Compliance audit on medico-legal documentation and reporting in University Child and Adolescent Mental Health Services at Lady Ridgeway Hospital for Children

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University Child and Adolescent Mental Health Services (UCAMHS) increasingly engage with assessments related to medico-legal problems involving child maltreatment, parenting capacity, behvaiour and mental state assessments and decisions related to child custody. Efficient and timely documentation and reporting are critical for legal and clinical accountability. This audit evaluates compliance with medico-legal documentation standards in UCAMHS at Lady Ridgeway Hospital for Children, Sri Lanka. A retrospective audit was conducted from January 2024 to July 2025, reviewing 58 consecutive medico-legal cases seen at the university-affiliated CAMHS unit. The audit tool assessed demographic profiles, referral quality and referral pathways as well as structured documentation, legal compliance, confidentiality protocols, and staff training. The majority of cases involved children aged 12 years (n = 8, 14.0%), with a slight male predominance (n = 32, 55.2%). The most common referral reasons were behavioural issues (n = 16, 27.6%) and sexual abuse (n = 11, 19.0%). Referral sources were documented in n = 48 (82.8%) of cases, most frequently from juvenile courts (n = 18, 31.0%). A complete account of the event history was available in n = 42 (72.4%), and informant details were recorded in n = 43 (74.1%). Mental state assessments were documented in n = 48 (82.8%), and risk assessments were present in n = 55 (94.8%). Timely submission of medico-legal reports occurred in n = 19 (32.8%) of cases. No clinical case conferences were conducted within 24 hours; however, institutional case conferences were held in n = 17 (29.3%). Confidentiality protocols were adhered to in all cases (n = 58, 100%). Reporting to probation services (n = 27, 46.6%) was more frequent than NCPA-related reporting (n = 5, 8.6%). Follow-up was planned for n = 44 (75.9%) of children, although only n = 23 (39.7%) attended follow-up appointments. The audit identified strengths in confidentiality and clinical documentation but revealed significant delays in reporting and gaps in inter-agency collaboration. Addressing these through clear SOPs, improved discharge planning, and staff training is recommended.

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