

CHILD SEXUAL ABUSE

SOME PRINCIPLES OF GOOD PRACTICE

A. PREPARED BY THE INDEPENDENT SECOND OPINION PANEL: NORTHERN REGIONAL HEALTH AUTHORITY

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## 1. INTRODUCTION

Although sexual abuse is properly considered to be part of the spectrum of problems affecting the health, growth and development of children, its very nature calls for an especially careful and considered approach when it is suspected. On the basis of our extensive clinical and academic experience as paediatricians and child psychiatrists, we propound some principles of good practice. Our ideas have been amplified by our recent experience in providing clinical second opinions in Cleveland.

## 2. DEFINITION

Definitions of what constitutes child sexual abuse vary widely. A general definition would be that given by Schechter and Roberge (1) "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles." A tighter descriptive and pragmatic definition is provided by Mrazek and Mrazek (2) who suggest that sexual abuse can be envisaged as one of four types: exposure (viewing of sexual acts, pornography, and exhibitionism); molestation (fondling of genitals - child's or adult's); sexual intercourse (oral, vaginal or anal on a non-assaultative and chronic basis) and rape (acute assaultative forced intercourse).

## 3. THE MODE OF PRESENTATION

Studies of populations of children who have been sexually abused, as well as clinical experience, reveal that the results of sexual abuse of children and young people may be manifested in one of five main ways (3):

- a) An account by the child
- b) Disturbed behaviour or changes of behaviour
- c) Physical symptoms or signs
- d) Association with other forms of maltreatment
- e) Allegations by parents, relatives, or other adults

Within these broad categories there are different degrees of likelihood that a particular presentation is linked to child sexual abuse. At this stage in our knowledge, it is not possible to place specific symptoms and signs in an accurate rank order, and to be able thereby to ascribe degrees of association with child sexual abuse. We can, however, note that certain signs and symptoms are associated with child sexual abuse, whereas others are less clearly linked. For ease of reference, we present a preliminary grouping of presentation by degree of likelihood of child sexual abuse in Table 1.

Some presentations have an established association with

child sexual abuse (Association with CSA); others are more tentatively linked (Low or Possible Association). It is hoped that future longitudinal studies of samples of abused children will allow these associations to be clarified, taking into account such factors as age and sex differences, and variables relating to type and circumstances of abuse, as well as the victim's understanding and method of coping with the experiences.

Groups of abused children have been studied (4 - 8) and this work has enabled us to construct Table 1, albeit tentatively. Other work which is relevant includes the study of young people, who, when surveyed, say they were abused as children, (9,10). Additionally, there have been studies of children with specific signs and symptoms (e.g. prostitution (11) and self harming behaviour (12)), that have investigated how many of these children were sexually abused.

From this review of the literature it is noted that few presentations are likely to be conclusively diagnostic of child sexual abuse. Some cases may have multiple modes of presentation, e.g. behavioural and physical, as well as an account by the child. If such presentations are unequivocal, then the probability of a history of previous sexual abuse is likely to be high. At the other end of the spectrum, a presentation at the less severe pole will give rise only to a suspicion that sexual abuse has occurred.

The issue of the child's age has given rise to complex accounts in the literature, (13,14). There is conflicting evidence as to whether an older age of the child is associated with greater or lesser ill-effects. In addition, clinical reports have suggested that the symptoms displayed by the child are different at different ages and developmental stages (15). However, there has been variable support for the notion that severity of outcome is related to age (16).

In summary, it seems that children can respond with a wide variety of symptoms to the specific trauma of sexual abuse. Nevertheless, there are some symptoms which occur relatively frequently in populations of sexually abused children at different ages: for example, the child aged 6 years or under may display sexualised behaviour (8,16,17); in the child 7 - 12 years, anxiety related symptoms are seen, sometimes with sexual preoccupations (6,16), and in the teenager, acting out behaviour (10), self harming (12,13,18), drug and alcohol abuse (13,18) and prostitution (11) are all symptoms resulting from sexual abuse. However, although these behaviour patterns may be common in abused children: they are not specific: that is, only a minority of children

with such behaviours will have been abused.

From the physician's point of view it is worth noting that children may present as an emergency or in the course of routine clinical practice.

#### 4. THE BASIS FOR SUSPICION

Although some presentations are more indicative of child sexual abuse than others, few presentations are specific in and of themselves. Thus while professional suspicion may be justified, professional certainty must be based on appropriate investigation. Having noted the mode of presentation, therefore, basis of suspicion should be considered and the nature and extent of the ensuing assessment, if any, should be determined by this. Who has been suspicious, and for what reasons? What is the capacity for objectivity and what is the quality of the source of the information? Other crucial considerations include the presence of vested interest or pre-judgement of issues by any person, whether professional or layman in the sequence of events associated with a suspicion of sexual abuse. These considerations constitute an argument for a system of checks and balances. We emphasise that the basis of suspicion is a step which enables the professional to proceed to the next stage of evaluation but is not tantamount to diagnosis itself. Once the basis of suspicion has been adequately examined, the professional response must be geared to the individual circumstances.

