PROMISE

Forensic medical interventions in Barnahus across Europe

Mapping results 2020

Contents

Medical interventions in Barnahus

Barnahus is an evolving model that can be adapted to different legal, socio-economic, and cultural contexts. *Promise overall goal* is that all Barnahus and similar services progressively develop excellence in practice according to international law and to the Barnahus Quality Standards:

All Barnahus implement multidisciplinary and interagency interventions[1], organized under one roof in a child-friendly setting[2], placing the best interests of the child[3] at the centre.

Each child is offered a balanced multidisciplinary, professional and child friendly intervention, managed through joint case management and review.

All Barnahus include "four rooms" embedded in a multidisciplinary and interagency environment.

- **Child Protection:** The Barnahus contributes to the assessment of protection needs and supports follow up concerning the child victim and siblings in the family.
- **Criminal justice investigation and proceedings:** The criminal investigation in Barnahus, including the forensic interview, respects the procedural safeguards of both the child and the defendant. A child-friendly forensic interview is carried out according to an evidence-based protocol by a specialised forensic interviewer to secure the best possible evidence and to protect the child from (re)traumatization. The interview is recorded and represents admissible evidence in Court.
- **Medical examination and treatment:** A child friendly medical evaluation is carried out by specialised and highly competent staff both for forensic investigative purposes and to ensure the child's physical well-being and recovery by the appropriate remedy.
- **Mental health examination and treatment:** All children are offered a mental health assessment and appropriate support by specialised and highly competence staff, including crisis support, short and long-term therapeutic services addressing the trauma of the child and non-offending family members and caretakers.

This resource looks closer at practice in Barnahus in ***the medical room***, with a starting point in the Barnahus Quality Standard 7 on Medical examination and treatment. Barnahus Quality Standard 7 focusses on ensuring that medical interventions are routine, that there is access to specialised staff, joint multidisciplinary case management and child participation.

The practice described in this resource was gathered through simple surveys and mapping exercises in 2020 with Barnahus and similar services in Europe. Information from the following countries are included in this overview: Albania, Bulgaria, Croatia, Cyprus, Germany, Estonia, Finland, Iceland, Ireland, Hungary, Netherlands, Norway, Poland, Slovenia, Spain, Sweden, and the UK. Specific examples and quotes from professionals and children are based on additional information that was provided by some of the countries involved in the mapping. The results presented in the visuals are from a survey that was carried out in 2020, which was completed by 17 respondents from Bulgaria, Croatia, Cyprus, Finland, Iceland, Ireland, Poland, Sweden, and the UK. 5 responses could not be connected with a specific country.

Medical examinations in Barnahus serve a dual purpose. On the one hand, a forensic medical examination can provide important evidence for the prosecution; on the other hand, it serves to assess the physical health of the child (top-to-toe) and to inform potential treatment and referrals to specialised treatment. The

[1] Barnahus Quality Standard 5
[2] Barnahus Quality Standard 4
[3] UNCRC art 3, Barnahus Quality Standard 1.1.

top-to-toe examination also has a therapeutic element in that it serves as an opportunity to reassure the child and caregivers that everything is normal, and that the child is in good health.

For further information on medical services in Barnahus, we recommend the Promise *mini-series of medical webinars*[4], which explores the many considerations for meeting the Barnahus quality standard 7 drawing on practice from different Barnahus in Europe. The webinar mini-series covers:

- Why medical evaluation is important for the wellbeing of children and the investigation;
- Best practices for a multidisciplinary cooperation which includes medical evaluation;
- The types of medical providers who should be available to the Barnahus and the additional training they may need;
- What a child-friendly exam room may look like;
- The process when a medical problem is detected that would otherwise would have gone unnoticed;
- Ensuring treatment and follow-up.

Overview of Practice in the medical room in Barnahus in Europe

Barnahus Quality Standard 7.1: Evaluation

Medical evaluations and/or forensic medical evaluations are routinely carried out in the Barnahus premises by specialised staff.

Indicators

- Medical examination, treatment, and potential referral to specialised medical treatment forms an integral part of the services that a Barnahus offers.

European Practice

Nearly all of the Barnahus in the mapping include medical services in their Barnahus. In some services the medical examination is central and is offered routinely, in others it is rarely part of the multidisciplinary response. The approach differs between countries, as well as between different Barnahus in the same country. Hence, medical examinations are not always routine.

