Somerset Safeguarding Children Partnership

Injuries to non-mobile babies and children policy

Including a Guide to Child Protection Medical Assessments

CONTENTS:

IF YOU ARE CONCERNED THAT A CHILD OR BABY MAY BE AT RISK OF, OR MAY BE SUFFERING SIGNIFICANT HARM CALL US ON

0300 123 2224

USEFUL RESOURCES:

TEN4FACES-P

South West Child Protection Procedures

Effective Support for Children and Families in Somerset

Early Help Assessment

INTRODUCTION

This policy highlights the actions required when babies and/or children present with injuries that may be, or are suspected to be due to physical abuse or non-accidental injury.

Children under the age of 2 years are at an increased risk of serious physical abuse and are rarely able to communicate the history themselves. Accidental injuries in non-mobile infants are unusual. Children with a disability who are not able to move independently are also at risk of serious physical abuse.

Even small injuries may be significant, and may be a sign that there is another injury which is not visible e.g. an infant with a small bruise may have multiple fractures in sites distant from the bruise. They may also be a "sentinel injury", i.e. an injury that, if not recognised as possibly inflicted and acted upon, is associated with later severe or fatal maltreatment.

FEATURES IN THE HISTORY THAT MAY INDICATE PHYSICAL ABUSE INCLUDE:

- A significant injury where there is no explanation.
- An explanation that does not fit with the pattern of injury seen.
- An explanation that does not fit with the motor developmental stage of the child.
- Injuries in infants or children who are not yet independently mobile.
- An explanation that varies when described by the same or different parents/carers.
- Multiple explanations that are proposed but do not explain the injury sustained.
- Delay in seeking medical attention - delayed presentation.
- An inappropriate parent or carer response e.g. unconcerned or aggressive.
- A history of inappropriate child response (e.g. did not cry, felt no pain).
- Presence of multiple injuries.
- Child or family known to Children's Social Care or subject to a Child Protection Plan.
- Previous history of unusual injury / illness e.g. unexplained apnoea (stopping breathing) or oro-nasal bleeding.
- Repeated attendance with injuries that may be due to neglect or abuse.

For information on definitions and terminology used relating to Injuries to non-mobile babies and children and Child Protection Medical Assessments, please click the link below or see Appendix 2.

CLICK HERE TO SEE DEFINITIONS

Responding to Injuries Pathway - Part 1

Keeping the child safe
Ensure child(ren) is kept safe at all times whilst considering what to do. If unsure keep child (ren) in a safe place whilst you get advice. Remember to consider any risks to the child(ren) from the parents/ carers. If there are risks do not leave the child(ren) alone and take appropriate action.

Child is observed, presents or is reported to have bruising, concerning or unexplained mark or other sentinel injury such as oro-nasal bleeding or subconjunctival haemorrhage, or tells you they have an injury or has been physically harmed.
Immediate injury/injuries may not be visible but risk of significant injury may be high based on report of safeguarding incident such as strangulation.

In An Emergency
Child has suffered or is at immediate risk of significant harm.

Call 999 Police/Ambulance
Ensure Child Safety
Call Somerset Direct

No immediate medical needs identified

Does the child need immediate medical attention?

Yes

No

Listen to the child's voice if the child is verbal and able to report.
Have they told you they have been hurt by someone (adult or child), family or friends?
Do you have a reason to believe that they have been hurt or sustained an injury? If the child is reporting accidental injury, this does not rule out physical abuse or neglect.
Continue to follow the pathway even if no history from child

Non-mobile
Injuries to non-mobile babies or non-mobile children (e.g. babies that can only roll, usually under 4 months, and non mobile child with additional needs).

see Part 2 - injuries to non-mobile babies & children

Mobile
Injuries to children who are mobile (e.g. able to crawl, cruise around furniture, pull to stand or walk).

see Part 3 - injuries to children who are mobile

Send child to hospital and refer to Children's Social Care
If required call **999** for an ambulance to take the child to the nearest Emergency Departmentand contact Police. Remember to follow up the child to check that they have attended hospital.
If they do not attend, Police and Social Care will need to be informed.
Request Involvement of child(ren) to Children's Social Care: 0300 123 2224
Out of hours Emergency Duty Team: 0300 123 2327
Follow up with a written EHA within 24-48 hours unless CSC advise it is not required.

