PATHWAY FOR CHILD SEXUAL ABUSE (CSA) MEDICALS (under 18 years)

This guidance has been developed to help practitioners manage concerns about possible child sexual abuse, but will not cover all possible cases, which need individual consideration and discussion. If this guidance is not followed, the professional must record the reason for not doing so and indicate if their judgement if informed by best practice, and if they are acting in the best interests of the child.

A medical examination has limitations in the validation of CSA as a high proportion of children who have been sexually abused have no Anogenital signs at examination. However, it is important to note that although the purpose of the examination is to look for signs which might support or confirm sexual abuse, it is also a holistic examination which serves to ensure the health and wellbeing of the child, to reassure and help begin the therapeutic process. Thus the value of a medical examination should not be underestimated.

This procedure outlines the pathways for child sexual abuse medicals. There are two distinct pathways which are determined by age of the child, although this can be discretionary if there are determinants such as Learning Disabilities which may influence the care provided. Where uncertainty exists on which pathway should be followed then this should be discussed with the SARC. Both pathways follow Kent and Medway Safeguarding Children Procedures.

Indications where a child sexual abuse medical should be considered:

- Allegation: A child may disclose to anyone and at any time. A clear allegation is not often made at an early stage in the process as the abuser may groom and/or threaten the child. If the child alleges acute sexual assault, urgent action is required. One reason that a child may not make an allegation is that they may be very young or pre-verbal.
- Where a responsible adult has legitimate concerns about CSA.
- Pregnancy in a child less than sixteen years.
- A Sexually Transmitted Infection (STI).
- Genital warts
- CSA and Child Sexual Exploitation should be considered when a young person aged 13-17 years is sexually active and/or pregnant.
- Ano- genital injury in a girl or boy with an absent or unsuitable explanation.

- Unexplained vaginal bleeding e.g. acute bleeding in the absence of accidental trauma or medical explanation.
- Unexplained rectal bleeding.
- Vaginal discharge/vulvo-vaginitis is more commonly reported in victims of CSA. However, vaginal discharge is common in girls. Signs that are recurrent or resistant to treatment are more concerning. Where a child presents repeatedly with vaginal discharge, a careful history and a full examination must be conducted by a clinician with skills in assessment for CSA to exclude the possibility of CSA. STI screening is indicated where there is visible vaginal discharge, particularly if this is recurrent.
- The insertion of a foreign body into the anus or vagina as a method of CSA is not often seen and is often due to other causes. However, CSA should be considered when a foreign body is found in the vagina or anus.
- Soiling/bowel disturbance/enuresis: Constipation, soiling and enuresis are common paediatric problems. Uncommonly they may have a physical cause and more often have a development/behavioural cause. CSA should be considered within the differential diagnosis.
- Behavioural Presentation: Children can express their distress following sexual abuse in a wide variety of ways including self-harm, aggression, anxiety, poor school performance and sexualised behaviours, as well as psychosomatic symptoms such as recurrent abdominal pain, enuresis or headaches. Children may be referred with masturbation: it is normal for children to masturbate, however this may be considered worrying if 'excessive'. Masturbation is usually defined as excessive if in public or interfering with life. Any major change in a child's behaviour should prompt a search for the cause and abuse should be considered if there is no obvious explanation. Resources are available to support the assessment of sexual behaviours e.g. the Child Sexual Exploitation Toolkit. Resources can be found on www.kscb.org.uk and www.mscb.org.uk .
- Social indicators: CSA should be considered in any child living with an adult who poses a risk to children or is in contact with a sexual offender.
- Where the perpetrator is a child, they should be considered as a victim in their own right and referred for a separate child protection investigation.
- Where there is evidence of physical abuse, emotional abuse, or neglect, CSA should be considered.

However, not all children will require a child sexual abuse medical examination. Some teenagers, for example, may engage in regular voluntary sexual activity. Others may have an isolated behaviour problem such as an eating disorder, substance misuse, missing etc.

Professionals must consider all physical findings together with other important clinical information, including the history, context, the child or young person's demeanour and

hearing what the child is saying through their words or behaviour, in order to make a diagnosis.

Adapted from 'The Physical Signs of Child Sexual Abuse' Royal College of Paediatrics & Child Health (2015).

Accidental Injuries:

Accidental injuries present with a variety of clinical findings and occur in children of all ages and genders. It is likely that most children with accidental injuries will be seen initially by clinicians in primary care or the emergency department. The importance lies in distinguishing accidental injury from injury due to sexual abuse. **All injuries requiring medical treatment should be managed and if sexual abuse is suspected then the CSA pathway must be followed.**

Is the child in need or urgent medical attention?

