May 2014

Guidance to support Practitioners working with Sexual Abuse

Inter-agency Practice Guidance

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Nottinghamshire SAFEGUARDING CHILDREN Board

NOTTINGHAM CITY Safeguarding Children BOARD

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1. Introduction

1.1 This practice guidance is issued as supplementary guidance to the Nottingham City Safeguarding Children Board (NCSCB) and Nottinghamshire Safeguarding Children Board (NSCB) Interagency Safeguarding Children Procedures and it should be read in conjunction with those procedures. It replaces the previous practice guidance which was issued in October 2006.

1.2 It is intended for colleagues who work with children, young people and families in all agencies and settings. It is a practical guide which encompasses a shared approach to understanding, recognising and managing sexual abuse in a robust and timely manner.

1.3 Sexual abuse is a complex and challenging area for all practitioners. Sexual abuse occurs across all groups of children irrespective of class, religion, culture, age or ability, although some children can have additional vulnerabilities. Perpetrators of abuse can be of either gender, family members, people known to the victim, strangers or professionals. Perpetrators may target vulnerable adults, including those with learning difficulties, mental health or substance use issues, in order to access their children.

1.4 Any response will need to ensure that children and young people carers, parents and families are supported through any intervention and beyond.

1.5 Although the terms 'allegation' and 'disclosure' are used within this guidance it is not intended that the reader should make a judgement on what is said by the child based on such descriptions. The important point is that the child should always be taken seriously.

1. Definition

2.1 The definition of sexual abuse is contained in 'Working Together to Safeguard Children' (DfE March 2013):

Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children and young people.

2. Legislation & Guidance

- *Children Act 2004* *www.legislation.gov.uk*
- *Children Act1989* *www.legislation.gov.uk*
- *Achieving Best Evidence in Criminal Proceedings* www.cps.gov.uk/legal/assets/uploads/files/Achieving%20Best%20
- *Use of Witness Intermediaries*
- *Sexual Offences Act 2003* *www.legislation.gov.uk*
- *Working Together 2013* *www.education.gov.uk*
- *NCSCB / NCSB Safeguarding Children Procedures and CSE Practice Guidance*
- *Guidelines on Prosecuting Cases of Child Sexual Abuse* *www.cps.gov.uk*

3. Specific Indicators / Issues

4.1 Identification of sexual abuse presents a multitude of challenges and complexities including:

- The abuse is usually hidden and secretive and can be recent or historic.
- Children and young people are not always aware that the behaviour is abusive.
- Perpetrators use various strategies to keep children and young people silent (eg threats to kill themselves, other family members or pets; risk of the family being broken up; risk of prison or going into care; manipulation using gifts, personal or institutional power; threats to withdraw affection; fear).
- Sexualised behaviours are often attributed to other factors with no consideration of current risks.
- The child's behaviour can be dismissed by professionals and adults as difficult to manage, aggressive or problematic or as a result of a child's disability attributing behaviours to developmental difficulties rather than striving to understand the cause of these.
- Practitioners may fail to consider sexual abuse as a possible explanation for physical symptoms or signs.
- Practitioners may make assumptions about perpetrators. Women as well as men can be perpetrators, as can young people. There may be more than one perpetrator and children may remain at risk even after a known or suspected perpetrator is no longer in contact with them.
- Perpetrators will also groom parents and other family members or they may use controlling or violent behaviours.
- Perpetrators may seek to control or manipulate the involvement of professionals with the child or young person (for example, by not allowing a professional to see the child or young person alone).
- Non-abusing carers may not be able to protect children from perpetrators because of their own vulnerabilities (for example, learning disabilities, domestic violence, substance misuse and mental ill-health). Female carers should not automatically be considered to be protective of the child or young person.

- The child or young person may have been manipulated to hurt others.
- Many forms of sexual abuse do not leave physical injury; therefore the findings of any medical examination may not provide evidence of sexual abuse.
- Children or young people may not be able to talk about sex or sexual abuse, particularly those who have additional communication needs.
- The perpetrator may be a person with a significant standing professionally or in the community.
- A child or young person may retract an allegation but this may be due to a number of reasons, including pressure to do so from the perpetrator.
- The allegations can relate to recent or historic events.
- Children, who frequently move across boundaries, or even between schools and GP practices, may be at risk of ongoing unrecognised abuse as each new professional attributes problems to historical abuse.
- Concerns such as sexualised behaviour, emotional or behavioural difficulties may be attributed to acknowledged abuse in the past, perhaps by a family member with whom there no longer is contact, when abuse is in fact still occurring with another perpetrator. This possibility must also be considered when children in foster or residential care exhibit sexualised behaviour or other indicators of possible abuse.
- Practitioners should be aware that the absence of positive findings of abuse as part of a medical assessment may not mean that the abuse has not occurred. Similarly any decision that there is insufficient evidence to take further police action does not mean that abuse has not occurred. Robust holistic multi-agency assessment is always required.
- **Appendix 1** gives guidance regarding the circumstances which would require a joint response by police and social care.

