HAUTE AUTORITÉ DE SANTÉ

SUMMARY OF GOOD PRACTICE GUIDELINES

Medical identification and reporting of incest: recognising intrafamilial child sexual abuse

May 2011

DEFINITIONS

Child sexual abuse	• To force or incite a minor to take part in a sexual activity, with or without physical contact, and/or to sexually exploit him/her
Minor	• Aged under 18 years.
Intrafamilial sexual abuse or incest involving a child	• Sexual abuse of a minor committed within the family by older relatives, a brother, sister or by any other person, including a cohabitant of a family member, with legal or de facto family authority over the victim. (According to the law dated 08/02/2010)
Reporting	• A professional report presenting, after evaluation, the circumstances of a child at risk requiring legal protection • Since 2007, this is exclusively intended for legal authorities and corresponds to the submission of a case to the court by the public prosecutor.

KEY POINTS

- Intrafamilial sexual abuse can occur irrespective of family and socio-economic circumstances, from the most privileged to the most modest.
- Disclosure can be accidental, unexpected and sometimes inconsistent (the child may retract or change his/her statement), which emphasises the importance of being vigilant regarding potential abuse, whatever the context of disclosure.
- Any change in the child's usual behaviour, for which there is no obvious explanation, may be suggestive of abuse.
- The absence of signs during the clinical examination does not rule out assault of a sexual nature even if the examination findings are not related to the child's statements.
- If there is a strong suspicion of sexual abuse and continuous (or frequent) contact with the perpetrator, it is essential to provide the child at risk with immediate protection (reporting or hospitalisation)

Improving the identification and increasing the number of reportings of cases of intrafamilial child sexual abuse depend to a large extent on the level of knowledge acquired by the doctor or professional who works with children in this area. Providing these individuals with initial and continuing professional training is essential so that they can be made aware of the abuse to enable them to "keep it in mind" during their practice, and to inform them about the steps to implement to protect the child at risk.

IDENTIFYING CIRCUMSTANCES

Identification by child's family and friends	• Medical professional, professional who works with children, or the state education system, child's close friends and family • In view of signs raising doubt or concern
Disclosure by child	• Disclosed accidentally, during a need to confide in a third party or by a deliberate revelation • The events recalled may be current or older and revealed even though they have ended.
Alerting features in the child and his/her close friends and family	• **General signs**: Non-specific, very varied signs of this type of abuse (e.g. eating behaviour problems, sleep disorders, difficulties in school, etc.) • **Anogenital signs**: Certain signs can be suggestive: if they are observed in the prepubertal child in the absence of any medical explanation, especially if they are repeated. • **Child behaviour**: Any change in the child's usual behaviour for which there is no obvious explanation can be suggestive of abuse. There may be no specific signs of sexual abuse. • **Behaviour of friends and family**: During a consultation be attentive to adult-child behaviour, adult-professional interactions and the attitude among the adults involved between themselves.

CONDUCTING THE MEDICAL, PHYSICAL AND MENTAL EXAMINATION

- All data collected during the medical examination are recorded in the medical file and not in the child's health record:
  - The information and words are transcribed again word for word, between inverted commas and as they have been understood or observed, avoiding any comment, interpretation or personal assessment.

Interview with the child and his/her family	• Conduct the interview alone with the child, whatever his/her age and with his/her agreement. • Allow the child to express him/herself spontaneously, avoiding rewording or interpreting his/her words, respecting periods of silence and encouraging open questions. • With the family: Adapt the interview to the participants (without being intrusive or making it seem like a police investigation).
Mental examination	The purpose is to look for suggestive but non-specific signs: • Post-traumatic stress disorder • Depressive state • Behavioural problems (regarding sex, relationships, in school) • Conduct disorders • Change in the child's intellectual and emotional development
Physical examination	• This should be adapted according to the practitioner (experience, abilities), the child (age, alerting signs) and the circumstances of discovery. The examination includes: ◦ *a complete clinical examination* ◦ a genital and anal examination should be performed if the doctor considers it useful • A normal genital and anal examination does not rule out the possibility of sexual abuse (very suspicious lesions are very rare, STIs (sexually transmitted infections) are unusual in children and rare in adolescents in these situations). • Look for signs of associated physical abuse. • Clinical signs suggestive of sexual abuse vary greatly in type and severity. • The circumstances warranting an emergency examination are rare: ◦ **forensic:** if the assault has occurred less than 72 hours ago, and there is the impression of penetration, to look for recent lesions ◦ **medical and surgical**: severe physical or mental signs (surgical lesions, acute psychological disturbance, etc.)

REPORTING BY THE DOCTOR

- Reporting to the public prosecutor is the only way to implement immediate legal protection for a child at risk. The public prosecutor may be contacted 24 hours a day, and the contact details are available from the local constabulary or the police (emergency police telephone number ☎17).
- If there are any questions, get advice beforehand from the district centre (Cellule de recueil des informations préoccupantes (CRIP) in France) for reporting child safety concerns.

Methods for drawing up the report	• Mention only what has been reported, understood or observed by the doctor, without personal interpretation (the reporting form from the *Conseil National de l'Ordre des Médecins* [French General Medical Council] may be used). • Report the wording used exactly, using the conditional (e.g. the mother reported to us that the child would have shown such a sign) and putting all the words between inverted commas. • Only mention a presumed author between inverted commas if she/he has been clearly named.
Sending the report	• Send the report in writing (fax followed by a letter with acknowledgement of receipt) after informing the public prosecutor by telephone. • The sole addressee is the Public Prosecutor of the Magistrates' Court of the location where the facts have been disclosed. • Keep a copy of the report: it must not be sent to the parents or the child.
Legal context of reporting	• The doctor does not have to be certain of the abuse or to provide proof of it to make a report. • According to article 226-14 of the Penal Code, if sexual abuse is suspected, the doctor is released from professional secrecy. • To draw up a report, the consent of the victim if a minor (< 18 years of age) is not compulsory.
Potential risks related to reporting	• To avoid these risks it is essential that the rules for drawing up the report be followed. • Risk of being convicted for false or malicious accusation: if the person reporting knows that the facts revealed were of a totally or partially inaccurate nature. • Risk of prosecution for failing to provide help: if it is demonstrated that the doctor has not undertaken effective step(s) to protect the child.

HAS

This summary presents the main points of the professional guidelines:
"Medical identification and reporting of incest: recognising intrafamilial child sexual abuse" – May 2011.
The full text of these guidelines and the scientific rationale can be consulted at **www.has-sante.fr**