V2 November 2024

Norfolk Safeguarding Children Partnership

Norfolk Safeguarding Children Partnership

Safeguarding Medical Examination Policy

Safeguarding Medical Examination Policy

1. Introduction

The purpose of this document is to:

- Guide practitioners from all agencies as to when a safeguarding medical examination may be helpful in the assessment of a child or young person when there are safeguarding concerns;
- To provide guidance for practitioners about the type of safeguarding medical examination which is indicated;
- This policy will guide practitioners in identifying who to request a safeguarding medical examination from and, if in doubt, how to obtain advice about the type and scope of assessment required;
- To guide practitioners from all agencies in determining the urgency of an examination.

For the purposes of this policy the term **safeguarding medical examination** is used. This is a holistic assessment by a medical practitioner which should include observation of general physical and emotional health and development and relevant physical examination.

2. Why is a safeguarding medical examination required?

The objectives of a safeguarding medical examination are:

- To identify the child's health needs (physical and emotional);
- As a component of a child protection investigation to assist in determining whether or not there is evidence of physical harm, neglect, sexual harm or emotional harm;
- To document clinical findings including injuries and (rarely) taking samples that may be used as evidence in a Police or Children's Services investigation, relevant to all types of abuse.

A safeguarding medical examination is rarely stand-alone evidence that a child has been intentionally harmed and should be undertaken only to decide whether the child needs treatment or as part of a multi-agency safeguarding assessment.

All paediatric safeguarding medical examinations will follow the employing organisation's protocols and procedures.

A safeguarding medical examination alone should never be used to determine whether a multi-agency investigation is required.

A safeguarding medical examination may be of value when:

- A child has experienced some form of harm where the cause is uncertain, and an intentional cause is a possibility;
- A child or young person may have physical, developmental or emotional evidence that may assist partner agencies with their assessment of a child and family;
- There is a possibility of gathering forensic evidence (e.g. specimens or photographs);
- There is concern from a young person and/or their carers which could be addressed through a safeguarding medical examination.

A safeguarding medical examination should be undertaken by a Medical Practitioner with the relevant qualifications and competencies for the type of safeguarding medical examination required. A practitioner should not undertake an examination for which they do not feel competent. Paediatric Clinicians should be working at ST4 level or above with relevant Level 3 child protection competencies (RCPCH Child Protection Service Delivery Standards, 2020).

To permit a successful safeguarding medical examination, the child will need to feel supported, and the doctor will need information about the child's past medical history. The child should, therefore, be accompanied by a parent or carer who is able to support the child and give relevant information about the child's current and previous health, unless there are exceptional

circumstances that mean that this is not possible. The accompanying adult or the young person themselves must be able to give valid consent to an examination (see section 6).

3. The Safeguarding Medical Examination: Guidance on deciding whether a safeguarding medical examination is required and who to ask and what it involves:

Children may be seen for safeguarding medical examination by a hospital paediatrician (acute paediatrics) or a community paediatrician. Acute paediatrics in Norfolk is based at the Norfolk and Norwich University Hospital (NNUH), James Paget University Hospital (JPUH) and Queen Elizabeth Hospital (QEH). Community paediatricians are doctors who specialise in developmental problems and long-term disabilities. In Norfolk community paediatricians offering safeguarding medical examinations are based at Norwich Community Hospital and St James Clinic, Kings Lynn.

A decision regarding the most appropriate clinician to see the child will depend on the child's presentation and age (see below).

3.1. Physical Injury

3.1.1 Acute severe injury

If there is a medical emergency the child should go to the nearest acute hospital and their acute medical needs should be addressed with the same degree of urgency as is the case for any other acute medical illness. The child should be seen in an appropriate place and by those professionals who have the facilities and skills to assess acutely unwell children. Usually this will be in an Emergency Department or an acute Paediatric Department within a hospital and any safeguarding concerns should be clearly communicated at the time of referral.

3.1.2 Non-mobile baby or child with any injury, or infant under 1 year with an injury with no credible or verifiable explanation (See Appendix 1).

A non-mobile child is a child who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking. It includes all babies under 6 months, and any baby or child who is unable to mobilise independently. Babies who can sit or roll are non-mobile until they can mobilise as above. Non-mobile babies have extremely limited scope to injure themselves and bruising is therefore highly suggestive of a non-accidental cause.

If the injury is identified by a clinician (eg doctor, nurse, health visitor, midwife) the case should be

discussed immediately with the acute Paediatric Consultant on-call regarding an urgent assessment in hospital. The clinician must also refer to the Children's Advice and Duty Service (CADS) and confirm this with the acute paediatric consultant on-call.

If the professional identifying the injury is a non-clinician (eg Education, Early Years), an immediate CADS referral should be made.

