to the purported mechanism.*
- *There is bleeding at acritical site (eg intracranial haemorrhage, retinal haemorrhage, gastrointestinal haemorrhage, intra spinal haemorrhage, hemarthrosis) with no correlating history of trauma or other explanation that adequately accounts for the bleeding).*
- *There is a suspicion of coagulopathy from personal history, family history and/or examination*.

**Examples of clinical presentations that are NOT LIKELY to require haematological investigations are:**

- *A child in whom a diagnosis of probable accidental injury is made and there is no clinical suspicion of an underlying haemostatic disorder.*
- *A child who has bruising that carries the imprint of a hand, ligature or implement.*
- *An independently mobile child with no history of bruising with minor trauma from an early age and no underlying suspicion of an underlying haemostatic disorder.*
- *A single bruise on the ears, neck cheeks, eyes, or genitalia in a fully mobile child with no clinical suspicion of acquired haemostatic disorder*.
- A history of major haemostatic challenge with no excessive bleeding (e.g., tonsillectomy) and no clinical suspicion of acquired haemostatic disorder, e.g., widespread petechiae, bruising and/or mucosal bleeding.
- Physical findings on examination consistent with a clear medical diagnosis: lesion not the result of inflicted injury, e.g., congenital dermal melanocytosis, congenital melanocytic naevi, striae.

*Information from RCPCH Child Protection Companion, Chapter 9*

### 1.2 Biochemistry investigations:

**Bone studies (calcium, phosphate and alkaline phosphatase), Vitamin D levels, parathyroid hormone level**

**Indication:** *The presence of a fracture where physical abuse is suspected.*

## 2. Radiology investigations:

### 2.1 Skeletal survey

**Indication:**
*A full skeletal survey is recommended in all children less than 2 years of age when physical abuse is suspected. If a decision is made NOT to do a skeletal survey, the reasons for the decision should be carefully documented.*

Skeletal survey should also be considered in:

a) *Severe inflicted injury in a child older than 2 years*
b) *A child with localised pain, limp or reluctance to use limb where abuse is suspected.*
c) *A child with a previous history of skeletal trauma and suspected abuse.*
d) *A child with unexplained neurological presentation or suspected acute head trauma*
e) *A child dying in suspicious or unusual circumstances (will be as part of PM investigations)*
f) *A twin of an infant (or sibling less than 2 years old) with signs of physical abuse*
g) *Older children with a disability and suspected physical abuse.*

Second Skeletal survey:

RCPCH recommends a repeat skeletal survey 11-14 days after the initial skeletal survey. If there is a decision not to repeat the skeletal survey, this should be made by the consultant responsible for the child protection concerns and clearly documented in the notes.

Second Skeletal survey is to:

a) *To check suspicious or unconfirmed findings on the initial survey, for example to confirm normal variants.*
b) *To look for additional injury, in particular rib fractures and metaphyseal fractures not visible on first survey as they were acute and difficult to visualise. A second skeletal survey has been found to provide additional information and may increase the yield of fractures by up to 27%.*
c) *To give more information about the age of the fracture, as directed by the radiologist.*

**How to arrange a skeletal survey:**

a) Decision that skeletal survey is needed is made by the consultant paediatrician responsible for managing safeguarding concerns.
b) Request SS on HIVE
   - in the request document the reason for requesting a SS, such as ? NAI or safeguarding concerns
   - request as an 'in patient'
   - Put in the request if sedation will be needed (paediatric consultant decision to give sedation or not)
c) Contact consultant paediatric radiologist on your site 'vet' the request. At Wythenshawe contact Dr Vidula Godhamgaonkar (deputy) via HIVE message. At RMCH contact the duty radiologist on vocera (0161 701 9603) and ask for paediatric radiologist on call. At NMGH call or HIVE message paediatric radiologists, Dr Sabrina Alam or Dr Debra Harris.
d) Contact radiographers ask to speak to senior radiographer (band 7) to arrange a time. At Wythenshawe contact on 0161 291 2190, at RMCH contact on 0161 701 4009, at NMGH 0161 720 2247
e) Consent for skeletal survey needs to be taken on consent form 2 (if being sedated) or consent form 3 (if not sedated) needs to be completed on HIVE.
   - Give parents either the information sheet on SS or booklet 'Child Protection Investigations explained'.
   - Take consent for second skeletal survey before discharge. This is especially important if the child is going into foster care.
f) A qualified nurse needs to go with child to have SS (so let the nurse in charge know the time of SS)
g) Parents can be with the child during the skeletal survey if that is supportive for the child.

