Northern Territory Government

DEPARTMENT OF **HEALTH AND COMMUNITY SERVICES**

Toolkit
for managing
child sexual abuse

nt.gov.au/**health**

Please keep the children of the Northern Territory safe.

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INTRODUCTION

This Toolkit is a guide for remote and urban Primary Health Care Practitioners (PHCPs) on how to manage sexual assault in health care settings. Clinicians and experts from agencies dealing with sexual assault developed the Toolkit.

The Toolkit contains practical information about:

BACKGROUND

Practitioners have legal responsibilities relating to the area of sexual activity in young people:

- Suspected sexual abuse or maltreatment in anyone under 18 must be reported (*Community Welfare Act 1983*)
- Parents must be informed if a person under 16 has a notifiable disease (*Notifiable Diseases Act 1999*)
- It is a criminal offence to have sex with a person under 16, but there is no legal obligation to report it. (*Criminal Code Act 2007*)

If you would like more information, please refer to the DHCS booklet: *Guidelines on Sexual Health Issues in Children and Young People, 2007*, or the DHCS website.

IF YOU REMAIN SILENT ABOUT SUSPECTED SEXUAL ASSAULT YOU ARE ALLOWING IT TO CONTINUE

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Guidelines for **suspected sexual assault, abuse or maltreatment in any person under 18:**

In all circumstances the law requires you to report the above to Family and Children's Services (FACS) or the Police.

Call the combined FACS/Police Central Intake Team on **1800 700 250** (24-hour number). This team will connect you with the counsellor/doctor team at Alice Springs or Darwin Sexual Assault Referral Centre (SARC), to coordinate a response, which may include evacuation.

Guidelines **if no sexual assault, but suspected sexual activity, STI or pregnancy:**

Client aged 13 years or under:	Call the combined FACS/Police Central Intake Team on **1800 700 250**. This team will connect you with the counsellor/doctor team at Alice Springs or Darwin SARC to discuss and coordinate a response, which may include evacuation.
Client aged 14-15 years	Consider whether the sexual activity is consensual. If not, or unsure, call **1800 700 250**. Investigate and manage the young person for STIs. Liaise with High Risk Obstetric Unit about support in managing pregnancy.
Client aged 16-17 years	Consider whether the sexual activity is consensual. If not, or unsure, call **1800 700 250**. Investigate and manage the young person for STIs. Manage as clinically indicated.

For further information refer to "Guidelines on the Management of Sexual Health Issues in Children and Young People", DHCS 2007.

IMPORTANT CONTACT NUMBERS

NT WIDE

The Central Intake Team (24 hours) (FACS and Police child abuse reporting line)	**1800 700 250**
Police (24 hours)	**131 444**

TOP END

Sexual Assault Referral Centre, Darwin (24 hours)	8922 7156
Police	
Via NT Govt Switchboard	8999 5511
Hospitals	
Royal Darwin Hospital	8922 8888
Katherine Hospital	8973 9211
Nhulunbuy Hospital	8987 0211
Patient Assisted Travel Scheme (PATS) Darwin	
Maningrida, Oenpelli Jabiru, Croker Is, Goulburn Is	8922 8134
Daly River, Peppimenarti, Wadeye, Emu Point, Tiwi Is	8922 8391
PATS Katherine	8973 9206
PATS Gove	8987 0222/ 8987 0201

CENTRAL AUSTRALIA

Sexual Assault Referral Centre, Alice Springs (24 hours)	8951 5880
Police	
Alice Springs	8951 8888
Tennant Creek	8962 4444
Hospitals	
Alice Springs Hospital	8951 7777
Tennant Creek Hospital	8962 4399
PATS Alice Springs	8951 7979
PATS Tennant Creek	8962 4262

Warning signs of sexual abuse

These prompts can help you identify possible sexual assault:

PHYSICAL
Private parts (genitalia)

- Injuries to backside, legs, breasts: eg cuts, bruising, bleeding
- Itching, swelling, pain
- Pus (discharge) coming from private parts
- Pain or stinging when going to toilet (urine, bowel motion)
- Frequent UTIs, going to toilet a lot +/- pain (urinary frequency)
- Pregnancy

Sexually Transmitted Infection

- Any STI. **DO NOT rely on STI test results to back up your suspicion of sexual assault**

EMOTIONAL / BEHAVIOURAL

- Acting out sexual acts inappropriate for their age
- Scared to go home / running away
- Suddenly don't want to go to school
- Nightmares / not sleeping well
- Substance abuse
- Changes in behaviour - good or bad
- Feeling sad, worrying, suicidal thoughts, self harm
- Getting love gifts

IN THE HEAD
(Psychosomatic)

- Stomach pain or headaches keep happening; feeling unwell that can't be explained
- Constantly complaining (multiple vague complaints)

PARTNER

- Big age difference - more than 2 years
- Being controlled; too scared to say "No"

THEIR STORY CHANGES, OR DOES NOT MATCH THEIR INJURIES / EXPLANATION
(inconsistency in explanations of cause of presenting symptoms and physical signs)

SEXUAL ASSAULT IS A CRIME!