#### 5. TAILORING THE ASSESSMENT

It is necessary to match the intrusiveness and extensiveness of the professional evaluation with the level of suspicion that exists in the individual case. As this is a complex and relatively new field, it would be inappropriate to attempt to offer a rigid prescription concerning the extensiveness of the evaluation. However, general guidelines can be given: for example, where there is a genuinely strong basis for suspicion, a full psychiatric and paediatric examination would be justified. In deciding the precise method of evaluation preferable in the individual case, the professional's own level of suspicion is an important factor. If the level of suspicion is set too high and the net is cast widely, then not only will a large number of genuine cases be picked up, but also a significant number of false positives. Thus, only in cases where the basis for suspicion has reasonable substance will psychological and paediatric assessment be indicated and justifiable. Conversely, in cases where there is a less strong basis, less intrusive psychological and physical investigations are called for. In such circumstances, it

may be considered appropriate for the child to be asked some screening questions by the paediatrician, and/or for the parent to be presented with the facts which include sexual abuse as one of the possibilities in a differential diagnosis. The response to such screening measures can then indicate whether further psychological evaluation and/or paediatric assessment should be considered.

To sum up, we recommend that the level of suspicion by the professional should be based on a judicious consideration of the mode of presentation, any prior history of sexual abuse, and the source of the information, as well as the screening assessment of the individual child. By this filtering process we consider that over-enthusiastic approaches with an excess of false positive cases can be avoided. Similarly, the other extreme, of professionals averting their gaze from suspicious evidence and thus giving rise to an excess of false negatives, can also be avoided. The presumption that abuse has taken place before the evidence is available has particularly damaging repercussions for the child and family. Equally, an abnormally low level of alertness to the possibility of child sexual abuse may deter children subsequently from trusting the adult world sufficiently to enable them to disclose their unfortunate secret.

#### 5. THE EVALUATION - GENERAL COMMENTS

- a) The parents should be given the same courtesy as the family of any other referred child. It is important for professionals to allow parents to talk about their problems and concerns freely, and within a helping or enabling context, and without a display of emotive overtones by the professionals. Furthermore, the existence of bias or pre-judgement on the part of the professionals may act as a considerable barrier to such a constructive context being developed in any particular case.
- b) All assessments should be carried out within a multi-disciplinary framework. The key professionals involved are likely to be social workers, paediatricians, child psychiatrists, psychologists and police. Other professional disciplines that may have knowledge of the family or can make a contribution should be involved; they include general practitioners, police surgeons, health visitors, community child health doctors, school nurses and education. A case conference will be convened by the Social Services Department to collate available information.
- c) Each Health District needs to devise a formula which

minimises the number of general and special physical examinations, as well as interviews, of children. For this to be achieved, examinations and assessments should be carried out only by suitably qualified experienced senior staff. Joint planning may be necessary to elicit information required by each assessor and to make it available to all relevant parties despite limited opportunities for personal interviews..

- d) As any short or long term sequelae are likely to be mainly in the form of psychological disturbance, child psychiatry and psychology services have a crucial role in the assessment and therapy of abused children: early consultation and/or referral to such services should therefore be considered.
- e) The child's and family's general practitioner should be contacted and involved at an early stage.

## 7. CONSENT TO CLINICAL ASSESSMENT

The usual arrangements apply when the examination is a standard physical, psychiatric and psychological assessment, and in that sense parental consent is implicit. This would include routine physical inspection and screening questions. In such circumstances, physical examination should not go beyond an external inspection of the ano-genital area. Consent for more detailed ano-genital assessment should be obtained when appropriate. The assent of the child should also be obtained. This also holds for any facilitative (enabling and encouraging) psychiatric and psychological approaches. Similarly, there should be consent and assent concerning the mode of recording (photography, one way mirrors, audio-taping, video-taping).

The question of written permission from parents needs to be considered carefully. It should always be obtained when:

- a) Disclosures or allegations have been made
- b) Further physical internal examinations have to be done under sedation or general anaesthesia.

When consent for examination is not forthcoming, it will be necessary to discuss appropriate action for the protection and assessment of the child with the social services/police. It should be noted that if a child is a Ward of Court, he/she should not be submitted to an examination or treatment without the permission of the court (except in an emergency). The publication of any reports or sharing of information relating to proceedings before the High Court is a contempt of court: no information can therefore be passed to anyone who is not a party to the proceedings, without the permission of the court.

8. TALKING TO PARENTS OR CARETAKERS

The findings should be communicated to the parents, the differential diagnosis discussed, and the need for further investigation explained. It is good practice to give parents detailed feedbacks. An accusatory stance by the physician is inappropriate.

9. DOCUMENTATION AND REPORTS

Detailed records should be made of all interviews and examinations.

