

Child Sexual Abuse Care Pathway and Service Standards

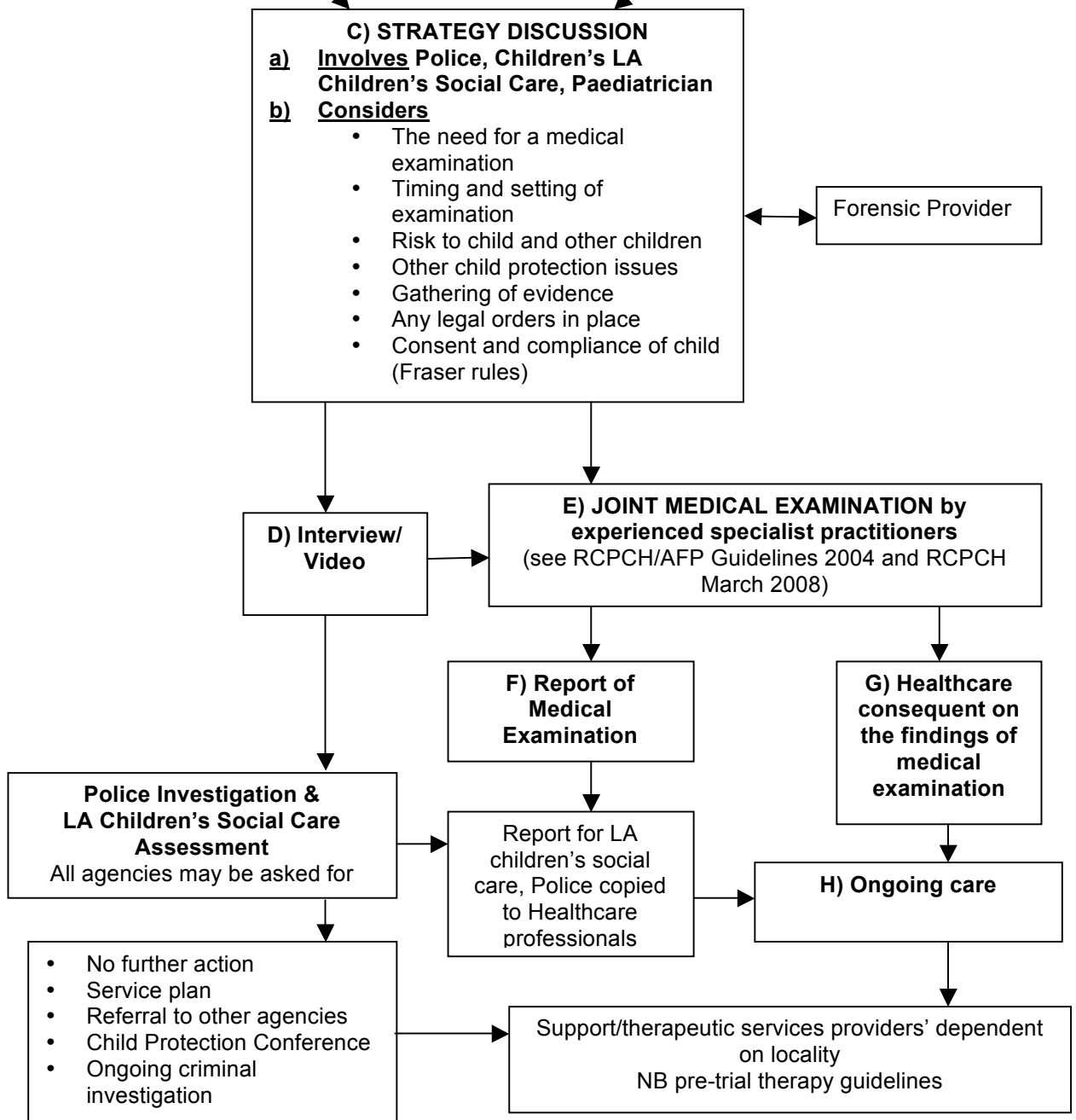
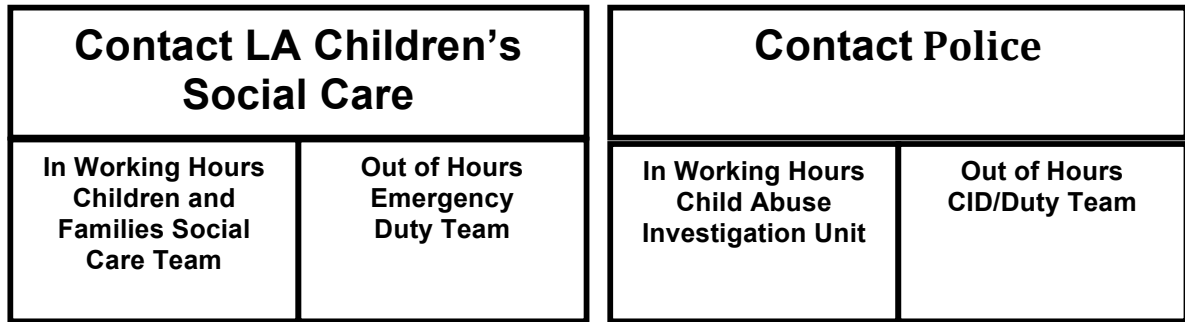
**PiP Child Protection Standing Group and
Child Sexual Abuse Services Project Group**