Worries or concerns of child sexual assault must be reported to 1800 700 250 (free call)

How to keep yourself safe

What to do if you are scared of payback

Sometimes you can worry for your safety or the child's if you report sexual assault. The law protects anyone who makes a report in good faith. Here are some suggestions for what to do when you make a report:

- Call trusted senior people in town eg AHW/nursing Directors or co-ordinators; managers; RMPs
- Call when no-one can overhear eg not from the health centre
- Ask someone else you trust at the health centre to be with you when you call
- FACS will be mindful around payback and always protects the identity of notifiers. When you call, plan with Central Intake/FACS the best approach to keeping you and/or the young person safe, because you know your community best.
- Take yourself and your family away from the community for a while and have a break
- Transfer somewhere else for a while
- You can be evacuated from your community by your work-group
- Talk with families, FACS Aboriginal Community Worker in your community
- Invite experts from town to talk with your community about the law and sexual abuse

You can do things now to prepare yourself and others if you need to report abuse:

- Tell your work-mates about the law, so everyone knows abuse must be reported
- Make a plan with your health centre about what to do if this situation arises
- Help your community to be aware of the law, and sexual abuse
- Use supports in your community to make you strong

BE STRONG!

Protect the little ones

Support for practitioners

When Child Sexual Assault (CSA) happens in a community, it affects everyone - not only the survivor and family.

As a worker in health you may work with survivors and/or perpetrators of CSA. It can help to know about some of the emotions and physical feelings you might have when you find out about CSA, and when you work with the survivor and/or perpetrator.

The information below may help you understand your feelings, and gives ideas that may help you cope.

At first you may feel:

- Shock, can't believe it
- Big anger
- Disgust
- Sadness

As time goes by, you might:

- Worry a lot
- Feel shame
- Feel guilt
- Have trouble sleeping or concentrating
- Feel sick, get the shakes, tense muscles
- Try to convince yourself the behaviour is OK - the perpetrator is otherwise a 'good person'
- Pull away from family and friends; stop doing things you usually like
- Find memories from when you grew up come back
- Be quick to anger

These are normal things, but NOT EVERYONE has them.

What to do about this:

Recognise how it's affecting you. This stress affects everyone differently. Try to look at what's happening to you. Then you can do something about it.

Some ideas for taking care of yourself:

- Use confidential professional help eg employee assistance providers, GP/RMP, Sexual Assault Referral Centre. Beware of talking to your friends or family – you must maintain confidentiality
- Get ongoing support from your supervisor and other trusted health workers
- Take care with alcohol or other substances
- Keep up your sleep and exercise routines
- Look after yourself more carefully during this time and let yourself settle down eg. go bush, fishing, to your homelands, try yoga, meditation, listen to music
- Write down your worries – this can help to get rid of them

How to look after yourself over a long time:

Sometimes you may need support over a long time. Think about these situations that may come up and worry you:

- Memories of your own past coming back. If this happens you should use a professional counsellor
- What you would do if you meet the perpetrator
- How you respond to the survivor and family
- How you respond to community reaction to CSA (they may talk amongst themselves, or close their eyes to it)
- How you get along with other workers at the health centre
- How to help children in the community to understand

What to do if you are working with the survivor and the perpetrator:

- Remember the perpetrator is innocent until proven guilty.
- Get ongoing support. Talk about your feelings.
- You have a duty of care to your patients. You can't let your feelings affect your care.
- Work out a plan with other staff at your health centre.
- If possible, hand the patient over to someone else.

