FORENSIC PAEDIATRICS
A Report by the Short Life Working Group

The Scottish Government
Riaghaltas na h-Alba

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Executive Summary

1. The delivery of high quality child protection services has been a key aim for the Scottish Government since the publication of 'It's everyone's job to make sure I'm alright'in 2002. The recent publication of National Guidance for Child Protection in Scotland continues to provide a national framework within which all agencies and practitioners at local level can agree processes for working together to safeguard and promote the welfare of children. 'Guidance for Health Professionals in Scotland' (2000)' Protecting Children: a shared responsibility' was produced to advise on the standardised pathways and templates for health examination of children with suspected or actual abuse and/or neglect. This guidance will be updated in 2012.

2. Since 2009 concerns have been expressed about the sustainability of forensic paediatric services for sexually abused children and in response a short life working group (SLWG) was established at the request of the then Head of Health and Social Care, Scottish Government, Dr Kevin Woods. Its remit was to examine the present service provision of medical examination to children who have been sexually abused across Scotland and identify means by which the availability and sustainability of these medical services could be improved. Although the SLWG was not specifically remitted to consider the examination of children who have been physically abused or neglected, it recognised that the same challenges face the provision of competently trained doctors for this group of children, for which the demand is far greater.

3. The prime importance of an interagency referral discussion (IRD) ALWAYS taking place in child protection referrals to police, social work or health professionals should be emphasised. The IRD allows decisions to be made primarily based on the needs and safety of the child and reduces the differences in expectation between police and health services on the timing of examination and collection of forensic evidence. It would also enable remote and rural areas to make decisions about the transfer of children to other centres where this is in the best interests of the child.

4. The medical assessment of sexually abused children is a low volume, highly specialised activity. The examination is usually carried out jointly by two doctors (a paediatrician and a forensic physician) with complementary skills. In the older age group (13-16 years old) an examination may be carried out by a doctor and a forensically trained nurse. Both doctors require to have been trained appropriately, to have sufficient practical experience in the specialist area and maintain a prescribed level of competence. Both must provide reports (whether joint or separate) and opinions which can later be used as oral and written evidence in court proceedings. Most of these paediatricians have additional training and competencies in child protection and become paediatricians "with a Special Interest in Child Protection" will provide local services within district general hospital (DGH) settings, and will participate in on-call (out of hours) rotas in acute general paediatrics, or in specialist child protection rotas. In addition there will be a few consultants with more specific specialist training and competencies who become "Specialist Paediatric Consultants in Child Protection". These specialists will provide tertiary services, including leadership, specialist clinical care and expert forensic opinion in complex cases. Any paediatrician who performs examination of children for child sexual abuse (CSA) should carry out a number of examinations over a year to maintain their competencies and attend continuous professional development (CPD) in the field of child protection.

5. The provision of suitably trained doctors (both paediatrician and forensic physician) has been adversely affected over the last ten years. There have been a number of high profile inquiries with media coverage of significant child abuse cases and changes in the paediatric training numbers and requirements. This has resulted in fewer paediatricians specialising in Community Child Health (CCH), where most trainees learn specific examination skills and competencies in child protection. Attracting consultant paediatricians to this work has proven challenging for many health boards in Scotland.

6. Most of the CSA examinations required across Scotland can be arranged during office hours/early evening. There are enough trained paediatricians to provide daytime services without delay; this includes four Health Boards which send their cases to neighbouring Boards for examinations. Out of hours services are provided by rotas of general paediatric consultants, general paediatric consultants with a special interest and "specialist" consultants in child protection. All paediatricians who perform forensic examinations out of hours have the appropriate competencies and clinical skills and carry out joint examinations with a forensic physician. Those general paediatric consultants who are competent perform forensic examinations jointly with forensic physicians including recording findings by videocolposcopy. These recordings can be discussed the next working day with the local specialist paediatrician.

7. Medical examination for physical abuse and neglect is more commonly performed by paediatricians than examination for CSA. Every consultant paediatrician who sees children and young people should be competent in the diagnosis and management of physical abuse and neglect. Present national guidance states that for some of these children, with complex physical abuse or injuries which are not readily explained, there is the need for a specialist 2 doctor (joint) paediatric/forensic examination. These examinations may be required to establish the diagnosis, or to assess the need for further investigation or treatment. The presence of two doctors in the joint paediatric/forensic examination is important for the corroboration of medical evidence in any subsequent criminal proceeding and is also good medical practice. At present this 2 doctor examination is not routinely performed in a standardised way in all Board areas in Scotland.

8. Quality of clinical input by paediatricians is monitored by local clinical governance systems and GMC processes of appraisal and revalidation. The NHS Board Chief Executive and Medical Director are responsible for systems to monitor the performance of individual doctors, and these systems should identify training needs for paediatricians.

9. It is clear that there are enough consultant general paediatricians across the country that can provide examination and opinion in physical abuse and neglect 24 hours a day. These consultants should be equipped with a range of tools to help them provide this service better;

- **Professional Standards** - protocols for assessment, recording of injuries, investigations, and management; e.g. provided by Royal College of Paediatrics and Child Health (RCPCH), West of Scotland managed clinical network (MCN)
- **Support** - from consultant paediatricians with a special interest in child protection on an on call rota for child protection; and
- **Training** - courses provided by local boards, Royal College of Paediatrics and Child Health (RCPCH), joint interagency courses, peer review.

10. Over the past 12 years, a range of local, regional and national Managed Clinical Networks have been established to support the delivery of healthcare services. A number of these networks support specialist children's services, which by their very nature, tend to face a number of key challenges including (but not exclusively):

- Workforce and service sustainability;
- Training and education;
- Variances in clinical practice across Scotland;
- The need for clinical audit to inform improvement;
- Transition;
- The need for holistic, inter-agency working (e.g. joint working between health, education, police and social care);
- the need to ensure equitable access to an equitable level of care;
- measuring service improvement outcomes

Scotland has three regional MCNs which deal with CSA. The West of Scotland network was set up in 2004 and is the most established. It encompasses all child protection matters. SEAT established a network in 2009 dealing exclusively with CSA. The North of Scotland network was established in December 2010. These three regional networks work closely together to standardise protocols for processing of referrals, standards of equipment, personnel, investigations and training, although the model of delivery may differ from region to region. To achieve consistency across Networks, standardised templates have been agreed, but are not yet fully implemented e.g.