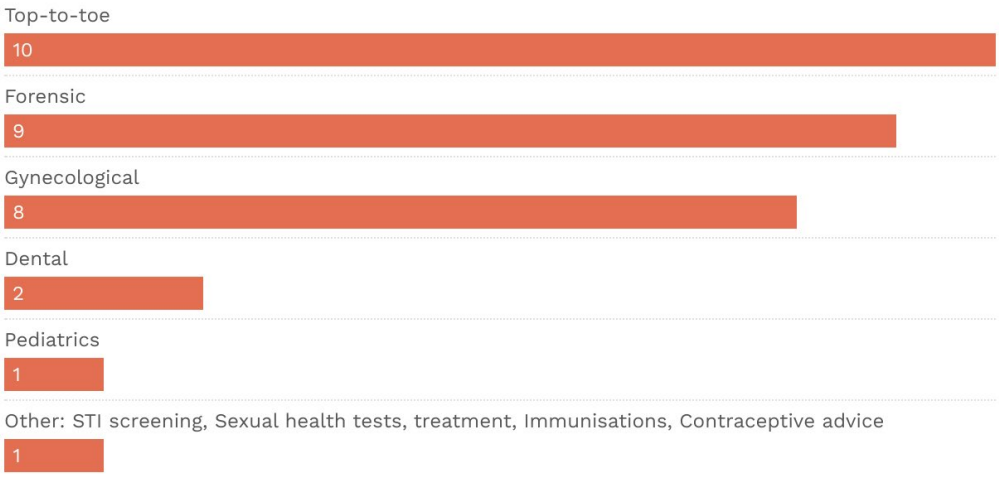
The types of medical examination vary between Barnahus, depending on law, procedures, and resources. Medical examinations carried out in Barnahus typically include top-to-toe, gynaecological examinations and in a few cases dental examinations.

[4] https://www.barnahus.eu/en/webinar/mini-series-on-medical-evaluation-a-key-criteria-for-the-barnahus-and-similar-setups/

Iceland only offers medical examination in cases of suspected sexual abuse, even though the Barnahus has a broader target group and examines multiple forms of violence.

Medical examinations in Barnahus are typically carried out after the forensic interview except in urgent or complicated cases where the child requires immediate or special interventions at a hospital setting. For example, in Barnahus Linköping in Sweden, the medical examinations are mostly done on the same day of the forensic interview (after the interview), to ensure that there is proper input to child protection and risk assessment. In urgent cases, the medical examination is carried out on the same day that the Barnahus receives the report about the case. Iceland notes that a medical examination also sometimes can be organised after therapy has begun, for example if the child discloses fear of injury, pregnancy, or disease. In Germany, the medical examination can also be held the same day as the forensic interview, if the child is referred to the Childhood-Haus (Barnahus) by the police directly. In Bulgaria, which does not have its own medical staff, Barnahus staff accompany the child to medical examinations.

What kind of medical assessment /interventions do you offer in Barnahus?



12 total responses, 2020 mapping of practice

Source: PROMISE Barnahus Network

Forensic Medical Examinations

Many Barnahus facilitate forensic medical examinations. Barnahus in Norway also facilitate forensic dental examinations.

In some countries, the forensic medical examination is carried out outside Barnahus, by special forensic experts in hospitals. The reasons for this is often that examinations only can be performed in certain settings or because the medical room in the Barnahus only are equipped for top-to-toe examinations. For example, in Helsinki, Finland, forensic medical examinations take place in the children's hospital, since the Barnahus type-unit does not have the necessary equipment. At times, depending on the availability of staff, limited medical examinations to detect and document bruises or other marks on the skin (as well as top-to-toe) can be carried out by a paediatrician in the unit. In Denmark, Barnahus are piloting top-to-toe examinations, however, they are not allowed to perform forensic medical examinations in Barnahus. In the Lighthouse in London, top-to-toe examinations are carried out, but forensic medical examinations are carried out at the Sexual assault referral centre (CYP Havens Service).

Forensic medical examinations are mostly ordered by the police, the prosecutor or through a court decision. For example, in Norway, the Common guidelines for the State Barnahus state that a medical examination shall be performed in cases where the prosecuting authority requests it for the sake of collecting evidence (clinical forensic examination). In cases of abuse in close relationships or sexual abuse where the prosecution has not requested a clinical forensic examination, a medical examination is *offered* to the suspected victim. Medical examinations are only conducted if the child caregivers give their consent.

In Denmark, forensic medical examinations are ordered by the police, however, as noted above, they do not take place in Barnahus. In Sweden, it is the police that orders forensic interviews, but for example Barnahus Linköping often plays a role in contacting and liaising with the medical staff who carry out forensic medical examinations in Barnahus. In Germany, medical forensics is of high importance, and there is no need for a police report to carry out a forensic medical examination. Forensic institutions try to offer low threshold access to forensic examinations to secure evidence on the body as early as possible, and the victim can still decide whether to report to the police later on.

The medical forensic examinations are in most cases carried out after the forensic interview, except in cases where the child needs urgent medical interventions, if there are known damages to a child's genitalia or if a child is found at a crime scene. Decisions to proceed with a forensic medical examination are based on different factors. The most important factor is the time passed the since the suspected abuse took place, which is closely connected to the probability of finding evidence. Many respondents specified a time limit of 72 hours for cases of sexual abuse and 7 days for other forms of physical abuse.

The forensic interview often serves as an important base for decisions concerning forensic medical examinations. The Netherlands however notes that there are many cases where evidence of abuse have been found without disclosure from the child, for example findings of sperm, without disclosure of penetration. Most countries report that forensic medical examinations are prioritised when there is a suspicion or knowledge of recent sexual abuse. Other factors that play a role include if a child discloses pain, the age of the child, or if the child needs urgent medical interventions.

