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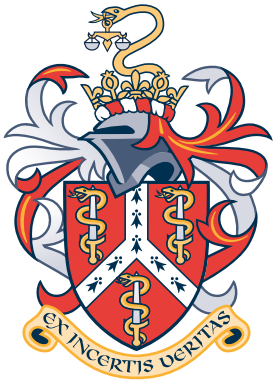

Faculty of Forensic & Legal Medicine

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

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1. Introduction

1.1 The United Nations Convention on 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'.*** Clinicians must practice in a child-centred way, with the child being the focus. In the UK this means anyone under the age of 18 years is a child.

1.2 Victims, complainants or complainers who disclose sexual violence, abuse, and assault are considered as children until their 18th birthday and services should be commissioned accordingly.

'Paediatric services should be considered for children and young people until their 18th birthday. However, some young people between the ages of 16-17 years may prefer to attend an adult service. In these cases, children's safeguarding procedures will still apply.'[2]

1.3 By definition, all sexual assault or exploitation of a person under the age of 18 years, is child abuse and therefore child abuse procedures, including statutory guidance, are engaged for those under 18 years old.

1.4 It is essential to have competent clinicians with the specific knowledge, skills and attitudes, to meet the needs of children and young people where sexual abuse, assault or exploitation is alleged or suspected (including where no allegations have been made). The evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination; the clinician undertaking the examination may also need to address specific issues of consent and reporting of child sexual abuse.[3]

1.5 Whilst organisations may wish to have a skill mix, it is important to consider the initial forensic medical examination is often the **only** opportunity to provide the required care, including acute injury assessment and obtaining forensic samples. The level of experience and skill required for a case often cannot be predicted at referral. Therefore, the clinicians involved must be competent to deal with the unexpected.

1.6 Paediatric sexual offence medicine (SOM) is highly specialised and in some geographic areas, low volume work. In some parts of the UK, practice may vary because of different regulations, for example, the requirement for corroboration, in Scotland, as well as the volume of work. The nature of paediatric SOM cases is such that it is not unusual to require input from other specialities, such as paediatric gynaecology, surgery or sexual health. Paediatric SOM services should therefore be embedded or closely networked with a wider health provision, enabling easy robust access.

1.7 These Quality Standards have been developed in response to the recognition by the Home Office[4] that the Faculty of Forensic & Legal Medicine (FFLM) is 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 the FFLM should set those standards in conjunction with the Forensic Regulator.

1.8 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 the doctor must recognise and work within the limits of their competence. Doctors should also be familiar with the GMC publication *0-18 years – guidance for all doctors* which deal with a range of issues related to the service delivery of these standards.[7]

1.9 The Nursing and Midwifery Council (NMC) sets the general professional standards for nurses and midwives working in the UK. For the individual nurse or midwife providing care, the NMC is clear they must recognise and work within their competence.[8]

1.10 It is essential an appropriately trained workforce with the required knowledge, skills, competence, and behaviours is available to support and improve the health outcomes of children and young people. In addition to meeting the standards set out in this document, clinicians in PSOM must be compliant with capabilities relevant to their Nation of practice:

- England: NHS England has produced a capabilities framework to facilitate this: *Paediatric Forensic Healthcare Practitioner Capabilities Framework for Child Sexual Abuse Assessment*
- Northern Ireland: *Medical Assessment of Alleged or Suspected Child Abuse and Neglect*
- Scotland: *Health assessment and examination - Healthcare professionals - supporting children and young people who may have experienced child sexual abuse: clinical pathway*
- Wales: *Safeguarding Wales*

1.11 Clinicians training in Paediatric SOM may come from different backgrounds, so 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.

1.12 This guidance applies to **ALL** clinicians who provide SOM services for children, i.e. those up to 18 years of age. This is regardless of:

- the professional background of the clinician;
- whether the clinician is working in a paediatric service, or an 'adult' or all-age service;
- whether the assessment of the child follows an acute or a non-recent incident.

