7 Minute Briefing on Child Sexual Abuse

For Paediatricians, Emergency Doctors, and other Health Staff

Contact-abuse affects at least 1 in 20 children

Child sexual abuse is more common than childhood epilepsy, cancers and congenital heart disease put together

- It is equally common as physical abuse.
- The average time from abuse to disclosure is **7 years**
- We **must** respond at the **same threshold as for other forms of abuse:** safeguarding does ***not*** require certainty to level of criminal justice system.
- If signs or concerns are present, multiagency strategy discussion must occur, to inlcude appropriate input from health
- Do show **professional curiosity** and **seek voice of the child.** See them without carer where possible.

Only 1 in 8 cases come to attention of authority over time

- **Allegations/disclosures -** Child needs to feel safe. Retractions are common. May be ambiguous, and language will reflect child's understanding and develpomental level
- **Behavioural signs** of emotional distress: these are non-specific but may include somatisation, mutism, wetting, soiling, eating disorders including obesity, self harming, sexualised behaviour and sexually harmful behaviour to self or others.
- **Physical signs** include STIs, ano-genital warts, pregnancy, anogenital trauma (bruising, laceration, bleeding), vaginal discharge, vaginal foreign bodies, bruising to thighs or buttocks, suction bruises, perianal scars, hymenal defects (specialist examination)

'Disclosures'

(allegations by a child)

- Document what the child says verbatim
- Ask open questions (‘can you tell me more about that?’, ‘who is that?’) and document what you asked.
- Don’t promise confidentiality, but be transparent in explaining what you will do.
- Do explain you need to talk to others to keep the child safe
- Read the Communicating with Children Guide - CSA Centre (see references)

Behavioural concerns

- Consider CSA in anogenital conditions which do not respond to usual treatment advice (including **wetting, soiling, unexplained genital pain, and intractable constipation/stool withholding**)
- Consider CSA in behavioural presentations including **medically unexplained symptoms, sexualised behaviour, mutism, self-harm, eating disorders, truancy, substance misuse, and insomnia**
- Think family – do any **siblings** show other signs emotional distress?
- Ask the child is anything else is bothering them. Consider 'cliff-hanger' prompts: "one of the things we always have to consider when someone has this problem, is sexual abuse..."
- Do consider behaviours in context of developmental age.
- Take safeguarding advice. Use professional meeting or strategy meeting to bring information together

Physical Signs

- Consider CSA in **unexplained anogenital bleeding.** This includes bleeding without consistent sign and history of accidental trauma, where no organic cause (such as friable labial fusion or inflamatory bowel disease) is suggested on history or external examination, and which is not deemed menstrual in nature.
- Consider CSA in **anogenital warts** (evidence suggests approximately 30-60% of cases are sexually transmitted, regardless of age-group or maternal infection)
- Consider CSA in all cases of **rectal or vaginal foreign-body,** other than toilet tissue, before puberty. Take safeguarding advice in unusual presentations in older children.
- Consider CSA in all cases of suspected **genital herpes or other STI, or pregnancy**

Ano-Genital injuries

- Consider CSA in all **anogenital injury** without clear history of accidental trauma, or where the injury is not consistent; take safeguarding advice if unsure.
- Consider CSA in all **non-midline or multiple anal lacerations ('fissures') or tags**, unless suspected inflammatory bowel disease
- Consider CSA in all **unexplained apparent ano-genital bleeding** (exclude urinary origin, puberty, urethral prolapse, lichen sclerosis and friable labial fusion by external examination)

Developed by Dr J Gifford on behalf of Coventry Safeguarding Children Partnership, 2022

Responding to concerns

- If you are **concerned** about CSA, seek safeguarding advice
- Put your concerns into effective "danger statements" and make a MASH referral (concern about possible sexual abuse = risk of significant harm)
  - **'You don't have to be sure to share'.** SARC examination is **child-friendly** and can be **therapeutic**
  - Strategy discussion should include **paediatrics AND SARC** representation
- Treat anogenital bleeding, bruising, ulceration and laceration, and suspected abuse within last 7 days (including based on allegation or last suspect contact) as **urgent. Specialist examination should occur within 24 hours** in such cases. Non-urgent cases should be seen as soon as possible.
- SARC examination can never exclude CSA, as most examinations are normal, but where there are physical findings it informs action; **'If we don't look, we won't find'**

Medical conditions to be aware of

- **Straddle injury:** should have clear event history; laceration, typically between labia majora and minora *unilaterally* . Suspicious if symetrical, central or involves vestibule (hollow opening between right and left labia minora)
- **Labial Fusion:** may be friable and bleed if stretched. Typically posterior but may be mid-labial.
- **Vulvovaginitis:** nonspecific inflamtory response to allergens and/or poor hygeine. Concern if recurrent, bloody discharge or not responsive to advice
- **Lichen Sclerosis:** classic 'figure of 8' pallor surounding genitals and anus may be absent in early stages; may present with itch (mistaken for sexualised behaviour) or spontanous haemorrhage (mistaken from trauma/bruising)
- **Threadworms**: may infest prepubertal vagina and cause intense itch (mistaken for sexualised behaviour); itch resolves on treatment with mebendazole.

POLY VICTIMISATION: Children who have experienced one form of abuse are more at risk of other forms. Children who experience **physical abuse** are **6 times more likely** to be sexually abused. **Neglect** is a recognised risk factor for sexual abuse both inside and outside the home. Consider Sexual Abuse in **ALL** cases of child maltreatment, and proactively ask about relevant signs/behaviours.

Inspection of anus and **external** genitalia should be part of the child protection assessment of **all** children under 5 with suspected physical abuse

Older children should be asked if they have any genital issues, and offered examination as part of child protection medical assessment

Examination in the SARC

Specialist examination not just about gathering trace evidence (DNA), but also looks for **physical injuries** with a magnifying colposcope (including healed injuries, which may be present **indefinitely** - it's never too late to refer)

It also provides **reassurance** - children are almost never as physically damaged as they perceive themselves to be; debunking myths may prevent secondary psychological difficulties

SARCs provide **holistic health care** including STI screening, Hep B vaccination, pregnancy screening, crisis care, Independent Sexual Violence Advisors and counselling referrals.

References and further reading:

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Royal College of Paediatrics and Child (RCPCH). September 2015 *Service specification for the clinical evaluation of children and young people who may have been sexually abused*. RCPCH London.

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