Chapter 5: Good Practice Recommendations

Every substantive chapter in this document contains good practice recommendations. All paediatricians should have due regard to these and should note that the list is revised in line with chapter updates (where necessary).

A full list of the good practice recommendations can be found below:

5.1. The Medical Assessment and Admission to Hospital (Chapter 6)

1. **The examining doctor**
    - The assessment of the child should be carried out by a paediatrician with Level 3 competences as per Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff[1].
    - Where a trainee carries out the assessment, they should be supervised by a consultant or senior paediatrician.

2. **Timescales**
    - All child protection assessments should be carried out within timescales appropriate to the type of abuse and the requirement for collection of evidential samples:
        - Physical injury: within 24 hours
        - Acute sexual assault: as soon as possible to obtain forensic evidence and prevent
        - pregnancy and infection
        - Historic sexual abuse, neglect or emotional abuse: the referral should be assessed according to clinical need and requirement of the child protection process. Children should not be kept waiting for more than 10 working days from the point of referral, unless there are clear mitigating factors agreed by all parties
        - Where police investigation or protection from harm is required: within 24 hours.

3. **Consent**
    - Informed consent for the paediatric assessment should be obtained and recorded (see Chapter 7).

4. **Chaperones**
    - Paediatric assessments should be undertaken with a chaperone present.

5. **Assessment of child**
    - All children and young people should be holistically assessed in child-friendly clinical environments appropriate to their age and clinical presentation with the necessary equipment and access to any investigations.
    - Other children in the family should always be considered in relation to their need for assessment.

- Appropriate time for the assessment is required for:
    - Detailed history from relevant parties
    - Developmental history
    - Observation of child interactions with parents and other people present
    - General and detailed examination
    - Relevant investigations
    - Documentation.
- The paediatrician should analyse, interpret their assessments and provide an opinion for the multiagency process.
- Paediatricians should seek advice when they have concerns and not work in isolation.
- All paediatricians should participate in regular safeguarding peer review.

6. **Communication with the child and family**
    - The paediatric assessment should be sensitive to the child's needs: the child should have an understanding as to why the assessment is taking place, be able to express their wishes and feelings, and participate in decisions affecting them.
    - Children should be given the opportunity of speaking alone as appropriate for their age and development.
    - The outcome of the assessment should be communicated to the child in a manner sensitive to their age and understanding and to the parents/carers.
    - If there is any suggestion of any language or communication difficulty for the child or parent, it is essential to work with a facilitator trained in safeguarding, e.g. a registered interpreter or an individual trained in sign language.

7. **Communication with the multiagency team**
    - The outcome of the assessment should be communicated to the agencies involved in safeguarding the child.
    - Verbal information to children's social care and the police should be followed up in writing with a formal report within three working days of an assessment.

8. **Documentation**
    - Clear contemporaneous documentation of all information relating to the case should be written in the child's medical record and should include subsequent communication.
    - It is recommended that a safeguarding proforma should be used (See Appendix 1).
    - Medical reports should be written for the primary care team and children's social care team (see Chapter 16).

9. **Professional differences**
    - If the paediatrician does not agree with the outcome of the child protection investigation, it is the doctor's responsibility to escalate their concerns to the multiagency team, aiming for resolution. Ongoing concerns need to be escalated according to local protocol and communicated to the Named Doctor for Child Protection.

5.2. Consent, Confidentiality and Information Sharing (Chapter 7)

1. Be familiar with GMC guidelines, such as Protecting Children and Young People: The responsibilities of All Doctors[2].

2. Seek informed consent from the person(s) with parental responsibility and/or a child with sufficient age and understanding.

3. Gain consent for the assessment in writing where possible.

4. Clearly document, with reasons, where you decide not to share information.

5. Understand that the child's welfare is paramount and the need to share information with other agencies overrides other concerns about confidentiality. Be proportionate when balancing the risks of disclosure against the consequences of non-disclosure.