**How to arrange second skeletal survey**

a) This should be completed 11-14 days after the 1st SS and will usually be completed after discharge.
b) Request SS on HIVE. To request while still an inpatient go to 'future outpatient orders'. Order skeletal survey, select your site (WYT, RMC or NMG) and as 'day case'. State that this is a second SS and if sedation will be given or not.
c) Also request 'Day case order' and find the 'Prep for Hospital tab' – you can then get consent and prescribe sedation (if needed) in preparation for 2nd skeletal survey.
d) Contact radiographers as previously to arrange a time and date.
e) Message paediatric radiologists to let them know that the 2nd SS has been requested.
f) Inform families, foster carers, CSC as appropriate (make sure that the contact details of who the child is discharged home with is documented)
g) Inform nurse in charge and make sure that the date in in the ward diary (so it can be planned for a qualified nurse to take down for SS)
h) Take consent for 2nd SS before discharge from ward.

Skeletal surveys are carried out to the technical standards recommended are in the RCR (Royal College of Radiologists) guideline ‘The radiological investigation of suspected physical abuse in children’ 2018.

### 2.2 Neuroimaging

Neuroimaging is the definitive diagnostic investigation and should be performed where abusive head trauma (AHT) is suspected. This includes children with:

a) *Unexplained sudden collapse.*
b) *Neurological symptoms and signs.*
c) *Enlarging head circumference*
d) *Persistent uniform cerebrospinal fluid (CSF) blood staining.*
e) *Infants less than 12 months of age when physical abuse is suspected.*

CT head scan is recommended as part of the investigation of any infant less than 1 year of age where there is evidence (signs or suspicion) of physical abuse and should be considered in any child up to the age of 2 years.

First line investigation is CT scan of head.

If there are positive signs on CT scan, a follow up MRI scan should be performed in 2-5 days. Both MRI head and MRI of whole spine should take place.

Further follow up scans may be clinically indicated, after discussion with lead paediatric consultant and radiology consultant.

**How to arrange a CT or MRI scan:**

a) Discuss with paediatric consultant responsible for child protection concerns about the imaging required.
b) Obtain consent from a person with parenteral responsibility for the scan.
c) Consider if sedation will be needed (see sedation guideline)
d) Request the investigation on HIVE.
e) Discuss with the duty radiologist or if the scan is urgent with the ‘on call’ radiologist via switch board or vocera.
f) If the scan is not urgent it will usually be completed with the skeletal survey. Ensure that the child has adequate analgesia and consider whether sedation is required.
g) If possible, discuss with the paediatric radiologists before scan is completed, contact afterwards so scan can be reported.

Additional investigations should be considered in any child with a possible AHT:

a) FBC at presentation repeated after 24-48 hours may demonstrate a rapidly falling and low haemoglobin level.
b) Coagulation studies will exclude major bleeding disorders, secondary coagulation defects are often recorded in the seriously ill child.
c) Septic screen to exclude infection, subdural collections can be associated with meningitis.

d) Urine sample for toxicology screen.
e) If glutaric aciduria is clinically suspected, neonatal blood spot screening results should be reviewed and a metabolic specialist should be consulted to advise on appropriate investigations; fibroblast culture may be required from skin biopsy.

