

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

Thames Valley

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Definitions

The definition of children is an individual up to their 18th birthday.

Acute cases are recent. There are urgent forensic and medical needs. In 2015 the definition of acute in children has been extended to 21 days. ref. Service Specifications, see page 1

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

RCPCH-Royal College of Paediatrics and Child Health

FFLM-Faculty of Forensic and Legal Medicine

AAP-American Academy of Paediatrics

1. Introduction

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

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

The Policy uses guidance from Every Child Matters, Working Together to Safeguard Children, the Children's National Services Framework (NSF) the Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused 2nd edition, September 2015, FFLM and RCPCH, The Physical Signs of Child Sexual Abuse RCPCH, FFLM, AAP May 2015 2nd edition, current FFLM relevant guidance documents and quality standard documents.

The policy

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

For the use by

Professionals involved in safeguarding children.

Police, Social Care, Forensic Physicians, Paediatricians, General Practitioners, Health Visitors, all Safeguarding and medical services.

2. SERVICE

The Sexual Assault Service accepts referrals of children and young people who may have suffered an acute sexual assault, sexual exploitation, and sexual abuse and of historic (delayed reporting) cases. 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.
- Screening of all historic cases, regardless of the age; all acute cases aged 12 and under, and all vulnerable young people acute cases for sexually transmitted infections (STIs).
- During Covid due to the reduced service in STI clinics children of all ages may be brought back to the service for STI screening to ensure they get the triple site testing as required.
- 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, Horizons for Oxfordshire children, Safe or elsewhere as appropriate.
- Referral for psychological support for the primary carer, if appropriate.
- Advice to Police, Social Care and other healthcare professionals at the time of the medical examination.
- Child Protection report sent to the general practitioner with a copy to the Designated/Named Paediatrician in the area the child lives, *for information only* in all cases, copy to the Police Officer in the Case and Social Worker.
- 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 with interpretation of findings.
- Giving evidence in all types of court, if required.

3. The examination

3.1 Criteria for Single Doctor or Joint medical examinations.

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

3.2 Reason to examine

- A forensic medical examination is necessary to secure forensic evidence, to help the police investigate the case. Forensic evidence is **not only swabs**-see below.
- To give an interpretation of findings to the police and social care in order to properly Safeguard the child, at the time of the examination and in the Child Protection report.
- To take care of the holistic needs of the child in order to attempt to minimise the potential physical and psychological sequelae of the alleged assault(s).
- 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 as an emergency at the Solace Centres where there is a reasonable possibility of obtaining DNA and other forensic evidence, such as injuries.
- The determining factors for DNA evidence are the time that has elapsed since the alleged abuse, the type of alleged assault/abuse and the pubertal status of the child.
- It must be noted that children often do not make a full allegation initially, therefore the default is to examine as soon as possible, regardless of the type of allegation and **even without an allegation**, when there is a suspicion of sexual crime.
- It is important to remember that forensic evidence may take the form of injury; acute, healing and healed therefore the timing of examinations must take this fact into account.

- **For this reason acute case must be considered to be up to 21 days post alleged event.** *ref Service Specifications for the Clinical Evaluation of Children and Young People who may have been sexually abused from the RCPCH FFLM 2nd edition September 2015*
- Forensic evidence, including in historic cases, may take many other forms, for example emotional reaction, behavioural changes, infections, urinary and bowel problems, withdrawal, self harm, 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/night they present, if less than 72 hours following acute sexual assault for collection of DNA evidence and as soon as possible for documentation of other forensic evidence, such as injuries. These time frames are not absolute and each case must be considered on an individual basis. They should always be seen regardless of time since alleged assault for their holistic care and documentation of other forensic evidence. See Service Specification September 2015 FFLM and RCPCH. **It is important that all parties are aware that the effectiveness of emergency contraception and HIV and Hep. B PEP declines hour by hour. Therefore a delay in examination and assessment of this need is unacceptable.**

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

Delay is never appropriate.

