The Shrewsbury and Telford Hospital NHS Trust

Child Protection Guideline

Please note that the Radiology Section highlighted in yellow at section 5.3.1 on page 6 is currently under review

Version 1.6

Lead Clinician:	Named Doctor for Child Protection
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Written by:	Dr Sashwat Saran (Consultant Community Paediatrician, Named Doctor for Child Protection) Dr Andrew Cowley (Consultant Paediatrician with a special interest in Haematology) Dr Jaya Amarnath (Consultant Radiologist – Paediatrics) Dr Anustupa Banerjee (Community Paediatric Trainee) Dr Deevena Chinthala (Community Paediatric Trainee)
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Comments:	Available on SATH Intranet. Please note that the Internet version of this document is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments Copies of this document should not be printed unless absolutely necessary as this could pose a risk of out of date copies in circulation within the Trust. This Guideline is to be read in conjunction with: ***Trust Safeguarding Children and Young People Policy***
Equality Impact Assessment (EQIA)	This document has been subject to an Equality Impact Assessment and is shown to have a positive impact on children.

For triennial review

Version	Implementation Date	History	Ratified By	Full Review Date
1	31st July 2015	Amalgamation of the guidelines "When to Refer to Social Services", "Non-Accidental Injury" and "Arranging a Child Protection Medical".	Paediatric Governance (June 2015) Paediatric Guidelines Group	July 2018
1.1	12th October 2015	Addition of 5.6 and 5.7	Lead approved	July 2018
1.2	16th December 2015	Clarification of the process at 5.4	Lead approved	July 2018
1.3	10th May 2016	Change of process at 6.0, 7.2 and Appx 1	Lead approved	July 2018
1.4	16th November 2016	Minor amendment to the flowchart for referral of sexual assault	Lead approved	July 2018
1.5	20 June 2019	RCR/RCPCH September 2017 guidance incorporated Haematological section updated Appendix 4,5,6,7, CP medical check list, Parent Information leaflet ,audit tool incorporated	Paediatric Clinical Director approved	20 June 2021
1.6	7th August 2019	Requested that the CP Guideline remains Live, but the Radiology section is highlighted as currently under review	Guideline Lead - Dr Mukhopadhyay, Dr Singh, Lead for Clinical Governance and Lead Clinician Dr Saran	20th June 2021

1.0 Introduction

This guidance supersedes the previous guidelines of When to Refer to Social Services, NAI Policy and Arranging a Child Protection Medical. Approximately one child per week dies of abuse or neglect in England and Wales.

GMC guidance (2012) states: *"You must act on any concerns you have about a child or young person who may be at risk of, or suffering, abuse or neglect"*

Lord Laming (2009) said that the possibility of child abuse should be pursued with the same rigour as for any other potentially fatal condition.

2.0 Scope

This policy will apply to all Paediatricians and Junior Doctors working within Paediatrics.

3.0 Aim(s)

To provide advice about the diagnosis and management of suspected Child Abuse

4.0 Definitions

This guideline covers suspected physical abuse and neglect. (Appendix 1) For suspected Sexual abuse, please read the appropriate guideline. For emotional abuse please discuss with a senior or the Named Professionals for the Trust.

4.1 Definition of Physical Abuse and Neglect

Abuse and neglect are forms of maltreatment of a child.

- **Physical** Hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child.
  This could also be a fabricated or deliberately induced illness by the parent /carer.

- **Neglect** The persistent failure to meet a child's basic physical and or emotional needs. Ignoring medical or physical care needs; failure to provide access to appropriate health, social care or educational services; the withholding of the necessities of life such as medication, adequate nutrition and clothing.

5.0 Process

All children, about whom there is any child protection concerns should be discussed with a Middle-Grade Doctor within 4 hours, have a safeguarding information sheet completed and the Consultant should be informed within 12 hours.

All children with concerning injuries should have a formal Child Protection Medical performed as soon as possible (see below) ideally this should be done with written informed consent from someone with parental responsibility for the child. If the parents refuse or threaten to remove a child, the case must be discussed urgently with a Consultant Paediatrician and consideration given to asking the police to attend and issue a Police Protection Order. Sometimes the warning of this is sufficient.

If the concerns seem justified the Children's Social Care must be informed, initially by phone, but this should be followed up in writing within 48 hours. All communications should be documented in the medical notes.

If the NAI pathway is to be used, then parents must be given the Non-Accidental Injury parent leaflet which explains the process

Consent for Radiological imaging:
The referring clinician should provide a clear explanation to the person with parental responsibility for the reasons for the imaging requested including the procedure and the risks and information leaflet should be provided (see appendix).

5.1 Detecting signs of abuse

When to suspect abuse:

- Injures for which there is no adequate explanation
- Injuries for which the explanation varies or differs between witnesses
- Injuries that are inconsistent with the child's motor development
- Delayed presentation
- Inappropriate response to injury (i.e. parent unaware of painful injury)

- Multiple Injuries
- Patterned Injuries
- See also Bruising Pathway and Fracture Pathway (Appendix 2 and 3)

5.2 Arranging a Child Protection Medical

5.2.1 Roles and Responsibilities

It is everyone's responsibility to ensure a child is safe.

The referral pathway is for children who are well and the timing of the medical examination can be discussed and pre-arranged.

As of the 21st September 2015, a formal agreement has been put in place to ensure a robust child protection rota is available 5 days/week (Monday-Friday 9 am – 4 pm) according to the following referral pathway (Appendix 1)

All emergency/ suspected life-threatening physical abuse cases should be admitted acutely to the Children's assessment unit /Emergency Department, Princess Royal Hospital .The child should be managed acutely and admitted to the Paediatric ward at the Princess Royal Hospital.