Several countries respond that forensic medical examinations can be crucial to secure important evidence. However, unlike top-to-toe examinations, forensic medical examinations should only be carried out if it is likely that evidence can be secured, and not routinely. Some Barnahus report that investigations often rely heavily on forensic medical examinations since the Courts prefer medical evidence of abuse, in particular in complicated cases. For example, in Estonia, the Barnahus plays an important role in guiding investigators towards a prioritisation of the oral testimony from the child to avoid unnecessary medical examinations, in particular where the suspected abuse happened months ago.

Barnahus Quality Standard 7.2: Treatment

Medical treatment is carried out in the Barnahus premises (unless urgent or complicated cases require special interventions at a hospital setting, as an outpatient or inpatient).

Indicators

- Medical treatment is carried out in the Barnahus premises (unless urgent or complicated cases require special interventions at a hospital setting, as an outpatient or inpatient).
- The Barnahus liaises with a local hospital for referral of relevant cases for further evaluation and treatment, including urgent or complicated cases that require special interventions at a hospital setting, as an outpatient or inpatient as well as with hospitals referring concerning cases to the service.

European Practice

Medical treatment in Barnahus is not as common as medical examinations and only involves simple procedures. Urgent medical treatment is always provided in a hospital. Many Barnahus have entered into collaborative agreements on health services with local hospitals, including to provide specialised and longer-term treatment.

For example, in Norway, there is a template agreement for cooperation between health services and police districts. The cooperation agreement is drawn up in accordance with the Common guidelines for the State Barnahus under the auspices of the Directorate of Health, "Professional advice for clinical forensic medicine and medical examinations in the State Barnahus ". The guidelines and the agreements help to ensure that all Barnahus provide access to the same services of high quality.

In Slovenia, a Barnahus law is currently under consultation. The draft law states that Barnahus shall provide premises and other assistance in carrying out a physical examination with purpose of ensuring, to the greatest extent possible, a careful and considerate treatment of the child and respect for his or her personal rights and interests.

Barnahus Quality Standard 7.3: Competent Staff

The medical examination is carried out by specialised staff who are trained to recognise indicators of physical, sexual, and emotional abuse as well as child neglect.

Indicators

- The medical evaluation and treatment in the Barnahus are carried out by a paediatrician, gynaecologist, forensic medicine physician or an advanced nurse with specialised training on child abuse and neglect depending on the needs of the child;
- Staff is competent in photo documentation of injuries and lesions on the victim’s body;
- Staff have access to, and competence to use, equipment for child-friendly general and genital examination in the Barnahus (e.g. video-colposcope for examination of sexual abuse and a high-quality camera for physical abuse). If there is no such equipment, the child is referred to a service which can perform the examination without delay.

European Practice

Professionalism and specialisation is fundamental to medical interventions in Barnahus. The countries involved in the mapping indicate that different types of specialised staff perform medical examinations, depending on the purpose of the examinations, and the type of injuries. Where the necessary equipment is not available, children are examined in hospital.

For example, in Germany, medical examinations are carried out by a specifically trained paediatrician, in most cases together with a forensic doctor. A paediatric nurse trained in child protection medicine is at hand as well. If the genitals of a child have to be examined, a paediatrician or gynaecologist with a qualification in child and youth gynaecology carries out the examination together with the forensic doctor. All medical examinations are performed according to national guidelines for multidisciplinary child protection medicine.

The Barnahus in Linköping has a fully equipped medical examination room and a video-colposcope. In cases where a medical examination is needed, it always takes place at the Barnahus. Blood samples and x-rays

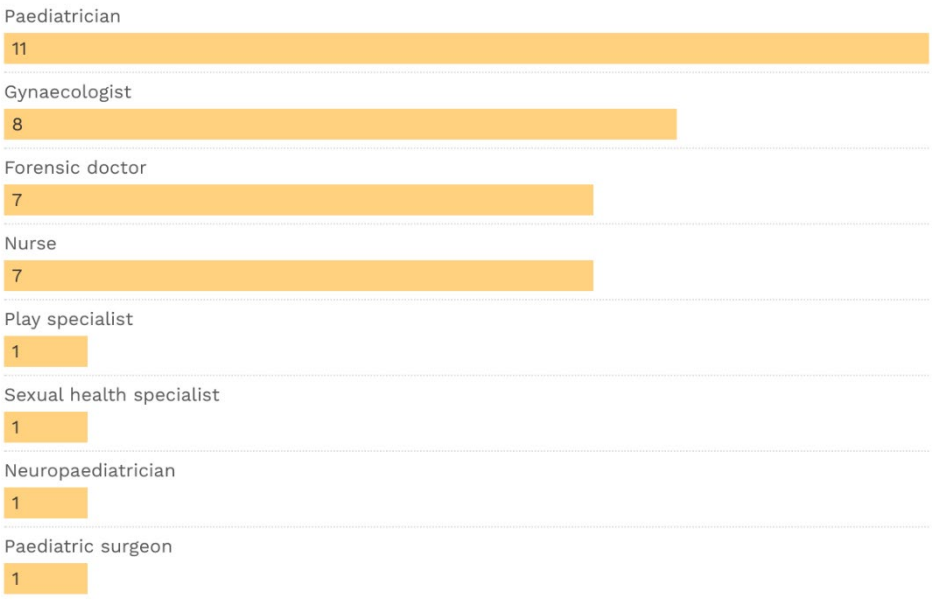
are taken at hospitals. Medical examinations are carried out by the paediatrician on call, often together with a forensic doctor. If the genitals of a child have to be examined, a nurse from the Division of Paediatric Urology Neuro and Bowel Disorders usually works closely with the paediatrician as they have experience and are good at supporting children during the examination. It is mostly the same paediatrician, who has extensive experience and expertise in the area, who carries out examinations in cases of sexual abuse. In cases of suspected child sexual abuse of a child who has reached puberty, a gynaecologist from the women's clinic carries out the examination. A dentist can also be called in if necessary.