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Version:	Final
Date:	June 2009
Date Approved:	June 2009
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Review Date:	June 2010
Name of responsible committee:	PiP Child Protection Standing Group CSA Services Project Group
Target Audience:	Designated professionals

PROCESS MAP TO GUIDE PROFESSIONALS WORKING IN CHILDREN'S SERVICES WHEN THERE IS CONCERN ABOUT THE POSSIBILITY OF CHILD SEXUAL ABUSE

EITHER

OR



Introduction

1. The document '*What to do if you're worried a child is being abused*' provides guidance about safeguarding processes, but little detail on the specialist assessments that may be required in cases of suspected or alleged child sexual abuse (CSA).
2. This 'care pathway' for CSA has been drawn up to inform all responsible for the effective provision of services for CSA, including arrangements for medical examination. The pathway applies when there is a referral or an allegation of sexual abuse of a child or young person following a strategy meeting (DOH 2003). It is intended to ensure that, following a strategy meeting, all children and young people (normally up to the age of 16 years), where sexual abuse is alleged or suspected:
 - a) see an appropriately experienced doctor for the joint paediatric assessment and forensic examination; and
 - b) receive care that meets certain minimum quality standards, with an overriding emphasis on the interests and wellbeing of the child throughout. Relevant standards have been drawn from a number of existing documents^{1,2,3,4,5,6,7,8}

Note: the pathway includes children up to the age of 16, the usual remit of paediatric services. The Children Act 1989, however, defines a child as up to their 18th birthday. There may be a role for paediatricians, in particular where a child over 16 years has known disabilities. For those aged 16-18, medical examinations will depend on locally agreed arrangements.

3. The pathway covers the processes leading to medical examination, the examination itself, and subsequent health care processes. The medical examination is only a small part of the process, but it plays a crucial role in ensuring the health care of the child. RCPCH guidelines on paediatric forensic examinations in relation to possible child sexual abuse make clear that the purpose of the examination is two-fold: it concerns BOTH health assessment and forensic examination.
4. The pathway assumes the general principle set out in the Frazer rules: the right to involvement of the child or young person in all decisions, as appropriate to age and understanding.
5. The care pathway and standards recognise the practicalities of service provision and service resourcing, but they reassert the importance, also expressed by Laming and others, of exceptional inter-agency collaboration and a highly skilled workforce.

