



The Management of Child Protection Medicals for All Children **And Procedures for the Discharge of Children Under 2 Years of Age**

1. Child safeguarding concern in the community

1.1 Follow guidance in Working Together to Safeguard Children 2015 and BSCB procedures; including the procedure for 'Injuries to non - mobile infants or children' and contacting the Joint Investigation team (JIT).

1.2 Strategy discussion between Children's Social Care and Police

1.2.1 Decision made to request a Child Protection medical

1.3 Arranging a Medical

1.3.1 Children's Social Care should contact the Paediatric Secretaries Office on any of the following numbers, if they wish to arrange an acute Child Protection Medical:

Dr Gouta's Secretary – Julie – 01226 432277

Dr Kerrin's Secretary – Lynn – 01226 432278

Dr Gupta's Secretary – Sara – 01226 432860

Dr Bhimsaria's Secretary – Kerry – 01226 432280

Dr Tumi & Dr Hamdan's Secretary – Judy – 01226 434362

If Children's Social Care wish to arrange a medical for an historical case of suspected child sexual abuse the usual route would be to contact New Street Secretaries on 01226 433150 or 01226 433184. However, if these are not available, contact the Paediatric Secretaries as above and arrangements will be made with Consultant Community Paediatric colleagues and fed back to Children's Social Care. Please note this service is currently under review.

1.3.2 The Paediatric Secretaries will take the details and the Paediatric Consultant on Call / Consultant of the Week will speak directly to the Social Worker and agree an appropriate time and venue for the medical including who is likely to conduct it.

1.3.3 Generally the medical will happen later the same day with the aim that the medical takes place at a time which suits the needs of the individual child, fits in with the availability of Social Worker, and does not compromise clinical care for acute patients in the department. It is not possible, however, to provide an exact time and acutely unwell children will take priority.

- 1.3.4 The Paediatric Consultant should be able to give the Social Worker a name of the doctor most likely to examine the child (usually a Paediatric Registrar). It should be acknowledged, however, that this is subject to change if other demands necessitate this.
- 1.3.5 The assessments will usually take place on the Children's Assessment Unit. We endeavour to conduct the medicals with minimal delay after the arrival of the child (and indeed the time agreed for the medical should be when there is thought to be least likelihood of delay). However, it should be recognised that sometimes other emergencies arise which means that medicals are delayed in an unforeseen manner.
- 1.3.6 **Out of hours:** Children's Social Care should contact the Paediatric Registrar on call via hospital switchboard 01226-730000
- 1.3.7 **Acute sexual abuse medicals:** are arranged by the police at Sheffield Children's Hospital SARC. Barnsley Hospital children's safeguarding team are contacted by SCH following the examination in order that they can coordinate any local follow up required.

1.4 The Medical

- 1.4.1 The child should be accompanied by a member of the Children's Social Care Team, who is familiar with the current situation, and shares the details they have about the family with the examining doctor. Children's Social Care should already have had a strategy discussion with Police and will be aware if the Police are planning any action at this stage (such as a video interview). The child should also be accompanied by someone who has parental responsibility (or is at the very least contactable by telephone to give consent for the medical).
- 1.4.2 It is important that any specific communication or interpreting needs are identified before the assessment so that appropriate arrangements can be made in advance (e.g. face to face interpreting services).
- 1.4.3 Please note that the whole process of the medical assessment, from arrival to departure, may take between 2-4 hours.
- 1.4.4 BHNFT has an internal child protection medical document which indicates all of the information that should be gathered, and examination to be performed. In cases where photography is required, there is a specific protocol in place.
- 1.4.5 At the end of the examination, and once the attending Doctor has discussed the case with the on-call Consultant, the Paediatric Doctor should provide the Social Worker with a provisional verbal opinion. Immediate plans for the child should be ascertained e.g. going home to the family / into care. The Paediatrician should let the Social Worker know if any further paediatric input needs to be arranged (e.g. investigations, follow up etc.).
- 1.4.6 The Paediatrician should provide the Social Worker with a written summary of their findings and any further follow up required, pending the completion of a full Child Protection Medical Report.