In Finland, where the examination takes place in the children's hospital, there is access to paediatricians and specialised staff, e.g., radiologists, neurologists, dentists, and social paediatricians. There are written guidelines for doctors on call concerning acute cases of sexual and physical abuse, including instruction on how to perform the medical examination, which tests to take, how to talk with the child and caregivers, how to document the findings etc.

Other medical staff in Barnahus include for example dentists, neuropaediatricians, paediatric surgent psychiatrist, sexual health specialists, play specialists. For example, in Norway, specialised dentists work in Barnahus to perform forensic dental examinations. An online resource for dentists has recently been launched, which contains guidance and online training for dentists who perform services in Barnahus. (tannbarnehus.no)

> *"We have all the equipment we need for high quality medical and forensic examination."* **(Staff, Germany)**

What type of medical staff do you have in Barnahus?



12 total responses, 2020 mapping of practice
Source: PROMISE Barnahus Network

Barnahus Quality Standard 7.3 Case review and planning

Medical staff is present in the forum for case review and planning that takes place on initial assessment and for follow-up case review meetings as appropriate.

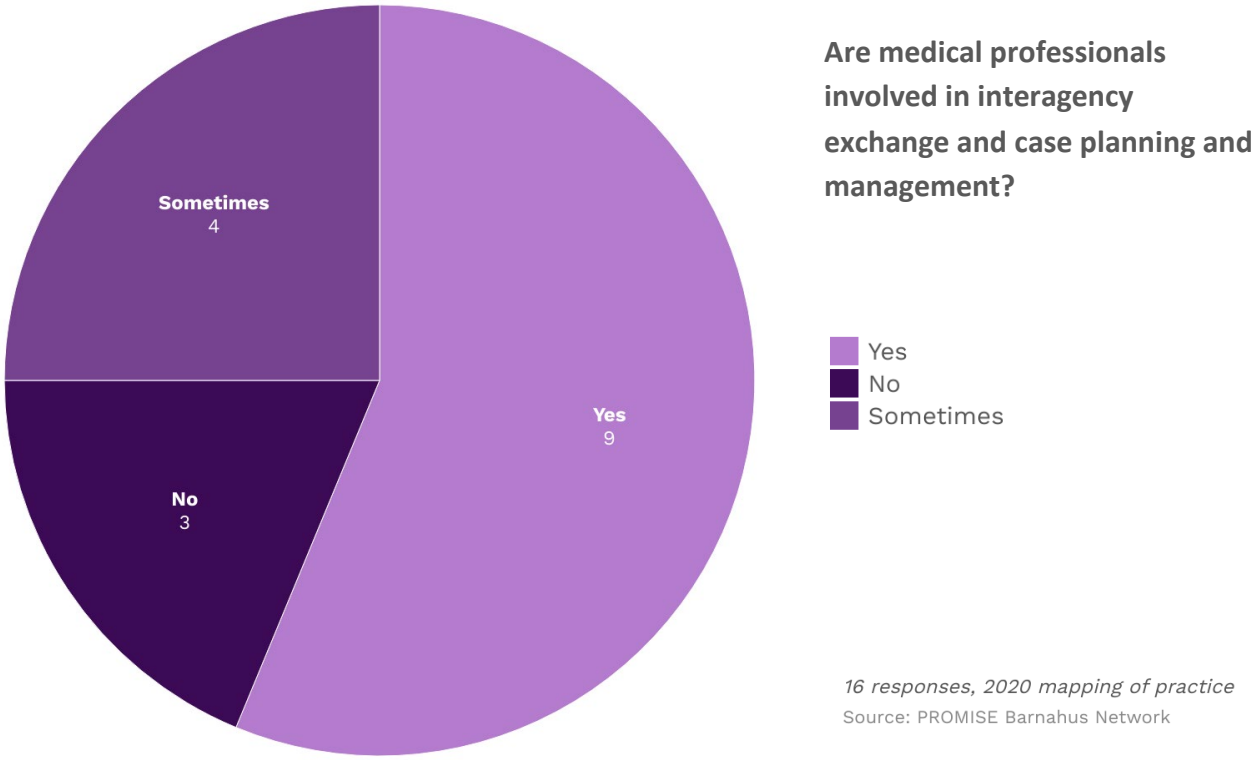
European practice

Many countries involved in the mapping state that medical staff are involved in interagency exchange and case planning and management.

