Conflicts, Challenges and Conundrums associated with Child Sexual Abuse: A Medico-legal Perspective

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Choice of Topic

- Repeated Themes from Professionals from different backgrounds
- How do you explain medico-legal findings to care-givers?
- As Health Care Professionals what is our role to the judiciary?
- The literature is confusing
- Medical Findings can sometimes confirm sexual abuse but never exclude it
- Expectations from the community and the NPA
- How do we make sense of all of this
Scope of Presentation

- Highlight certain key issues/themes linked to learning objectives
- Issues chosen not exhaustive
- Based on my experience over a number of years of clinical practice
- Issues that were raised from multi-disciplinary professionals at workshops
- A few scenarios will be used to demonstrate learning points
- Some Recommendations going forward
Some of the topics that will be covered (1)

- Therapeutic Role vs the Forensic Role of a Health Care Practitioner (HCP)
- Taking a Medical History: What are the pitfalls? (Related to the incident)
- The Process of Disclosure in child sexual abuse and its implications
- The Timing of the Clinical/Medico-legal Examination
- Consent for the medical examination: parent available/not available/parent perpetrator
- Should a child be examined at 2am? A Medical Emergency?
- Chaperone and others present during examination
- Medical Examination Positions in Child Sexual Abuse
- Medical Examination Techniques in Child Sexual Abuse
Topics (cont. 2)

• Anatomy of the Female Genital Tract in a child: self-cleansing vaginas?
• Normal Variants of Genital Anatomical Structures
• Sexually Transmitted Infections in Children
• HIV and Child Sexual Abuse
• Who would be an ideal HCP to examine a case of Child Sexual Abuse?
• Interpretation of a Negative Medical Examination
• Formulation of a conclusion in the Medico-legal Report (J88 Form)
• Collection of Forensic Evidence and the chain of evidence
Topics (cont.3)

- Role of Forensic Photography, Colposcopy and Imaging
- Compulsory testing of the perpetrator: Is this of any value?
Statistics

• No accurate statistics of sexual offences in South Africa
• Sexual Assault/Rape statistics are high – SA at the epicenter
• We do know the number of the cases that are reported to the police
• Number reported to police is an underestimation for various reasons
• Number of cases reported to DoH are higher as not all cases are reported to SAPS
Sexual Assault Statistics - Nationally

• The sexual offences crime category contains the crimes detailed in the Criminal Law (Sexual Offences and Related Matters) Act. Crimes that fall under this broad category include rape, compelled rape, sexual assault, incest, bestiality, statutory rape and sexual grooming of children, among others.

• As a result, when this crime category increases or decreases, it is unclear what crimes are driving the change.

• In 2015/16, 51,895 sexual offences were recorded – from 01 April 2015 to 31 March 2016

• an average of 142.2 per day.

• (The Daily Maverick, accessed 31 October 2016)
<table>
<thead>
<tr>
<th>Data Element Name</th>
<th>No. of cases (KZN)</th>
<th>%</th>
<th>eThekwini No. of Cases</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sexual Assault case new (SACN)</td>
<td>11 515</td>
<td>100%</td>
<td>3 972</td>
<td>100%</td>
</tr>
<tr>
<td>2. SACN: offered comfort packs</td>
<td>1 978</td>
<td>17%</td>
<td>96</td>
<td>2%</td>
</tr>
<tr>
<td>3. Sexual Assault Prophylaxis new</td>
<td>5 014</td>
<td>44%</td>
<td>1 675</td>
<td>42%</td>
</tr>
<tr>
<td>4. Sexual Assault case reporting after 72 hours</td>
<td>4 031</td>
<td>35%</td>
<td>1 230</td>
<td>31%</td>
</tr>
<tr>
<td>5. Sexual Assault case testing positive prior to PEP</td>
<td>1 825</td>
<td>16%</td>
<td>670</td>
<td>17%</td>
</tr>
<tr>
<td>6. Sexual Assault case under 12 years</td>
<td>4 498</td>
<td>39%</td>
<td>1 567</td>
<td>39%</td>
</tr>
</tbody>
</table>
Self test

• For each of the following 3 slides indicate whether or not:
  • The clinical features are normal?
  • The child has been sexually abused?
Learning objectives

• Understand the normal anatomy and development of the female genital tract

• Undertake the medical examination of a child that was raped

• Recognise features of rape in children

• Be able to interpret clinical findings in children
What is Childhood Sexual Abuse?