4.2 There is not always a clear allegation or disclosure by the child or young person in relation to sexual abuse and it is important to recognise that the absence of this does not rule out the possibility of abuse. Research evidence suggests that a large proportion of children who are abused may never make a clear disclosure to a professional. It is also important to recognise that children disclose in many different ways. In some cases they may tell friends or family members. Children may also disclose inadvertently or partially through comments or conversation. Some of the emotional and behavioural responses which may be associated with sexual abuse can be regarded as forms of non-verbal disclosure.

4.3 Disclosures of abuse which happened in the past will in most cases require the same safeguarding response as disclosures of current abuse. In some cases a person who discloses abuse which took place in the past recognises the need to ensure the safety of others.

4.4 In some cases, the child or young person may be still at risk, but may make a partial disclosure by talking about past abuse.

4.5 **What is a disclosure?** A disclosure is a child letting someone know that they are unhappy about something – this may be verbally or through their actions or behaviour. The words "sexual abuse" are unlikely to feature in a verbal disclosure although the child may use colloquialisms or slang terms or they may hint as to what has happened. The person hearing the child may not make sense of what the child is saying whilst they are saying it and only realise later – this is not a problem. In terms of behaviour, a change may be noticed, for example the child's behaviour and emotional presentation many not match, the child may be engaging in sexualised behaviour or behaviour that indicates trauma.

4.6 A disclosure is not necessarily a discrete event. A professional does not ordinarily have a conversation with a child knowing that a disclosure will be made. Perhaps you have a gut feeling that something is not quite right and are asking the child if they are okay. It may be that during a conversation or a number of conversations, the child will reveal information to suggest that sexual abuse may be happening. Professionals who work with children know how to talk and interact with children and just need to use their listening skills. Let the child talk, clarify if you are unsure; use open questions – that's it. Try to avoid extreme emotional responses, these create worry and impede conversation. Make a contemporaneous note of the conversation and information whilst fresh in your mind.

4.7 **Remember:**

- There are non verbal indicators of sexual abuse.
- A child or young person is more likely to tell a friend or family member.
- Disclosures may happen partially through play / comments or conversions.
- Children with disabilities may have an increased level of vulnerability due to the challenges of communication and the level of personal care needed.

4.8 ***How abuse presents*.** There are a number of possible indicators of sexual abuse but professionals must be mindful of the behaviour in context and an approach of careful analysis and interpretation is needed. Many of the indicators are not specific for sexual abuse and may also be triggered by other sources of distress for the child or linked to development or other vulnerability factors. Any significant change in a child's behaviour needs to be explored and abuse should be a consideration. Indicators may include:

4.9 ***Emotional and behavioural Indicators***

- Poor concentration/decrease in school performance

- Nightmares/sleep disturbance
- Regression in some behaviours
- Anxiety/low mood/aggression
- Social withdrawal
- Self harm/suicide
- Running away and missing from home
- Multiple 'consensual' sexual acts

4.10 ***Sexualised behaviour***

Children, as part of their development, will explore and experiment in terms of their body. However, many children who have been sexually abused will show persistent and unusual sexualised behaviour. Any concerns will need to be subject to a full assessment.

- Explicit or inappropriate sexual knowledge/language/behaviour
- Sexually explicit play and drawings
- Compulsive masturbation and not responding to social rules on masturbation
- Sexual plan/masturbation that is judged to be inappropriate to a child's age, development and circumstances
- Persistent sexualised behaviour
- Sexually abusive / harmful behaviour towards other children

4.11 ***Physical indicators***

- Sexually transmitted disease
- Recurrent urinary tract infections
- Genital and rectal itching and soreness
- Unexplained bleeding and discharges
- Bruising in the genital region
- Unexplained pregnancy
- Self Harm
- Day- or night-time wetting in a child, which starts in a child who has previously been dry, and persists despite adequate assessment and management, if there is no known stressful situation unrelated to maltreatment, and no medical explanation (for example, urinary tract infection);
- Deliberate wetting by a child, or Encopresis (repeatedly defecating a normal stool in an inappropriate place) or repeated, deliberate smearing of faeces by a child
- Frequent presentations with non-specific health issues, for example, abdominal pain, headaches.

4. Interventions

5.1 In the absence of an unequivocal allegation of sexual abuse, professionals can experience difficulties in initial response and subsequent handling of sexual abuse concerns.

5.2 Any approach will need careful and planned intervention which will include background research and liaison between all partner agencies in order to ensure children and young people are not exposed to further risks.

5.3 Child sexual abuse is an extremely complex area of investigation. Hasty or inappropriate action on receipt of a 'disclosure' could inadvertently alert the abuser(s), thereby jeopardising any subsequent investigation. For this reason, unless there is also information that a child or young person's physical safety is at imminent risk, agencies must consider whether there is a need to take immediate action or for a discussion to take place at a strategy meeting. It is important, however, for there to be no delay in responding to a child's disclosure as this could lead to a child feeling they have not been taken seriously. When agencies are making referrals to Children's Social Care, they should first consider the need to inform the parents of the child or whether doing so might alert the abuser(s) and therefore place the child or other children at additional risk (see below).

