sexual assault, child protection and safeguarding

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outline

• the scope of sexual abuse / assault
• overview of the Sexual Assault Referral Centres
• the forensic examination – what do we actually do?
• other thoughts / considerations
what is the actual scope of the problem?
(NSPCC (National Society for Prevention of Cruelty to Children) study by Radford et al 2011)

• 4.8% of 11-17 year olds in the UK have experienced contact sexual abuse
• 16.5% have experienced non contact sexual abuse
• females >> males
• 65.9% of contact sexual abuse reported by 0-17 year olds was perpetrated by assailants < 18 years of age
study also showed....

1/3 of 11-17 year olds who experienced contact sexual abuse by adult
&
4/5 of 11-17 year olds who experienced contact sexual abuse by a ‘peer’

TOLD NOBODY
almost 1 in 10

(9.4%)

11 -17 year olds experienced some form of sexual abuse in the past year

(including both contact & non-contact)
based on 2011 census, there are roughly 660,000 children between the ages 11-17 years living in London, which means

9.4% of 660,000

= 62,040

11-17 year olds have experienced some form of sexual abuse in the past year

that's 1,193 per week and 170 per day
how many forensic examinations do the Havens perform on < 18 year olds each year?

351  2011 – 2012
249  2012 – 2013

Pan-Havens
tens of thousands of children in London have not told anyone that they have experienced sexual abuse

they may also be at risk of further abuse
(and/or at risk of abusing others)
• the odds highly favour that health professionals working with children, will at some time in their career encounter children who have experienced sexual abuse.......
who’s at risk?

• high incidence of partner exploitation and violence in intimate teen relationships (Barter C et al, NSPCC, 2009)

• other at risk groups:
  ◦ substance misusers
  ◦ gang members
  ◦ learning disabled
  ◦ lesbian, gay, bisexual and transgender community
  ◦ trafficked individuals
  ◦ victims of honor-based violence
case history

• Sarah (16 yo) was brought in an ambulance to the Accident and Emergency Department after being found with a stab wound to her leg by some pedestrians- in A/E she said she had been raped by her boyfriend- but then refused to give further details....
assessment

• history
  – what do you need to know?
  – what other information would you like?
• physical assessment
what does she need from you?

› listen

› believe
  ◦ the vast majority of sexual assault allegations are true
  ◦ whether they are or not is for a court of law to decide, not you

› don’t judge

› be sensitive

› help
first account

• what do you need to know?
  – what happened?
  – when did it happen?
  – where did it happen?
  – who did it?

• clearly document: your name, where and when you took the account, what action you’ve taken
confidentiality?
case continued

- Sarah refused to give any information in regards to her assailant but would give information about the event.....
what else to consider.....

- consider immediate safety
- treatment of injuries (ie bleeding, broken bones)
- offer baseline screening for STIs
- baseline HIV test or serum save sample
- consider HIV post exposure prophylaxis within 72 hours
- hepatitis B vaccination (+/- immunoglobulin)
- prevention of pregnancy
- carry out self harm assessment
- be aware of any child protection issues
- etc
- etc
- etc
• early evidence kit (EEK)
• chain of evidence - The origin and history of any exhibit presented as evidence in a court of law must be clearly demonstrated to have followed an unbroken chain from its source to the court.
this is getting complicated....

• back to Sarah
sexual assault referral centres –what they do

- forensic examinations following acute sexual assault
  - obtain information
  - collect forensic evidence
  - document injuries
  - provide immediate medical aftercare
  - afterwards to arrange f/u care & liaise with other services (GPs, A & E, gynae, CAMHS, social services...)

  - police or self-referral (if 13+ & Gillick competent)

- when requested, statements for & attendance in court
Locard’s principle: every contact leaves a trace

Time frame for DNA evidence:
- < 7 days (vaginal rape - adolescent)
- < 3 days (anal rape)
- < 3 days (vaginal rape – pre-pubertal)
- < 48 hours (digital penetration)
...don’t forget
remember to think broadly when securing possible evidence
so what actually happens at a forensic medical examination?

- client speaks to support worker and they explain process
- history obtained from police or if self referral - from client
- discuss confidentiality and obtain consent
- obtain any forensically relevant information
- obtain DNA swab
- skin swabs
- injury documentation
- genital exam
- aftercare
what is included in physical examination

• top to toe examination to obtain forensic samples & document any injuries
  – in an as reassuring and friendly environment as possible
  – while avoiding contamination
• document findings on body maps & in notes
  – location & pattern of injuries
  – consider medical photography
• document ano-genital examination with colposcope – with consent

the most common finding is a normal examination
experience in genital examination UK

- GPs and paediatricians in the UK do NOT routinely examine the genital area of children & are actually discouraged from doing so.
- They often lack confidence in both examination & documentation of findings.

Based on what you know, what would you think if a doctor wrote this statement?

