National Clinical Child Protection Network

Guidance on Producing Reports APPROVED: October 2025

Title:	**Report writing for child protection medical examinations – best practice guideline**
Version:	V0.1
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Target Audience:	Medical and Community paediatricians, Forensic Physicians and Child Protection Paediatricians who may contribute to the assessment of children with suspected physical abuse.
Keywords:	Specialist medical report, Soul and Conscience Report, forensic medical report, forensic medical examination, comprehensive medical examination for neglect, child sexual abuse, physical abuse, child abuse
National Child Protection Network Guidance:	This guidance has been produced with the support of the National Clinical Network for Child Protection in Scotland. The guidance represents the key considerations that health boards could reasonably be expected to provide support for. Each guidance document is primarily to support clinical care and is designed to be modified by individual boards or centres with local contact information, investigation sets and/ or clinical systems information.

Introduction

The purpose of these guidelines is to provide support in writing a child protection medical report. The purpose of the medical report is to provide a full, detailed and accurate account of a history and examination, analysis of findings and forensic opinion. These guidelines are suitable for paediatric doctors and forensic physicians required to produce child protection medical reports.

Across the country there are different terminologies used for the name of this report e.g. specialist medical report, soul and conscience report. For the purposes of these guidelines, we will refer to the documentation as a child protection medical report.

This report may be used to inform statutory agencies of the probability of abuse and risk of significant harm. If the case proceeds to court, the medical report will assist the court in planning for a child's safety and welfare. This report must allow non-medical partner agencies and courts to understand the medical evidence.

A good medical report will be factually correct, well-reasoned, evidence-based and clearly presented. The report should be written in a standardised format. Not everyone who reads your report will be medically qualified. Use non-medical

language where possible or explain any medical terms in layman's terms in brackets.

A standard proforma is used to document the child protection medical assessment. This proforma should be used to contemporaneously document history and examination findings. It should also be used to formulate the child protection medical report using headings from the proforma.

In practice, a detailed joint report, produced by the examining paediatrician and forensic physician should be available within three to four weeks following joint paediatric forensic examinations. This is as per *the Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland* report.

This guideline recommends that a single joint forensic medical report should be co-authored by the paediatrician and the forensic physician. This allows for a unified and clear opinion to be presented to agencies out with health.

Format

The medical report should be typed with a font size of at least 12 and 1.5 line spacing. The report should be justified. Every page should be numbered and numbering paragraphs should be considered.

Each medical report should have a standardised front page (see appendix). This page should have patient demographics including name, date of birth, address and community health index (CHI) number.

The front page should state that this is a confidential medical report and is not to be copied or circulated without permission of the author. Signatures and demographics of the examining doctors should also be included on the cover page.

Following the paragraphs described below, if a section of the proforma is not relevant (e.g. Adolescent, Genital Examination Findings), this heading should be omitted from the medical report. If a heading or section is relevant but was not examined, this should be documented in the report. It should be included when the relevant information has been obtained.

Specialist Child Protection Team
[Insert address]

Ref.:

Switchboard: []
Direct Tel: [ ]
Internal Ext: [ ]
Enquiries to: [ ]
Email: [ ]

Date Received:
Date Typed:

Not to be copied or circulated without permission of report author(s)

CONFIDENTIAL MEDICAL REPORT

Name of Child:

Date of Birth:
CHI No:

Address:

Signature …….. **Date:**
Dr
Consultant Paediatrician (Child Protection)

Signature …….. **Date:**
Dr
Forensic Physician

Copies to:
GP

Health Visitor / School Nurse
Police
Social work services
Hospital notes

Brief CV – Dr (Consultant)

Each examining doctor to insert a single paragraph CV summarizing their qualifications, current role and child protection experience. The purpose of this paragraph is to give credibility to the report.

Brief CV – Dr (Forensic Physician)

[insert as above]

1. Examination Details

1.1 Date of Examination:
Time of Examination
Location:
Type of Examination:
Doctors:

2. Witnesses to Examination / Consent

2.1 State names and role of others present at the examination such as family members, social work, police, other professionals eg interpreter if required.

2.2 If the child/young person has capacity to give consent and does so, then this should be clearly documented (which can be in addition to consent from person with parental responsibility).

