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 **Policy for Management of Children who may have been sexually assaulted/abused/exploited**

 **Thames Valley**

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| In consultation with: | Thames Valley PoliceThames Valley Paediatricians, Dr Sheila Paul |
| To be read in association with: | -Service specifications for the clinical evaluation of children and young people who may have been sexually abused Sept. 2015 FFLM, RCPCH.-Recommendations for Collection of Forensic Specimens from complainants and suspects FFLM June 2023 updated every 6 months. -Quality standards for clinicians undertaking Paediatric Sexual Offences medicine March 2021-Guidance for best practice for the management of intimate images which may become evidence in court RCPCH & FFLM June 2020 |
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**Definitions**

**The definition of a child is an individual up to their 18th birthday.**

**Acute** cases are recent. There are urgent forensic and medical needs. In 2015 the definition of acute in children has been extended to 21 days.

**Historic/delayed** reporting cases are not recent; may be weeks/months/years ago.

**RCPCH**-Royal College of Paediatrics and Child Health

**FFLM-**Faculty of Forensic and Legal Medicine

**AAP**-American Academy of Paediatrics

**PR-**Parental Responsibility

**1.** **Introduction**

This operational policy outlines the processes to be followed for children who may have been sexually abused/assaulted/exploited.

**All doctors who work in the Thames Valley sexual assault service are Forensic Physicians (FPs), appropriately trained and experienced to examine adults and children of all ages.**

The Policy uses guidance from Every Child Matters, Working Together to Safeguard Children, the Children’s National Services Framework (NSF) the Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused 2nd edition, September 2015, FFLM, RCPCH, The Physical Signs of Child Sexual Abuse RCPCH, FFLM, AAP May 2015 2nd edition, and the 3rd edition which is due to be finalised; summer 2023 current FFLM relevant guidance documents and Quality Standard documents.

Guidelines are regularly updated and any change to guidance as a result Dr Paul will inform without delay.

 **The policy**

* Defines services available at the Solace Centres and other venues from the Thames Valley Sexual Assault Service for children and young people (YP) up to their 18th birthday.
* Provides guidance to all regarding referrals to the Sexual Assault Service.
* Provides clarity for all staff members regarding their responsibilities towards children and young persons.
* Appendices 1 – 4 set out the specifics relating to each geographical area in the Thames Valley.

**For the use by**

Professionals involved in Safeguarding children.

Police, Social Care, Forensic Physicians, Paediatricians, General Practitioners, Health Visitors, Emergency Departments, Sexual health clinics, all Safeguarding and medical services.

1. **SERVICE**

The Sexual Assault Service accepts referrals of children and young people who may have suffered an acute sexual assault, sexual exploitation, sexual abuse and of historic (delayed reporting) cases. This is regardless of whether there is an allegation, a suspicion is enough to refer. Referrals can be made directly by the police, young people themselves or via a third party, including other professional agencies.

The following services are available for young people and children, usually at one of the Solace Centres, at other venues when needed such as inpatient psychiatric unit, prison, ED etc.