There should be two reports - from medical and from social services - specifying the information available, the assessments undertaken, the conclusions, the alternative explanations and the reasons for the proposed course of action. They should also give an account of the corroborative evidence - medical, social, family and psychological.

Statements to the police should be prepared as promptly as possible, and concise reports made available for case conferences and/or Court hearings.

10. THE PHYSICAL EXAMINATION IN CHILD SEXUAL ABUSE

a) The clinical approach to the child and family should follow the established principles of good paediatric practice (19) and includes:

- a comprehensive history of health, growth, development, illness and behaviour.
- an appropriate family and social history
- a comprehensive physical examination including appropriate developmental assessment and investigations.

b) The environmental ambience A paediatric environment is desirable. The interviews and examinations should take place in quiet comfortable surroundings away from the general clinical bustle. Sufficient time should be allocated and as few people as possible should be present. The mother can often help with the examination, which can be done on her lap in the case of young children.

c) The physical assessment should always begin with a systematic general examination.

The forensic examination should be part of the physical examination; only one such examination should be done, and that by appropriately trained doctors.

A joint examination between a paediatrician or other children's doctor and an experienced police surgeon may be the most appropriate arrangement. In the event of a difference of opinion, which we hope would occur very seldom we would suggest that consideration be given to referral to a Regional Specialist Panel.

Repeated physical examinations are to be avoided unless there are overwhelming medical indications; the permission of the parents must be obtained for each examination. Doctors should bear in mind that it is not wise to rely exclusively on physical examination, except in the clearest cases.

In addition to the gathering of forensic evidence, screening for sexually transmitted diseases, AIDS, and pregnancy testing should be undertaken when appropriate. The appropriate handling of specimen material is essential.

- d) The sex of the examiner is not usually a critical factor with young children. Older pubertal children should be given a choice if this is practicable.
- e) Photography is desirable as a record in itself and because it may reduce the need for subsequent examinations. It should take place only at the time of the initial examination, preferably by the examiner and if not, by a photographer of the same sex as the child. It should be borne in mind that photography on separate or subsequent occasions constitutes further examinations of the child.

There is no substitute for accurate detailed accounts and diagrams of the physical appearances in the medical records, and an appropriate proforma can be very effective.

- f) Every effort should be made to minimise any traumatic consequences of the physical examination.
  - Children should be asked, whenever possible who they would prefer to be present, and should be helped to be at ease and comfortable
  - The examination should be deferred if there is any resistance
  - Minimal touching by the examiner is desirable
  - Junior medical staff should not examine suspected cases on admission or in casualty departments unless there is a life threatening problem. Preferably, the



consultant or deputy should be contacted.

- g) The differential diagnosis Alternative explanations should be considered. Abnormal physical signs are rarely unequivocally diagnostic, with the exception of the presence of semen, or blood of a different group to that of the child.

## 11. THE PSYCHIATRIC ASSESSMENT

### A. The Parents

An assessment of the family is essential, incorporating parental psychological problems, an explanation as to how the family functions, and the parents' parenting potential. Parents should be interviewed both jointly and individually.

### B. The Child

- a) The concept of the disclosure interview. The value of this concept is questionable, as traditionally it incorporates the preconception that non-disclosure is tantamount to denial. It also seems to preclude the possibility that sexual abuse has not occurred. Disclosure techniques include investigative play, the validity and utility of which may be hampered by suggestion, leading questions, and the possibility that the investigative procedure itself may be sexualising and abusive.
- b) Evaluative assessment is preferable to a disclosure interview. This should follow the same principles as a general psychiatric examination, particularly bearing in mind the following points.
1. It is desirable to see the child on his or her own as well as with other members of the family.
  2. Initially there should not be any leading or suggestive questions.
  3. Essentially an open ended questioning technique is used.
  4. In the first stage, general evidence of the following are sought; traumatisation, bonding problems, behaviour change, behavioural disturbance, social relational problems with peers or adults, unusual attitude, knowledge of sexuality in relation to family patterns, possibilities of fabrication.
  5. If there is a sufficiently well established basis for

suspicion, then the first stage may be followed by a facilitative second stage. Here great skill is required to avoid the extreme of being overtly leading during questioning or, on the other hand, being insufficiently enabling. The clinician also now faces a dilemma: on the one hand being aware that secrecy and an admonition not to tell are often an integral part of known cases of sexual abuse, and on the other hand recognising that at this stage there may only be a suspicion and no certainty of sexual abuse. Therefore to use leading questions may well confuse the issue both clinically as well as legally. Several methods of approach are available