For example, Finland, Germany, Ireland, Sweden, and Poland indicate that medical staff are present in in the joint consultation meeting where cases are planned and reviewed. In Barnahus Linköping, the involvement of medical staff can be maintained thanks to the rotating schedules of the paediatricians in the hospital, in which the Barnahus is a regular and recurrent feature.

> *"We enjoy having a well-functioning and robust machinery that facilitates good communication between the partners. It makes our job easier."*
> **Paediatrician, Linköping, Sweden**

In the Lighthouse in London, medical staff are present in the intake meeting and weekly case review team. In Cyprus, the medical staff are sometimes present, but not that often since the social worker has access to the medical files. In Bulgaria, which does not have its own medical staff, external staff can be present in interagency meetings if they are invited.



Right to be heard and receive information (Standard 7.4)

Children and family/caregivers receive adequate information regarding available and necessary treatments and can influence the timing, location and set up of interventions.

Indicators

- Children and caregivers are provided with adequate information about the examination and available treatment;
- The Barnahus invites and gives due weight to the child's views regarding examination and treatment.

European Practice

Access to information and listening carefully to children's views before, during and after medical examinations forms an integral part of a child-friendly approach to medical examinations. Barnahus in Europe use different means to involve and consult with children.

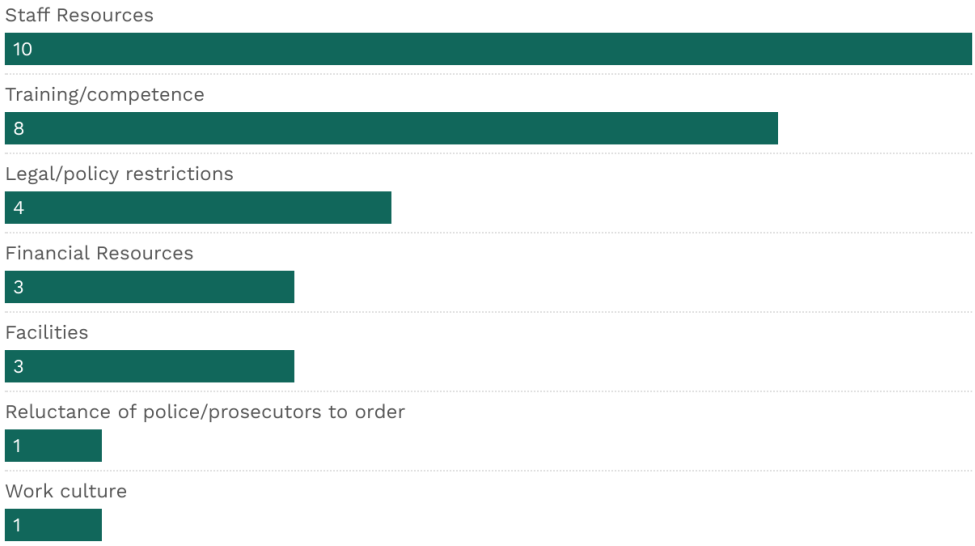
In Iceland, the child is prepared for the medical examination through a short interview by a nurse. A general physical examination is then performed by a male paediatrician. If needed, a female gynaecologist performs an examination of a child's genitals with the help of a female nurse, without the presence of the male paediatrician. The doctors do not force the child, instead they try to create peace, security, and a relaxed environment. The doctors then review the results of both examinations together and review a video recording of the genital examination. Both doctors and the nurse often sit down with a parent or with the child to explain the results.

In Slovenia, the draft law proposes provisions to ensure children's right to information and to influence decisions regarding medical examination. For example, the draft law includes an emphasis on an "explanatory duty" (article 31), which is intended to minimise distress during the physical examination. This involves explaining the meaning and nature of the medical actions, including how the findings are relevant to the criminal proceedings, to the child before the medical examination. If, despite careful explanations, the child objects to examination, the draft law allows for the possibility to carry out the medical examination by examining the medical documentation and the data on file, if possible. A (direct) physical examination will thus not be performed in the event of insurmountable opposition from the child.

3. Challenges

Many of the countries included in the mapping indicate that lack of training and access to medical staff are key challenges to fulfilling standards regarding medical interventions in Barnahus. For example, forensic medical professionals may not have specific training in examining children, or specialisation in detecting child sexual violence. In some cases, it is difficult to convince hospitals and clinics to allocate staff to Barnahus. In Barnahus Linköping this has been addressed by coming to an agreement with the hospital to have rotating schedules of the paediatricians in the hospital, in which the Barnahus is a regular and recurrent feature.

What are the key obstacles in your country concerning medical interventions in Barnahus?