“there is no evidence of penetration”

More accurate to write “no visible acute injury” – and perhaps to note that this does NOT negate an allegation of sexual assault.
experience in genital examination

A survey of US physicians (paediatricians, family practitioners and A & E physicians) in 1996 found many were not able to correctly identify pre-pubertal female genital anatomy from a picture.*

% incorrectly who incorrectly identified each area:

- hymen 38%
- urethra 28%
- labia majora 21%
- labia minora 17%
- clitoris 6%

This study was repeated in a national survey of paediatric chief residents with largely similar results.
and we might do some colposcopy.....
speculum & proctoscope are NOT used in pre-pubertal children

in pre-pubertal children the ano-genital swabs are typically all external.
what happened with Sarah???

• she agreed to come to the Sexual Assaults Referral Centre, but wanted to come as a self referral........ without police involvement
• general principles are the same as for adults

• children under 16 may have capacity to consent for their own medical care depending on their maturity and ability to fully understand the nature of the examination / treatment for which consent is being asked

• if a child understands and can assess the advantages / disadvantages and essentially make a truly informed decision then he / she is “Gillick Competent”

• if Gillick competent, 13+ can attend Haven as ‘self-referral’
“Gillick Competent” refers to capacity of < 16 year old to make a decision.

“Fraser Guidelines” relate to steps clinicians take to decide if they can prescribe contraceptives to < 16 year olds.

See also handout from MPS available from http://www.medicalprotection.org/mps-consent-publication-children-young-people.pdf
• so Sarah came to the Haven as a self referral……
• she told her story but refused to name her assailant.
• she agreed to skin swabs but declined genital examination.
• she agreed to HIV serum save but declined post exposure prophylaxis
• she agreed to follow up care
• in her story Sarah revealed she had been in a relationship with her assailant for 3 years. He said he was '21' when they met- but she believed he was older. He had met her when she was 11 through a friend. He groomed her and eventually had her performing sexual acts on other men for money.

• Sarah refused to give his details but the concerns regarding her safety were such that she ended up in a residential care home.

• Sarah continued to show high risk behaviour and at a later follow up appointment was pregnant and needed referral for termination of pregnancy.
what happens in the aftermath...

- attempted suicide
- eating disorders
- depression/anxiety
- externalising behaviours
- risky sexual behaviours /
- other types of abuse / victimisation
important considerations

• psychological care for patient and family
  – Counselling
  – CAMHS referral
  – Cognitive therapy
  – Antidepressants
  – Treatment of post-traumatic stress disorder
if the case is a police case and goes to court important to consider......
Christian et al.

- minority of children had genital injuries

- 58% of children with sperm / semen identified had no evidence of acute genital injury

- likelihood identifying forensic evidence higher if injury or history of ejaculation

- several children forensic evidence found that was NOT anticipated by history given
healing of genital injuries
McCann et al 2007

113 pre- & 126 pubertal females examined
1 hour to 3 days post injury & re-examined

- petechiae 1 - 3 days
- abrasions 3 - 4 days
- bruising 2 – 18 days
- oedema by 5 days
- superficial lacerations to vestibule 2 days
- hymenal lacerations – by up to few weeks (partial or complete healing)
- deep lacerations perineum  by 20 days

most injuries healed fast and left no trace
% positive DNA by time elapsed since alleged assault  (from Giardet study)
why might there be no findings?

- the most common ‘finding’ is a normal examination
- some injuries heal very quickly (others may not yet have appeared)
- skill of examiner / cooperation of child with examination
- pubertal hymen is elastic (pregnancy with ‘intact hymen’)
- there may not have been an assault

while no injury ≠ no assault

injury ≠ assault
Useful references

• Langlois NE and Gresham, GA The ageing of bruises: a review and study of the colour changes with time Forensic Sci Int. 1991 Sep;50(2):227-38.
• Langlois NEI. The science behind the quest to determine the age of bruises – a review of the English Language Literature Forensic Sci Med Pathol 2007 3:241 -251
http://www.rcpch.ac.uk/sites/default/files/CSA%20Interim%20statement%20FINAL%20August%202011.pdf
Additional references

- American Academy of Pediatrics [www.aap.org](http://www.aap.org) slide series on child sexual abuse and physical abuse
- McCann et al articles on healing of hymenal and non-hymenal injuries
- Pediatric Atlas > Chapter 10. Surgery and Genitourinary - From AccessEmergencyMedicine website
- [http://www.forensicmed.co.uk/wounds/bitemarks/](http://www.forensicmed.co.uk/wounds/bitemarks/)
- Radford et al 2011 , Child abuse and neglect in the UK today
- 2011 census from ONS
- NSPCC
- Additional images from D Muram et al., internet and Haven presentations
Other references

• Chiva – Children’s HIV Association
  – Post-exposure prophylaxis (PEP) Guidelines for children and adolescents exposed to blood-borne viruses – reviewed March 2011
    http://www.chiva.org.uk/professionals/health/guidelines/pep/young-pep-ref.html

• UK guideline for the use of post-exposure prophylaxis for HIV following sexual exposure (2011)

• United Kingdom National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People – 2010