SUPPORTS TO HELP YOU ARE:

Aboriginal Health Worker Directors, senior Nursing and Medical staff

Trusted workers at other Health Centres

Employee Assistance Scheme (EAS) – 08 8941 1752

Bush Crisis Line/CRANA – 1800 805 391

The Sexual Assault Referral Service (SARC)

- 8922 7156 – Darwin
- 8951 5880 – Alice Springs
- 8962 4364 – Tennant Creek

Lifeline – 131 114; DV/SA National Hot Line – 1800 019 116

Ruby Gaea, Darwin Centre Against Rape – 8945 0155

The roles of agencies

There are several agencies in the NT involved in the management of sexual health issues in children and young people. They include:

Family And Children's Services (FACS)

is responsible for protecting children from abuse within their families.

Central Intake Team (CIT)

is the main point of entry for all reports of child maltreatment. Phone the 24-hour child abuse number 1800 700 250, or the Police, to report child maltreatment.

Child Abuse Taskforce (CAT)

undertakes the more complex investigations of maltreatment of children and young people, and prosecutes offenders.

Sexual Assault Referral Centre (SARC)

provides a 24-hour integrated counselling, specialist forensic, medical and management service for children and adults who have experienced sexual assault. SARC responds to acute, chronic, past or on-going sexual assaults or suspicions of sexual assault.

Sexual Health and Blood Borne Virus (SHBBV) Unit

has a broad public health approach to control of STIs, HIV and related diseases, including diagnosis, treatment and care, surveillance and reporting, as well as prevention education and ongoing support.

Police

are responsible for assessing and investigating all reports of physical and sexual abuse against children.

For more information refer to pages 12-14 in the *"Guidelines on the management of Sexual Health Issues in Children and Young People"*, DHCS 2007.

What happens when a report is made

FLOWCHART OF A CASE OF CHILD SEXUAL ASSAULT

PHCP suspects sexual assault

↓

Calls **Central Intake Team** on **1800 700 250** to report/discuss

↓

Central Intake Team(CIT)

- gathers & records info
- checks FACS & Police history

↓

Consults with Police

- Are there protective concerns and is FACS involvement necessary?
- Is a criminal investigation warranted?

NO →

- No further action
- Reasons fed back to notifier
- Possible offer of other services/ referrals

Refers to SARC Team

- On call worker gathers info
- Counsellor/Dr consult with PHCP or CIT

YES

Involvement & Feedback

COORDINATED RESPONSE OCCURS:

FACS	SARC	POLICE
• Case referred to local FACS office • Intervention, support &/or referrals provided	• Dr discusses medical management with PHCP • Forensic examination arranged as required • Co-ordinates transport and accommodation with RMO & PATS • Co-ordinates interviews with Police and FACS • Provide support and info to child & family	Police investigation occurs: • Police gather evidence for prosecution • Provide advice/ access to supports

Frequently asked questions

Who can report a case to the Central Intake Team (CIT)?

Anyone, preferably the person who first receives the information as second-hand reports are less helpful. The legal obligation to report rests with the person who receives the information or has a suspicion of sexual assault in a young person. It may be of benefit to the person making the report if somebody else is with them for support when they call the CIT.

When should I make a report to the Central Intake Team?

The trigger to report is when you **suspect** that a young person is being sexually assaulted, abused or maltreated.

Should I report a case even if I'm not sure if abuse is occurring?

Yes. Your report will be linked with other information on the CIT database (possibly from well before your time), and may complete a picture of abuse that was previously not possible. You will not be legally liable for any mistaken report you made in good faith.

Am I required to tell my Health Centre Manager I've reported a case to CIT?

Ideally yes, but there are some situations where you may choose to tell a different trusted senior colleague. It is important to have someone senior aware that you made a report so they can look out for you. If you have safety concerns for yourself or others, it is important to tell your manager because they may need to provide/authorise resources to maintain the safety of yourself or the young person.

How can I be sure that something is being done about a case I've reported?

Your information will always be added to the CIT database for use immediately or in the future. On some occasions the information you provide might not constitute maltreatment, so there will be no child protection investigation. If you would like to know about the outcome of your report you can contact the CIT.

FACS and the Police will act on a case if they have enough evidence. FACS generally only becomes involved in cases where the perpetrator is a family member or if the family is not protecting the young person from harm. In other cases only the Police are involved. Sometimes the Police can't rely only on your report to take action. The Police can't take action if there is no evidence, for example if a young person says nothing in a Police interview.

As with health service provision, limited resources can at times restrict what FACS and Police are able to do.

I'm aware that a person under 16 is having consensual sex. Am I obligated to report this to Police or FACS?