• 1. According to Kempe: it is the involvement of a child in sexual activity:
  a. To which he/she does not consent
  b. That he/she does not understand on the basis of his/her developmental age
  c. That violates the norms of society

• 2. Faller describes it as the involvement of a child in sexual activity where there is an imbalance of power on the basis of age/strength, assertiveness, wealth or social status

• SEXUAL ABUSE IS DEFINED BY WHAT THE CHILD SAYS, COMPARED WITH PHYSICAL ABUSE WHICH IS DEFINED BY WHAT ONE SEES
What is meant by Sexual Activity: 4 Classes

• 1. SUSPECTED ABUSE: Where the signs and symptoms suggest abuse but the child is unable or unwilling to confirm this;

• 2. MILD OR NON-CONTACT ABUSE: Verbal harassment, exhibitionism or exposure to pornography;

• 3. MODERATE OR CONTACT ABUSE: Fondling of the breast or genitalia of the child or perpetrator by the perpetrator or child;

• 4. SEVERE OR PENETRATIVE ABUSE: Penetration of the mouth, anus or vagina with any object. This may be the consequence of a process of seduction or one of rape
EPIDEMIOLOGY

• GENDER:
  • One in three girls (33%) and one in five boys (20%) will be sexually abused before 16 years of age

• AGE:
  • Girls: Two peaks: less than 6 years and early teens
  • Boys: Single peak: 7-9 years although this has increased to 12-13 years of age
Therapeutic vs Forensic Role (1)

- Therapeutic Role
  1. Medical History
  2. Clinical examination
  3. Treatment: injuries or incidental illnesses
  4. Prophylaxis: Pregnancy, STI’s and HIV
  5. Counselling
  6. Medical Referrals
Therapeutic vs Forensic Role (2)

• Forensic Role:

• Need to assess the facts in a cold, clinical, objective manner without being judgmental

• Formulate a conclusion with the available facts gleaned from the medical examination

• Use evidence based medicine

• Be able to substantiate your conclusions with peer reviewed literature: texts, journal articles etc
Paradigm shift from therapeutic to forensic

• All Forensic Health Care Practitioners need to understand their forensic role
• Must be able to appraise the medical findings elicited accordingly
• Avoid the temptation to make up findings
• Some may feel that they are “letting the patient down”
• A competent Forensic HCP must be able to explain his findings to court
• He/She is not there to convict or acquit a perpetrator
• Understand that he is a witness for the court not one or other party
• Must be consistent in his testimony to maintain his integrity
History of the incident

- Understand the purpose of the History of the incident: guide the medical examination & forensic evidence collection
- Be brief: Try and capture this in a couple of lines
- Be relevant and pertinent
- Avoid too much detail
- Be aware of using exact dates and times and names of individual
- Validate the history with the victim or the caregiver
- Use of an interpreter: Full names recorded on the J88 form
The Process of Disclosure of CSA

• Complex process evolving over time, rather than a simple, single event
• Invariably occurs over days and weeks after the event
• Within 48 hours in less than half the cases
• Mean time to disclosure about 7 days
• Delay is a consequence of the process of abuse and the associated feelings of guilt, shame, coercion, fear and other factors
The Timing of the Clinical/Medico-legal Examination

- This is absolutely critical; as the time interval is inversely proportional to the likelihood of obtaining quality forensic evidence from the medical examination.
- It will impact on whether the clinical findings will be positive or negative.
- Early examinations allow for collection of good quality forensic evidence.
- Concept of ‘self-cleaning’ vaginas in children.
- With healing of injuries leave little to see and interpretation of healing or healed injuries of the genitalia becomes difficult to interpret.
- With delayed examinations: opportunities for provision of Post-exposure Prophylaxis for pregnancy, STI's and HIV is lost.
Consent for the medical examination: parent available/not available/parent perpetrator

- Imperative that we have the co-operation of the child first and foremost
- Consent will usually be obtained by the parent or care-giver
- If not available consent may be obtained from Medical Manager, police official, court
- If parent is the abuser consider admitting the child and investigating
- Remember ito the Children’s Act: always act in the best interest of the child principle
Should a child be examined at 2am? A Medical Emergency?

- KZN DoH: “No patient may be turned away”
- Is it in the best interest of the child to be examined at some unearthly hour when the child should be sleeping?
- An emergency medical examination is required when:
  - 1. There is genital or anal pain
  - 2. Evidence of genital or anal bleeding or injury
  - 3. When the window of opportunity for the collection of forensic evidence is running out.