- The use of different degrees of facilitation in questioning, the use of cues and prompts to memory including anatomically correct dolls. Permission-giving and enabling questions may be described as providing a mild to moderate degree of facilitation for the child. Objective questions which require a "yes" or "no" answer may be considered as providing a moderate degree of facilitation. At the other end of the scale, questions which ask "did this happen or that?" the "either", "or", question as well as the hypothetical question, for example "if daddy had touched you how would you have felt?" clearly represent a marked and unacceptable degree of facilitation. The extent to which facilitative questions may be considered to be leading, takes into account not only the question itself, but also the persistence of the interviewers, the sequence of questions (i.e. whether facilitative or interspersed with other more open-ended approaches, the sensitivity of the examiner to the child's pace, emotions or responses, or the over use of an authoritative or overbearing driven style on the part of the interviewer with "rewards" given for the "right" answer. All these factors may be considered to be pointers to the degree to which this facilitative second stage may be considered as leading.
- Anatomically correct dolls are often used in the assessment of suspected sexual abuse. They are used by trained professionals as well as, unfortunately, those who are not trained to use them. They should not be used without an understanding of child development, play, fantasising and psychopathology. They should certainly not be used as the first stage method of evaluation. They may be a useful adjunct to the facilitative second stage, but in our view there

are too many questions concerning the validity and reliability of anatomically correct dolls to recommend their use as a first stage diagnostic aid. They might be useful when a child has indicated sexual abuse at some level, but has then become stuck or wishes to describe a particular detail about sexual abuse and simply does not have the words and concepts, but might be able to show the evaluator. They can be useful with young, barely verbal children when other signs point to a strong likelihood of sexual abuse, e.g. physical findings.

- c) Investigative play interviews In general, extended investigative play interviews with the express purpose of attempting to get a child to disclose sexual abuse should be avoided. There may be a place for a small predetermined number of play-orientated interviews with a child with whom there is good reason to suspect sexual abuse, but even in this situation the interviewer must exercise particular care to avoid excessive or inappropriate facilitation. Clinical experience suggests that sometimes an approach in itself may become abusive. By contrast, a period of free play for the young child in the context of a facilitative second stage may be a useful component of an evaluative assessment.
- 6) Videotape technology Videotapes are now seen as medical records and as such are subject to conditions similar to those for any other records that may be produced in evidence. Thus, tapes have evidential qualities in addition to their clinical utility. For evidential purposes, detailed and careful recording of all interview material is essential and videotaping is one means of achieving this. Closed circuit television with video recording can reduce the overall number of interviews by allowing the professionals to view the session unobtrusively. However, there are disadvantages: the unavailability of reliable high quality equipment with reproducible sound; the possible interference with the relationship with the child or even the reduction of spontaneity of accounts.

## 12. CONCLUSIONS ABOUT SEXUAL ABUSE - INTERPRETATION OF FINDINGS

- a) Interpretation and explanations The information gathered must be interpreted; this requires experience and also knowledge of psychological aspects of child development, children's play and fantasy, the accuracy of memory of young children and older children, and the extent of their suggestibility and facilitation.

Alternative explanations of findings should be considered and a degree of open-mindedness must be maintained.

- b) Feedback to parents and other adults The paediatrician or child psychiatrist should discuss and explain findings, differential diagnosis and conclusions without being accusatory. It can be useful to invite adults to see matters from the child's perspective when reviewing the situation with adults involved in the case.
- c) The conclusions The same principles apply as outlined in the physical and psychiatric examination sections. The assessor should be open-minded and consider multiple explanations. Conclusions should be based on findings derived from full assessment of both the child and the family and not merely on one piece of evidence. Psychological abnormalities, unless sexually explicit, may also have alternative explanations. The diagnosis of sexual abuse is a composite one, which does not rely on the finding in one particular area, but the adding together of information from facets of the child's and family's life. Unlike physical abuse of children, proportionately more weight derives from the statement of the child. Finally, it is essential that the assessors be reasonably expeditious so that early decisions can be made about the child's future.
- d) Fabrication It is important to consider the possibility that children may fabricate or that spurious allegations may be made by parents or caretakers, as for example in matrimonial disputes in order to deny access (20). However, this is not a common phenomenon (under 10%) and it occurs across the age band (21). In younger children ideas may be put into their minds. Some manipulative fabrication may occur, particularly in older girls.
- e) Open-mindedness This is important, as abuse may or may not have occurred; there may be fabrication or we simply may not know or never know. It is for this reason that we have to depend on the balance of probabilities which, in turn is dependent on physical, family, social and psychological evidence. For these reasons, family assessment is essential. Where there are doubts or disputes, it is helpful to ascertain whether information at interview tallies with information from other sources.
- f) Balance of probabilities Practitioners should try to assess whether child sexual abuse has taken place on the basis of balance of probabilities. This term is not necessarily used in its legal technical sense, but

rather it connotes a process whereby all factors have been taken into account, both those in favour and those against the hypothesis, and these factors have been weighed against each other. On this basis the practitioner comes to a judgement as to whether it is probable that abuse has taken place.

### 13. CONFIDENTIALITY

- a) With any work with children, the principles of confidentiality are the same. However, in cases of alleged sexual abuse, complex questions of confidentiality inevitably arise because the conflict between professional ethics and public interest in the detection of child sexual abuse.

