

The child has a medical assessment or examination

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1. Who is this document for?

This practice guide is aimed principally at police and/or social care professionals who have referred a child¹ for a paediatric medical examination following suspected sexual abuse, and in part, at those conducting the examination.

It is also relevant to other professionals involved in supporting the child and their family, to help them understand what a medical examination involves.

2. What is a paediatric medical examination?

The 2023 update of the Ministry of Justice’s guidance [Achieving Best Evidence in Criminal Proceedings](#) makes clear that, in *any* situation where there are concerns that a child has been sexual abused, a paediatric medical examination – also known as a *forensic medical examination* or a *medical assessment* – should be considered. The College of Policing’s [Authorised Professional Practice](#) recognises that this should happen even if the suspected abuse is non-recent. If a child has

¹ In this document we use the term ‘child’ to refer to anyone under the age of 18. See [An introduction to the child sexual abuse response pathway](#) for more about terminology.

been the victim of a crime and has a physical or mental health need as a result, the [Victims' Code](#) states that they have a right to access medical support.

A medical examination offers the opportunity to look for **supportive evidence** and gather **forensic samples in some cases**, but it also allows for a holistic conversation and assessment of the child's general **wellbeing and health needs**. The CSA Centre has produced a [video](#) explaining what happens, and a research report ([The Role and Scope of Medical Examinations When There Are Concerns about Child Sexual Abuse](#)) which presents evidence on the value of a medical examination and the experiences of children who have had medical examinations.

Medical examinations can take place in a number of settings, including sexual assault referral centres (SARCs) and, only in cases where the suspected or disclosed abuse is non-recent, children's health clinics.

A decision around a medical examination should take into account the child's wishes and worries, any symptoms of concern, and any evidential opportunities; it should be made in consultation with a health clinician who has expertise in child sexual abuse. The clinician should be invited to attend the strategy discussion to offer their expertise to this decision. It is also important that a child makes an informed decision to give consent for all or part of the medical examination - as a professional working with that child it is your role to offer them information to help them making this decision. Some SARCs will have someone available to speak to the child and the family about the process, or advise the social worker or police officer about how to do this.

3. How may the child be feeling?

A child may feel anxious about having a medical examination. They may worry that it will hurt, they may not want to show parts of their body, particularly for teenagers and older children, and they may be uncertain about what it involves if no one has explained what to expect. On the other hand, some children may welcome the examination for the reassurance it may provide and the opportunity to ask questions.

"I am feeling confident about this check-up. I am okay with what will come out of it." (1)

"I feel scared about it because I don't know what's going to happen." (1)

"I feel a bit worried and frightened because of the results." (1)

"I don't want anyone looking at my body." (1)

"I got my mum to ask [the questions] even though I was in the room with her, I wanted to be there to know what's going on but I wanted her to say [that I had been abused]." (2)

*“It would have been better if it had of been a woman wouldn't it? ...
Because it was a man that done [the rape], you know what I mean?” (2)*

*“I feel that every time I see a new doctor or counsellor I am having to
rehash the entire experience which can be really stressful.” (3)*

It is important that the child understands that they can make choices and this is about their health and wellbeing. They can bring along a parent or other adult to support them if they wish.

4. How can all professionals best help the child before the medical examination?

a) Establish how soon the examination should happen

A key factor in the timing of a medical examination is the length of time since the sexual abuse is believed to have taken place. Where this is suspected, it may be the last time the child was with the person of concern.

If the last contact was within the previous seven days, the child's case is designated as *'acute'* or *'recent'* (although this may vary in different areas; your local SARC can advise):

- Specialist medical advice should be sought from a clinician with medical expertise in paediatric sexual offences, ideally **within one hour** of the report of abuse or concerns of abuse being raised.
- The child should then be offered and given a medical examination **as soon as possible**; the Faculty of Forensic and Legal Medicine has produced flowcharts outlining the timing considerations for medical examinations of [pre-pubertal children](#) and of [post-pubertal children and adults](#).
- Consideration should be given ideally at the multi-agency strategy discussion to the medical examination's **timing, purpose and content** in relation to a formal (Achieving Best Evidence) **police interview** with the child. A health clinician with expertise in this area should be consulted.
- However, waiting for the multi-agency strategy discussion is not a reason to delay the medical examination (see section 4b below). It is vital that time-critical health opportunities (to provide emergency contraception or protection against HIV risk, for example) and forensic opportunities (e.g. time frames for forensic samples) are not lost.