3.5 Young people aged 13-their 18th birthday

- Are seen as an emergency the day/night they present if less than 7 days following acute sexual assault for collection of DNA evidence and as soon as possible for documentation of other forensic evidence, such as injuries. These time frames are not absolute and each case must be considered on an individual basis. They should always be seen regardless of time since alleged assault for their holistic care and

documentation of any other forensic evidence. See Service Specification September 2015 FFLM and RCPCH. **It is important that all parties are aware that the effectiveness of emergency contraception and HIV and Hep. B PEP declines hour by hour. Therefore a delay in examination and assessment of this need is unacceptable.**

3.6 Guidance, advice, help

Refer to persistence data/forensic time scales, not relying on these alone, and take advice from an experienced forensic doctor when making the decision as to timing of medicals. All children should have a full Forensic Medical Examination (ref Guidance on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse, FFLM and RCPCH) which, depending on their geographical area of residence, will be either in the paediatric department of the local hospital or in one of the Sexual Assault Referral Centres (SARCs) - see Appendices. **With regard to night-time examinations please also refer to the FFLM Guidance and discuss with an experienced forensic doctor. Examinations MUST be conducted at night if considered necessary.**

The decision must include the need for 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 call the Clinical Lead of the Sexual Assault Service at any time to discuss the case.

3.7 Historic (delayed reporting) cases

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

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

4. ACCEPTING CASES

4.1 Police Referrals

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

after the medical examination. **Any strategy meetings MUST include the appropriate doctor from health, either FP or Paediatrician..**

4.2 Non–Police Referrals

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

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.
- Reason for telephone call.

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

5. CONDUCTING THE FORENSIC EXAMINATION IN A PAEDIATRIC CASE

5.1 Role of the Crisis Support Worker

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

5.2 Pre examination

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

When two doctors are needed, usually the FP and paediatrician, the venue of examination will be discussed and the SARC used for all acute cases if at all possible. The doctors 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 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 1983.
See GMC Guidance for further detail.

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

6. After care

6.1 STIs and emergency contraception.

Emergency contraception is provided if appropriate.

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

6.2 Young people between 13 and their 18th birthday are followed up at the local STI sexual health clinic.

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

6.3 STI screening for prepubertal children and vulnerable older children

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

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)

7. Medical notes

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

- 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, and carers. Horizons are available for trauma Therapy for children aged 4 years plus in Oxfordshire.
- A comprehensive Child Protection report must be written in all cases and sent to the general practitioner without delay, copied to the Safeguarding Paediatrician in the area the child lives, *for information only*, copied to the Police Officer in the Case and Social Worker. If necessary the Officer in the Case (OIC) will forward the Social Worker's copy to them.
- The 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.
- Robust follow up must be arranged if the child is started on HIV PEP and hepatitis B immunisation.

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.

8. Female genital mutilation.

8.1 Background

Since October 2015 it has been mandatory and an individual responsibility to report suspected or known cases of FGM, in a child, or where there is a

suspicion that a child is to be taken for this procedure either in the UK or abroad. People who will be in this position include child-minders, nursery workers, teachers, and health professionals. This list is not exhaustive.

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

8.2 Action

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

Call the police on 101 to report.

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

Call the police on 999.

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

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

8.3 Medical assessment.

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

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

- These assessments must not be rushed and 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.
- Every effort is made to conduct the examinations in an unrushed, child friendly environment. This environment is available in both SARCs.
- Who does the examinations depends on the geographical location of the child and absolutely reflects the policy for examining children who have been sexually assaulted/abused/exploited. See appendices.

8.4 Planned examinations

- a) Milton Keynes. Planned examinations are done by Dr Paul or occasionally by another doctor who has the skills.
- b) Buckinghamshire ditto
- c) West Berkshire ditto
- d) East Berkshire Dr Louise Watson, paediatrician, when Dr Louise Watson is away, Dr Paul
- e) Oxfordshire done by Dr Sarah Haden, Maria Finnis and with support from Dr Brenda Kelly consultant obstetrician.