2.3 A person with parental responsibility can give consent. It will be important to check prior to the examination who is legally able to give consent and that they will be attending to give consent (may be the Local Authority if a court order is in place).

2.4 The consent below can be adapted/shortened depending on the nature and extent of the examination and investigations required.

2.5 Ideally written consent should be obtained, however if only verbal consent is available, state clearly why written consent was not obtained. Witnesses to verbal consent being given must be documented in the report.

2.6 Example**:**

2.6a [ ] gave fully informed, written consent to the medical examination, photography and DVD of clinical findings, forensic samples to be taken, laboratory investigations and radiology investigations.

2.6b [ ] also consented to the use of any photographs, digital recordings, radiological images and the results of any laboratory investigations in support of clinical evidence in court proceedings, and for the sharing of information from the medical examination with Social Work, the Police, the GP and the School Nurse/Health Visitor.

3. Reason for Referral

3.1 State who/what agency requested the examination.

3.2 It is important to clearly identify who has briefed you and the sources of the information provided. It may be easier to separate information from different sources into separate paragraphs.

3.3 Information may have been shared without the child/young person/parent/carer present – if this is the case, then this should be noted. State who was present in the room when this information was shared.

3.4 Where possible, include specific questions asked and any verbatim language in quotation marks.

3.5 Social background that has directly led to this examination being carried out should be included here.

3.6 Be mindful of language used – describe allegations of what is reported rather than making judgements or statements of fact.

4. Detailed Medical History

4.1 Identify sources of information, such as parent, electronic health records or local authority reports.

4.2 Where parental reports differ to recorded information, this discrepancy must be described.

5. Symptomatology

5.1 Report both positive and negative history.

5.2 Document concerns around reported behaviour including ASD/ADHD

6. Developmental History / School Progress

6.1 Record who has described developmental ability.

6.2 If information is available from nursery/school/medical records, this should be noted (including the source of information).

7. Family History

7.1 State who has provided the medical family history, in verbatim where necessary.

8. Social History

8.1 State who is living with the child.

8.2 Document any drug/alcohol/domestic violence/forensic history stating the source of information.

8.3 Include details of previous involvement with Social Work/Child Protection Services/Police.

8.4 Helpful to state if no previous concerns from Social Work/Police (if known).

9. Adolescent

9.1 Report as per proforma prompts stating source of information.

10. Forensic Sexual Assault

10.1 Report as per proforma prompts stating source of information.
This paragraph is only relevant to examination for child sexual abuse.

11. Emotional Wellbeing Risk Assessment

11.1 This should be a factual report of what is observed rather than an analysis of mental or emotional health. Analysis will be reported under 'conclusion'.

11.2 Report as per proforma prompts.

12. General Examination Findings

12. 1 Factual information of what you saw should be documented in a systematic way, following the standardised medical report proforma. It is important to list both positive and negative findings.

12. 2 This section should start with a general overview of how the child presented including their physical appearance (clothing, hygiene), his/her behaviour (e.g. quiet and withdrawn) and interaction with parent/carer and professionals.

12. 3 Each of the child's growth parameters and centiles should be documented. This includes height and weight in all children and head circumference in younger children. Body mass index can also be documented to record over or underweight children.

12. 4 Describe a head to toe survey as well as developmental findings, as appropriate. Older children should have their pubertal Tanner stage documented.

12.5 Example:
On examination, patient X was bright, chatty and confident. He was keen to interact with the history and was cooperative with examination. X responded appropriately to requests from his mother and professionals in the examination room. X was appropriately dressed in well-fitting clothes. X had clean, short blonde hair. His weight was Xkg which is 75th – 91st centile and his height was Xcm which is 50th – 75th centile. Examination of the cardiovascular, respiratory and gastrointestinal system were normal. Conjunctiva were pink. His fingernails were short and dirt was evident under all ten fingernails. His toenails were short and clean. He had good dentition with minimal visible plaque.

12. 6 For all external skin findings, these should be numbered and described (size, site, shape, colour). It is useful to assign a number to each finding on the body map and use the same numbering for the report. A table/ list can be a very helpful way of documenting this in the report. Injuries can be grouped together (e.g. bruises on left knee followed by description of size, shape, colour).