The formally agreed and published monthly rota is primarily for elective child protection referrals received from police and social services or expected via the general practitioner where the child is well with no life-threatening injuries or concerns.

5.2.2 Pathway

Mon-Friday 9 am to 4 pm:

Contact Child Protection admin team based at Coral house on mobile **07854961218 or 01743450800** who will discuss with the on-call registrar or the consultant (if no registrar is available) the timing of the child protection medical. This is included in the child protection Rota published monthly.

Mon-Friday 4 pm to 9 pm:

Contact Triage Consultant via bleep**,** who will discuss with the relevant consultant the timing of the child protection medical. The consultant will be the acute on-call consultant for Paediatrics at the Princess Royal Hospital on 01952 641222. A decision may be agreed that the child could be seen by the child protection rota person on-call the next working day. It would be the general paediatric consultant's responsibility to phone the Child Protection admin the next working day to ensure that this is arranged.

Mon – Friday 9 pm to 9 am:

Contact on-call General Paeds registrar, Bleep 277 via switchboard – **01952 641222** who will discuss the timing of the child protection medical and discuss with the on-call consultant as appropriate.

Weekends and Bank Holidays:

Contact Acute general paediatrics via switchboard – 01952 641222
9 am to 3 pm – Triage phone on **07715 046840**
3 pm to 9 am - Contact on call General Paeds registrar on Bleep 277

5.2.3 Place of medicals

All Child Protection medicals should be done by agreement either on the Children's Assessment Unit or within the Paediatric Department at the Princess Royal Hospital in Telford.

5.2.4 Categorisation and Coding of CP medicals

All medicals must be coded according to the category. They are divided into simple and complex. It is expected that the majority will be simple (approx. 75%) with a small number being complex (up to 25%)

Typically a simple case will involve 2 hours of consultant time, no more than an FBC, clotting screen and child protection medical report.

Typically a complex case will involve 4 hours of consultant time, blood tests, radiology and clinical photography, and likely attendance at a case conference.

They must be coded correctly as follows by coding team:-

CP medical category – confirmed and coded
Simple = K05 (PRH), AE31 (RSH)
Complex = PAETCP (PRH)

5.2.5 Nursing Staff

It has been agreed that the nurses on CAU will be responsible for documentation of the child protection medical, with both acute parameters eg vital signs and growth parameters including head circumference. If required SATH should provide a chaperone, nursing assistant via the CAU.

5.2.6 Documentation

All cases need to be documented on SATH Child Protection Proforma and will remain in the child's SATH Paediatric notes.

5.2.7 Typing, Correspondence

Will be done by the Child Protection secretary, and in her absence, by the general paediatric Consultant of the week's secretary, and will need to be done within 72 hours of the medical being conducted.
The secretary will also need to check that the medical is recorded as above and the report is uploaded on Y drive (Child Protection folder).

5.3 Investigations

Physical abuse in children of >1 year and <2 years of age – Full skeletal survey (CT brain if clinical concerns).

Physical abuse in children of < 12 months of age - Full skeletal survey, CT brain & fundoscopy by Ophthalmologist.

Under Review for discussion (if there are significant concerns about the index child):

1. Where a child is suspected of being a victim of physical abuse, in the following children under 2 years of age, consider imaging regardless of the findings from physical examination:
    A. Any multiple birth siblings
    B. Sibling's and children living in the same household or family

2. If there is suspected abdominal or significant thoracic or injuries, Body CT is the imaging modality of choice as for accidental trauma. CT chest may be considered when there is doubt regarding the nature of rib abnormality identified on chest radiographs.

5.3.1 Radiology *Please note that this section is currently under review*

CT head should be requested as an emergency if there is any concern of a head injury. Discuss with Dr Amarnath if available or the radiologist covering CT scans or if out of hours with the on-call radiologist.

Request cards must state all the relevant history, examination findings and clinical suspicion of physical abuse and GMC number of the referring clinician. Clinician completing the request card must ensure that all the details including the responsible consultant's name are accurate.

Non-emergency CT head/Skeletal survey request must be discussed with Dr Amarnath at the earliest opportunity by middle-grade paediatrician or consultant. If Dr Amarnath is unavailable, discuss with another radiologist (Dr Rob Manns) who is able to supervise the skeletal survey and provide a primary report.

If a local radiologist is unavailable contact BCH radiology department (Dr Karl Johnson or Dr Adam Oates). Note that justification of the skeletal survey by a Paediatric trained radiologist is mandatory before the imaging takes place (RCR/RCPCH guidance 2017)

Request cards should include the name of the radiologist justifying the procedure. The card should be handed over to the radiology department which will be scanned on to CRIS.

Imaging will be arranged at a mutually convenient time during office hours.

The skeletal survey takes 45-60 minutes to perform so please ensure adequate analgesia – especially with a known fracture. Sedation may be needed (see sedation guidelines)

Request cards for follow up skeletal survey to be given to the radiology department at the time of the first skeletal survey. Radiology department will give the appointment letter for follow-up imaging on the same day to the paediatric staff. Follow up appointment needs to be conveyed to the carers/Children's Social Care

5.3.2 Procedure for Skeletal Survey

Consultant Paediatric consultant /registrar performing the child protection medical should contact Dr Karl Johnson **(karl.johnson2@nhs.net)** at BCH to ensure that he is available to report. Please provide him with all the clinical information. His secretary is: **jenniferwright1@nhs.net** Phone number is 01213339727.