5.3. Parental Factors (Chapter 8)

1. Questions about known risk factors should be sought and documented as a matter of course: for example, domestic abuse (DA), substance and alcohol misuse, intellectual disability and mental health problems.

2. Paediatricians should recognise when adult behaviour is severely impacting on the child and the threshold for referral to children's social care has been met.

3. Paediatricians should consider the risk to the life of a parent when referring to other agencies following disclosure of DA.

5.4. Recognition of Physical abuse (Chapter 9)

1. The paediatrician needs to adopt a forensic approach to the assessment of a child with suspected physical abuse, matching the history to the clinical findings to determine the likelihood of intentional injury. Ask the question: '*Does the explanation match the clinical findings?*'.

2. The explanation for injury should always be considered in the context of the child's development.

3. Children less than two years of age are at an increased risk of severe physical abuse. When physical abuse is suspected, thorough investigation to exclude occult injury (e.g. fractures, intracranial injury, and internal injury):
    - A full skeletal survey with repeat imaging: a single skeletal survey will miss fractures and additional imaging, according to the Royal College of Radiologists (RCR) radiological guidance, is required

- Blood investigations should be considered as per guidance if there is bruising. (NB. If a skeletal survey is to be performed, bone investigations should be done at the same time whether or not a fracture is known or suspected)
- Computerised tomography (CT) head scan in children less than one year of age and considered between 12 and 24 months
- Ophthalmology examination should be performed within 24 hours of medical examination or as soon as possible
- Intra-abdominal injury may be clinically occult and the need for abdominal CT requires active consideration
- If the CT head scan is abnormal or there are persistent neurological features, then an MRI brain and spinal scan is recommended.

This investigation strategy is not limited to infants and toddlers and should be considered according to severity of injury in older children.

4. Caution should be exhibited when ageing injuries. This is an imprecise science. Fractures can be aged by a radiologist from inspection of the extent of healing on X-rays in broad time frames only.

5. A bruise cannot be aged accurately from visual clinical assessment or from a photograph. At this point in time, the practice of estimating the age of a bruise from its colour has no scientific basis and should be avoided in child protection proceedings. Terms such as 'fresh' or 'old' bruising should be avoided.

5.5. Child Sexual Abuse (Chapter 10)

1. It is acknowledged that most paediatricians will not have the expertise to assess or manage children who allege sexual abuse or are suspected of being subjected to sexual abuse, but after initial assessment, will refer to a clinician with more specialised skills, specific training and competences in the forensic assessment.

2. Any doctor who undertakes a forensic assessment of a child who may have been sexually abused must have the necessary skills and competences and be familiar with recent guidance, for example:
   - The Physical Signs of Child Sexual Abuse[3] (Royal College of Paediatrics and Child Health (RCPCH))
   - Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse[4] (Faculty of Forensic and Legal Medicine (FFLM)/RCPCH)
   - Quality Standards for Doctors Undertaking Paediatric Sexual Offence Medicine (PSOM)[5] (FFLM)
   - Child sexual abuse (CSA) forensic medical examinations: Interim Guidance regarding numbers of examinations and the maintenance of competence[6] (FFLM/RCPCH)
   - Service specification for the clinical evaluation of children and young people who may have been sexually abused[7] (FFLM/RCPCH)
   - Guidance on emergency contraception[8] (Faculty of Sexual and Reproductive Healthcare (FSRH))
   - Guidelines on prevention of sexually transmitted diseases (British Association for Sexual Health and HIV (BASHH)).

3. Children should be examined in child friendly facilities with access to colposcope/photo-documentation. The timing of the examination is crucial, and the following must be considered:
    - Immediate health care needs, including alleviation of acute symptoms and signs
    - Need to obtain forensic evidence
    - Prevention of STIs: prophylaxis for HIV must be given within 72 hours post assault and is most effective when given as soon as possible
    - Prevention of pregnancy: emergency contraception can be given up to 72 hours (levonorgestrel) or five days (ulipristal acetate, copper-bearing intrauterine device) post assault.