12. 7 If the child or adult present offers an explanation for a particular skin finding, include the question you asked as well as the answer. Leading questions should be avoided.

12. 8 Do not give your opinion on injuries in this section of the report. It is important not to imply mechanism of injury with words such as 'fingertip bruising'. Use layman's term to describe anatomical position of injuries (to the left/ right of, above, below) and avoid terms such as medial/ lateral/ superior/ inferior. Remember layman's terms for naming body parts (kneecap versus patella, birthmark versus naevus).

13. Genital Examination Findings – Female / Male and 14. Anal Examination – Male & Female

13. 1 If ano-genital examination is required, document the positions the child was asked to adopt (e.g. supine/ knees to chest/ left lateral). Include in the report how genitalia was visualised (e.g. colposcope) and if digital recording and/or photographs were obtained.

13. 2 Comment on all normal findings as well as abnormal findings.

13. 3 Comment on how the child coped with this part of the examination.

13.4 Interpretation of findings can be described in the conclusion. This paragraph is a descriptive statement of what has been observed.

15. Investigations

15. 1 Any investigations performed should be listed in the medical report. Investigations can be formatted as a table or bullet point style list. Available and pending results should be documented in this section.

15. 2 An indication of timeline for pending results should be given. Interpretation of available results can be given in this section. Any investigations which still require to be performed should also be documented.

15. 3 Investigations performed by the forensic medical examiner should be listed as per the contemporaneous notes in the examination proforma. The anatomical site of sampling and whether DNA swabs were dry or wet should be listed.

15.4 If an investigation has been sent under chain of evidence custody, this must be documented.

15.5 Investigations that were declined by the child or consenting adult should be documented in the medical report.

16. Conclusions / Advice Given

16.1 The purpose of the conclusion is to present a clear opinion that guides partner agencies in understanding the risks to a child's safety and wellbeing in the context of multi-agency concerns.

16.2 Start the conclusion with a **summary** of pertinent information from the background information. This should be no more than 2-3 sentences.

16.3 Following a summary, the next paragraph of the conclusion should be an analysis of the findings from examination.

16.4 When referring to analysis of injuries and findings, refer to the injury as numbered in the examination paragraphs 12, 13 and 14.

16.5 Describe all injuries in groups of what is concerning and what is not. For example, "injuries 2, 4, 5, 6, and 9 numbered in the above paragraphs are bruises typically seen in accidental injuries in children of X's age and stage of development. These are not concerning for abuse." or "injury numbered 8 in the above is a patterned bruise which is consistent with X's disclosure of being hit with a …."

16.6 Use literature evidence and reference these during your analysis. For example "petechiae in association with bruising is a predictor for abusive injury" The Child Protection Companion is a good source of evidence based statements that can be referenced.

16.7 Once you have listed an analysis of the injuries found, the final paragraph of the conclusion should be your opinion. This is your conclusion that has been drawn from the preceding summary and analysis.

16.8 Within the opinion, there is scope to give a differential diagnosis, but the preferred diagnosis must be clearly communicated.

16.9 Stay within the realms of your expertise and highlight any limitations to this report or the conclusion given.

16.10 It is important to state that negative findings do not negate the disclosure that a child has made. This is especially relevant to disclosures of physical and sexual assault.

16.11 If there are no clinical findings to support abuse, this may not mean "no abuse", and this must be clearly communicated.

17. Safety Planning / Action Plan

17.1 This is a short statement on the agreed immediate care arrangements of the child. Where relevant, this should be provided to the examiners by the social workers attending the examination.

17.2 A list of medical recommendations should be made (such as treatment to be prescribed for an identified health need)

17.3 Any medical referrals or follow up plans that have been made must be communicated along with an anticipated timeframe.

18. Copying the report

18.1 The report should be copied to those referenced in the consent form take. This includes police, social work, GP, health visitor and/or school nurse.

18.2 Any referrals that are required following examination should be sent as a separate clinical letter with only the details relevant to the clinical concern.

References:

Child protection service delivery standards - RCPCH Child Protection Portal

Chapter 16: Records and Reports - RCPCH Child Protection Portal

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