* Choices for self-referrals depending on the age and capacity of the child and in keeping within Child Protection Responsibilities. These are unusual and older children with capacity only.
* Initial needs assessment and triage of appointment.
* Holistic medical examination of acute and historic (delayed reporting) cases of child sexual assault/abuse/exploitation. This includes physical, social, psychological well-being, mental health, and for younger children developmental assessment.
* For acute cases taking forensic samples and careful documentation of any injury, including photo documentation if consent is given. .
* Emergency contraception.
* Initiation of, or referral on to the Paediatric Infectious Diseases consultant or Sexual Health Clinic, for Post-Exposure Prophylaxis to prevent HIV and Hepatitis B, .
* Sexually transmitted infection (STI) screening of all historic cases, regardless of the age and regardless of when the alleged crime(s) were committed.
* STI screening 2 weeks post alleged assault/post last episode of abuse, of all acute cases aged 12 and under and all vulnerable young people .
* Referral on to the STI clinic for acute cases aged 13 and above, if appropriate, by letter given to the patient/carer/child as appropriate.
* Health information and advice for children and their carers.
* Referral to Community Paediatricians if there are developmental concerns and to the acute paediatrician if there are physical problems that indicate the need for referral, in the usual manner appropriate to the local area. **For emergency referrals a telephone call must be made and also a letter of referral done.**
* Referral to Child and Adolescent Mental Health Services (CAMHS) as appropriate.
* Referral for play therapy, trauma therapy, psychological support for children aged 4 + to Trust House Reading, Horizons for Oxfordshire children, Safe or elsewhere as appropriate.
* Referral for psychological support for the primary carer, if appropriate.
* Advice to Police, Social Care and other healthcare professionals at the time of the medical examination.
* Child Protection report sent to the general practitioner with a copy to the Designated/Named Paediatrician in the area the child lives, *for information only*, copy to the Police Officer in the Case and Social Worker, promptly, in all cases.
* The Crisis Support Worker (CSW) notifies the school nurse of the child’s attendance, giving only demographic detail, using the appropriate form.
* The CSW notifies the MASH team in the geographical area the child lives, of the patient’s attendance, giving only demographic detail, using the appropriate form.
* Provision of court report/statement for police if requested with interpretation of findings.
* Giving evidence in all types of court, if required.
1. **The examination**

**3.1 Criteria for Single Doctor or Joint medical examinations.**

One doctor with all the necessary skills will conduct the examination. A second doctor with complementary skills will be called **only** if one doctor does not have all the necessary skills. See appendices for detail.

**3.2 Reason to examine**

* A forensic medical examination is necessary to secure forensic evidence, to help the police investigate the case. Forensic evidence is **not only swabs**-see below.
* To give an interpretation of findings to the police and social care at the time of the examination and in the Child Protection Report ,in order to properly Safeguard the child.
* To take care of the holistic needs of the child in order to attempt to minimise the potential physical and psychological sequelae of the alleged assault(s) which may be multitudinous.
* To plan on going care for the child or young person.
* For reassurance to the child and their carer.

When planning a forensic medical examination of a child the following must be considered:

* **3.3 Allegation or suspected acute sexual assault.**

**“The swab is not the job”**

 Children and young people are seen as an **emergency** at one of the two Sexual Assault Referral Centres where there is a reasonable possibility of obtaining DNA and other forensic evidence, such as injuries and in other venues if needed such as ED, prison, psychiatric inpatient unit etc.

* The determining factors for DNA evidence are the time that has elapsed since the alleged abuse, the type of alleged assault/abuse and the pubertal status of the child.
* It must be noted that children often do not make a full allegation initially, therefore the default is to examine as soon as possible, regardless of the type of allegation and **even without an allegation,** when there is a suspicion of sexual crime.
* It is important to remember that forensic evidence may take the form of injury; acute, healing and healed therefore the timing of examinations must take this fact into account.
* **For this reason, acute case must be considered to be up to 21 days post alleged event.** *ref Service Specifications for the Clinical Evaluation of Children and Young People who may have been sexually abused from the RCPCH FFLM 2nd edition September 2015*
* Forensic evidence, including in historic cases, may take many other forms, for example emotional reaction, behavioural changes, infections, urinary and bowel problems, withdrawal, self-harm, eating disorders, suicide attempts, substance misuse including alcohol, school avoidance, sexually transmitted infection, pregnancy in a child etc. This list is not exhaustive.
* Children are also seen in order to address their holistic needs and to attempt to minimise the physical and psychological sequelae of the alleged assault/abuse*.*
* Psychological well-being and mental health needs are very carefully assessed, as the effect from sexual crime can be devastating.
* Risk assessment for HIV and hepatitis B and post exposure prophylaxis is instigated when appropriate.
* Risk assessment for emergency contraception is done and instigated when appropriate.
* **It is important that all parties are aware that the effectiveness of emergency contraception and HIV and Hep. B PEP declines hour by hour. Therefore, a delay in examination and assessment of this need is unacceptable**.