TEN-4-FACESp
A screening tool for concerning bruises

Contact Numbers:

On call Paediatrician for Yeovil District Hospital, Musgrove Park Hospital or Royal United Hospital (see appendix 2)
Children's Social Care: **0300 123 2224**
Out of Hours Emergency Duty Team: **0300 123 2327**

Responding to Injuries Pathway - Part 2

Non-mobile Babies or Non-mobile Children

Child is observed, presents or is reported to have bruising, concerning or unexplained mark or other sentinel injury such as oro-nasal bleeding or subconjunctival haemorrhage. Document clear description of sustained marks/ injury/ bruises on a body map.

Seek Explaination

Do not ask leading questions or offer suggestions of how this may have occurred. If possible, always try to examine the child naked to see if there are any other marks, bruises or injuries. No explanation, inadequate or unlikely explanation, or explanation provided does not rule out abuse/neglect/poor supervision.

In Infants

If considered to be a birthmark or sustained during birth, please confirm by:

> Checking PHCHR (red book)
> Contacting GP
> Contacting midwife
> Ask parents if they have an old picture

If uncertain whether birthmark or not, then discuss with on call Paediatrician and arrange for either baby or photographs to be reviewed by Paediatrics without requesting involvement from CSC in the first instance.

If adequately explained rationale for decision making needs to be clearly documented in PHCHR (red book) including clear description of any sustained marks/ injury/bruises on a body map or photos, and share with professionals involved.

Continue following the safeguarding process and enquiries as per multi-agency discussions. Follow your own organisation's procedures and utilise the Effective Support Document and consider whether early help or statutory support is required.

Unexplained injury and suspected non-accidental injury

Request Involvement of Children's Social Care 0300 123 2224

Request an urgent Strategy Discussion takes place. Follow up with a written EHA within 24-48 hours if requested.

Do not delay

Strategy Discussion

To be chaired by CSC. A social worker, Police and Paediatrician to be present as minumum. Other relevant practitioners will be invited.

- Timing of Strategy Discussion should not delay any clinical treatment or investigation required.
- Discussion held around conduct and timing of criminal investigation and whether enquiries under Section 47 of the Children Act 1989 should be undertaken. This should include if a Child Protection Medical Assessment (CPMA) is required.
- If there are grounds to initiate enquiries under Section 47, decisions should be made as to what immediate and short-term action is required to support the child, and who will do what by when.

In/Core Hours Paediatrician attendance and medical to be arranged via safeguarding admin. **Out of hours** attendance and medical to be arranged via on call Paediatrician - may be following day.

Re-Strategy

If the plan from an initial Strategy is changed or if a Strategy Discussion is held out of hours and there are outstanding actions or missing information a follow-up Strategy should be held.

Is a Child Protection Medical Assessment required?

No

Yes

Parent/carer consent obtained. If no consent given, then re-strategy required inorder for a multi-agency response which may include consideration of application to court.

Escalation

If you feel your referral is not appropriately actioned, escalate your concerns and contact the safeguarding lead for your organisation. Refer to the Local Safeguarding Children Partnership escalation policy available at: somersetsafeguardingchildren.org.uk

Contact Numbers:

On call Paediatrician for Yeovil District Hospital, Musgrove Park Hospital or Royal United Hospital (see appendix 2)

Children's Social Care: **0300 123 2224**

Out of Hours Emergency Duty Team: **0300 123 2327**

Responding to Injuries Pathway - Part 3
Mobile Children

Child is observed, presents, or is reported/reports themselves to have an injury.

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Seek Explanation

Do not ask leading questions or offer suggestions of how this may have occurred.
Listen to the child's voice if the child is verbal and able to report. Have they told you they have been hurt by someone (adult or child), family or friends? Do you have a reason to believe that they have been hurt or sustained an injury? If the child is reporting accidental injury, this does not rule out physical abuse or neglect.

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Mark/bruising/injury present but explanation fitting with presentation, abuse not suspected.

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Direct for appropriate medical attention and assessment if required. Only refer to Emergency Department without delay if in need of emergency medical attention.

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Document observations including clear description of any sustained marks/ injury/bruises on a body map or photos. Consider information sharing with GP/ Health Visitor/ School Nurse.

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Utilise the Effective Support Document and consider whether early help or statutory support is required.