¹ Working Together (WT) to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children. HM Government. (2006)

² Guidance on Paediatric Forensic Examinations in relation to Possible Child Sexual Abuse RCPCH/AFP. (September 2004)

³ The Victoria Climbié inquiry TSO 2003 (chaired by Lord Laming)

⁴ Guidance on investigating child abuse and safeguarding children (Assoc of Chief Police Officers 2005)(ACPO)

⁵ What to do if you're worried a child is being abused (DOH 2003)

⁶ The Physical Signs of Child Sexual Abuse, An evidence –based review and guidance for best practice RCPCH (March 2008)

⁷ Guide for Services for Children Provided by Sexual Assault Referral Centres (SARCs), DoH Draft March 2008

⁸ The Child Protection Companion RCPCH 2006

6. The care pathway currently comprises:
- a) **a process map**, intended to capture the key sequence of events that form the pathway. This has been presented in terms that should be recognisable to all professionals involved in the care of children.
 - b) a document that elaborates events identified within the process map, indicating **standards of service** that should guide resourcing and operation of the service.
7. The standards, and a small number of key indicators are proposed to provide a basis for 'audit' so that the quality of service provided can be measured and assured by Local Safeguarding Children Boards (LSCBs) (and other regulators).

The care pathway is intended to be reviewed and revised regularly and associated guidance and 'standard' documents or templates may be adopted or developed for use by specialist practitioners as an integral part of the pathway.

Definition

“Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.”

(WT 1.32)

Responsibilities

“Everyone who works or has contact with children, parents, and other adults in contact with children should be able to recognise, and know how to act upon, evidence that a child’s health or development is or may be being impaired and especially when they are suffering, or at risk of suffering, significant harm”

(WT 5.7)

*“If somebody believes that a child may be suffering, or may be at risk of suffering significant harm, then s/he should always **REFER** his or her concerns to the LA children’s social care.”*

(WT 5.16)

National Institute for Health and Clinical Excellence (NICE) is producing guidance on ‘When to suspect child maltreatment’ in preparation due for publication in July 2009

All staff members who have or become aware of concerns about the safety of a child or children should know

- *what services are available locally*
- *how to gain access to them*
- *what sources of further advice and expertise are available*
- *who to contact in what circumstances, and how and*
- *when to make a referral to LA children’s social care*

(WT 5.11)

List of Standards

A) PRESENTATION

Child/young person presents, leading to disclosure/suspicion of CSA.

B) REFERRAL

All staff should refer to their Local Safeguarding Children Board (LSCB) interagency guidance and the National documents - *Working Together to Safeguard Children 2006* and *What to do If You're Worried a Child is Being Abused* (DOH 2003)

"A referral is a communication between agencies which alerts the agency to a concern for a child. This includes communication from the police to LA Children's Social Care, NSPCC, school or health care professional and a communication from one of these agencies to the police." (ACPO 2005:6.4.1:p75 and also see 7.2)

"Where it is decided that it is in the best interests of the child to proceed with a full criminal investigation, the investigation is the responsibility of the police...There will however be less serious cases where, after discussion, it is decided that the best interests of the child are served by LA Children's Social Care-led assessment rather than a full investigation...Where any doubt exists as to the seriousness of the case, the police should take responsibility from the outset..." (ACPO 2005: 7.2.1)

1. **Police have a clear protocol to involve a paediatrician, agreed with health agencies.**
2. **There should be a paediatrician on the "on call" rota, who can give advice on and co-ordinate a medical assessment in suspected child sexual abuse. Local arrangements may vary but details need to be shared with the investigating agencies.** (See also ACPO 2005 guidance on the role of the examining doctor: 4.6.3 p52 and Strategy discussions at 7.3, p85)

C) MULTI-AGENCY STRATEGY DISCUSSION

3. The strategy discussion is the primary mechanism through which professionals can discuss and determine the best course of action for a child, the time and place at which a medical examination, if required, should be conducted and to seek any specialist advice needed e.g. from the Forensic Science service.

"Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm, there should be a strategy discussion... convened by LA children's social care and those participating should be sufficiently senior and able, therefore, to contribute to the discussion of available information and to make decisions on behalf of their agencies. If the child is a hospital patient (in or out-patient) or receiving services from a child development team, the medical consultant responsible for the child's health care should be involved, as should the senior nurse if the child is an in-patient. **Where a medical examination may be necessary or has taken place a senior doctor from those providing services should also be involved.**" (WT 5.54)

4. To assist the examination, the **investigating Police Officers should provide the forensic physician/paediatrician with the account that the victim has provided to the police.** (ACPO 2005 advises that “There should be a strategy discussion between the police, LA Children’s Social Care and other agencies, when relevant...).
5. **“Any information shared, all decisions reached, and the basis for those decisions, should be clearly recorded by the chair of the strategy discussion and circulated within one working day to all parties to the discussion.”**
(WT 5.57)