**3.4 Children under 13 years**

* Are seen as emergencies the day/night they present, if less than 72 hours following acute sexual assault ,for collection of DNA evidence and as soon as possible for documentation of other forensic evidence, such as injuries. These time frames are not absolute, and each case must be considered on an individual basis. They should always be seen regardless of time since alleged assault, for their holistic care and documentation of other forensic evidence. See Service Specification September 2015 FFLM and RCPCH. **It is important that all parties are aware that the effectiveness of emergency contraception and HIV and Hep. B PEP declines hour by hour. Therefore, a delay in examination and assessment of this need is unacceptable**.

**Please note that studies show that despite forensic time scales/persistence data, in a prepubertal child the vast majority of DNA evidence is lost after 13 hours**

**Delay is never appropriate.**

**3.5 Young people aged 13-their 18th birthday**

* Are seen as an emergency the day/night they present if less than 7 days following alleged acute sexual assault, for collection of DNA evidence and as soon as possible for documentation of other forensic evidence, such as injuries. These time frames are not absolute, and each case must be considered on an individual basis. They should always be seen regardless of time since alleged assault for their holistic care and documentation of any other forensic evidence. See Service Specification September 2015 FFLM and RCPCH. **It is important that all parties are aware that the effectiveness of emergency contraception and HIV and Hep. B PEP declines hour by hour. Therefore, a delay in examination and assessment of this need is unacceptable**.

**Delay is never appropriate.**

**3.6 Guidance, advice, help**

Refer to persistence data/forensic time scales, not relying on these alone, and take advice from an experienced forensic doctor when making the decision as to timing of medicals. All children should have a full Forensic Medical Examination (ref Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse, FFLM and RCPCH) which, will be in one of the Sexual Assault Referral Centres (SARCs) - see Appendices-or in other venues if needed such as EDs, prisons, psychiatric inpatient units etc .

 Regarding night-time examinations please also refer to the FFLM Guidance and discuss with an experienced forensic doctor. Examinations MUST be conducted at night if considered necessary.

The decision must include addressing the need for emergency contraception and prophylaxis for HIV/hepatitis B, as well as general medical needs, including mental health, forensic evidence collection and documentation of injury, which will heal very quickly and potentially disappear without trace in a healthy child.

**The Duty Forensic Physician may call the Clinical Lead of the Sexual Assault Service at any time to discuss the case.**

**3.7 Allegations of or suspected historic (delayed reporting) cases**

Children of all ages are referred direct to the relevant paediatrician or Clinical Lead of the Sexual Assault Service. See appendices for guidance.

If the SARCs or the Call Centre are called regarding an historic case, put the referrer in contact with the forensic doctor/paediatrician who is to examine-see appendices.

1. **ACCEPTING CASES**
	1. **Police Referrals**

Call taken by the Crisis Support Worker (CSW) or the Call Centre is documented on proformas; the CSW/Call Centre contacts the forensic physician (FP) with the details who will, depending on the case, contact the relevant Paediatrician or Clinical Lead of the Sexual Assault Service. **In all cases** **there must be clear communication between the police, social care, directly with the doctor on duty for the sexual assault service or Clinical Lead**. This communication must not delay the examination but MUST take place prior to a medical examination. A full strategy meeting may have to be deferred until after the medical examination. **Any strategy meetings MUST include the appropriate doctor from health, either FP or Paediatrician.**

**4.2 Non–Police Referrals**

Call is taken by the Solace CSW/Call Centre who completes the initial assessment proforma and liaises with the duty FP with the details who will, depending on the case, contact the relevant Paediatrician or Clinical Lead of the Sexual Assault Service. **In all cases** **there must be clear communication between the referrer directly with the doctor on duty for the sexual assault service or Clinical Lead**.