5.4 ***Key Principles in responding to sexual abuse concerns.*** When responding to allegations/disclosures it is important to remember to maintain clear and positive inter agency communication:

- Take what the child says seriously.
- Remain calm.
- Listen.
- Avoid personal opinions, assumptions and questions.
- Try to avoid an emotional response.
- Reassure the young person they are not to blame.
- Know the limits of confidentiality.
- Explain what will happen next.
- Clarify by reflecting.
- Keep clear detailed and contemporaneous records of all concerns and discussions.
- Seek advice from safeguarding leads such as named or designated professionals: Children's Social Care can be consulted for further advice.
- If sexual abuse is suspected, make a referral to Children's Social Care.
- Following a referral to Children's Social Care, a strategy discussion/meeting should be held.
- A medical examination should be considered in all cases which will include a generic assessment and include not only collation of any forensic evidence, but also other evidence of potential neglect or physical harm. Positive consideration should be given to the medical examination of other children in the family.

- In some circumstances a joint enquiry/investigation team may need to speak to a suspected child victim without the knowledge of the parent or caregiver. Relevant circumstances would include the possibility that a child would be threatened or otherwise coerced into silence, a strong likelihood that important evidence would be destroyed or that the child in question did not wish the parent to be involved at that stage and is competent to take that decision. The strategy discussion should decide on the most appropriate timing of parental participation. Any decision to progress without the knowledge or consent of those with parental responsibility must be recorded with the reason clearly stated.
- If a decision is made by the CPS that a prosecution should not be pursued, this should be discussed with the CPS to ensure that any such decision has been fully informed and is in the child/young person's best interests.
- The support needs of the child must be considered at every point of the investigation and intervention. Consideration should be given to the provision of therapy for child witnesses prior to criminal proceedings – 'There is no bar to a victim seeking pre-trial therapy or counselling and neither the police nor the CPS should prevent therapy from taking place prior to the trial', Guidelines on Prosecuting Cases of Child Sexual Abuse, 2013. This guidance makes it clear that the best interests and welfare of the child or young person is paramount in deciding when and in what form therapeutic intervention help is given.

5.5 ***Multi agency discussion/meetings.*** Complex concerns require discussions between agencies in the form of a strategy meeting to plan interventions and make sure that police and children's services secure good quality evidence to protect the victim or victims. This may mean that a child or young person is not safeguarded immediately but that they will be protected in the medium to long term. Complex concerns include those where there is suspicion of parental and/or family involvement; involvement of a professional; presence of a sex offender; history of child sexual abuse referrals or offences; child on child abuse; children with communication issues or learning disabilities. Setting up a strategy meeting with appropriate professionals should be prioritised as poorly planned intervention leaves children unsafe and unprotected with agencies unable to take action. Investigations and decision making must not be allowed to drift.

5.6 Strategy Meetings should be organised in line with the NCSCB/NSCB Safeguarding Children Procedures.

5.7 Strategy meetings will need information about:

- Previous concerns relating to the child or family.
- The family structure.
- Links to potential offenders.
- Case history and history of intervention.

- Disclosure information and professionals involved.
- Information about the child.
- Current whereabouts of the child and specific risks.
- Any potential witnesses.
- Any safeguarding risks to other children.

5.8 The aims of the strategy meeting will be to:

- Plan the intervention and investigation.
- Plan any medical examination.
- Decide when to inform parents/carers and who will do this.
- Plan the Achieving Best Evidence (ABE) Interview – this is part of the joint police and Children's Social Care investigation process and should only be conducted by appropriately qualified and trained staff.
- **Appendix 2** provides guidance for staff involved in undertaking an interview with a child under Achieving Best Evidence.

5.9 **Appendix 3** provides a suggested template for the conduct of meetings where there are concerns regarding complex abuse. There is an expectation that all agency representatives prepare and bring the relevant information to the meeting.

5.10 ***What should take place first: video interview or medical examination?*** For sexual abuse allegations, ordinarily the interview of the child should take place prior to the joint medical examination. The advantage of such an approach is that it allows the child or young person to identify what parts of the body require examination by medical professionals and avoid having to conduct a further medical after the interview. Carrying out the interview first should also prevent the child having to repeat the disclosure to the examining doctor(s).

5.11 Any decision should be balanced with the potential risks of the loss or cross contamination of forensic material. Where necessary, the police will discuss the circumstances with either the Forensic Medical Examiner or Consultant Paediatrician and seek their advice and guidance in the circumstances.

5.12 **Appendix 4** provides information for practitioners to use to help a young person's understanding about medical examinations.