Or in his absence to Dr Adam Oates **(adam.oates@nhs.net),** His secretary is Paula Smith (paulasmith11@nhs.net). The phone number is 01213339730.The fax number is 0121 333 9726.

Email patient demographics (i.e. Date of birth, unit number etc.) to bchpacs@nhs.net

This will be picked up by the PACS manager at BCH and 'verified' and will be available for review on BCH PACS. Please do this as soon as it is practicable, especially over a weekend (as images may be deleted after 24 hours if not verified)

Please mention in the BCH referral letter to send a copy of the report from BCH to the referring local paediatric consultant and also to Radiology for incorporation into local PACS (Radiology PA lisa.mansell1@nhs.net and Dr Amarnath jaya.amarnath1@nhs.net)

If the CT head is abnormal the child will need an MRI head and spine, under sedation, urgently within 2-5 days – (see protocol below).
Paediatric team to ensure that MRI request card is given to radiology and that this is arranged within the stipulated time as far as possible.
All skeletal surveys should have a follow up skeletal survey 11-14 days later. This would include CXR with oblique's, all forearm bones and repeat of suspicious areas on the initial skeletal survey as advised by the radiologist.
All follow up imaging (skeletal survey/ CT/ MRI) will need a formal second report from BCH.

If a child fails to attend follow up an appointment, radiology appointments staff will inform named nurse for child protection, Teresa Tanner (Ex 4195)/email Teresa.Tanner@nhs.net

5.4 Blood Tests

All children with unexplained bruises or suspected non-accidental bruising should have a bleeding history taken along with a full clotting screen. Blood group testing is not required. BCH do this but it needs to be booked with them and the blood sent over specially.
The bleeding history will need to include

Family history – especially sibling, paternal or maternal easy bleeding. Epistaxis, menorrhagia. Any significant bleeding post operation, injury.

Personal history – e.g. Previous bruising, bleeding examples:-.

Neonate:

Cephalohaematoma, bleeding post heel prick, post vaccinations. Please confirm if Vitamin K was given and how if less than 4 weeks old.

Infant:

Easy bruising, spontaneous haematomas or following vaccination, gum bleeds following dental eruption, muscle / joint bleeds

Older child:

Bleeding following surgery, trauma, dental extraction epistaxis, menorrhagia.

Investigations will include:

- FBC + film
- PT, PTT, Fibrinogen
- Factor VIII
- Von Willebrand factor activity and antigen
- Factor XIII

All these can be accessed on Review – Test Groups – Paediatrics – NAI protocol, and the lab will send them to BCH so we get a rapid turn-round.

Interpretation of results:

Normal ranges for PT/PTT based on age (healthy term)

	Day 1	Day 5	1 month	3 months	6 months	Over 1 year
PT (s)	13 +/- 1.4	12.4 +/- 1.5	11.8+/- 1.3	11.9+/- 1.2	12.3 +/- 0.8	12.4+/- 0.8
PTT (seconds)	42.9+/- 5.8	42.6+/- 8.6	40.4+/- 7.4	37.1+/- 6.5	35.5+/- 3.7	33.5+/- 3.4

FBC = Platelets should be more than 150 with a normal differential.

- If normal FBC, PT and PTT and no significant family or personal history – reassure.

- If normal FBC, PT and PTT but significant family history, personal history then please refer to Paediatric Haematology locally as an outpatient.
- If abnormal basic screen e.g. FBC, PT, PTT then please discuss with Dr Andrew Cowley or Dr Tabitha Parsons as per rotawatch. If out of hours discuss with the consultant on call or the Paediatric Haematologist at Birmingham Children's Hospital.

All children with fractures should have

Bone profile including calcium, magnesium, phosphate and Vitamin D.

Although it is usually easy to diagnose Rickets, this may prevent arguments in Court.

5.5 Photographs

All injuries should be photographed promptly. If the police are already involved it may be easier to ask SOCO (Scenes of Crime Officers) to take the photographs, but always worth being there to ensure the correct views are taken.

If the police are not involved or interested you will have to arrange this.

- Parental consent is needed. Ensure the box is ticked on the CP medical record sheet, as the consent forms do not say for Social Service / Police purposes.
- If parents refuse consent you must explain that by doing the photographs, the evidence is being taken that may help them. If they continue to refuse you may need the Police.
- Medical Photography via switch 24 hours a day, they may not guarantee a service out of hours. If there is going to be a significant delay, then there is a camera available in the Medical Devices Library (more often used for photos of pressure sores)
- If using the camera from the Medical Device Library, the SD card is kept in the CD cupboard. If not there ask the porter to collect one with the Camera, these will need to be signed for.
- Camera to be returned to the Medical Device Library, but the SD card to be kept in a sealed enveloped, signed and dated with the request form until the Medical Photographer can collect it. This is the responsibility of the Consultant.
- Please ensure there is a scale in all the photos.
- Please request 2 copies of the photos (one for the notes and one for Social Care or Police)

5.6 Siblings/other children in the household

Consideration should be given to the safety of any other children in the household and as to whether they should be investigated. It would be normal to arrange a CP medical, fundoscopy and skeletal survey for any children less than 2yrs old, but this should be a Consultant decision.

5.7 Burns

The opinion of a plastic surgeon should be obtained for any possible burns, even if they do not warrant transfer – Contact via the Burns Unit at BCH.