If the last contact was more than seven days ago, the case is designated as *'non-recent'* (although some SARCs may do this if more than ten days - your local SARC can advise):

- The child should be offered and given a medical examination in a timely manner, and ideally **within two weeks** of a decision being made that an assessment is required. This will usually, but not always, follow a formal (Achieving Best Evidence) police interview.
- Children with symptoms or signs of concern (such as bruising) should be seen sooner.

In considering when a medical examination should take place, you should also take account of other factors including:

- **the child's wishes and worries** (if they are in pain or have symptoms of concern, for example)
- whether they have any **immediate health or wellbeing needs** (such as significant injury, anxiety or suicidal ideation) requiring urgent treatment
- Special educational needs or disabilities which mean additional support or adaptations will need to be made.
- any action needing to be taken by other agencies to **ensure the child's immediate safety**, such as an emergency protection order.

It is always important to ensure that relevant contextual information is provided to the professional who will conduct the examination. If the medical examination is to take place after the police/social worker have formally interviewed the child, this must include information from that interview. Information about the child's communication and support needs must also be included.

b) Focus on the child's needs in a multi-agency strategy discussion

Unless the child has acute healthcare needs (e.g. bleeding, significant intoxication or other physical injury), a **multi-agency strategy discussion** between professionals should take place before the medical examination. This can be carried out in one or several telephone or videocalls or in person meetings, and should include input from the paediatrician or clinician likely to conduct the medical examination or other appropriately qualified health professional.

When you are referring the child for a medical examination be clear who has **parental responsibility** for the child before the examination takes place and seek appropriate permissions where relevant. (If the child is the subject of a care order, for example, parental responsibility will lie with the local authority children's social care team.) The child may or may not be able to **give their consent** to having the examination, depending on their age and their ability; see the [NHS guidance on children and consent](#) for more information.

- If the child *cannot* give their own consent, someone with parental responsibility (who is not associated with the alleged or suspected abuse) will need to do so and will need to accompany the child to the examination.
- If the child *can* give their own consent, it may still be preferential to have someone with parental responsibility available in person (subject to the child's preference) or on the phone during the examination.

Consider too how the child and their non-abusing parent(s)² can be **supported on the day** of the medical examination. For example:

- How will they get to the venue and home again? Do they have transport needs and does financial support need to be provided?
- Is an interpreter required?
- Is the venue accessible and welcoming for them? Think about the child's individual characteristics – their age, sex, cultural background and communication needs. Does it have disabled access?
- Can the child's choices be accommodated (in terms of the sex/gender/ethnicity of the examiner, for example, or who they wish to bring as their support person)?
- Also, what support they will have afterwards from family and/or other professionals.

However long ago the suspected sexual abuse happened, *all* children having a medical examination should be offered access to an **independent sexual violence adviser** (ISVA) or a **child and young person's sexual violence advocate** (CYPSVA³), who can support them and their family. If a referral for an ISVA/CYPSVA has not already been made, try to ensure that this is actioned at the medical examination. (The Survivors Trust website enables you to [search for an ISVA service in your local area.](#))

c) Helping the child prepare for the medical examination

If you are referring the child for a medical examination, make sure they and their non-abusing parent(s) are given appropriate information in advance about **what a**

² In line with the above, from here on we use 'parent' to mean someone in a parental or principal care-giving role to a child; this may be their biological parent, step-parent, adoptive parent, foster parent or other relative fulfilling that role, or a member of the children's social care team acting as corporate parent. We use the term 'non-abusing' to mean a parent who is *not considered to have been involved in sexually abusing the child*, even if they may have previously come to agencies' attention for other reasons.

³ Also abbreviated to CHISVA or ChISVA.

medical examination will involve and **why it is recommended**. This should be provided by a well-informed professional, in a sensitive and supportive way that is appropriate to the child's age and ability. If an ISVA or CYPSVA has already been allocated to the family, they may provide the information, otherwise, the CSA Centre has produced [resources to support you](#) in providing it, including a short video explaining what happens in a medical examination.

