CHILD SEXUAL ABUSE

Screening

Consider the possibility of child sexual abuse (CSA):

- During routine child health checks (see CHILD HEALTH SCREENING protocol).
- Opportunistically during clinic visits for other reasons, particularly if routine health checks missed.

Presentations of abuse may include:

- **Observation or concern raised by others** - e.g. child carer, teacher, other parent, health worker, nurse or doctor. Includes:
- sexualised behaviour inappropriate for developmental stage.
- STI and / or pregnancy in a minor – All STIs in children under 14 years are notified via KPHU to Department of Child Protection (DCP) and Police. STI or pregnancy may reflect consensual sexual activity amongst teenagers but needs careful exploration and follow-up.
- **Disclosure by child.**

Case Definition

A child in this definition is under the age of 16 years.

CSA involves any form of sexual behaviour that the child has not consented to or is unable to consent to, for example:

- exposing the child to pornographic material or sexual acts.
- asking child to perform sexual acts on another person.
- taking visual images of child for pornographic purposes.
- performing sexual acts on child, including fondling, kissing, inappropriate touching, and any form of penetration (oral, anal, vaginal).

Principles of Management

- Co-ordination of the response to child sexual abuse is through the **Regional on-call Paediatrician**. Even for older children / teenagers, contact the Regional on-call Paediatrician who will assist with medical advice, support and linkage with other agencies.
- Proceed through management steps according to your level of skill, experience and confidence: seek help early if needed.
- Ensure child's safety as a priority. Be aware the perpetrator could be the person presenting with the child.
- Attend to immediate / urgent medical concerns.
- Take time to carefully document everything.
- Believe the child who discloses abuse.

History and Documentation

- Confidentiality is vital and discussion should be limited only to those directly involved.
- It is very important to ensure that you document everything clearly, carefully and in detail. Your record may form the basis of a legal document.
- Note time and place of consult / examination plus name, title and role of those present during different parts of consultation.
- Document questions asked and the responses of both the child and adult if present, word for word if possible. Questioning must be open and non-directive (refer to Department of Health Guidelines - which ones? Specific name might be good for examples of questions).
- In cases of suspected abuse, further history can be sought in conjunction with DCP to clarify level of suspicion. Maintain confidentiality and do not openly discuss the allegation / suspicion.

Management

- Contact the **Regional on-call Paediatrician** whose role is to provide medical advice and support, and to coordinate the regional response to child sexual abuse.
- **ALL** disclosures by children should be referred to DCP (Crisis Care after hours).
- In ALL cases of suspected child abuse, discuss with the DCP (Crisis Care after hours). Referral does not mean automatic removal of the child. DCP keeps records of previously reported concerns of which health staff may not be aware, therefore all information is relevant.
- If you are not confident of child's immediate safety, discussion with DCP must occur before child leaves the clinic. Most presentations / disclosures of child sexual abuse are delayed / not acute and need a timely but not urgent response.

When alleged abuse has occurred within the past 72 hours this should be considered an emergency.

Immediate care

1. If there are serious injuries, immediately stabilise and transfer to hospital according to usual emergency protocols. Notify the regional on-call Paediatrician.
2. **IN ADDITION:** inform DCP and Police. Hospital has ability to put in place a temporary holding order and DCP can issue emergency care orders if required. In remote settings, police may also be of assistance during emergency preparation and transfer.

It is very important that forensic evidence is collected as soon as possible.

1. Contact the **regional paediatrician** to discuss transfer of the child to the most appropriate location for examination by a trained practitioner.
2. Notify **DCP and Police** in the nearest location / town.
3. Remember that while collection of forensic evidence is important at this stage, emotional support for the child and parent / guardian is also central to immediate and ongoing care.

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3. Remember that while collection of forensic evidence is important at this stage, emotional support for the child and parent / guardian is also central to immediate and ongoing care.
4. **Arrange transportation** by most efficient means – for very remote sites, RFDS evacuation may be required.
5. If transfer is delayed, encourage child NOT to have a shower, wash, brush teeth or change clothes, but consider collecting **"comfort specimens"**. These are collected to allow the child to drink or go to the toilet for comfort, while preserving forensic evidence.

