Kent Safeguarding Children
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Medway
Safeguarding
Children Partnership
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children together

Pathway for child sexual abuse (CSA) medicals (under 18-year-olds)

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Summary of Purpose	This guidance has been developed to help practitioners manage concerns about possible child sexual abuse (CSA), but will not cover all possible cases, which need individual consideration and discussion. The guidance outlines the pathways for CSA medicals.
Accessibility	This document can be made available in large print, or in electronic format. There are no copies currently available in other languages.
Equalities Impact Assessment	During the preparation of this policy and when considering the roles and responsibilities of all agencies, organisations and staff involved, care has been taken to promote fairness, equality, and diversity, in the services delivered regardless of disability, ethnic origin, race, gender, age, religious beliefs or sexual orientation.
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Policy Review Date	This document will be reviewed in June 2025.

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1. Introduction

This guidance has been developed to help practitioners manage concerns about possible child sexual abuse (CSA), but will not cover all possible cases, which need individual consideration and discussion. If this guidance is not followed, the professional must record the reason for not doing so and indicate if their judgement is informed by best practice and if they are acting in the best interests of the child.

A medical examination has limitations in the validation of CSA as a high proportion of children who have been sexually abused have no anogenital signs at examination. However, it is important to note that although the purpose of the examination is to look for signs which might support or confirm sexual abuse, it is also a holistic examination which serves to ensure the health and wellbeing of the child, to reassure and help begin the therapeutic process. Thus the value of a medical examination should not be underestimated.

The guidance outlines the pathways for child sexual abuse medicals. There are two distinct pathways which are determined by age of the child, although this can be discretionary if there are determinants such as learning disabilities, which may influence the care provided. Where uncertainty exists on which pathway should be followed then this should be discussed with the Sexual Assault Referral Centre (SARC). Both pathways follow the Kent and Medway safeguarding children procedures.

2. Indicators where a child sexual abuse (CSA) medical should be considered

- Allegation of sexual assault (a child may disclose to anyone and at any time. A clear allegation is not often made at an early stage in the process as the abuser may groom and/or threaten the child. If the child alleges acute sexual assault, urgent action is required. One reason that a child may not make an allegation is that they may be very young or pre-verbal).
- Where a responsible adult has legitimate concerns about CSA
- Pregnancy in a child less than sixteen years
- A sexually transmitted infection (STI)
- Genital warts
- CSA and child sexual exploitation should be considered when a young person aged 13-17-years is sexually active and/or pregnant.
- Anogenital injury with an absent or unsuitable explanation
- Unexplained vaginal bleeding e.g. acute bleeding in the absence of accidental trauma or medical explanation.
- Unexplained rectal bleeding
- Vaginal discharge/vulvovaginitis is more commonly reported in victims of CSA. However, vaginal discharge is common in girls. Signs that are recurrent or resistant to treatment are more concerning. Where a child presents repeatedly with vaginal discharge, a careful history and a full examination must be conducted by a clinician with skills in assessment for CSA to exclude the possibility of CSA. STI screening is indicated where there is visible vaginal discharge, particularly if this is recurrent.
- The insertion of a foreign body into the anus or vagina as a method of CSA is not often seen and is often due to other causes. However, CSA should be considered when a foreign body is found in the vagina or anus.
- Soiling/bowel disturbance/enuresis: constipation, soiling and enuresis are common paediatric problems. Uncommonly they may have a physical cause and more often have a development/behavioural cause. CSA should be considered within the different diagnosis.
- Behavioural presentation: children can express their distress following sexual abuse in a wide variety of ways including self-harm, aggression, anxiety, poor school performance and sexualised behaviour, as well as psychosomatic symptoms such as recurrent abdominal pain, enuresis or headaches. Children may be referred with masturbation – it is normal for children to masturbate; however, this may be considered worrying if ‘excessive’. Masturbation is usually defined as excessive if in public or interfering with life. Any major change in a child’s behaviour should prompt a search for the cause and abuse should be considered if there is no obvious explanation.
- Social indicators: CSA should be considered in any child living with an adult who poses a risk to children or is in contact with a sexual offender.
- Where the perpetrator is a child, they should be considered as a victim in their own right and referred for a separate child protection investigation.