Your local SARC or children's service may also have its own resources. Examples from individual SARCs include:

- [Visiting Our SARC: A Guide for Children \(Mountain Healthcare\)](#).
- [Visiting Our SARC: A Guide for Young People \(Mountain Healthcare\)](#).
- [Guide to Our SARC for Adults and Young People \(The Elms; a document tailored to people with learning difficulties\)](#).
- [St Mary's Centre: I am a young person](#)

Reassure the child that:

- they will be able to decide **which aspects** of the medical examination they want, if any. Many health and wellbeing needs can be identified, and some evidential aspects facilitated, without a physical examination.
- although they may be asked some questions in order to establish the scope of the medical examination, and they will be able to talk about the abuse if they want to, they will not usually be asked during the medical examination to **repeat** anything that they have already said to other professionals about it
- the medical examination will take careful account of **their wishes, worries and expectations**
- relevant results will be disclosed to children's social care, and to the police if a criminal investigation is under way, but **confidentiality will be maintained as per national guidance** in all other respects
- The purpose is to primarily ensure the health and well-being of the child.

Make sure that the child knows that **they need not be alone** during the medical examination:

- If they wish, they can be accompanied by their parent(s) or another person of choice (excluding people of concern). If they already have an ISVA/CYPSVA, they should be able to ask for that person to be present at the medical examination, where that is practical.
- All examinations will be supported by a professional such as a crisis worker, play therapist or nurse.

Bear in mind, though, that the child (especially an older child/young person) may, for a number of reasons, **want to be on their own** when examined; they should have choice about this.

If the child declines to have a medical examination, or an examination is not carried out for any other reason, try to ensure that the child is offered other appropriate health tests/check-ups for issues such as:

- sexually transmitted infections and blood-borne infections
- emergency contraception
- worries about self-harm and other psychological impacts
- general health and wellbeing.

Your local SARC or children's health clinic can provide advice on this.

5. How can the examining health professional best help the child?

Detailed guidance around the competency and capabilities of clinicians seeing children, and best practice in relation to paediatric forensic examinations, can be found in the documents listed at the end of this practice guide.

a) Before the examination

Try to obtain all the information you can about the child, what the concerns are and what they have said (if relevant). The examination includes taking a holistic history, but information may be available in advance from the referring professionals, which will prevent the need for the child to repeat their account. If other sources of information such as medical records are available, these may provide additional information (about any special educational needs, for example). It's important to know **the language used by the child** to describe the abuse.

In particular, the police should have given you information from their formal (Achieving Best Evidence) interview with the child, if this has already taken place.

You also need to be aware of any actions (e.g. court orders, arrests, legal proceedings) taken or planned by other agencies around the child's safety and aftercare.

Establish who has parental responsibility for the child (see section 4b above); if that person refuses to consent for their child to be examined, the local authority may apply for an emergency protection order or a child assessment order so that the medical examination can take place. The child may have the capacity to give consent for the examination under the process of Gillick competence, but this

cannot be assumed in advance. Children over the age of 16 are presumed to be able to consent for themselves unless they lack capacity.

Ensure the child's communication needs are addressed.

b) During the examination

Like all professionals interacting with the child, it's important for you to bear the child's individual circumstances and characteristics in mind during the medical examination – their age and stage of development; their sex; their ethnicity, religion and culture; their social class; any disabilities or learning difficulties they have; and their sexual orientation and gender identity – while not making assumptions based on those circumstances and characteristics. Our practice guide [Taking account of diversity](#) contains more information.

It is crucial to take the child's wishes, concerns and expectations into account, and to listen to and address any worries they have.

They should be given choice throughout the examination, including about:

- which aspects (if any) of the physical examination, offered tests and aftercare options they want
- who (if anyone) they want with them during the examination.

Details of the alleged or suspected abuse should already have been shared, and the child **should not be asked to repeat them** during the examination – but you may need to ask specific additional questions, so that you can provide or make a referral for appropriate health and wellbeing interventions (if considering the need for emergency contraception, for example). Explain this to the child.

Think about **how you ask questions**, the **language** you use and your **body language**. The structuring of questions is important: In those children who have not had a formal police interview, open questions should be used where possible and all responses documented.

Our [Communicating with Children Guide](#) contains detailed information about core communication skills and questions you can ask.

If the child gives you any information during the examination that raises **new safeguarding concerns** (about additional suspects or victims, for example), share this immediately with the police and/or children's social care. Explain to the child, in a way they will understand, that you are doing this.