6.0 Training/ Key Performance Indicators

6.1 Staff are aware of the policy and action to be taken if abuse is suspected

6.2 Key staff receives appropriate training

7.0 Monitoring of Policy

Monitoring the effectiveness of this policy will provide assurance to the Trust that the specified risks in relation to child abuse are being managed appropriately. An annual report highlighting any trends in referrals will be produced by the Lead for Child Protection for the Director of Service Delivery based on the Key Performance Indicators (see next section). Any themes arising will be presented at the Quality & Safety Meeting

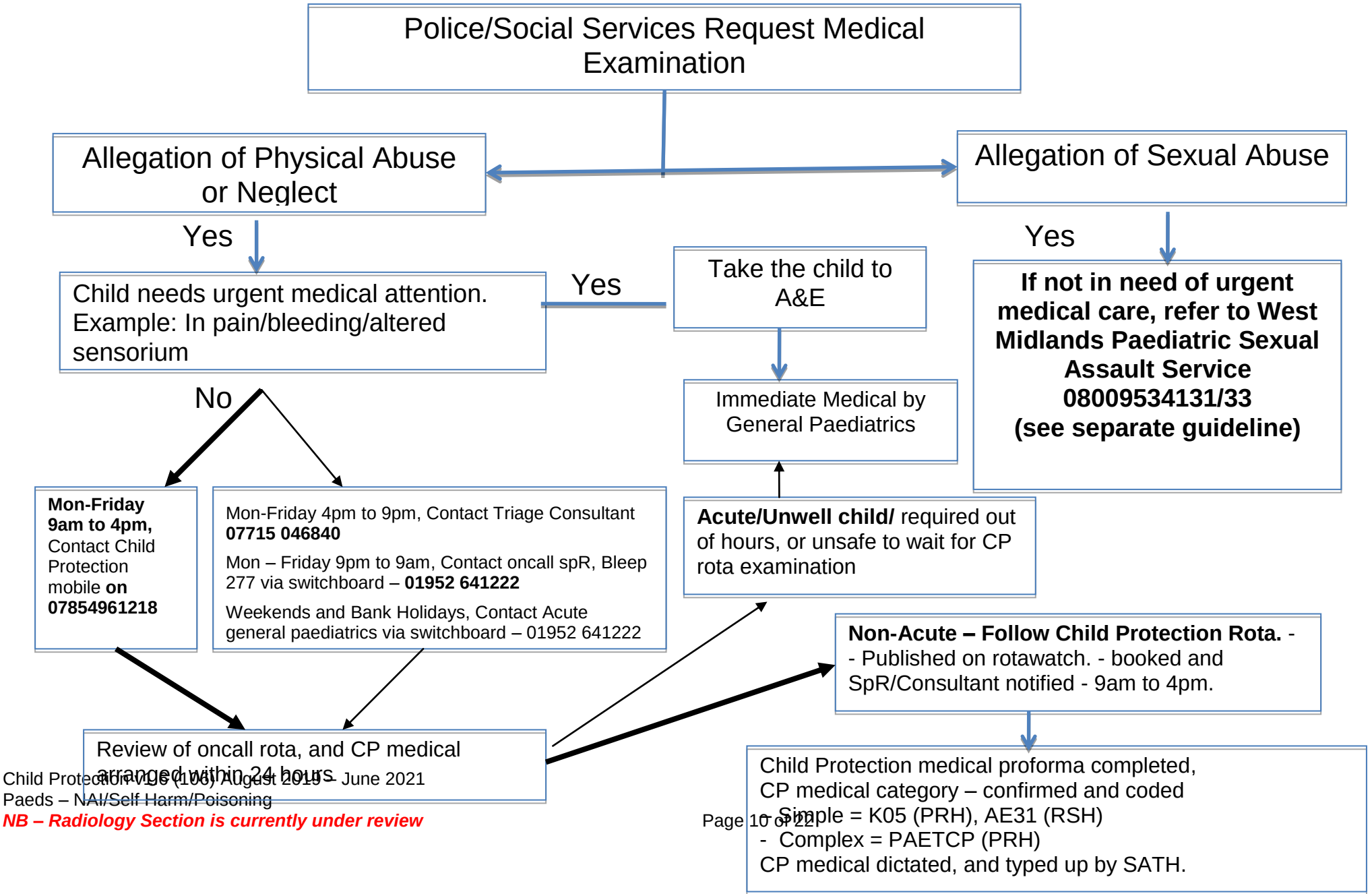
8.0 References and Associated Trust Documents

- The Radiological Investigation of Suspected Physical Abuse in Children (September 2017). A joint publication from The Royal College of Radiologists and The Society of Radiographers, Endorsed by the Royal College of Paediatrics and Child Health.

