**Policy for Management of Child Cases**

**Thames Valley Sexual Assault Service**

|  |  |
| --- | --- |
| Author(s): | Dr Sheila Paul, Clinical Director and Lead for Children, Thames Valley Sexual Assault Service |
| In consultation with: | Thames Valley Paediatricians |
| 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 and RCPCH, and  Recommendations for Collection of Forensic Specimens from complainants and suspects FFLM January 2019 |
| Reviewed by: | Governance Committee – Thames Valley Sexual Assault Service and Thames Valley Paediatricians |
| Finalised | Dr Sheila Paul |
| Issue date: | March 2019 |
| Date approved: | March 2019 |
| Review date: | March 2020 |

**1.** **Introduction**

This Local Operational Policy outlines the processes to be followed for children up to aged 18 years who may have been sexually abused/assaulted/exploited.

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 and RCPCH, The Physical Signs of Child Sexual Abuse RCPCH and FFLM May 2015 2nd edition, all current FFLM relevant Guidance documents.

**The policy**

* Defines services available at the Solace Centres and by the Thames Valley Sexual Assault Service for children and young people (YP) up to aged 18.
* 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.

1. **SERVICES**

The Sexual Assault Service accepts referrals of children and young people (0-17) who have suffered an acute sexual assault, and there is also provision for examination of historic (delayed reporting) cases via appointment. 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 at the Solace Centre:

* Choices for self-referrals depending on the age of the child and in keeping within Child Protection Responsibilities.
* Initial needs assessment.
* Holistic medical examination of acute and historic (delayed reporting) cases of child sexual assault/abuse/exploitation.
* Emergency contraception.
* Initiation of, or referral on, for Post-Exposure Prophylaxis to prevent HIV and Hepatitis B, to the Infectious Diseases consultant or GUM clinic. See flow charts in the medical records.
* Screening of all child historic and all prepubertal acute cases for STIs.
* Referral on to the STI clinic for acute children aged 13 and above, if appropriate, by letter given to the patient/carer.
* 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 or elsewhere as appropriate.
* Referral for psychological support for the primary carer, if appropriate.
* Advice to Police, Social Care and other healthcare professionals.
* Contact by comprehensive letter with the general practitioner with a copy of the letter to the Designated/Named Paediatrician in the area the child lives, *for information only* in all cases up to aged 18 years. This must be copied to the Officer in the Case and Social Worker. If necessary send the copy to the Officer in the Case and ask they forward it to Social Care.
* The Crisis Support Worker (CSW) notifies the school nurse of the patient’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, within 10 working days.
* Giving evidence in all types of court, if required.

1. **The examination**

**3.1 Criteria for Single Doctor or Joint medical examinations (Solace Centre Forensic Physician (FP) and Community / Acute Paediatrician)**

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 take care of the holistic needs of the child in order to attempt to minimise the physical and psychological sequelae of the alleged assault(s).
* 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 of suspected acute sexual assault**

* Children and young people are seen at the Solace Centres where there is a reasonable possibility of obtaining DNA and other forensic evidence.
* 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 also take many other forms, for example emotional reaction, behavioural changes, infections, urinary and bowel problems, withdrawal, self harm, suicide attempts, substance misuse including alcohol, school avoidance, sexually transmitted infection, pregnancy in a child etc.
* 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*.*
* 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**.
* Psychological well being and mental health needs are very carefully assessed.

**3.4 Pre-pubertal children under 13 years**

Are seen as emergencies the day 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.

**Please note that studies show that despite forensic time scales/persistence data, the vast majority of DNA evidence is lost after 13 hours therefore delay is never appropriate.**

**3.5 Young people aged 13-17**

Are seen as an emergency the day/night they present if less than 7 days 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 any other forensic evidence. See Service Specification September 2015 FFLM and RCPCH.

**3.6 Guidance, advice, help**

Refer to persistence data, but not relying on these alone, and take advice from an experienced 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, depending on their geographical area of residence, will be either in the paediatric department of the local hospital or in the SARC - see Appendices. With regard to night-time examinations please also refer to the FFLM Guidance 31.5.13 and discuss with an experienced doctor. These MUST be conducted at night if considered necessary.

Part of the decision must include the risk of needing emergency contraception and prophylaxis for HIV/hepatitis B, as well as general medical needs, including mental health, and forensic evidence collection.