## 3. Photography

a) Photographs should be taken of all significant visible findings and these photographs should be of a standard that is suitable to be used in court. The photographer should use a ruler in the photograph to size the injury.
b) Consent should be obtained for medical photography.
c) Photographs should be taken of significant visible findings at the time of the child protection medical assessment or the next working day.
d) 'Out of hours' photographs can be taken on Rover device which directly uploads to the patients HIVE electronic records. Written consent to take the photographs should be obtained.

e) **Medical illustration** – complete a request on HIVE.
Working hours Mon- Fri 08.30 – 16.30.
Telephone:
RMCH: 0161 276 4139
Wythenshawe Hospital: 0161 291 5832
NMGH: 0161 720 2373

f) Clinical photographs should not be routinely sent with the report.
g) Photographs can be made available to social care, police or a court by asking them to contact the Subject Access Team on e mail: SAR.MFT@mft.nhs.uk.

## 4. Ophthalmology review

**Indication**:
*Where there are concerns about abusive head trauma.*

**To arrange an ophthalmology review**:

ORC and Wythenshawe: Contact the on-call ophthalmology registrar at Manchester Eye Hospital on 0161 701 4163 (or via switchboard) and arrange for the child to be seen in an urgent eye clinic. The registrar will advise which clinic to take the child to. Complete a referral to ophthalmology on HIVE. The child must be accompanied by a member of staff, even if the parents will also be present at the appointment. The outcome of the assessment will be recorded on the child's HIVE record.

NMGH: email urgentreferrals@nca.nhs.uk and call the Ophthalmology registrar at Rochdale Infirmary, via switch board.

## 5. Forensic Dentistry

**Indication:**

- *Human bites are always inflicted injuries which may or may not be abusive in nature. They are currently the only physically abusive injury with the potential to identify the perpetrator from the injury itself where salivary DNA is present. Very rarely, clear dental characteristics may also assist with this.*

- *Many human bites are not recognised as such and are dismissed as bruises or other injuries. Any bruise with the shape of opposing curves should be treated a suspicious of a bite.*

- *Early recognition of a potential bite may enable forensic evidence to be collected which may identify the person responsible. The police or a forensic physician may be able to swab the injury for DNA analysis and/or seize clothing which may have been bitten through for analysis. It is important to advise against washing the bitten area. DNA can be obtained 48 hours after the bite or if the area is unwashed 168 hours (7 days).*
- *Ideally the services of a Forensic Odontologist should be sought by the police to consider if there are features which allow confirmation that this is a human bite mark. Occasionally there may be features which allow a Forensic Odontologist to give an opinion on the age or identity of the person responsible.*

**Role for paediatrician:**

a) Discuss referral to a Forensic Odontologist at the strategy meeting stage and this would be arranged by the police. It is unlikely that a joint assessment will be able to take place with a Forensic Odontologist and paediatrician so the paediatrician should perform a medical assessment in the normal way.
b) Paediatrician to give an opinion within their area of expertise.
c) The injury should be measured and document on a body map.
d) Medical photography should be obtained.

## 6. Other investigations to consider depending on presentation:

a) Urine toxically
b) U&E, LFT, Lipase
c) Abdominal USS, abdominal CT scan or other x rays
d) Swabs
e) Urine culture
f) Many more depending on presentation.

## Information and guidance from:


1) Royal Collage of Paediatrics and Child Health, Child Protection Companion, Chapter 9
2) Haematological evaluation of bruising and bleeding in children undergoing child protection investigation for possible physical maltreatment; British Society for Haematology, Sept 2022

3) Royal College of Radiologists guideline ‘The radiological investigation of suspected physical abuse in children’ 2018.

Associated Trust guidelines:

4) Diagnostic guideline for haematological evaluation of bruising and bleeding in children undergoing child protection investigation for possible physical maltreatment, Dr J Grainger, 2024
*5)* Safeguarding management of Injuries in Infants, Dr Wilkins, Dr O’Connor, Dec 2022

## Appendix B: Terms of Reference for Safeguarding Peer Review

### MFT Acute Services
### Child Protection Peer Review Process

### Framework and Terms of Reference:

1. It is a requirement for doctors undertaking Child Protection or Section 47 medicals to participate regularly in Safeguarding Peer Review. Peer review processes in the acute services at RMCH, Wythenshawe Hospital and North Manchester General Hospital are aligned with the Good Practice Recommendations for Peer Review in Safeguarding; RCPCH May 2012, updated 2022.