Marks/bruising/injuries are not reported to be accidental or likely/suspected physical abuse/non-accidental injury.

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Request Involvement of Children's Social Care 0300 123 2224

Request an urgent Strategy Discussion takes place.
Follow up with a written Early Hepl Assessment (EHA) within 24-48 hours if requested.
Do not delay

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PROFESSIONAL RESPONSIBILITIES

Safeguarding children is everyone's responsibility!

If anyone recognises a baby or child is at risk of harm or significant harm, it is their responsibility to refer appropriately to Children's Social Care.

Children's Social Care:

Children's Social Care are responsible for organising and leading a Strategy Discussion where it is suspected that a baby or child has suffered from a non-accidental injury or physical abuse. Children's Social Care are responsible for requesting that a Police representative and a Paediatrician or appropriate health representative is invited to the Strategy Discussion.

Police:

The Police are responsible for considering whether a criminal investigation is required and leading on any further action required.

Paediatrician:

The Paediatrician will be responsible for deciding whether a Child Protection Medical Assessment is required, performing the medical assessment and providing an opinion and report.

WHAT TO DO IF ANY TYPE OF INJURIES (INCLUDING BRUISES) ARE SEEN ON A NON-MOBILE BABY OR CHILD WHERE THERE ARE CONCERNS ABOUT NON-ACCIDENTAL INJURIES

All practitioners should discuss the injury / bruise / mark with the parent and carer and enquire into its explanation and establish a timeline for the injury. The child's record should be reviewed, and details of the account and injuries should be documented on the child's record(s) including the use of line drawings or photographs (where available). Photographs should only be included with parental consent and should not include intimate images.

If there is reference in documentation, or parental photos to the bruise or mark at birth or on post-natal checks, then both the marks and the documentation need to be carefully recorded in both medical records and the Parent-Held Child Health Record (PHCHR), this is commonly known as the 'red book' and in these instances no onward referrals are necessary.

If a mark on a non-mobile baby is clearly a birthmark then this needs to be clearly documented in both medical records and PHCHR to include body maps. It is important to note that not all birth marks are present at birth and may take a number of weeks to become fully visible. It should also be noted that slate grey naevi or blue spot can be present on any area of the body, not just buttocks and back.

If the clinician has difficulty in deciding if a mark is a birth mark or injury, then arrangements can be made with the on-call Paediatrician at the local paediatric department to review the child or photographs of the mark to help decide. This is not a suitable route if the mark or injury is not thought to be a birth mark. A review of the patient in a few days can assist differentiation as a birth mark will not change in appearance like a bruise.

Bruising in children is the most common injury sustained from physical abuse. It can be difficult for practitioners to distinguish between abusive and non-abusive bruises (see Appendix 1 for further guidance).

If a bruise in a pre-ambulant baby, or other injury suggesting non-accidental injury is found by a practitioner, the practitioner should advise and explain to the parents/carers of the child that a request for involvement will need to be made to Children's Social Care and there may be a requirement for the child to have a Child Protection Medical Assessment. A clear explanation about the risks to non-independently mobile babies or children, (or alternative explanation to why you are concerned and request for involvement) is important. It is good practice to discuss concerns with the child if this is appropriate.

In an emergency, or if you have concerns about the safety of the child, yourself, or other staff you should call the Police immediately.

A request for involvement from Children's Social Care should be telephoned through to Somerset Direct **0300 123 2224**. A clear explanation about the concerns should be provided and a request made for an urgent Strategy Discussion. This should be followed up by a written request for involvement to Children's Social Care within 24-48 hours.

WHO SHOULD BE INVITED TO A STRATEGY DISCUSSION?

Children's Social Care will lead on organising the Strategy Discussion. A Strategy Discussion invitation should always be sent to the following professionals (where professionals cannot attend, either a suitable representative should attend or a written update of any pertinent / relevant information should be provided).

- Children's Social Care
- Police
- A representative from health, those that should be invited from different agencies include:
  - The child's GP and (both) parents / carers GP (note that parents may have different GP's, if this is the case both should be invited).
  - Somerset NHS Foundation Trust (a Paediatrician should be requested, in addition to the Safeguarding Advisory Service).
  - The local hospital to the patient if different from above.
  - Public Health Nursing Safeguarding Team
  - The Bridge Sexual Abuse Referral Centre (SARC) if sexual abuse is indicated.