5.13 **Appendix 5** gives guidance relating to the need for consent to a medical examination. It should be noted that the medical examination will not only assist the criminal investigation, but it can also provide the child or young person with reassurance about their physical health.

5. Resources and Tools

6.1 **Appendix 6** outlines a theoretical framework for understanding sexual abuse.

6.2 **Appendix 7** provides details of counselling and support services.

6.3 Separate guidance is available for practitioners completing chronologies and genograms to assist assessments.

Appendix 1

GUIDANCE ON RESPONDING TO CONCERNS ABOUT SEXUAL ABUSE AND JOINT INVESTIGATIONS

Case Information	Action
1) Allegation of sexual abuse upon a child – a child makes an allegation of sexual abuse, including historical allegations	In these situations a strategy discussion/meeting will take place with the likely outcome being that the police and Children's Social Care will undertake a **joint** investigation with the police having the lead for the criminal investigation. Within these enquiries any siblings of the child should also be considered
2) Concerns about symptoms of 'possible' sexual assault – a child is medically examined following the conclusion of an assessment that suggests they may have experienced a sexual assault and found to have symptoms supporting this concern. The child does not make an allegation or is too young to do so.	In these situations a strategy discussion/meeting will take place with the likely outcome being that the police and Children's Social Care will undertake a **joint** investigation with the police having the lead for the criminal investigation. Within these enquiries any siblings of the child should also be considered
3) Sexualised behaviour – report of a child simulating sexual activity alone or with others.	Children's Social Care will undertake enquiries as a **single** agency, unless there is additional information to indicate that a crime may have been committed. If a crime may have been committed, a child protection strategy discussion/meeting will be arranged and a joint investigation carried out between the Police and Children's social care, with the police having the lead for the criminal aspect of the investigation.
4) Child on child sexual abuse – report of young people engaged in sexual activity	Children's Social Care assessment will evaluate whether there is any information or evidence to indicate age inappropriateness/consent/coercion or exploitation. A strategy discussion will take place between the police and Children's Social Care to decide if a strategy meeting will be convened, in accordance with Nottinghamshire and Nottingham City's Safeguarding Children Boards child protection procedures, and in order to plan the appropriate level of intervention. If one of the children involved is aged less than 13 years, a **joint** investigation must be undertaken by the Police and children's social care, with the Police having the lead for the criminal aspect of the investigation.

Appendix 2

THE INVESTIGATIVE INTERVIEW

Interviews conducted under Achieving Best Evidence guidance should only be undertaken by appropriately qualified and trained police and Children's Social Care staff.

When speaking to a child prior to a video interview ensure:

- A written record of the content of the discussion, time, setting and people present is made.
- There is no legal requirement for a parent or adult to be present, or give consent, for a professional to talk to a child in order to establish their welfare.
- Use open questions.
- Listen and record verbatim any disclosure.
- Once welfare established or potential offences disclosed, professionals should not ask further questions.

Planning the interview with the child must be done by way of a meeting between the two investigating professionals (police and Children's Social Care). This should **not** be done over the telephone.

The planning and preparation will consider the following:

- The child's level of development
- Who should lead the interview?
- Who else might be present?

Consideration should be given to using interpreters and/or witness intermediaries.

Main principles:

- All interviews will be undertaken in accordance with Achieving Best Evidence (ABE) guidance.
- Where a child is not video interviewed, the alternatives are a written statement or a question and answer interview.
- A video interview should only be conducted where:

    1. The child has the ability to engage in an interview; *and*
    2. The child has the ability to give evidence in court; *and*
    3. There has been clear verbal allegation/disclosure of abuse from a child; *or*
    4. One child is implicated by another witness as a victim of abuse; *or*
    5. There are substantial grounds for suspecting abuse has occurred.

- In order to establish these criteria it will normally be necessary to have a short assessment interview with the child to establish whether or not a child has anything to say about the allegation or suspicions that led to

the referral. There is a need to avoid coaching: however, this will be an opportunity to assess the appropriateness of recording the interview and the child's willingness to be interviewed on DVD and to answer his/her questions about the reasons for the interview.

- **Listen to the child**. Any question directed to the child at this stage must be in accordance with ABE.
- Never stop a child who is freely recalling significant events.
- An accurate and detailed record of a discussion must be made. If the discussion includes a disclosure of abuse, that part must be recorded verbatim and contemporaneously or, at the very least, as soon as possible after the contact. Notes should be made on the agreed investigation forms or in the Police Officer's notebook. Times and persons present should be included.
- Record all subsequent events up to the time of the substantive interview.
- Even if no disclosure of a potential criminal offence is made, accurate recording is essential as decisions about risk may be made on the strength of them.
- If there are concerns in respect of other siblings in the household, the issue of contamination of evidence will need to be addressed.
- The interview plan will need to take into account any special needs of the child.
- Any additional people in the interview suite should be discouraged.