Much depends on who is the patient and to whom the confidentiality is extended. Nevertheless, the doctor has to reconcile the extent to which confidentiality can be maintained, in the face of best interests of the child. In practice, the welfare and best interests of the child come first even though this may conflict with the best interests of the parents. In child sexual abuse confidential material may be shared with other professionals helping the patient (social workers), with the understanding that confidentiality extends to them as well. Doctors have been encouraged to share information with the police who, over and above protection, have a detection and prosecution role; they will be more willing to share this information when they have concluded that child sexual abuse is probable rather than merely possible, and particularly so whenever any risk, to the child is involved.

- b) When social workers are involved in the assessment, it would seem sensible for medical confidentiality to be extended to them. Parents need to appreciate that there may be wider sharing of information by social workers with professionals from many other disciplines; the doctor must also realise this. In multi-disciplinary settings, the doctor should clarify who has custody of the notes and the confidential information in them, and who has access to them.
- c) When the child is a patient, parents cannot expect to be accorded the benefits of confidentiality: it must therefore be made clear to them that all relevant information given by them to the doctor concerning the child and any information resulting from the subsequent assessments may need to be shared among professionals working on the case; this also applies too video recordings. The professional has an obligation to alert

the family to the extent of this potential sharing of information.

- d) When all the members of the family are patients, confidentiality becomes even more complex; in court proceedings about welfare, the doctor is obliged to reveal all relevant material to the court. When the paediatrician or child psychiatrist feels that this is not in the best interests of the child, his view should be brought to the attention of the court. In civil cases it may be possible for the court to restrict dissemination of the records.
- e) Older children's permission or assent is required to disclose confidential information, provided that they have sufficient understanding and intelligence to do this. Although, in younger children, any necessary consent can be given by the person who is "in loco parentis", the parents' informed consent should be sought as well.

#### 14. GENERAL MANAGEMENT

- a) Sexual abuse does not usually call for an emergency medical response unless:
  - There are serious health risks to the child (e.g. bleeding, evidence of acute infection).
  - Samples are needed for forensic purposes when abuse is thought to have taken place in the preceding 72 hours (e.g. semen).
  - There is serious psychiatric disturbance
- b) Sexual abuse does not usually call for an immediate legal response unless there is a strong possibility that a perpetrator may commit further immediate sexual assaults on the child in question or on other children; or when there is a risk of violence from the alleged perpetrator, or when the non-abusive caretaker is incapable of protecting the child.

The presence of items listed in (a) may well necessitate admission of the child to a hospital for either paediatric or psychiatric reasons. The presence of items listed in (b) need not normally result in an admission to hospital unless there is an accompanying medical reason, but do call for protection of the child. The multi-disciplinary team can then decide how best to achieve this.

c) Admission to hospital This may be necessary under the following circumstances:

1. For the treatment of the child
2. To undertake further medical investigations
3. As indicated, at times admission may be arranged for the protection of a child at immediate high risk of further abuse or when the child is fearful of returning home. Under these circumstances admission to hospital should be considered as a stop-gap measure until alternative provisions are made.

It should be emphasised that hospitals cannot provide adequate substitute care for young children; therefore children should be admitted with a parent or other family member if at all possible. If this is not possible, free visiting of appropriate family members and friends should be encouraged. The admission of a child to hospital without a parent or familiar adult, and with the intention of isolating the child from the family in order to obtain further information about possible sexual abuse, should take place only after the most careful consideration of the likely benefits as opposed to the possible harm to the child. Generally speaking, hospitals do not provide the appropriate environment for this purpose. Nursing staff and junior medical staff must be fully informed of the circumstances of any admission, be appropriately involved in the care of the patient and be adequately supported in this role.

d) Place of Safety Orders These are primarily the responsibility of the Social Services Department or the Police. They should be sought only;

1. When there is a high risk of immediate further abuse to the child and no alternative methods are available to protect the child
2. When parents refuse all further assessment and there is a high probability that abuse has occurred. Under these circumstances a Place of Safety Order should be sought only after full consultation with Social Services, preferably at a Case Conference, even when convened in haste. Wardship proceedings may have a place, but this is an issue which is still under discussion.

When a strong suspicion arises, it would be sensible for the response by Social Services to be a considered exercise rather than an automatic one. This is a crucial time for the Medical Agencies and Social Services to collaborate in assessments which would give

rise to a series of moderating checks and balances. If these are followed by full multi-disciplinary consultation, it is probable that a sound conclusion will be reached in the best interests of the child and fairness to the family. It will be remembered that three conclusions are possible: on the balance of probabilities, "yes" and "no", and also the important category, "don't know".

Such a strategy should limit the overuse of the Place of Safety Order. A 28-day Place of Safety Order is a useful device when there is strong evidence of abuse, but it is a long time to separate children from their families, when evidence is less certain. The other side of the coin is the effect of the two contrasting experiences. Known severe or persistent sexual abuse carries a psychological risk to the child that can justify separation. However, separation from parents and family disruption have potential for short and long term traumatic effects. Therefore, good judgement is needed in those cases where there are doubts and uncertainties about the existence of abuse.

