RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Faculty of Forensic & Legal Medicine

Quality Standards for clinicians undertaking Paediatric Sexual Offence Medicine (PSOM)

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1. Introduction

1.1 The United Nations Convention of the Rights of the Child (UNCRC)[1] defines a child as everyone under 18, "unless under the law applicable to the child, majority is attained earlier".

1.2 Victims of sexual violence and assault should be considered as children and young people until their 18th birthday and services should be commissioned accordingly.[2]

1.3 It is essential to have competent clinicians in terms of knowledge, skills and attitudes to understand the needs of the child and to provide safe care for child complainants of alleged sexual abuse, assault and exploitation or where sexual abuse is suspected but no allegations have been made. The evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination; the examiner may also need to address specific issues of consent and reporting of child sexual abuse.[3]

1.4 Paediatric SOM is a highly specialised and in some areas, low volume work. In some parts of the UK, practice may vary because of different regulations as well as the volume of work.

1.5 These Quality Standards have been developed in response to the recognition by the Home Office[4] as the FFLM being responsible for the standards to be expected in forensic healthcare and forensic examination and in response to the *Violence Against Women and Children Taskforce Report*[5] along with the Government's interim response[6], where it was agreed that the FFLM should set those standards in conjunction with the Forensic Regulator.

1.6 The General Medical Council (GMC) sets the standards for doctors working in the United Kingdom. For the individual doctor providing care, the GMC is clear that the doctor must recognise and work within the limits of his/her competence. Doctors should also be familiar with GMC guidance "Protecting children and young people" and "0-18 years – guidance for all doctors" which deal with a range of issues related to the service delivery of these standards.[7]

1.7 The Nursing and Midwifery Council (NMC) sets the general professional standards for nurses working in the UK. For the individual nurse providing care, the NMC is clear that the nurse must recognise and work within his/her competence.[8]

1.8 Clinicians in PSOM training may come from different backgrounds, so it is essential that the exact period and content of training should be tailored to meet the needs and requirements of the individual clinician with the overall outcome: a competent paediatric forensic practitioner.

1.9 For senior doctors, experienced in conducting forensic child sexual abuse (CSA) examinations there is a new route to the Licentiate in Forensic & Legal Medicine (LFFLM (SOM) [c]). Candidates must hold MRCPCH or MFSRH or MRCOG or MRCGP and have at least two years of active participation in CSA examinations in the three years prior to application. This route to LFFLM (c) is available until 31 December 2022 and further details can be found *here*.

1.10 This guidance applies to **ALL** children and young people and is for the acute assessment of children and young people, delayed reporting (non-recent) assessments, or where there is suspicion of sexual abuse but no allegations have been made. There is no one service delivery model that is necessarily the best, however all models should work to the same set of service delivery standards.

2. The Forensic Medical Examination (FME)

2.1 Where concerns are raised about possible child abuse it is important for that child and family that there is an appropriate response from all agencies.[9] A forensic medical examination (FME) is a child protection medical assessment and standards for these assessments are set by the Royal College of Paediatrics and Child Health (RCPCH)[10] and include in standard 4:

- Child protection medical assessments are carried out by paediatric clinicians working at ST4 level or equivalent and above with relevant Level 3 child protection competencies.

2.2 Unless an out of hours emergency, a multi-agency discussion must take place either face to face, virtually or via the telephone and must involve an appropriately knowledgeable and skilled clinician, ideally the one likely to conduct the medical examination.