**2. Purpose:**

- To provide a proactive culture of learning, professional development and support, education and training, service improvement and improvement of multiagency processes.
- To provide support in a non-hierarchical environment, decrease professional isolation, promote the sharing of best practice and understanding of the complexities of safeguarding situations.
- Participation in Peer Review provides service-level assurance that case findings are objective, opinions are evidence-based and reports meet professional standards.
- The fact that a clinician regularly attends effective Peer Review may help reassure the courts as to the quality of their work. It will also contribute to the evidence collected by a clinician for the purposes of annual appraisal and revalidation.

**3. Aims:**

- To retrospectively review cases, photo-documentation, the medical report/witness statement, the evidence-base, and multiagency process/working/communication.
- To provide a proactive culture of learning, promote quality improvement, maintain high evidence-based clinical standards, provide training and support.
- To provide a supportive environment to discuss cases with peers undertaking similar work, in order to help prevent professional isolation and aid sharing of best practice.

**4. Objectives of Peer Review:**

- To provide time for discussion of cases in a non-threatening atmosphere seeking to minimize time pressure at the meeting within the context of any concurrent clinical exigencies.
- To view photo documentation accompanying the case presentation and provide an objective description of findings.
- To review cases to ensure appropriate evidence-based management and opinion.
- To provide support through the sharing of professional experiences of others
- To help identify areas for additional training for the group and/or individuals concerned.
- To stimulate ideas for audit and/or research.

**5. Membership:**

- All paediatricians conducting child protection medicals.
- Paediatricians in training to access training opportunities.

- Members of the MDT involved in safeguarding to access training opportunities.

## 6. Process:

- Peer review will meet regularly to reflect the case load managed. At RMCH this is twice monthly. At Wythenshawe this is at least 8 times a year. At NMGH once every 4 weeks.
- Attendances are recorded and regular attendance is expected and monitored.
- The meeting is chaired by the Named Doctor for Safeguarding Children, or a nominated deputy.
- Minutes of the meetings are made, documenting attendance list, learning points and actions.
- Examining doctors should be present for the discussion of the case unless otherwise agreed.
- Photographic evidence should be produced and reviewed prior to case information being shared.
- Where possible the group will seek a consensus view on the case. The lead consultant for each case is responsible for ensuring any actions required are carried out.
- Colleagues' names and opinions should not be used without consent in reports.

Dr Clare Wilkins
Dr Louise O'Conner
Dr Mercedes Osuagwu
Named Doctors for Safeguarding Children,
MFT Acute Services,
July 2022

### Definition

- **Peer Review** is the evaluation of work by colleagues in the same field in order to maintain or enhance the quality of the work or performance. It is a process to ensure that a child protection assessment and the medical opinion are as robust, accurate and evidence-based as possible.
- All aspects of a child protection case may be Peer Reviewed including the findings, interpretation of findings, documentation, case management, and report or witness statement.
- The word peer is often defined as a person of equal standing. However, in the context of Peer Review, it is generally used in a broader sense to refer to people in the same profession who are of the same or higher ranking.
- Peer Review is a form of reflective practice. Peer Review involves a group of peers discussing and providing opinions which the individual can accept or reject.

**Appendix C**

## GUIDANCE ON THE FORMAT FOR DICTATING REPORTS FOR CHILDREN'S SOCIAL CARE

### PRIVATE & CONFIDENTIAL – MEDICAL REPORT

Name, address, DOB, NHS number

**Date of Child Protection Medical:**

**Time of Examination:**

**Name of Examining Doctor:**

**Name of Supervising Consultant:**

**Venue:**

**Medical Examination Requested by:**

**Attending Social Worker(s):**

**General Practitioner:** (GP read code: 9FZ)

**School/ Nursery:**

**Subject of a Multi-agency Child Protection Plan:** YES / NO (if yes, which category)

**Persons Present at Consultation:**

1) **Your name, qualifications, grade and years in child health.**

   Add in 'Child protection medical completed with written consent from ……..'