“Cases of abuse in which the victim does not require urgent medical attention allow for a medical examination to be carefully planned. The purpose of any forensic examination in such a case is to assess the medical needs of the child and record any evidence relevant to the case”. (ACPO 2005: 4.6.2 p52)

D) INTERVIEW OF CHILD AND/OR WITNESSES

6. **The video interview should (usually) happen first i.e. before the examination, subject to agreements reached at the strategy meeting:**

“The investigating officer should discuss with the forensic physician or paediatrician whether it might be more appropriate to conduct a victim interview prior to the forensic medical examination. The advantage of such a procedure is that it may suggest additional opportunities for evidence collection and prevent the possibility of a further examination to check on any disclosures made during the interview. Carrying out the interview first should prevent the child from having to repeat the disclosure to the examining doctor...” (ACPO 2005: 4.6.2 p52)

7. **If an interview takes place prior to the medical examination, relevant history is available to the paediatrician in advance of the medical examination.**
(ACPO 2005 4.6.4)
8. The welfare of the child may dictate the need for medical treatment without delay. **“..... When it is decided that the examination should take place before the interview, the examining physician or paediatrician will need to speak to the child so that the required samples can be collected and the scope of the examination determined... The conversation should be recorded by the examining physician or paediatrician and included in their witness statement”.**
(ACPO 2005: 4.6.2 p52)

E) JOINT MEDICAL EXAMINATION

Purpose and Timing

9. **Timing of the medical: the needs and routines of the child/young person should be sensitively considered along with the need for forensic examination** (See ACPO 2005 4.6.2 p51 on the timing of the forensic examination).

10. The following **five issues should be taken into account when deciding when the forensic examination should take place** (RCPCH 2008)
- The medical care of the child or young person.
 - The need for a forensic clinical examination – in view of the timescale for healing of signs.
 - The needs for forensic sampling – the likelihood of positive DNA is highest immediately after the event.
 - The likelihood of positive culture for sexually transmitted infection (esp. Hep B, Hep C and HIV).
 - Legal requirements (Police and Criminal Evidence Act).

“The first priority of the services must be the health and welfare of the child. The collection of (forensic) evidence which could assist the criminal justice process is important, but must take place alongside the health and welfare needs of the child”. (DH March 2008)

11. Procedures may be required to gather and preserve forensic evidence. Timing of the medical examination may be affected by the deterioration of potential evidence such as bodily fluids or by healing processes. It should be noted that it is possible for body fluids such as semen to be recovered up to seven days after an assault and this may also prompt the need for an early examination if the abuse is disclosed near to this time limit. (ACPO 2005)

If there is uncertainty, advice can be sought from the Forensic Science Service.

12. **Even where forensic evidence may not be secured, where there is other evidence that significant harm from sexual abuse may have been suffered, a health/medical examination should still be considered, and offered to the child and carers as part of a therapeutic process.**

The purpose of the examination is two-fold: it concerns BOTH health assessment and forensic examination. The health assessment is a basis for action to protect the health of the child/young person. The process map thus indicates other health care processes that should be accessible, about which information should be available, and to which the child/young person should be referred, as appropriate, following the examination. (RCPCH/AFP guidance)

Examination: Examiner(s)

13. **Experienced paediatrician(s) should be identified and accessible, if not 24 hours seven days per week, then at least between 9am and 5pm 365 days/year.**

“An ideal service should be available 24/7, providing a service for some part or all of every day, including weekends. To achieve adequate medical staffing rotas for acute medical child protection work may well need to draw on networks such as managed clinical networks”. (DH March 2008)

Commissioners/PCTs must consider how the service can be provided out of hours. It is acknowledged that the ideal conditions for the examination are likely to be during normal working hours. (ACPO 2005:4.6.2 p51)

14. **“Any doctor (e.g. paediatrician or forensic physician) who undertakes a forensic assessment of a child who may have been subjected to abuse must have particular core skills”** (RCPCH/AFP). These have been updated (RCPCH 2008).