No. While it is a criminal offence in the NT to have sex with a person under the age of 16, there is no obligation to report this. However, it is important to think about whether the sexual activity is consensual. If not, it needs to be reported. It is recommended a report is made to CIT if the young person does not have the intellectual capacity and social maturity to consent to sex; there is an age difference of more than two years between the sexual partners; the young person has little power in the relationship; does not have the capacity to say 'no'; or the sexual activity was not voluntary.

Are most young people evacuated following a report to the Central Intake Team?

No. Urgent evacuations occur where there are concerns for the young person's immediate safety or where a forensic medical examination is required. Generally these are rare. Reports are often historical and there is no forensic value in examining the young person. Sometimes young people will be brought to SARC following an event because they may speak more openly away from their community, or for counselling or to access a range of services.

Is the Central Intake Team number only used for reporting sexual assault?

No. The 1800 700 250 number receives reports of any form of neglect, abuse or maltreatment of young people. For example, most notifications to this number are for failure to thrive and domestic violence.

Why shouldn't I wait for a positive STI result before reporting to CIT?

Children and young people who have been sexually assaulted rarely have an STI, so the presence of an STI should not be relied upon to trigger a report to the CIT. A case should be reported to CIT if you suspect it was contracted through sexual assault or coercion.

Can I contact the Police directly for advice about a maltreatment issue?

Yes. Call 8922 3553 and ask for the Child Abuse Taskforce, and you will be connected to a Police officer knowledgeable in the area.

Can SARC be used as a resource even if I haven't made a report to CIT?

Yes. You can contact and discuss cases with SARC staff outside the CIT framework, because SARC can offer guidance and expert advice before a formal report of sexual assault is made.

How can I be sure confidentiality of the sexual assault documentation at my health centre will be maintained?

At those health centres using Primary Care Information System (PCIS), there are different levels of security allowing access to client information: only those with permission to access it can. Your Remote Medical Practitioner (RMP) has the highest level of security and can give others permission to access information, so liaise with him/her about your concerns. PCIS can also track users and their reasons for accessing information.

If your health centre only has paper records, seal any documentation in envelopes with a link back to the client file. Speak to your manager about secure storage because this is very important for the safety of the young person and yourself.

The following pages contain information that may be culturally sensitive to Indigenous people.

The pages are colour coded to assist Indigenous readers determine which pages to access.

Appendices with non-sensitive information commence on page 22.

CASE EXAMPLES

women's business

Information for women appears on pages 14-17.

CASE EXAMPLE

men's business

Information for men appears on pages 18-20.

Two case examples are presented to help the PHCP understand what happens when reports about a female are made to the Central Intake Team. These are examples only. Similar cases may occur differently in real life depending on the specifics of the situation.

Women's Business — case example 1

L is a 13-year-old girl brought to the health centre because of lower abdominal pain and some dysuria. Both L and her mother deny any possibility of sexual activity. The RAN finds there is no history of vaginal discharge and L is only mildly unwell with temp 37.4 and slight lower abdominal tenderness but no peritonism. She is treated for a UTI (antibiotics) and urine is sent for testing (microscopy and culture).

The results come back as pyuria, no growth. A PCR test of the laboratory-stored urine is ordered (after talking with mother), and comes back showing chlamydia but not gonorrhoea. A second appointment for L is organised without her mother.

What happens next?

Primary Health Care Practitioners – PHCPS (AHW, RAN and RMP) get involved:

When L and her mother first came in, the RAN followed the CARPA Manual based on the presenting symptoms, and gave her medication for a UTI. Now that the tests confirm chlamydia, the RAN needs to work on two issues: the clinical side, and possible sexual abuse. She asks the female AHW to join the consultation, to help make L feel more comfortable, and so she can give ongoing support to L and her family.

1. Clinical Presentation and STI management:

- The staff check how L is responding to the medication. They tell L about STIs: what they are, why they must be treated and how L can protect herself from them. L is told that because she is under 16 with a notifiable disease, the law says L's parents must be told about the STI (Notifiable Diseases Act).
- They arrange for L to have a pregnancy test and blood tests for other STIs.The PHCPs believe L has a good understanding of what is involved, and accept her informed consent to these extra tests.
- The PHCP tells L it would be helpful if her mother knew of her sexual relationship, so her mother can support her with her contraception and other possible health issues. L asks for them all to tell her mother together, which they then arrange.