Parent/Carer Involvement

In the majority of investigations it is expected that concerns will be shared with the parents/carers before the child is seen. As a general rule, information should be shared with parents/carers unless to do so would affect the safety and welfare of the child or other children, or be detrimental to the criminal investigation. If a decision is made not to inform the parents/carer the reasons must be recorded. The needs and safety of the child must be the first consideration when determining at what point parents/carers should be informed of concerns. The child should never be interviewed in the presence of an alleged or suspected perpetrator.

Unless the child has sufficient understanding to agree to being interviewed in his/her own right, the agreement of a parent or a person with parental responsibility or the authorisation of a court is required.

The investigating team may need to interview a suspected child victim without the knowledge of the parent or carer in certain situations. In all cases where the police are involved, the decision about when to inform the parent or carer will have a bearing on the conduct of the police investigation, and the strategy discussion/meeting should decide on the most appropriate timing of parental participation. It is not good practice, from an evidential perspective, for a parent to be allowed in an interview or in the monitoring room particularly if the parent is the person to whom the child has disclosed.

Appendix 3

SAFEGUARDING CHILDREN AND YOUNG PEOPLE
STRATEGY MEETING WHEN THERE ARE CONCERNS OF COMPLEX ABUSE

Agenda

1. **Introductions and reason for meeting**

2. **Family structure/household composition (genogram if possible)**

3. **Chronological information about the child or young person's allegation**

4. **Background Information:**
   - Child health
   - Children's services
   - Education
   - Police
   - Adult health
   - Other

5. **Actions taken so far:**
   - eg examination, interview
   - Views of the child/young person, if available

6. **Analysis:**
   - Information missing
   - Preliminary results, if available
   - Risks and protective factors within the child, young person and family members
   - Consideration regarding seeing the child/young person alone
   - Consent for examination
   - Use of an intermediary
   - Siblings needs
   - Parents/carer's needs
   - Control of information
   - Potential media interest

7. **Actions Needed:**
   - eg examination/video interview

8. **Agreed Plan:**
   - Individual and agency tasks, timetable and responsible person
   - Support to family

9. **Follow up meeting:**

Confidentiality Statement

This multi agency case discussion meeting is being convened under Nottingham City and Nottinghamshire Safeguarding Children Board inter-agency procedures relating to concerns raised that a child or young person has been sexually abused.

The discussion and minutes from this meeting are confidential and <u>should not</u> be shared outside this forum without permission of the chair.

Appendix 4

INFORMATION FOR CHILDREN AND YOUNG PEOPLE WHO HAVE BEEN SEXUALLY ABUSED OR ASSAULTED

The following guide provides practitioners with information regarding a medical examination to help explain this to a child or young person.

Reason for examination

The examination is needed to gather evidence for the police and to check for injuries and infections, which may need treatment. Even if the police do not require an examination, you can ask to be examined to make sure that you are OK.

If the police and a doctor think it is the right thing to do, they will ask you if you would like to have an examination. Two senior doctors, a Consultant Paediatrician and a Forensic Medical Examiner from the police usually perform this examination.

The Consultant Paediatrician is trained in the examination of children and young people who have been sexually abused or assaulted and the Forensic Medical Examiner is trained in collecting forensic evidence for the police.

What does the examination involve?

It involves performing a “top to toe” physical examination such as listening to heart and lungs, looking in your mouth. The doctor will examine you for any injuries such as cuts and bruises, which may have occurred during the incident. They will make careful notes of where the injuries are and what they look like.

With your permission a colposcope (a piece of equipment which has a bright light and magnifies images) may be used to examine your private parts (genitals). The colposcope does not touch your body or go inside you; it is positioned about 30 centimetres away from you. The colposcope helps to clearly demonstrate any injuries and often means that the time taken for the examination is much shorter. A recording may be taken of the examination so that if there are unusual findings a second opinion can be sought without you having to have a further examination. This recording can also be used as evidence for a potential prosecution. You cannot be identified from the recording which is always kept locked and secure.

The doctors may need to take samples, using cotton wool swabs, from your skin and from areas involved in the assault, such as the vagina, anus or mouth. These swabs can then be used by the police to obtain DNA evidence, which can help with the successful prosecution of the perpetrator of the assault or abuse.

Depending on when the assault/abuse happened, swabs may also be taken to check for infections. You may also be asked to give blood and urine samples; these can also check for infections and or alcohol or drugs.

The doctors will keep you informed about everything that is happening and if any point you are uncomfortable with the examination you can ask for a break or that the examination be stopped.

The clothes that you were wearing at the time of the assault may be sent to the police laboratory for examination and then be kept as evidence.

What happens afterwards?

The doctors will explain their findings to you and you can ask them any questions you may have. If you are at risk of becoming pregnant, the doctor will offer you emergency contraception, usually the 'morning after pill'. They can also give you a single dose of antibiotics to prevent you developing chlamydia, the most common sexually transmitted infection.

What happens to the evidence?

The police will keep the samples taken during the forensic examination for testing. Any information and results obtained are police evidence. The police will then liaise directly with you about their findings.
If a recording of the examination is taken this will be kept locked and secure. It may be seen by an expert doctor for the defence.