A strategy discussion should always be convened for injuries in non-mobile children, or for unexplained injuries in mobile infants under 1 year, including when the child is already known to Children's Social Care or Early Help (see Appendix 4).

It is the responsibility of the referring clinician to ensure the child arrives in hospital unless otherwise explicitly agreed.

3.1.3 Children over one year of age with physical injury (see Appendix 2)

If any child presents with an injury that raises suspicion of physical abuse, or without adequate explanation (eg. bruising to the face, ears, buttocks, genital area or trunk, or an unusual number or pattern of injuries), or if the child has limited scope to injure themselves because of a physical disability and sustains an unexplained injury, the professional identifying the injury/bruising should contact CADS. **This list is not exhaustive and any pattern of bruising or injury that is of concern and without sufficient explanation should be referred to CADS.** The resulting strategy discussion should include a paediatrician to advise on the timing and appropriate medical professional to see the child (See Appendix 4).

3.1.4 General Practitioners

GPs should not be asked to see children for child protection safeguarding medical examinations. However, there may be circumstances where, following strategy discussion, it is not thought that a formal child protection safeguarding medical examination is needed but it is felt that a medical review is required, and that the child could be seen by their own GP rather than by a paediatrician – for example for review of a medical condition, skin rash or suspected birth mark. This must be discussed and agreed with the GP prior to attendance.

In this situation the GP should be contacted by the social worker to explain the situation and should be in agreement with seeing the child. If the GP feels that what they are being asked to do is outside their area of expertise they should request that a paediatrician sees the child. Should the GP become involved and subsequently wish to seek a second opinion they should contact the relevant

on-call Paediatrician.

Appointments must NOT be made without prior discussion with the GP.

3.2 Disclosure of sexual assault

When a child or young person under the age of 18 discloses sexual assault or a concern is raised by a parent, carer or other agency that the young person may have been sexually harmed then the first point of contact is CADS.

An initial strategy discussion will be convened before any decision is made about an examination. **The strategy discussion must include a Health representative with relevant experience (Mountain Healthcare Doctor (under 13 years) or Forensic Nurse Examiner (13 years and over)), and will decide whether an examination is indicated, and when and where the young person should be examined, based on the information available at the time of the referral. The information below is a guide to help decide on the urgency of an assessment and where this could be done.**

3.2.1 When to consider child or young person is at high risk of Child Sexual Abuse (CSA):

Acute assault: This is an assault that has occurred within the previous 72 hours (pre pubertal) to 7 days (post pubertal)

If there is an allegation by a child or young person, who has given a clear description of events that indicates they been sexually assaulted, this would suggest a high risk for CSA. The nature of the assault may involve touching and/or attempted or actual penetration (oral, anal or vaginal). The forensic window for specimens depends on the nature of the assault and varies from 2 days up to 7 days.

In this case:

- The child/young person will usually require a forensic examination to obtain forensic evidence (images/specimens). (See SARC pathway Appendix 3).
    - This examination will take place at the Sexual Assault Referral Centre (SARC) within the forensic window. It should be convened as soon as reasonably possible, preferably within 24 hours.
    - There is limited out of hours provision in Norfolk for under 13s. However, a regional Saturday rota has been in place since January 2022. The rota rotates through Bedfordshire, Cambridgeshire, Hertfordshire, Essex and Suffolk on a five-weekly rotation, so children would need to travel to these locations to be seen. Clinic times are 11am-3pm. Access to a forensic examiner is via the Mountain Healthcare pathway and support service -0330 223 0099.
    - Children who present out of hours and who cannot be seen in the Saturday clinic will be seen as soon as is possible the next working day for forensic examination. However, if there are concerns about significant injury in children (eg bleeding) that may require urgent

treatment they should be referred to the acute hospital for assessment.

- Examinations should be avoided at night unless it is agreed jointly between health, police and children's social care that it is in the child's best interests to do so. This will depend on the nature of the assault and age of the child/young person.
- Achieving Best Evidence (ABE) interview should preferably be undertaken before an examination. This should be as soon as possible after the allegation so that information from the child can be obtained. This will provide the most important evidence because examination, particularly in younger children, is usually normal even when abuse has taken place. A younger child's memory of events may be affected by those around them. This may not be possible if a registered intermediary is required. In 13-18-year-olds the ABE may be done before or after the examination.
- The decision regarding ABE should be taken on a case-by-case basis as the ABE may not be achievable within a short timeframe due to the need for trained intermediaries. There may be an agreement to examine the child or young person before the ABE if there is a chance that the forensic window may be missed, or it is agreed that it is in the child's best interest to have an earlier examination.
- If there is a significant injury the child will need to go to the local Paediatric Assessment Unit to be assessed. They may require examination under an anaesthetic. In this situation the Mountain Healthcare Doctor (<13yrs) or Nurse Examiner (>13 yrs) should be contacted to consider forensic sampling.
- The young person may require Sexually Transmitted Infection (STI) screening depending on the clinical assessment. In those over 13 this will be arranged through Integrated Contraception and Sexual Health Services (iCASH) but for those under 13 this will be arranged via the examining Mountain Healthcare Doctor. Consideration should also be given to toxicology screening if history suggestive.