**4.3 The call**

Solace staff taking the call should obtain and record the following information:

* Name and age of child.
* Person with parental responsibility (PR).
* Telephone number, both landline and mobile of person with PR and child if relevant. .
* Full address.
* Brief account of allegation, including time elapsed since alleged assault/for chronic abuse the last alleged episode.
* Reason for telephone call.

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**It is important that the child does not get lost in the process.**

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1. **CONDUCTING THE FORENSIC EXAMINATION IN A PAEDIATRIC CASE**

**5.1 Role of the Crisis Support Worker**

The CSW is there to support the child, the family and the FP conducting the examination. They will usually be present in the examination, depending on the child’s wishes.

**5.2 Pre examination**

Most cases will be examined by one doctor, the duty FP or Clinical Lead, in the SARC.

When two doctors are needed, usually the FP and paediatrician, the venue of examination will be discussed and the SARC used for all acute cases, if at all possible, because of the need for forensic integrity. The doctors should discuss the management of the case and agree their roles, and who will write the report and statement, depending upon their level of experience and expertise The FP is always responsible for taking the forensic samples.

**5.3** **Consent**

Fully informed, written consent for the medical examination and procedures involved will be taken by the examining doctor(s) as per General Medical Council (GMC) Guidance. A competent child of any age can give consent for the medical examination, alone. This must be carefully assessed and must include a telephone discussion with the Clinical Lead.

For all other children consent must be given by the person with PR or by a court order, and the child.

Where a care order has been obtained for that child or young person, the Local Authority **may** have parental responsibility for that child or young person, either joint with the parent(s) or alone and then the social worker is able to give consent.

In the event of the allegation being made against the adult with parental responsibility, it is the role of Social Care for the child’s borough of residence to obtain an emergency court order to cover consent for the forensic examination, although in many cases this will be unnecessary, as the parent will still give consent.

**Where the child or young person refuses consent, this is respected, and an examination should not be undertaken.**

**5.4 Confidentiality**

All SARC staff are expected to maintain the confidentiality of patient/client information, follow the GMC Guidelines and other regulatory bodies. However, when there are concerns about the safety or wellbeing of a child/young person, there are four ways in which the disclosure of confidential information can be justified:

* With the consent of the parent/carer and/or child or young person who has capacity.
* Without consent when the disclosure is required by law or by order of the court.
* Without consent when disclosure is considered necessary to safeguard and protect a child/young person, and/or protect the public interest
* Without consent under the Mental Health Act 1983.

See GMC Guidance for further detail.

Whatever the circumstances, the primary duty and responsibility of the examining doctor is to act in the child or young person’s best interests. Only information that is relevant to the concern about the child or young person should be disclosed to other professionals who have a Duty of Care towards the child or young person. Information should only ever be shared on a ‘need to know’ basis.

**5.6**  **The examination**

This will be conducted with a suitable chaperone present, respecting the choice of the child, if possible. The examinations are carefully geared to the age of the child, with no internal vaginal examinations done of female children unless they are young people, fully consent and it is necessary.

**5.7**  **Photo-documentation**

Please refer to the Faculty of Forensic and Legal Medicine Guidance for best practice for the Management of Intimate Images that may become evidence in court **(**[www.FFLM.ac.uk](http://www.FFLM.ac.uk) **)**

1. **After care**

**6.1 Emergency contraception.**

Emergency contraception is provided if appropriate.

**6.2** **Sexually transmitted infection**

Post exposure prophylaxis (PEP) against HIV, Hepatitis B and other infections, are discussed, risk assessed and provided for either in the SARC or by the paediatric ID consultant, without delay. Sexually transmitted disease screening is done or planned as appropriate. Further advice may need to be sought from specialists, the Paediatrician, Sexual Health Clinic or Infectious Diseases consultant as required. There is a 24-hour paediatric ID service at the John Radcliffe Hospital, Dr Dominic Kelly and team., to be accessed by the hospital switchboard.