2. Possibility of Sexual Abuse:

- The staff look at the Child Sexual Abuse (CSA) Indicators Sheet to revise the possible warning signs of CSA.
- At this second appointment, the RAN and AHW speak with L about sexual activity in case there was information L didn't want to say in front of her mother, and to get any extra information. (Refer to Attachment 1, for the type of information they would gather) They know not to probe L for information as their questions could be seen as leading, and the information would not be admissible in a prosecution. Although the staff know it usually takes a long time for a young person to talk about their sexual experiences, on this day L admits the sex was consensual with her 14-year-old boyfriend. She names her boyfriend, P. They find that alcohol or drugs or threats were not involved, and confirm their understanding that L lives with her supportive parents and siblings. He is her first and only sexual partner.
- Under the DHCS "Guidelines for the Management of Sexual Health issues in Children

and Young People", everyone aged 13 years and under who is suspected/known to be sexually active must be reported to the Central Intake Team. So the RAN calls 1800 700 250, and tells them L has an STI and there is no evidence of sexual assault. (STIs in this age group must be seen as a possible sign of sexual assault and therefore reported.)

- The staff tell the RMP about the case, and that they've reported it to the Central Intake Team. The RMP confirms that all the listed treatment interventions have been done, including contact tracing and telling L about protective behaviours. They discuss follow-up plans, and that it is possible that L will be referred to visiting staff, another organisation or community resources for ongoing support regarding her sexual health.

Central Intake Team (CIT) assesses the case:

- When the RAN calls, the CIT asks the PHCP questions (see Appendix 1), and records details of the case
- The CIT:
  - tells the RAN that SARC will shortly be in touch to discuss the case
  - checks their database for information about L and her family and with the Police to see if they have any relevant information, but there is none
  - briefly outlines the case to SARC and arranges for them to call the RAN ASAP
- After consideration, the CIT decides not to investigate this case and tells the local FACS office and the PHCPs
- However the CIT is concerned about L's boyfriend and how he got the STI. They ask to be informed if the PHCPs get any information about this.

SARC Team contacts the PHCP:

- The SARC team gather more information from the PHCPs, along the lines of questions listed in Attachment 1. SARC's particular concern is with L's immediate and future safety.
- After liaising with CIT, SARC decide they have no immediate role to play in L's management because L is in a consensual sexual relationship with the knowledge of her mother, and is receiving ongoing sexual health care from the health centre. They ask the PHCPs to contact them if they have any concerns about possible sexual assault related to this or any other cases.
- SARC is available to provide ongoing individual advice to the PHCPs.

FACS:

- FACS does not need to get involved in L's case because there are no parenting issues, and no force/coercion was involved in the sexual activity.

STI Team:

- Copies of all STI pathology results go to this team. As for all confirmed STI's in children aged 13 and under, the STI team member contacts the PHCP to confirm L's DOB and the specimen so they are accurately recorded on the Centre for Disease Control (CDC) database. The team member also reminds the PHCP they have to report the case to the CIT. (As the STI team don't have a direct relationship with L, the law prohibits them from reporting the case to FACS because this would breach confidentiality.)
- The PHCPs are reminded that they are responsible for contact tracing, and that the STI team is available for ongoing advice.

Women's Business — case example 2

T is a 15-year-old girl who attends a Women's Health Day. She seeks out the PHCP who she knows and likes and asks to see her after the screening ends. She looks quite uncomfortable and anxious and is reluctant to say more.

What happens next?

PHCP takes T to talk in private:

- T says she's worried because she is bleeding from her private parts after a man attacked her. She has told no one else about this. She is worried that her family or community members might think she is causing trouble if she does.
- T gets very upset as she tells what happened to her. She was out two nights ago with a group of friends and they were drinking. She was walking home late, and a man who is staying at her house came up and put his arm around her and touched her breasts. She pulled away but he grabbed her tightly. She felt frightened and sick but couldn't run. She was by herself. He said she was old enough now and that this would be a good for her. She told him to stop, but he pushed her onto her back on the ground and pulled down her shorts and underpants. He got on top of her and pinned her down with his body, she could hardly breathe. He put his fingers inside her (vagina) and then his penis; it hurt her a lot. She was bleeding and had a lot of pain inside and outside. He got up and left her. She vomited and then pulled her clothes back on and went home. She has never had sex before.
- The man lives in another community with his family, but comes to visit occasionally. He has returned home already.
- The PHCP asks T about her pain and bleeding and how she is feeling now and makes brief notes. The pain and bleeding have almost gone.
- The PHCP rings the RMP and they decide that no treatment (eg emergency contraception) or tests will be done at the health centre until they have discussed the case with SARC. When SARC is in contact they discuss whether the PHCP should take any action to preserve any forensic evidence (see Appendix 2)
- The PHCP reports the situation to Central Intake on 1800 700 250.