14 total responses, 2020 mapping of practice
Source: PROMISE Barnahus Network

Another challenge to medical services in Barnahus is when law and regulations restricts medical services in settings outside hospitals or medical clinics. Barnahus from across Europe approach this challenge in different ways. In some countries, close collaboration with nearby hospitals and clinics provides for child friendly medical services, including forensic medical examination. Another solution may involve developing cooperation agreements with relevant authorities. In Estonia, such an agreement allows for medical examinations in Barnahus case by case in the same way that home visits are allowed. In some countries, specific Barnahus law (e.g. Denmark, Slovenia) or national guidelines (e.g. Norway) allow and govern medical services in Barnahus.

> *"We can take the time the child needs not being interrupted and rushed like in an emergency room."*
> **(Staff, Germany)**

> *"Thank you for answering all my questions."*
> **(12-year-old girl, Germany)**

Annex 1. Law and Guidance

International Legal Framework

The UN Convention on the Rights of the Child (UNCRC) article 24 recognises the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

UNCRC Article 19 furthermore clarifies that protective measures for child victims of violence should include […] forms of prevention and for identification, reporting, referral, investigation, treatment, and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

The UN Committee on the Rights of the Child (CRC) has emphasised that different types of victim support, including medical, mental health, social and legal services, should be made available to child victims and the non-offending caregivers and other family members. The CRC also promotes follow up and longer-term interventions. Victim support should be decided through a participatory approach and undue delay must be avoided. Special attention must be given to inviting and giving due weight to the child's views (CRC General Comment no 13). The CRC furthermore emphasises measures to promote physical and psychological recovery of victims of violence, including medical services (CRC General Comment no 13).

The EU Directive of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography ('Child Sexual Abuse Directive') and the EU Directive of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime ('Victim Rights Directive) introduce several articles that are of relevance to medical interventions in Barnahus, including taking du account of the child's view, provision of information, right to assistance and support, individual assessment, involvement of trained professionals and keeping medical examinations to a minimum (in the context of criminal investigations).

The Lanzarote convention articles 5.1 (training and awareness), 5.2 (training and awareness on child sexual violence), 14.1 (physical recovery of victims), 31.1 (general principles, including information about rights and services), 31.6 (information adapted to child) also cover certain aspects related to medical services in Barnahus.

The CoE Guidelines for Child-friendly justice (2010) Ch IV.A.1 (a-l) (Right to information), Ch. IV.D.3 (Right to be heard), Ch IV.A. 2-4, and IV.B.25 (Right to information and consultation before the trial) provides extensive guidance on children's right to information and to be heard. Ch IV.E.80 stipulates that healthcare should be provided, ideally free of charge and that children and caregivers should be informed promptly of such services.

The CoE Guidelines on child-friendly health care (2011) Ch. IV.19. also set out several relevant recommendations including on children's participation and protection, especially the cross-cutting principles set out in Ch III and Ch. IV. articles 19, 23.

The table below shows the relationship between the European Barnahus Standard 7 and key legal obligations set out in three European legal instruments: the 2010 Council of Europe Convention for the protection of children against sexual exploitation and sexual abuse (the Lanzarote Convention), the EU Directive of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography ('Child Sexual Abuse Directive') and the EU Directive of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime ('Victim Rights Directive).

The first column in the table (Practice/Operational Standard) lists the European Barnahus Standards. The second column indicates legal obligations that are most relevant to each standard. The third column in the table (Legal Instruments) indicates the specific articles in the three European legal instruments specified above which relate to the relevant obligations. This column also refers to recitals in these legal instruments which provide important interpretative guidance on the legal obligations[5].

7. Medical Examination	Taking due account of the views of the child	Victim Rights Directive: Article 1. 2; 10.1 and 10.2 Sexual Abuse Directive: 19.3 Lanzarote Convention: Article 14.1
	Provision of information	Victim Rights Directive: Article 1.1.; 3; 4; 6 Lanzarote Convention: Article 31.1, 31.6
	Right to interpretation & translation	Victim Rights Directive: Article 5.2-3; 7.1-7.8 Lanzarote Convention: 31.6
	Provision of assistance and support	Victim Rights Directive: Recital 38, Article 8. 1-5, 9. 1.-3, 25. 4 Sexual Abuse Directive: Recital 31, Article 18.1 Lanzarote Convention: Article 14.1
	Individual assessment of each child's circumstances and non-offending family members' needs	Victim Rights Directive: Recital 9, 55, 56, Article 22. 1, 22.4 Sexual Abuse Directive: 19.3
	Involvement of trained professionals in psychosocial assessment, forensic interview and physical examinations /Training and Tools	Victim Rights Directive: Article 25.4 Sexual Abuse Directive: Recital 36 Lanzarote Convention: Article 5.1, 5.2
	CRIMINAL INVESTIGATION: (Forensic) Medical examinations are kept to a minimum	Victim Rights Directive: Article 20 (c) (d)

[5] Lind Haldorsson, Olivia (2017) *European Barnahus Quality Standards: Guidance for Multidisciplinary and Interagency Response to Child Victims and Witnesses of Violence* www.childrenatrisk.eu/promise/standards and O'Donnell, Rebecca (2017) *PROMISE Compendium of Law and Guidance: European and International Instruments concerning Child Victims and Witnesses of Violence*, Stockholm, PROMISE Project Series

Annex 2. Summary of research[6]

Need for Coordinated approach

In their research in relation to the Child Advocacy Centres (CAC) in the USA, Ornstein & Smith (2011) state that a core component of the multidisciplinary approach to the investigation of an abuse allegation is the medical assessment. In the early planning stages of service development, consideration should be given as to how medical services will be delivered, but there is no singular model for delivery of medical services. Ornstein & Smith 2011 do suggest that all child victims of the CAC should be offered a medical examination for allegations of sexual abuse during the investigation.