- Any educational setting, early years providers or childcare (e.g. school / nursery / childminder / wrap-around).
- Voluntary, Community, Faith and Social Enterprise (VCFSE) / leisure / creche.
- Any other professionals currently supporting the child and who may be able to assist in assessing risk or providing support to the child or their family.

The responsibility for arranging the Child Protection Medical remains with Children's Social Care (for contact details, see Appendix 2).

GUIDE TO CHILD PROTECTION MEDICAL ASSESSMENT

What is a Child Protection Medical Assessment?

It is a holistic paediatric assessment of a child referred to Children's Social Care and / or the Police because of suspected abuse or neglect. It assists in the multi-agency response to a child's health, welfare, and safety by:

1. undertaking a careful top-to-toe evidence-based assessment to document any evidence of physical abuse or neglect.
2. undertaking a detailed paediatric assessment of the child's health and development.
3. detecting any hidden issues that might affect the child's health, social or educational outcomes.
4. assessing the child's health needs within the context of family, school and community.

A Child Protection Assessment must take place as part of a multi-agency assessment and should coincide with a Strategy Discussion led by Children's Social Care. The Strategy Discussion will determine, in consultation with a Paediatrician, the need and timing required of the assessment.

ARRANGING CHILD PROTECTION MEDICAL ASSESSMENTS

A Child Protection Medical Assessment can be requested as an action arising from a Strategy Discussion or, very occasionally take place prior to the Strategy Discussion if the child is already in hospital. A Child Protection Medical Assessment should not be requested in order to determine if a Strategy Discussion is required.

The Strategy Discussion must consider the need for and the timing of a Child Protection Medical Assessment.

The medical assessment of a child with suspected physical abuse should normally be commenced within 24 hours of the request to health; timing should be based on clinical need. If this standard is not met, then the reasons should be clearly recorded in the child's health record. Some children need to be seen as an emergency (very young infants, strangulation, possible head injury) but most are seen in a planned clinic slot by an experienced Child Protection Specialist Paediatrician.

Either the Police or Children's Social Care can request a Child Protection Medical Assessment. The assessment should be arranged with the nearest acute provider of paediatric services - either the hospital or Community Health Safeguarding Children Team, or the on-call Consultant Paediatrician when out of hours (details for arranging Child Protection Medical Assessment can be found in Appendix 2).

CONSENT

Informed consent should be taken for each Child Protection Medical Assessment; ideally this would be written consent, but when consent is being obtained over the telephone, documentation that verbal consent was given should be written in the child's medical record by the person taking consent.

The following people may give consent to a Child Protection Medical Assessment:

- The child or young person if they are deemed to have capacity.
- Any person with Parental Responsibility, providing they have the capacity to do so.
- The Local Authority when the child is the subject of a care order (though the parent should be informed and if actively opposing assessment, this needs to go back to court depending on the percentage allocation of Parental Responsibility by court).

The following people may give consent to a Child Protection Medical Assessment:

- The child or young person if they are deemed to have capacity.
- Any person with Parental Responsibility, providing they have the capacity to do so.
- The Local Authority when the child is the subject of a care order (though the parent should be informed and if actively opposing assessment, this needs to go back to court depending on the percentage allocation of Parental Responsibility by court).
- The High Court when the child is a ward of court.
- A Family Proceedings Court as part of a direction attached to an Emergency Protection Order, an Interim Care Order or a Child Assessment Order.

If consent is withheld for any part of the assessment, including examination, photography, or investigation then this is recorded, including subsequent discussions and any actions taken.

Where circumstances do not allow permission to be obtained and the child needs emergency medical treatment, the medical practitioner may:

- Regard the child to be of an age and level of understanding to give their own consent.
- Decide to proceed without consent on a best interests basis.

In these circumstances, parents must be informed by the medical practitioner 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 consider whether it is in the child's best interests to seek a court order.

If the Local Authority wishes an assessment to take place, but the person with Parental Responsibility refuses to give consent, the Paediatrician should consider the case in its entirety and if the Paediatrician decides the assessment is in the child's best interest and / or there is a public interest then it should refer back to the Local Authority to obtain consent by court order. Advice can be taken from senior colleagues and indemnity organisations. The Local Authority would need a court order to override the refusal of the party with Parental Responsibility.