- Where there is evidence of physical abuse, emotional abuse, or neglect, CSA should be considered.

However, not all children will require a CSA medical examination. Some young people, for example, may engage in regular voluntary sexual activity. Others may have an isolated behaviour problem such as an eating disorder, substance misuse, missing episodes etc.

Professionals must consider all physical findings together with other important clinical information, including the history, context, the child or young person's demeanour and hearing what the child is saying through their words or behaviour, in order to make a diagnosis.

(Adapted from the Royal College of Paediatrics and Child Heath 'Physical sign of child sexual abuse – an evidence-based review and guidance for best practice 2015').

3. Accidental injuries

Accidental injuries present with a variety of clinical findings and occur in children of all ages and genders. It is likely that most children with accidental injuries will be seen initially by clinicians in primary care or the emergency department. The importance lies in distinguishing accidental injury from injury due to sexual abuse. All injuries requiring medical treatment should be managed and if sexual abuse is suspected then the child sexual abuse pathway must be followed.

4. Is the child in need of urgent medical attention?

If a child is in need of urgent medical attention e.g. acute bleeding, they should be taken to the nearest hospitals Accident and Emergency Department (A&E) for stabilisation. Once the child's condition is stable and A&E staff/hospital paediatricians are concerned about possible child sexual abuse (CSA) they should refer to the flowchart for managing CSA (appendix 1).

5. Female genital mutilation (FGM)

Professionals who suspect female genital mutilation (FGM) or identify children who have had FGM should refer to the Kent and Medway Multi-Agency Female Genital Mutilation (FGM) Operational Guidelines[1], to ensure they meet their statutory duty to report and safeguarding children.

Mandatory reporting duty

[1] https://www.kscmp.org.uk/procedures/kent-and-medway-safeguarding-procedures

The Serious Crime Act 2015[2] inserted a duty into the Female Genital Mutilation Act 2003[3] which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18-year-olds which they identify in the course of their professional work to the police.

'Known' cases are those where either a child informs the person that an act of FGM, however described, has been carried out on them, or where the person observes physical signs on a child appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section one of the Female Genital Mutilation Act 2003[4].

6. What to do if you have concerns?

Where a professional identifies any indicators outlined above, advice should be sought initially from the Kent and Medway Sexual Assault Referral Centre (SARC)[5].

- 01622 72 64 61 (weekdays, 9am to 5pm)
- 0800 133 7432 (out of hours)

The SARC offers care and support to men, women and children who have experienced rape or sexual assault.

Following consultation with the SARC; if advised or if the professional remains concerned then a request for support/referral should be made following the Kent and Medway safeguarding children procedures to:

- Kent Integrated Children's Services (Front Door): **https://www.kscmp.org.uk/guidance/worried-about-a-child**
- Medway Council Children's Social Care: **https://www.medwayscp.org.uk/mscb/info/5/mscb-1/34/worried-child**
- Kent and Medway Out of Hours Team: 03000 41 91 91

Remember to use your organisations secure email when sending confidential information.

If the indicators of sexual abuse are clear and a direct request for support/referral to the local authority children's social care services has been made, make sure SARC are invited to the strategy discussion.

For looked after children you must follow this pathway and liaise with the allocated social worker.

7. What happens after a request for support/referral is made?

[2] Serious Crime Act 2015 (legislation.gov.uk)
[3] Female Genital Mutilation Act 2003 (legislation.gov.uk)
[4] Female Genital Mutilation Act 2003 (legislation.gov.uk)
[5] http://www.beechhousesarc.org/

Once a request for support/referral has been received a professional discussion (always led by Kent Integrated Children's Service / Medway Council Children's Social Care) or a Strategy Discussion will take place. This should always include input from the Sexual Assault Referral Centre (SARC), and for a looked after child, their allocated social worker should be included. The discussion will include a risk assessment of sexual health needs and emotional wellbeing.