2.3 A FME is a comprehensive assessment, which includes addressing the complex issues of capacity and consent, the clinical history and full physical examination (including developmental and mental health assessment), and detailed documentation including the use of line drawings and photo documentation. Additionally the assessment includes:[11]

- The collection of relevant forensic samples, if appropriate;
- The identification of injury outside the anogenital area with the clinician putting into context, dependent upon the circumstances of the case, any positive and negative findings and consideration of potential differential diagnoses;
- An assessment of the ano-genital area with the clinician putting into context, dependent upon the circumstances of the case, any positive and negative findings and consideration of potential differential diagnoses;
- Investigations including case specific STI screening and management of positive results;
- The identification of physical features or concerns from the wider consultation which suggest the child has experienced other categories of abuse or has any unmet health needs;[12]
- Arranging any necessary aftercare including mental health needs;
- Feedback and reassurance to children and carers from the clinician after the examination;
- Writing a report with an opinion.

2.4 A provisional report must be provided to the social worker and police at the time of the FME, setting out the professional opinion of the examining clinician, as far as they are able at that time, regarding the likelihood of abuse based on the history and examination of that child.

2.5 Following the FME, a child protection medical report must be written and sent to the GP, designated or named paediatrician and social care. Depending on local arrangements this may also include police. This is the typed report containing the professional opinion of the examining clinician regarding the likelihood of abuse being the cause of the presenting symptoms and signs in the child and how they came to arrive at that opinion in order to properly safeguard the child or young person.

2.6 A report for the court may also be required. This is a report written purely to assist the court and may take the form of answering specific questions put to the clinician by the court or in the format of a statement.

3. Recruitment

3.1 It is recommended that all clinicians in training who are doctors (defined as working in PSOM for less than two years) should have at least three years training in a relevant specialty in an approved practice setting following satisfactory completion of foundation training (FY1 and FY2).

3.2 It is recommended that all nurses should have at least three years whole time equivalent post registration clinical experience in paediatric nursing at Advanced Practitioner Level.

3.3 Relevant specialties or experience for PSOM would include:

- Paediatrics
- General Practice
- Emergency Medicine
- Paediatric Gynaecology
- Contraceptive and Sexual Health Services
- Paediatric nursing.

3.4 Precision in communication is essential. Clinicians must have demonstrable skills in listening, reading, writing and speaking English that enable effective communication in clinical practice with patients, their families, colleagues, and in legal fora. Doctors and nurses must comply with GMC and NMC[13] requirements respectively.

4. Initial training

All clinicians, prior to commencing any work that is not directly supervised:

4.1 Must attend an initial accredited training course[14] in PSOM or the RCPCH Child Sexual Assault and the Forensic Examination course before commencing clinical work. A recommended syllabus is available for courses in SOM. See *Recommendations for Introductory Training Courses in Sexual Offence Medicine (SOM)*.

4.2 Must have successfully completed Immediate Life Support (ILS) or Paediatric Immediate Life Support (PILS) training as accredited by the Resuscitation Council UK (RCUK) within the last year.

4.3 Must complete training in Safeguarding Children and Young People (Intercollegiate Document minimum Level 3 plus).

4.4 Should complete training in statement writing and courtroom skills.

4.5 Should have training in equality and diversity issues.

5. Workplace-based supervision

All clinicians in training, whether from a nursing or medical background:

5.1 Should receive induction training to cover the policies and procedures of the workplace, e.g. SARC/Trust/ outsourced provider.

5.2 Should be assigned a FFLM/RCPCH educational/clinical supervisor who will be a subject knowledge expert with explicit training in effective supervision, responsible for supervising the clinician and establishing when the clinician is safe to practise independently.

5.3 Should have an initial assessment by the named educational/clinical supervisor of the individual clinician's training needs so that appropriate training and continued maintenance of competence can be achieved.

5.4 Should complete the Licentiate of the Faculty of Forensic & Legal Medicine in Sexual Offence Medicine (formerly known as the DFCASA) either as LFFLM (SOM) or LFFLM (SOM) (c) or MFFLM (SOM) and must have this as evidence of competency in order to be able to work autonomously.

6. Continuing professional development

All clinicians:

6.1 Must fulfil the GMC or NMC[15] requirements for revalidation. It is essential that any appraisal is robust in covering the forensic aspect of their work.