Comfort Specimens are:

- **Mouth rinse.** Take 20mls of sterile water, have the patient swish it around his/her mouth and spit it into a yellow top container.
- **Genital gauze swab.** The child may be able to do this themself. Take sterile gauze and wipe it across the genital area and place in a yellow top container.
- **Peri-anal wipe.** Again, the child may be able to do this themselves. Take sterile gauze, wipe it across the anal area and place in yellow top container.
- **First void urine.** Preferably do this after the wipes above. Get the child to pass urine into a yellow top container - the first bit of urine is especially important. Once there is more than one yellow top container worth of urine, the child can pass the rest into the toilet.

Label all of the above yellow topped containers with the child's name, DOB, date, time and place the samples were taken. Place them in a plastic specimen bag, then in a paper bag. Fold the top of this bag over and seal it (e.g. sticky tape or staples). Then sign YOUR name, the date and the time across the seal and place the bag into the fridge (preferably locked). Hand the samples over to the police as soon as possible.

6. Consider the need for **emergency contraception** if transfer will be delayed.

When alleged abuse has occurred more than 72 hours ago:

1. There is no need for forensic samples.
2. Notify **DCP and police** in nearest town.
3. Discuss **all children** with Regional Paediatrician to determine pathway for further examination / investigation.
4. **For post-pubertal children/teenagers,** medical care provided by the usual GP may be more appropriate. Screen for STIs (includes PCR for gonorrhea and chlamydia, blood for hepatitis B / C / HIV / Syphilis) and consider the need for pregnancy testing.

   However, if not comfortable with skills in providing care in this setting, discuss with the Regional on-call Paediatrician. Alternatives may include follow-up with the Paediatrician or with a GP in the region who has experience in child and / or adult sexual abuse.
5. Psychosocial follow-up and support is paramount. Be aware that suicide risk is heightened in children who have been sexually abused. Counselling and social services available are listed in the table below.

Follow–up

The importance of psychosocial follow-up and support can not be overemphasised. Be aware that suicide risk is heightened in children who have been abused.

Ensure that child and family have access to appropriate ongoing counselling and support services. Although specialist counselling may be required, support from a trusted local health worker will be a valuable resource.

Arrange follow up testing for pregnancy and STIs in consultation with the Paediatrician and / or GP involved.

- Two weeks later: PCR for gonorrhea and chlamydia and pregnancy testing if indicated.
- 3 months later: Follow-up Hepatitis B&C, HIV and Syphilis serology.

Service	Details	Contact
Regional Paediatrician	24 hour on call service via Derby Regional Hospital.	9193 3333
Police	Contact nearest office, or contact Broome head office (number provided here).	9194 0200
Department of Child Protection (DCP)	Mon to Fri 8am - 4.30pm. Contact nearest office, or contact Broome head office (number provided here).	9192 1317
Crisis Care	After hours contact for child protection issues.	1800 199 008
Princess Margaret Hospital	Child Protection Unit (Mon to Fri 8.30am - 5.00pm).	9340 8646
	Emergency Department (after hours).	9340 8222
KAMSC Regional Centre for Social and Emotional Well Being (SEWB)	Mon to Fri 8am - 4.30pm. Provides SEWB training, counselling, support and advice for providers; occasional individual client counselling.	9192 6435
Marninwarntikura Fitzroy Women's Resource Centre	Mon to Fri 8am - 4.30pm. Offer (adult) sexual assault counselling.	9191 5126
Social Support Unit, OVAHS, Kununurra	Mon to Fri 8am - 4.30pm. General counselling / social support.	9168 1288
Kinway	State wide telephone counselling service.	1800 812 511
	Sexual abuse / assault counselling services based in Kununurra and Broome, covers the Kimberley.	9169 1117
Kimberley Mental Health and Drug Service	Mon to Fri 8am - 4.30pm. Acute mental health services.	9194 2640
Kids Help Line	24 hour telephone counselling for children and young people aged 5 - 25 years.	1800 551 800

