Child Protection Paediatric Examination Proforma

This proforma is designed to be completed as appropriate for individual cases

The sections with this symbol ✓ contain data required for national MCN and Public Health Scotland.

✓ 1. Child Details

Name of child

Date of birth:
CHI number:

Address and postcode

Age
Sex* Female ☐ Male ☐
(*see over for CSA cases)
School / Nursery attended

ion	☐
Significant Learning Disability	☐
Autistic Spectrum Disorder	☐
ADHD	☐
Mental Health Issues	☐
Drugs/Alcohol	☐
Previous LAAC	☐

Child Protection Registration
Is the child on/ever been on CPR:
No ☐ Yes ☐ Details:

Current Experience

Seeking Asylum	☐
Child Exploitation	☐
Residential Care	☐
LAC -home	☐
LAAC- foster care	☐

Names and DOB of Parent(s) / Carer(s) attending:

✓ 2. Examination details

Date of examination:

Time of examination:

Out of Hours or weekend	Yes		No	

Location of examination:

Type of examination:

Acute Joint Paediatric Forensic – sexual (≤ 7 days)	☐
Elective Joint Paediatric Forensic – sexual (> 7 days)	☐
Joint Paediatric Forensic – physical/neglect	☐
Specialist Medical (single doctor)	☐
Specialist Medical – sexual (single doctor)	☐
Forensic Physician Only:	☐

Doctors
Examiner 1:
Designation:
GMC number:
Male / Female:

Examiner 2:
Designation:
GMC number:
Male/Femal

Name CHI Date

✓ 3. Category - tick relevant box(es) to indicate type(s) of abuse

	At Referral	Your conclusion after assessment		At Referral	Your conclusion after assessment
Physical abuse	☐	☐	FGM	☐	☐
Sexual abuse	☐	☐	CSE	☐	☐
Emotional abuse	☐	☐	No clinical findings but other concerns that suggest abuse		☐
Neglect	☐	☐	Not abuse		☐
Fabricated or induced illness	☐	☐	Clinical findings but not conclusive of abuse		☐

✓ 4. For CSA cases only

Source of Referral:

Date and time start of IRD:

Date and time of referral to Health:

If there was a delay, what was the reason:

Child /Family were given the opportunity to express their preference of sex of examiner(s):

Female preferred: ☐
Male preferred: ☐
No preference: ☐
Not asked: ☐

Sexual Orientation (optional if under 13)

Heterosexual ☐
Gay ☐
Lesbian ☐
Bisexual ☐
Not certain ☐
Not disclosed ☐

Consent Form from National Proforma

5. Consent to history, examination, investigations and report

Child's Name: ..... DOB.....

Address: ..... CHI No.....

"A guide to the medical examination of your child" information leaflet given Yes No

Permission must be obtained from parent(s) or other(s) with responsibility for the child and from the child where appropriate.

I give permission for:

1. Medical Examination	Yes	No	N/A
2. Photography of Clinical Findings	Yes	No	N/A
3. DVD of Genital Findings	Yes	No	N/A

Photographs, DVDs and Radiological images will be stored securely as part of the clinical records. They may be used to support clinical evidence of injury and may need to be shared with other doctors involved in any court proceedings.
I understand that Photographs, Digital recordings and Radiological images may be used to support clinical evidence in court proceeding.

I understand that this medical examination and recorded clinical findings may be used for Peer Review with specialist doctors

I understand the information from the medical examination will be shared with:
Social Services, Police, GP and Health Visitor (for pre-school children) and School Nurse.

Photographs, Digital recordings and Radiological images can be used for Teaching and Training of other professionals working in Child Protection proceedings. Photographs, DVDs and Radiological images used for this purpose are anonymised.
I give permission for anonymised Photographs / Digital recordings / Radiological images of my child to be used for Teaching and Training Yes No N/A

The procedure has been fully explained to me and I understand that I have the right to withdraw my consent at any stage during the procedure.

Name..... Parent/Carer/Professional/Young Person

Signed: ..... Date.....

Examining Doctor(s) .....

Signature: ..... Date.....

Name CHI Date

History of events

✓ Date of most recent alleged event

✓ Location type (Home/School/Nursery, Outside i.e. park)

Name CHI Date

7. Detailed Medical History

Perinatal History

Birth Weight		Kg	Gestation:	
Place of Birth			Delivery	
Pregnancy				
Neonatal Health				
Feeding				

Immunisations: Detail

Past History

(e.g. A&E Visits, hospital admissions)

8. Symptomatology

	Description / comment
Gastrointestinal (e.g. constipation, soiling, bleeding / pain on defaecation)	
Urinary (e.g. UTI, frequency, dysuria, wetting)	
Sleep (e.g.. Night walking, nightmares)	
Behaviour (e.g.. Wetting, soiling, self-harm, sexualised behaviour)	
Medication	
Allergies	

9. Developmental History / School Progress

	Comment
Gross Motor/Locomotor	
Fine Motor/Manipulation	
Vision and Hearing	
Speech & Language Skills	
Social Interactive Skills	
Social self-help skills	
Additional support needs	

10. Family History (including any history of fractures/bruising/bleeding)

Family Tree:

11. Social History

Consider: Parental occupation(s) / Parental Health including drug / alcohol use / Domestic violence
Number of bedrooms and sleeping arrangements

Name CHI Date

12. Adolescent

					Description/comment
Menarche	Yes		No		e.g.. Age
LMP (date)	Frequency of periods				Duration
Tampons	Yes		No		
Pads	Yes		No		
Vaginal Discharge	Yes		No		
Irritation	Yes		No		
Bleeding	Yes		No		
Smell	Yes		No		
Dysuria	Yes		No		
Sexual experience	Yes		No		
No. of consensual partners			Date last sexual intercourse		
Contraception (and type)	Yes		No		
Smoking	Yes		No		
Alcohol	Yes		No		
Drugs	Yes		No		

13. Forensic Sexual Assault

					Description/comment
Time of last contact with abuser					
Has HIV risk assessment of the suspect been considered?	Yes		No		
Number of hours since last sexual intercourse	Hours				
Condom used?	Yes		No		
Drugs/alcohol taken during event	Yes		No		
Bowels opened since event	Yes		No		
Passed urine since event	Yes		No		
Washing/bathing since event	Yes		No		
Teeth brushed since event	Yes		No		
Eating/drinking since event	Yes		No		
Changed clothes	Yes		No		
Complaints of pain, bleeding	Yes		No		

✓ 14. Emotional Wellbeing Risk Assessment

Do they show any signs of depression/anxiety/ or behavioural problems? If so please document.	
Does the caregiver have any concerns or any anxieties following the incident?	
What positive coping strategies / support networks does the child/YP or care giver have in place?	
Have you ever self-harmed? Method used? Did you tell anyone? Did you seek medical attention?	Details:

15. General examination

Name(s) of persons present

Weight		Height		Head circumference	
kgs	centile	cm	centile	cm	centile

General appearance (hygiene)