**6.3 Young people between 13 and their 18th birthday, seen acutely are followed up at the local STI sexual health clinic.**

The acute young person should be actively encouraged to attend for follow-up care at their local STI clinics. An appointment will be made for the young person either at the time of the forensic examination or by telephone by the CSW, a referral letter being done by the doctor and given to the patient/carer. The GP should be asked to check that STI screening has taken place as planned and to be robust with follow up of children started on PEP for HIV in the SARC.

**6.4** **STI screening for children aged 12 and under and vulnerable older children seen acutely**

This will be arranged in the SARCs at the appropriate timing.

**6.5** **STI screening of historic cases**

This will be done at the time of the forensic medical examination, regardless of age, to prevent the necessity for a second examination of the child.

**Positive results to STI screening**

The Forensic Physician will receive results and arrange treatment. Children over age of 13 will receive treatment from the local sexual health clinic or GP

Children under the age of 13 will be referred to the local paediatric or paediatric Infectious Diseases team for treatment.

For Buckinghamshire patients Forensic Physician to contact Named Doctor for Safeguarding Dr Caroline Lowdon via switchboard 01296 315000 or work mobile 07866 171756. In absence of Dr Lowdon liaise with on call paediatrician on bleep 593 who will arrange for the child to be seen on Children’s Day Unit at Wycombe hospital within 48 hours.

For other areas call the Named/designated paediatricians.

Dr Keya Ali in Milton Keynes

Dr Louise Watson in E Berkshire

Dr Ann Gordon in West Berkshire

Dr Maria Finnis and Dr Harjinder Gill in Oxfordshire.

If unable to reach them call the on-call paediatrician via hospital switchboard.

If any difficulty call Dr Sheila Paul, the Clinical Lead.

**6.6 Therapy/mental health services.**

All children from Oxfordshire to be referred to Horizon., if appropriate, 01865 902 634 ; use the referral form and email to horizon@oxfordhealth.nhs.uk

All children from elsewhere to Trust House Reading for Trauma Therapy, if appropriate.

Other mental health referrals should the need arise e.g., CAMHs, assessment under the MHA.

1. **Medical notes**

**7.1** The FP should complete the Paediatric Summary and leave this at the SARC. The FP needs to have ready access to the notes for writing reports/statements/attending further strategy meetings and child protection meetings/court.

* History and examination findings.
* Any actions taken.
* Follow-up arrangements, e.g., need for STI screen at the appropriate interval, contraception etc.
* Any necessary referral on to the general paediatrician for acute paediatric needs and/or the community paediatrician for developmental needs, which must be managed with a telephone call at the time and a comprehensive letter, in the usual manner.
* Great care must be taken deciding on the mental health and psychological wellbeing needs. Trust House Reading are available in the whole TV area for trauma therapy for children aged 4 years plus, and carers. Horizons are available for Trauma Therapy for children aged 4 years plus in Oxfordshire.
* A comprehensive Child Protection report must be written promptly in all cases and sent to the general practitioner without delay, copied to the Safeguarding Paediatrician in the area the child lives, *for information only,* copied to the Police Officer in the Case and Social Worker. If necessary, the Officer in the Case (OIC) will forward the Social Worker’s copy to them.
* The designated safeguarding lead for the school should be informed, by the CSW, of attendance.
* The MASH team in the area in which the child lives must be informed of the child’s attendance by the CSW.
* The GP must be asked to ensure STI screening has taken place as planned; and to be robust in follow up of any problems found in the forensic medical including mental health and if the child has been commenced on PEP for HIV or Hepatitis B in the SARC. It must be made clear to the GP we are a one stop forensic service and have no facility to order blood tests or prescribe.
* Robust follow up with the Sexual health Clinic or paediatrician or Infectious Diseases paediatrician must be arranged if the child is started on HIV PEP and hepatitis B immunisation.

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**7.2 RECORD KEEPING AND SHARING INFORMATION**

Guidance for staff on the legislation and due diligence pertaining to accurate record keeping, the systems in use to maintain patient records, storage and agreements around sharing of information are contained in the Staff handbook; GMC and FFLM guidance.