A child who is of sufficient age and understanding may refuse some, or all of a medical assessment. Refusal should only be overridden by a court. The child's attention should be drawn to their right to give or refuse consent to an assessment or treatment if they are 16 or over, or if the child is under 16 and the doctor considers they have sufficient understanding to recognise of the consequences of consent or refusal.

Legal advice should be sought if it is not clear who can provide consent for a particular child. If the appropriate consent cannot be contained, it is inadvisable to conduct a formal Child Protection Medical Assessment.

In this situation, a carefully recorded clinical examination and necessary treatment may still be undertaken, with the consent of the child where appropriate. In these circumstances, parents must be informed by the medical practitioner as soon as possible and a full record must be made at the time.

CHILD PROTECTION MEDICAL REPORTS

A Child Protection Medical Report should demonstrate a holistic approach to the child and assess the child's wellbeing, including mental health, development and cognitive ability.

The assessment, professional opinion and outcome resulting from a Child Protection Medical Assessment should be clearly recorded and communicated to the requesting professional as well as to the family and child as appropriate. It can be helpful to document the summary of the initial findings and give a copy to the Social Worker or Police Officer attending the medical (with the original being kept in the child's medical record).

The full Child Protection Medical Report must be typed and signed as soon as possible and should be available within **10 working days** of the assessment. The report should be completed in accordance with the guidance in the RCPCH Child Protection Companion (RCPCH, 2013).

The report should include:

- date, time and place of assessment
- those present
- who gave consent and how (child / parent, written / verbal)
- a verbatim record of the carer's and child's accounts of injuries and concerns noting any discrepancies or changes to the story
- confirmation of the child's developmental progress (especially important in the cases of neglect)
- a factual observation of the child's presentation, appearance (e.g. dirt under fingernails) and behaviour
- other findings relevant to the child (for example, squint, learning or speech problems etc.)
- site, size, shape of any marks or injuries
- opinion of whether injury is consistent with explanation

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

Remember that many professionals using the report are not medically trained, so it needs to be written in such a way that it can be understood by a lay person. Avoid using jargon, acronyms or abbreviations. Be clear what is fact and what is opinion.

Consider the background to the Child Protection Medical, where there have already been significant safeguarding concerns, the chances that an injury is non-accidental is increased. Try to be as clear as it is possible to be about your conclusions i.e. that in your opinion, this is or is not likely to be a non-accidental injury.

LANGUAGE THAT MAY BE USED IN CHILD PROTECTION ASSESSMENT

This is a glossary to help ensure there is a shared understanding of what these terms mean.

Consistent / Compatible with:

The assessment findings (e.g. an injury) could have been caused by a given explanation (e.g. history from child / parent). However, this does not mean that other causes are not possible.

Not consistent / compatible with:

The assessment findings (e.g. injury) could not have been caused or is unlikely to have been caused by the given explanation (e.g. history from child / parent).

More likely than not:

One cause is more likely than another i.e. to the standard of being more than 50% likely.

Inflicted / Non-Accidental Injury:

Injury caused by someone else, most likely due to physical abuse.

Accidental Injury:

Injury that can be reasonable explained through an accidental mechanism sustained during normal movement / play / activities; this takes account of the developmental level / abilities / behaviour of the child.

Unexplained Injury:

An injury where no plausible explanation has been given and there is no clear medical explanation. This may require further consideration to decide whether the injury is more likely to be inflicted or accidental.

Index / Subject Child:

The main child who has presented with a concern. This could be because they have an injury, have said they have been hurt or there is some other reason why abuse is suspected. This is used where several children in a family require a Child Protection medical to indicate the child that initiated the concern.

Medical terms doctors may use in reports - these should also be explained in the reports:

Abrasion:

A superficial injury involving only the outer layers of the skin that does not extend to the full thickness of the epidermis. Can be linear abrasion (scratch) or broad abrasion (graze).

Birthmark:

These may be of different types - slate grey naevi or blue spot (blue/grey mark under the skin often of buttocks but may be anywhere), cafe o lait (brown marks under the skin), haemangioma (raised or flat red mark under the skin) or others.

Bruise:

Visible evidence of leakage of blood into soft tissue as a result of injury to the blood vessels.

Burns:

An injury to the skin caused by heat or due to radiation, radioactivity, electricity, friction or contact with other chemicals. Thermal (heat) burns can occur from hot liquids, hot solids or flames.