3.2.2 Non recent sexual assault: This is an assault that has occurred more than 72 hours ago in pre pubertal child or more than 7 days ago in a post pubertal young person

If the alleged sexual assault is outside of the forensic window for specimens:

- Achieving Best Evidence (ABE) interview should preferably be undertaken before an examination. This should be as soon as possible after the allegation so that information from the child can be obtained. This will provide the most important evidence because examination, particularly in younger children is usually normal even when sexual abuse has taken place. A younger child's memory of events may be affected by those around them. In 13-18 year olds the ABE may be done before or after the examination. This may not be possible if a registered intermediary is required.

- If it is agreed that a CSA examination is required, then the examination will be arranged within working hours at the SARC. Images may be obtained (still or moving), but no forensic samples (DNA) will be required. The young person may need STI screening as above. (See SARC pathway appendix 3a/b).

3.2.3 When the presentation indicates an uncertain risk of CSA/ uncertain benefit from forensic safeguarding medical examination

For example, there may be a history of contact with a separated parent and the child has said something unusual which has worried the other parent, or the child may report they are sore, or a parent feels that the genital area looks red.

When taking the history from a parent it is important to note that children do not usually have a good understanding of their genital anatomy, thus are less likely to be able to give as clear a description of events than older children. Unless the child can give a clear description of a potential assault, a report from a parent should be assessed in the context of the child's developmental stage and the events surrounding their concerns.

In this scenario if the parent presents a child as above to a clinical service with genital symptoms e.g. to their GP or to an acute service, the clinician should examine the child as part of their assessment including examination of the genitalia within the competencies of their professional role. The clinician may want a second opinion but should not feel inhibited from an initial external examination as for any clinical condition. An examination can identify medical causes for symptoms and/or offer reassurance of no injury, but cannot rule out whether the child may have experienced some form of abuse, as genital examination is usually normal in children even when abuse has taken place (see Appendix 5).

As such the priority should be evidential interview rather than examination. If there is no

clinical reason and history does not suggest that CSA is likely, there may be no need for a further formal safeguarding medical examination. Otherwise follow guidance as above.

3.2.4 Presentation suggests low risk of CSA (may or may not require strategy discussion)

There would be a low risk of CSA if there has been no clear allegation, but the child is brought to the attention of medical care (GP, A & E, Paediatric Department) with symptoms but no specific safeguarding concern from a parent.

Whilst it is important to ask a parent or carer whether they have any concern that the child may have been intentionally harmed, consideration should be given to the presentation and history given. When the child is of pre-school age it will be more difficult to ask them directly whether they have been harmed.

They may be presented by their parents or by their educational setting, police or children's services with history of:

- Soreness in genital region
- Redness
- Bleeding
- Discharge
- Accident/Straddle injury

If there are genital symptoms the child will need a clinical examination to assess for conditions such as vulvo-vaginitis, infection (e.g. Group A Streptococcus), lichen sclerosis, normal physiological discharge, straddle injury or urinary tract infection (UTI).

This may be referred to the child's GP (if not initially presented to GP) or the paediatric team in the child's local area. The concerns from another agency (children's Services/police) **should always be discussed with the examining clinician** so they are aware of the circumstances and can agree that they are the best person to examine the child and have the relevant expertise and competencies to do so.

If the examining clinician is uncertain re their findings clinical and forensic advice can be sought from Mountain Healthcare Doctors or Strategy Coordinators. Tel: 0330 223 0099 see Section 5.

3.3 Female genital mutilation (FGM)

In cases where it is suspected a child may be at risk of FGM an immediate referral to CADS and Police should be made. A mandatory duty was introduced via the Serious Crimes Act in October 2015, which requires all regulated professionals (Health, Teachers and Social Workers) to report all known cases of FGM in girls under the age of 18, who are identified in the course of their professional work directly to the Police (Call 101). This is a personal duty and cannot be transferred to anyone else.

Once reported, a risk assessment according to the Government guideline 'Multi-agency Practice Guidelines: Female Genital Mutilation (HM Government 2014)' will then be followed. Please see NSCP FGM policy.