Skin colour | Hair colour

Demeanour/behaviour

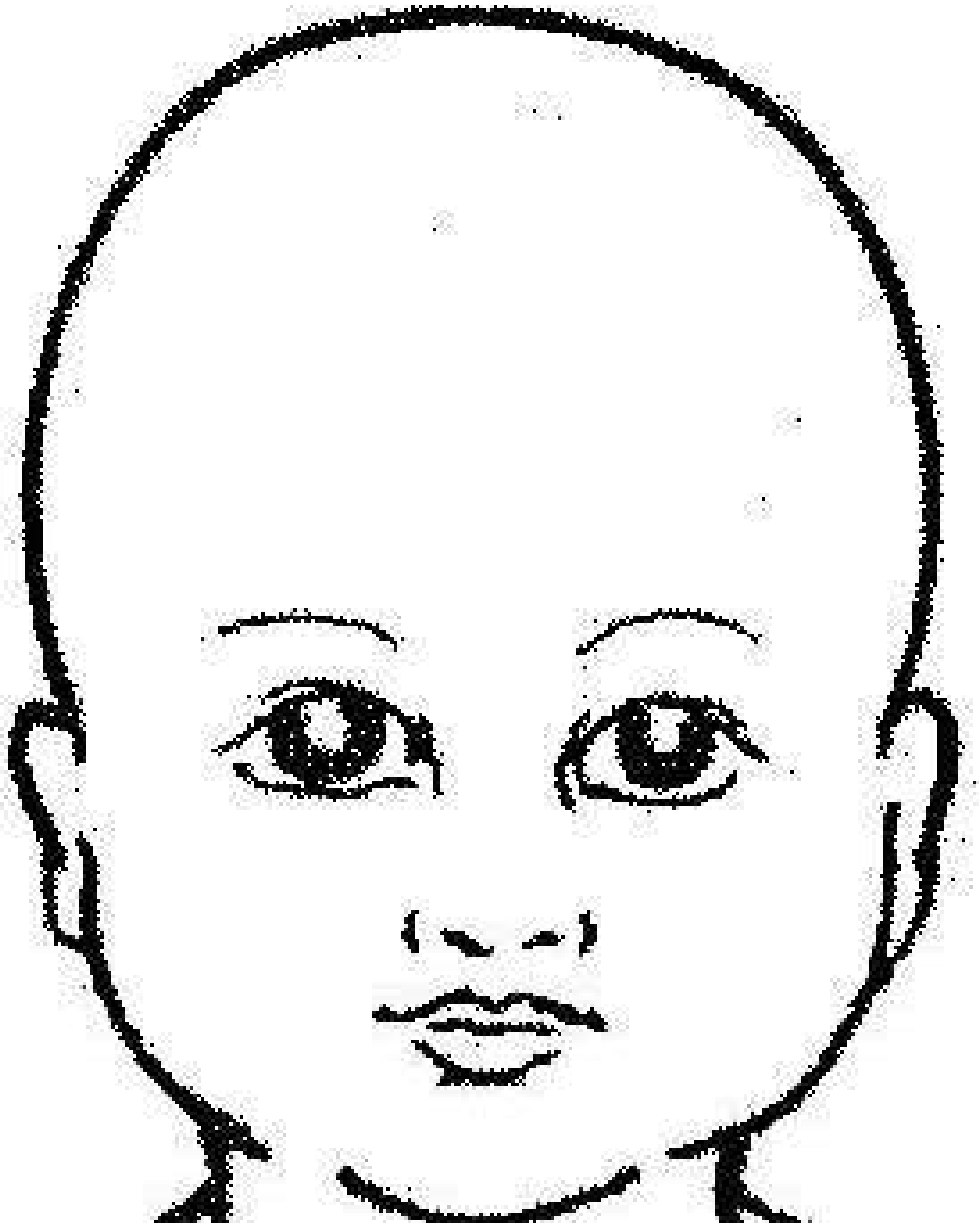
Cardiovascular System		**Central Nervous System**
Pulse	BP	Tone/Power
Heart sounds		Reflexes/Coordination
Respiratory System		**Abdomen**
Trachea/air entry/percussion note etc.		Tenderness/masses/L.K.K.S
Breath sounds		Bowel sounds

Head to Toe Survey inc. measurements, colour, shape, site, type of injury etc.

	Examined	Injuries	See body chart
Scalp/hair	Y ☐ N ☐	Y ☐ N ☐	
Face	Y ☐ N ☐	Y ☐ N ☐	
Ears R / L	Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐	
Inside mouth/palate	Y ☐ N ☐	Y ☐ N ☐	
Teeth	Y ☐ N ☐	Y ☐ N ☐	
Neck **Back**	Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐	
Buttocks	Y ☐ N ☐	Y ☐ N ☐	
Arms R / L	Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐	
Hands/wrists R / L **Fingers/nails** R / L note if cut/broken/false	Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐	
Front of chest	Y ☐ N ☐	Y ☐ N ☐	
Breasts (Tanner stage)	Y ☐ N ☐	Y ☐ N ☐	
Abdomen	Y ☐ N ☐	Y ☐ N ☐	
Legs R / L	Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐	
Feet/ankles/soles R / L	Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐	

Name CHI Date

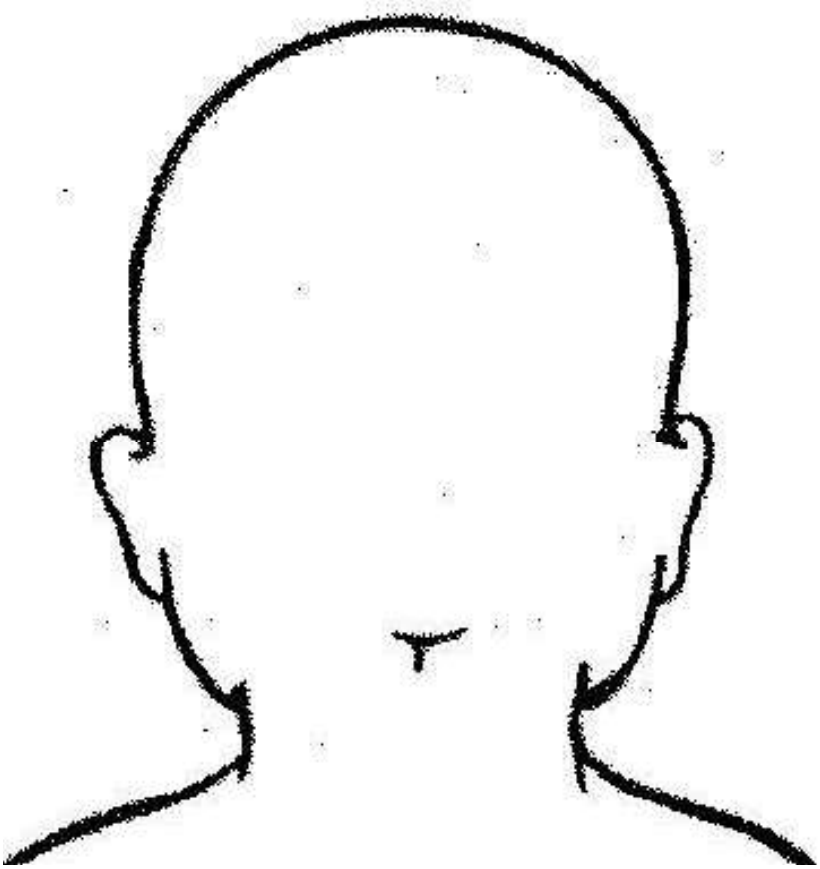
Body diagrams	
Injuries as pictured below ☐	**No injuries detected ☐**



