

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

Produced by

**The Royal College of Paediatrics and Child Health and
The Association of Forensic Physicians**

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The Royal College of Paediatrics and Child Health and the Association of Forensic Physicians have agreed that for this paper 'a child' will be defined as anyone under the age of 16¹.

Background to this guidance

In 1988 the Association of Police Surgeons (now the Association of Forensic Physicians) and the British Paediatric Association (BPA) 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 statement. Furthermore, there have been advances in diagnostic techniques, in particular the use of the colposcope, which were not covered by the original statement. This guidance attempts to address the deficiencies in the previous statement by describing further elements of good practice regarding the paediatric forensic assessment of children who may have been sexually abused. Following comments from medical and legal practitioners slight amendments have been made to the 2002 version of this document to reflect changing practice.

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.

Paediatric Forensic Examinations

A Paediatric Forensic Examination is required whenever a child has made a disclosure of sexual abuse or the referring agency/ies strongly suspect abuse has occurred. It consists of the clinical history and examination, detailed documentation (including the use of line drawings) and photodocumentation, 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 are to be differentiated from paediatric examinations which are undertaken when the child has perceived or actual medical problems, for example a child referred to the Paediatric Service with recurrent vulvovaginitis. In such a child, sexual abuse would be part of the differential diagnosis to be considered but not the most likely aetiology. These paediatric examinations may be undertaken by any suitably qualified practitioner with the necessary knowledge, skills and attitude for the particular case.

Who should conduct a Paediatric Forensic Examination?

Good practice dictates that 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**. In addition, certain **case dependent skills** may be necessary to assess the child fully. These case dependent skills will depend on the age and gender of the child and the suspected nature and timing of the possible abuse. The list of core skills and examples of case dependent skills are given below.

Core skills:

1. The ability to communicate comfortably with children and their carers about these sensitive issues.
2. To understand, and be sensitive to, the child's developmental, social and emotional needs and intellectual level.
3. An understanding of consent and confidentiality as they relate to children.
4. The 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).
5. An understanding of the normal genital and anal anatomy, and its variants, for the age and gender of the child to be examined.
6. An understanding of the diagnosis and differential diagnosis of physical signs.
7. Competence in the use of a colposcope and obtaining photo-documentation ensuring that the latter properly reflects the clinical findings and documenting if it does not.
8. An understanding of what forensic samples may be appropriate to the investigation and how these samples should be obtained and packaged according to the current Association of Chief Police Officers, Forensic Science Service and Association of Forensic Physicians guidance.
9. The ability to comprehensively and precisely document the clinical findings in their contemporaneous notes.
10. The competence to produce a detailed statement/ report describing and interpreting the clinical findings.
11. A willingness to communicate and co-operate 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.
12. The aptitude to present the evidence, and be cross-examined, in subsequent civil and criminal proceedings.
13. An ability to discuss the presentation and findings in the context of the child's level of development and the relevant medical literature.

Case dependent skills:

Any or all of the following components may be pertinent to the examination of a given child.

1. 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.
2. Training in prophylaxis (including Hepatitis B, HIV), screening and diagnosis of sexually transmitted infections.

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 examination of a child takes place it is desirable that a permanent record of the genital/anal findings, in the form of photo-documentation (video or still image) is available to allow a second opinion to be obtained regarding the nature and interpretation of the findings. Similarly, any relevant general physical injuries or signs should be photo-documented. 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. The two professionals need to determine in advance of the assessment who will undertake which component of the examination.

Colposcopy and photo-documentation

It is considered to be good practice for a permanent record (still photographs or video) of the genital/anal findings to be obtained whenever these areas are examined during the forensic assessment of a child who may have been subjected to sexual abuse. These images are usually obtained via a colposcope.

The prime intention of such documentation is to support the clinical examination. Therefore, the images should be of adequate quality to demonstrate the clinical findings and if they do not this should be recorded in the clinical notes. In addition, photodocumentation may enable additional medical opinions to be obtained regarding the description and interpretation of the clinical findings. However, the use of photodocumentation does not preclude further examination(s) (with photodocumentation) 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.

In order to allay any concerns that the public may have regarding the use of photodocumentation the following must be adhered to: -

Photodocumentation must only be obtained with the specific informed consent of the child and/or person who holds parental responsibility for the child.

- All still photographs and/or videos will be coded (identifiable only to the doctors concerned) and retained as part of the doctor's medical records.
- The still photographs and/or videos will be stored securely in accordance with local policy.
- In obtaining consent the examinee should be advised that the still photographs or videos are diagnostic tools and, consequently, they might be shown to other medical experts, including experts instructed by solicitors acting for a defendant.
- If permission is given the still photographs and/or videos may also be used for teaching other doctors.
- In the rare event of the presiding officer of the court (judge) requiring the still photographs and/or videos the doctor should be present to interpret the findings when the still photographs/ videos are shown to the court.
- If a child or parent refuses photo-documentation this must be respected and recorded in the notes. In such circumstances the practitioner should usually continue with the Paediatric Forensic Examination providing they have valid consent.

Support for the child and carers

Support for the child and carers must be available throughout the Paediatric Forensic Examination.

Contemporaneous notes

When joint examinations are conducted both doctors must make comprehensive, contemporaneous notes which should include line drawings even if photodocumentation 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 designated doctor with advice from the senior forensic physician for the Constabulary and then ratified through the Area Child Protection Committee. These protocols must be relevant to children and young persons up to the age of 16 years of age¹ 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 Area Child Protection Committee.

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Association of Forensic Physicians website: www.afpweb.org.uk

Royal College of Paediatrics & Child Health website: www.rcpch.ac.uk

ⁱ 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