If a child is in need of urgent medical attention e.g. acute bleeding s/he should be taken to the nearest hospital Accident and Emergency Department (A&E) for stabilisation. **Once the child's condition is stable and A&E staff/hospital paediatricians are concerned about possible CSA they should refer to the flowchart for managing CSA (appendix 1).**

Female Genital Mutilation (FGM)

Professionals who suspect FGM or identify children who have had FGM should refer to the Local Safeguard Children Board (KSCB/MSCB) FGM Operational Guidelines, to ensure they meet their statutory duty to report and safeguard children.

What to do if you have concerns?

Where a professional identifies **any indicators outlined above** advice should be sought initially from the:

Kent and Medway Sexual Assault Referral Centre (SARC)

0330 223 1267 (under 13's) or 0330 223 1622 (Over 13's) 24 hour call centre

The SARC offers care and support to men, women and children who have experienced rape or sexual assault.

Following consultation with the SARC; if advised or if the professional remains concerned then a referral should be made following the Kent and Medway Safeguarding Children Procedures to:

Kent Central Duty Team – email referral form to CentralDutyTeam@kent.gcsx.gov.uk

Kent Inter-Agency Referral Form: http://www.kscb.org.uk/procedures/child-in-need-chin

Medway Child Assessment and Duty Team (CADS) – 01634 33 44 66

Kent and Medway Out of Hours Team – 03000 41 91 91

Remember to use your organisations secure email when sending confidential information.

What happens after a referral is made?

Following a referral being received by CDT/CADS a professional discussion (always led by SCS /CSC) or a strategy discussion will take place. This should always include input from the SARC. The discussion will include a risk assessment of sexual health needs and emotional wellbeing.

The SARC will contact a suitably qualified and trained Forensic Professional/Paediatrician to ensure that appropriate health representation is part of the strategy or professional discussion.

There are two possible outcomes of the strategy discussion:

1. **No further action required from a SARC medical perspective**. However, should the child require a Paediatric Medical then this should be arranged according to local health arrangements.

2. **A CSA Examination**. Appointment booked with the SARC for the child to attend a comprehensive examination that will consider the child's physical health and growth, developmental and mental health, and a forensic examination where indicated.

   Who carries out the CSA examination?

   Competencies listed in the documents below define who may carry out this examination:

   - The Faculty of Forensic and Legal Medicine '2017 Guidelines for the Collection of Forensic Specimens from Complainants and Suspects'.
   - The joint Royal College of Paediatrics and Child Health (RCPCH) & Faculty of Forensic Legal Medicine (FFLM) Guidance (2015 and 2017).

- RCPCH Purple Book 2015.

All examinations will follow the SARC operational procedures.

Arranging a CSA Examination:

- The CSA examination depends on the age of the child, whether the abuse is acute, non-urgent and the need for forensic samples.
- Examinations should be carried out within the timescales defined by the FFLM Guidance. In the case of very recent abuse (within the last 72 hours) forensic skills and samples are mandatory and therefore require timely discussion with the SARC. The examination should be carried out within 72 hours. Acute examinations include examinations within a week of the event, to document injuries. All non-urgent cases should be seen within 2 weeks of referral.
- Appointments to be agreed with the SARC and the referring agency. Examination will ideally take place in the daytime during the week but urgent cases (as defined by the forensic window) may need to be transferred to the London Havens out of hours including bank holidays and weekends. If the child(ren) are in need of urgent medical care take to A&E. The SARC will need to arrange in-reach into hospital for forensic window samples or arrange by appointment at the SARC at a later date.
- As best practice dictates it is expected that a Police Officer or Social Worker should accompany the child to the CSA examination where practicable. If forensic samples are expected in the case of recent abuse, a Police Officer should be present for the chain of evidence.
- Examining professional(s) to brief Police Officer or Social Workers about the outcome.
- Examining professional(s) to send report to the Police, Social Worker, GP, and the Named Doctor for Safeguarding or child's Paediatrician, and a copy is to be kept in the patient's file.

In case of professional disagreement between Health/Social Services/ Police:

Concerns to be escalated through:

- The Escalation Policy http://www.proceduresonline.com/kentandmedway/chapters/p_resolution.html
- Kent Central Duty Team (CDT) – 03000 41 11 11
- Medway Child Assessment and Duty Service – 01634 33 44 66
- Central Duty Team Out of Hours – 03000 41 91 91
- Kent Police – 101
- Kent and Medway Sexual Assault Referral Centre (SARC) 24hr call centre – 0330 223 1622

References:

The Faculty of Forensic and Legal Medicine (FFLM) Guidance 2017: Recommendations for the collection of forensic specimens from complainants and suspects.

RCPCH/FFLM: Service specification for the clinical evaluation of children and young people who may have been sexually abused (2015/2017).

RCPCH (2015): Physical signs of child sexual abuse.

2005 Department of Health: Report 'National Service Guidelines for Developing Sexual Assault Referral Centres.

Link to RCPCH resources: www.rcpch.ac.uk

Appendix 1
Flowchart for Child Sexual Abuse Examinations