PATHWAY FOR CHILD SEXUAL ABUSE (CSA) MEDICALS

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 is 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.

*Indications where a child sexual abuse medical should be considered:

- Where a sexually transmitted infection or pregnancy is found in a child.
- Anogenital warts – though there can be vertical transmission, a significant proportion of warts are associated with sexual transmission and therefore a sexual abuse medical must be considered.
- Where signs of a problem such as recurrent vaginal discharge, genital bleeding, secondary enuresis occur in conjunction with a relevant history of concern.
- Where a child or someone else alleges the child has been sexually abused/raped/assaulted etc.
- Where there are signs of injury that may cause concerns, such as a genital injury.
- When there is evidence of physical abuse, emotional abuse or neglect.
- When there is a behavioural disturbance e.g. actual or threatened self harm, inappropriate sexualised behaviour, encopresis, aggression, cruelty to other children or animals, substance misuse, eating disorder, in conjunction with a relevant history of concern.
- When there is a history of “worrying” contact with a sexual offender.
- When the child is a sibling or friend of an index child.

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 etc.

*Adapted from “The Physical Signs of Child Sexual Abuse” Royal College of Paediatrics & Child Health.

In case of any of the above concerns the relevant Health professional (e.g. Health Visitor, School Nurse, GP, medical professional etc.) to refer to SOCIAL SERVICES using inter-agency referral form.

In case of urgent referral please contact Social Services by telephone and/or secure email. All email referrals to the Kent Contact and Assessment Services (previously County Duty) must be made by nhs.net account to kassecure@kent.gcsx.gov.uk

If a child is in need of urgent medical attention s/he should be taken to the nearest hospital A & E department.

If the health professional wishes to discuss concerns with a senior community paediatrician prior to referral to Social Services please telephone between 9.00 – 5.00pm weekdays only:

South West Kent locality: 01892 539144 Shepway: 01303 262225 Canterbury: 01227 812080
Dartford, Gravesham, Swanley: 01322 428240 Ashford: 01233 898930 Thanet: 01233 898976
Maidstone locality: 01622 742300 Dover: 01304 222521

Rota for West Kent paediatric doctors for CSA medicals is also kept by Sharon Hickmott tel. 01892 539144

Following referral, Social Services to call a Strategy Discussion (always Social Services led) which should include input from a Senior Community Paediatrician who can be contacted as above. If a paediatrician cannot be present, they should communicate their opinion directly or via a Named nurse for Safeguarding. The referrer’s contribution is also vital to the strategy discussion.

Kent Safeguarding Professionals June 2013
There are four possible outcomes of the strategy discussion:

1. **No further action required from a medical perspective.**

2. **A complete Paediatric Medical Assessment - Community Paediatrician to arrange**
   To be carried out when the concern is primarily medical, i.e. perceived or actual medical problems such as recurrent vulvovaginitis/recurrent UTIs but no other concerning features. Photo-documentation will be done if required, with appropriate consent.

3. **A Child Sexual Abuse Examination**
   Written informed consent to be taken for these assessments from someone with parental responsibility, where appropriate. Medical to include history taking, general examination, anogenital examination, photo-documentation and relevant forensic samples, if necessary. Forensic samples are usually required if the child is last thought to have had contact with an abuser within the previous 72 hours. Chain of evidence for such samples needs to be maintained.

   Photo-documentation should include a video/DVD recording of the examination, as this provides best evidence for peer review, any legal proceedings and prevents the need for a further examination to corroborate findings. After care is provided as appropriate, including treatment, further screening for sexually transmitted infections after required intervals, and to feed back results of any investigations undertaken.

   **Who carries out the child sexual abuse examination?**
   Any doctor (paediatrician or forensic physician) who has the competencies required as listed in the document ‘Guidelines on Paediatric Forensic Examinations in relation to Possible Child Sexual Abuse’ October 2007. If one doctor does not have all the necessary competencies, two doctors with complementary skills should conduct a joint examination, with prior agreement as to who will undertake which component of the examination. In practice it is preferable to have two examiners, such as a paediatrician and a forensic medical examiner or two paediatricians, to ensure thoroughness. In the case of recent abuse (within the last 72 hours) forensic competencies and samples are required. It may be necessary to involve another medical professional such as a genitourinary physician, gynaecologist or family planning doctor if the case demands it.

   **Examples of how these skills could be provided across the paediatric age range are:**
   - Paediatrician + Forensic Medical Examiner (FME) or two paediatricians if child is under 13 years
   - FME alone if child aged 13 years or over

   **Arranging a CSA Examination:**
   - The timing of the CSA examination depends on the age of child, whether the abuse is acute, chronic or historic and the need for forensic samples. In the case of recent abuse (within the last 72 hours) forensic skills and samples are mandatory.
   - Date and venue to be agreed with all doctors involved and the referring agency. Examination should take place in daytime hours, unless urgent medical attention is required for bleeding/ injury.
   - Police/Social Worker to accompany child to CSA examination. If forensic samples are expected in the case of recent abuse, police officer to be present for the chain of evidence.
   - Examining Doctor(s) to brief Police/ Social Worker about outcome
   - Examining Doctor(s) to send report to Police, Social Worker, GP and a copy to be kept in the patient’s file

4. **In case of professional disagreement between Health/ Social Services/ Police:**
   Concerns to be escalated through Social Services (0845 762 6777), Police HQ (01622 690690 and ask for area required) or Health as per KSCB procedures.

References:
RCPCH  *The Physical Signs of Sexual Abuse March 2008*
RCPCH  *Guidelines on Paediatric Forensic Examinations in relation to possible Child Sexual Abuse Oct 2007*
ALGORITHM FOR CHILD SEXUAL ABUSE EXAMINATIONS

Concern about Child Sexual Abuse (CSA)

Referral to social services (using telephone and referral form)

Initial Strategy discussion

Decision about whether CSA examination required

Yes

Professional disagreement - escalate

Acute/ acute on chronic: last contact <72hrs previously

CSA examination plus forensic samples

Report to social services/ police/ GP re: outcome
Arrange further STI screening and ISVA if CSA likely

No

Further action decided at strategy discussion, including whether a paediatric medical assessment is required

Outcome strategy discussion

Key: STI Sexually Transmitted Infection
     ISVA Independent Sexual Violence Adviser

This flowchart is intended as an aide memoire only – for more detailed advice please refer to the pathway for child sexual abuse

Kent Safeguarding Professionals June 2013