Appendix 2: Example Medical Report

Introduction

[Child/rens name] e.g. *John Smith*

[Date of Birth] *(E.g. 26/10/2008)*

[Child's NHS No]:

[Child's Address]:

[Place of examination] e.g. *The Children's Centre, St Elsewhere Hospital,*

[Date of Examination] e.g. *19th January 2013*

[Time of Examination] e.g. *commencing at 13.45 hrs and finishing at 15.00 hrs*

[Examining Doctor]

[Supervising Consultant] (Where examining doctor is trainee)

Brief CV (if required)

I am a registered medical practitioner and hold the qualifications of [e.g. MB BS MRCPCH MMsc]. I work as [Role] e.g. Specialty Trainee year 7 in Paediatrics at [Place of Work] e.g. Department of Paediatrics, St. Elsewhere's Hospital and have worked in [Department] e.g. the Paediatric Department with supervision from [name of Consultant supervisor] Dr Sarah White, Consultant Paediatrician in that capacity since [date]. I have worked in paediatrics for [insert number of years].

History

Reason for examination

I was asked to examine [name] e.g. *John Smith* **[Date of Birth]** *(e.g. 26/10/2008)* **on [date] e.g.** *19th January 2013* **by** *[insert name and role] e.g. Davy Jones, Social Worker,* **following a referral from his school where the teacher had observed bruising to his eye and cheek and on further questioning John had said his mother had hit him.**

Present During the Assessment:

Present during the examination was [name of the child] *e.g. John Smith,* **his mother**, **[name]** *e.g. Patricia Smith,* **and his Social Worker [name]** *e.g. Davy Jones.* **John's** *s***tepfather [name]** *e.g. Andrew Smith* **and his half-sister [name] e***.g. Lucy Smith [***DOB***] 01/01/2010* **remained in the waiting area. [Name] e.g.** *Staff nurse Susan Black* **chaperoned the examination**.

Details of the assessment

The assessment was carried out at [place] e.g. *The Children's Centre, St Elsewhere Hospital,* **on [date] e.g.** *19th January 2013* **at [time] e.g.** *commencing at 13.45 hrs and finishing at 15.00 hrs*

Consent for the examination

Written consent for the examination, photography and sharing of the report with Agencies [names] *e.g. Social Care and the Police* **was obtained from [Mother/Father/Local Authority/Other]** *e.g. Patricia Smith, John's mother***, who has parental responsibility.**

Presenting History (include all recorded information)

Possible sources referred to could include:

- **Verbal report from allocated social worker**
- **Verbal report from parent/carer/child**
- **Medical notes**
- **Red Book**
- **X ray reports**

Summary information could include:

- **Summary information from accompanying social worker - describe as reported to you.**
    - *E.g. John's Social worker, Davy Jones, told me that John's teacher, Mrs Alice Short, at John's school, Woodall Primary School, had noticed that John had bruising to his eye and cheek two days ago [insert date]. Mrs Short had asked John what had happened and he is alleged to have said that his mother had hit him when he broke a plate. Mrs Short contacted Social Care and John was spoken to at school by Davy Jones but did not repeat this allegation.*
    - *Davy Jones spoke to John's mother, Patricia Smith, on the day prior to the examination [insert date], who reported that she had been playing catch with John and had thrown a tennis ball toward him and had hit him in the eye. John's stepfather and baby sister were reported to be in another room at the time.*
- **Summary information from parent/carer if primary witness – include the questions asked and the answer's given**
    - *E.g. I asked John's mother, Patricia Smith, what had happened? She said "I was playing catch with a tennis ball. I threw the ball and it hit John in the eye". I asked her what happened next and she said "I put cold water on his eye". I asked her if John was upset and she said "No". I asked her if anyone else saw what happened and she said "No".* **She said** *"his dad was in another room and Lucy was sleeping".*
- **Direct report from the child:**

- *E.g. John was subdued and did not respond when I asked him what happened.*
- *E.g. I asked John what happened – he said 'my mother hit me here" (John pointed to his Right cheek). John's mother then said "you're a liar, I'll tell your dad".*

Medical History

(Remember: Do not use medical jargon - Non-medical people will be the primary readership. If used please include in parenthesis following a non-medical explanation.)

Use the Red Book and health records if information regarding medical attendances, immunisations and growth pattern are relevant.

Symptom History

E.g. John is reported to be a healthy child with no symptoms on direct inquiry, no known allergies and is not on any medication.

Birth History (for younger children)

E.g. John was born at St Elsewhere's Hospital by normal delivery [insert birth weight] with no complications. He was bottle fed and weaned at four months. He has not yet received his 12 month vaccination or his preschool booster. His mother said she had never received any appointments.

Past medical history

E.g. John has had no significant illnesses or admissions to hospital.

John has attended A&E on three occasions [insert dates and reasons]

Other relevant family/social information

E.g. John lives with his mother, Patricia Smith, his stepfather Andrew Smith and his half sibling, Lucy Smith. Patricia and Andrew are unemployed. John has no contact with his natural father, Wayne Hunter. Davy Jones, social worker, reported that Patricia and Wayne separated following significant domestic violence when John was a baby. Davy Jones also said that Woodall Primary School have reported that both Patricia and Andrew have appeared late to collect John from school and on several occasions (documented in school's referral to Social care) have behaved aggressively and smelt of alcohol.

On direct questioning Patricia denied any alcohol, substance use or domestic violence but reported that both she and Andrew smoke. The family have two Rottweiler dogs. The family live in a two bedroom council house that is reported as damp.

Davy Jones reported that there were concerns re the state of the home when he visited as there were dog faeces on the floor, no carpets, two broken windows upstairs and John was sleeping on a soiled mattress on the floor of the living room.