- 1.4.7 At this stage there should be a discussion about the timing and distribution of the Child Protection Medical Report. The usual standard would be to provide a report within 5 working days. In some cases this report will be needed urgently, however, to enable Social Care to make swift decisions about the placement of the child. If this is the case it should be made clear at this time and the Paediatric team should expedite the report as far as possible.
- 1.4.8 All children under the age of 6 months who have a Child Protection Medical must also be seen by the Paediatric Consultant. Other cases will always be discussed with the Consultant prior to discharge; the Consultant will review the child personally if they think it is necessary or on request of the Registrar.
- 1.4.9 If the episode of assessment is thus completed then the Consultant on call, who has been consulted and may have seen the child themselves, will hold responsibility for the case.
- 1.4.10 If the child is admitted to the ward for further treatment / assessment then the Consultant of the Week will usually have on-going responsibility for the case. **If the child is admitted follow 2.2 onwards in the section below.**
- 1.4.11 On rare occasions there will need for a discussion between the Consultant of the Week and the Consultant on call the previous night to decide who is the most appropriate person to have on-going responsibility (e.g. based on degree of involvement with the case / parents / other agencies).
- 1.4.12 The name of the responsible Paediatric Consultant should be made clear in the hospital records and to Children's Social Care and other agencies as appropriate.

1.5 Child Protection Report

- 1.5.1 BHNFT has a detailed template for Child Protection Reports which should be followed when dictating the report. Additionally there are guidelines available on their intranet page as to how these reports are dictated, digitally sent to the secretaries for typing and checked by the examining doctor.
- 1.5.2 There is a system to send the checked report to the Consultant for adjustment as needed, and authorisation (even if the Consultant has not seen the child they will have some input into the opinion expressed, based on their knowledge of the case and how it might be interpreted).
- 1.5.3 The expectation is that Child Protection reports would be completed and ready to distribute to relevant agencies within 5 working days (ideally within 3 working days as advised in the RCPCH Child Protection Companion, 2013).
- 1.5.4 Some will have more urgency than this, and for some the timescale is less urgent.
- 1.5.5 Due to other pressures of clinical work some reports may take longer to turn around. However the Paediatric Department should commit to giving Child Protection Reports priority over most clinical matters other than unwell inpatients.
- 1.5.6 The Paediatric Registrars will need support and guidance from the Consultants both in the content of the reports and in ensuring that they are delivered in a timely fashion. As the Paediatric Registrars work a shift pattern it is not

necessarily easy for them to find time to dictate the reports. They need support from Consultants to have time to do so, and there should be monitoring by the Consultants responsible for individual cases to ensure the reports are made available in a reasonable time.

- 1.5.7** The majority of the reports will be typed and distributed by Dr Kerrin's secretary, and Dr Kerrin (as Named Doctor for Safeguarding Children, BHNFT) will provide some overview of consistency and quality at this stage, feeding back to paediatric staff as needed.

1.6 After the Production of the Child Protection Report

- 1.6.1** The Child Protection Report should be sent to the relevant person in Children's Social Care, to the School Nurse or Health Visitor, GP and to any other professionals involved. It should also be filed in the hospital notes. Additionally a copy goes to the Safeguarding Nurses at Barnsley Hospital and in the Community.
- 1.6.2** The safeguarding team at BHNFT will monitor the timeliness of reports and will be able to audit the efficiency of the system overall. They will also act as a safeguarded to ensure that intended actions happen (for example chest X-ray after skeletal survey).
- 1.6.3** Children's Social Care should provide written feedback about the outcome of their investigations, to BHNFT so that this can be filed in the notes. The report that Children's Social Care provides to indicate that a case is completed would be sufficient for this purpose and we acknowledge that this may be some time after the original medical examination. This feedback can be sent securely by email to barnsleysafeguardingchildren@nhs.net for onward internal distribution.