There is no one service delivery model which 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 (including assault and exploitation) it is important for that child and family there is an appropriate response from all agencies.[9,10] 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).[11] These 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 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 assessment; assessment for physical abuse, emotional abuse and neglect; mental health assessment; and detailed documentation including the use of line drawings and photo documentation. Additionally, the assessment includes:[12]

- The collection of relevant forensic samples, if appropriate.
- The identification and correct forensic classification of any injury outside 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 diagnose.[11]

- An assessment of the ano-genital area, with the clinician putting into context, as they relate to the circumstances of the case, any positive and negative findings and consideration of potential differential diagnoses.
- If relevant, an assessment for non-fatal strangulation.
- Investigations including sexually transmitted infection (STI) screening with chain of evidence procedures, where appropriate, and management of positive results.[13, 14, 15] Triple site testing would be the default position, unless case specifics dictate otherwise.
- The identification of physical features or concerns from the wider consultation which suggest the child has experienced other categories of abuse.
- A review whether there are any unmet health needs.[16]
- 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 up-to-date, evidenced-based interpretation of findings.

2.4 A provisional report must be provided to the social worker and police (if involved) 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. Provisional reports must be subject to an accuracy check and an independent critical conclusions check in accordance with Forensic Science Regulator guidance.[17, 18, 19]

2.5 Following the FME, a comprehensive child protection medical report must be written and sent to the GP and Children's social care; police if they are involved. 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 or signs in the child and how they came to arrive at that opinion in order to properly safeguard the child or young person. It is good practice to ensure child protection medical reports are shared with the relevant Child Safeguarding teams within Health. Locally agreed processes for this should be in place for this.

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. All reports shall be subject to an independent peer review of all critical conclusions by a second competent individual in accordance with Forensic Science Regulator guidance.[17]

3. Recruitment

3.1 It is recommended 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, or equivalent, and FY2).

3.2 It is recommended all nurses and midwives should have at least three years post- registration clinical experience in paediatric nursing at Advanced Nurse Practitioner Level.[20]

3.3 Relevant specialties or experience for doctors for PSOM includes:

- Paediatrics
- General Practice
- Emergency Medicine
- Sexual Health
- Paediatric Gynaecology

Relevant experience for nurses and midwives includes:

- Contraceptive and Sexual Health Services
- Emergency Departments where paediatric patients are routinely seen
- School nursing
- Paediatric nursing

3.4 Precision in communication is essential. Clinicians must have demonstrable skills in listening, reading, writing and speaking English which enable effective communication in clinical practice with patients, their families, colleagues, and in legal fora.[21, 22] Doctors and nurses/midwives must comply with GMC and NMC requirements respectively.[23, 24]

4. Initial training

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

4.1 Must attend an FFLM initial accredited training course 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 and PSOM.[25, 26]

4.2 Must have up-to-date, as a minimum, Basic Life Support (BLS) and Paediatric Basic Life Support (Paediatric BLS) training as accredited by the Resuscitation Council UK (RCUK) or Advanced Life Support Group (ALSG) certification.

4.3 Must have completed training in Safeguarding Children and Young People (Intercollegiate Document minimum Level 3).[27]

4.4 Must complete training in statement writing and courtroom skills.

4.5 Must have completed training in equality, diversity and inclusion.

5. Workplace-based supervision

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

5.1 Should receive induction training to cover the policies and procedures of the workplace, e.g., Sexual Assault Referral Centre (SARC)/Trust/Health Board/independent healthcare service (private providers).[28]

5.2 Should be assigned an FFLM/RCPCH educational supervisor and clinical supervisor(s), who will be subject knowledge expert(s) 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 The Educational Supervisor/Clinical Supervisor should have completed the Licentiate of the Faculty of Forensic & Legal Medicine in Sexual Offence Medicine, either as LFFLM (SOM) (a+c) or LFFLM (SOM) (c), or MFFLM (SOM).

6. Continuing professional development

6.1 All clinicians in PSOM must have completed initial training and work-based supervision, and have their competencies signed off by the clinical lead of the service before they are able to practise independently of direct (on-site) supervision.