Make a contemporaneous record of any new information that is spontaneously offered by the child, as it may be needed later if the case goes to court. Ensure this is recorded in the child's own words.

Think about the child's emotional health and wellbeing and ensure that appropriate referrals for further support are made if appropriate. These might include **mental health** referrals via the local Child and Adolescent Mental Health Service (CAMHS), or referrals for **specialist therapeutic support** via the voluntary sector or other agencies in the local area. As a matter of routine, these referrals should consider the wider family and carers. See our [Get support](#) page for details of national and local specialist services.

You should also consider referrals for **sexual health follow-up support** (if this is not provided at the medical examination) and other referrals which may not be directly related to child sexual abuse, such as a GP appointment if there are developmental concerns.

Remember that many children who have been sexually abused have also experienced **other forms of harm** such as neglect, physical abuse or domestic abuse. The medical examination must consider and proactively explore this in a holistic manner and take appropriate action.

At the end of the examination, provide some **immediate feedback**, appropriate to their age and developmental level, to the child and any accompanying adult(s). This may be as simple as saying, "Everything looks healthy." Give them space and time to ask any questions, and explain what you will do next (see below).

If the medical examination **has not found physical evidence of sexual abuse**, take care to explain clearly to the child and any accompanying adult(s) that this is very common, and **does not mean that the abuse didn't occur**.

c) After the examination

On the day of the medical examination, provide **feedback (ideally in writing)** to the referring and relevant agencies. This may be a brief summary of the examination's findings and any recommendations. Write too to the child, where age appropriate, and the child's non-abusing parent(s), copying in the child's GP.

As soon as possible after that, share a **safeguarding medical report** with relevant agencies; this should include an evidence-based opinion.

Make sure you know what your local procedures recommend for the management of photo-documentation and intimate images resulting from the examination, in line with best practice recommended by the FFLM/RCPCH's [Guidance for Best Practice for the Management of Intimate Images Which May Become Evidence in Court](#) (2020).

It is essential to preserve all notes and records concerning medical examinations, as they may be required for disclosure as part of any subsequent criminal or family court proceedings.

6. Where next?

- [The child is formally interviewed.](#)
- [Police arrest the suspect or invite them in for interview.](#)

Or [return to the response pathway.](#)

Sources of quotations

The quotations in this practice guide, from children who have been referred for medical examinations, illustrate how the child may be feeling at this point and how your actions can make a difference.

- (1) Marks, S., Lamb, R. and Tzioumi, D. (2009). [Do no more harm: The psychological stress of the medical examination for alleged child sexual abuse.](#) *Journal of Paediatrics and Child Health*, 45(3):125–132.
- (2) Skinner, T. and Taylor, H. (2009). [“Being shut out in the Dark”: Young survivors' experiences of reporting a sexual offence.](#) *Feminist Criminology*, 4(2):130–150.
- (3) Smith, N., Dogaru, C. and Ellis, F. (2015). [Hear Me. Believe Me. Respect Me. A Survey of Adult Survivors of Child Sexual Abuse and Their Experiences of Support Services.](#) Ipswich: Survivors in Transition.

Procedures to be followed in cases of child abuse are set out in the UK Government’s statutory guidance for England,

[Working together to safeguard children 2026: statutory guidance](#) and in the [Wales Safeguarding Procedures](#) (2020). Also relevant here are the College of Policing’s [Authorised Professional Practice on Investigating Child Abuse and Safeguarding Children: Further Investigation](#) (2022); the Ministry of Justice’s [Achieving Best Evidence in Criminal Proceedings](#) (updated 2023); the General Medical Council’s [Child Protection Examinations; Quality Standards for Clinicians Undertaking Paediatric Sexual Offence Medicine](#) (2021); the [Service Specification for the Clinical Evaluation of Children and Young People Who May Have Been Sexually Abused](#) (2015) from the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM) and the Royal College of Paediatrics & Child Health (RCPCH); and the RCPCH’s [Child Protection Service Delivery Standards](#) (2020).

This practice guide is underpinned by the above documents, and is not intended to repeat or replace them. It should be read alongside your local child protection procedures.

This guide is part of our [child sexual abuse response pathway](#), designed to ensure that professional responses to concerns about child sexual abuse meet

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the needs of children and their families. It aims to bring clarity to key response points, helping you keep the child's needs and perspectives central.