- National Consent Form;
- Stage 1 Medical Report – completed by the paediatrician undertaking the direct examination of a child;
- Stage 2 Medical Report – required for court purposes and completed by the paediatrician who examined the child or by a specialist/expert commenting on the Stage 1 Report. This report contains an opinion and allows further analysis of findings, additional findings and supportive evidence from the literature when necessary.

11. New models for the provision of medical staff trained in forensic examination have been piloted in Tayside. The NHS has provided a new contract in agreement with local police authorities for forensic services i.e. health services to police custody cells, and examination of individuals in cases of sudden death, assault, sexual assault and road traffic accident (RTA). The service consists of a number of nurses and forensic physicians. Only forensic physicians (not nurses) participate in joint 2 doctor examinations in a standardised way with local paediatricians. Anecdotal evidence suggests this has improved the quality and consistency of examination and recording of physical evidence in child cases, and support to general paediatricians who take part in joint paediatric forensic examinations which encourages local paediatricians to participate in child protection. This model of provision of forensic paediatric services could be the benchmark for other Boards to follow.

SHORT LIFE WORKING GROUP

1. The SLWG was constituted by the Scottish Government in response to concerns raised by Association of Chief Police Officers in Scotland (ACPOS) regarding the provision of forensic paediatric services across Scotland. The SLWG comprised specialist paediatricians in forensic paediatrics, general paediatricians from District General Hospitals, members of the RCPCH, Faculty of Forensic and Legal Medicine (FFLM), representatives from Crown Office and Procurator Fiscal Service (COPFS) and police. The full membership list is at Annex A. It met four times with the aim of exploring sustainable models of service provision for access to “specialist” child protection medical expertise during and outwith office hours, which fit with the present configuration of paediatric services. Although the remit of the group was to explore the provision of forensic services for children who had been sexually abused, it was recognised that the demand for forensic medical examination of children with physical injury and neglect, far outweighs the present demand for CSA. Therefore, recommendations for the service for physical abuse and neglect were also discussed and considered as equally important to sustain and improve.

Summary of Recommendations

The following recommendations were agreed by the Short Life Working Group as minimum requirements to deliver a safe, sustainable clinical service for the examination of children who have suffered physical abuse and neglect and sexual abuse. The recommendations for Child Sexual Abuse describe services for children who may present with historical sexual abuse or acute sexual assault. For this Report historical abuse is defined as any sexual abuse occurring more than 7 days previously. Acute sexual abuse is that which is committed within the previous 7 days. Acute sexual assault is that which has occurred in the previous 72 hours.

The NHSScotland Healthcare Quality Strategy launched in 2010, stated a whole systems approach, aligned to deliver three Quality Ambitions which provides the focus for everything NHSScotland does. These three Ambitions state that care encounters should be consistently person centred, clinically effective and safe for every person, every time. The six healthcare quality outcomes provide a more comprehensive description of the priority areas for improvement in support of the Quality Ambitions, and provide a context for discussions about actions. The six healthcare Quality outcomes are listed in Annex B. The following recommendations have been mapped to one or more of these quality outcomes.

These recommendations should significantly contribute to continuous quality improvement in clinical services for children who have been abused and will help NHSScotland and its partner agencies to consistently deliver care that is person-centred, clinically effective and safe, for every person, all the time.

PROVISION OF SERVICE FOR CSA IN CHILDREN

1. All Boards will provide access to a competently trained paediatrician who can carry out examinations with videocolopscopy for CSA examination together with a forensic physician within 4 hours of referral as clinically and forensically appropriate in cases of acute sexual assault in children and young people under 16 years old to comply with RCPCH standards of clinical care and gathering forensic samples. The maximum waiting time for an examination will be dependant on clinical presentation but should not exceed 12 hours. (Quality Outcomes 3,6)

2. All Boards should provide facilities to record high quality images using colposcopic equipment in all cases of CSA which should be similar in make and model across Regions. These images should be digitally recorded and may be sent for specialist opinions when required. A consent form for digital recordings should be nationally agreed and available. (Quality Outcome 3)

3. In Boards where general paediatricians who are competent and skilled carry out joint 2 doctor examinations, the provision of access to specialist paediatric forensic opinion will be developed across network areas (regions), to provide specialist medical opinion and a Stage 2 Medical Report. (Quality Outcome 5)

4. All Boards will ensure a national medical report template will be used by all paediatricians and forensic physicians conducting forensic examinations for CSA. (Quality Outcome 5)

5. All Boards will ensure standardised cleaning and decontamination policies for the child friendly examination suites which are adopted by all NHS and police premises with a protocol agreed by police, COPFS and NHS Boards. (Quality Outcome 3)

PROVISION OF SERVICES FOR PHYSICAL ABUSE AND NEGLECT IN CHILDREN

1. All Boards will provide access to a consultant paediatrician 24 hours a day to give advice about physical injuries and neglect in children. These consultants must have completed RCPCH level 3 Safeguarding Children and Young People. (Quality Outcomes 3,4,5)

2. All Boards should ensure robust processes are in place to deliver joint forensic 2 doctor examination in significant or complex physical abuse e.g. complex bruising, burns, non accidental head injury (NAHI), fractures, suffocation and poisoning. These examinations should be conducted by a consultant with special interest in child protection and another appropriately trained and experienced doctor (which could include a forensic physician) to corroborate findings and collate best evidence and advise on clinical management. (Quality Outcomes 3,4,6)

3. All Boards will provide access to a consultant with special interest in child protection for advice for all complex injuries e.g. burns, fractures, NAHI, suffocation, poisonings and complex patterns of bruising. These specialist paediatricians should have additional training and experience. (Quality Outcomes 3,4,5)