FGM-IS is a system which provides a national IT for healthcare professionals and administrative staff to record that a girl has a family history of FGM. It is part of the NHS Spine. Healthcare professionals and administrative staff can view, add and remove the FGM indicator, and it can be accessed via the Summary Care Record Application (SCRa), or with a local clinical system integrated with FGM-IS http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/#a01

3.4 Neglect

Any professional who has concerns about a child who may be subject to neglect should contact CADS in accordance with the NSCP policy on neglect. A community or acute paediatrician according to the locality (see Appendix 4) should be involved in the strategy discussion and consideration given to whether a safeguarding medical examination is required. This should be considered in all situations, including when the case is already open to Children's Social Care or Early Help.

4. Advice and consultation

For all professionals wanting advice regarding safeguarding concerns:
If there are safeguarding concerns about a child, it is advisable to consult within individual organisations initially and to follow the organisations' safeguarding protocols.
If, because of this consultation, concerns remain then you need to contact:

- Children's Advice and Duty Service (CADS) **Monday–Friday 09:00 to 17:00 on 0344 800 8021**, or out of hours though the Emergency Duty Team (EDT) on **0344 800 8020**. It is important to seek informed consent from the person(s) with parental responsibility unless seeking consent would put the young person at greater risk of harm.

The CADS consultation should include a joint decision between the consultant social worker and the referrer regarding actions to be taken using the guidance in section 3.

For children living on the borders of Norfolk contact may be with the relevant county Children's Social Care service (refer to the relevant Partnership Board policy).

If the CADS consultation indicates that a medical assessment is required, CADS will contact the relevant paediatric team (see below Appendix 2/4) to involve them in a strategy discussion prior to the medical assessment. This is to ensure that the most appropriate decision is made with respect to where, when, and with whom the medical assessment should take place.

4.1 For Health Practitioners wanting advice prior to contacting CADS

If clinicians need initial advice from a health practitioner about a potential safeguarding medical assessment of a child during working hours, they can discuss this with:

- The Named Doctor or Nurse within their Trust or organisation.

For GPs/Primary care clinicians

- GP Practice Safeguarding Lead
- The Designated Safeguarding Team (Named GP, Designated Doctor or Nurse) for Norfolk and Waveney – **01603 257164**
- The duty community Paediatrician for West **01553 668601** and Central Norfolk – **01603 508969** (Mon-Fri 09:00-1700)
- East – Consultant Paediatrician on-call **01493 452452** anytime or Safeguarding Office **01493 453964** Mon-Fri 0830-1600

Where a family lives on the borders of Norfolk as long as they are within the Norfolk border, please use contacts as above. If in Suffolk or Cambridgeshire please refer to the relevant Local Safeguarding Partnership policies.

5. Arranging a medical examination

5.1 If it is apparent that a safeguarding paediatric medical examination is required CADS will contact the relevant Paediatric Team (see algorithm Appendix 4)

Where it is considered likely that the child will need a medical examination, the case will be referred onto an allocated Social Worker who will arrange a strategy discussion with relevant professionals (depending on where the child or young person lives) which will include a paediatrician.

There are three acute Trusts covering Norfolk (James Paget University Hospital, Norfolk and Norwich University Hospital, Queen Elizabeth Hospital), and one community Trust (Norfolk Community Health and Care NHS Trust) which covers the West and Central areas. If it is considered that a medical examination is required, the assessing clinician will be contacted by a Consultant Social Worker to be part of that strategy discussion. If the child is already in hospital the strategy discussion would include the treating clinicians and other professionals as deemed necessary.

The Consultant Social Worker will convene a strategy discussion and decide with the appropriate clinician where and when the child should be seen. The Consultant Social Worker may ask the referring practitioner to contact the duty Paediatric Team (see table below), if the level of concern is such that it cannot wait for a strategy discussion.

Central
09:00-17:00
Duty Community Paediatrician
01603 508969

Central
Out of Hours
NNUH Paediatric Consultant On call
01603 286286

West Norfolk
09:00-17:00
Duty Community Paediatrician
01553 668601

West Norfolk
Out of Hours
QEH Paediatric Consultant on call
01553 613613

East Norfolk
Anytime
Mon-Fri 0830-1600
JPUH Paediatric Consultant on call
01493 452452
Safeguarding Team
01493 453964

Child Sexual Assault (Whole of Norfolk)
Anytime
Mountain Healthcare
0330 223 0099

5.2. Additional information about the past medical history may be obtained from:

- The GP's record (SystmOne or EMIS)
- Previous visits to the hospital within the hospital medical records
- Some children have complex health needs and will have records in several hospitals/NHS Community Trust/ CAMHS
- Younger children may have important medical information held by the Community Health Team which may include the Health Visitor and School Nurse and Family Nurse Partnership and these will be available on SystmOne.
- Community child health records are electronic (SystmOne). It is important to ensure access to all units within SystmOne i.e. Health Visiting, School Nursing, Looked After Children (LAC), Disability and Specialist Health and Primary Care as all are under separate provider units. There may also be paper records for children born before 2010.