- *In all other cases the child should be put to bed and examined the following morning*
Chaperone and others present during examination

• Chaperones play a vital role: with evidence collection
• Name of the chaperone must be recorded on the J88 form
• Record also if the chaperone has been used as an interpreter
• In the case of young children have the mother present in the consulting room to reassure the child
• Do not crowd out the room
• Do not be influenced by the care giver
Examination Positions
Genital examination

2 positions
  • Supine
  • Knee-chest

• 2 techniques
  • Labial Separation
  • Labial Traction

• Always include the examination of the anus
Summary

• Assessment requires time, privacy & consent

• Examine the whole child

• Genital examination includes 2 positions & 2 techniques
Assessment exercise 1
Scenario 1
Amahle is 4 years old
Brought by her preschool teacher
Yellow PVD & abnormal behaviour
Family: Lives with single dad & his father & father’s girlfriend who are heavy drinkers and cannot be contacted
You admit Amahle as: assessment abnormal & suspicious of sexual abuse
Family furious re: examination, suspicions of sexual abuse & admission

How do you justify your actions?
Could you have done anything different?
• Primary responsibility
  • Amahle

• Consent is essential
  • From Amahle
  • From the parent/guardian or SAP 308

• Diagnosis
  • Based on history, examination and special investigations
  • Not preferences of parent

• Valid complaint regarding admission
  • More appropriate steps are available to ensure her safety
Scenario 2

Sibongile is 12 years old, gaining weight, moody, withdrawn & unresponsive for 4 months pregnant despite normal genital examination & no menarche (first menstrual period)

Family: Lives with mom & dad, uncle & girlfriend. Mom & dad work, recently girlfriend got a job. Uncle started sexually abusing Sibongile. The abuse stopped when he was arrested for assaulting a neighbour. Estimated 25 episodes of sexual abuse.

Discuss:

1. Failure to disclose abuse even after uncle arrested
2. Normal genital examination
3. Pregnancy prophylaxis
• Non disclosure
  • Fear or coercion
    • Uncle is violent
    • Fear that family will not believe her
  • Manipulation
    • Intra-familial abuse

• Normal genital examination
  • Intra-familial abuse with grooming
  • Prolonged interval between abuse and examination
  • High oestrogen profile with protective or masking effect on hymen

• Pregnancy can occur before menarche
  • Prophylaxis must be based on thelarche (breast) not menarche
  • Provide Sibongile with options to manage her pregnancy
Anatomy of genital tract and implications

• The size of the genital structures will increase with growth and ageing
• Susceptibility to acute injury is reduced in an oestogenised hymen due to:
  1. Lubrication and reduced friction secondary to leucorrhoea
  2. Increased elasticity of the hymenal membrane
• Structural changes to the hymen are affected by:
  1. The increased elasticity of the oestrogenised hymen
  2. The growth of the hymenal membrane at puberty which may encroach upon and mask pre-existing structural changes such as notches
Anatomy of female genital tract and implications

• The consequences of sexual intercourse are also influenced by oestrogen:

  • 1. Sexually transmitted infections are uncommon when the vaginal pH is high:

    a) Chlamydia and Trichomonas infections are therefore extremely uncommon in prepubertal children

    b) Their occurrence should always raise the possibility of sexual abuse

• 2. Conception is closely related to oestrogen levels and the risk of pregnancy rises once Tanner stage 3 development has been reached
Normal Variants: Clitoris

- May host normal dermatological lesions such as naevi or sexually transmitted infections such as Herpes simplex
Normal variants: Urethral orifice

• Variable shape, size and position

• Common abnormalities include:

1. Urethral prolapse

2. Urethral caruncle

• Peri-urethral folds/bands occur in most girls as a bridge of tissue extending from the side of the urethral meatus laterally to the vestibule with the same colour and texture of the adjacent tissue
Normal variants: vestibule

• The vestibule usually has an area of erythema in the sulcus and its adjacent tissue. When there is uniform bilateral erythema throughout the vestibule this is suggestive of inflammation, infection or trauma.

• Vestibular bands are similar to the paraurethral bands and are a narrow bridge of tissue between the outer margin of the hymen and the vestibule found in up to 45% of girls.
Normal variants: Labia, posterior fourchette & perineum

• These may be involved in skin conditions such as lichen sclerosis et atrophicus and capillary haemangiomata that can mimic sexual abuse

• Midline avascular lesions and irregular epithelium are commonly found in the posterior fourchette
Normal variants: Hymen

• Configuration refers to the shape of the hymenal membrane.

• The commoner variations include:

1. Fimbriated with multiple folds of fleshy redundant hymenal tissue. This is indicative of an oestrogenised hymen so is common in the neonatal period and in adolescence

2. Annular or circumferential hymen which is common in childhood

3. Crescentic hymen with no hymenal tissue anteriorly between 11 and 1 o’clock. This is also common in childhood
Normal Variants: Hymenal Orifice

- The hymenal orifice is the opening in the centre of the hymenal membrane. This is normal and a completely intact membrane or imperforate hymen is unusual and abnormal.