Examinations may identify injuries needing treatment and follow up, or may provide reassurance to a child that they are physically 'ok' or normal. In addition, the result of an examination can provide investigators with a clearer understanding of injuries sustained and can clarify how an injury was sustained. Walsh, Cross, Jones, Simone and Kilko (2007) examined the impact of Child Advocacy Centre's and other factors on the use of the forensic medical examination as part of the response to reported child sexual abuse.

The authors advocate for forensic medical examinations as an important part of a comprehensive response to an investigation of child sexual abuse to ensure appropriate care for the child and support the legal process. They propose three purposes of exams:

1) identify medical evidence;
2) screen for injuries and conditions needing medical treatment;
3) reassurance of the child's wellbeing.

They furthermore advocate for a multidisciplinary discussion to occur on the optimal referral criteria for children in cases where an examination will most likely not reveal any forensic evidence but will provide the child and caregiver with reassurance about their bodily integrity. Adam & co (2016) also reiterate the belief that all children who are suspected victims of child sexual abuse should be offered an examination performed by a medical provider with specialized training in sexual abuse evaluation. They state obtaining details about the abuse is typically coordinated with a multidisciplinary team and may be obtained by a forensic interviewer or a medical professional. Due to differences in purpose and approach, the medical history may differ, yet complement, the forensic interview.

Blesken & Co (2019) provide a significant number of evidence-based recommendations in their guidelines for child abuse and neglect. Recommendation number 16 places emphasis on the importance of a multi-professional approach where the is a threat to child welfare in order to confirm or exclude neglect and abuse of children.

Timing of Medical Interventions

Ornstein & Smith (2011) recommended that in cases of sexual abuse, cases should be categorised into two groups: urgent and less urgent medical care. The document provides guidance for these two categories and advises that in the latter circumstance i.e., less urgent, the forensic interview should be conducted before the medical examination. For the urgent category, requirements as outlined include complaints of pain, ano-

[6] This summary of research was completed by Ms Niamh O'Loughlin, Social Worker at Barnahus Galway, Ireland and first appeared in their (2020) *Evaluation of research in the area of Forensic Medicals in Child sexual abuse.*

genital injury, 24-72 hours since contact with the perpetrator, mental health crisis, HIV etc. The less urgent category requires that the child is not symptomatic, no ano-genital pain, no bleeding or discharge, over 72 hours since contact with the perpetrator and the child is in a place of safety. Ornstein & Smith also refer to a case outside 72 hours as a historical case.

In their research Walsh, Cross, Jones, Simone and Kilko (2007) reference Hibbard, 1998 & Jenny 2000, stating that forensic medical examinations are usually recommended within 72 hours of the assault occurring because the passage of time and the healing process can obscure medical evidence if the delay is longer. They outline that when 72 hours have already transpired and in a non-acute situation, a short delay is acceptable if it avoids the exam being conducted under 'chaotic circumstances'.

Similarly, Adam & Co (2016) recommend that the medical evaluation can be prioritised as emergency, urgent, or non-urgent. An emergency evaluation should be done without delay, and urgent and non-urgent evaluations should be done within 1 to 7 days. Previous versions of guidelines suggested changing the "72-hour rule" for evidence collection in pre-pubertal children to the "24-hour rule." Subsequent studies have confirmed that DNA is predominantly recovered when examinations of pre-pubertal children are conducted less than 24 hours from the time of the assault. Importantly, the presence of significant physical findings does not predict recovery of foreign DNA and should not be the basis for collecting forensic evidence.

Blesken & Co (2019) in their guidelines make a number of evidence-based recommendations in relation to timings of interventions. Recommendation 57 states that when children are suspected of being subject to child abuse, their initial statement should be recorded using a forensic interview, as part of a multi-professional diagnosis, as promptly as possible from the time of the last incident. They further explain that need for special training for employees who encounter children who are possibly giving their first statements regarding the threat to child welfare. Recommendation 112 requires that all children suspected of being sexually abused must be physically examined in a manner specific to their gender and level of development. It says the necessity and timing of the examination depend on the period between the indicated sexual assault and the time of examination. It further recommends that the necessity and sequence of interventions must be determined for each individual case by a multi-professional team and findings of interventions must be evaluated jointly. Recommendation 113 advises that for children with acute injury or acute suspicion of sexual abuse, injury to the abdomen should be ruled out immediately. Recommendation 116 requires that children suspected of being sexually abused in the previous 24 hours have an ano-genital examination immediately. Recommendation 117 states that if the sexual abuse incident occurred within the previous 72 hours or up to 7 days, an ano-genital examination should be performed as soon as possible. Recommendations 117 & 118 advises that ano-genital examinations should be offered to children outside the 7-day window and that STI exams, pregnancy tests and structured anamnesis should be performed regardless of timeframe since the incident.