There is not a single health record that encompasses an overview of all of a child's medical and developmental needs. The MASH Health Practitioners currently have access to SystmOne only and this will only provide a limited view if the GP uses a different system i.e. EMIS or there is no open record to share. The hospitals have full access to their own hospital records only.

Within hospitals some departments keep separate records and clinicians should be aware of this i.e. A&E attendances are recorded separately.

Adherence to best practice ensures that the conclusions drawn by Paediatricians and Forensic Nurse Examiners in Norfolk following medical examinations are informed by current evidenced based literature, discussed with a colleague and subject to consensus peer review.

5.3. Timing and Location of Examination

The timing of the examination depends on the health needs of the child/young person, the gathering of evidence and the legal requirements.
Practitioners must determine the purpose and scope of the medical examination. Normally this will require that the child and family will have been seen by a member of Children's Services social care staff and may also have been seen by the police. This initial assessment will determine the urgency and type of medical examination required. This will have been agreed as part of the strategy discussion at MASH. The child will normally attend with social care staff and/or police at the time of the medical examination.

Medical examinations must be pre-arranged and agreed as part of a strategy discussion with a Paediatrician or other examining professional. Medical examinations should usually be arranged within 24 hours of the referral. **Children should not be brought unannounced to A&E Paediatric Department or GP surgery unless there is a need for urgent medical treatment.** If there is a serious injury the child should be managed by the acute hospital team.

Appointments for medical examinations where there are safeguarding concerns should not be booked with GP surgery by parents or professionals without prior consultation with the GP and agreement over timing and appropriateness.

The timing and location of a medical examination should take into account the medical urgency, the safety of the child and the developmental and cultural needs of the child. This requires discussion between the referrer and the paediatrician.

Consideration should be given for instance to the child's need for sleep and the educational commitments of an older child.

For children where there is an alleged sexual assault (whether or not it is anticipated that there may be forensic specimens) a decision will be taken at the strategy meeting/discussion with Mountain Healthcare (0330 223 0099) with regard to the timing of the examination (See section 3.2). The examinations should usually be done within working hours, however if due to the circumstances of the allegation, the loss of the forensic window and the wishes of the child/young person it may be agreed that it is in their best interests to examine the child out of hours, although the only out of hours forensic service for under 13-year-olds in Norfolk is currently the regional Saturday clinics provided by Mountain Healthcare.

6. Consent

Consent to examine a child or young person (under 16) must be obtained prior to undertaking a medical examination. You must be satisfied and the person giving consent is fully informed. It is the responsibility of the examining Doctor to ensure that consent for the examination has been obtained. (See GMC guidance, RCPCH Child Protection Companion).

Consent may be given:

- By a young person over 16 years of age.
- By a young person who is under 16 years of age but of sufficient maturity and understanding to make the decision (assessed as Gillick Competent).
- By a parent or carer who holds parental responsibility.
- By the Local Authority if they have joint parental responsibility. It is good practice to inform the parent if it is safe to do so.
- By the High Court if the child is a ward of Court.
- By the Family Proceedings Court as part of a direction attached to an Emergency Protection Order, an Interim Care Order or a Child Assessment Order.
- When a child is looked after (LAC) under Section 20, their parent will have given general consent authorising medical treatment but it would be important to obtain consent for any non-routine assessment. Young people and children assessed as competent can consent themselves.

Consent for an examination cannot be given by an accompanying adult who does not hold parental responsibility e.g. stepparent, grandparent or foster carer. Parental responsibility is a legal term and is defined by the Children Act 1989 and 2004 which relates to the powers, duties, and responsibilities that an adult may hold over a child.

The Children Act states 'the interests of the child are paramount' thus if the medical team feel that the child or young person needs urgent medical attention this may override the requirement to obtain immediate consent.

A separate consent is required for any photo evidence obtained and would be given by a parent or carer at the time of the examination.

A person with parental responsibility should attend any medical assessment with the child or young person unless there are exceptional circumstances, and these should be discussed with the clinician undertaking the examination.