The SARC will contact a suitably qualified/trained forensic professional/paediatrician to ensure that appropriate health representation is part of the strategy or professional discussion.

There are two possible outcomes of the strategy discussion:

- No further action required from a SARC medical perspective. However, should the child require a paediatric medical then this should be arranged according to local health arrangements.
- A child sexual abuse (CSA) examination. Appointment booked with SARC for the child to attend a comprehensive examination that will consider the child's physical health and growth, developmental and mental health, and forensic examination where indicated.

Who carries out the CSA examination?

Competencies listed in the documents below define who may carry out this examination:

- The Faculty of Forensic and Legal Medicine (FFLM) recommendations for the collection of forensic specimens from complaints and suspects.

- Royal College of Paediatrics and Child Health (RCPCH) and Faculty of Forensic and Legal Medicine (FLLM) service specification for the clinical evaluation of children and young people who may have been sexually abuse (2015).

- RCPCH physical signs of child sexual abuse 2015 (purple book)

All examinations will follow the SARC operational procedures[6].

Arranging a CSA examination

- The CSA examination depends on the age of the child, whether the abuse is acute, non-urgent and the need for forensic samples.
- Examinations should be carried out within the timescales defined by the FFLM guidance. In the case of recent abuse (within the last 72 hours) forensic skills and samples are mandatory and therefore require timely discussions with the SARC. The examination should be carried out within 72 hours. An acute examination includes examinations within a week of the event, to document injuries. All non-urgent cases should be seen within 2 weeks of referral.

[6] Operational-procedures-and-equipment-for-clinical-facilities-in-SARCs-FFLM-Nov-19.pdf

- Appointments to be agreed with the SARC and the referring agency. Examination will ideally take place in the daytime during the week, but urgent cases may need to be transferred to the London Havens out of hours (including bank holidays and weekends). If the child is in need of urgent medical care, they should be taken to the local hospital Accident and Emergency Department (A&E). The SARC will need to arrange in-reach into the hospital for forensic samples or arrange by appointment at the SARC at a later date.
- As best practice dictates it is expected that a police officer or social worker should accompany the child to the CSA examination where practicable. If forensic samples are expected in the case of recent abuse, a police officer should be present for the chain of evidence.
- Examining professional(s) to brief police officer or social worker about the outcome.
- Examining professional(s) to send report to the social worker. GP, named doctor for safeguarding/child's paediatrician and the police where there is an open investigation. A copy is to be kept in the patients file/electronic record.
- Children and young people will be referred to their local sexual health services as required.
- Children and young people will be supported emotionally by a specialist counselling service, and referrals to mental health services will be made when required.

Please note: Covid-19 screening questions will now asked.

In case of professional disagreement between Health/Social Care/Police

In cases of professional disagreement, concerns should be escalated by following your organisations escalation pathway/policy and/or the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) Escalation and Professional Challenge Policy[7] or the Medway Safeguarding Children Partnership (MSCP) Escalation Policy[8].

8. References

- The Faculty of Forensic and Legal Medicine (FFLM) recommendations for the collection of forensic specimens from complaints and suspects.

- Royal College of Paediatrics and Child Health (RCPCH) and Faculty of Forensic and Legal Medicine (FLLM) service specification for the clinical evaluation of children and young people who may have been sexually abuse (2015).

- RCPCH physical signs of child sexual abuse 2015 (purple book)

[7] https://www.kscmp.org.uk/procedures/kent-and-medway-safeguarding-procedures
[8] https://www.medwayscp.org.uk/mscb/info/5/mscb-1/30/resolving-professional-differences-escalation-policy

- National Service Guidelines for Developing Sexual Assault Referral Centres (SARCs) 2005

- RCPCH resources

- HM Government - Multi-agency statutory guidance on Female Genital Mutilation (publishing.service.gov.uk)

Appendix 1: Flowchart for child sexual abuse examinations