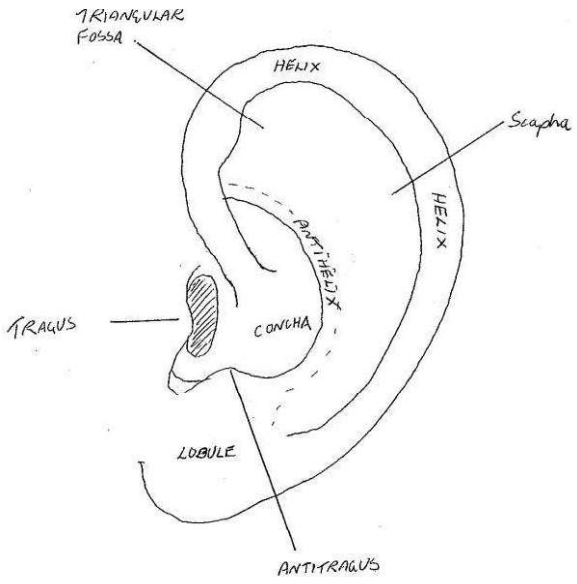
R **L**

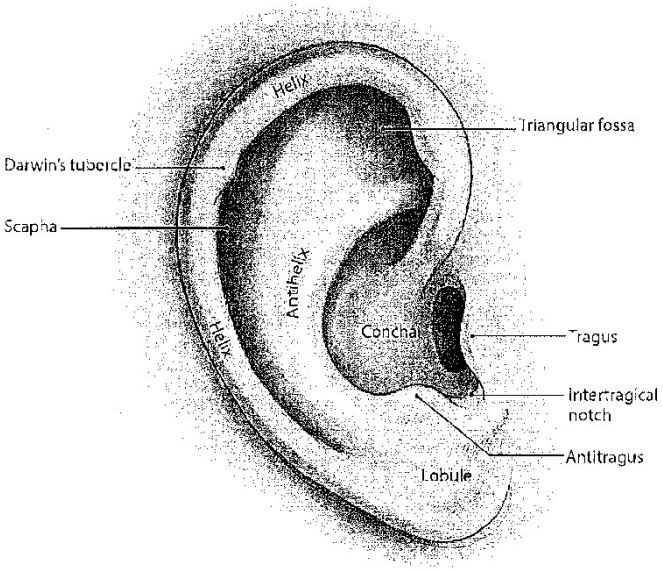
Name CHI Date

Body diagrams	
Injuries as pictured below ☐	**No injuries detected ☐**



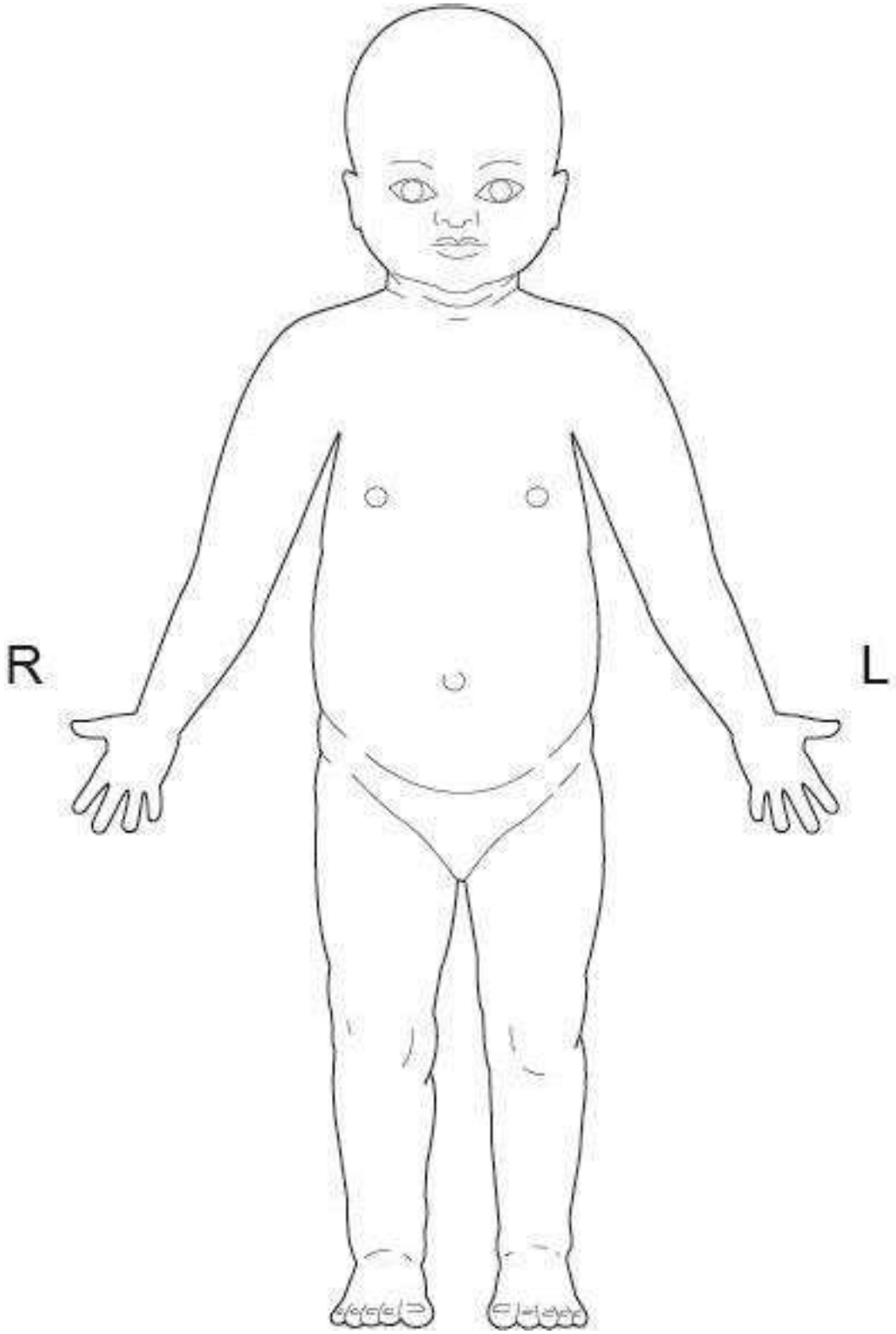