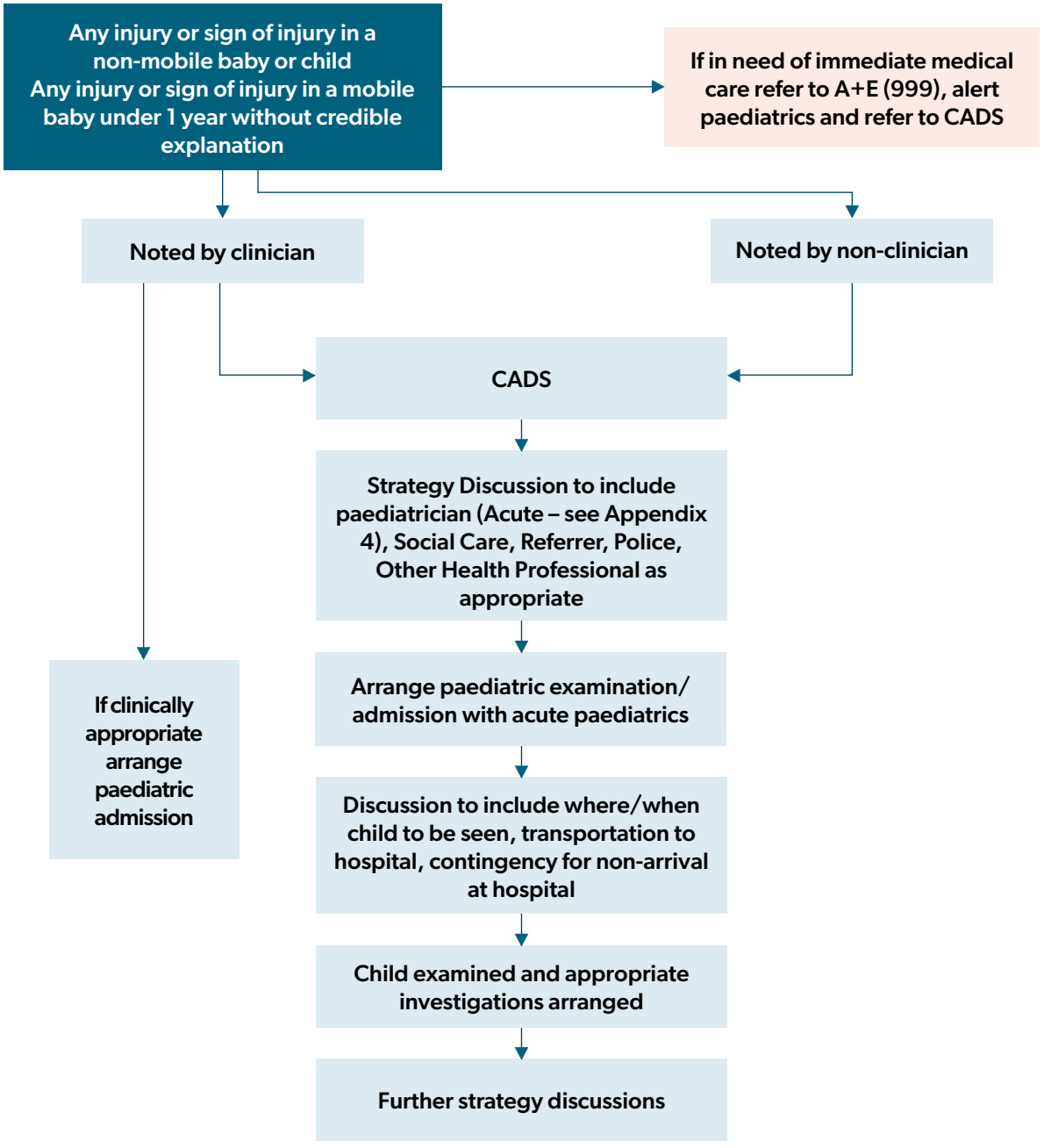
7. Information Gathering and Sharing

Information about the child's examination is gathered on a proforma that is included in the child's hospital medical records. It should also be documented on the child's electronic record that an examination has taken place. The proforma should be scanned and saved onto the child's electronic record in accordance with the Trust's record-keeping policy.

The paediatrician will prepare a medical report based on the findings recorded in the pro-forma. This report is shared with the referrer, children's social care, the GP and the police where necessary. In certain circumstances the report may be shared with the child's family. It is also included in the child's electronic record. This report may be used if the case goes to Court with the consent of the report writer. In some circumstances a report may be withheld if the child's interests may be jeopardised by circulating the report or where criminal proceedings may be jeopardised.

If a Court orders an examination, the resulting examination report is the property of the Court and would only be circulated to those named in the Court's instructions. However, these reports would also be kept in the child's medical record. If someone else requests a report that may be included as part of a submission to Court, the standard arrangements for any medical report would apply.