The CIT team assessing the problem:

- The Central Intake team (CIT) asks the PHCP questions (see Appendix 1), and records the information.
- The CIT:
  - tells the PHCP that SARC will be in touch shortly to discuss the case
  - checks their database for information about T (any child protection history for example) and the alleged perpetrator, and asks the Police to check their records but there is none.
  - decides there is enough evidence to take action and inform SARC, FACS and the Police so a co-ordinated response can occur.
  - briefly outlines the case to SARC and arranges for them to call the PHCP ASAP
- The CIT tells the PHCP that the case is "being actioned".

SARC begins coordinating:

- After talking to the PHCPs and T, SARC arranges to evacuate her to town as soon as possible. This is to support and protect her emotionally and physically and to assess and treat her medically and forensically. The sooner the forensic examination is done after an assault, the better (preferably before 72 hours for a vaginal rape, earlier for oral and anal rape)

- The SARC counsellor discusses with T and the PHCP who is the best person to travel with her. T's mother is identified. The PHCP helps T tell her mother what has happened and that they need to go to SARC in town.
- The SARC counsellor coordinates transport and accommodation for them (with the RMP and PATS). Another excuse is made for their travel so the reason for the evacuation is kept secret. The counsellor also lets the Police know that T is coming in
- The SARC doctor contacts the PHCPs to clarify the clinical situation and forensic issues. (see Attachment 2 re forensic evidence)
- When T arrives at SARC, the counsellor describes the role of the SARC team, including the clinical and forensic consults, the Police interview, and T's right to decide whether to formally make a report of the assault to the Police. T and her mother agree to do so.

The police interview T with her mother:

- In the Police interview, T describes what happened. With consent, this is recorded on DVD so that if/when charges are laid there will be a record. This material is treated with the utmost confidentiality.
- Police decide they have enough information to proceed with a Criminal Investigation, and the town-based Major Crimes Unit/Regional Investigations take it on. They will interview a number of people, including the PHCP's as part of the investigation.

SARC and the medical consultation:

- The doctor sees T with her mother, as T is happy to have her present for support. The doctor explains the interview and examination. Her mother signs the consent to the interview, examination, collection of specimens and photography. She also consents to passing the results of these, including any reports by the SARC counsellor or doctor to the Police or Department of Justice for further action.
- T repeats her story of forced vaginal rape. The doctor lets her tell it without asking any leading questions. She explains her role in assessing and documenting any injuries and providing preventive treatment for STIs (antibiotics) and pregnancy (emergency contraception). The doctor examines her, takes specimens for STIs (including blood) and collects forensic specimens including some of T's clothes. The examination is recorded on DVD and T's physical and genital injuries and emotional state are documented.
- The SARC doctor explains what she has found. She reassures T and her mother that the injuries will heal. She offers T emergency contraception and prophylactic antibiotics for chlamydia and gonorrhoea.
- The doctor will contact T, her mother or the health centre with the result of the STI tests. She tells T she needs repeat tests in 2 and 12 weeks.
- She informs the PHC team about current and future clinical management.
- The SARC counsellor counsels T, and gives her mother information about problems that T may experience and what she might do to help – or to get help with these. T, her mother and the PHCP can contact SARC for support by phone.
- SARC liaises with the PHC Team, and Police and together with T and her mother and they determine the best time for T to return home. The SARC counsellor arranges this.
- SARC may help T's in the future, for example as her advocate, eg with DPP interviews and court appearances.

FACS:

- FACS do not become involved in T's case because the alleged offender is not a relative, and because her parents are supportive and protective. If they were not then FACS might have had a role.

The SHBBV Unit:

- The SHBBV Unit is not involved because no STI has been found.

A case example is presented to help the PHCP understand what happens when a report about a male is made to the Central Intake Team. It is an example only. Similar cases may occur differently in real life depending on the specifics of the situation.

Men's Business — case example

P is the 14-year-old boy who was named as L's sexual contact in Scenario 1. L is a 13-year-old girl with chlamydia who was reported to the Central Intake Team. The PHCPs bring him to the health centre for contact tracing. Initially he denies sexual activity with anyone ever, but where did the STI come from…?

What happens next?