- HM Government -2018, Working Together to Safeguard Children

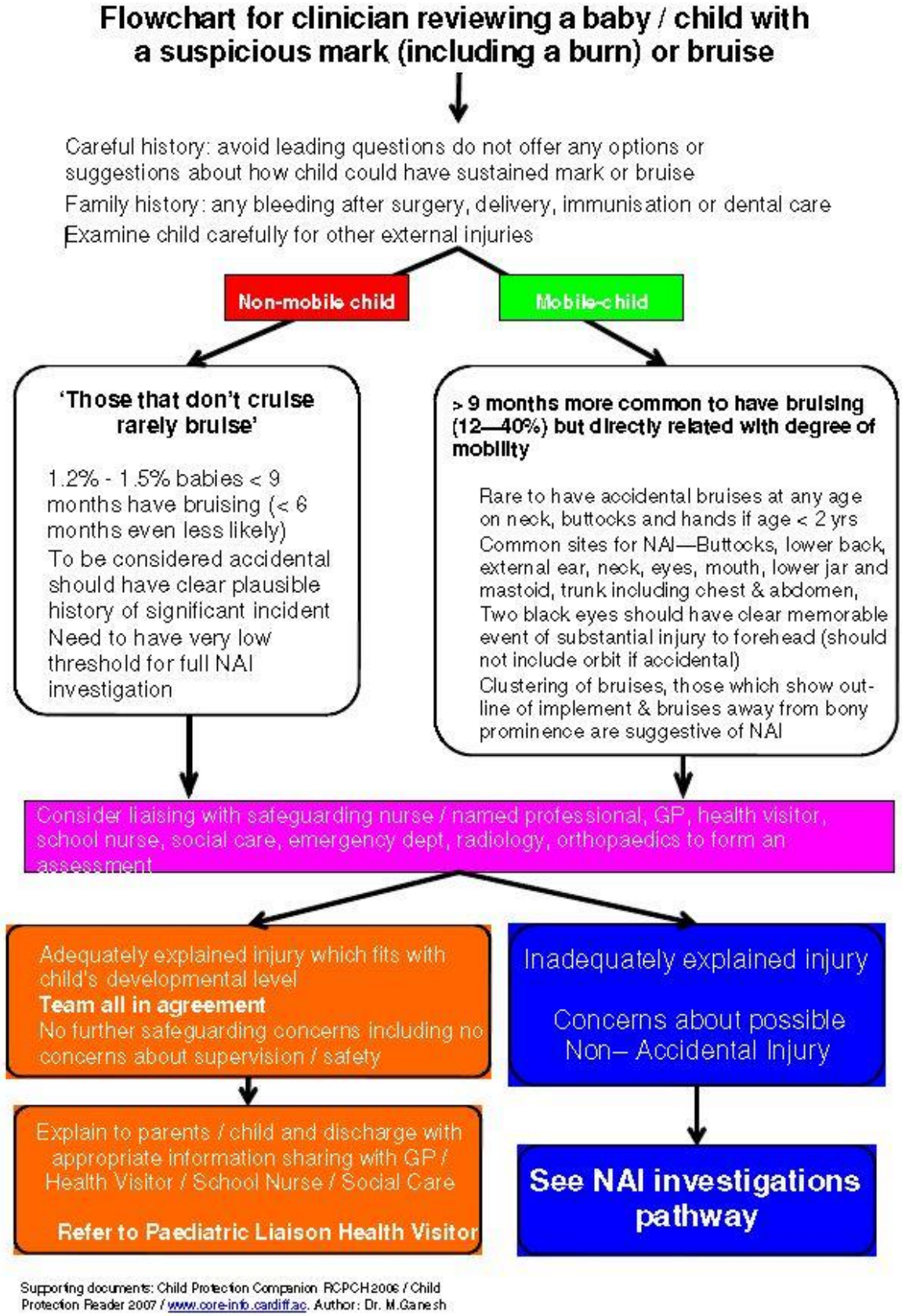
- NMC -2015 Code of Professional Conduct

Appendix 1 -Referral Pathway for arranging medical examination for suspected physical abuse



NB – Radiology Section is currently under review

Appendix 2


Flowchart for clinician reviewing a baby / child with a suspicious mark (including a burn) or bruise
Careful history: avoid leading questions do not offer any options or suggestions about how child could have sustained mark or bruise
Family history: any bleeding after surgery, delivery, immunisation or dental care
Examine child carefully for other external injuries
Non-mobile child
Mobile child
'Those that don't cruise rarely bruise'
1.2% - 1.5% babies < 9 months have bruising (< 6 months even less likely)
To be considered accidental should have clear plausible history of significant incident
Need to have very low threshold for full NAI investigation
> 9 months more common to have bruising (12—40%) but directly related with degree of mobility
Rare to have accidental bruises at any age on neck, buttocks and hands if age < 2 yrs
Common sites for NAI—Buttocks, lower back, external ear, neck, eyes, mouth, lower jar and mastoid, trunk including chest & abdomen,
Two black eyes should have clear memorable event of substantial injury to forehead (should not include orbit if accidental)
Clustering of bruises, those which show out-line of implement & bruises away from bony prominence are suggestive of NAI
Consider liaising with safeguarding nurse / named professional, GP, health visitor, school nurse, social care, emergency dept, radiology, orthopaedics to form an assessment
Adequately explained injury which fits with child's developmental level
Team all in agreement
No further safeguarding concerns including no concerns about supervision / safety
Inadequately explained injury
Concerns about possible Non– Accidental Injury
Explain to parents / child and discharge with appropriate information sharing with GP / Health Visitor / School Nurse / Social Care
Refer to Paediatric Liaison Health Visitor
See NAI investigations pathway
Supporting documents: Child Protection Companion RCPCH2006 / Child Protection Reader 2007 / www.core-info.cardiff.ac. Author: Dr. M.Ganesh

Appendix 3

Please affix patient label

CHILD PROTECTION/SAFEGUARDING MEDICALS

Please complete for any child who has a safeguarding medical and return it to the nurse in charge of CAU. The nurse must place in the box for Hazel/Linda to record.

Child protection medical carried out by:

Community Paediatric Team

Name:

OR

Paeds Associate Specialist/Registrar/Consultant

Name:

Did child have any of the following? If so please tick…

- Blood tests, (FBC, clotting/extended clotting) ☐
- X Rays ☐
- Clinical Photography ☐

Episode recorded on Sema ☐ Date recorded on Sema

Signature:

Forward this form to Tina Kirby, W&C Business Manager (c/o Haematology Corridor, PRH) at end of each month.

