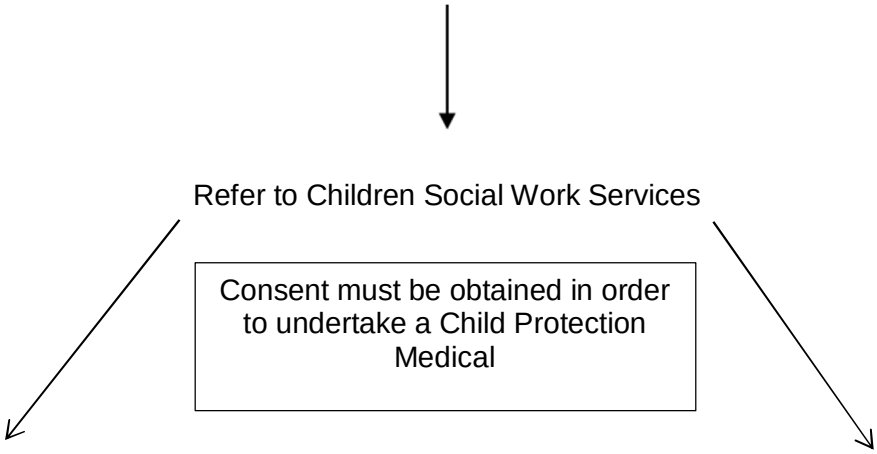
Leeds Multi-Agency Procedure for Professionals Requesting Child Protection Medicals Pathway

A professional is concerned a child may have suffered abuse



IN HOURS (Monday-Friday 09.00hrs to 17.00hrs)

Social Worker to contact Community Paediatric Department for an appointment for a Child Protection Medical on:

0113 2064327

If no appointment is available on the day and the Social Worker feels the Child Protection Medical is urgent then they must discuss this with the Community Paediatrician.

If not urgent then the Social Worker needs to arrange a suitable appointment as soon as possible. Please see Appendix 1 for child protection assessments booking guidelines.

Out of HOURS (17.00hrs to 09.00hrs, Weekends and Bank Holidays)

Social Worker to contact the 'On Call' Consultant Paediatrician to discuss the child's attendance at the Leeds General Infirmary for a Child Protection Medical on:

0113 2432799

If a child has been sexually assaulted please follow the Forensic medial pathway on the Leeds LSCB website.

If a child needs urgent medical attention do not delay call 999

Paediatric Assessments

When a Paediatric Assessment is necessary

Strategy Discussions must consider, in consultation with the paediatrician (if not part of the discussion or meeting), the need for and timing of a paediatric assessment. Consideration must also be given as to whether there are any other children in the household who may also require a paediatric assessment.

Paediatric assessments should always be considered necessary where there has been a disclosure or there is a suspicion of any form of abuse to a child.

Additional considerations are the need to:

- Secure forensic evidence;
- Obtain medical documentation.

In cases of severe neglect, physical injury or acute (recent) penetrative sexual abuse, the assessment should be undertaken on the day of the referral, where compatible with the welfare of the child.

Only suitably qualified health specialists may physically examine the child for the purposes of a paediatric assessment. Other staff should note any visible marks or injuries on a body map and document details in their recording.

Purpose of Paediatric Assessment

The purpose of a paediatric assessment is:

- To diagnose any injury or harm to the child and to initiate treatment as required;
- To 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 arrange for follow up and review of the child as required, noting new symptoms including psychological effects.

Consent for Paediatric Assessment/Medical Treatment

The following may give consent to a paediatric assessment:

- A young person of 16 and over;
- A child of under 16 where a doctor considers he or she is of sufficient age and understanding to give informed consent and is “Fraser Competent”;
- Any person with Parental Responsibility;
- The local authority when the child is the subject of a Care Order (although the parent/carer should be informed);
- The local authority when the child is Accommodated and the parent/carers have abandoned the child or are physically or mentally unable to give such authority;

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- The High Court when the child is a Ward of Court;
- A Court as part of a direction attached to an Emergency Protection Order, an Interim Care Order or a Child Assessment Order.

Where the child is the subject of ongoing Court proceedings, legal advice should be obtained about obtaining the Court's permission to the paediatric assessment.

It is generally good practice to seek wherever possible the permission of a parent for children under 16 prior to any paediatric assessment and/or other medical treatment even if the child is judged to be of sufficient understanding to give consent in their own right. If this is not considered possible or appropriate, then the reasons should be clearly recorded.

When a child is Looked After and a parent/carer has given general consent authorising medical treatment for the child, legal advice must be taken about whether this provides consent for a paediatric assessment for child protection purposes (the parent/carer still has full parental responsibility for the child). Where the local authority shares Parental Responsibility for the child, the local authority must also consent to the paediatric assessment.

A child who is of sufficient understanding may refuse some or all of the paediatric assessment, although refusal can potentially be overridden by a court.

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

- The medical practitioner may decide to proceed without consent; and/or
- The medical practitioner may regard the child to be of an age and level of understanding to give her/his own consent and be Fraser Competent.

In these circumstances, parents must be informed as soon as possible and a full record must be made at the time.

In non-emergency situations, when parental permission is not obtained, the social worker and manager must seek legal advice - see Section 9.2, Parental Consent above.