**The Duty Forensic Physician may always discuss the case with the Clinical Director (CD) for the Sexual Assault Service.**

**3.7 Suspected historic (delayed reporting) cases**

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

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

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

Call taken by the Crisis Support Worker (CSW) is documented on proformas; the CSW contacts the FP with the details who will, depending on the case, contact the relevant Paediatrician or CD 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 CD**. 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 health. This can be done by telephone if necessary**.

**4.2 Non–Police Referrals**

Call is taken by the Solace CSW who completes the initial assessment proforma, discusses choices, and liaises with the duty FP with the details who will, depending on the case, contact the relevant Paediatrician or CD of the Sexual Assault Service.

**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.
* Full address.
* Brief account of allegation, including time elapsed since alleged assault.
* Child’s reason for telephone call.

.

CSW should aim to keep the child engaged and on the line, whilst using other lines to contact relevant parties.

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

.

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

**5.1 Role of the Crisis Support Worker**

The CSW should meet and greet the child or young person and accompanying people, and show them to the waiting area. For all paediatric cases that attend for a forensic medical examination the CSW also informs the Social Care department in the geographical area the child comes from, and the school/nursery nurse or safeguarding lead, if they are attending school, or nursery, giving demographic details only.

**5.2 Pre examination**

Most cases will be examined by one doctor, the duty FP or CD, in the Solace centre.

When two doctors are needed, usually the FP and paediatrician, the examination will be conducted in the hospital the paediatrician is on call for. They should discuss the management of the case and agree their roles depending upon their level of experience and the child or young person’s wishes when s/he is seen. The FP is 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. It must be written. A competent child of any age can give consent alone for the medical examination. This must be carefully assessed and must include a telephone discussion with the CD.

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

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

In certain cases (i.e. 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.

**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 well being 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 in order to safeguard and protect a child/young person, and/or protect the public interest
* Without consent under the Mental Health Act 1982.

See GMC Guidance for further detail.

Whatever the circumstances, the primary duty and responsibility of the professional 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 ‘needs to know’ basis.

**5.6**  **The examination**

This will be conducted with a suitable chaperone present, if possible respecting the choice of the child. 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.

1. **After care**

**6.1 STIs and emergency contraception.**

The FP and/or paediatrician, depending on who is examining, should consider the need for, and explain, emergency contraception, and provide it.

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, STI clinic or Infectious Diseases consultant as required.

**6.2 Young people between 13 and 17 years 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.

**6.3** **STI screening for prepubertal children**

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

**6.4** **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 for the child.

**6.5** **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. **Medical notes**

**7.1** The FP should complete the Paediatric/Adolescent Summary and leave this at the Solace Centre, unless historic cases, when the notes will stay with the examining doctor for follow up. *The doctor should be registered with the ICO.* This should clearly outline:

* 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 acute 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 well being needs. Trust House Reading are available in the whole TV area for trauma therapy for children aged 4 years plus, all carers and adults. Horizons are available for trauma Therapy for children aged 4 years plus in Oxfordshire.
* A comprehensive letter must be written in all cases up to the age of 18 years 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 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 school nurse 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.

.

**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.**
   1. This is becoming more common, due to raising of awareness and may require special action. Please follow the latest guidance.

<https://www.gov.uk/government/news/new-measures-to-end-fgm-on-international-day-of-zero-tolerance>

**Suspected FGM Guidance for Thames Valley, October 2016**

**9.2 Background**

Since October 2015 it has been mandatory 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. This is an individual responsibility. People who will be in this position include child-minders, nursery workers, teachers, 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.

**9.3 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.

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. 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 hours a day. 0800 028 3550.

**9.4 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 through and done by a doctor without the necessary skills unless there are acute medical needs.
* It is better to wait for a few days in order 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 at all possible the examination must be done with the primary carer present to reassure the child.
* The examinations are always age appropriate and therefore not abusive.
* Every effort is made to conduct the examinations in an unrushed, child friendly environment. This environment is available in both Sexual Assault Referral Centres (SARCs).
* Who does the examinations depends on the geographical location of the child and absolutely reflects the policy for examining children who have been sexually assaulted/abused/exploited. See appendices.

**9.5 Planned examinations**

1. Milton Keynes. Planned examinations are done by Dr Paul or occasionally by another doctor who has the skills.
2. Buckinghamshire ditto
3. West Berkshire ditto
4. East Berkshire Dr Louise Watson, paediatrician, when Dr Louise Watson is away, Dr Paul
5. Oxfordshire done by Dr Clare Robertson/ Dr Maria Finnis and team.