Appendix 4:

Radiology Consent form For Suspected Physical Abuse in Children

Patient identifier detail/label
Name:
Date of birth:
Hospital No:
NHS number:
Male/female:

Sections 1 and 2 to be completed by the referring doctor

1. Details of proposed radiological investigations

I have explained the procedure to the person with parental responsibility for the child, or accompanying member of staff if that individual is attending with the child, including:

- Radiological imaging (Skeletal survey/Plain x-rays/ CT /MRI) will take place within the radiology department at PRH, Telford. Two radiographers and a paediatric nurse or a doctor and sometimes play therapist will be present during the skeletal survey
  Child needs to be still for each image, you or a member of staff will be required to hold the child still. A further follow-up imaging will be arranged at 11-14 days.

- Provided the advice leaflet YES / NO

- The reasons for the radiological investigation(s):

- Any risks associated with the investigation(s):

Signature of referring doctor:
Date:

Name (print): Job Title:

GMC No:

2. **Where applicable:** Details of any court order supporting this examination, for example, Emergency Protection Order or equivalent

• Court order number:
• Additional information, for example, date of expiry:

TO BE COMPLETED BY THE INTERPRETER (IF PRESENT):

3. I have, to the best of my ability; accurately communicated the information provided by the doctor to the person with parental responsibility and relayed any queries back to the doctor.

Signed:

Date:

Name (print):

Special requirements

4. The communication and access needs of the person with parental responsibility have been met, for example, language interpretation, sign language, access needs etc. (circle which is appropriate)
No specific needs identified or **Yes If yes please state what was provided:**

5. To be completed by the person with parental responsibility/legal guardian:

- I confirm that I have legal responsibility for this child.
- I agree with the radiological investigation(s) described in this form being performed on my child.
- I confirm I have had the opportunity to have any questions about the procedure answered.
- Should sedation or general anaesthetic be required I understand that I will have the opportunity to discuss the details with the paediatrician or anaesthetist. I understand an additional consent form will be required.

Signature: Date:

Name (print):

Relationship to child:
Section 6 and 7 to be completed by lead radiographer on admitting child to imaging room for procedure

6. Confirmation of agreement
I have:
- Confirmed the identity of the child with the person with parental responsibility Checked that they have no further questions
- Checked prior documentation of consent
- Ensured that they give permission for the radiological examination(s) including any required immobilisation to go ahead.

Signed: Date:

Name (print): Job title:

7. If the person with parental responsibility withdraws consent at any time during the procedure, the signature is required below, along with the reason for withdrawal.

Reason:

Signed (person with parental responsibility):

Date: Time:

Signed (radiographer):

Date: Time:

Adapted from:
The radiological investigation of suspected physical abuse in children (Sept 2017 BFCR(17)4). www.rcr.ac.uk endorsed by RCPCH

Appendix 5:

Information leaflet for those with parental responsibility

This information is for those with parental responsibility for children who need X-rays and scans when there are concerns raised for a child's welfare.

Why are any tests needed in this situation?

NHS hospitals and all their employees have a duty to protect children. Staff are encouraged and expected to raise concerns if they believe the care or welfare of a child is at risk. Although this can be upsetting and difficult for those with parental responsibility, the child's wellbeing and safety come first.

If any concerns are raised, it is important that these are investigated fully. As part of the investigation, it is essential to identify any injuries. In younger children and babies, injuries can be difficult to find. For example, bruising on the surface of the brain can occur without any apparent injury to the outside of the head. Similarly, bones may be broken without any obvious external signs. X-rays and scans can help to diagnose these injuries.

What X-rays and scans will be needed?

A baby or young child will require a skeletal survey X-ray examination and a computed tomography (CT) head scan. Other tests may also be necessary, which could include ultrasound, nuclear medicine or magnetic resonance imaging (MRI) scans.

What is a skeletal survey?
This examination takes place over two visits about two weeks apart. You will be given an appointment for the second visit once the first appointment is complete.

First appointment
The skeletal survey is carried out by appropriately educated and trained paediatric radiographers who are skilled in dealing with children. They will help you and your child throughout the examination. A nurse, or another healthcare professional, will also be present to help and support you and your child.

A skeletal survey is an X-ray examination of the whole body and will involve at least thirty separate X-ray images. This can take up to an hour to perform. Your child will need to keep still for each image taken. You may be asked to help hold your child still although toys and other distractions will be available. You may want to bring your child's favourite toy or comforter to help with this. Sometimes your child will be sedated; you will be able to discuss this with your doctor. The staff present will be able to help you in holding your child safely, so as to cause as little distress as possible to both you and your child. You will need to wear a special protective apron while holding your child to prevent your own exposure to X-rays. If you are pregnant or could be pregnant, you must tell the radiographer. You will not be allowed to hold your child in this case. It is not unusual for a child to become distressed or grizzly during the procedure due to the need to be kept still for the images. You will be able to comfort your child between X-ray images.
The radiographers who perform the X-rays will not know the result. The images will be reported by a Consultant Radiologist. The results will be discussed with you by the doctor looking after your child's care.

Second appointment
Sometimes recent injuries are not visible initially and will only be seen on images obtained later. The skeletal survey examination is not complete until a shorter second series of images has been taken. You should ensure your child returns for the second appointment

11–14 days after the first series. You will be given an appointment to bring your child back for these images. The process of taking the images will be very similar to your first appointment.