4. All Boards should demonstrate that out of hours paediatric services for children who have suffered physical abuse meet RCPCH and FFLM quality standards and provide safe forensic and clinical care to any child and young person who presents with acute physical abuse. Boards should consider establishing a regional out of hours service with access to paediatricians with special interest in child protection to provide advice and medical opinion in child protection. (Quality Outcomes 3,5)

5. All Boards should ensure that there are compliance procedures to ensure MCN standards for the investigation and management of common (forensic) presentations of child abuse, e.g. NAHI, bruising for children under 1 year, and child deaths are adhered to. (Quality Outcome 6)

WORKFORCE AND SUSTAINABILITY

1. Regional Planning Groups should demonstrate that there is access to specialist advice, support and medical examinations for CSA services for all DGH and specialist children's hospitals. (Quality Outcomes 5,6)

2. All Boards should identify at least one consultant paediatrician with special interest in child protection. In larger Boards there may be a requirement for more consultants to have post CCT training, to obtain safeguarding competencies (level 4 and 5). (Quality Outcomes 5,6)

3. There is an urgent need for the NHS in Scotland, in conjunction with NHS Education for Scotland (NES) and RCPCH, to ensure there are sufficient paediatric trainees in specialist CCH training programmes at ST 5 - 8, to replace present consultants in tertiary hospitals, who are "Specialist Paediatric Consultants in Child Protection", fulfilling the role of "designated" doctors. (Quality Outcomes 3,5,6)

4. An option appraisal should be carried out at a national level by the Scottish Government to consider new models for workforce and skill mix to deliver high quality specialist forensic examination for children and young people who have suffered CSA. Further expansion of the Tayside pilot should be considered in order to encourage local paediatricians to develop interest and specialist training in forensic paediatrics. (Quality Outcomes 5,6)

TRAINING AND SKILLS FOR PAEDIATRICIANS

1. All MCN leads should carry out a training needs analysis to ensure that all consultants in acute general paediatrics who examine children with physical injuries are competent and skilled, in the diagnosis and management of child abuse. (Quality Outcomes 5,6)

2. All MCN leads should stipulate the training requirements for Consultants who perform CSA examinations in their region, based on the RCPCH competencies (training matrix). All MCN network leads should develop a system to ensure current paediatricians performing CSA examinations in their region have appropriate supervision over the MCN Region and advise local Board systems for clinical governance and appraisal about these requirements. All doctors carrying out CSA examinations should have updates on the clinical evaluation of sexual abuse in children, including the use of the colposcope, every 4 years. (Quality Outcomes 5,6)

3. All consultant paediatricians "with a Special Interest in Child Protection" should evidence the maintenance of skills and training in child protection including number of cases seen, peer review sessions attended (NAI and CSA) other courses and CPD undertaken. This information on numbers and quality may be collated locally or regionally to ensure standards for training are maintained over the MCN Region. This will be done by the MCN lead clinicians working across Scotland and will be in job description. (Quality Outcomes 5,6)

4. RCPCH and NES should work to create an accreditation scheme to ensure local, regional and national training courses in child protection for paediatricians and forensic physicians are delivering appropriate skills and knowledge of competency framework. (Quality Outcomes 5,6)

5. All job descriptions for new consultant posts for general paediatrics should stipulate as essential the minimum requirements for competency in examination of children suspected of having suffered child abuse. Additional specific competencies should be stipulated for any new specialist consultant post in Child Protection. (Quality Outcomes 4,5,6)

6. All job descriptions for consultant posts for general paediatricians which have acute on-call duties should detail explicitly the responsibilities for examination of children with physical and sexual abuse and participation in 2 doctor forensic examinations for sexual abuse. (Quality Outcomes 4,5,6)

7. Joint training programme for paediatricians and forensic physicians should take place annually, with input from COPFS and ACPOS to standardise the quality of forensic paediatric reports used for court purposes across Scotland. (Quality Outcomes 5,6)

8. MCN leads will promote the RCPCH recommendations regarding the number of peer review sessions required per year to maintain competence. (Quality Outcome 5)

TRAINING AND SKILLS FOR FORENSIC PHYSICIANS

1. All forensic physicians who perform paediatric forensic examinations should have undertaken a basic level of paediatric training accredited by FFLM or other recognised training bodies (e.g. NES, RCPCH). (Quality Outcomes 3,5,6)

2. All forensic physicians should comply with the basic requirements to maintain competencies and skills in CSA examinations. This should be agreed across Scotland. (Quality Outcome 3)

3. Forensic physicians should access appropriate courses to obtain and retain their skills in examination of children and young people. (Quality Outcome 3, 5)

4. FFLM will set out necessary requirements for revalidation, including evidence of CPD, peer review and qualifications plus minimum caseload. (Quality Outcome 5)

5. New forensic physicians should have job descriptions which indicate their requirement to achieve relevant post-graduate qualification (membership of the Faculty of Forensic and Legal Medicine (MFFLM) or Diploma in Forensic and Clinical Aspects of Sexual Assault (DFCASA)) in forensic paediatrics. (Quality Outcomes 3,5,6)

6. FFLM to offer more courses throughout the year, of an introductory and developmental nature (Quality Outcomes 3,5,6)

GOVERNANCE, DATA COLLECTION AND ACTIVITY

1. Data sets for all specialist child protection cases in a region should be created across an MCN region, in order to capture standardised information on all paediatric forensic activity, and provide the basis for robust governance, accountability and audit arrangements. (Quality Outcomes 5,6)

2. All three MCNs should implement a quality assurance programme using the available tools from Healthcare Improvement Scotland (NHS HIS) and National Services Division (NHS NSD). (Quality Outcomes 5,6)

3. There should be a national strategic planning and review group which provide an overview of specialist paediatric forensic services across Scotland, and should include MCN leads and forensic physician representation. (Quality Outcomes 5,6)

4. The NHS in conjunction with the police boards/authorities should ensure that forensic paediatric services meet these standards, by providing a joint governance process. (Quality Outcomes 5,6)

5. The three regional MCNs for child protection should report to Regional Planning Groups and produce annual reports, which outline key performance indicators and outcome measures against which progress can be measured. (Quality Outcomes 5,6)

6. MCN’s should support consultant paediatricians with special interest in child protection who may work across a Region to provide specialist services in child protection. They should meet regularly for peer review at Board or Regional level and national peer review. (Quality Outcomes 5,6)

Chapter 1

CURRENT PROVISION

1. Child abuse involves acts of commission or omission, which result in harm to the child. The type of abuse can be physical, emotional, sexual, or due to neglect. There are standard definitions produced by Scottish Government in the guidance 2010.