The PCHPs are the first involved:

- P is asked to come to the Health Centre for contact tracing. The PHCP talks with P about his general health, and behaviour. P admits he had sex with L and agrees to have his urine tested. The results show P has chlamydia, and no other STIs. The PHCP manages the case following the CARPA Guidelines and CDC booklet, Management of STI in PHC Settings, talking about STIs, prevention and checking and treating his sex partner(s). He tells P the law says that his parents must be told about the chlamydia (a notifiable disease). The PHCP is aware that P's parents are alcoholics and aren't supportive. P also says they don't care so there's no point in telling them.
- When asked about other sexual contacts, P denies any, but seems upset. Eventually he says that a relative who is an elder in the community, had sex with him. P did not want this; he is scared of this man and his group. He hasn't told anyone and has become withdrawn and depressed and is smoking lots of dope. It's not clear if these assaults have stopped.
- The PHCP knows not to ask questions because this can affect information needed for an investigation. The PHCP tells P what's happened to him has to be reported to FACS, and needs to be looked into.
- The PHCP calls the Central Intake Team. This PHCP tells only the health centre manager, RMP and staff directly involved that a report has been made. Confidentiality is very important for P's safety and for the progress of any investigation.

The Central Intake Team (CIT) assessing the problem:

- The CIT asks the PHCP questions (see Attachment 1), and records the information.
- The CIT:
  - tells the PCHP that SARC will shortly be in touch to discuss the case.
  - briefly outlines the case and asks SARC to call the PHCP back ASAP.
  - checks its records for information about P (eg any child protection history), and asks the Police to check their records. There is nothing relating to P
- The decision is that there is enough evidence to take action and inform SARC, FACS and the Police so a co-ordinated response can occur.
- CIT contacts the PHCP to say the case is "being actioned", and that P will have a FACS caseworker.

Back to the PHCPs:

Closely involving P, the PHCP liaises with FACS, SARC and Police to work out the best way to support him when his family is told of the disclosure of abuse, and the STI. They all agree it would not be helpful to tell his parents at this time, and P requests that instead his mother's brother (a protective male relative) is told. The agencies follow P's request, and also work to keep him safe, decrease the trauma he and possibly his family will experience, and help the investigation along.

The PHCP and AHW (if not the notifier) and P work out the details of the meeting, making sure too many people aren't present.

A CO-ORDINATED RESPONSE OCCURS:

- Because the responses are co-ordinated between SARC, Police and FACS, some of the actions described will happen at the same time, and others in sequence. All the agencies are worried that P could be in danger from this relative, and possibly other men. He needs to be protected because of the continuing risk from them and his own depression and possible self-harming behaviour.

SARC's role coordinating:

- SARC organises for P and his uncle to go to SARC in town for interviews with Police, FACS and the SARC team. They arrange transport with the RMP on call and accommodation as a priority. SARC arranges for the Police and FACS to get P's statement before the SARC doctor's examination.
- The evacuation is quite delicate and difficult in this small community as the alleged perpetrator has a wide circle of influence, so another excuse is made for their travel. Extreme confidentiality is needed because of concerns about P's safety.

The Police (with FACS) interviewing initially:

- In the FACS/Police interview, P denies his initial statement for fear of payback against him or his family, but over a few days the complete story unfolds. This man forced P to perform oral sex a number of times, and then gave P oral sex. He raped P's backside twice. P's backside was sore and bled a little at first, but this has gone now. This statement is very important, especially if P later denies what he has said.

SARC provide forensic and therapeutic roles:

- After this, the SARC team meet P and explain what they do. P and his uncle consent to the clinical and forensic medical examination and the collection of evidence, including a DVD recording that may be shown in court. The findings are there are no acute, chronic or previous general or physical injuries to his private parts. (This is not unexpected; it is usual that forensic examinations do not find any acute injuries or healing.) The SARC doctor feeds the results back to P and his uncle. The SARC doctor contacts the PHCPs to discuss P's medical management so far. She cannot discuss the forensic aspects of the case.

- The SARC counsellor gives P counselling, and tells his uncle about how this experience may affect P – what to look out for and how to help him now and when they are back in their community. They make a follow-up appointment.
- SARC liaises with FACS, the PHC Team and Police who with P and his uncle, work out when P is safe to go back to his community, and arrange it.
- P meets with the counsellor before he returns home. The counsellor thinks he will need a lot of support, and they can provide ongoing help from in town.