Skills required:

- An ability to communicate comfortably with children and their carers about sensitive issues.
- An understanding of and sensitivity to the child's developmental, social and emotional needs and his or her intellectual level.
- An understanding of consent and confidentiality as they relate to children and young people.
- Competence to conduct a comprehensive general and genital examination of a child and skill in the different techniques used to facilitate the genital examination.
- An understanding, based on current research evidence, of the normal genital and anal anatomy and its variants for the age and gender of the child to be examined.
- An understanding, based on the current research evidence, of the diagnosis and differential diagnosis of physical signs associated with abuse.
- Competence in the use of a colposcope and in obtaining photo-documentation ensuring that the latter properly reflects the clinical findings and documenting if it does not.
- An understanding of what forensic samples may be appropriate to the investigation and how these samples should be obtained and packaged.
- The ability to comprehensively and precisely document the clinical findings in contemporaneous notes.
- The competence to produce a detailed statement or report describing and interpreting the clinical findings.
- An understanding of the importance of communicating and co-operating with other agencies and professionals involved in the care of the child; this may include attending a case conference, referral to other health professionals e.g. paediatricians, psychiatrists, genitourinary physicians.
- The ability to present the evidence, and be cross-examined, in subsequent civil or criminal proceedings.
- An understanding of the different types of post-coital contraception available, the indications and contraindications of the various methods, and the capacity to prescribe the hormonal types of contraception where appropriate.
- Understanding of prophylaxis (including Hepatitis S, HIV), screening and diagnosis of sexually transmitted infections.

15. A joint examination (two paediatricians or one paediatrician and a Forensic Medical Examiner/Forensic Physician) (FME/FP) should be arranged if a single doctor does not have all the necessary knowledge, skills and experience for the examination (RCPCH/AFP p3).

It may be necessary to involve another medical professional e.g. GUM physician.

“...professionals ... need to determine in advance of the assessment what skills they bring to the examination and who will undertake which component of the examination” (RCPCH 2008 p 124).

16. If one doctor performs the examination, a permanent record in the form of photo-documentation should be made. (RCPCH/AFP p3).

17. Any doctor undertaking CSA examinations should have access to peer support and review. An example of this is the West Midlands Child Protection Special Interest Group.

18. All doctors undertaking CSA examinations should undertake appropriate CPD, to be reviewed at their appraisal.

Facilities, Location and Environment

19. It is **'every examiner's responsibility to ensure there is a therapeutic and supportive environment for the child and carer(s) during the medical examination.'** (RCPCH/AFP) – **'culturally sensitive'** – to age, gender, ethnicity, religion of child.
20. 'Support for child and carers throughout' (RCPCH/AFP p4) **Care should be available outside the examination from a professional who is not part of the examination process** – Nurse or Care Worker (LA Children's Social Care/Police). Access to play materials appropriate to age should be ensured.
21. **The medical examination should be undertaken EITHER in a purpose built examination facility OR in a healthcare facility, with access to basic clinical investigations for health needs – swabs, urine samples.**

PCTs jointly commission services of Sexual Assault Referral Centres (SARCs) with the police and voluntary sector organisation for victims of rape and sexual assault, including services for children and young people. SARCs provide forensic, medical and counselling services involving specialist sexual health input. (WT 2.51)

"A child abuse assessment service may be provided as part of a SARC which also provides services for adults. However, in such cases, exclusive and separate dedicated children's and young people's facilities and clinical environment should be provided, with staff specifically trained to work with children, as set out in the *National Service Framework for Children, Young People & Maternity Services*. (Standard 7-hospital services) (DH March 2008)

22. **"Permanent record (still photos or video) to be obtained (usually via colposcope)"** (RCPCH/AFP p3)
 - 22.1. with specific informed consent(s)
 - 22.2. forming part of medical record
 - 22.3. stored securely

Consent, History Taking, Examination

"Children should be informed, consulted and involved in any matter affecting them, according to their age and understanding." (ACPO 2005: 4.8.1 p58)

"When an examining doctor seeks consent, the patient (and carer) must be given sufficient information in a way that can be understood to enable them to exercise their right to make informed decisions about their care. Failure to obtain consent for examination may constitute an assault". (RCPCH 2008)