Left ear **Right ear**





Name CHI Date

Body diagrams	
Injuries as pictured below ☐	**No injuries detected** ☐



Name CHI Date

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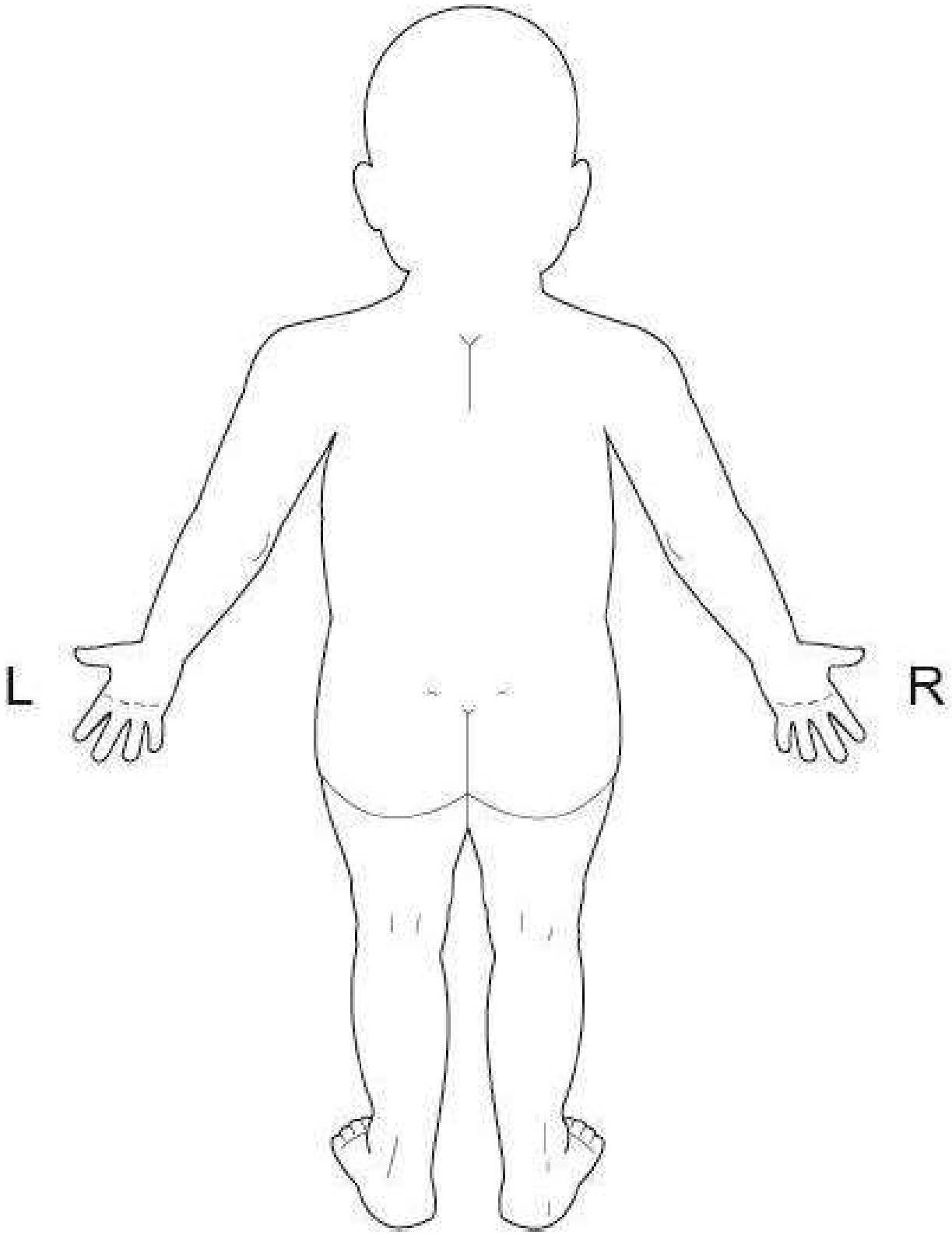