Follow up arrangements

All children and young people are offered a follow up appointment with a Consultant Paediatrician. This appointment is an opportunity for you to discuss any health concerns you may have with a consultant experienced in seeing children and young people. You will be offered screening tests for sexually transmitted infections such as chlamydia, gonorrhoea, hepatitis and HIV. Tests offered are a self-taken vaginal swab (girls), or urine sample (boys and girls) and a blood test. A pregnancy test can also be done on a urine sample.

Referral for emotional/psychological support will be offered and you can ask for this service at any point.

Appendix 5

CONSENT FOR MEDICAL EXAMINATION

A Forensic Medical Examiner (FME) has to consider the issue of consent before undertaking an examination.

Consent MUST be obtained.

Parental Responsibility (PR): Those persons with PR will be asked to consent before the medical examination can be undertaken. If consent is not given then further consideration is needed in conjunction with medical colleagues and may include seeking legal advice.

Over 16: Section 8 of the Family Law Reform Act 1969 allows for persons aged 16 and over to give informed consent to surgical or dental treatment. It is presumed this applies to examinations and assessments undertaken for forensic purposes.

Under 16: 'The ability of a child under the age of 16 to make his own medical decisions is evaluated according to chronological age, considered in conjunction with the child's mental and emotional maturity, intelligence and comprehension. This is known as Gillick or Fraser Competency.'
This is taken form 'Sexual Assault – A Forensic Clinicians Practice Guidance'

Appendix 6

A THEORETICAL FRAMEWORK FOR UNDERSTANDING SEXUAL ABUSE

1 Angela Brown and David Finklehor's 'Traumagenic Dynamics' model offers a way of understanding the impact of childhood sexual abuse. They describe four elements:

- Traumatic Sexualisation.
- Stigmatisation.
- Betrayal.
- Powerlessness.

2 Below is an outline of how the model can be used to understand children's experience of and responses to sexual abuse. The **dynamics** section outlines how sexual abuse works and what the abuser does; the **psychological impact** section lists possible ways a child is affected by this abuse; the **behaviour section** offers some of the things you may observe children and young people doing as a consequence of the above.

Traumatic Sexualisation

3 A child's normal sexual development is inappropriately shaped and their normal behaviour may become sexualised by the experience of abuse.

4 **Dynamics**

The abuser exchanges attention and/or affection for sex.
The abuser transmits misconceptions about sexual behaviour and sexual morality.
The abuser rewards the child for sexual behaviour inappropriate to their developmental level.
The abuser sexually distorts the child's healthy need for love and care.
Family, community and society eroticise children (explicitly expressed through child pornography and the cultural sexualisation of children) and withhold appropriate sex education.

5 **Psychological Impact**

The child becomes inappropriately aware or preoccupied with sexual issues.
The child associates sexual or intimate activity with negative memories and feelings.
The child confuses giving and receiving love and care with sex.
The older child or adolescent experiences confusion about sexual identity and sexual norms.

6 **Behaviour**

Any sexual behaviour outside the range of normal sexual development:

- Sexual preoccupation or compulsive sexual behaviour.

- Seeking attention through sexualised talking, touching and invitations to touch.
- Self neglecting sexual behaviours.

Stigmatisation

7 A sense of shame and responsibility is communicated to the child through the experience of sexual abuse and is then compounded by negative responses from family, community and society.

8 **Dynamics**
The abuser explicitly denigrates the child.
The abuser directly blames the child for the abusive acts.
The abuser tricks the child into feeling responsible for the abuse – as an active or passive participant.
The abuser pressurises or tricks the child into keeping the abuse a secret.
The abuser keeps the child isolated from peers.

9 The family or community reacts:
- With shock and disbelief.
- By blaming the child.
- By stereotyping the child as damaged goods.
- By reinforcing the secrecy.

10 **Psychological Impact**
The child feels bad, dirty, guilty, ashamed and abandoned.
The child experiences a sense of difference from others, especially peers.
The child develops a negative self image and low self esteem.
The child experienced themselves as damaged or unworthy.

11 **Behaviour**
The child isolates themselves from others.
The child harms themselves.
The child attempts suicide.
The older child or adolescent uses alcohol or drugs excessively.
The older child or adolescent becomes involved in criminal activity.

Betrayal

12 An adult purposefully violates a child's needs, expectations and trust of adult care.

13 **Dynamics**
The offender manipulates the trust and vulnerability of the child.
The offender violates the child's expectation that adults will provide care and protection.
The offender looks out for their own interests, disregarding the child's wellbeing.

The family, community and society fail to provide support and protection.

14 **Psychological Impact**
The child experiences an extreme loss of security, both physical and emotional.
The child experiences confusion around whom and what is safe or trustworthy.
The child feels frightened, distressed, angry, hostile and rejected.