- e) Case Conferences It is desirable that an attempt be made to arrange Case Conferences at a time convenient to all senior staff, both from the hospital and the community services. This is because personal attendance by key hospital staff is essential, and if at all possible a written report should be made available by that time. Some case conferences appear to be rather large and we suggest that they be limited to those directly concerned with the case.
- f) All management should be planned in the context of the procedures devised by the local multi-disciplinary Child Protection Committee.
- g) In each Region there should be a core group of highly skilled professionals who can provide an assessment of the most contentious cases. However, not all cases will require the comprehensive and time consuming assessments indicated above (such as those undertaken by the Second Opinion Panel in Cleveland). Thus, while a core group will be invaluable, the resource would need to be utilised selectively. Such a resource should be available not only for clinical assessment, but for consultation, training and research.

## 15. INVESTIGATION AND TREATMENT OF CO-EXISTING ILLNESSES

These will need to be undertaken.



16. THE ASSESSMENT OF SIBLINGS

This should be arranged whenever there is a high probability of sexual abuse in the index case. It should include a physical examination if this is thought to be indicated. Parental consent should be obtained but if refused, a Place of Safety Order or Wardship Proceedings may have to be instituted by the Social Services Department after appropriate consultation. The physical assessment should be a planned exercise ensuring the minimum of discomfort, with the timing of assessments geared to the individual circumstances.

17. SECOND OPINIONS

Parents who request a second opinion should be advised to consult their general practitioner in order to obtain an opinion from someone of their own choice. Doctors and social workers would be wise to consider obtaining a second opinion in cases of doubt and difficulty. The objectives should be carefully defined and ways of minimising trauma to the child and family should be considered. If a second opinion is being obtained, then those professionals who carried out the initial assessment should make all information available to those carrying out the second assessment to avoid, as far as possible, unnecessary replications of interviews and examinations. In child care proceedings, all second opinions regardless of their favourability or otherwise to any party should be available to the Court. If this is not done, in our opinion the best interests of the child may not be served.

18. INDIVIDUAL AND FAMILY THERAPY

A normal family environment should always be sought. Therapeutic intervention, although not denying the importance of abuse, should aim at avoiding further sexualisation or emphasis on the importance of the original abuse.

19. FOSTER PARENTS require careful preparation and continued guidance and help.

20. FOLLOW UP

Appropriate arrangements should include monitoring of health, growth and development.

21. NATIONAL STATISTICS should be gathered of all substantiated cases in order to provide a picture of the size of the problem both within and across Regions.

## 22. CONCLUSIONS

Medical experts should be aware of the weight and influence their conclusions carry with respect to other professional groups. They need to be cautious in the manner in which they couch their conclusions. This is necessary because not only is medical practice based upon a specialised sphere of knowledge and experience, but there is also a traditional degree of trust which is invested in this practice by public and other professional groups.

Medical experts should present their conclusions with the level of confidence or degree of certainty appropriate to their findings. In child sexual abuse, where there may be a range of opinion, it seems appropriate to let other professional groups know of this potential variation in opinion.

The range and interpretation of anal and genital findings is a good example. Norms for different ages and population groups with or without the presence of other potentially complicating ano-genital or generalised medical conditions have not yet been clearly established. There has been some well-conducted descriptive work (22,23,24,25). These and similar papers should enable the practitioner to draw qualified conclusions in the individual case, especially when these physical findings are in keeping with the account given by the child and/or the family dynamics.

Categorical conclusions are seldom in order when physical findings are considered in isolation. Similar considerations apply to findings from psychiatric or psychological assessment alone, such as in relation to assessment using anatomically correct dolls, or any other single sign or symptom.

It is essential to keep an open mind, to listen to the child and family and to collate all available information before formulating a view. It may not be possible to be certain about a diagnosis even when a great deal of information is available. The practitioner should come to a judgement about the balance of probabilities on the basis of the processes described earlier.

We suggest that rarely should any one individual have the power to weigh, sift and filter all the clinical evidence, to diagnose, and to decide the implications of that diagnosis. Social Services Departments, paediatricians and/or police surgeons and child psychiatrists will all have major roles, different but related, in the assessment of child sexual abuse at a clinical level. Such a system of checks and balances does not dictate any form of group

diagnosis or diagnosis by committee - on the contrary, it calls for a recognition of the necessity for multidisciplinary approaches involving professionals with different bases of knowledge, expertise, experience, and sharing the results of their assessment.

The interests of the child and family will best be served by a sensitive multidisciplinary approach which makes use of all the resources, professional experience and skills available in the local community.