Name CHI Date

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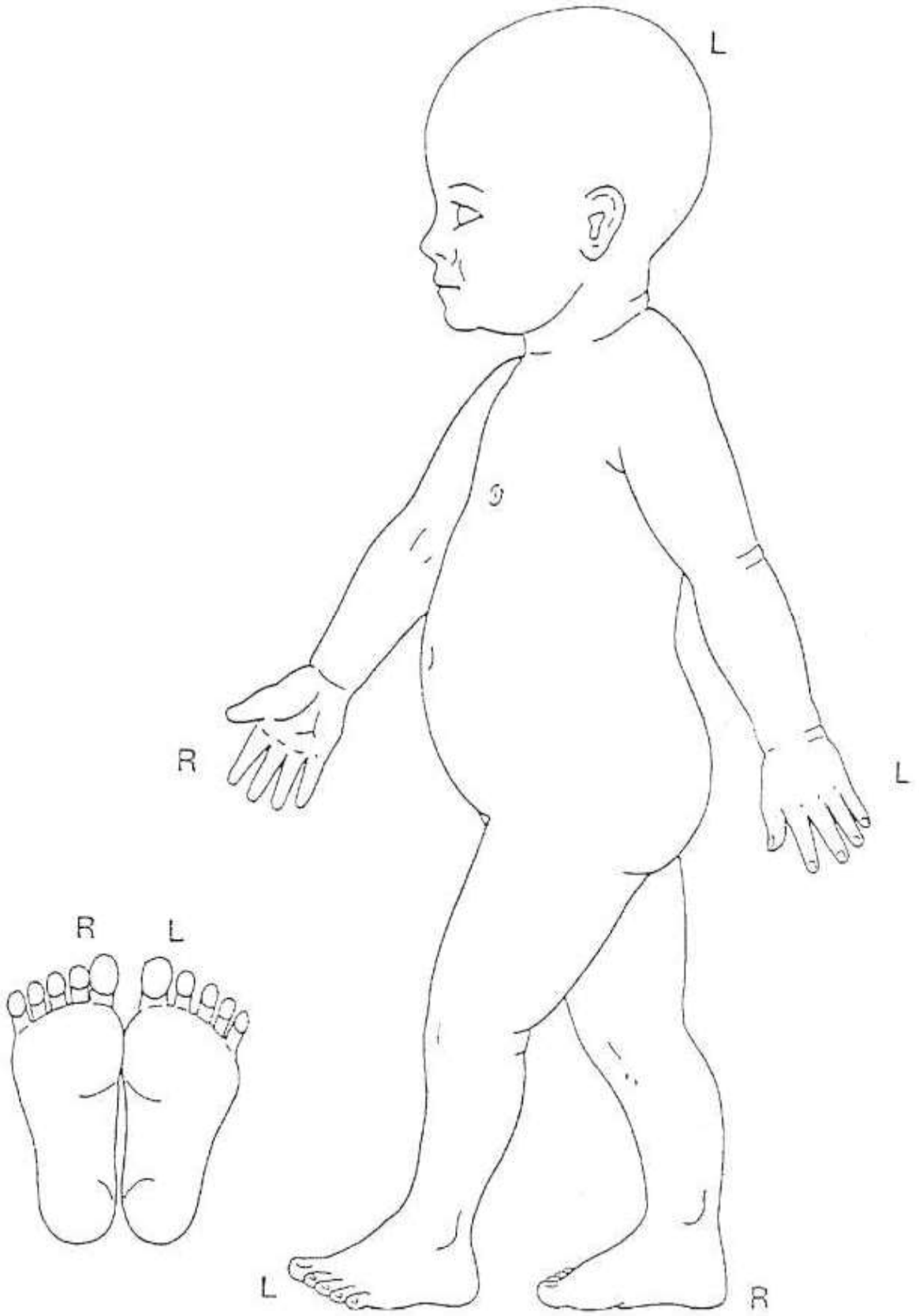
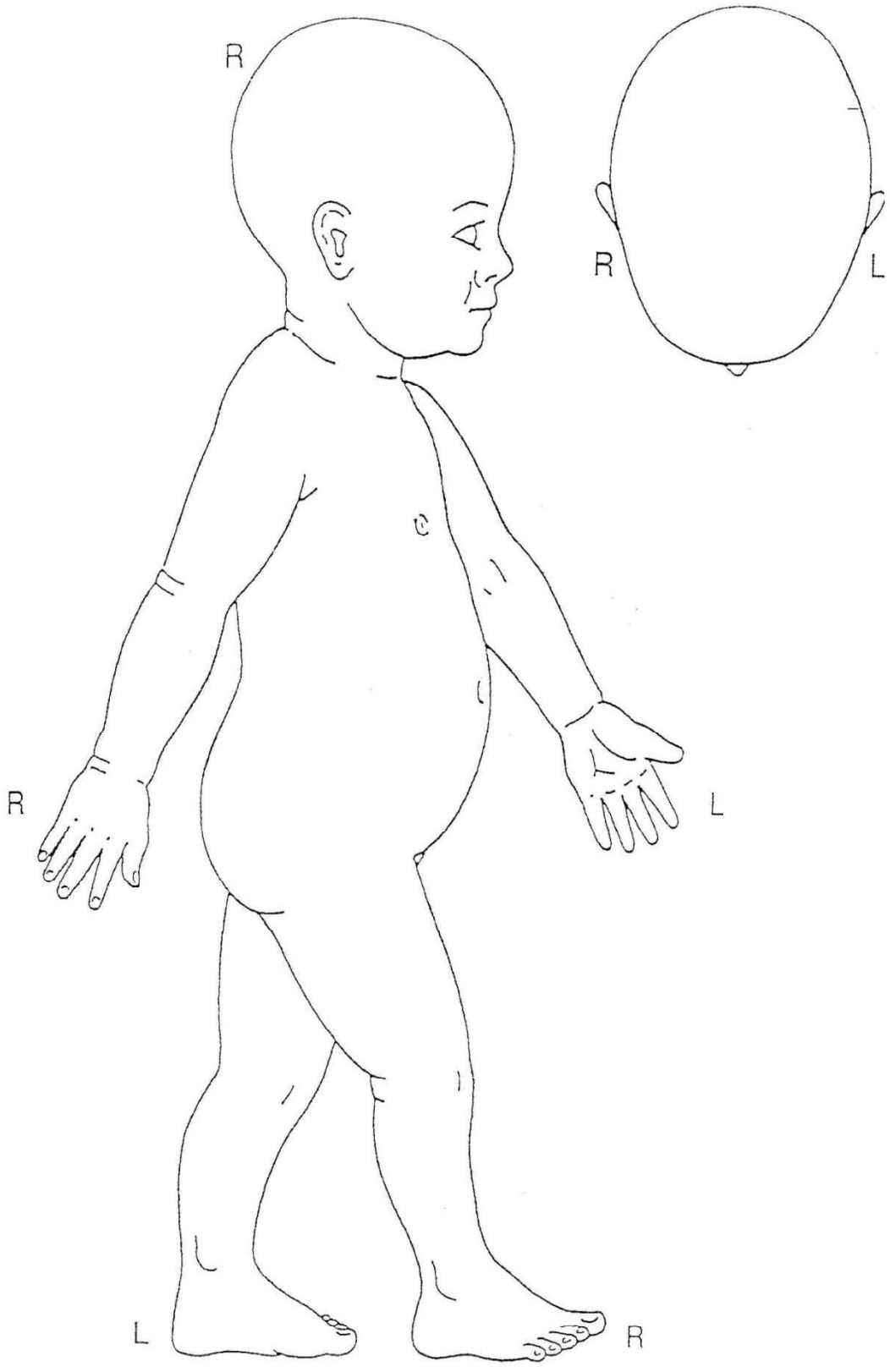