23. ACPO guidance states that **"A forensic medical examination may only be carried out with the consent of the child, if they have the capacity to consent, or with the consent of the parent, carer or person with parental responsibility.** If there is no one with parental responsibility available, or they refuse consent, then the local authority may apply for an emergency protection order or a child assessment order" and "It is the forensic physician or medical care professional who should be satisfied that consent has been obtained". (ACPO 2005:4.6.1, p54)

24. **Consent, including refusal of consent, must be clarified** (RCPCH/AFP 2004, RCPCH 2008; MDU, BMA, GMC guidelines, ACPO 2005 4.6.2 p51). A standard form of documentation should be in use across the PiP area.
25. **The issue of obtaining informed consent should be an explicit objective of a strategy discussion.**
26. **Children subject to legal orders, such as an interim care order, also require leave of the court to be presented for medical examination.**
27. Paediatrician conduct: It is important that **even initial discussions with children are conducted in a way that minimises any distress caused to them, and maximises the likelihood that they will provide accurate and complete information.** It is important, wherever possible, to have separate communication with a child. Leading or suggestive communication should always be avoided. (WT 5.64 p92)
28. **During the examination, the examining physician/paediatrician may need to speak to the child, especially if a video interview has not taken place. The conversation should be recorded by the examining physician or paediatrician in their witness statement.** (ACPO 2005 p 52)
29. **If forensic (or other) sampling is to be undertaken, the rationale for taking and processing should be discussed. It may be necessary for the investigating police officer to remain present or near to the place where it is being undertaken to ensure the chain of evidence.**
30. **Necessary, written and informed consents must be sought, obtained and recorded for:**
 - 30.1. The exam itself
 - 30.2. The photo record (consent and storage need to be considered carefully if undertaken by the clinician, according to local policy. It is appropriate for a child/carer to understand the purpose/use of this recording). RCPCH 2008 contains helpful information on this matter
 - 30.3. Use of data for teaching/peer review

Contemporaneous Notes

‘The contemporaneous notes of the doctor(s) responsible for documenting and interpreting the genital and anal findings should include line drawings even if photo-documentation has been obtained’. (RCPCH 2008)

31. **“A comprehensive assessment considering the physical development and emotional well being of the child or young person against the background of any relevant medical, family or social history must be undertaken.** This enables a full evaluation of the degree of significant harm suffered or likely to be suffered...” (RCPCH/AFP 2004)
32. Effective history taking and recording of examination findings lead to a better informed assessment and diagnosis. **There should be use of agreed standard reporting format to assure greater consistency in depth and quality of information.**

Guidance on history taking, examination technique and using a colposcope is provided by the RCPCH Child Protection Companion (RCPCH 2006) and The Physical Signs of Child Sexual Abuse guidance. (RCPCH 2008)

33. **A secure storage facility should be available.**
34. **The paediatrician and forensic physician should try to give an immediate verbal opinion and provide a written statement after any forensic examination**, which outlines the findings of the examination and expresses their opinion. (ACPO 2005: 4.6.4 pp53)
35. **Police officers investigating child abuse should be prepared to question the views of other professionals.** (ACPO 2005: 4.10 p63)

F) REPORT OF THE MEDICAL EXAMINATION

36. **Following a child protection medical, a detailed medical report will be produced. It should be dictated within 24 hours, typed and signed as soon as possible and circulated.**
37. **The report should include details of the relevant agencies who will receive a copy of the report**, as a minimum to the General Practitioner and any Social Worker and Police Officer involved. The use of medical terminology should be avoided, or where its use is essential, terms should be defined. **Parents and older child victims will not normally receive a copy of the report though they should be aware of the outcome of the examination.**
38. **The medical report should outline the findings of the examination and give an opinion that is clear.** The significance of normal findings will need to be considered. **The report should also include details of any follow up arrangements.**

'Great care must be taken over construction of the report as it may well be used as medical evidence in court even if originally it is prepared for a professionals' meeting or a child protection conference. (RCPCH 2006 Ch 10)

G) HEALTH CARE CONSEQUENT ON THE EXAMINATION FINDINGS

"appropriate arrangements for any ongoing medical assessments and necessary intervention, ensuring that psychological support is made available". (RCPCH/AFP p4)