FACS and ongoing welfare and safety:

- This case involves family, so FACS leads the case. The FACS caseworker meets P and his uncle while they are in town. She arranges to see P to assess and support him in his community, using an excuse to meet, so people are not suspicious.
- Later, FACS works out with P, his uncle, the PHCP and Police when and who will tell his parents about the sexual abuse and STI.
- FACS would need to ensure P's safety prior to his return. If this is not guaranteed he may need to be taken into care until that is resolved.
- FACS coordinates the best way to keep P safe after he goes back home. FACS arranges for P's uncle to provide ongoing support, and for P to be with kids his own age in supervised, fun activities (eg youth group).

The investigation continues:

- The Police investigate the allegations, and interview other people and the alleged offender/s. As this information may be used in court, the information is kept extremely confidential.

STI team and surveillance:

- Refer to Scenario 1 (L) for the STI team's involvement

Appendices

APPENDIX 1
Reporting information

It is helpful if the PHCP can provide the following information before making a report to the Central Intake Team, but it is not essential. It is more important for the PHCP to simply receive the young person's story and provide support.

The PHCP shouldn't probe for information before calling CIT, because questions may be leading and the information will not be admissible in a prosecution. Also, the child should only be questioned once, and then only by specially trained interviewers.

- Notifier's contact information
- Young person's demographics
- Family information
- Where is the young person?
- What are the young person's living circumstances?
- Is the environment safe?
- Does the young person understand what is happening?
- Previous involvement of other agencies
- What makes you think there may be maltreatment?
- Do you know who the perpetrator may be?

When working with SARC, they are likely to ask you about:

- The young person's current physical status: Does he/she need urgent medical treatment? Is the young person's health at risk? (PID, other STIs, re-infection, pregnancy etc)
- Current emotional and mental status
- Is the young person safe? Physically, emotionally and sexually. Does he/she have an effective guardian and advocate?
- Is there any relevant past medical / social history?
- Has the young person been sexually active previously, and if so for how long?
- Issues of consent to sexual relationships in a young person (power imbalance, physical and verbal coercion etc)
- What has the PHCP done so far?
- How have the opinions, diagnoses, management plans and follow-up been communicated to the young person, the family and the PHCPs?

Again, the PHCP does not need to have all the above information before talking with staff.

APPENDIX 2
Preserving forensic evidence in sexual assault

The following information applies equally for young person and adults:

- It is important that when the Police interview the victim, they get the story "fresh," where s/he hasn't had to tell it over and over, getting confused or changing it.
- PHCPs need to collect a brief clinical history and not ask extra questions.
- PHCPs must seek advice early from SARC (through the CIT) to find out how much they should do. In most cases needing an investigation, the SARC doctor will recommend that only basic first aid and clinical STI treatment is started at the Health Centre.
- After a sexual assault, evidence is collected to help establish:
  - that a sex act(s) occurred (what happened?)
  - the identity of the perpetrator (who did it?)
  - lack of consent
- When a forensic medical examination is conducted, evidence is collected and stored according to strict and secure protocols (chain of evidence) in order to be admissible in court.

EXAMPLES OF SOURCES OF EVIDENCE COLLECTED IN A FORENSIC MEDICAL EXAMINATION—FOR INFORMATION ONLY:

Site	Potential evidence of:	Possible PHCP action – SEEK ADVICE FROM SARC
Clothing	Perpetrator Site of crime	Retain clothing (special collection and storage requirements)
Skin	Perpetrator eg saliva after kissing, sucking, biting, ejaculation	Don't wash, shower etc Forensic specimens collected at SARC
Genitals	Vaginal, genital contact by perpetrator eg semen, sperm, saliva Lack of consent eg injury	Don't wash Forensic specimens collected at SARC
Mouth	Oral penetration and evidence of perpetrator or injury	Don't eat, drink, wash teeth Forensic specimens collected at SARC
Anus	Anal penetration and evidence of perpetrator or injury	Don't wash Forensic specimens collected at SARC
Urine	Drug facilitated assault	Collect first catch urine for toxicology (note storage requirements)

NOTE: There may be little advantage in collecting forensic evidence – depending on the time and type of assault; this needs to be discussed with the SARC doctor.

KEY POINTS:

- **The collection and handling of forensic evidence is a specialised field**
- **PHCP's should seek advice from SARC doctors so they don't compromise the chain of evidence**

NOTES

SEXUAL ASSAULT IS A CRIME!

Worries or concerns of child sexual assault must be reported to 1800 700 250 (free call)

Toolkit for managing child sexual abuse

If you would like more information,
please refer to the DHCS booklet:
Guidelines on Sexual Health Issues in Children and Young People 2007,
or visit the DHCS website.

nt.gov.au/**health**

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