5.6. Neglect (Chapter 11)

1. Make it your practice to routinely record who is present at all healthcare contacts and how the child interacts with each of those present, including adults the child is less familiar with. This information may then be used if needed to inform future assessments of the child and family.

2. If you have concerns that a child is experiencing neglect communicate those concerns to children's social care services and request a multi-agency assessment
    - As thresholds for neglect vary between professionals, paediatricians should be prepared to challenge other professionals to ensure appropriate assessment and ongoing management of the child's needs
    - Healthcare professionals should request a multi-agency meeting to reach agreement if necessary.

3. Paediatricians should contribute to the identification and assessments of children where there are concerns about possible neglect. Meet the medical needs that you are able to and refer on for those you cannot meet (e.g. speech and language therapy, special educational needs, dental examination including dental examination and treatment, audiology, vision, immunisations, infant or child and adolescent mental health service).

4. A chronology should be completed from healthcare records, including attendance rates and reasons for non-attendance, immunisation status and compliance with treatment, when there are concerns about possible neglect.

5. Ensure that the child's future growth and developmental progress are assessed on a regular basis.

5.7. Emotional Abuse (Chapter 12)

1. Emotional abuse and neglect are persistent harmful interactions with the child by the caregiver: it is important to observe and document child-parent interactions over time and in different environments. This is a powerful tool and contributes to the assessment of psychological maltreatment.

5.8. Perplexing Presentations (including FII) (Chapter 13)

1. Professionals should follow local interagency procedures and the RCPCH guidance[9].

2. The need for a detailed chronology is paramount.
3. Paediatricians should avoid iatrogenic harm and only undertake tests or treatments that are clearly indicated.

4. Admission to hospital can be helpful for close observation to differentiate between erroneous and true reports of symptoms and signs.

5.9. Abuse in Special Circumstances (Chapter 14)

1. Professionals should balance cultural sensitivity with the need to recognise and prevent child maltreatment.

2. Do not delay if you believe a child is at risk (e.g. of forced marriage); often there may only be one opportunity to act to safeguard the child.

5.10. Infant and Child Deaths (Chapter 15)

1. Paediatricians should follow national multiagency processes following the death of child.

2. A paediatrician should always attend the multiagency meetings following the death of a child.

5.11. Records and Reports (Chapter 16)

1. Clear contemporaneous documentation should be written in the child's medical record, to include telephone conversations and discussions with the multiagency team.

2. A safeguarding proforma assists the initial assessment (see Appendix 1).

3. Document reasons for any deviations or difficulties.

4. Document positive and negative findings.

5. When summarising your findings, discuss differential diagnoses, base your opinions on the balance of probability supported with the evidence base.

6. There should be no discrepancies between notes, reports and police statements.

5.12. Photo-Documentation (Chapter 17)

1. Paediatricians should work to a locally agreed protocol to ensure adequate standards of photography, including storage of images.

2. Photograph all significant visible findings using an L-shaped metric scale to measure the size of injuries.

3. Record whether the photo documentation represents what you saw at examination.

4. Obtain consent to take images and for which purposes they can be used; e.g. to share images at peer review or use for teaching purposes.

5.13. Court Proceedings: Giving Evidence (Chapter 18)

1. Know which court you are going to, and why, prepare in advance and seek appropriate advice.

2. Understand the difference between professional witnesses of fact and expert witnesses.

3. Seek feedback on your evidence to enable improvement.

5.14. Training and Support (Chapter 19)

1. Paediatricians involved in child protection work need access to emotional support, peer review and clinical supervision in order to be competent and confident in this stressful and demanding area of work. This should be identified within job plans.

2. All paediatricians should attain and maintain level 3 competences as listed in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff[1] throughout their career.

References

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Update information

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