



Guidelines

Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse

The medico-legal guidelines and recommendations published by the Faculty are for general information only. Appropriate specific advice should be sought from your medical defence organisation or professional association. The Faculty has one or more senior persons from each of the three medical defence organisations on its Board, but for the avoidance of doubt, endorsement of the medico-legal guidelines or recommendations published by the Faculty has not been sought from any of the medical defence organisations.

Background

In 1988 the Association of Police Surgeons (APS - now incorporated into the Faculty of Forensic and Legal Medicine) and the British Paediatric Association (BPA - now incorporated into the Royal College of Paediatric and Child Health) wrote a 'Joint Statement on Child Sexual Abuse' which described good practice for those members of the two bodies who conduct assessments of children who may have been sexually abused (APS & BPA, Appendix I, in *Report of the Inquiry into Child Abuse in Cleveland 1987* HMSO 1988. re-issued in 1993).

Whilst the contents of that statement are still valid, members of the respective bodies have sought advice on a number of issues not addressed in the 1988 or the 2002 versions of this statement.

This document attempts to address the deficiencies in the previous statements by describing further elements of good practice.

These amendments are summarized as follows:

- It is essential that high quality photo-documentation be obtained during a paediatric forensic examination. If this is not obtained the practitioner must document in his/her notes the reasons for this;
- A single doctor can conduct a paediatric forensic examination provided he/she has all the necessary skills;
- The examining doctor must ensure that they are familiar with evidence-based guidance regarding the interpretation of the signs.

Paediatric forensic examinations

A paediatric forensic examination will be required whenever a child has made a disclosure of sexual abuse, or sexual abuse has been witnessed, or when a referring agency strongly suspects abuse has occurred. It consists of the clinical history and examination, detailed documentation (including the use of line drawings) and photo-documentation, as well as obtaining any relevant forensic samples, writing a report and arranging any necessary aftercare. It is every examiner's responsibility to ensure that there is a therapeutic and supportive environment for the child and carer(s) during the medical examination.

Paediatric forensic examinations differ from paediatric examinations which are undertaken when the child has perceived or actual medical problems, such as recurrent vulvovaginitis. In such a situation sexual abuse would be part of the differential diagnosis. These paediatric examinations may be undertaken by any suitably qualified practitioner with the necessary knowledge and skills.

It must be remembered that the health needs of the child are paramount in approaching any medical examination whatever the alleged circumstances leading to the need to gather forensic evidence.

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, by the child as described in the Children Act, 1989 and the Children (Scotland) Act, 1995. Evaluating significant harm in sexual abuse includes not only the documentation of any genital and or anal injury but also any accompanying physical injury, the possibility of a sexually transmitted infection or pregnancy and the short/long term psychological or psychiatric sequelae. This assessment must also lead the planning of any ongoing investigation or treatment required by the child and appropriate reassurance for the child and family.

Who should conduct a paediatric forensic examination?

Any doctor (paediatrician or forensic physician) who undertakes a forensic assessment of a child who may have been subjected to sexual abuse must have particular skills. The child or young person must be assessed fully but appropriately dependent on the age and gender of the child, and the suspected nature and timing of the possible abuse.

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 people¹.
- Competence to conduct a comprehensive general and genital examination of a child and skill in the different techniques used to facilitate the genital examination (e.g. labial traction).

- 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 packaged¹.
- 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.
- Training in prophylaxis (including Hepatitis B, HIV), screening and diagnosis of sexually transmitted infections.

¹ According to the current guidance of the Faculty of Forensic and Legal Medicine

Single or Joint examinations

A single doctor examination may take place provided the doctor concerned has the necessary knowledge, skills and experience for the particular case. When a single doctor does not have all the necessary knowledge, skills and experience for a particular paediatric forensic examination two doctors with **complementary skills** should conduct a joint examination. Usually such examinations involve a paediatrician and a forensic physician (forensic medical examiner, police surgeon, forensic medical officer). However, it may be necessary to involve another medical professional such as a genitourinary physician or family planning doctor, if the case demands it.

If two professionals are involved they need to determine in advance of the assessment what skills they bring to the examination and who will undertake which component of the examination.

Colposcopy and photo-documentation

It is essential for a permanent record (still photographs, video, CD or DVD) of the genital/anal findings to be obtained whenever these areas are examined during the paediatric forensic assessment of a child who may have been subjected to sexual abuse. These images may be obtained via a colposcope. Similarly, any relevant general physical injuries or signs should be photo-documented.

The prime intention of photo-documentation is to support the clinical examination. Therefore, the images should be of adequate quality to demonstrate the clinical findings; if the images do not demonstrate the clinical findings the reason for this should be recorded in the clinical notes. In addition, photo-documentation may enable additional medical opinions to be obtained regarding the description and interpretation of the clinical findings. However, the use of photo-documentation does not preclude further examination(s) (with photo-documentation) which may be required, for example, because the initial assessment was incomplete, to determine the significance of certain signs or to observe the healing of injuries. It must be appreciated that further examinations conducted some time after the initial assessment may not reflect the original findings due to healing or the onset of puberty.

Support for the child and carers

Support for the child and carers must be available throughout the paediatric forensic examination.

Contemporaneous notes

All clinicians involved in the examination must make comprehensive, contemporaneous notes to cover the components of the examination that they are responsible for (as agreed prior to the assessment). 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.

Statements/Reports

When joint examinations are conducted the doctors should decide who will write the report for child protection purposes; this is usually the paediatrician.

It must be recognised that both doctors may be required to provide statements/reports for court proceedings and both may be required to give evidence in court. In some situations the court may accept a joint statement/report. However, if there is any disagreement between the doctors regarding the findings or their interpretation the doctors should write separate statements/reports detailing the areas of disagreement. In such circumstances it is considered good practice to obtain the opinion of an independent medical expert using the contemporaneous notes and still photographs or videos.

Even when there is no apparent disagreement the doctors may opt or be asked to provide separate statements/reports; it is acceptable for these to be available to the other doctor in order that any discrepancy in opinions can be identified and acknowledged in the statements/reports.

It is good practice to provide annotated diagrams with a statement to assist the court with the interpretation of the clinical findings.

Local protocols

Local protocols should be formulated by the named and designated doctor with advice from the senior forensic physician for the Constabulary and then ratified through the Local Safeguarding Children's Board (Child Protection Committee). These protocols must be relevant to children and young persons up to the age of 16 years of age² and must be applicable to both acute and chronic cases of sexual assault, bearing in mind that acute sexual assault may necessitate an out-of-hours examination to preserve forensic evidence.

The protocols should systematically address the lines of communication when an allegation is received and who will decide the appropriate time and place for the examination.

On-going care

Each child examined should have appropriate arrangements made for any ongoing medical assessments and necessary intervention, ensuring that appropriate psychological support is made available. This will depend on local arrangements and should be carried out by the Locality Consultant Paediatrician or by a consultant with specific expertise in child abuse/child sexual abuse. These matters should also be addressed by the Local Safeguarding Children's Board (Child Protection Committee).

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Agreed by the Council and the Standing Committee on Child Protection of the Royal College of Paediatrics and Child Health and the Academic Committee of the Faculty of Forensic and Legal Medicine

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² The good practice described in this paper may also be applicable to young people over 16 years of age if they have special needs or vulnerabilities