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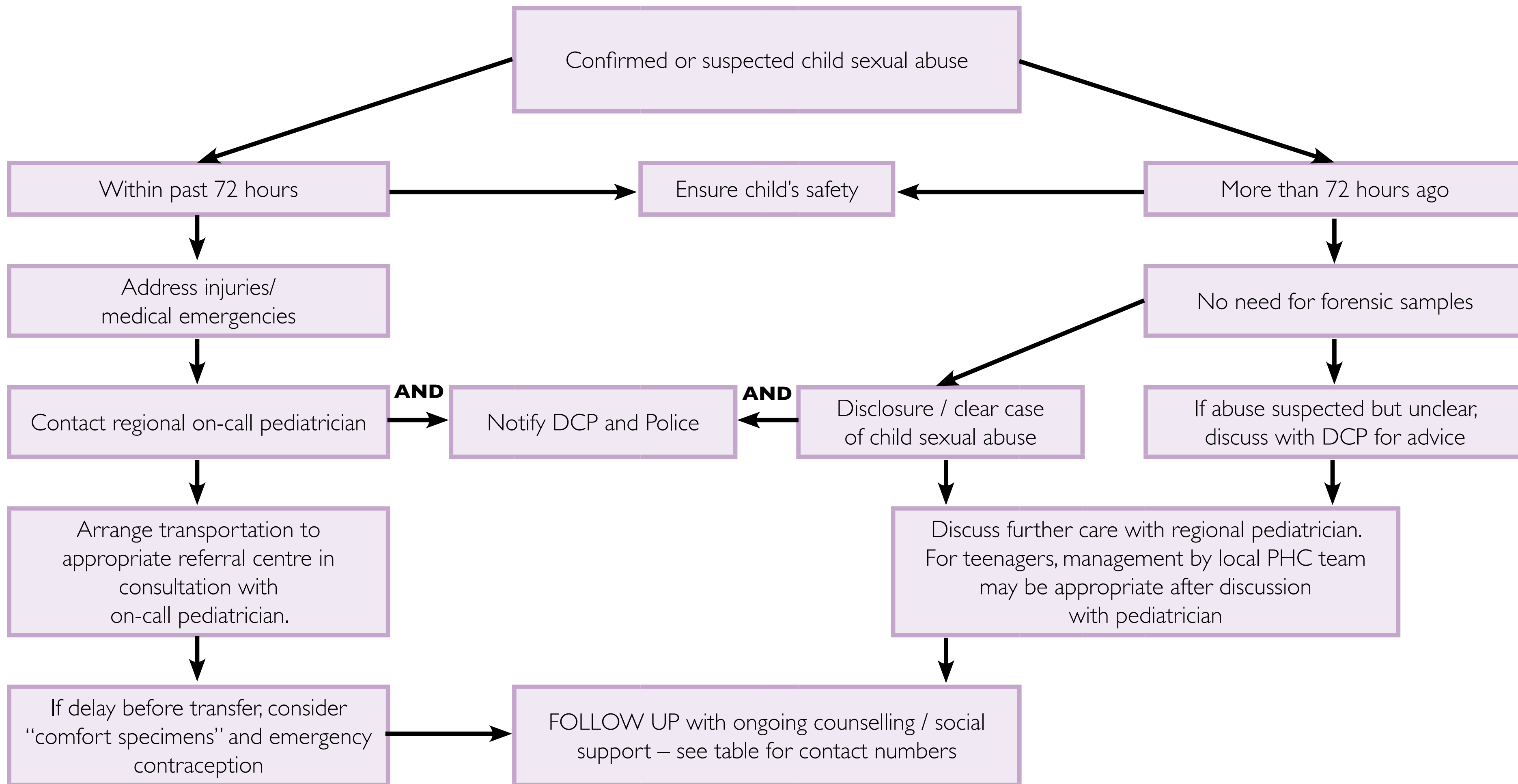

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