2. The pathway and management of physical and sexual abuse in children may be different depending on the initial agency involved and presentation of signs and symptoms. However, the interagency response and health involvement at the earliest stage should result in medical examination being carried out at an appropriate time, in an appropriate setting and by appropriately trained health professionals.

3. Responsibility for the provision of adequate clinical facilities for the forensic examination of children, and the provision of clinicians who are appropriately skilled and confident in carrying out medical examinations for all forms of child abuse, resides with health boards and police boards/authorities. Forensic physicians provide corroboration and forensic support in these examinations, and work closely with Police authorities in provision of health support to other forensic work. For sexual assault cases in older children (13-16) examination may be carried out in adult sexual assault centres, following discussion with paediatricians.

4. All child sexual abuse examinations (acute or historical) are undertaken as a two doctor joint exam (paediatrician and forensic physician) with videocolposcopy used to record the examination findings. The paediatrician may be a general or community paediatrician who has received additional training and skills in the use of videocolposcopy. To give an opinion in cases of sexual abuse, paediatricians must have received additional specialist training in the interpretation of the clinical signs, work within clinical networks for child protection and attend a regular Peer Review process with colleagues who perform similar examinations. Forensic physicians can be General Practitioners contracted by police to gather appropriate evidence or other medical professionals but must fulfil requirements as stipulated in the joint FFLM, RCP London document. The available number and training of these doctors varies considerably across Scotland as do the services provided and not all forensic physicians carry out examinations of children who have been sexually abused.

5. The service model which provides for children who require a forensic examination in cases of child sexual abuse varies across Scotland due to geographical and workforce demands. These challenges are not new - Mok and Bussitil carried out an audit of the medical services for CSA in Scotland in 2001/2 to establish how widely guidance was being followed by practitioners, NHS Trusts and health boards. They found a lack of standards across Scotland in the structure of local services, process of referral and documentation of injuries in children referred for investigation of child sexual abuse. Their report, 'Expertise in the medical examination of suspected child sexual abuse' made a number of recommendations for training and workforce development of both consultant paediatricians and forensic physicians.

Daytime Services

6. All Health boards provide daytime services for the examination of children who may have been sexually abused. This daytime service is provided Monday – Friday up to 5pm and in some areas until 8pm and on a Saturday and Sunday. This service can provide planned medical examinations for the vast majority of children with sexual abuse or who have made allegations of historical sexual abuse. In four Board areas (Dumfries and Galloway, Western Isles, Orkney and Shetland) arrangements for the transfer of children to neighbouring Boards for examination is made, as there are currently no trained paediatricians to carry out forensic examinations for CSA, and limited daytime availability of forensic physicians.

Out of Hours Services

7. It is much less common for a child to present with acute sexual assault and only in exceptional circumstances that an emergency out of hours forensic medical examination is required. The likelihood of gathering DNA evidence and of documenting ano–genital injuries declines steadily over time. The current recommendation is that evidence can be gathered up to 7 days post assault. RCPCH "Facing the Future: Standards for Paediatric Services" has stated that 'depending on the needs of the child or young person (clinical, forensic and safety) the child or young person must be assessed and an opinion provided usually within 12 hours of presentation when there are recent injuries. Specialist paediatric and forensic opinion should be available to all units within 4 hours of all acute sexual assaults.'

8. All Health Boards are currently able to provide a service for children with acute child sexual abuse. However, the service is vulnerable to the same workforce related challenges as other paediatric services, i.e. imminent retirals, locum positions to fill consultant gaps and no identified paediatrician currently in the training programmes training to become specialists in the area of child protection. In addition, keeping the competencies and skills for this work of those who have been trained is challenging because of the limited number of examinations carried out.

9. Cases of physical abuse and injuries will be seen in hospital by a variety of specialist paediatric services. More serious injuries may be managed in intensive care, orthopaedics, burns or neurosurgical units. The examination, investigation and recording of injuries may be inconsistent across these specialties although proformas should be available in all paediatric services to be used in child protection cases. In these complex cases a specialist 2 (joint) doctor paediatric forensic examination will be carried out to ensure specialist opinion and forensic evidence is collated in a standardised way. However this model is not practised in all Board areas.

10. Cases of child physical abuse including injuries will usually be seen in hospital settings by a variety of specialist teams e.g. general paediatric (acute on-call) team, trauma specialists, orthopaedics, burns, intensive care and neurosurgical teams. The examination, investigation and recording of forensic evidence can be inconsistent across these specialties in some areas of Scotland. In some areas, these complex injuries, will be examined by 2 doctors in a joint paediatric forensic examination to ensure a high standard of forensic evidence, provide specialist child protection advice, and medical care to the child.

Chapter 2

MEDICAL WORKFORCE IN FORENSIC PAEDIATRICS

1. The current paediatric workforce providing forensic examinations in children comprises;

   1. Consultant Paediatricians (who have obtained C.C.T in paediatrics) with additional training and experience in child protection;
   2. Specialty doctors and associate specialist paediatricians with additional experience and training (usually as part of Community Child Health) in child protection who may be in consultant led teams.
   3. Forensic physicians who are independently contracted to carry out a number of different duties.

These medical staff may have different levels of competence and skills in child protection. Figure 1 shows the relative numbers of paediatricians in each level of competence across Scotland. Actual numbers are discussed in chapter 2 paragraph 5.