Erythema:

Redness of the skin caused by dilation (widening) of the underlying capillaries (small blood vessels).

Haematoma:

A collection of blood forming a mass or lump under the skin.

Laceration:

Wound splitting the full thickness of the skin, usually from blunt trauma.

Incision:

Wound splitting the skin, usually caused by a sharp object e.g. blade.

Mark:

An area of skin that is a different colour to the surrounding skin. This is a generic term and could indicate an injury (recent or healed) or a skin issue (e.g. birth mark/medical cause). When this term is used, a description of the appearance of the mark should be documented and an opinion on what the mark is should be offered.

Petechiae:

A small, distinct pin-prick sized bruise (<2mm) that occurs when blood vessels rupture. May be single or multiple.

Scar:

Fibrous tissue that replaces normal tissue after the healing of a wound.

Subconjunctival Haemorrhage:

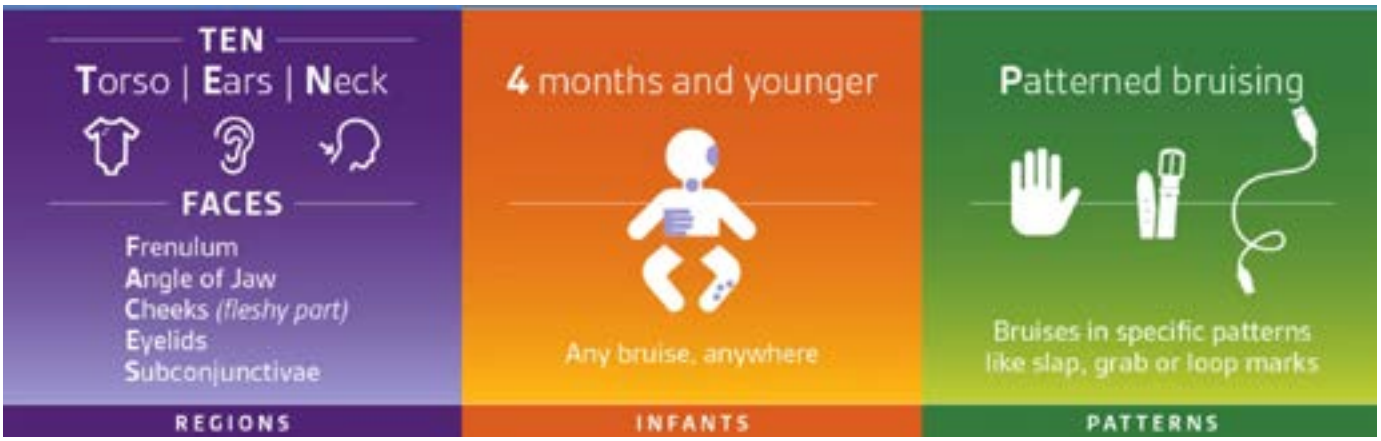
Bleeding into the white of the eye due to ruptured blood vessels. Commonly occur at birth but may not be noted until a few days old. Those occurring after 2 weeks of age are significantly associated with non-accidental injury.

Oro-Nasal:

Of nose and mouth.

APPENDIX 1: TEN-4-FACES-P

The TEN-4-FACES-p acronym is a useful decision tool to help screen children under 4 years old, with bruising to support identification when a bruise is more likely to be non-accidental injury.



TEN-4-FACES-P Poster available to download here!

Accidental Bruising:	Non-Accidental Bruising:
More common in older, mobile children.	Uncommon in babies and non-mobile children.
More common in larger families.	Bruising away from bony prominence.
Typically over bony prominences.	Head most common site. Other common sites: torso, ear, neck, thigh, arms.
More commonly on the front of the body, knees and shins.	Bruises that carry an imprint of an implement or ligature.
Less 5% of bruising on the cheeks and around the eyes are associated with accidental injury.	Patterned bruising may be accompanied by petechiae.
	Cluster bruising.
Slips, trips and falls commonly cause bruising to the back of the head, front of the face (including T of forehead), nose and upper lip.	Multiple bruises of uniform shape.
	Scalping - a boggy swelling to the forehead with periorbital oedema, typically caused by hair pulling.

APPENDIX 2: Definitions

Child Protection Medical Assessment:

A Child Protection Medical Assessment is undertaken at the request of either social care or Police as an outcome of a multi-agency Strategy Discussion.