6.2 All doctors practising independently should hold or be working towards MFFLM (SOM) or hold MRCPCH and be working towards the LFFLM (SOM) (a+c) or LFFLM (SOM) (c).

6.3 All nurses and midwives who wish to practise in PSOM will need to have a nursing qualification and paediatric experience as documented in paragraph 3.2 and hold or be working towards the LFFLM (SOM) (a+c) or LFFLM (SOM) (c), and be supervised within a senior medical practitioner led team.

6.4 It is recognised some clinicians work on a self-employed basis, including as locum or bank staff, and as such have less support and line management compared to embedded members of the team. Clinicians working in this way in PSOM should have obtained MFFLM (SOM) or MRCPCH plus LFFLM (SOM (a+c) or LFFLM (SOM) (c).

6.5 All clinicians must have as a minimum annual Basic Life Support (BLS) and Paediatric Basic Life Support (Paediatric BLS) training as accredited by the Resuscitation Council UK (RCUK) or ALSG.

6.6 All clinicians must have Safeguarding training as indicated in 4.3 above at least every three years.

6.7 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.

6.8 All clinicians must attend a minimum of 4 peer review meetings per year.[19]

6.9 All clinicians 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 must have appropriate supervision.

7.2 All clinicians must make detailed contemporaneous notes, including safety netting plans, 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 personally responsible for identifiable personal information should register with the Information Commissioner's Office (ICO).[29, 30]

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) (a+c) or LFFLM (SOM) (c).

7.4 The contracted clinical workforce should have a minimum of 25% of clinicians with MFFLM (SOM) or MRCPCH with LFFLM (SOM) (a+c) or LFFLM (SOM) (c) and be working towards 50% of clinicians having this qualification by 2028.

7.5 There must be a Clinical Lead who must be GMC registered, with a licence to practise. They must hold a qualification in clinical forensic and legal medicine ideally MFFLM but as a minimum LFFLM (SOM) (a+c) or LFFLM (SOM) (c) and must have appropriate paediatric knowledge, skills and experience.[31, 32] If the Clinical Lead is working in a remote capacity, there must be access to a medically qualified locality lead.

7.6 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) (a+c) 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.

7.7 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.

8. Notes

8.1 The report by Lord Laming following the Victoria Climbie Inquiry[33] 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 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[34] **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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September 2015

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Send any feedback and comments to forensic.medicine@fflm.ac.uk

The Equality Impact Assessment needs to be completed so that any decisions made are compliant with the aims of the Public Sector Equality Duty – and that any adverse impact for any protected characteristics are identified and resolved.

Equality Impact Assessment	
Does the scheme affect one of the following groups more or less favourably than another?	**If yes, explain impact and any valid legal and/or justifiable exception**
Age	**No.** These QS specifically addresses the needs of children and young people, i.e. those who have not reached their 18th birthday. **The UN Convention on the Rights of the Child is considered throughout.**
Disability	**No.** As above. In addition, it is recognised that a disability may increase the risk of child sexual abuse, (CSA), including child sexual exploitation, (CSE)
Sex	**No.** QS apply to any child, regardless of sex.
Gender reassignment (including transgender)	**No.** QS apply to any child, however they may identify, in whichever gender(s).
Marriage and civil partnership	**No.** Young people may enter into marriage or civil partnership: In England & Wales, from age 18 years, in which case QS would not apply In Northern Ireland and Scotland, from age 16 years, where the QS would apply
Pregnancy and maternity	**No.** QS apply to and should meet the needs of pregnant young people.
Race	**No.** The QS aim to meet the needs of children and young people, their parents are carers.
Religion or belief Consider and detail	**No.**
Sexual orientation Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people	**No.** QS will meet the needs of LGBTQ+ children and young people, recognising that some research shows a higher prevalence of sexual abuse in this group
Carers	**No.** QS are developed to meet the needs of children and their parents and carers
Other identified groups	**No.**
Is the impact of the scheme likely to be negative? No; it is child-centred	**No.** QS are intended to have a positive impact on the lives of children, young people and their families and carers

Prepared using an NHS England template

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