2) **Brief summary of concerns:**

3) **History:**

   Current concerns/complaints/allegations – in the child's/parent's own words

   - Information from others – whom eg 'social worker told me…….'

4) **Relevant family history & social History:**

5) **Medical history:**

   Including relevant past medical history
   - Developmental milestones/ school progress
   - Behavior

6) **Examination:**

General – quiet & withdrawn / uncontrollable; cleanliness, any signs of neglect

Growth including height and weight and centiles

List injuries / bruises – size, site, shape, colour,

General examination including developmental findings, if appropriate.

**7) Investigations:**

Eg skeletal survey, CT scan, blood tests

Photos taken or not

**8) Interpretation:**

Interpretation of all clinical findings, both positive and negative, for example:

a) The group of bruises (nos 6, 7, 8) on the shins would be in keeping with normal day to day activities.
b) The bruises 1 and 2 on the front of the right upper arm together with bruise 3 on the back of the right upper arm could be indicative of a firm grip.

9) **Opinion and conclusion**: (as clear as possible)

Include – opinion whether this may be abuse

Any recommendations
Any follow up arrangements

**Doctors name:** **Consultant Name:**
**Signature:** **Signature:**
**Professional grade:** **GMC number:**

**GMC number:**

**Copies to:** **Consider copies to:**
Social worker (with phone no. and contact details)
GP
Health Visitor or School Nurse
Safeguarding Specialist Nurses for site
Community Safeguarding Team (eg. Manchester/Trafford/Stockport)
Police
Other professionals involved, eg Community Paediatrician, LAC nurse

CEW- Revised 2024

## Appendix D: Manchester community Dental Referral Form

**Community Paediatric Service**
The Coral Suite
Moss Side Health Centre
Monton Street
Manchester
M14 4GP
Tel: 0161 232 4552

**DENTAL REFERRALS**
**Community Child Protection Clinic- - Coral Suite**

| | | | |
|---|---|---|---|
| **Name:** *(Populated via EMIS)* | | | **DOB:** **Age:** *(Populated via EMIS)* |
| **Name Of Social Worker:** **Email address** | | **SW Base:** **Telephone Number:** **Mobile Number:** | |
| **Language Spoken By Child:** **Ethnic Origin:** *(Populated via EMIS)* | | **Interpreter Needed:** YES/NO | |
| **Additional physical / learning needs:** **(State if fit and well)** | | **Who has parental responsibility :** | |
| **Current Address:** *(Populated via EMIS)* | | **If in foster care/care home** **Parents Address:** | |
| **GP** | *(Populated via EMIS)* | | |
| **NHS No:** | *(Populated via EMIS)* | **Is the child known to Social Services** | **YES/NO** |
| **Health Visitor / School Nurse Base:** | | **Is the child subject to Child Protection Plan** | **YES/NO** |
| **Date last saw Dentist (if known): "State if never"** | | **If yes what Category:** | |
| | | **Is the Child Subject to Child in Need** | **YES/NO** |
| **Dental practice (if known):** | | **Is the child Looked After (LAC)** | **YES/NO** |
| | | **Is the child under Court Order** | **YES/NO** |

**Reason for dental referral: (please tick)**

| Please tick | |
|---|---|
| | **Pain** |
| | **Sleep disturbance** |
| | **Visible caries / poor dental hygiene** |
| | **Unmet dental need** |
| | **Expert opinion required** |
| | **Summary of concern (please specify)** |

**Timescales / Urgency eg. Court**

**Print Name of Referring Paediatrician:**
**Signed:** **Date:**

**Address: The Coral Suite, Moss Side Health Centre, Monton Street, Manchester, M14 4GP**
**Tel: 0161 232 4552**
**Email Address:- mft.cpcadmin@nhs.net**