- Inferior rim, the amount of tissue present posteriorly at 6 o’clock between the hymenal rim and the posterior vaginal wall, must be at least 1 mm in thickness.

- Bump/Mound/projection is a protrusion from the free edge of the hymen either as an extension of an intravaginal ridge or the hymen itself.

- Tags occur when an intravaginal or external ridge protrudes beyond the hymenal rim. These occur most frequently in the midline and are thought to represent the remnants of a septate hymen.

- Notch or cleft is U or V shaped disruption of the free edge of the hymen. Anterior notches between 9 and 3 o’clock are usually benign.
Normal Variants: Vagina

- Intra-vaginal ridges: are narrow ridges of mucosa covered fibrotic tissue attached to the inner surface of the hymen that run longitudinally along the posterior and lateral vaginal walls.

- Intra-vaginal columns are broad intra-vaginal ridges found in the midline anteriorly and posteriorly.
Sexually Transmitted Diseases in Children
HIV and Child Sexual Abuse

- All child victims will be tested for HIV - algorithm
- If negative will be offered Anti-retroviral therapy (ART)
- ART is offered on the basis of the history and not on the clinical findings
- Appropriate blood tests would be done: LFT, RFT and FBC
- Dosage schedule is based on body weight
- Triple therapy is now routine for 28 days: dispensed ab initio
- Repeat testing done in 6 weeks
WHO SHOULD CONDUCT THE EXAMINATION? Education & Training

- In CSA, examinations require high level of skill & knowledge in THIS field, not just as a generalist, as the examination is of complex nature
- **Examining clinician should be appropriately qualified**
- In the UK, prescribed requirements exist: *(Joint Guidance)* by *Faculty of Forensic & Legal Medicine* and *Royal College of Paediatrics & Child Health* (2007).
- However in SA - no such prescribed *guidelines*. The level of training of medical students involves a few lectures or seminars, and NO experience!!!
- Guidelines also stress high quality photo-documentation. In SA, photo documentation is **hardly ever** used because of lack of training, equipment and that admissibility of such evidence is problematic in court – issues of **storage, access & confidentiality** of the images compound the issue.
Specific competencies required of an examiner 1

1. An ability to communicate comfortably with children & their carers about sensitive issues.

2. An understanding of & sensitivity to the child’s developmental, social and emotional needs.

3. An understanding of consent & confidentiality as they relate to children and young people.

4. Competence to conduct a comprehensive general examination & genital examination of a child, & skill in the different techniques used to facilitate the genital examination eg: labial traction.

5. An understanding, based on current research evidence, of the normal genital anatomy & its variants, for the age and gender of the child to be examined.

6. An understanding, based on current research evidence, of the diagnosis & differential diagnosis of physical signs associated with abuse, and application of best-practice guidelines on interpretation of clinical findings, e.g Adam’s Classification

7. Competency in the use of a colposcope & obtaining photo documentation, ensuring that the latter properly reflects the clinical findings & documenting if it does not.
Specific competencies required of an examiner 2

8. An understanding of what **forensic samples** may be appropriate to the investigation & how samples should be obtained and packaged.

9. Ability to **document** comprehensively & precisely the clinical findings in contemporaneous notes.

10. The **competence to produce a detailed statement** or report describing and interpreting the clinical findings (eg: J88).

11. Understanding of the importance of **communicating & co-operating** with other agencies (eg: SAPS, DSD, NPA) & other professionals (eg: psychologists, gynecologists, pediatricians).

12. **Ability to present the evidence & be cross-examined**, in subsequent criminal or civil proceedings.

13. Understanding of the different types of **post-coital contraception** available, their indications & CI’s, and the capacity to prescribe hormonal contraception, where appropriate.

14. **Training in PEP** including Hepatitis B, human immunodeficiency (HIV), screening & diagnosis of STI’s.
Interpretation of a Negative Examination
Formulation of a conclusion in the Medico-legal Report
Collection of Forensic Evidence and the Chain of Custody
Role of Forensic Photography, Colposcopy and Imaging
Compulsory Testing of the Perpetrator: of what value?
Recommendations moving forward

- Recognition of Clinical Forensic Medicine as a specialist discipline in Medicine
- Recognition of Forensic Nursing as a discipline by the SANC
- Minimum Standards for the HCP who examine CSA victims
- Revalidation/Continued Professional Development of HCP
- CSA needs to be integrated into the undergraduate medical curriculum
- Closer engagement between the DoH and the SAPS Forensic Science Laboratory
- Understand and implement Best interest of child concept by all professionals
- When giving expert testimony use this as an opportunity to educate the court
- Outreach programmes to empower communities on CSA
- Introduce best standards for the practice of Clinical Forensic Medicine