Examples/Demographics

Ornstein & Smith 2011 highlight the importance of genital examination findings being carefully interpreted and documented by practitioners, as the majority of medical examinations conducted in children with suspected abuse have normal or non-specific findings and neither confirm nor refute an allegation of abuse. In a large retrospective review of 2,384 children referred for a medical evaluation who disclosed sexual abuse, Ornstein & Smith 2011 found only 4% had an abnormal examination.

Similarly, Lauritsen & Charles 2001 examined the evidence in 34 sexual abuse cases on forensic medical examinations conducted more than one week after the incident of abuse occurred. 20 cases had normal findings, 13 had non-specific findings, and in 1 case there was a traumatic finding. Lauritsen & Charles (2001) went on to discuss that the time passed between the sexual abuse incident and the time of examination is important to ano-genital findings at examination. They find that a medical examination in

cases of child sexual abuse seldom provides legal proof of sexual abuse and the most important evidence is the story told by the child. Therefore, they view the forensic medical examination as a supplement, which may support or remain neutral to the story told by the child.

Adam, Harper, Knudson & Reville (1994) also support the above view, their study provides data evidencing the majority of children with legally confirmed sexual abuse will have normal or non-specific findings with abnormal findings rarely found. It was found that the best predictors of abnormal findings in victims is 1) the time elapsed since the assault and 2) a report of bleeding at the time of assault. The study affirms that the history of assault provided by the child is probably the most important evidence of sexual abuse and that when a child can make a clear consistent and detailed statement, physical examinations should not be solely relied upon to provide the proof before proceeding with criminal charges.

Research from Palusi, Cox, Shatz & Schultze (2005) collected data on cases where immediate forensic medical examinations were recommended to victims of Child Sexual Abuse. They compared the findings from children seen within 72 hours of the reported sexual contact and those seen non-urgently. They evaluated 190 cases of children under 13 over a 5-year period and 9% had positive findings. From this research, the authors identified that female children over 10 years old who report ejaculation or genital contact without bathing have the highest likelihood of positive examinations or forensic evidence. They recommend that while there are other potential benefits of early examination, physicians seeking to identify forensic evidence should consider the needs of the child and other factors when determining the timing of medical assessment after sexual abuse.

Walsh, Cross, Jones, Simone and Kilko (2007) collected data from a sample of Child Advocacy Centre sites in the USA in relation to the structures for Forensic Medical Examinations. They refer to the ‘LCC’ in Charleston, South Carolina who provide medical examinations to clients when investigators suspect abuse based on the outcome of the forensic interview or at the request of child/parent. They discuss the National Child Advocacy Centre who refer for medical examination if there is reason to suspect there is physical evidence, injury, infection, or pregnancy or at the request of child/parent. The ‘PCAC’ in Pittsburgh, Pennsylvania referrals were made to the centre at the discretion of the Law enforcement and Child Protective Services investigator. The findings of this research were that medical exams used for forensic purposes offer higher rates of forensic evidence within the 72-hour window from alleged sexual contact than those seen after 1 week. The demographic for referrals appeared to be young female children who were injured and had suspected penetration.

Annex 3. Photos from the medical rooms at Barnahus

On this page: images from Finland

On this page: images from Finland

On this page: images from Linköping, Sweden

To the left:
Childhood Haus, Heidelberg

Bottom:
Barnahus Tallinn

PROMISE

Implementing the Barnahus Quality Standards throughout Europe

PROMISE is supporting Europe to adopt the Barnahus model as a standard practice for providing child victims and witnesses of violence rapid access to justice and care. We undertake this work to fulfil the PROMISE vision: a Europe where all children enjoy their right to be protected from violence.

A Barnahus provides multi-disciplinary and interagency collaboration to ensure that child victims and witnesses of violence benefit from a child-friendly, professional and effective response in a safe environment which prevents (re)traumatisation. With the formal support from national authorities, PROMISE provides opportunities to translate national commitment into action and engage internationally in the process. In addition, regular networking and strategic communications continually activate our growing network of professionals and stakeholders who are committed to introducing and expanding Barnahus services nationally.

The first PROMISE project (2015-2017) set European standards and engaged a broad network of professionals. The second PROMISE project (2017-2019) promoted national level progress towards meeting the standards and formalised the PROMISE Barnahus Network. The current project (2020-2022) is expand these activities to include University training, case management tools, with a view to establishing a European Competence Centre for Barnahus and laying the groundwork for an accreditation system for Barnhaus.

PROMISE is managed by the Children at Risk Unit at the Council of the Baltic Sea States Secretariat.

Access the PROMISE tools and learn more at www.barnahus.eu

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