1. **Female genital mutilation.**

**8.1 Background**

Since October 2015 it has been mandatory and an individual responsibility to report suspected or known cases of FGM, in a child, or where there is a suspicion that a child is to be taken for this procedure either in the UK or abroad. People who will be in this position include child-minders, nursery workers, teachers, and health professionals. This list is not exhaustive.

Since the new legislation and the training that has been given to those working with children, there has been an increase in the number of reported suspected cases.

**8.2 Action**

* If you have been told by a child, they have had FGM or you have seen a physical sign of FGM, or what you believe may be FGM then:

Call the police on 101 to report.

* If there is thought to be immediate risk, for example, she has very recently undergone the procedure, has medical complications suspected of being caused by the procedure, or is at immediate risk of having it done, then -

Call the police on 999.

* If you become aware of an adult female who has had this procedure, she can be signposted to services offering support and advice, e.g., the Oxford Rose Clinic.

You must also do a safeguarding assessment, as there may be other family members such as younger sisters, who are children, or the individual may have female children or be pregnant. If this is the case -

Call children’s social care who will hold a multiagency meeting including the police to decide how to proceed.

There is always an out of hours duty social workers so do not leave the reporting until in hours.

* The NSPCC helpline will give advice regarding this 24 hour a day. 0800 028 3550.

**8.3 Medical assessment**.

The assessment of the child for suspected FGM will be undertaken either acutely (within the same day), if needed because of acute medical needs, or by planned appointment.

**Children who need medical assessment must be seen by a doctor with the appropriate skills.**

* These assessments must not be rushed and must not be done by a doctor without the necessary skills unless there are acute medical needs.
* It is better to wait for a few days for the examination to be done by an appropriately skilled doctor, unless medical needs dictate an emergency examination is needed.
* The examinations should always be photo documented. This provides the means for a second opinion, if needed, without the necessity to re- examine the child.
* If possible, the examination must be done with the primary carer present to reassure the child.
* The examinations are always age appropriate.
* Every effort is made to conduct the examinations in an unrushed, child friendly environment. This environment is available in both SARCs.
* Who does the examinations depends on the geographical location of the child and reflects the policy for examining children who have been sexually assaulted/abused/exploited. See appendices.

**8.4 Planned examinations**

1. Milton Keynes. Planned examinations are done by Dr Paul, Dr Ejide, Dr Ibrahim, or Dr Zafrani who have the skills.
2. Buckinghamshire ditto
3. West Berkshire ditto
4. East Berkshire Dr Louise Watson, paediatrician, when Dr Louise Watson is away, Dr Paul, Dr Ejide, Dr. Ibrahim, or Dr Zafrani,
5. Oxfordshire done by Dr Sarah Haden, Dr Maria Finnis and with support from Dr Brenda Kelly consultant obstetrician.

Medical needs always take priority over forensic needs and are to be dealt with by the appropriate person, who may be the general practitioner or may be the duty paediatrician, depending on what the needs are. This list is not exhaustive.

**8.5 Emergency examinations**.

* At times a joint examination with the duty acute paediatrician and the duty forensic physician may be needed, if there are medical needs requiring hospital care.
* It is possible that neither doctor has experience with FGM and neither are appropriately skilled to make the assessment. Photo documentation is the solution, so the resultant images can be shown to the Clinical Lead of the service Dr Paul , or Dr Ejide, Dr Ibrahim or Dr Zafrani , or another specialist for help with interpretation.
* For hospital examinations photo documentation may not be possible, as the Thames Valley Sexual Assault service do not have a portable colposcope.
* In some hospitals, in hours, there is a colposcope that can be used for these examinations - Upton in East Berkshire and the John Radcliffe in Oxfordshire.
* In the other hospitals it may be possible to use medical photography, if available, but under these circumstances still photographs are the only possibility. Moving images are much easier to interpret, as stills may mislead.
* All FGM examinations done in the SARCs should be photo documented.
* Medical advice can be sought from the duty forensic physician, 0800 970 9953 and/or the Clinical Lead of the Service, Dr Paul 0800 970 9953/ 07899 870 679.
1. **CHILD EXPLOITATION**

**Child exploitation** must be considered in **all cases** and any suspicions discussed with the officer in the case and the social worker.