For additional guidance to doctors, see the Protecting Children and Young People - the Responsibilities of all Doctors' (GMC 2012).

Arranging the Paediatric Assessment

Paediatric assessments must take into account the need for both specialist paediatric expertise and forensic requirements in relation to the gathering of evidence.

Only approved Consultant Paediatricians, Police Surgeons or other suitably qualified specialists may undertake paediatric assessments carried out as part of a Section 47 Enquiry.

There should be only one paediatric examination of the child.

Where child sexual abuse is suspected, usually two doctors with complementary skills will conduct a joint paediatric assessment. A single doctor may carry out the assessment where he or she has the necessary knowledge, skills and experience for the particular case. For further guidance, see Guidance on Paediatric Forensic Examinations in relation to possible

child sexual abuse, September 2004, issued by the Royal College of Paediatrics and Child Health and the Association of Forensic Physicians (which can be found at the Royal College of Paediatrics and Child Health Website.

Consideration should be given to the gender of the examining doctor in consultation with the child and the parents.

Referrals for paediatric assessments should be made by the social worker, who should contact the on call senior doctor and also make him/her aware of the circumstances of the case. A senior doctor is available for consultation at all times. The police will arrange attendance of a Police surgeon if required. The extent of any questioning of the child by the doctor will depend on the type of abuse and the age and understanding of the child.

In planning the paediatric assessment, the social worker, the manager responsible, the Police CPPU and relevant doctor(s) must consider whether it might be necessary to take photographic evidence, for example, for use in care or criminal proceedings or where a second opinion may be necessary. Where such arrangements are necessary, the child and parents must be informed and prepared and careful consideration given to the impact on the child.

If the child refuses to be examined or becomes distressed during the examination, consideration must be given to arranging a further examination.

Recording of Paediatric Assessment

At the conclusion of the paediatric assessment, the doctor must give a verbal report explaining his or her findings to the social worker/Police officer attending, followed by a written report as soon as practicable.

Disclosure of the information contained in the report to the parent(s) of the child and/or the child should be agreed in consultation with the Children's Social Care Service and the Police.

The report should include:

- Date, time and place of examination;
- Those present;
- Who gave consent and how (child/parent, written, phone or in person);
- A verbatim record of the carer's and child's accounts of injuries and concerns noting any discrepancies or changes of story;
- Documentary findings in both words and diagrams;
- Site, size, shape and where possible age of any marks or injuries;
- Other findings relevant to the child e.g. squint, learning problems, speech problems etc;
- Confirmation of the child's developmental progress (especially important in cases of neglect);
- Time examination ended;
- Medical opinion of the likely cause of injury or harm.

All reports and diagrams should be signed and dated by the doctor undertaking the examination.

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If criminal or family proceedings are instituted, the doctor's written report may be filed and served as well as the doctor's statement of evidence. The doctor's attendance at subsequent Court hearings may also be required.

Where there has been a joint paediatric assessment, the doctors involved should agree which of them will provide the report. If they disagree in their clinical findings and interpretations, they should both provide full reports and usually a further independent medical opinion should be obtained. For further guidance, see Guidance on Paediatric Forensic Examinations in relation to possible child sexual abuse, September 2004, issued by the Royal College of Paediatrics and Child Health and the Association of Forensic Physicians.

Appendix 1

Child Protection Assessments Booking Guidelines

Acute Child Protection daily clinic Slots

Appointments within 24 working hours

1. Physical Injury
2. Acute Sexual Assault
3. Vaginal Bleeding
4. Where Police investigation or protection from harm is required within 24 hours
5. Urgent FGM - at immediate risk of female genital mutilation

Acute sexual assault should be discussed with the covering consultant to ensure appropriate arrangements can be made e.g. if a joint exam with a Forensic Medical Examiner is necessary.

Siblings associated with an acute Physical Injury - should aim for next working day following index child

Appointments within 10 working days

1. Court requested examinations
2. Sexual Abuse where there is no forensic need but is of recent disclosure.
3. Neglect
4. STI e.g. GC/CT/suspected anogenital Herpes in a child under 12 or a non-sexually active teenager (where there is an urgent need see within 24 hours) all cases to be discussed with consultant of the day
5. Abandonment where there is a need for early assessment e.g. for court advice.

Suitable Child Protection cases for either acute or a follow up clinic (1 hour) but within 10 days of referral:

1. Historic sexual abuse e.g. Older than 3 months
2. Recurrent Vulvovaginitis with elements of concern (e.g. GP referral, Nephrology)
3. Suspected foreign body
4. Uncertain sexual abuse e.g. abnormal physical finding
5. Sexualised Behaviour
6. Anogenital warts
7. Suspected Child Sexual Exploitation
8. Contact with sex offender (either convicted or suspected) where there is no immediate need
9. Self-harming behaviour with child protection concerns.
10. Old physical injury
11. Longstanding neglect
12. Long standing emotional abuse
13. Cases where there is time to plan for an assessment
14. Sibling examination where there is no immediate need
15. Large families with no immediate need but to retain them under the same examining doctor (examining doctor to notify Jenny)
16. Vague concerns but requesting an overall assessment e.g. neglect
17. FGM where there are non-urgent child protection concerns.

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