Appendix 3: Police Statement Example

Statement of Witness

(C.J. Act 1967, S.9; M.C. Act, 1980, S.102; M.C. Rules, 1981,r.70)

Statement of	[doctor's name]
Age of Witness	Over 21
Occupation	Registered Medical Practitioner
	[Role] e.g. Specialist Registrar in Paediatrics
Contact Number	[number]

This statement consisting of [number] pages signed by me, is true to the best of my knowledge and belief, and I make it knowing that if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated the [date] Ref: [child's name]

Signed ……

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

Optional inclusions: I am up to date with my child protection training and have attended level 3 courses on safeguarding children. I regularly attend peer review meetings.

Introduction

I have been asked to prepare this report by [name] e.g. DC X of [Agency] e.g. the Child Abuse Investigation Team in Y.

It concerns my examination of [name] e.g. John Smith [Date of Birth] (e.g. 26/10/2008) 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.

Present during the examination

Child	[name]	*e.g. John Smith*
Mother	[name]	e.g. Patricia Smith
Stepfather	[name]	*e.g. Andrew Smith*
Sibling	[name]	e.g. Lucy Smith DoB 01/01/2010
Social Worker	[name]	*e.g. Davy Jones*
Other	[name]	e.g. Staff Nurse Susan Black

Reason for examination

I was asked to examine John Smith by *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 on [date] e.g. *19th January 2013.*

Consent for the assessment

Written consent for the examination and photography was obtained from [Mother/Father/Local Authority/Other] e.g. Patricia Smith, John's mother, who has parental responsibility.

Presenting History

Include all recorded factual information

Possible Sources referred to could include:

- Summary information from accompanying social worker - **briefly describe as this is hearsay but provides the context for the examination.**
    - *E.g. The Social worker [insert nane] told me that John's teacher [insert name and school] had noticed two days prior to the examination that John had bruising to his eye and cheek. John had alleged to his teacher that his mother had hit him. John did not repeat this allegation to the social worker [insert name].*
    - *The Social worker [insert name] spoke to John's mother on the day prior to the examination, who reported that she had been playing catch with John and had thrown a tennis ball toward him which had hit him in the eye.*

- Summary information from parent/carer if primary witness – **include the questions asked and the answers given**
    - *E.g. I asked John's mother [insert name] e.g. 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 John's mother what happened next and she said "I put cold water on his eye". I asked her if John was upset and she said "No".*

- 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)*

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. John has no contact with his natural father, Wayne Hunter.

Developmental assessment/school progress

E.g. John's mother reported that he has delayed speech development and receives Speech Therapy at school. His mother also reported the Health visitor had referred him 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.

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.

Overall account of the child(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

- *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. No abnormalities were found in the Ear, Nose, Throat, cardiovascular, respiratory, neurological or abdominal examinations.

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.

Other healthcare needs

[Issues around healthcare needs that are not currently met.]

E.g. John had a right sided convergent squint (his right eye was turning inwards)

Summary and opinion

[Give an opinion regarding the cause of the injuries providing a rationale for having reached a particular conclusion]

E.g. In my opinion/experience the bruise below John's right eye extending to his jaw (labelled 1) is consistent with a forceful blow from an outstretched hand and consistent with the history given by John to his teacher. 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. I have further concerns in relation to his clinical presentation. I assessed John as having an expressive speech delay. His failure to attend three appointments for his squint, his active head lice, moderate dental decay, grubby appearance and his delayed vaccinations are of concern and neglect of his needs should be considered in the absence of an adequate explanation.

Immediate action (highlight the people responsible for each action)

E.g. I arranged for John to have blood tests to exclude a clotting disorder and medical photography to document the injuries.

Follow up arrangements

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.