15 **Behaviour**
The child is excessively clingy and dependant.
The child avoids contact, isolates themselves, is hostile or aggressive.
The child is unable to judge the trustworthiness of others.
Self neglecting or risk taking behaviour.
The older child or adolescent experiences discomfort in intimate relationships.

Powerlessness

16 A child's sense of will, effectiveness and mastery over themselves and their environment is continually undermined through the experience of sexual abuse.

17 **Dynamics**
The offender invades the child's body.
The offender uses force, threats or tricks.
The offender maintains the threat of repeated abuse or harm.
The offender ensures that the child has no control over the abusive situation.

18 Family, community or society disbelieve and fail to take the child seriously. Society's failure to take the child's experience seriously is echoed in the judicial system's failure to support, protect or compensate children and adults with regard to the experience of sexual abuse.

19 **Psychological Impact**
The child feels anxious or frightened.
The child has a heightened sense of impending danger (real or imagined); the child experiences a lowered sense of t heir own efficacy in the world.
The child identifies them self as victim.
The child has a need to control.
The child identifies themselves with the perpetrator.

20 **Behaviour**
The child becomes depressed.
The child experiences nightmares (often sexualised), phobias, eating or sleeping disorders.
The child remains vulnerable to subsequent victimisation.

The child asserts their power inappropriately, ie bullying, generalised aggressive behaviours (perhaps sexualised).

The Degree of Impact of Sexual Abuse

21 The impact of child sexual abuse can be short term or extend into the long term – depending upon pre-existing factors such as attachments and resilience, the nature of the abuse and upon the response of others to the abuse. Other factors include:

- The **relationship** between the victim and the abuser. The closer the relationship, the higher the risk of trauma and the greater the possibility that the young person's ability to trust will be damaged.
- The **age** of the young person when the abuse began and the **length of time** that it occurred. An ongoing abusive relationship that begins at an early age is potentially more damaging to the young person.
- The type of sexual activity involved in the abuse. Sexual acts or activity involving no physical contact seem to be less traumatic.
- The degree of force used to coerce the young person. Violence increases the trauma for the young person.
- How others responded to the young person's disclosure. If the young person was not believed, was blamed, or was shunned by others, the trauma increases.
- The support available to the young person following the disclosure. Lack of support increases the trauma and feelings of loneliness, helplessness and unworthiness.

22 These factors may have different significance for every young person. All sexual abuse is harmful and each young person experiences a different sense of pain or trauma.

23 It is important to remember that signs and symptoms may be very difficult for adults to read. Equally, children may not show any signs or symptoms of being sexually abused.

Appendix 7

COUNSELLING AND SUPPORT SERVICES

LOCAL SERVICES

NGY

NGY myplace, 29-31 Castle Gate, Nottingham NG1 7AR
Tel: 0115 952 5040

Email:info@base51.org.uk

Office opening: Mon-Fri 9.00am-5.00pm

Drop-in sessions: Mon 2.00pm-4.00pm and Thurs 4.00pm-6.00pm

NGY (previously Base 51) offers young people between the ages of 12 and 25 a safe and confidential space in which there is an opportunity to explore, identify and understand past and present experiences. Their aim is to help young people discover new ways of coping and to feel and think better about themselves and their lives and promote greater wellbeing.

NGYs counselling service includes emotional support for young people, a drop-in service where no appointment is necessary, weekly one-to-one counselling, crisis intervention service, support for a wide range of issues, consultation to parents and carers, as well as professionals and agencies. NGY offer other services outside of counselling, including:

- Medical services
- Housing support services
- Under 18s service
- Families support service
- Rough sleepers support service

CAMHS (Child and Adolescent Mental Health Service)

Tel: Thorneywood 0115 54405100 or St John Street 01623 650921

www.camhs.org.uk

Service aim:
"All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, have access to timely, integrated high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for children and young people and their families."

IMARA

Imara is a project to assist families who had been affected by child abuse in the Nottingham City area. In the future they hope to be in a position to expand their services to include the whole of Nottinghamshire County

7 Musters Road
West Bridgford
Nottingham
NG2 7PP
www.imara.org.uk

MALT (Multi-Agency Locality Teams)

Tel: 0115 9158900

www.nottinghamcity.gov.uk

The main focus of Multi-Agency Locality Teams is the emotional wellbeing of children and young people. MALTs:

- Provide assessment to help children, young people and adults to engage in successful interventions leading to change and positive outcomes.
- Support the achievement and effective inclusion of children and young people in schools, their families and communities.
- Provide support and challenges to schools in carrying out their responsibilities in meeting the needs of pupils and families in line with government and Local Authority priorities, plans and values.
- Provide a range of interventions including training, consultation, group work, whole school approaches, assessment and more.
- Facilitate positive change for vulnerable children and those with exceptional needs.

OPAZ (Nottinghamshire Sexual Assault Referral Centre)

Helpline – 0845 600 1588
www.topazcentre.org.uk

Provides multi agency support to victims aged 13 and over. Facilities include a supportive environment for forensic examinations, support from a crisis worker and up to 8 sessions of face-to-face support.