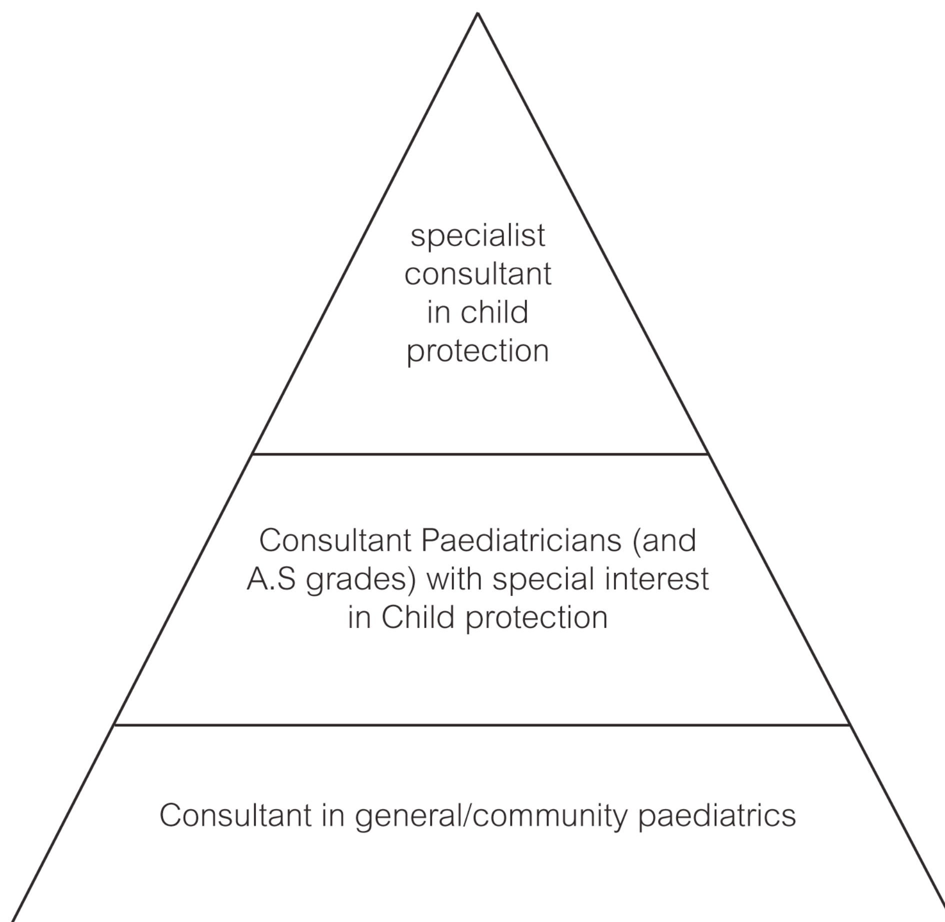

Figure 1

Figure 1: Levels of competence and types of paediatricians working in child protection.

3. The RCPCH has not recognised child protection as a subspecialty in its own right, but the 6 levels of competency detailed in the Intercollegiate guidance distinguishes 3 higher levels (levels 4, 5 and 6) where more specialist and expert roles in child protection are defined (annex C). A paediatrician (level 4) with a Special Interest in child Protection is defined as a consultant who has had further training and experience in child protection and is competent in carrying out paediatric forensic examinations, including the interpretation of injury. They undertake CPD and take part in peer review, give advice to non-specialist colleagues and offer mentoring and support to more junior colleagues, and usually work solely in their Board area.

4. As shown in figure 1, there are 2 levels of consultant with additional competencies in child protection. The larger group are usually “Paediatricians with a Special Interest” and will be a consultant paediatrician in general or community child health working in a District General Hospital. The “Specialist Paediatric Consultant in Child Protection” of which there are 6 in Scotland (called tertiary specialists) work within a tertiary centre. In Scotland, these specialists in child protection are usually a consultant paediatrician providing specialist clinical care and forensic opinion in complex cases. While they are likely to have an active caseload, they also perform a mentoring and supervisory role to the developing specialists and provide opinion to colleagues (Annex D). If there is more than one consultant in a Board area with a special interest in child protection there will be the need to have a “lead clinician”. These consultants may have Level 6 competencies and work across their region usually leading an MCN and providing national policy advice to government and other bodies. The number of tertiary specialists is falling and the number of paediatricians with a special interest is rising, as the consultants combine secondary and tertiary roles.

Table 1
Paediatric workforce numbers

Health Board	**No of paediatricians Providing forensic services for CSA**
A & A	1
Borders	2
D & G	0
Forth Valley	4
GG & C	12
Grampian	3
Highland	2
Lanarkshire	4
Lothian	10
Orkney	0
Shetland	0
Tayside	4
Western Isles	0
TOTAL	**42**

5. Currently 42 paediatricians provide forensic services (31 consultants and 11 specialty doctors). These paediatricians will include general and community based paediatricians with a special interest in child protection and “specialist” tertiary consultants in child protection. There are 6 considered to work in tertiary centres (3 in

GG & C, 1 in Lothian, 2 in Grampian). However, in keeping with the trends in medical workforce in CCH the age range suggests that there will be significant reductions in this number due to retirals over the next 5-10 years. As there are very few CCH sub specialty trainees in the Deaneries and none specialising in the area of child protection, building and sustaining a competent specialist workforce will be challenging in the next 10 years. It is likely that centralisation is inevitable particularly out of hours. In addition, due to paediatric medical workforce changes CCH services are already threatened and it is likely that future consultant posts in community child health will be combined with acute general on call duties. This model already exists in many regions in Scotland, and forensic medical work is carried out by general paediatricians who have received additional training in the evaluation of CSA including the use of colposcopy after becoming consultants. This may lead to a reduction in the number of specialist paediatricians in the future, with more consultant posts having general paediatric duties; and with increasing gaps in middle grade rotas, the amount of time dedicated to this specialist role, may reduce in future job plans. However the present demand for specialist tertiary advice suggests that there is a need for 2-3 tertiary specialists in each MCN.