Developmental assessment/school progress

E.g. John's mother reported that John reached all his milestones at the right time except for his speech. He receives Speech Therapy at school. His mother also reported the Health visitor had referred John to the Community eye clinic for a squint and was awaiting an appointment. The Social Worker reported that three appointments had been sent but not attended. John's mother said "maybe the dogs ate the letters".

A report from Woodall Primary School given to Davy Jones has identified that John is making slow but steady progress. He is reported to be a quiet child but can be easily frustrated on account of his speech delay. He tends to play alongside his peers rather than mixing and can at times be aggressive to other children.

Patricia Smith reported that John is boisterous at home and does not like his sister, often stealing her toys.

Examination

Who was present for the examination?

E.g. Patricia Smith, John's mother and chaperone [insert name and title] e.g. Staff Nurse Susan Black.

Give an overall account of John's presentation, demeanour and behaviour:

E.g. John was subdued throughout the assessment gave no eye contact and responded to questions with a nod. He had grubby clothes, active head lice, dirty hands and feet.

E.g. John was appropriately /dressed, clean and tidy.

Provide growth parameters

Height	[height] cm	[centile]
Weight	[weight] kg	[centile]
Head circumference	[OFC] cm	[centile] (under 1 year olds)
BMI if overweight		

Injuries and explanation given for each injury (If no explanation given please document this)

Remember to document all injuries on body maps and list bruises including the explanation

- *A series of five horizontal, parallel, linear, petechial bruises (fine pinpoint bruises due to broken tiny blood vessels) each measuring 5cm x 0.1 cm, and each 1cm apart from the other, present on the outer aspect of the right cheek extending from below the right eye to the jaw. John gave no explanation. His mother said 'I threw the tennis ball and hit him in the eye'*
- *A healed scar measuring 1.2cm x 0.2cm was present on the right forehead. Mother said this was sustained by a head injury three years ago when he fell off a slide at the park.*
- *A linear scratch mark 2cm below the left shoulder blade. Mother did not know how this happened.*

Describe the systems examination

E.g. *John had a right sided convergent squint (his right eye was turning inwards) and his teeth had a number of dental caries.*

E.g. General physical examination including ear nose and throat (ENT), cardiovascular, respiratory, neurological and abdominal examinations were otherwise normal.

Developmental assessment

E.g. I assessed John's development using the 'Schedule of Growing Skills' [The Schedule of Growing Skills (SGS) is a recognised tool used to assess a child's development across nine key areas]

The assessment revealed John has delayed expressive speech development.

Summary and Opinion

[Summarise the assessment and give an opinion regarding any concerns and the cause of the injuries providing a rationale for having reached a particular conclusion]

E.g. I saw John Smith (DOB 26/10/2008) on 19th January 2013 following a referral from Davy Jones, Social Worker at St Elsewhere's Hospital with bruising to his eye and cheek on 19th January 2013. John was accompanied by his mother, Patricia Smith and Social Worker, Davy Jones for the assessment. The examination was chaperoned by Staff Nurse, Susan Black. Written consent for the assessment was obtained from Patricia Smith.

John has alleged to his school teacher, Mrs Alice Short that his mother hit him on the cheek. John repeated the allegation to me today at the assessment. Patricia Smith reported John's

injury to his cheek and eye occurred when she threw a tennis ball which hit him in the eye, during play.

On examination John had a series of five horizontal, parallel, linear, petechial bruises (fine pinpoint bruises due to broken tiny blood vessels) present on the outer aspect of the right cheek extending from below the right eye to the jaw (numbered 1 in the report).

In my opinion the bruising to John's right eye and cheek is consistent with a forceful blow from an outstretched hand and consistent with the history given by John to his teacher and myself. The history that his mother gave of the account was not compatible with the injuries.

Reference the evidence base (where available)

E.g. *Abusive bruises are often located away from bony prominences and are found predominantly over soft tissue areas such as the cheeks (Maguire S, Mann MK, Sibert J, Kemp A. Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? Archives of Disease in Childhood 2005;90:182-6). Petechial haemorrhages in association with bruising are a strong predictor of abusive injury (Nayak K, Spencer N, Shenoy M, Rubithon J, Coad N, Logan S. How useful is the presence of petechiae in distinguishing non-accidental from accidental injury? Child Abuse & Neglect 2006;30(5):549-55).*

The forehead scar (numbered 2 in the report) is compatible with the history given. The linear scratch to John's upper back (numbered 3 in the report) could be accidental but it would be useful to explore the source of the injury further with John.

Additional information

E.g.: There are a number of indicators of neglect of John's needs to include his failure to attend three appointments for his squint (John is at risk of losing the vision in his eye if his squint is not treated), his active head lice, grubby appearance, moderate dental decay and his delayed vaccinations. The reported house conditions and the school's concerns add to the picture and require further investigation.

I assessed John as having adequate growth and an expressive speech delay.

Immediate Action (please highlight the people responsible for each action)

E.g. I arranged for John to have blood tests to exclude a clotting disorder.
Photographs were taken of the injuries by the medical illustration department.

Follow up arrangements and any actions/recommendations

E.g. I arranged to see John for follow up and review of the results in one week's time. The appointment was handed to his mother and Social worker.

John requires re-referral for his squint to the ophthalmologist and a referral to a dentist which I have arranged.

I would recommend an assessment of John's half sibling, Lucy Smith.

Copies of report to be sent to

[List] e.g.

- Allocated Social Worker [name]
- Children's Social Work Child Protection co-ordinator [name]
- General Practitioner [name]
- Health Visitor [name]
- Named Doctor/Nurse for Child Protection [name]
- Other [name]
- Parents [name]