2. Safeguarding concern relating to a child in BHNFT

(For example presentation at Emergency Department, via Orthopaedics, Children's Outpatient Department, or Paediatric Ward)

- 2.1** The Paediatric team contact the Joint Investigation Team (JIT) by phone (01226-438831 or ext. 8831) as soon as they have assessed the situation and are concerned about the possibility of potentially significant safeguarding issues. Out of hours the Emergency Duty Team is contacted (08449841800), with a phone call to JIT the next working day. If staff are unsure how to proceed they should contact the Named Nurses / Midwife for advice on 2092 or the paediatric Consultant on call.
- 2.2** Many of the children where concerns are raised about non-accidental injury, leading to hospital admission, are under 2 years of age and there are national recommendations regarding the type of investigations to undertake if non accidental injury is being considered:
- Skeletal survey
 - CT head scan (under 1 year)
 - Specialist eye examination
 - Possibly blood tests / medical photography
- 2.3** The skeletal survey is a comprehensive set of X rays to look for evidence of fractures that might not otherwise be apparent on clinical examination (e.g. rib fractures). As this is such a specialist

(and lengthy: 1-2 hours) assessment, it is only done by certain trained radiographers and is not performed out of hours. The survey is reported by two Consultant Radiologists, with the aim to do this immediately after the procedure. Sometimes the images are difficult to interpret and a further opinion may be needed from specialists at Sheffield Children's Hospital.

2.3.1 The skeletal survey follows a strict protocol to maintain the chain of evidence, and requires evidence of consent from someone with parental responsibility. The survey is mostly used in pre-verbal babies and infants, though occasionally is indicated above the age of 2 years; however, it becomes technically more difficult in the older age group, who may not cooperate with the process.

2.3.2 Every child who has had a skeletal survey will need a repeat chest X ray 10-14 days later. This is to look for evidence of healing of fractures which may not have been apparent on the original films. The date of this repeat investigation will be documented in the hospital notes and carers will be given an appointment letter.

2.3.4 The CT scan may require sedation and may take a day or so to arrange. Sometimes this also needs viewing by Sheffield Children's Hospital specialists and occasionally a more detailed MRI scan at SCH is indicated.

2.3.5 It may therefore take a while to complete all the necessary tests, and the results may not always be straightforward to interpret.

2.4 There will be occasions when the time needed to complete these hospital investigations and / or for Children's Social Care to conclude their initial enquiries, will span a weekend. In such cases, there should be a strategy meeting on the ward, by early Friday afternoon, between the Paediatric Consultant (or occasionally a middle grade doctor), ward nurse, Social Care Manager and a Police representative. This is to ensure that a plan is in place relating to management over the weekend particularly for the information of the incoming Consultant of the Week.

2.5 Once medical management is complete and the child is ready (or about to be ready) for discharge, there will be a strategy meeting held between the Paediatric Consultant (or occasionally a middle grade doctor), a Social Care Manager and a representative from the Police. Others professionals may be invited as appropriate. This will be minuted by the administrative support of the Named Nurses Safeguarding Children, and will note the agreed decisions regarding discharge destination and any follow up plans; copies of minutes will be filed in the notes and distributed to those who attended.

2.6 In all cases, from the beginning of the admission consideration should be given to who is able to visit on the ward, supervision of the child on the ward, etc. This will require at the very least, regular telephone conversations between Children's Social Care and the nursing / medical staff caring for the child. All such conversations will be recorded in the hospital notes so the personnel involved and plans are clear.

2.7 A typewritten D1 discharge summary will be completed and a copy given to Social Worker, parent / foster carer before discharge – this will have details of follow up arrangements including date and time of repeat Chest X-Ray if the child has had a skeletal survey

2.8 A formal Medical Report will subsequently be produced as per section 1.5 above. This is typically done (or at least started) by the Paediatric Registrar who completed the initial medical examination. Note that this individual may be rostered to days off or nights by this stage. Also note that these cases are often complex and the analysis and wording of the report requires significant consultant input. The Consultant in charge of the case has responsibility for supporting the Registrar in producing a quality report in a reasonable timeframe and keeping Children's

Social Care updated if there are likely to be any delays. Children's Social Care will already have written information about the medical opinion from their minutes of the ward strategy meeting.

- 2.9** Written feedback should be received from Children's Social Care as in section 1.6.3 above.