Forensic Physicians

6. The present forensic physician workforce is contracted by the police authorities/Boards. The following table indicates the total number of doctors employed in each police authority with the numbers employed to carry out paediatric examinations. In addition, in adult practice forensic nurses play an active role and work is underway to investigate the development of the paediatric role. There is no expectation that nurses will replace either the forensic physician or paediatrician but it is clear that their skills can be used more effectively in this area, particularly in an advocacy function.

Table 2 Forensic physician workforce numbers

Police Authority	**Total no of Doctors employed**	**No working in child protection**
Strathclyde	85	6
Central	7	7
L & B	7	7
D & G	4	4
Grampian	6	6
Fife	5	5
Tayside	9	3
Northern	4	4
TOTAL	127	42

7. The Scottish Government conducted a pilot of a new partnership model between the local Health Board and Police authority in Tayside. This model did not significantly change the model of two doctor joint examinations in CSA. Although there were Custody Nurses in this model, none of these nurses were involved in the examination of CSA cases.

8. Forensic physicians are encouraged to be members of the Faculty of Forensic and Legal Medicine, but individual police forces recruit their own forensic physicians. The ACPOS Health/Medical Services Reference Group is creating a template for use by NHSScotland and police forces when contracting forensic medical services and it is hoped that NHSScotland will remain one of the employers of forensic physicians, allowing clinical governance processes for paediatricians and forensic physicians to be managed by NHS Board Medical Directors.

Chapter 3

TRAINING AND SKILLS FOR PAEDIATRICIANS

1. The RCPCH oversees the training of all paediatricians. There are 3 stages of training to become a Consultant:-

- Basic Specialist Training in Paediatrics – which provides competencies on recognition and basic assessment of a child in need of protection. This is the level expected of a junior paediatric trainee;
- Core higher specialist training in paediatrics – which provides competencies on management of a child in need of protection. This is the level expected of a senior trainee who has gained a wider experience of working with children;
- Post-core higher specialist training – which provides competencies to know when an expert genital examination is needed and the role of colposcopy as part of that. This is the level expected of a trainee who is ready to take up a consultant post (i.e. has a CCT in general paediatrics or CCH).

Above this level additional competencies to develop specialist interests are provided by RCPCH. This would allow training in the conduct of sexual abuse examinations including the use of the colposcope. This does not necessarily confer expert status on the doctor.

2. The normal programme of training takes eight years until a paediatrician receives a CCT before they are deemed competent to apply for a consultant post. In child protection, there are specific levels of competency from level 1 to 6 described in the Intercollegiate document “Safeguarding Competencies” published in 2010. All trainees at ST 6-8 should obtain level 3 competencies before the end of their training and all consultants presently working as general paediatricians should aim to have level 3 Safeguarding Competencies or equivalent. After the CCT a consultant can gain additional competencies e.g. level 4,5 and 6.

3. There is no mandatory requirement for further qualifications for consultants with a special interest in child protection. However RCPCH has recommended that specialists performing examinations for CSA should be required to gain further qualifications such as the Diploma in Forensic and Clinical Aspects of Sexual Assault.There is also a recognised need for ongoing training, at a range of levels, to complement qualifications.

4. At present the training courses of those involved in forensic paediatric examinations is made up of national, accredited courses and local courses. Local training is not subject to accreditation and, while there is an appreciation of the need for flexibility and independence to create appropriate training courses, this needs to be balanced by a requirement to ensure training is adequate and appropriate.

5. It is recommended that paediatricians are required to see and undertake 10 examinations a year to maintain competencies. RCPCH recently recommended a minimum of 4 peer review sessions a year.

6. Training for paediatricians and forensic physicians on evidence gathering, report writing and giving evidence in court in cases of child sexual abuse has been arranged in the past by the RCPCH and Faculty of Advocates with appropriate input from COPFS, but these are not regularly held.

Chapter 4

TRAINING AND SKILLS FOR FORENSIC PHYSICIANS

1. The Faculty of Forensic and Legal Medicine (FFLM) is the governing body for forensic physician training. All forensic physicians are encouraged to be a member of the Faculty but membership is variable. The FFLM produced Quality Standards in Forensic Medicine (2010) and has a membership course (approved in 2010). FFLM collaborates with other colleges including Royal College of Obstetricians and Gynaecologists (RCOG) and RCPCH to run the Diploma (DFCASA) which provides basic competency levels in forensic work. In addition, the General Medical Council (GMC) agreed in March 2011 to recognise GP's with additional expertise in this area as credentialing towards being a specialist. An introductory course for forensic physicians carrying out the examination of children should be mandatory but there is no individual who has national responsibility for the quality of forensic physicians who carry out paediatric examinations. There are now clear requirements for forensic physicians who examine children to have a minimum level of competency and skill, evidence of training and CPD (50 credits per year), peer review and have undertaken a minimum caseload.

2. Any doctor (paediatrician or forensic physician) who undertakes a forensic assessment of a child who may have been subjected to sexual abuse must have particular skills. The appropriate skills of a Forensic Physician are detailed in "The Role of the Forensic Physician (Sept 2010)" and "Quality Standards in Forensic Medicine, General Forensic (GFM) and Sexual Offence Medicine (SOM), Faculty of Forensic and Legal Medicine, Royal College of Physicians of London" .

3. There are no national requirements for governance or training systems within the current terms of employment of forensic physicians. However, the Scottish Government has funded a 3 year pilot project in Tayside providing forensic medical and healthcare in police custody settings (FMS). This project allows the development of suitable supports and governance of the forensic physician services for children who have suffered sexual abuse.

Chapter 5

GOVERNANCE, DATA COLLECTION AND ACTIVITY

1. Data for the number of single and joint examinations in Scotland is not routinely collected across Scotland, and definitions are not standardised. However, for the SLWG the figures for 2010 were collated by the Chair after personal correspondence. In addition the MCN in SEAT had already establishes a database for all examinations in the south east.