Nottingham Rape Crisis

Helpline: 0115 9410440
Tel: 0115 947 0064

Provides helpline and face-to-face support to women and girl victims across Nottinghamshire.

Nottingham Counselling Service

Tel: 0115 950 1743
Email: info@nottinghamcounsellingcentre.org.uk

Provides counselling for female victims aged 16 and over.

Victim Support – East Midlands

Tel: 0116 249 3302
0300 303 1947

Provides support for victims and someone to talk to in confidence, information on police and court procedures, help in dealing with other organisations, information about compensation and insurance and information on other sources of help.

NATIONAL SERVICES

Childline

Tel: 0800 11 11 (24 hour national helpline)

www.childline.org.uk

ChildLine is a counselling service for children and young people. At ChildLine bases around the UK, trained volunteers are on hand to provide advice and support 24 hours a day. And children can get in touch in any of the following ways – whichever makes them feel most comfortable and in control:

- by phone
- online.

Their website also features advice, creative tools, videos and games to help children express how they feel and give them the confidence to speak out. Information and support is also available by text on range of issues.

Barnardo's

Tel: 0208 550 8822

Email: info@barnardos.org.uk

www.barnardos.org.uk

Barnardo's can help children whatever the issue from drug misuse to disability; youth crime to mental health; sexual abuse to domestic violence; child poverty to homelessness.

ISAS

Incest and sexual abuse survivors
Helpline and counselling to male and female survivors of rape and childhood abuse

Helpline 01636 610 313

NSPCC

Tel: 0808 800 5000 (National Child Protection Helpline – 24 hour)

Email: help@nspcc.org.uk

Local contact number: 0115 960 5418

www.nspcc.org.uk
Runs a wide range of services for both children and adults across the UK, including national help lines.

Parentline Plus

Tel: 0800 800 2222 (National Helpline – 7am to Midnight)

www.parentlineplus.org.uk

www.familylives.org.uk

Parentline Plus is the leading national charity providing help and support to anyone caring for children – parents, grandparents, step-parents, relatives – for families living together as well as apart.

They have a highly trained team of parents and we understand the challenges, advising families on issues big and small to ensure that life is better for all.

Supportline

Tel: 01708 765200

Email: info@supportline.org.uk

www.supportline.org.uk

Offer confidential emotional support to children, young adults and adults by telephone, email and post. They work with callers to develop healthy, positive coping strategies, an inner feeling of strength and increased self esteem to encourage healing, recovery and moving forward with life. Supportline is

open to any individual of any age. It is particularly aimed at those who are socially isolated, vulnerable, at risk groups, and victims of any form of abuse.

Supportline also keeps information on other agencies, support groups & counsellors throughout the UK and this service can also be used by professionals seeking sources of help for the clients in their care.

Parents Protect / Stop It Now!

Tel: 0808 1000 900

Email: help@stopitnow.org.uk

www.parentsprotect.co.uk

This is a child sexual abuse awareness and prevention website. It provides an online learning service, details of warning signs for parents/carers, details of how to create a family safety plan and signposting to other useful services.

MOSAC

Tel: 0800 980 1958 or 0208 293 9990

www.mosac.org.uk

Supporting non-abusing parents and carers of sexually abused children. They offer practical support dealing with external agencies such as Children's Social Care, the courts, housing offices and the Police. They can support you through meetings and help you with paperwork and bureaucracy where necessary. They also offer counselling, support groups, information service and a national confidential helpline.

CROP (Coalition for the removal of pimping)

Tel: 0113 2403040

Email: info@cropuk.org.uk

www.cropuk.org.uk

CROP's substantial experience, specialist expertise and family-centred approach to tackling child sexual exploitation means that it can support, encourage and enable parents and families to be actively involved in responding to the devastating, complex and multiple issues that arise as a result of the sexual exploitation of their child.

Survivors Trust

Tel: 02380 338080

Email: admin@cisters.org.uk

www.thesurvivorstrust.org.uk

National umbrella agency for over 135 specialist rape, sexual violence and childhood sexual abuse support organisations throughout the UK.

Respond

Tel: 0808 808 0700

Email: isva@respond.org.uk

www.respond.org.uk

Supporting people with learning difficulties, their families, carers and professionals affected by trauma and abuse.

Lucy Faithfull Foundation

www.lucyfaithfull.org

Child protection charity working to reduce the risk of children being sexually abused. Work with families, adult male and female sexual abusers, young people with inappropriate sexual behaviours, victims of abuse and other family members. Provide assessments and training.

NAPAC (National Association for people abused in childhood)

Free Helpline (10.00am–9.00pm Mon-Thurs and 10.00am-6.00pm Fri)

– 0800 085 3330 from landlines or 0808 801 0331 from a mobile

Provides support and information for people abused in childhood

support@napac.org.uk

www.napac.org.uk