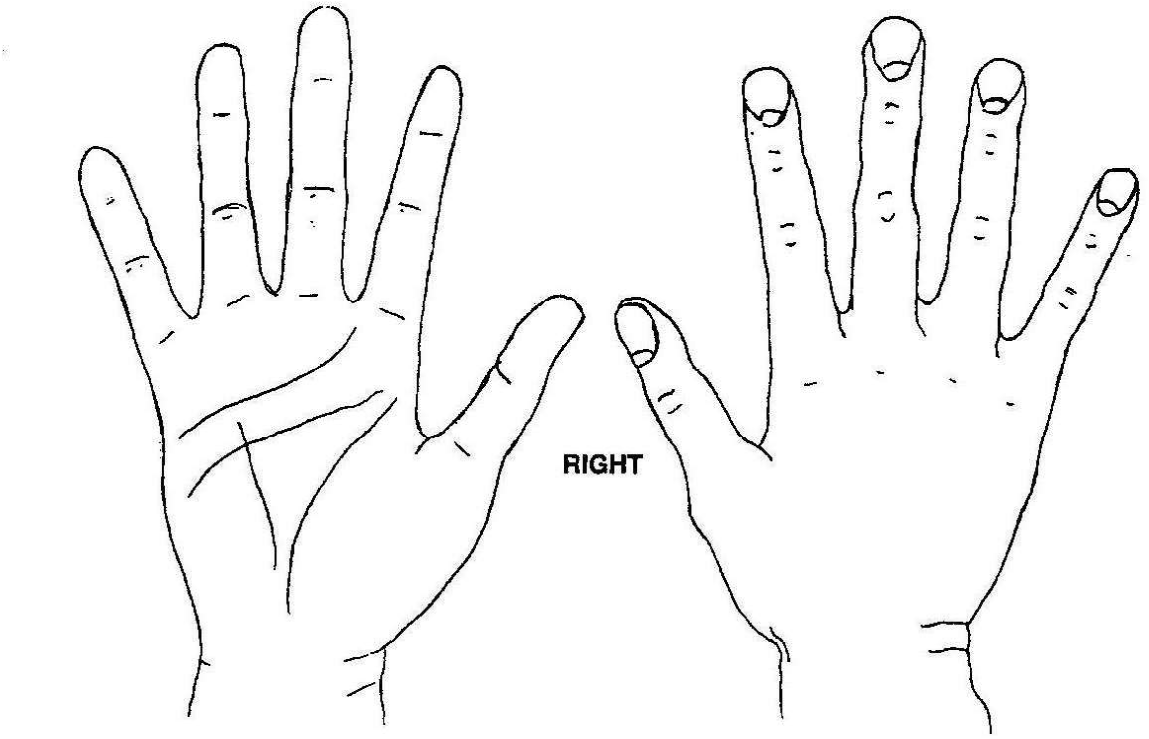
Name CHI Date

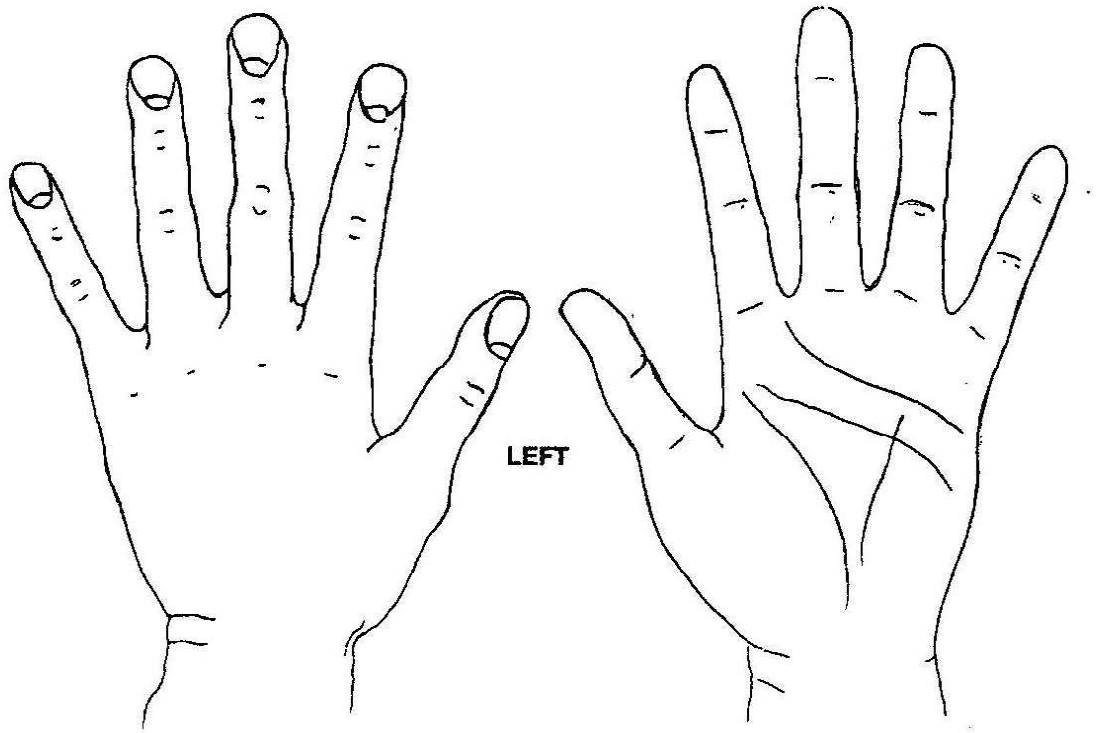
Injuries as pictured below ☐	**No injuries detected** ☐



Name CHI Date

Injuries as pictured below ☐	**No injuries detected** ☐





Name CHI Date

16. Genital examination - Female

Tanner stage: Breast 1 2 3 4 5 Pubic hair 1 2 3 4 5

	Yes	No	Reason not used
✓Colposcope used			
Digital Recording			
Photographs taken			

Exam position used:	Supine		Prone knee chest		Left lateral	

Method of Exam of Hymen	Separation		Traction		Water	
	Swab		Catheter			

Type of Hymen	Annular		Crescentic		Fimbriated	
	Sleeve		Septate		Other	
Describe Other						

Findings – Genitalia:	Normal		Non specific		Abnormal	

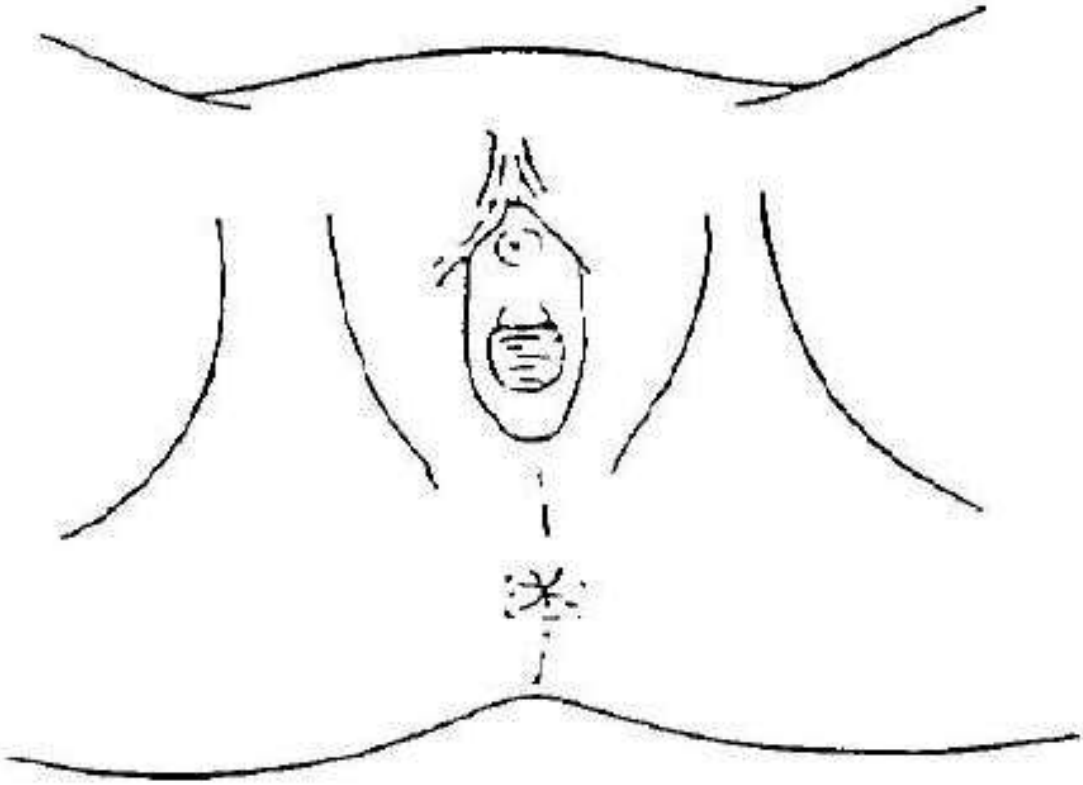
Vulva and Clitoris	Yes	No	Describe location & extent
Reddening			
Abrasion			
Oedema			
Bruising			
Laceration			
Labial fusion			
Discharge			
Bleeding			