Table 3 number of medical examinations for CSA

Date/ source of statistics	Board/service	In Hours (0900 – 1700)	Out of Hours (1700 – 0900 plus weekends)	Comments	Total by Region
Board	GGC (under 13s)	30	8		
Archway, Jan – Dec 2010	Archway (13-16 yrs plus LAAC)	13 (GGC: 8, A&A: 3, Lanarkshire: 1, Highland: 1)	30 (GGC: 22, A&A: 2, Lanarkshire: 5, Highland: 1)		
Board	Forth Valley	23	2		
Board	Lanarkshire	21	3		
Board	Ayrshire & Arran	8	?		
Board	Dumfries & Galloway	2	0		
Total West		**97**	**43**		**140**

Date/ source of statistics	Board/service	In Hours (0900 – 1700	Out of Hours (1700 – 0900 plus weekends)	Comments	Total by Region
	Fife	26	3		
SEAT	Lothian RHSC	91	27	Vega Suite 24 Includes paediatric gynaecological examinations	
	Borders	18	2		
Total SEAT		**135**	**32**		**167**
North	Grampian	80	4	Includes 13-16yr olds	
North	Tayside	7	1	Tayside has opted to be part of NoS MCN	
North	Highland	19	4	Includes 13-16yr olds	
North	Orkney & Shetland				
Total North		**106**	**9**		**115**

2. SLWG data suggests 422 examinations for Child Sexual Abuse (CSA) were carried out in 2009-2010. Of these, 84 were out of hours examinations, a large number of which were in the 13-16 year old age group. This age group often present with signs and symptoms similar to adult acute sexual assault and require similar services and follow up (e.g. for sexual health advice, blood borne virus screening, other contraceptive advice).

3. Clinical and financial governance of health services provided by NHSScotland is the responsibility of NHS Boards. The NHS Quality Strategy underlines the importance of clinical governance and sets out how it can support quality and minimise risks.

Scrutiny of healthcare and child protection

4. Gaps in service standards were previously highlighted in HMiE Children's Services Inspection reports from Angus Council, Argyll and Bute, South Ayrshire, Orkney, Western Isles, East Ayrshire and West Dunbartonshire.

5. The HMIE report “How well do we protect Scotland’s children?” summarised integrated inspection reports of children’s services from 2005-2009. The following comments were made regarding medical examinations:

“In most areas suitably trained doctors were available to carry out medical examinations and, in most areas, these were carried out without delay. In the few areas where there were delays in carrying out medical examinations of children, this was associated with a lack of clear guidance to staff or, was due to staff failing to follow established guidance or procedures. However, paediatricians were not always consulted appropriately when a medical examination of the child was a consideration. In these circumstances the wider health needs of children were not always considered or met well. In some areas children were examined by doctors without the required experience or training. In a few areas children were not always examined in appropriate facilities.”

6. The Care Inspectorate is the independent scrutiny and improvement body for care and children's services. Healthcare Improvement Scotland (HIS) scrutinises healthcare services. HIS and the Care Inspectorate scrutinise these areas previously done by;

- Her Majesty’s Inspectorate of Education (HMIE);
- NHS Quality Improvement Scotland (NHS QIS);
- Social Work Inspection Agency (SWIA); and
- The Care Commission.

MCN Governance

7. The three MCN’s in Scotland are at different stages of evolution, for example South East and Tayside (SEAT) MCN deals with CSA only. All three received funding from the National Delivery Plan for Specialist Children’s Services via regional planning groups, and are subject to scrutiny and governance from the regional planning groups. It is planned that Healthcare Improvement Scotland (HIS) will participate in the performance assessment of some MCNs.

8. In addition, MCN networks have their own governance requirements and arrangements. NHS HIS provides guidance and support for networks on implementing a programme of quality assurance. Network standards can be based on existing national standards or, where these do not exist, drawn up and agreed by the networks.

9. Given that the three networks already work collaboratively and intend to do so to a greater degree in future, there is an appetite for overall governance of the child protection networks. The suggestion from the networks themselves is to form a collaborative group comprising regional MCN leads and others which would report to the Child and Young People’s Health Support Group.

Telemedicine

10. A project has been completed looking at the use of telemedicine conducted by the Scottish Centre for Telehealth in child protection in particular whether the required standards of evidence could still be met. The quality of the recording would be a crucial aspect for evidential purposes. The legal and ethical frameworks which govern forensic data management of physically or sexually abused children are complex. The project tested the efficacy of telemedicine and the reliability and robustness of the network. It concluded that it is technically possible to share images but infrastructure problems require improving to ensure optimal reliability and discussion with COPFS regarding evidential integrity is ongoing.

Annex A

Short Life Working Group – Remit and Membership

Role and Remit

The Group agreed the following remit:
To explore sustainable models of service provision for access to "specialist" child protection medical expertise during and outwith office hours, which fit with the present configuration of paediatric services.

Membership

Dr Kate McKay, National Clinical Lead for Children and Young People's Health in Scotland (Chair)
DSI Lesley Boal, Detective Superintendent, Lothian and Borders Police
Lorraine Currie, Child Health Commissioner NHS Grampian
Dr George Fernie, President, Faculty of Forensic and Legal Medicine
John Froggatt, Deputy Director, Child and Maternal Health Division, Scottish Government
Louise Gallacher, Head of Victim and Diversity Policy, Crown Office and Procurator Fiscal Service
Dr Helen Hammond, Consultant Community Paediatrican, NHS Lothian
Dr Jean Herbison, Clinical Director, Child Protection, NHS Greater Glasgow and Clyde
Dr Jane Macdonnell, Consultant Paediatrician, NHS Borders
Dr Liz Myerscough, Consultant Paediatrician, Community Child Health, NHS Grampian

Annex B

NHSScotland Healthcare Quality Strategy: Quality Outcomes and Indicators Quality Outcomes and Indicators

The NHS Scotland healthcare Quality Strategy sets the overall direction for achieving NHS Scotland's aim of delivering the highest quality of healthcare services to people in Scotland.