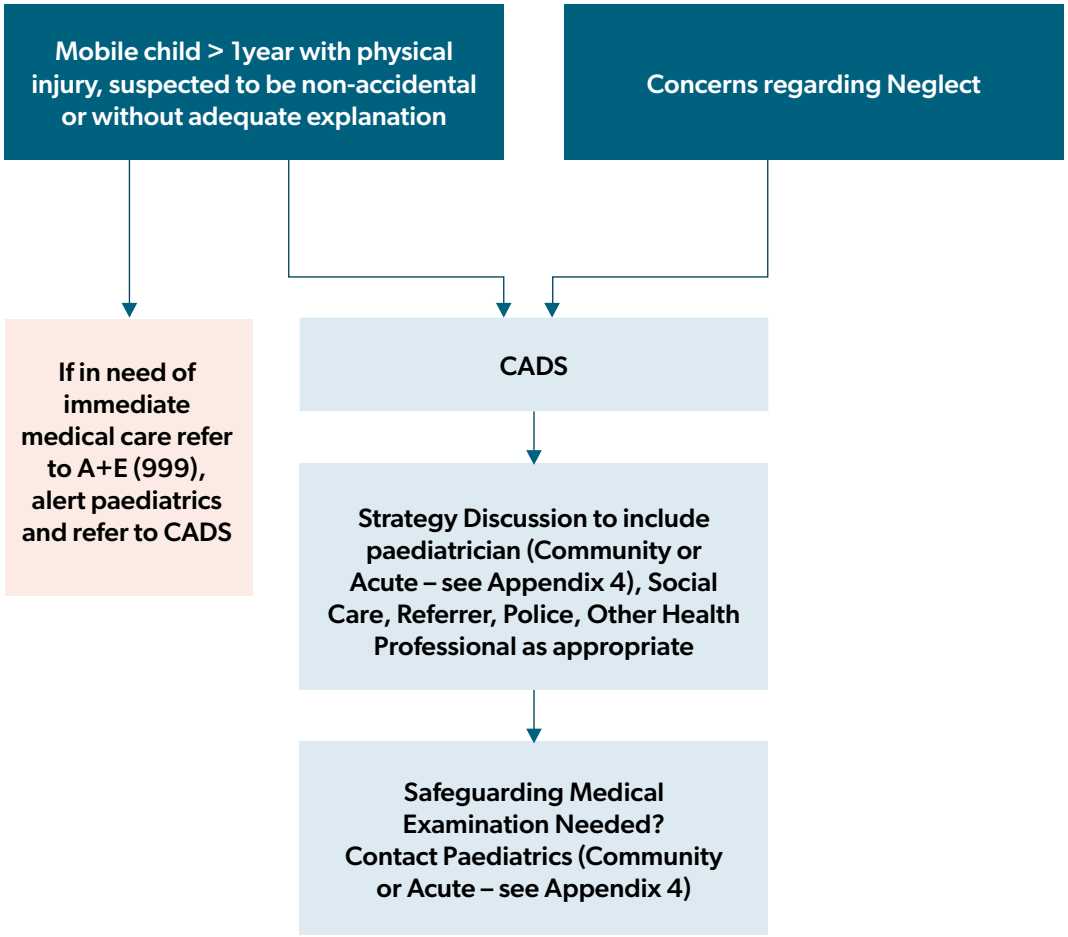
Appendix 1 - Non-mobile children and babies under 1 year



NB GPs must NOT be asked to see children for child protection medical examinations

If a formal child protection medical examination is not felt to be needed but it is felt that a medical review is required (eg for confirmation of birthmark) this must be discussed and agreed with the GP prior to attendance

Appendix 2 – Injury to Mobile Child >1 year or Concerns about Neglect



NB GPs should NOT be asked to see children for child protection medical examinations