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INDEPENDENT SECOND OPINION PANEL:  
NORTHERN REGIONAL HEALTH AUTHORITY

TABLE 1

MODE OF PRESENTATION

LIKELIHOOD OF CHILD SEXUAL ABUSE (CSA)	BEHAVIOUR/EVENTUAL DISORDER	CHILD'S ACCOUNT	PHYSICAL SIGNS AND SYMPTOMS	OTHER TREATMENT
Association with CSA	Sexualised behaviour Post-traumatic stress symptoms with sexual pre-occupations Prostitution Promiscuity Acute anxiety syndrome Self mutilation Psychosomatic complaints Drug and alcohol abuse Runaway	Clear by child, substantially or in response to open-ended enquiry	Overt chronic signs (ano-genital) Signs of acute trauma (ano-genital) Gonorrhoea/syphilis/AIDS Incest pregnancy Unexplained ano-genital bruising, scratches	Neglect Physical abuse
Low or Possible Association with CSA	Acute behaviour change (unexplained) Enuresis and encopresis Para-suicide Anorexia nervosa	Vague by child or no response to highly facilitative method	Marginal ano-genital signs Teenage pregnancy Recurrent urinary infection Recurrent vaginal discharge Recurrent abdominal pain Other <sup>condition</sup> infections, e.g. Chlamydia	

COMMENT: THIS TABLE CONSTITUTES AN AID TO CLINICAL JUDGEMENT RATHER THAN A SET OF INFLEXIBLE CRITERIA

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28 October 1987

ANALYSIS OF STATISTICS PROVIDED BY REGIONAL HEALTH AUTHORITY  
ON REGIONAL REFERENCE GROUP AND INDEPENDANT REVIEW PANEL

1. I attach two tables of analysis of the figures at the back of Dr Donaldson's statements RMO2 & RMO3, undertaken at the request of the judge.

- TABLE 1 shows figures for the Regional Reference Group
- TABLE 2 shows figures for the Independent Review Panel

2. I also attach the pie chart which the judge referred to yesterday, showing a breakdown derived from both tables.

Alan Davey

Initial & Date

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Sub folder

Classified under FOI Exemption(s)

Section

Classified under

*3/1/88*

Judge

List of Documents considered useful for Professor Kolvin's evidence

Independent Panel second opinions

Professor Kolvin's guidelines

Doctor Donaldson's evidence on Independent panel (RMO2) and table.

Doctor Donaldson's evidence on Regional Reference Group (RMO3) and table.

Bundle of correspondence provided by Messrs Crutes.

Sarah's schedules on Independent Panel and Regional Reference Group.

Mrs Babar's letter to Messrs Crutes dated 24/9/87



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and table.

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NORTHERN REGIONAL HEALTH AUTHORITY

REGIONAL REFERENCE GROUP : OPERATIONAL POLICY

- 1 The Group has been established to provide a broader basis to decision making in the medical diagnosis of child sexual abuse in the South Tees District. It is intended as a pilot scheme and will be closely monitored.
- 2 It is accepted that the source and nature of referral of cases to the Consultant Paediatrician may vary. It may be, for example, from a field social worker, a General Practitioner, another professional or agency with or without disclosure or allegations.

Paediatric assessment within South Tees

- 3 The primary assessment of a child for evidence of child sexual abuse will be carried out by one of the Consultant Paediatricians in the South Tees District.
- 4 Parental permission will be sought for examinations in all cases, except where the appropriate court order waives the need for this permission.
- 5 Because of the need to keep to a minimum the number of examinations on children and, in the special circumstances in which the new procedure has been adopted only one of the South Tees Consultant Paediatricians will be involved, no second within-district consultation will be carried out.

### Involvement of the Regional Reference Group and Timing

- 6 If a South Tees based Consultant Paediatrician suspects sexual abuse of a child he/she will call in a second Consultant Paediatrician from the Regional Reference Group and also discuss the case with one of the Child Psychiatrists from the Group.
- 7 The second paediatrician is to be made available to provide a independent second opinion.
- 8 This second Consultant Paediatrician will visit as soon as is practicable and conduct an independent assessment of the child.
  - a In some cases because of the mode of presentation, or the obvious seriousness of the case, a social worker and/or the police will already be involved at the time the child presents to the Consultant Paediatrician in South Tees. In such cases, if the police deem the involvement of a police surgeon to be necessary to collect forensic evidence, whenever possible the visit of the Reference Group Paediatrician and the police surgeon should be coordinated so as to enable a single joint assessment of the child to take place.
  - b In the remaining cases, the social worker or other agencies may not have been involved at the time of presentation. In these circumstances, the second Paediatrician from the Regional Reference Group will visit to pass an opinion usually before contact is made with the social services department.

#### Formulating the medical advice and further action

- 9 Only after this, would the Social Services Department be given the two medical opinions (jointly) so that a decision can be made on what further action is required. It is hoped that the majority of medical opinions will broadly coincide. If they do not, it is suggested that discussion take place between the two consultant paediatricians on what course of action should follow. If a consensus cannot be reached and one of the opinions believes that the social services department or other agencies should be informed, then the two separate opinions should be put forward.

#### Circumstances of the second assessments

- 10 The second Paediatrician will conduct the assessment under circumstances according to his/her preferred practice. Those currently on the Reference Group prefer to see the child and the family on their own and undertake a full paediatric assessment of the child, enlisting the parents' cooperation as appropriate, and only turning to the question of inspection for the possible signs of child sexual abuse towards the end of the examination.