The Quality Alliance Board agreed six healthcare Quality Outcomes which provide a comprehensive description of the priority area for improvement in support of the Quality Ambitions.

The six healthcare Quality Outcomes are:

1. Everyone gets the best start in life, and is able to live a longer healthier life.
2. People are able to live well at home or in the community.
3. Healthcare is safe for every person, every time.
4. Everyone has a positive experience of healthcare.
5. Staff feel supported and engaged.
6. The best use is made of available resources.

Annex C

RCPCH Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff

Grade	Criteria	Competency	Training	Review
Non child health medical staff	Intercollegiate Level 1 (all staff working in healthcare settings) Intercollegiate Level 2 (staff who have infrequent contact with parents, children and young people)	Not applicable	Health organizations including Trusts Multi agency training including Safeguarding Boards E learning programmes being developed	3 yearly Job review process
Child health staff				
ST 1-3	Intercollegiate Level 3 (all staff working predominantly with children, young people and parents)	RCPCH Level 1 (Basic) "Safeguarding 1': RCPCH SHO safeguarding children course – Recognition and Response	Multiagency training e.g. NSPCC, BASPCAN conferences, LSCB*	Course completed
ST 4,5 SASSG	Intercollegiate Level 3	RCPCH Level 2 (Core) "Safeguarding 2': RCPCH SpR e-learning programme. LSCB*	Multiagency training e.g. NSPCC, BASPCAN conferences, LSCB*	Course completed
ST 6-8 SASSG	Intercollegiate Level 3	RCPCH (Specialist) competences Level 3 General Level 3 Community	Knowledge, skills, experience in post. Post graduate training days, local and national, with CPD recognition e.g. MSc modules, CPSIG conferences Multiagency training e.g. NSPCC, BASPCAN conferences, Special Study module in safeguarding (module written March 2010)	RITA process/ ARCP
Consultant doctors SASSG	Intercollegiate Level 3	E-learning (RCPCH) Maintaining and Updating Competences	Post graduate training days, local and national, with CPD recognition e.g. MSc modules, CPSIG conferences Multiagency training e.g. NSPCC, BASPCAN conferences,	2-3 yearly to keep updated Job appraisal

Named/ Designated doctors	Intercollegiate Level 4 (Named professionals) Intercollegiate Level 5 (Designated professionals)		Post graduate training days, local and national, with CPD recognition e.g. Named/ Designated professionals conference, MSc modules, CPSIG conferences Multiagency training e.g. NSPCC, BASPCAN conferences,	Job appraisal
Tertiary specialists E.g. 2nd opinion doctors, expert witnesses?	Intercollegiate Level 6 (Expert)		Post graduate training days, local and national, with CPD recognition e.g. MSc modules, CPSIG conferences Multiagency training e.g. NSPCC, BASPCAN conferences,	Job appraisal

Annex D

Definitions of Tasks performed by a Paediatrician in Forensic Paediatrics

1. Paediatricians with a "Special Interest in Child Protection"

- Participation in daytime and out of hours child protection rotas. They may have their training origins in Acute or Community Child Health and are likely to be combining their posts with other community and/or acute responsibilities. Their contribution to rotas can be very variable, from 5 sessions per week to out of hours only. It is essential that these duties are explicit and protected within job plans.
- These are paediatricians who have had further training and experience in child protection and are competent in the provision of paediatric/forensic examination including the interpretation of injury.
- They work within the structure of local and regional services and with support and advice from tertiary specialists.
- The current RCPCH curriculum may be inadequate for these enhanced posts. In the future it will be important for skills and competencies to be defined for this level, in relation to all forms of abuse, including physical abuse, sexual abuse and neglect. Appropriate post-graduate qualifications will need to be identified with options such as DFCASA, DMJ or Fellowship of the Faculty of Forensic and Legal Medicine, or a post-graduate qualification through RCPCH or modular credentialing. (For paediatricians the preference is for RCPCH training programmes because these can be linked to ST training and to RCPCH standards and guidelines).
- There is a requirement for regular attendance at peer review, a minimum of 5 times per year, a need to undertake regular CPD and to keep abreast of the child protection literature.
- These consultants will offer mentoring, supervision and support to more junior colleagues, and participate in multi-agency training.
- Their duties will include giving advice to non-specialist colleagues for example GPs, health visitors and adult physicians.
- They will be required to give advice to social work, police and education through regular contribution to IRD/tripartite/strategy discussions.

2. "Specialist Consultant Paediatrician in Child Protection"

These paediatricians will be consultants usually working in tertiary centres, or across regional MCN's. It is important to note that these post holders alone cannot deliver the services without the support of a team of Paediatricians with a Special Interest and junior staff. Tertiary specialists fulfil the following functions:

Strategic

- Providing strong leadership in the field of child protection, including leading regional MCN's and participating at a national level.
- Offering commitment to the strategic development of the service.
- Providing advice to Health Boards and regional planning groups in relation to policy and practice, service development, high profile cases.
- Provides a link with Lead Nurse in child protection and other nursing professionals across the Board.

Clinical

- Providing specialist clinical care and expert forensic opinion in complex cases.
- Providing specialist advice and support for consultant and junior medical staff managing difficult and complex cases, both in the community and the hospitals. This includes cases being managed by other specialties e.g. Paediatric Surgery, Plastics, Orthopaedics and A & E.

Training and Education

- Providing an overview of clinical governance (including contributing to multi-agency IRD reviews, significant case reviews, audit and research).
- Providing leadership and supervision of post-graduate training at all levels within the community and hospital services.
- Providing leadership of peer review.
- Providing a second opinion to colleagues across the regional MCN.
- Providing expert opinion to the courts.
- Providing the lead Paediatrician role for each local authority Child Protection Committee (in most cases currently also the health vice chair).
- Taking an active role in multi-agency training and quality assurance.
- Having an active role in College activities.

Annex E

References and Publications

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