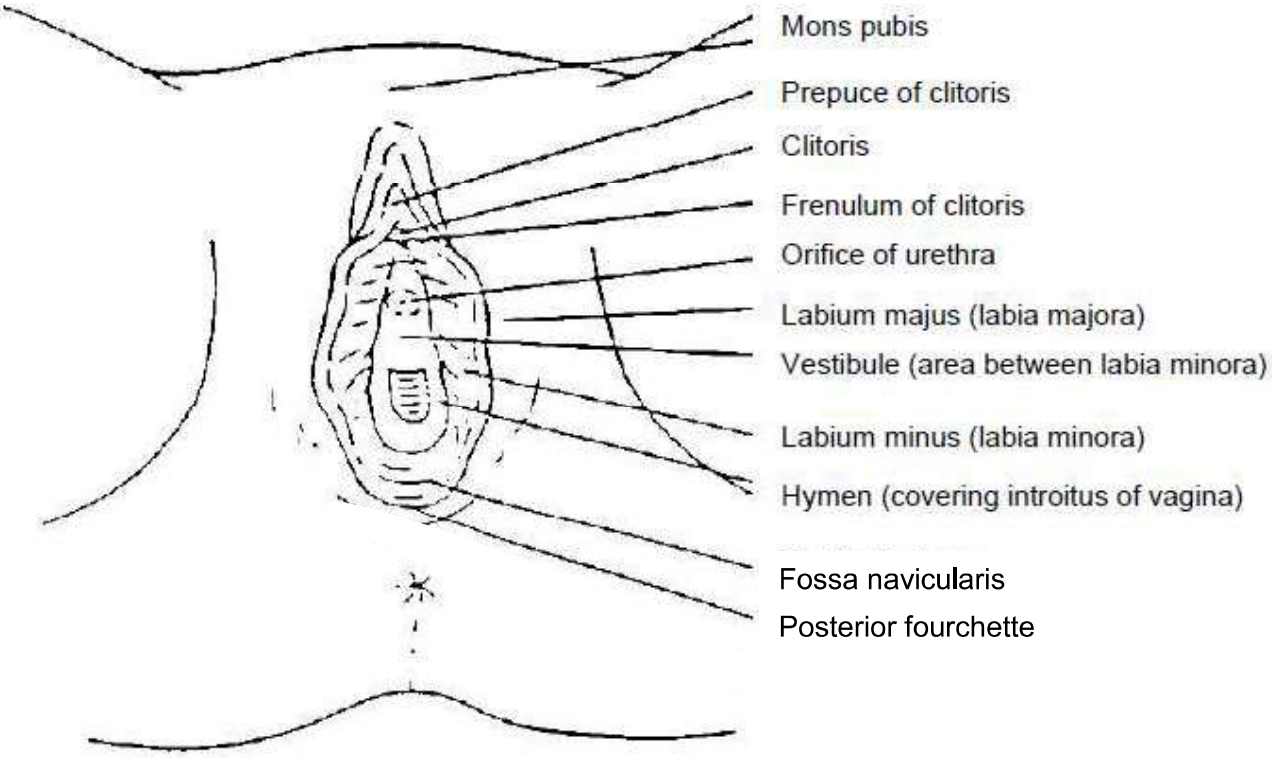
Urethra, Vestibule and Fossa navicularis	Yes	No	Describe location & extent
Reddening			
Abrasion			
Oedema			

Hymen (use the clock face to describe sites)

	Yes	No						
Reddening								
Abrasion								
Oedema								
Bruising								
Laceration			Partial		Complete			
Site of Laceration								
Transection			Site					
Notch			Site		Superficial		Deep	
Narrow rim								
Posterior fourchette	Normal		Abnormal					
Vagina	Normal		Abnormal		Not Seen			
Other Findings								

Name CHI Date





Name CHI Date

17. Genital examination - Male

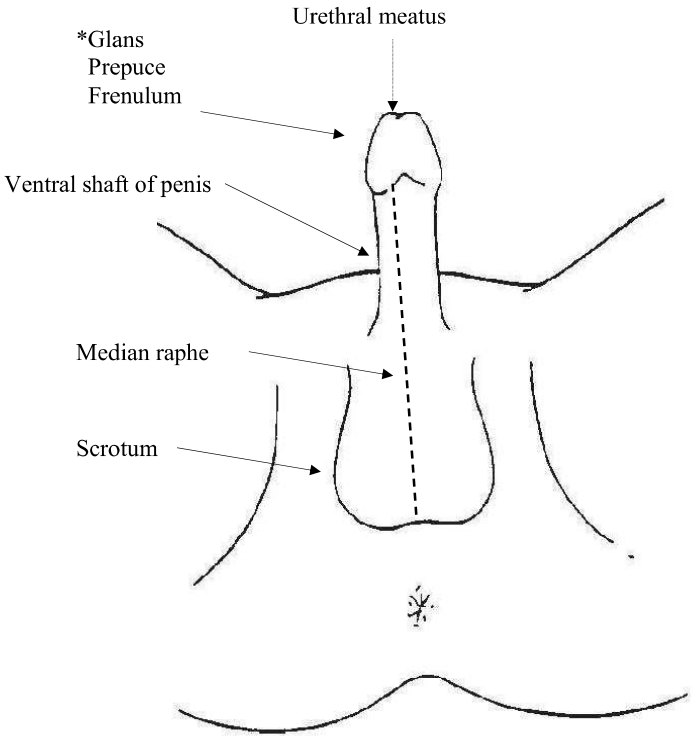
Tanner stage: Genitalia 1 2 3 4 5 Pubic hair 1 2 3 4 5