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.

**9.6 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 no experience with FGM and is not appropriately skilled to make the assessment. Photo documentation is the solution, so the resultant images can be shown to the CD of the service 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 and the John Radcliffe.
* In the other hospitals it may be possible to use medical photography, if available and in hours, but under these circumstances still photographs are the only possibility. Moving images are much easier to interpret, as stills may mislead.
* All query FGM examinations done in the SARCs should be photo documented.
* Medical advice can be sought from the duty forensic physician, 0300 130 3036 and/or the Clinical Director of the Service, Dr Paul 07899870679.

1. **CHILD EXPLOITATION**

**Child exploitation** must be considered in **all cases** and any suspicions discussed with the OIC. Please refer to Spotting the Signs, a national proforma for identifying the risk of child exploitation in the health service, complied by Karen Rogstad and Georgia Johnston April 2014.

<http://www.bashh.org/documents/Spotting-the-signs-CSE-%20a%20national%20proforma%20April%202014%20online.pdf>

The CD 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. 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/CD. **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.**

Accidental trauma, the child should be taken to A and E.

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

**APPENDIX 1**

**THAMES VALLEY POLICE GUIDANCE**

This guidance document is in response to the requirement within Thames Valley Police for local procedures of Child Examinations for 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. Thames Valley Police staff is wholly committed to delivering a professional, responsive and caring service to children suspected of being sexually assaulted/abused/exploited, as are staff at the SARCs.

This guidance document applies to children aged 17 years and under.

**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 treatment 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.**

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

* There may be trauma/haemorrhage or other symptoms that requires urgent medical attention.
* 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 e.g. bruising, healed hymenal injuries, perianal scars. Forensic evidence may also include changes of behaviour; emotional problems; recurrent genital or urinary problems; school avoidance etc.**

**If the child has urgent medical needs contact the SARC duty FP via the Crisis Support Worker. If necessary the FP should liaise with the Clinical Director of the Sexual Assault Service and/or Safeguarding Paediatrician or duty Paediatrician, depending on the age of the child, history of assault, time and place of presentation of the case, skills of the FP. This will vary with geographical area - appendices.**

**If the child is seriously injured then the child will need to be taken to the local hospital A&E department without delay.**

**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**

**Child aged 0 - 12 years**

Contact should be made with the Solace Centre duty FP. If the FP is not appropriately trained to examine children under 13 years of age, and the examination is urgent, the duty FP will call the Consultant Paediatrician at Milton Keynes General Hospital / Stoke Mandeville / Wycombe Hospital and arrangements will be made to complete the examination together with the duty FP.

One of the examining doctors must have an understanding of which forensic samples need to be taken in accordance with FFLM recommendations.

**If the child is aged 13 years and above then the duty FP will conduct the examination.**

Children aged 13 years and above who have severe disabilities or who are pre-pubertal may be more appropriately examined by a doctor with the skills required for those aged 12 years and under.

**Non urgent** cases should be planned with Dr Sheila Paul at an agreed time.

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

**Telephone Numbers:**

Sexual Assault Service 0800 953 4113

Dr Sheila Paul 07899 870 679

Milton Keynes Hospital 01908 660033

Stoke Mandeville Hospital 01296 315000

Wycombe General Hospital 01494 526161

**APPENDIX 3**

**West Berkshire**

**Acute Cases**

**Child aged 0 - 12 years**

Contact should be made with the Solace Centre duty FP. If the FP is not appropriately trained to examine children less than 13 years of age arrangements should be made with Dr Sheila Paul when the examination can take place.

There is currently no Paediatrician to help conduct examinations within West Berks.

**If the child is 13 years of age or over then the duty FP will conduct the examination.**

Children aged 13 years and above who have severe disabilities or who are pre-pubertal may be more appropriately examined by a doctor with the skills required for those aged 12 years and under.

**Non urgent** cases should be planned with Dr Sheila Paul at an agreed time.

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

**Telephone Numbers:**

Sexual Assault Service 0800 953 4113

Dr Sheila Paul 07899 870 679

**Appendix 4**

**East Berkshire**

**Acute cases**

**Children under 13 years of age**

Children aged 12 years and under to be seen by the community paediatrician, usually Dr Louise Watson. Call the Child Development Centre, Fir Tree House, Upton Hospital to arrange. If Dr Watson is not available, or if out of hours, the child will be seen in the SARC. If the SARC duty FP does not have all the required skills then the duty consultant paediatrician at Wexham Park hospital can be asked to examine with the FP, in the hospital, tough no photo documentation is available.