- 11 Conditions for the physical examination should be optimal in terms of attending nursing staff, lighting and the room should not be unnecessarily crowded with staff.

#### Documentation

- 12 All records should be clearly documented and any photographs should be taken in such a way that the negatives are marked automatically to link them uniquely to the records.

HEALTH SERVICES  
HEALTH AUTHORITY

DISTRICT OFFICE  
FOLK HOSPITAL  
NINTH ST  
MIDDLETOWN  
CLEVELAND OHIO 44130  
Telephone: MIDDLETOWN 2200

13 In circumstances where medical opinions or recommendations are made to social services, written reports should be available shortly afterwards.

20th July 1987

L J DONALDSON  
REGIONAL MEDICAL OFFICER/HEAD OF CLINICAL POLICY

20 July 1987

(Note: These guidelines will be subject to periodic revision in the light of the experience of operating them.)

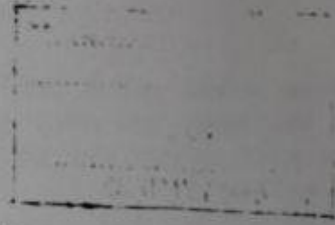
# Queen Elizabeth Hospital

Gateshead Health Authority

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(STD Code: 091)

Sheriff Hill  
Gateshead  
Tyne & Wear  
NE9 6SX

Your Ref:  
Our Ref: SC/KP



Redacted  
under FOI  
exemption  
section 38  
and 40 (2)

13th July, 1987

Dr. L. J. Donaldson,  
Regional Medical Officer,  
Northern Regional Health Authority,  
Benfield Road,  
Newcastle upon Tyne.  
NE5 4PY

Dear Dr. Donaldson,

As I understand it, we have to provide a report on the children that we see in Middlesbrough, please find enclosed medical account. In addition I wanted to add that I was able to examine these children in the way that I wished without interference and the facilities were excellent. The only difficulty arose in relation to the Police Surgeon.

In this particular case the two children were already on care orders. I recruited the Social Worker, Mrs. Joy Trotter, to help in place of mother, as it is my practice to actively involve mothers in the physical examination of their children. Mrs. Trotter did splendidly in this role.

For good or ill I wanted to examine these children on my own and the Police Surgeon who came late was invited to review the genitalia of [redacted] with me and this was undertaken satisfactorily, although he was clearly less happy with that approach. Following discussion however I was able to explain the reasons and invited him to stay during the examination of the boy. For some reason he did not and I am not entirely clear why. You will see from the enclosed there were indeed physical findings of some significance. That aside, the procedure seemed to go well and I do not believe the children were unduly traumatised by the process.

In relation to the recent meeting there were some issues that I would like to comment about. I think it is inevitable while the diagnosis of sexual abuse evolves, that children will have multiple examinations. Clearly it is important to minimize these, but I am not sure that it is any less traumatic to be seen by a single person several times than by a lot of people once. I am personally of the opinion that examining the genitalia is a normal paediatric practice and certainly in the current "modern" climate where nudity is much more accepted in family life it can be done sensitively and without generating difficulty. I accept that this is different in the context of adolescents.

/continued.....

In relation to the use of glass rods, there is a difference of view. I personally have been using them for sometime and find them a very effective way of demonstrating the hymen intactness both to my own satisfaction and to parents. It is not really instrumentation of the vagina and the out cry has come from people who I suspect have not seen the rods in use. I think the diagnosis of sexual abuse requires a combination of inputs, social, Psychological, medical and requires information from these three aspects before one can either make or refute a diagnosis. Clearly the absolute diagnosis can only really come with a disclosure and marrying up physical signs with the history. Making or dismissing a diagnosis is a joint affair and I suspect that is the root of many of the problems in Teesside.

Finally if this problem is as common as "experts" are telling us then there are 4,000 children in Gateshead who have or who are being abused. Even if that is a gross over estimate we would have trouble in coping with 400. I think it needs to be recognised that all Districts are being asked to see increasing numbers of children who may or may not have been abused, but I know that you are already aware of these, and in Gateshead in June we were asked to see 30 children. If these numbers describe the problem at all it is quite clearly inappropriate to think in terms of an essentially Newcastle based Specialist Unit dealing with such children. Clearly it is going to be important to generate Units of excellence, but I am sure it is the responsibility of every District to set up a co-ordination system for the management of child abuse. I think we have been lucky in Gateshead, but this process is still evolving though I remain unhappy with some aspects, not least that all our disclosure work, such as it is, has been very heavily influenced by Women Police Officers who clearly come to that series of interviews with a very different agenda, but I am sure that this is something that will be corrected in time.

If you have any comments about the enclosed report I would welcome those.

Yours sincerely,

S. Court  
Consultant Paediatrician



Section 38 + 40 (a)

Closed until

3/10/14