39. **Immediate follow-up should be available in relation to:**
 - 39.1. **Pregnancy test**
 - 39.2. **Post-coital contraception**
 - 39.3. **STD screening** including blood borne viruses (e.g. Hep b, HIV These may depend on local arrangements with Departments of GU Medicine)

*"A child requiring medical attention following assault or abuse for suspected sexually transmitted infection/s should have access to a GUM clinic. The staff and service at the clinic should be young person/child centred and ideally work together with a Paediatrician under the *National Guidelines on Management of Suspected Sexually Transmitted Infections in Children and Young People* (British Association of Sexual Health and HIV) (BASHH) (DH March 2008)*

NB. Guidance on STD testing is also available through RCPCH documentation *The Physical Signs of Child Sexual Abuse.* (RCPCH 2008)

40. **Follow-up information and advice for parents should be readily available.**

41. It is important that **children in whom abuse or neglect has been identified are offered appropriate paediatric follow up.**
42. **Psycho-social follow-up should be available and offered as appropriate:**
- 42.1. If specific symptoms, refer to CAMHS or (via LA Children's Social Care) other specialist service provider, NSPCC counsellors. This may depend on local arrangements/services.
43. **All referrals for counselling, therapy etc must be guided by national and local pre-trial therapy guidelines.** Families should be given appropriate leaflets and the police **MUST** be informed.
44. General support to child/family to help with distress - on the ground contact should be provided:
- 44.1. Social Workers
 - 44.2. Victim Support Network
 - 44.3. Specialist Voluntary Organisations

H) ONGOING CARE

45. **Following the examination there should be discussion with police/LA Children's Social Care to determine ongoing care** requirements for these children, and to agree whose responsibility it is to follow this through.
46. It is the responsibility of the examining doctor to **ensure that arrangements are in place for follow up health provision.** This may include liaison with community nursing (health visitors/school nurses) and contact with any local service providers, especially if the child is assessed outside of their local area. The use of networks of Named and Designated health professionals can facilitate this process.

QUALITY ASSURANCE: KEY SENTINEL MEASURES PROPOSED

Monitoring and assurance of child protection procedures is a crucial responsibility. Authority rests with the LSCBs, health commissioners and regulators, with whom providers should actively cooperate. The following sentinel indicators, which relate to the different stages of the pathway, are suggested:

Under A) and B)

A training programme consistent with the Inter-collegiate document on 'Competences in Safeguarding' is in place and audited to assess its compliance, coverage of professionals and service managers with responsibility for safeguarding, and its effectiveness.

Under C)

100% of cases referred to statutory agencies where CSA is suspected are subject to a strategy discussion involving a paediatrician.

Under D and/or E)

Patient information leaflets for parents and children are always used as part of the consent process.

Written consent is always secured.

Under F)

All medical examinations generate a report.

The quality of reports is audited using a validated audit tool.

Under G)

Children are referred appropriately (in accordance with national guidance) following the medical examination to GUM services.

Literature Review

Working Together to Safeguard Children 2006	HM Government
Guidance on Paediatric Forensic Examinations in relation to possible Child Sexual Abuse Sept 2004	RCPCH/AFP
The Victoria Climbié Inquiry 2003	TSO
Guidance on investigating child abuse and safeguarding children 2005	ACPO
What to do if you're worried a child is being abused 2003	Department of Health
The Physical Signs of Child Sexual Abuse March 2008	RCPCH
Guide for Services for Children Provided by Sexual Assault Referral Centres (SARCs) Draft March 2008	Department of Health
Child Protection Companion 2006	RCPCH
ACPO 2005 Guidance	ACPO
National Guidelines on Management of Suspected Sexually Transmitted Infections in Children and Young People 2008	Department of Health
Gillick; Respondent v. West Norfolk and Wisbech Area Health Authority 1986	Lord Fraser's judgement
Medical Defence Union Guidelines	MDU
British Medical Association Guidelines	BMA
General Medical Council Guidelines	GMC
Royal College Paediatrics and Child Health	RCPCH
Association of Chief Police Officers	ACPO

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