Vulnerable children with complex medical histories and/or learning difficulties, who are 13 and over, should be treated in the same way as under13.

**Children aged 13 and older**

Will be seen in the SARC by the duty FP

**Historic cases**

Children aged 12 and under and vulnerable children will be seen by the community paediatrician, unless not available then by Dr Sheila Paul.

Children aged 13 and over will be seen by Dr Sheila Paul

**Telephone numbers**

**Sexual Assault Service 0800 953 4113**

**Child Development centre 0300 365 0123**

**Wexham Park Hospital 01753 633000**

**Dr Sheila Paul 07899 870 679**

**APPENDIX 5**

**Oxfordshire**

**During office hours Monday-Friday 0900-1700**

**Menarche means 1st menstrual period and does not equate to puberty.**

**Children under 13 years of age/older if pre menarche in girls.**

Contact the Community Paediatric Services at Oxford Children’s Hospital where a medical examination can be arranged.

All children up to 13 years / pre menarche should be seen by a Paediatrician and the FP may be requested to conduct a joint examination at the hospital.

**Children aged 13 years and older or younger if post menarchal (girls), will be referred to the duty Solace Centre FP to be examined at the Solace Centre.**

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.

**Out of Hours**

**Children up to 13 years of age or older if pre menarche (girls)**

* Contact the ACUTE ON CALL PAEDIATRIC REGISTRAR at the Oxford Children’s Hospital located at the John Radcliffe Site bleep 1392 or the Horton Hospital, Banbury.
* The Registrar will discuss the case with the Duty Consultant Paediatrician and refer to the CSA protocols on the intranet.
* They will discuss with the FP and if appropriate arrange a joint examination with the duty FP, at the hospital. The Paediatrician will carry out the Paediatric examination whilst the FP will collect the forensic samples.
* Following this examination arrangement can be made by the Consultant Paediatrician, at the earliest opportunity, for photo documentation to be undertaken in the community paediatric department during Office hours, if felt to be necessary, and the case to be reviewed.

**Children aged 13 years and above or younger if post menarchal (girls)**

If the child has injuries or bleeding from the anus/genital area, take them to

Children’s Emergency Department at the Oxford Children’s Hospital / Horton

General Hospital Banbury to be managed by the on-call Paediatrician and the

duty FP on the Sexual Assault Service rota.

* If there are no apparent acute medical needs the child should be examined by the duty FP on the Sexual Assault Service rota.
* Children in this age range who have severe disabilities or who are pre-pubertal maybe more appropriately examined by a Paediatrician.

**In all cases any acute medical concerns or onward referral to paediatrics for further input e.g. post exposure prophylaxis must be made by telephone to the on-call paediatric registrar at the children’s hospital, Oxford bleep 1392 (out of hours) or community paediatrician (office hours) and followed up by a letter, done at the time and either faxed or given to the child/carer to be hand delivered. If the referral is regarding HIV prophylaxis only, contact Paediatric Infectious Diseases consultant via switchboard.**

**Non-urgent** cases aged 12 and under, and pre menarchal (girls) should be planned with Community Paediatrics at an agreed convenient time. Non-urgent cases aged 13 and above will be examined by Dr Sheila Paul.

**Telephone numbers**

Children’s Hospital John Radcliffe switchboard 01865 741166

Acute paediatric registrar on call ask for bleep 1392

Horton Hospital Banbury 01295 275500

Ask for paediatric registrar/consultant on call

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

Dr Clare Robertson, Consultant Paediatrician, Designated Doctor for Safeguarding

01865 231994

Dr Sarah Haden, Consultant Paediatrician 01865 231994

Dr Maria Finnis, Consultant Paediatrician 01865 231 994

Sexual Assault Service 0800 953 4113

Dr Sheila Paul 07899870679

Medical staff, police, and social workers may refer all children from Oxfordshire for posttraumatic support/guidance to Horizons.

CAMHS Horizon Service, Des Roches Square, Unit 5, Witan Way, Witney Oxfordshire OX 28 4BE

**Return completed form to:** [oxfordhealth.horizon@nhs.net](mailto:oxfordhealth.horizon@nhs.net)