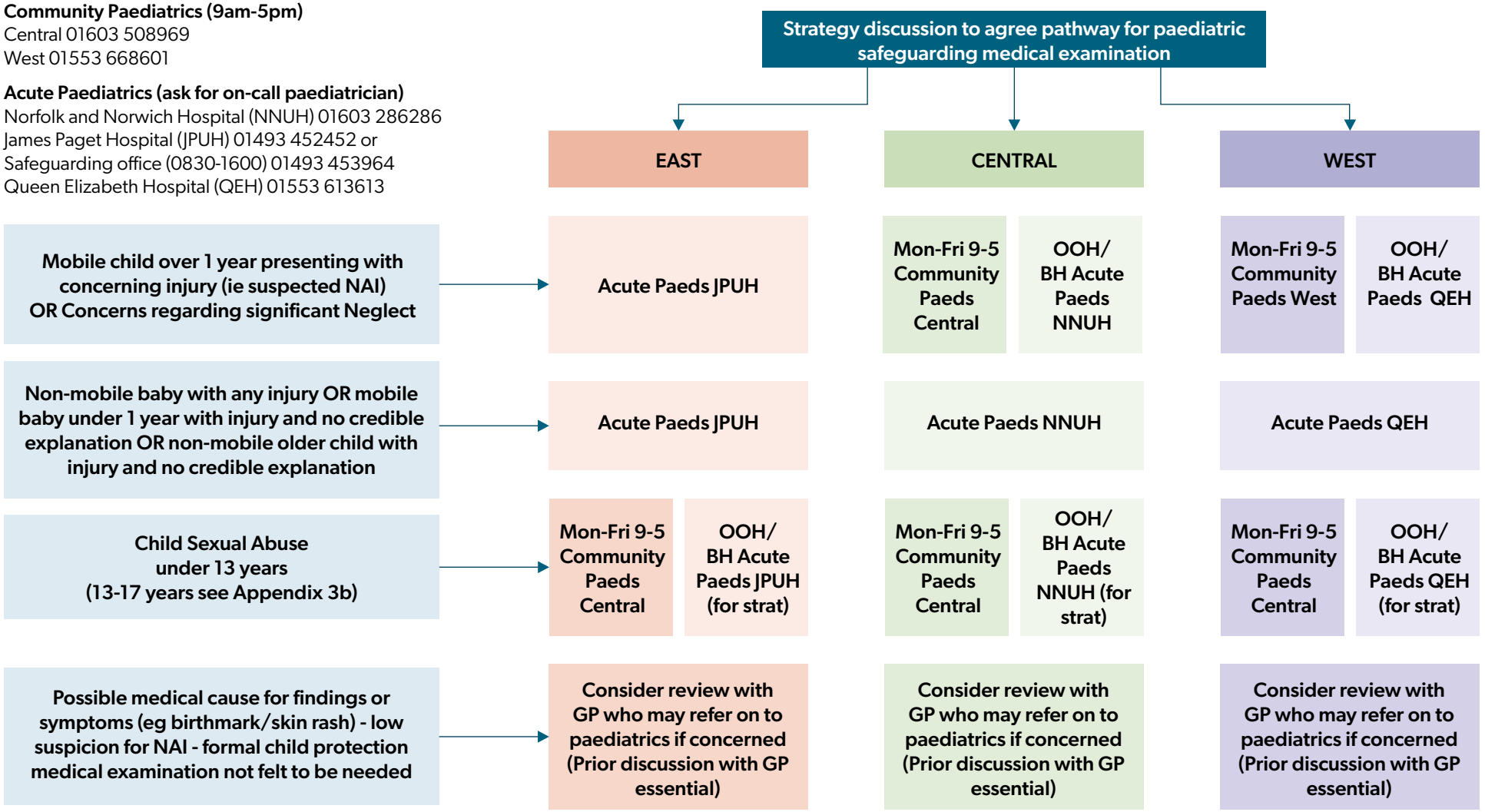
If a formal child protection medical examination is not felt to be needed but it is felt that a medical review is required this must be discussed and agreed with the GP prior to attendance

- Medical Examinations Appendix 3a – SARC Child Care Pathway Under 13 years
- Medical Examinations Appendix 3b – SARC Child Care Pathway 13-17 years

Appendix 4 - Strategy discussion to agree pathway for paediatric safeguarding medical examination

Community Paediatrics (9am-5pm)
Central 01603 508969
West 01553 668601

Acute Paediatrics (ask for on-call paediatrician)
Norfolk and Norwich Hospital (NNUH) 01603 286286
James Paget Hospital (JPUH) 01493 452452 or
Safeguarding office (0830-1600) 01493 453964
Queen Elizabeth Hospital (QEH) 01553 613613



Appendix 5 – References

Resources and References

1. Royal College of Paediatrics and Child Health (RCPCH) key child protection evidence https://www.rcpch.ac.uk/key-topics/child-protection/evidence-reviews

2. Genital findings in cases of child sexual abuse: Genital vs. vaginal penetration. Gallion, L J Milam, L L Littrell. J Pediatr Adolesc Gynecol 2016 Reviewed by Nancy D. Kellogg, M.D.RCPCH Child protection companion 2014

3. General Medical Council: Protecting Children and Young People: responsibilities of all doctors (May 2018) https://www.gmc-uk.org/ethical-guidance/ethical-guidance-fordoctors/protecting-children-and-young-people

4. General Medical Council: 0-18 Guidance for all doctors (May 2018) https://www.gmcuk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years

5. RCPCH Child Protection Companion https://www.rcpch.ac.uk/resources/child-protectioncompanion-about

6. RCPCH Child Protection Service Delivery Standards (October 2020) https://childprotection.rcpch.ac.uk/resources/service-delivery-standards/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