Occasionally it results from concerns, for the wellbeing of a child already receiving clinical care prior to the Strategy Discussion. It is comprehensive, including full clinical history and assessment, and detailed documentation including the use of line drawings and photo documentation. The assessment includes obtaining any relevant investigations, arranging any necessary aftercare, and writing a report with an opinion. Usually, it is part of a Section 47 enquiry, but can also take place under Section 17 or an open decision at Strategy Discussion prior to further information being sought.

Strategy Discussion:

A Strategy Discussion is held whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm. This takes place as a multi-agency discussion led by Children's Social Care, including Police, Health and any other professionals involved in supporting the child.

Non-mobile baby:

A baby who is not yet rolling, crawling, bottom shuffling, pulling to stand, cruising or walking independently. The younger the child, the greater the risk that injuries or bruises are non-accidental and the greater potential risk of future harm.

Not independently mobile:

Children with a disability - older children who are not independently mobile by reason of a disability should be considered in a similar way to non-mobile babies. Children with disabilities may have a higher incidence of abuse, whether or not they are mobile. This procedure does not apply to children with a disability who are independently mobile in a wheelchair and who can give consistent plausible explanation for accidental bruising.

Sentinel Injuries:

Sentinel injuries are injuries that occur in young and developmentally immature infants who could not have hurt themselves. These include bruises, nasal / oral injuries and bleeding, subconjuntival haemorrhages, and head swellings.

APPENDIX 3: How to arrange a Child Protection Medical Assessment

West Somerset (Taunton):

In hours: Monday to Friday 9am to 4pm - contact on call Paediatric Consultant at Musgrove Park Hospital (MPH) via safeguarding administrator (01823 343293 or 07900138207).

CP medicals will be undertaken in the child outpatient department (Mon - Fri, usually 14:00 hours appointments), and will be seen within 24 hours. An appropriate safety plan should be agreed at initial Strategy Discussion for all children, pending a CP Medical Assessment. Children should not be admitted to hospital as a "place of safety" if they do not require medical treatment.

Out of hours: Monday to Friday 4pm to 9am, weekends and bank holidays: refer via the on call general Paediatric Consultant (via hospital switchboard).

Medically urgent (including non-mobile children with concerning injury), or cases presenting over the weekend, will be seen on the paediatric ward.

East Somerset (Yeovil):

In hours: Monday to Friday 9am to 5pm - contact on call Paediatric Consultant at Yeovil Hospital (YDH) via safeguarding administrator (01823 343293 or 07900138207).

Out of hours: Monday to Friday 5pm to 9am, weekends and bank holidays: call YDH switchboard (01935 475122) and ask for on call Consultant General Paediatrician.

Monday to Friday - 8pm to 8am/ Weekends - 5pm to 8am: contact YDH switchboard (01935 4752122) and ask for the on call Consultant General Paediatrician.

If a child is admitted to YDH for treatment of injuries, a CP medical assessment will be undertaken by the acute paediatric team.

East Mendip (Bath):

In hours: Monday to Friday 9am to 5pm: call Community Paediatricians (01225 394514 or 07540668801) or email vcl.bathnes@nhs.net

Out of hours: Monday to Friday 5pm to 8pm / Weekends and bank Holidays 9am to 5pm: Call RUH switchboard (01225 428331) and ask for the Consultant Community Paediatrician on call for Child Protection.

Monday to Friday - 8pm to 8am / Weekends – 5pm to 8am: Contact RUH switchboard (01225 428331) and ask for Consultant General Paediatrician on call.

If a child is to be admitted to RUH for treatment of injuries CP medical assessment will be undertaken by the acute paediatric team.

USEFUL INFORMATION:

South West Child Protection Procedures

Effective support for Children and Families in Somerset (2023, SSCP)

Birmingham Solihull Child Protection Medical Assessments toolkit

Child Protection Companion

Child Protection Service Delivery Standards

National Review of Non-Accidental Inury in under 1s

Child Protection Medical Assessments - NYSCP

Working Together to Safeguard Children 2023

Child Maltreatment: when to suspect maltreatment in under 18s

TEN-4-FACES-p - Stanley Manne Children's Research Institute

TEN-4-FACES-P Poster

Somerset Safeguarding Children Partnership

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