CT brain scan
A CT scan is performed by experienced radiographers and produces images of the brain and the skull. The scan is relatively quick although your child will need to lie very still. If you are not pregnant you may be able to stay with your child. Sometimes sedation may be used to help to keep your child still.

The radiographers who perform the CT brain scan will not know the result. The scan will be reported by a Consultant Radiologist. The results will be discussed with you by the doctor looking after your child's care.

MRI scan
It may be necessary for your child to have an MRI scan of their brain and other areas. This will be performed by experienced radiographers. The MRI scanner looks similar to a CT scanner, but the interior is more like a tunnel. An MRI scan can take up to one hour and is noisy. Your child will need to be perfectly still for this and may need a general anaesthetic/sedation.
The paediatric doctor will explain to you the details of the anaesthetic before your child has the MRI. You will be asked to provide your agreement for this procedure to be undertaken.
The radiographers who perform the MRI scan will not know the result. The scan will be reported by a Consultant Radiologist. The results will be discussed with you by the doctor looking after your child's care.

Can I stay with my child at all times?
Those with parental responsibility may be able to stay in the room with their child during these examinations. If you are allowed to stay, the radiographer will tell you where to stand/sit and will ensure that you and your child are safe. Sometimes you may be asked to assist staff in holding your child. The radiographer will help you to do this safely. You do not have to remain in the room if you choose not to, as there will be experienced health staff present to look after your child.
In the X-ray or CT scan room, you will be required to wear a heavy protective apron to protect you from the scattered radiation.
If your child is having an ultrasound or MRI scan you do not have to wear any protective clothing.
The MRI radiographers will go through a checklist with you to ensure that it is safe for you and your child to be in close contact with the MRI magnet.
If there is any possibility that you may be pregnant, please tell the radiographer.

Pregnant mother or guardian?
A baby in the womb can be particularly sensitive to the radiation of an X-ray or CT scan. If you are or may be, pregnant you can accompany your child to the X-ray department. You may not be allowed in the actual X-ray or scanner room when the X-rays are being used. A friend or relative may be able to accompany your child if necessary. Professional health staff will always be there to look after your child.

Risks

Radiation
We are all exposed to natural background radiation. This is made up of cosmic rays, radon; from some foods and from the ground. Every X-ray gives us a small additional dose of radiation.

A skeletal survey is equivalent to a few months' background radiation.

A CT head scan is equivalent to about 18 months' background radiation.

These extra exposures to radiation slightly increase the lifetime cancer risk, but the increase in risk is very small. Your child will not be exposed to any more X-rays and scans than is absolutely necessary to adequately complete the examinations. Before any examination that uses radiation is carried out, the benefits of having the examination are closely weighed against the risks of the radiation itself. All X-ray doses are kept 'as low as reasonably practicable' to ensure that images of high diagnostic quality are obtained without exceeding accepted doses. This is particularly the case with children as they are still growing and more susceptible to radiation. The radiographers will use techniques to try to ensure that they achieve the correct X-ray first time and use various methods to keep the dose to your child as minimal as possible. Your child will not be exposed to any more radiation than needed to gain the examinations required.

For further information:
NHS Choices – Radiation: www.nhs.uk/conditions/Radiation/Pages/Introduction.aspx
GOV UK – Radiation: risks from low levels of ionising radiation, 2008:
www.gov.uk/government/collections/radiation-risks-from-low-levels-of-ionising-radiation
You can also seek further information from your radiographer.

MRI
Extensive research has been carried out into whether the magnetic fields and radio waves used during MRI scans could pose a risk to the human body. No evidence has been found to suggest there's a risk, which means MRI scans are one of the safest medical procedures currently available. Not everyone can have an MRI scan. For example, they're not always possible for people who have certain types of metal implants fitted, such as a pacemaker (www.nhs.uk/conditions/pacemaker implantation/pages/introduction.aspx) (a battery-operated device that helps to control an irregular heartbeat [www.nhs.uk/conditions/Heart-palpitations/Pages/Introduction.aspx]).
A safety check will be done by the radiographer for you and your child before an MRI scan.

Adapted from: The radiological investigation of suspected physical abuse in children (Sept 2017 BFCR(17)4). www.rcr.ac.uk endorsed by RCPCH

Appendix 6:

Follow-up imaging form for those with parental responsibility

Second visit

Follow-up imaging for unexplained injuries: to be given to the person with parental responsibility

This appointment is logged on to the hospital's booking system to ensure that in the event of your child not attending, an alert is produced.

Follow-up imaging

Follow-up X-ray imaging, between 11–14 days after the primary survey, is always required for children that have undergone X-rays for skeletal surveys. Other follow-up imaging may also be required.

An appointment is needed for these examinations.

Please ensure that:

Name:

DOB:

NHS number:

Attends for further imaging (please specify):

On:

Time:

Place:

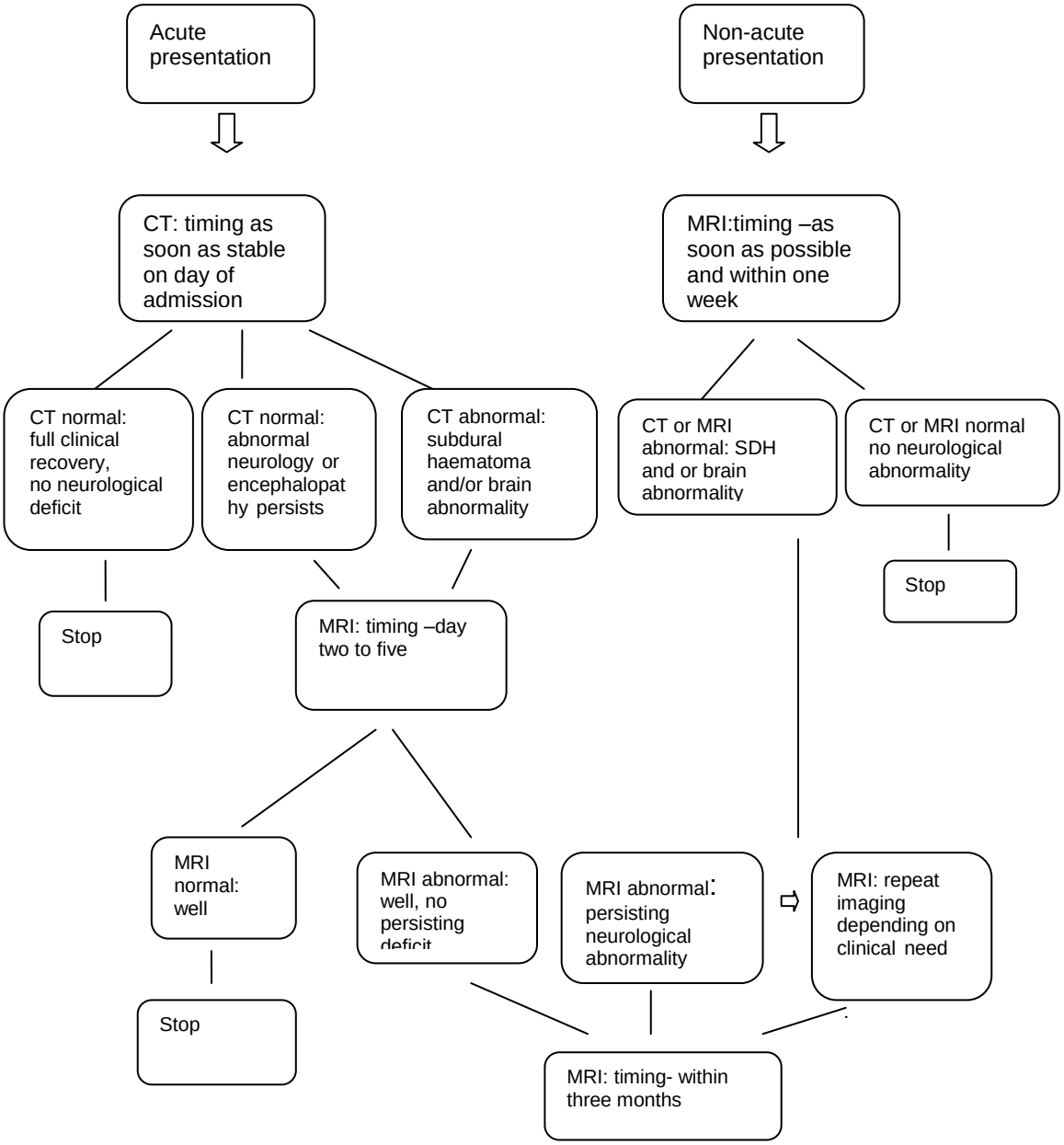
Contact details of hospital department: 01952 461222, extension 4201

Follow-up imaging is an essential part of the original skeletal survey, and a complete report cannot be given until these images have been taken.

Please contact the hospital if there are any problems with attending this appointment. Failure to attend this appointment will result in action being taken to ensure that your child has the follow-up imaging required.

Appendix 7

Neuro Imaging algorithm for suspected physical abuse (as per Royal college of Radiology)



Please affix patient label

Child Protection Medical Checklist

	Date	By Whom	Results seen (by whom)	Any action needed
Child Protection Medical Done				
Child Protection Medical Typed				
Child Protection Medical sent to Police / Social Worker				
CP Bloods				
Any other Bloods needed? If so what / why?				
Skeletal Survey/Other images				
SS/Other images sent to BCH for second opinion				
SS/Other images report back from BCH				
SS/Other images letter to SW / Police				
2nd SS/Other images completed				
Follow up letter sent to Police / SW				
Anything else?				
Any Follow up?				

The Shrewsbury and Telford Hospital NHS Trust

Information for Parents

Unexplained injuries

Your child has been admitted with an injury and we are not sure how it happened. Because of this we have a legal requirement to follow our safeguarding pathway.
This leaflet will explain what will happen next and what you should expect.

We recognise that young people heal best when their families are part of the team. Our paediatric team is committed to providing patient and family centred care, an approach now embraced in paediatric facilities around the world. The key principals are:

• Dignity and respect

•Information sharing
• Participation
• Working together.

We understand that this will be an extremely difficult time for you and hope that you understand the reasons that it is necessary. If you have any questions at any stage during this process then please speak to the nurse or doctor looking after you and your child.

If you have any concerns about your care please contact:
Patient Advice and Liaison Service (**PALS**) PALS will act on your behalf when handling patient and family concerns. They can also help you get support from other local or national agencies. PALS, is a confidential service.

Visit: www.sath.nhs.uk/patients-and-visitors/complaints.aspx,
or phone:
Princess Royal Hospital: **01952 282888**
Royal Shrewsbury Hospital: **01743 261691**

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KPI	Timeliness	Standard
1. Referral to the child protection medical examination	Neglect -10 working days Physical injury-24 hours	RCPCH
2. Timeline from the CP Medical examination to the final report sent to the Social care	3 working days	RCPCH: 72 hours
3. Follow-up imaging performed or not	Within 14 days	RCR/RCPCH
4. Information leaflet Shared with the Parents/Carers		RCR/RCPCH