The Clinical Lead is available for telephone advice.

1. **UNEXPLAINED GENITAL BLEEDING**

There are many potential causes ref The Physical Signs of Child Sexual Abuse 2nd edition RCPCH and FFLM May 2015., 3rd edition to be published summer 2023.

Refer to a paediatrician, the urgency being judged at presentation.

If there is a suspicion of sexual abuse, e.g., an allegation by the child or other person-follow the CSA pathways.

“Grey” cases require a discussion with the paediatrician/Clinical Lead. **Remember, children often do not make an allegation, despite the existence of sexual abuse, for numerous reasons. Therefore, lack of allegation does not necessarily negate sexual abuse.**

Most importantly, the child must be examined by a doctor familiar with the anatomy, whether this is the FP on duty or the paediatrician.

1. **Strategy meetings and CP meetings**

It is important that the forensic physician is present , either the on call if emergency, the doctor who examined the child , or the Clinical Lead.

Email invitations are not always picked up in time if the doctor is doing clinical work rather than computer work ,**so ALWAYS make the call , to the duty FP via the Call Centre or Dr Paul direct.**

Call Centre 0800 970 9953

Dr Paul 07899 870 679

Sheila.paul2@nhs.net

**APPENDIX 1**

**THAMES VALLEY POLICE GUIDANCE**

This guidance document is in response to the requirement within Thames Valley Police for local procedures of Paediatric Forensic Medical Examinations for suspected/confirmed Child Sexual offences. It is designed to best comply with the Service Specifications for the Clinical Evaluation of Children and Young People who may have been sexually abused, 2nd edition, September 2015 from the FFLM and RCPCH and the Quality Standards from the RCPCH and FFLM for these examinations.

 Thames Valley Police staff are wholly committed to delivering a professional, responsive and caring service to children suspected of being sexually assaulted/abused/exploited, as are all who work in the Sexual Assault Service.

This guidance document applies to children, who are individuals from birth to their 18th birthday and all deserve a best practice service.

**Intention**

The intention of this document is to provide guidance to the forensic physicians (FPs), Paediatricians, Police Officers, ED staff; Sexual Health clinics; GPs; Social Care and other users in respect of child examination procedures in order to:

* Provide best practice investigation of child sexual abuse/assault/exploitation.
* Provide best practice holistic care of children suspected of being sexually abused/assaulted/exploited.

**General Principles**

**Children aged 12 years and under usually present historically i.e., non-emergency but may present as an emergency.**

**in addition, children who are being exploited and usually an older age group, also rarely present acutely, as they are often not aware they are being exploited.**

 **All acute cases require urgent forensic medical examination, because: -**

* If the child is seriously injured, then they will need to be taken to the nearest hospital without delay for urgent medical attention.
* Urgent medical needs take precedence over forensic needs.
* Other acute medical needs may dictate e.g., emergency contraception and sexually transmitted disease prevention.
* There is a high chance of finding important forensic evidence that may be lost over a certain time frame; this includes both swabs for foreign DNA and injury, either fresh or healing. (For DNA evidence ref persistence data).
* Note that as well as swabs for foreign DNA, forensic evidence includes injuries, both fresh, healing and healed. These may be found up to days or even years later e.g., bruising, healed genital injuries, perianal scars. Forensic evidence may also include changes of behaviour; emotional problems; recurrent genital or urinary problems; school avoidance, etc this list is not exhaustive. .