Medical needs always take priority over forensic needs and are to be dealt with by the appropriate person, who may be the general practitioner or may be the duty paediatrician, depending on what the needs are.

8.5 Emergency examinations.

- At times a joint examination with the duty acute paediatrician and the duty forensic physician may be needed, if there are medical needs requiring hospital care.
- It is possible that neither doctor has experience with FGM and neither are appropriately skilled to make the assessment. Photo documentation is the solution, so the resultant images can be shown to

the Clinical Lead of the service or another specialist for help with interpretation.

- For hospital examinations photo documentation may not be possible, as the Thames Valley Sexual Assault service do not have a portable colposcope.
- In some hospitals, in hours, there is a colposcope that can be used for these examinations - Upton in East Berkshire and the John Radcliffe in Oxfordshire.
- In the other hospitals it may be possible to use medical photography, if available, but under these circumstances still photographs are the only possibility. Moving images are much easier to interpret, as stills may mislead.
- All FGM examinations done in the SARC's should be photo documented.
- Medical advice can be sought from the duty forensic physician, 0800 970 9953 and/or the Clinical Director of the Service, Dr Paul 0800 970 9953/ 07899870679.

9. CHILD EXPLOITATION

Child exploitation must be considered in **all cases** and any suspicions discussed with the officer in the case. Please refer to Spotting the Signs, a national proforma for identifying the risk of child exploitation in the health service, compiled 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 Clinical Lead is available for telephone advice.

10. 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/Clinical Lead.
Remember, children often do not make an allegation, despite the existence of sexual abuse, for numerous reasons. Therefore lack of allegation does not necessarily negate sexual abuse.

Accidental trauma, the child should be taken to the Emergency Department.

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 are 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.

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 genital injuries, perianal scars. Forensic evidence may also include changes of behaviour; emotional problems; recurrent genital or urinary problems; school avoidance etc.

If the child is seriously injured then the child will need to be taken to the local hospital ED 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

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

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

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

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

Telephone Numbers:

Sexual Assault Service call centre 0800 970 9953; 0800 953 4113

Dr Sheila Paul 07899 870 679

APPENDIX 3

West Berkshire

Acute Cases

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

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

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

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

Telephone Numbers:

Sexual Assault Service 0800 970 9953 ; 0800 953 4113

Dr Sheila Paul 07899 870 679

Appendix 4

East Berkshire

Acute cases

Children under 13 years of age

In hours, children aged 12 years and under may be seen by the community paediatricians, if an appropriately trained paediatrician is available. The forensic physician on call may be needed to join the paediatrician. Call the Child Development Centre, Fir Tree House, Upton Hospital to arrange.

If no community paediatrician is available the child will be seen in the SARC.

Out of hours, the child will be seen in the SARC.

Children aged 13 and older

Will be seen in the SARC by the duty forensic physician.

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

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

Historic cases

Children aged 12 and under and vulnerable children will be seen by the community paediatricians, by appointment in hours, if none available within the required time frame, which will vary depending on medical and safeguarding needs, by Dr Sheila Paul or another forensic physician in the SARC.

Children aged 13 and over will be seen by Dr Sheila Paul or another forensic physician in the SARC..

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

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

Telephone numbers

Sexual Assault Service 0800 970 9953 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; and all pre menarchal 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 and all pre menarchal 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. **Forensic integrity must be considered and a therefore SARC examination may be best practice..**
- 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 emailed securely 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 all pre menarchal (girls) should be planned with Community Paediatrics at an agreed convenient time. Non-urgent cases aged 13 and above and post menarchal girls 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 maria Finnis and Dr Harjinder Gill , consultant paediatricians and Designated doctors for Safeguarding

	01865 231994
Dr Sarah Haden, Consultant Paediatrician	01865 231994
Sexual Assault Service	0800 970 9953
	0800 953 4113
Dr Sheila Paul	07899870679

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

CAMHS Horizon Service

Return completed form to: oxfordhealth.horizon@nhs.net