6.2 Must have annual Immediate Life Support or Paediatric Immediate Life Support training as accredited by the Resuscitation Council UK (RCUK).

6.3 Must have Safeguarding training as indicated in 4.3 above at least every three years.

6.4 All doctors who wish to practise independently in Paediatric SOM will need to pass the MFFLM (SOM) Membership examination or MRCPCH plus LFFLM (SOM). All nurses who wish to practice autonomously in Paediatric SOM will need to have a paediatric nursing qualification and experience, pass the LFFLM (SOM) or LFFLM (SOM) (c) and be supervised within a senior medical practitioner led team.

6.5 Paediatric SOM is highly specialised and in some areas, low volume work. Clinicians should ensure they undertake sufficient clinical examinations in order to maintain experience and expertise and for those clinicians on agreed leave e.g. parental leave, a period of supervision on return to work should be considered.

6.6 Must attend a minimum of 4 peer review meetings per year.

6.7 Must attend a FFLM/RCPCH approved one-day 'SARC Best Practice' course at least every three years.

7. Service level Standard

7.1 It is essential to recruit a highly-trained workforce to ensure patient safety, high quality care and aftercare, integrity of forensic sampling, statement writing and courtroom skills in order to give the child the medical care and safeguarding they require, and give the best possible assistance to the Family Court and criminal justice system. As stated above, all clinicians in training should have appropriate supervision.

7.2 All clinicians must keep detailed contemporaneous notes and ensure effective communication between colleagues and other professionals including safety netting of vulnerable patients. There must be clear procedures in place for sharing confidential information, and individual clinicians who are responsible for control of notes should register with the Information Commissioner.[16]

7.3 All clinicians should be able to access advice (by telephone) when on duty from an experienced consultant (or equivalent) forensic physician with MFFLM (SOM) or Consultant Paediatrician with at least LFFLM (SOM) or LFFLM (SOM)(c).

7.4 The contracted medical workforce should be working towards a minimum of 25% of forensic physicians and paediatricians with MFFLM (SOM) or MRCPCH with LFFLM (SOM) or LFFLM (SOM)(c) achieving this by 2024.

7.5 Where a two-clinician examination is taking place it must be clear which clinician is taking responsibility for which aspect of the examination. The clinician who is responsible for the forensic aspect, including the identification and interpretation of positive and negative findings, must have at least LFFLM (SOM) or LFFLM (SOM)(c) as a forensic qualification and the clinician responsible for the holistic paediatric aspect must be suitably qualified in paediatric practice to do so. Scottish law requires corroboration of findings necessitating examinations by two doctors.

7.6 All clinicians undertaking this work must have sufficient protected time for attending strategy and child protection meetings, the preparation of statements and reports for child protection requirements, criminal and family courts and for attendance at Court reflected in their job plans.

8. Notes

8.1 The report by Lord Laming following the Victoria Climbie Inquiry[17] gave a number of healthcare recommendations. There is much emphasis placed on senior doctors being involved when child abuse is suspected. Although not all children undergoing a forensic medical examination for sexual abuse will be admitted and seen in a hospital setting, the RCPCH and FFLM believe that it is within the spirit of the report that the relevant recommendations should apply e.g.

Recommendation 75:

'In a case of possible deliberate harm to a child in hospital, when permission is required from the child's carer for the investigation of such possible deliberate harm, or for the treatment of a child's injuries, the permission must be sought by a doctor above the grade of senior house officer.'

In addition, recommendations 65 to 74 and 76 to 80 are also relevant in this context.

8.2 The RCPCH and FFLM are of the view that sexual violence against children and young people should have equivalence with physical abuse in terms of the robustness and quality of the healthcare response. Moreover it should be acknowledged that different types of child abuse often co-exist. With this in mind, it is the view of the RCPCH and FFLM[18] that all children and young people, that is those up to the age of 18 years, should always be seen by a clinician with the requisite seniority, knowledge, skills and experience.

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