**“The swab is not the job”**

**Historic (delayed reporting) cases require a planned examination, if possible, within 2 weeks of referral.**

**Court**

If a case goes to Court examining doctor(s) will give a fully informed forensic medical opinion on the findings. If they are not qualified to do so, then an expert witness will be instructed*.*

Expert witnesses can be obtained via the NPIA.

**APPENDIX 2**

**Milton Keynes & Buckinghamshire**

**Acute Cases**

Contact should be made with the Solace Centre duty FP via the call centre.

If the FP requires the assistance of a paediatrician for whatever reason, they will arrange that with the hospital local to the SARC.

**Non urgent** cases should be planned with Dr Sheila Paul they will be seen by her or another FP in the SARC.

**Advice can be taken from the Clinical Lead, Dr Paul, at any time**

**Telephone Numbers:**

Sexual Assault Service Call Centre 0800 970 9953

Dr Sheila Paul 07899 870 679

Sheila.paul2@nhs.net

**APPENDIX 3**

**West Berkshire**

**Acute Cases**

Contact should be made with the Solace Centre duty FP via the call centre.

If the FP requires the assistance of a paediatrician for whatever reason, they will arrange that with the hospital local to the SARC.

**Non urgent** cases should be planned with Dr Sheila Paul; they will be seen by her or another FP in the SARC.

**Advice can be taken from the Solace SARC and the Clinical Lead, Dr Paul, at any time.**

**Telephone Numbers:**

Sexual Assault Service call Centre 0800 970 9953

Dr Sheila Paul 07899 870 679

Sheila.paul2@nhs.net

**Appendix 4**

**East Berkshire.**

**Acute cases**

Contact should be made with the Solace Centre duty FP via the call centre.

If the FP requires the assistance of a paediatrician for whatever reason, they will arrange that with the hospital local to the SARC.

**Non urgent cases**

Children aged 12 and under and vulnerable older children will be seen by the community paediatricians, by appointment in hours, in the hospital.

If no community paediatrician is available within the required time frame, which will vary depending on medical and safeguarding needs, cases should be planned with Dr Sheila Paul; they will be seen by her or another FP in the SARC.

Children aged 13 and over should be planned with Dr Sheila Paul; they will be seen by her or another FP in the SARC.

Vulnerable children aged 13 and over, joint examination with the community paediatrician should be considered.

 If the forensic physician requires the assistance of a paediatrician for whatever reason, they will arrange that with the hospital local to the SARC.

**Telephone numbers**

Sexual Assault Service 0800 970 9953

Child Development centre 0300 365 0123

Wexham Park Hospital 0300 614 5000

Dr Sheila Paul 07899 870 679

Sheila.paul2@nhs.net

**APPENDIX 5.**

**Oxfordshire**

**Acute cases**

Contact should be made with the Solace Centre duty FP via the call centre.

If the FP requires the assistance of a paediatrician for whatever reason, they will arrange that with the hospital local to the SARC.

**Non urgent cases**

Aged 12 and under, and all pre menarchal (girls) should be planned with Community Paediatrics at an agreed convenient time to be examined in the hospital.

Aged 13 years and older or younger if post menarchal (girls), should be planned with Dr Sheila Paul; they will be seen by her or another FP in the SARC.

In certain cases, such as children over 13 years of age with learning difficulties or complex emotional behavioural disturbance, discuss with the Community Paediatrician to decide which is the best setting for the examination and by whom.

**Telephone numbers**

Children’s Hospital John Radcliffe switchboard 01865 741166

Acute paediatric registrar on call bleep 1392

Horton Hospital Banbury 01295 275500

Ask for paediatric registrar/consultant on call

Community Paediatricians, daytime on call rota Monday-Friday 0900-1700.

01865 231 959

Dr Maria Finnis and Dr Harjinder Gill , consultant paediatricians and Designated doctors for Safeguarding Dr Sarah Haden, Consultant Paediatrician

01865 231994 and choose the option of which consultant you would like to talk to.

Sexual Assault Service Call Centre 0800 970 9953

Dr Sheila Paul 07899870679

Sheila.paul2@nhs.net