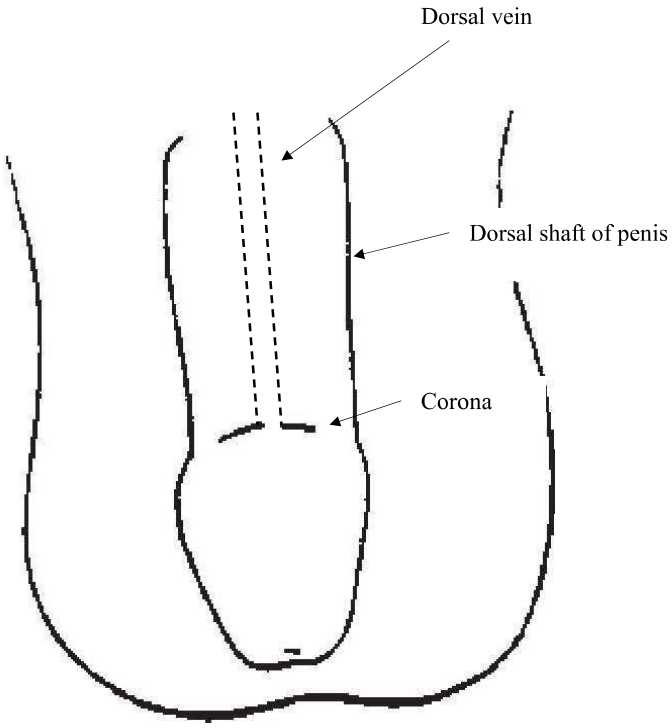
	Yes	No	Reason not used
✓Colposcope used			
Digital Recording			
Photographs taken			

Penis circumcised			
Foreskin retractable			
Frenulum intact			

Testes	

Findings - genitalia	Normal		Non Specific		Abnormal	
Describe abnormalities						





* Glans – the conic expansion that forms the head of the penis
Prepuce - the free fold of skin that covers, more or less completely, the glans penis in the uncircumcised male.
Frenulum – small fold of skin that attaches the prepuce to the ventral surface of the penis

Name CHI Date

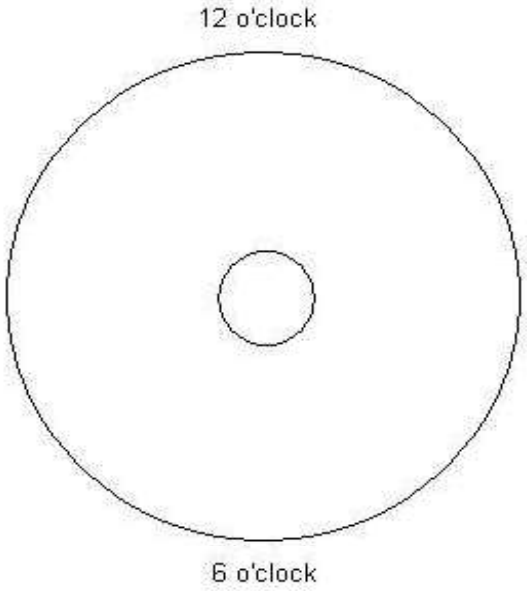
18. Anal examination – Male and Female

	Yes	No	Reason not used
✓ Colposcope used			
Digital Recording			
Photographs taken			

Exam position used	Supine / knee chest				Left lateral	
Findings – Anus	Normal		Non Specific		Abnormal	

Details of anal findings

	Yes	No
Anal / perianal erythema		
Perianal venous congestion		
Anal / perianal bruising		
Immediate anal dilatation (present as buttocks parted and no change over 30 seconds) Note if stool present		
Dynamic anal dilatation (not present as buttocks parted but occurs within 30 seconds) Note if stool present		
Warts		
Burns		
Other		



Anal Lacerations			Superficial	
			Deep or extensive	
			Number	
Scars			Site Number	
Tags			Site Number	

Name CHI Date

19. Investigations

	Investigation	Date Requested	Result or Why not done
Eyes	Retinal examination		
Radiology	CT Head		
	MRI Brain and spine		
	Skeletal survey		
	Follow up skeletal survey views		
	Abdominal CT should be considered if serious history of trauma / abnormal LFTs		
Bloods	FBC		
	Coagulation screen		
	Blood Culture / CRP/ septic screen		
	Extended NAI Coagulation Screen		
	Renal and liver function		
	Ca, Mg, Phosphate, Alkaline Phosphatase		
	Vit D, PTH		
	Copper, zinc		
	Further metabolic tests if indicated (AA if large head for instance)		
Blood Borne Virus Screen	VDRL HIV Hep B Hep C		
Urine	MSU		
	Toxicology		
	Pregnancy test		

Swabs taken:

	Vulval	HVS	Anal	Urine	Oral	Date	Result
Universal							
Gonococcal PCR							
Chlamydia PCR							
Trichomonas							
HSV and syphilis PCR							

Photography	Taken by:	Sites:

19. Investigations - continued

Forensic sample	ID Number; Wet/dry	Time
Skin swab[1] ; Site:		
Vulva swab		
Low vagina swab		
High vagina swab		
Endocervical swab		
Speculum swab		
'Blind' swab		
Additional samples[2]		
Early Evidence[3]		
Toxicology: Urine	N/A	
Toxicology:Blood	N/A	
Toxicology: Hair		
Photographs locus:	N/A	

1. Skin swab of body fluids such as semen or blood, over scratch, bite mark, 'lovebite', hands, inner thighs, breasts, buttocks (not an exhaustive list)

2. Additional samples – mouth swab, mouth rinse, fingernail swabs or clippings

3. Urine, Tissue paper, sanitary wear for perpetrator DNA

20. Conclusions / Advice given to Police / Social Services

Remember to complete section 3 - categorise type(s) of abuse after assessment for data collection

✓ 21. Safety Planning

Where is the child/young person to go after leaving?
What concerns do you have about safety? Details:
Details of any safety plan discussion:

✓ 22. Action Plan

Referrals	**Details**
Referral to GP	Required ☐ Arranged ☐
Referral to general paediatrician	Required ☐ Arranged ☐
Referral to specialist	Required ☐ Arranged ☐
Referral to ophthalmologist	Required ☐ Arranged ☐

Medication
Medication given YES ☐ NO ☐

Other Actions

Admit to hospital	☐	Consider CPO / CAO	☐
Case Conference requested	☐	Other	☐

Reports

Initial Report to SW/Police/GP ☐ **Soul and Conscience report to be provided within 4 weeks** ☐

✓ 22. Action Plan – continued

For CSA Cases

Emergency contraception Required ☐ Arranged ☐ Method given:

STI screening referral Required ☐ Arranged ☐

Is the child/YP considered to be at risk of Hep B? : Yes ☐ No ☐
If **yes** has treatment been offered?: Yes ☐ Declined ☐
If within 48hrs has child/YP been commenced on prophylaxis?: Yes ☐ No ☐

Is the child/YP considered to be at risk of HIV? : Yes ☐ No ☐
If **yes** has treatment been offered?: Yes ☐ Declined ☐
If within 72 hours has the child/YP been commenced on prophylaxis ?: Yes ☐ No ☐

Referral to CAMHS Required ☐ Arranged ☐

Referral to other support service: Required ☐ Arranged ☐

Define service referral made too:

If No please give reason: i.e. services not available Details:

Post sexual assault leaflet given YES ☐ NO ☐

Advice given to patient &/carer YES ☐ NO ☐

Name / Title of examining doctor(s)	**Signature of examining doctor(s)**

Date / time completed: