University of Southampton

Faculty of Health Sciences

Multi-agency response to childhood sexual abuse: a case study that explores the role of a specialist centre

Lindsay Voss, RN, BN (Hons)

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ABSTRACT

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MULTIAGENCY RESPONSE TO CHILDHOOD SEXUAL ABUSE: A CASE STUDY THAT EXPLORES THE ROLE OF A SPECIALIST CENTRE

By Lindsay Voss

This study explores the role of a specialist centre in responding to actual or suspected childhood sexual abuse. Children, families and professionals from several agencies are required to navigate an intricate journey when abuse is suspected to have occurred. Through the application of case study research methods in which a specialist centre forms 'the case', the complexities of the journey are explored.

The literature review highlights the emergent nature of 'knowledge' about specialist children's centres. To inform the research study, papers that focus on children and families' experience of the multiagency response, the rate of positive medical findings on examination and their relationship with criminal justice outcomes are examined. The available literature relating to the nursing role in responding to child sexual abuse is also reviewed.

This case study comprises three data sets: 1) Sixty children (0-17 years) who attended the Centre following suspected sexual abuse were 'tracked' to ascertain reasons for referral, type of examination undertaken and outcomes in terms of health status, social care input and criminal justice actions. 2) Semi structured interviews with 16 professionals (paediatricians, nurses, police officers and social workers) in which their perceptions of the centre were explored. 3) Analysis of patient and parent/carer satisfaction questionnaires.

Medical examination rarely confirmed abuse had occurred and only 13% of cases were pursued within criminal justice systems. However, 66% of children had an identified health need that required professional follow up. Interviews demonstrated that professionals believed the Centre provided a 'child friendly' facility that enhanced multiagency co-operation, but challenges associated with the principles of multiagency working were identified. Patient questionnaires demonstrated positive views of the care received by those who completed them.

Findings from the three data sets are presented as the child's journey through a complex series of events in a case study 'story'. The study demonstrates the way in which professionals may be distracted by the medico-legal demands of the 'system'.

Children's active participation in decision making should be promoted when actual or suspected abuse has occurred and a combined approach by multi-agency professionals, based on the individual needs of each child, is advocated not only during attendance at the specialist centre but also during a follow up period. Where abuse is not confirmed, children may benefit from continued care from health professionals. Nursing has the potential to adopt a greater leadership role in achieving the required change.

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Declaration of Authorship

I, Lindsay Voss declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

……..

……

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;

5. I have acknowledged all main sources of help;

6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;

7. None of this work has been published before submission.

Signed:

Date: 7th May 2015

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Definitions and Abbreviations

Definitions related to childhood (National Institute for Health and Care Excellence 2009:4)

- Infant - aged under 1 year
- Child - aged under 13 years
- Young person – aged 13-17 years

(Throughout this study the term 'child' or 'children' is used to refer to all within the 0-17 year group)

Forensic: relating to the application of scientific methods to the investigation of crime (Murray et al (eds) 2005)

SARC Sexual Abuse Referral Centre

CAC Child Advocacy Centre

Child sexual abuse:

'Forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities such as involving children looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

(HM Government, 2013:86)

Section 47 (1) of the Children Act 1989 states:

Where a local authority:

(a) are informed that a child who lives, or is found, in their area (i) is the subject of a emergency protection order, or (ii) is in police protection; and

(b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:

the authority shall make, or cause to be made, such enquires as they consider necessary to enable them to decide whether they should take any action to safeguard and promote the child's welfare.

Section 53 of the Children Act 2004 amends both section 17 and section 47 of the Children Act 1989, to require in each case that before determining what services to provide or what action to take, the local authority shall, so far as is reasonably practicable and consistent with the child's welfare:

(a) ascertain the child's wishes and feelings regarding the provision of those services or the action to be taken; and

(b) give due consideration (with regard to the child's age and understanding) to such wishes and feelings of the child as they have been able to ascertain.

Chapter 1: Introduction and Background

1.1 Introduction to the research and rationale for the study

When actual or suspected childhood sexual abuse is reported to statutory agencies, a complicated response involving police, children's social care and health services may be initiated. Children, families and professionals alike are required to navigate a journey that comprises a complex series of events. Using case study research methods in which a children's specialist centre forms the case, this study explores that journey. It is intended that the study findings will inform professionals about the needs of children who have, or may have been sexually abused or assaulted. In this section of the thesis the rationale for the study is presented.

This study was conceptualised as a means by which a range of professionals, particularly commissioners and providers of health services, might better understand the activity within a specialist centre that provides a response to children following actual or suspected childhood sexual abuse. The study was planned prior to publicity about the so-called 'celebrity' abuse cases such as that of Jimmy Savile or Rolf Harris. Whilst public mood and government attention may be influenced by such high profile cases, momentum in terms of taking effective action may be less easily maintained as publicity fades. For example, in Cleveland in 1987 many children were removed temporarily from their families as a result of suspected sexual abuse. The 'crisis' that ensued (Butler Sloss 1988, Campbell 1988) received significant attention and also resulted in numerous recommendations aimed at improving services for victims of childhood sexual abuse. Whilst the recommendations arising from the Inquiry achieved many positive changes, the subject of child sexual abuse had not, until very recently, continued to receive the same degree of media or public attention as other forms of abuse.

It is suggested that sexual abuse thrives in a climate of silence and secrecy and this may underpin reasons for numbers of children who are identified as being at risk being notably small when compared with children suffering from other forms of maltreatment. In March 2013, only 2,030 children in England were subject to statutory child protection plans under the category of sexual abuse compared with 17,930 who were judged to be at significant risk of neglect (National Society for the Prevention of Cruelty to Children 2014). This figure suggests, based on prevalence studies (e.g. Radford et al 2011), that child sexual abuse may be both unrecognised and under-reported. Potential reasons for this position are manifest and beyond the scope of this study.

Gang related sexual exploitation of children cases has also prompted renewed awareness of the subject (e.g. Rochdale Safeguarding Children Board 2013, Oxfordshire County Council 2013).

Efforts to understand and tackle the issue of child sexual exploitation are being made by both the children's commissioner (Berelowitz et al 2013) and the Government (Department of Health 2014, Home Office 2013). These developments may assist professionals and the wider public in understanding something of the scale and nature of childhood sexual abuse in the UK. However, the reality for many children is that sexual abuse is perpetrated by a trusted family member or friend (Radford et al 2011). This population of children has been known to specialist doctors, nurses, social workers and police officers for many years and yet has received scant attention within the wider National Health Service (NHS).

These factors were influential in prompting a professional interest in studying statutory agencies' responses to sexual abuse. When a specialist multiagency referral centre was commissioned specifically for the needs of this population of children, it became apparent that in order to inform the development of the service, a greater understanding of their experiences and requirements was crucial. Therefore, the aim of this study is to better understand the role of a specific specialist centre that provides services for children in the acute aftermath of suspected sexual abuse. Through the application of case study research methods in which the specialist centre forms 'the case', the children's journeys are explored. The case study story offers insight into the day to day reality of attending or working in the specialist centre.

1.2 Background to the study

In this background section the historical context, definitions and prevalence rates for child sexual in the UK abuse are presented. The development of specialist services for adults and child victims of sexual abuse and some difficulties in defining interagency working are explored. Local context, service provision for victims of child sexual abuse and the 'case' that forms the focus of this study are also described.

1.2.1 Childhood abuse in the UK

It is difficult to choose a 'starting place' from which child protection practice in the UK has evolved, but it may be helpful to consider a brief overview of the historical context that frames the study. A brief chronology of significant events is presented in Appendix 1.

Association between multiple fractures in the long bones and chronic subdural haematoma in babies by Caffey (1946) appears to have been an early development in the recognition by medical staff of deliberate harm of children. Kempe et al (1962) published evidence in relation to the prevalence of injured babies, and the term 'battered baby syndrome' became more commonly used. In the UK a publication entitled 'The Battered Baby' (DHSS 1970) suggested that Medical

Officers of Health should consult with Children's Officers (social workers) and 'other local people of social agencies', and this appears to mark the early beginning of interagency working for the purpose of preventing or responding to child abuse.

Corby (2006) suggests that the inquiries that followed the deaths of children Maria Colwell (Department of Health and Social Security 1974) and Jasmine Beckford (Brent 1985) were influential in making 'child protection' subject to state intervention and the emergence of the system for 'registering' children at risk of abuse or neglect. In 1986, the draft guidelines of 'Working Together' which require agencies to co-operate for the benefit of children were produced and have been subsequently amended (DHSS 1988, DH 1991, 1999; HM Government 2006, 2010, 2013). The Children Acts (HM Government 1989, 2004) provide the legislative framework that requires NHS Trusts (and other bodies) to perform key duties to safeguard and promote the welfare of children. Schofield and Thoburn (1996) suggest the Children Act 1989 represented:

> 'a radical change in the way in which the rights of children both to care and to participate in decision making were to be viewed by courts and by all agencies who work within the child protection system'.
>
> (Schofield and Thoburn, 1996:5)

Basic rights for children were further strengthened in 1991 when the United Kingdom became a signatory to the United Nations (UN) Convention on the Rights of the Child (UN 1989). The Children Act (1989) and the UN Convention on the Rights of the Child (UN 1989), Corby (2006) suggests, through influencing society's attitude to child maltreatment, may have greater impact than changes in child protection systems and procedures. The UN Convention stresses that children should live free from abuse, have rights to education, rights against labour exploitation and rights to live with their parents.

In relation to childhood sexual abuse specifically, the 'Cleveland Affair' which involved numerous children being taken into statutory care following the 'diagnosis' of sexual abuse by two paediatricians using an anal dilatation test without corroborative history (Hobbs et al 1999) is particularly significant. Although child sexual abuse was confirmed as being widespread in the ensuing Butler-Sloss Inquiry (1988), the Affair focused attention on the role of the medical profession in 'diagnosing' abuse or as Hobbs et al (1999) suggest, adopting the view of the abused child having a 'disorder' which requires treatment. Indeed, many children were admitted to hospital on the grounds of 'abnormal' genital signs. Given the varied legal and sociological perspectives of social workers and police officers, it perhaps should not be surprising that the 'Affair' was marked by serious inter-professional conflict which, Campbell (1988) suggests,

eclipsed the needs of the children and their families. The Butler-Sloss Inquiry is a seminal report and her conclusion that children's interests were largely overlooked by professionals has underpinned much subsequent policy development. Specifically in relation to medical examination she recommended:

'Children should not be subjected to repeated medical examinations solely for evidential purposes. Where appropriate, according to age and understanding, the consent of the child should be obtained before any medical examination or photography'

(Butler Sloss, 1988:245)

The Report also recommended that greater considerations be given to the rights of parents and that co-ordination and co-operation between statutory agencies should be improved. The extent to which these principles are 'lived' in every day practice may be illuminated by this study.

1.2.2 Defining child sexual abuse

Statutory guidance provides a definition of child sexual abuse:

'Forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities such as involving children looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet)'.

(HM Government, 2013:86)

Previous Working Together (2010) guidance refers to sexual activity in young people under 13 years and states:

'A child under 13 is not legally capable of consenting to sexual activity. Any offence under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate a risk of significant harm to the child'.

(HM Government, 2010:141)

Regarding 13 to 15 year olds it states:

'Sexual activity with a child under 16 is also an offence. Where it is consensual it may be less serious than if the child were under 13, but may nevertheless have serious consequences for the welfare of the young'.

(HM Government, 2010:143)

The 13 to 15 year age group pose a particular challenge as they may, in some circumstances, constitute part of a 'hidden group' as described by Creighton (2004), in which neither victim nor perpetrator is aware that abuse has occurred. Girls and boys within this age group may also be

vulnerable to so called 'boyfriend' abuse in which they are sexually exploited by an older male, who, following a period of 'grooming' introduces them to gang or group led sexual abuse (DH 2014). Sexual activity aged less than 16 years is illegal under the Sexual Offences Act 2003, (and may, in theory, involve criminal charges if it comes to the attention of the police).

Further complexity exists with some 16 and 17 year olds, as although sexual activity does not constitute an offence (unless the perpetrator holds a position of trust) some, as discussed later, may be vulnerable due to disability, including learning disability, and may therefore be at greater risk of sexual abuse and exploitation. For professionals working with this age group, judgements must be made about the risk of 'significant harm' as defined in the Children Act (HM Government 1989), and appropriate action to minimise further harm must be taken.

Complex scenarios may therefore be presented to professionals involved in medical examination following alleged sexual abuse, and Pillai (2005: 58) advises that there is a need 'to be extremely cautious about any examination that may be more in the parents' or the public interest than of benefit to that individual child'.

1.2.3 Prevalence rates for childhood sexual abuse

In planning services for victims of childhood sexual abuse, it is important to establish an estimate of prevalence rates within the local and national population. This is difficult for a number of reasons and Creighton's (2004) 'iceberg' analogy where only one portion of the whole is visible, provides a useful aid in illustrating the problem. The visible population of children who have been abused are included in the figures for the number of reported sexual offences against children. In England on 31st March 2013, there were 43,140 children subject to child protection planning, of which 2,030 were deemed to be at risk of sexual abuse (National Society for the Prevention of Cruelty to Children (NSPCC) 2014). Numbers of children subject to planning due to risk of sexual abuse have remained almost constant since 2009 (when the figure was 2000) whereas overall numbers of children who are deemed to be at risk of all forms of abuse and neglect has risen from 34,000. These figures refer to those children who required a high level of statutory protection but do not include those who may be removed from their families into local authority care due to a high risk of sexual abuse, or conversely those who may have been adequately protected by their own families without any social care intervention at all. Neither does it include the 'hidden' layers as described by Creighton.

In attempting to ascertain how many children may be included in this 'invisible' group, two large scale surveys carried out on behalf of the NSPCC provide information about the scale of the problem in the UK. Cawson et al (2000) suggested 16% of girls and 7 % of boys aged less than 18 years experienced contact sexual abuse (i.e. direct physical contact was involved rather than offences involving indecent images, internet etc.) with 6.8% of children experiencing forced or coercive acts. Radford et al's (2011) findings suggest that 4.8% of the 11-17 year group had been sexually assaulted either by an adult or another child or young person. Children were the alleged perpetrators for 65.9% of contact sexual abuse, with girls being the main victims. Direct comparisons between the 2000 and the 2011 studies cannot be made due to differences in methodology, but in the 18-24 year old group the number of people reporting forced or coercive sexual acts in their childhood had declined from 6.8% in the 2000 study to 5% in 2009. Radford et al explore potential theories for the apparent decline which they hypothesised may be due to: a decline in prevalence of maltreatment across all social groups, a decline in maltreatment within more advantaged families with disadvantaged groups being 'left behind' (p114), or, a reduction of prevalence of maltreatment in disadvantaged groups due to a focus on reducing inequalities in children and young people's health and wellbeing. When further analysis of the data was undertaken, the authors concluded that despite considerable variation in prevalence rates between social-demographic groups that the reduction in prevalence was similar across groups or in some cases more marked for disadvantaged groups. A summary of findings from these studies in presented in Table 1.

Radford et al (2011) also confirmed that some groups of children are at greater risk of experiencing multiple forms of maltreatment. They include children with: special educational needs, long standing disability or illness, a parent with enduring physical, learning or psychiatric problems, violent homes, separated parents, lower socio-economic circumstances and parents who misuse drugs or alcohol.

The results of self-reported findings such as those published by the NSPCC are difficult to verify and may provide an underestimate of prevalence rates. If however, Radford et al's (2011) potentially conservative figure of 4.8% (girls and boys) having experienced forced or coercive sexual acts is applied to the estimated child population of England of 11. 4 million aged 0-17 years (DfE 2013) it may be estimated that for half a million (547,000) children, coercive sexual assault is, or has been a concern. For the population of children who may access the services of the Centre, estimated as 100,000 (0-18 years), using the same figure, there are 4,800 children who may have experienced coercive sexual abuse.

Table 1 Prevalence of forced or coercive sexual acts in childhood

(from Cawson et al (2000) and Radford et al (2011)

	Cawson et al (2000)	**Radford et al (2011)**	
Year of data collection	**1998/9**	**2009**	**2009**
Number of participants	2689	1761	2275
Age of participants at interview	18-24 years	18-24 years	11-17 years
Findings	6.8% had experienced forced or coercive acts during childhood	5% had experienced forced or coercive acts. 11.3% had experienced contact sexual abuse. 4.5 % had been raped or forced into sex by another child. 3% had been sexually abused by a boyfriend or girlfriend on a date. 1.0% had been sexually abused by a parent or guardian.	4.8% had experienced contact sexual abuse. 16.5% had experienced sexual abuse when non contact offences are included. Majority of perpetrators were male, either adult or another child or young person known to the victim.
Comments	This excludes perceived consensual sexual activity by adolescents aged over 13 years (which professionals /parents may perceive as abusive)	Forced or coercive acts were defined as: rape or attempted rape or forced sexual contact by an adult or child; contact sexual abuse by a parent, guardian or sibling when child aged under 18 years; contact sexual abuse by an adult to a child under 13 years; contact sexual abuse by an adult relative to a child under 16 years.	This part of the study was designed to provide a picture of current levels of child abuse in the UK. The participants are younger and incidence of sexual abuse increases with age of young person.

1.2.4 The development of adults' specialist sexual abuse referral centres

Specialist centres for victims of sexual abuse that provide health, advocacy and criminal justice services in one location have been in development in the UK since the late 20th century and their continued development is supported by The Stern Review (Home Office 2010). This review and the Government's subsequent response to it (HM Government 2011) continue to promote multiagency efforts to improve reporting and response to these crimes.

The drive for improved interagency working in relation to adult sexual assault does not appear to have been connected with the events in Cleveland, but appear to have been more greatly influenced by The Women's National Commission, an advisory umbrella body for women's groups. Smith (1989) cited by Lovett et al (2004) outlines the difficulties that had been identified for adult victims of sexual assault and rape in the 1980s:

- low reporting of rape
- delays in locating a forensic doctor
- lack of female forensic doctors
- the environment in which forensic examinations took place
- the manner in which examinations were conducted
- inconsistency of evidence gathering
- absence of medical follow up and support
- lack of co-ordination between agencies

Some of these problems were overcome through the development of the one stop location Sexual Abuse Referral Centres (SARCs), the benefits of which are outlined below in Box 1.

Box 1 Summary of the benefits of a SARC adapted from '*A resource for developing sexual assault referral centres*' (DH, Home Office, ACPO 2009)

For **victims:**

- High standard of care, privacy and dignity
- Integrated medical, forensic, advice and support services
- Higher level of satisfaction in investigation and criminal justice processes
- Less likely to withdraw allegations
- Provision for victims who do not want to present to the police

For **police** and **forensic examiners**

- Police time is released if a crisis worker is available to support victim
- High standard of facilities and equipment for forensic examination.
- Some SARCs can take forensic samples 'anonymously' i.e. without the victim having to report to the police (builds a picture of the perpetrator even if the crime is not recorded)

For **health services**

- Overcomes inconsistent standards as SARCs staff are properly trained
- Relieves pressure on other health services (e.g. accident and emergency, genito urinary)

- Reduces risk of unwanted pregnancy and sexually transmitted diseases.
- Good immediate care and counselling may reduce need for ongoing services
- SARCs provide a focus for the development of professional practice and support for clinicians including forensic medical examiners

For the criminal justice system**:**

- High standard of evidence gathering and forensic reports.
- Potentially longer term cost benefits can be achieved as SARCs increase confidence in the criminal justice system – bringing more offenders to justice.

Other:

- SARCs act as a centre of excellence and expertise and provide advice, training and support to health practitioners and other professionals involved in this work.
- SARCs facilitate innovation and development in relation to forensic and legal practice changes.
- Increased co-ordination between agencies (though there remains potential for further development).
- SARCs facilitate the development of services such as case tracking and support / advocacy which address long standing gaps.

SARCs are therefore welcome developments in improving the delivery of a 'joined up' approach to sexual violence. However, despite 35% of female rape victims being less than 16 years of age (Taylor and Chaplin 2011) SARCs have been developed largely in response to the needs of adult victims and little is known about the needs of children and young people, particularly those in the younger age groups. Lovett et al's (2004) evaluation of SARCs demonstrated benefits for adult victims but young people aged less than 16 years were excluded from the study due to ethical difficulties.

1.2.5 Development of specialist services for children

There has been little consistency in the development of specialist centres for children who are suspected to have been sexually abused either in the UK or the USA. As with adult services, Child Advocacy Centres (CACs) in the USA were aimed at co-ordinating services for victims of child abuse. Walsh et al (2007) suggest that the multidisciplinary investigation team is a defining and universal element of CACs, but add that although CACs share a similar philosophy, the settings, population and service delivery vary tremendously. They cite Jackson (2004) who found that 47% of CACs did not provide onsite medical facilities which is one of the standards required for accreditation by the National Children's Alliance.

In the UK it appears a similarly disparate range of facilities for children exist and the Department of Health (DH), Home Office and Association of Chief Police Officers (ACPO), 2009) recommended that services for child victims of sexual abuse or violence should be modelled on those of adult SARCs. Currently, little consistency exists and substantial enquiries across England show different

models of services for children have evolved. Some sit within adult SARCs, others within acute or community paediatric health settings. Watkeys et al (2008) found that young children often had to travel to a number of different locations such as hospitals or police facilities in order to access appropriate services. Extensive enquiries across England show that weekend and out of hours' provision is scarce due to the sporadic nature of the demand and financial costs associated with the requirement for paediatricians to be on call. Varying thresholds and criteria for access to services exist, dependent on local arrangements.

While most adult SARCs will provide a service to adolescents, some require a disclosure of sexual abuse to have been made. This requirement may exclude younger children and those with disabilities who may display behavioural indicators of abuse in the absence of verbal disclosure. Additional uncertainty may be associated with a lack of clarity about the timescale of the suspected or alleged abuse. Children with disabilities are particularly vulnerable to sexual abuse (Radford et al 2011) and yet this group of children may not be aware that abuse has occurred at all, or may be unable to communicate when it has. In these situations, professionals must find a balance between providing a thorough response that ensures children are adequately assessed and protected, with that of 'overreacting' to vague or unsubstantiated concerns. This research study focuses on a specialist centre where, subject to a police or social care investigation, children may be referred when a concern or suspicion that sexual abuse has occurred, but there may be no clear verbal disclosure made by the child. For example, concerns may arise as a result of children carrying out sexually explicit behaviour or play which may be an indicator that sexual abuse has occurred.

1.2.6 Interagency working

These considerations are the collective responsibility of statutory agencies. The Children Acts 1989 and 2004, statutory guidance (HM Government 2013) and numerous policy directives require professionals from police, children's social care and health services to 'work together' (HM Government 2013). Although this principle was introduced in the 1980s (Department of Health and Social Security (DHSS) 1988), in practice, the multiple perspectives of individual professionals and their employing organisations mean that this is not achieved easily.

The concepts of 'joint working' or 'collaboration' are frequently referred to when referring to the professional response to childhood abuse, but it is apparent that greater understanding of these terms is needed. Horwath and Morrison (2007:55) highlight the ambiguities associated with the requirement for agencies to collaborate. Although their article refers to higher level multiagency strategic action, their observations that 'communication', 'co-operation', 'co-ordination' 'coalition'

and 'integration' are not synonymous but feature different levels of 'partnership' working may have resonance for the study.

1.2.7 Medical and nursing position on child protection medical examination

The Royal College of Paediatrics and Child Health (RCPCH) and Association of Forensic Physicians (or preceding organisations) have produced a number of practice guidance documents for paediatric forensic examinations in relation to possible child sexual abuse. The most recent comprehensive guidance (RCPCH 2007) acknowledged the importance of providing child centred services that focus on emotional and physical health needs of the child at the time of medical examination. Similarly, the British Medical Association (2004) guidance emphasised the need to seek a child's agreement before proceeding in child abuse examinations and the necessity of avoiding repeated examinations.

The nursing profession in the UK has produced little national guidance that addresses the potential for nursing to contribute to enhanced or specialist care in relation to children who may have been sexually abused. In general terms, the Chief Nursing Officer (DH 2012) suggests nurses can be instrumental in leading the development of well co-ordinated services and, in relation to childhood abuse, this is a key concept for this clinical doctorate. Lovett et al's study (2004) identified co-ordination of services and the provision of 'case tracking' (keeping the victim informed of the progress of any criminal justice developments) and advocacy as beneficial to adult victims and yet this role in relation to children remains largely unexplored. Although Regan et al (2004) undertook an evaluation of the potential benefits of 'forensic nursing' in improving outcomes for adult victims, currently there is little evidence about what constitutes 'quality' in relation to clinical child protection medical services. This is a key gap in the knowledge of those who commission or provide health services for children who have been sexually abused.

1.2.8 Description of the local service

This research study focuses on a local specialist referral centre that opened in 2009 and is referred to throughout this thesis as 'the Centre'. Prior to the development of the Centre, and in common with many areas in the UK, the environment for the service was less than ideal. Children and families were asked to attend a cramped room within an acute hospital. A single examination room opened on to a busy hospital corridor, with no waiting area for children, families or professionals. As well as the inherent difficulties in communicating effectively about sensitive issues in such conditions, fears were also expressed about lack of confidentiality for children as it was commonly known as the 'abuse room'.

In contrast, the Centre is a self contained unit accommodating a medical examination room with video colposcopy facilities and several interviewing rooms including one that may be used for police and social care video interviewing of children and young people. There is a waiting room for children and families equipped with toys and comfortable seating and age appropriate art on the walls. An examination room with adjoining bathroom meets the required standard for forensic medical examination required by criminal justice services. Office space is available for the on-site specialist nurse and for visiting professionals such as police officers and social workers.

Children may access its services following a concern or suspicion of sexual abuse having occurred (i.e. a verbal disclosure is not a pre-requisite). It is open 9am to 7pm throughout the week but at weekends and on bank holidays the service is commissioned from a different venue as part of a county wide service.

1.2.9 Identifying the case

When the Centre opened in 2009 it appeared that a local 'gold standard' service had become available that enabled local children's facilities to achieve parity with that of the adult SARC and which represented a landmark in the development of local provision for childhood victims of sexual abuse. The Centre was identified as 'the case' (Stake 1995) which I wished to study to enable me to answer some key questions posed by Wolcott (1994:12): 'what is going on here?', 'how do things work?' and 'what is to be made of it all?' There was little available literature to refer to in planning the study, as single discipline literature was not helpful in providing insight into an interagency facility. Stanley (2011) in her commentary on the work of Hambke (2010) and Wilmer (2011) suggests the use of the term 'sexual assault' criminalises the subject and use of 'psychosexual trauma' medicalises it. By adopting a case study research approach that considered all activity I wished to avoid an emphasis on professional differences or 'tribalism' (Atkins 1998). Organisational and professional 'constructs' can present a barrier for any researcher who attempts to understand the experience of children following abuse and by identifying the Centre as the case, rather than any specific activity, it was considered that the impact of these differences might be overcome.

1.3 Insider role

The drive to undertake this study arose during personal experience of providing direct clinical nursing care in the child protection service that preceded the development of the Centre. This clinical practitioner experience and 'insider' status in terms of employment impacted on ethical and study design decisions which are further explored within this thesis. Pelias (2011:662)

suggests researchers who claim insider status 'indicate that they share cultural membership with the group under investigation'. In order to be explicit about the way in which my position as researcher and as a nurse changed and evolved during the course of the study, an overview is presented in this section and forms the basis for more detailed discussion in chapters 3 and 7.

Insider status was largely due to employment within the health trust in which the research took place and this issue is discussed below. However, I also had some nursing experience of working within the child protection medical service which was influential on my researcher role. Rolfe (1998) argues that research which focuses on individual nurse-patient relationships is the basis for generating meaningful knowledge and theory for use in practice. He suggests that unless clinical nursing research is carried out by nurses themselves, that a 'theory-practice gap' (p672) will persist as knowledge is 'handed down' to practitioners in a hierarchical approach. Whilst this is a compelling argument, my role as provider of direct clinical care was fleeting and ceased soon after the Centre opened (see table 2) and so it was not possible to adopt the type of researcher role advocated by Rolfe. However, this prior experience did assist in enabling relationships to be built with some of the professional participants thereby further contributing to insider status in terms of shared culture (Pelias 2011).

As Simons (2009:36) suggests, researchers must 'choose a role' (p36) and it may be helpful to provide the context for the researcher role that I chose. During the research planning and design stage, prior to ethics application and data collection, I concluded that a study in which my nursing 'identity' or practitioner 'self' was centrally positioned within the research, risked alienating those participants from non-nursing backgrounds. As the Centre is a multiagency facility, I wished to set aside my own preconceived 'nursing' ideas and allow my thinking to be challenged by alternative views and perspectives. Whilst acknowledging that it is not possible, or desirable, within qualitative inquiry to entirely separate from one's own previous knowledge and experience, I chose to distance my researcher role from my professional nursing identity. Simons suggests there are numerous options when choosing the researcher stance, for example; documenter of events, story-teller, historian, collaborator, or educator. She suggests that these roles may change or integrate at different stages of a research study. I chose to adopt the role of 'impartial observer' (Simons 2009:37) whilst acknowledging that qualitative inquiry is subjective, and that I was 'implicated' in the research (Pelias 2011:662). Therefore, whatever position I might consciously wish to adopt, the inquiry would be guided by personal intuitive knowledge (Lincoln 2011) and in writing up the study I would be 'clarifying things for myself' (Pelias 2011:662).

The choice of 'impartial' researcher role is significant and requires further discussion. Fulton et al (2012) suggest the professional doctorate supports the development of work based skills and knowledge that transcend professional boundaries and overcome issues such as the 'compartmentalisation' of knowledge. Having noted compartmentalisation (later referred to as 'silo working') within multiagency practice, I wished to conduct a research study in which overt professional interests might be minimised. The impartial observer role was therefore a rational and conscious decision, whilst it was also acknowledged that given my socially situated position as both a nurse, and a senior nurse, it was not anticipated that achieving impartiality would be without challenges. Reflexivity, through which I self-monitored the impact of personal biases, beliefs and personal experiences (Berger 2015) on the research, was an important strategy for ensuring the rigour of the study. Being 'politically and ethically self-aware' (Pelias 2011:662) and continuously reviewing personal and professional influences and relationships was integral to the framework of the inquiry (see table 6). The extent to which impartiality was achieved within the context of qualitative inquiry is further discussed in chapter 7.

Although my practitioner involvement ceased prior to applying for ethical approval in January 2011, my role as a senior nurse within the NHS organisation that delivered and commissioned health services in the Centre, gave me 'insider' status in terms of my employment within the organisation in which I conducted the study. Simmons (2007), in discussing research that she undertook as a senior manager within her 'own' organisation, suggests that insider status resulting from employment arrangements (rather than shared cultural membership with participants) may impact on recruitment and access to the field as well as relationships with peers and seniors and also role and loyalty conflicts. Similarly, Blythe et al (2013) suggest there are challenges and benefits to insider status which must be managed through practical strategies. Recruitment to studies and rapport-building may be facilitated by shared characteristics with participants or gatekeepers, the risks associated with the insider position must also be clearly identified and managed.

An identified risk was the potential for my position and relationships within the NHS and other agencies to be used to gain access to the study and to participants. As a designated nurse for safeguarding, I fulfilled a leadership role not only across the NHS 'system' but also in the multiagency arena as a member of the local safeguarding children board (LSCB). It was therefore essential that the utmost care was taken in the planning and conducting of the ethical aspects of this study and these factors are further considered in chapter 3. Table 2 provides an overview of my roles throughout the course of this study.

Table 2 Professional role changes during the study period

Year	Professional role	Researcher role
2008	I was the named nurse (a statutory role) for safeguarding children in a primary care trust and undertook additional 'forensic' training to assist with child protection medical examinations (particularly sexual abuse examination).	Professional curiosity / 'puzzlement' (Stake 1995) arose regarding the statutory services' 'management of child sexual abuse during this time.
2009	The Centre opened in May 2009. I became designated nurse for safeguarding children (a more senior role) but remained part of the on call rota for the out of hours' services. Contact with the Centre was infrequent and 'ad hoc' during 2009. Member of the Local Safeguarding Children Board from 2009.	A number of potential research study designs were considered and case study approach was decided upon.
2010	All direct clinical contact with the Centre ceased during 2010.	The research study protocol was developed.
2011	My employment transferred from the provider service to the commissioning arm of the primary care trust (PCT).	Ethics approval application for the study was submitted in January 2011 (completed March 2011). Data for case tracking element accessed after March 2011 from the health trust, children's social care and police. Interviews with professionals took place between September 2011 and June 2012.
2012	Unchanged	Completed data collection and started data analysis and report writing.
2013	Clinical Commissioning Groups (CCG) were established following the Health and Social Care Act (HM Government 2012), and my role transferred from a PCT to a CCG. CCGs require designated professionals to provide expert advice on the commissioning of services such as the Centre.	Data analysis and report writing.
2014	Unchanged	Finalising report.

This timeline of events is intended to provide the context in which the study was undertaken and to provide clarity regarding professional and researcher roles.

1.4 Overview of the thesis

This section provides an overview of the way in which the thesis is presented.

Chapter 2 presents a critical analysis of literature relevant to the study. As there are few specialist children's centres in the UK, it was not surprising that there was little available evidence with which to inform the development of the research protocol. Therefore, evidence pertaining to specific associated themes was scrutinised. This process demonstrated the developing nature of the evidence base and was helpful in confirming that the study design was appropriate in attempting to gain broad understanding of the whole 'case' rather than focusing on its component parts.

The research aim and methods are outlined in Chapter 3. The study comprised three data sets:

- 60 children who attended the Centre in the preceding seven days were 'tracked' to ascertain reason for referral, type of examination undertaken, clinical findings and outcomes in terms of health status, social care input and criminal justice actions;
- Semi structured interviews were undertaken with four paediatricians, four nurses, four police officers and four social workers;
- Patient and parent/ carer satisfaction questionnaires in routine use in the Centre were analysed. The means by which data were 'transformed' (Wolcott 1994) into meaningful findings are described. Wolcott's (1994) guidance is used to provide clarity to the analysis process.

Chapter 4 presents findings from each of the three research questions, with minimal interpretation. This fulfils the first stage of data analysis and assists in answering the question posed by Wolcott, i.e. 'what is going on?' These data are presented as they may be of interest to audiences who have an interest in specific areas of this study.

The next stage of analysis addresses the 'why things work and why things don't' question posed by Wolcott. In Chapter 5, the case study 'story' aggregates the three sets of data to reflect a child's potential 'journey' through a child protection 'system'. This approach was adopted to enable findings to be made accessible to non-academic audiences and is also consistent with the symbolism employed by Professor Eileen Munro in her wide reaching review of child protection systems in England (Department for Education (DfE) 2011a, 2011b,).

As the findings are discussed, the final question in the analytical process 'what is to be made of it all?' is addressed in Chapter 6. The necessity for professionals to focus relentlessly on children's

rights to participate in making decisions that will affect them is highlighted. As other studies have concluded, the study findings suggest that professionals can be distracted by the 'systems' in which they work.

Finally, in Chapter 7, the research approach is critiqued and the study is concluded.

1.5 Conclusion

Chapter 1 has considered the rationale for this study by exploring the context of childhood abuse in the UK, its prevalence rates, and some of the difficulties that exist in terms of identifying and responding to the issue. Whilst SARCs have been positively evaluated for adults, service provision for child victims of sexual abuse is inconsistent and there is a paucity of evidence to inform further developments. Some of the difficulties associated with the terminology 'working together' have also been considered.

This background section supports the rationale for this study, the aim of which is to explore the role of a specialist centre in providing a multiagency response to children and young people who may have been sexually abused. The intention is for findings to be used to contribute to greater knowledge and improved practice in the specialist centre. Although not generalisable, findings may have value within the wider NHS and multiagency arena.

In the next chapter, a critical analysis of literature relating to several aspects of the response to childhood sexual abuse is presented.

Chapter 2: Literature Review

2.1 Introduction

This chapter provides a critical review of literature related to the research questions and an overview of the principles and research that are relevant to the study.

2.2 Literature search

2.2.1 Purpose of the literature review

The purpose of undertaking the literature review was to investigate the current knowledge base relating to this field of practice. It also assisted in identifying gaps in the knowledge base and major questions in the subject. Bell (2005) suggests that through critical appraisal of the literature, the student can develop expertise in the field and this was also a relevant consideration.

For this study, the empirical evidence base is relatively weak. However, it was helpful to explore some of the debates raised by other researchers and to identify and acknowledge both consensus and conflict within the available literature. Therefore, a broad 'scan' of the current body of evidence was undertaken during the early stages of the protocol development and this provided the 'groundwork' from which further inquiry grew. The review, presented below, provides the best evidence currently available.

2.2.2 Search methods

A preliminary literature search was undertaken in 2008 to inform the development of the research protocol. In August 2011, this search was further developed and refined to ensure a comprehensive and up to date search. Embase, Medline, PsychINFO, Cochrane Library, Cumulated Index of Nursing and Allied Health (CINAHL) and Web of Knowledge databases were systematically searched using key words 'child sexual abuse' and ' multiagency response' or 'referral centre' (and synonyms). This identified only two papers and so the search terms were broadened to include 'child sexual abuse', 'medical examination' and 'physical examination' combined with Boolean terms 'and' and 'or'. This stage of the search yielded 99 papers. The inclusion criteria for the search are presented in Table 2. Following this main search, other databases and relevant websites were reviewed as shown in Stage 3 in Table 3.

Table 3 **Literature search inclusion criteria**

Papers published between 1st January 2000 and 1st August 2011
Country of publication: UK and other European countries, Australia, New Zealand, North America and Hong Kong
Papers published in English language
Papers published in academic journals
Papers reporting original research in relation to child sexual abuse and multiagency response, or child sexual abuse and physical or medical examination and which focus on: • Children, young people and carers' perceptions of the multiagency response following possible child sexual abuse • Rate of positive genital findings at medical examination for possible child sexual abuse • Legal outcomes following medical examination for possible child sexual abuse • The role of nursing within the multiagency response to child sexual abuse

The titles of the 99 papers were reviewed for relevance and 38 papers were excluded at this stage. The abstracts of the remaining 61 papers were obtained and reviewed. The majority of these were excluded because they did not meet the inclusion criteria outlined above or because they focused on the following areas:

- Interpretation of specific anogenital signs and symptoms
- Children's experience of the abuse itself
- Adults' experience of child sexual abuse

Of the 61 abstracts, 20 met the inclusion criteria and were appraised for the purpose of the review.

Further relevant material was found in books, journals, opinion articles and policies. Although they were excluded from the review, they were valuable in enhancing knowledge and insight into some of the discussions taking place within the field of practice and their influence in shaping the researcher's approach must be acknowledged.

In order to ensure there had been no publications that might significantly influence the discussion, a further search was undertaken in December 2013. Although some papers of interest were identified, none met the criteria for inclusion in the review.

The literature search strategy is summarised in Table 4.

Table 4 Literature Search Strategy

Stage	Date	Database or search engine	Search terms	Inclusion criteria	Results
1.	August 2011	NHS Evidence (Cinahl, Medline and British Nursing Index), Embase, Psychinfo, Web of Knowledge	Child abuse, sexual **and** multiagency response **or** referral centre	Published since 1st January 2000, English language	2 articles identified. Because so few articles were found the search terms were changed as below.
2.	August 2011	NHS Evidence (Cinahl, Medline and British Nursing index) Embase, Psychinfo, Web of Knowledge	Child sexual abuse **and** medical examination **or** physical examination	Published since 1st January 2000, English language	99 articles – all titles reviewed for relevance. 61 titles were identified as relevant and all abstracts were reviewed. When 2 duplicates and non relevant articles were removed, 20 articles were identified for inclusion in the literature review.

Stage	Date	Database or search engine	Search terms	Inclusion criteria	Results
3.	July - November 2011	Cochrane database, and websites: Nursing Midwifery Council, Google Scholar, National Institute of Clinical Excellence, Department of Health, Home Office, Department for Education, Royal College of Nursing, Royal College of Paediatrics and Child Health, NSPCC	Child protection or child abuse	Not applicable	Useful contextual information e.g. Stern Review (Home Office 2010) and information regarding the cost of child abuse (NICE 2011) but no new academic articles for inclusion in literature review.

2.2.3 Search outcome

The search revealed minimal evidence relating to children's specialist sexual abuse referral centres and so the parameters for the literature search were expanded as outlined above. Appendix 2 provides information regarding study aim, design methodology, country of origin and key findings from all studies included in this review.

2.3 Themes arising from the literature review.

This section analyses key findings within each theme. Themes were drawn from the inclusion criteria. In order to 'make sense' of the evidence and to ensure a consistent approach to critiquing the evidence the Critical Appraisal Skills Programme (2010) tools were used. Reference was made to the qualitative, case control and cohort study tools which provide a checklist for each research approach, against which the studies were considered. For instance, the tools require the consideration of factors relating to the design, aim of the study, recruitment strategies, ethical considerations, rigor of analysis and others. Whilst not all the studies included in this review would meet all the requirements of the tools and weaknesses in several studies have been identified below, each paper was considered valuable to some extent in providing greater clarity in terms of the current knowledge base.

2.3.1 Children, young people and carers' perceptions of the multiagency response

Much of the available literature relating to multiagency facilities that provide a response to childhood sexual abuse has been produced as a result of research studies in the USA where Children's Advocacy Centres (CACs) have been in development since the 1970s. As outlined in Section 1, they are multidisciplinary, specialist facilities that investigate child abuse and should provide onsite medical examination. Caution must be used when considering findings from the USA and elsewhere due to differences in health service provision as well as legal, cultural and demographic differences.

Walsh et al (2007) evaluated four CAC and four non CAC facilities and retrospectively reviewed 1,220 case records of children who had undergone forensic medical examination following alleged child sexual abuse. Findings suggested girls, white victims, younger children and children with injuries were more likely to be forensically examined. Those who were seen in a CAC were twice as likely to have forensic medical exam and four times more likely to have a medical examination where non penetrative acts were alleged. Comparisons between CAC sites however, was problematic due to variability in the Centres, with some unable to provide onsite medical examination facilities resulting in children having to travel to hospital or clinics. This position may

also exist in the UK where children's facilities have evolved without standardised arrangements being in place.

A number of studies explored children and carers' attitudes to the post abuse response. Jones et al (2007) undertook a multi-site evaluation of CAC and non CAC sites, also in the USA. The attitudes of non-offending caregivers (n=229) and children(n=90) in CAC and non CAC sites were compared, and although the study has limitations relating to sampling procedures, the authors conclude that the CAC model can have a statistically significant effect on improving caregivers' level of satisfaction ($p<0.002$). No statistically significant benefit for CACs on children's satisfaction was demonstrated although it is notable that 35% of children from CAC samples described themselves as being 'not at all' or 'not very' scared compared to 13% from non CAC sites ($p=0.021$). The authors hypothesise that many non CAC sites have made efforts to improve the 'child-friendliness' of the investigation process and this may, to an extent, explain the 'disappointing' (p1081) results in terms of children failing to have a higher rate of satisfaction with CAC sites. Where children expressed dissatisfaction with the investigatory process there were no statistically significant differences between CAC and non CAC sites. Combined results of CAC and non CAC sites showed 20% of children felt 'very scared' during forensic interviews, 11% felt that investigators did not understand children very well, or at all, and 19% felt that investigators did not adequately explain what was happening. One aim of CACs is to reduce repeated interviewing of children and yet 33% (in CACs and non CACs) felt they had to explain things too many times.

Davies et al (2000) undertook interviews with children (n=51) and caregivers (n=124) in New Zealand following alleged child sexual abuse. Interviews were conducted either after completion of an evidential interview (phase 1), or after the police had closed the file (phase 2). It is not clear what proportion of the sample underwent medical examination but the authors state that post examination 42.9% (n=9) of children said they felt a 'bit better', 28.6% (n=6) felt no different, but 23.8% (n=5) said they felt worse. Sample sizes and response rates are low, but this finding does suggest that caution should be applied in claiming 'reassurance' as a key purpose of the examination. The children's negative responses reflected a perceived lack of choice or preparation for the medical examination. 'Some' (no figures provided) children and parents were concerned about photographs of genitalia being obtained, and were unclear about how they would be used suggesting that consent issues needed further exploration. Carers also cited delays in the medical examination taking place and repeated questioning as negative issues, but again no specific figures are provided. Some caregivers reported a perceived lack of support from social workers, particularly where the alleged perpetrator was a parent or parent's partner. 53.2% (n=66) of caregivers spontaneously disclosed during the interview that they themselves were survivors of

sexual abuse, suggesting that although children's needs should always be the primary focus of professional activity, the needs of parents may also be a significant consideration. This study is of limited value due to sample sizes and non-specific reporting.

Allard-Dansereau et al's study (2001) in Canada explored maternal perceptions of the emotional impact of medical examination following child sexual abuse (n=50) through the administration of a Likert scale questionnaire. Non English speakers were excluded from the study which may impact on the representativeness of the findings and the authors acknowledge the inherent bias in interviewing mothers 6 months after the medical examination. However, in common with Davies et al (2000), the study highlights the need to ensure non abusing carers (who are often mothers) feel engaged in the investigation process, and an understanding of their perception is valuable. The study concludes 62% of mothers felt reassured about the physical integrity of their child following the examination. In 69.4 % of the cases, the visit was not perceived as negative by the mothers, with 24.5% being perceived as negative and 6.1% being perceived as strongly negative. The physician was perceived as very kind in 63% of cases, kind in 31% and unkind in 6%. This 'kindness', whilst not clearly defined, appeared to be an important factor in alleviating the emotional impact of the examination. The study showed that mothers felt significantly higher fear of sexual abuse evaluation for their children than for an ordinary medical visit ($p<0.001$). These findings, the authors suggest, should prompt reappraisal of the purpose of the medical evaluation, given the low rate of positive findings (in other studies) and their view that 'some' believe the examination to be 'harmful and not in the best interests of the child' (p218). This view contrasts sharply with Walsh et al (2007), Heger et al (2002), and others who claim the examination may be viewed by children and their caregivers as reassuring.

The 'reassuring' purpose of examination is supported by the findings of Mears et al (2003) in the USA. Using the State-Trait Anxiety Inventory (STAI) and Miller Behavioural Style Scale (MBSS), the post examination perceptions of children (n=77) aged 11-17 years were significantly more positive than pre examination ($p<0.001$) with 78% stating that the medical examination was 'helpful' and made them 'feel better'. Adolescents were invited to view the medical examination, including genital examination, via video colposcopy and 79% of the girls chose to watch the video monitor. It is difficult to assess, due to non-specific reporting, whether good quality explanation and preparation of participants prior to medical examination contributed to improved satisfaction among participants. Levels of anxiety in participants were significantly decreased post examination ($p<0.001$). However, not all participants were reassured by medical examination and negative experiences were also reported (34.2% painful, 44.7% scary, 51.3% embarrassing).

Marks et al's (2009) undertook a study in Australia of expectations and emotional responses of children and their parents or carers (n=71) to the medical examination post sexual abuse. Using an anxiety scale (unclear if validated), 57% of parents had anticipated the medical examination to be stressful for their child and only 17% perceived that it was. Of children, 66% reported feeling scared before the medical with 54% citing embarrassment as a key factor. Although the authors report the children experienced less pain and felt less scared than they had anticipated, the differences were not statistically significant, (i.e. $p>0.05$) and this statement is therefore of little value in terms of contributing to an empirical evidence base.

In common with Allard-Dansereau et al (2001), Marks et al's study highlighted that staff attitude, 'calm' demeanour, 'lack of judgement' and 'being told what was happening' (p127-128) was perceived positively. Parents were less anxious ($p<0.05$) when their child was examined by a trainee doctor, which the authors suggest may be due to trainees receiving relevant, recent training. This study has a number of limitations, notably the participation rate, as only 78 out of an eligible sample of 275 were approached for inclusion in the study, (of which 71 consented) suggesting some bias. Also, data regarding the children's experiences are largely inconclusive.

In common with Mears et al (2003), several studies utilised validated tools to measure anxiety levels. Scribano et al (2010) in the USA used a Multidimensional Anxiety Score for Children (March 1997) and 17% of children reported significant anxiety prior to examination, and 15.4% afterwards (n=175). The Genital Examination Distress Scale (GEDs) was used by Palusci and Cyrus (2001) in a USA study of children (n=227) referred following suspected sexual abuse. The study aimed to evaluate the impact on children's anxiety of observing the video-colposcopy monitor during anogenital examination. Eighty five per cent of participants chose to watch the video-colposcope and none demonstrated negative reactions 'beyond verbalizing dislike of video-colposcopy' (p1540). The authors suggest that 'most' children are interested in watching their anogenital examination using video-colposcopy but impact on reducing anxiety is not confirmed. The authors also suggest that the GEDs 'objectively' measures a child's reaction to stress and thereby assists clinicians in identifying those children who may require greater preparation. The GEDs did not however identify any children who had not already been observed by clinicians to be anxious.

The characteristics of children (n=175) who experience negative responses to anogenital examination was explored by Horner et al (2009) in the USA using the Multidimensional Anxiety Scale for Children-10 (March 1997). The researchers invited a total population of attendees for child sexual abuse assessment to participate in the study and found that 83% of victims attending

for child sexual abuse assessment did not report clinically significant anxiety, but those who did were significantly more likely to have a cognitive disability ($p<0.001$), to have experienced invasive sexual abuse ($p<0.02$), or to have a chronic medical ($p<0.005$) or mental health diagnosis ($p<0.005$). Lack of medical insurance (perhaps suggesting socio-economic deprivation) was also found to be a factor ($p<0.001$). The authors note the baseline anxiety of children living in those circumstances may be higher than the general population of children. The study concludes professionals should attempt to alleviate anxiety in children even if they do not exhibit obvious signs.

One theory emerging from this section of the review is that of the medical examination serving a wider purpose than that of securing forensic evidence. Some authors suggest the examination provides physical and psychological reassurance about bodily integrity. For children, there is little evidence to support this theory and although Mears et al's findings support the hypothesis, other studies are largely inconclusive (Scribano 2010, Marks et al 2009, Jones et al 2007, Davies et al 2000). There is more convincing evidence to support the theory that caregivers (mostly mothers) are reassured following children' medical examination (Marks et al 2009, Jones et al 2007, Allard-Dansereau et al 2000) and, given their key role in supporting the children, this is an important consideration.

Facilities where examinations are conducted appear to differ considerably and this factor combined with variables such as the form of abuse, level of resilience, clinician competence or attitude, all impact on findings. It is therefore expected that results from studies will be inconsistent. This review of the literature relating to the theme of children, young people and their carers' perceptions has highlighted a lack of qualitative or narrative data related to children's experiences and this presents a gap in collective knowledge. Whilst many children and young people may not welcome the examination it would be helpful to seek understanding as to whether, in their view, the eventual outcome of the examination or investigative processes, compensated for the experience.

2.3.2 Rate of positive genital findings

This section of the literature review considers the rate of clinically significant genital findings when children are examined post suspected sexual abuse. One function of the anogenital component of medical evaluation is to assess the significance of any injuries or conditions that may confirm that sexual abuse has taken place. Forensic sampling may also be undertaken. The Royal College of Paediatrics and Child Health (2008) '*Physical signs of child sexual abuse',* (supported by a supplementary statement published in 2011) provides an evidence based review

and guidance for best practice in the UK. In the USA, Adams' (2001, 2008, 2011) and Adams et al's (2007) classification system has been developed through a similar systematic review of published research, medical and laboratory findings and expert discussion to reach consensus on the best evidence. While these publications appear to provide the best available evidence base, they are not universally referred to within the primary papers that have been selected as part of this literature review. Both Adams and the RCPCH acknowledge that evidence continues to evolve and remind clinicians of their responsibility to keep abreast of the literature.

For health professionals who are required to explain the purpose of the medical examination and to seek informed consent from children, young people and families, it is important to have an understanding of some of the uncertainties and variables that exist.

This section of the review does not focus on evidence related to specific anogenital signs but provides a perspective on the wide variation of findings and the evolving nature of the evidence base. As well as the emergent nature of the evidence, other factors may have influenced reported findings.

- Variations in terminology to describe clinical findings
- Paediatricians' peer review was less easily facilitated prior to routine use of video colposcopy
- Research studies used differing samples (e.g. boys /girls, pre and post pubertal, timing or type of suspected abuse)
- Variations in research questions

This is a particularly complex subject with wide variations in findings which can be difficult to assimilate, particularly for non medical audiences. To provide greater clarity regarding these findings, the papers relating to ano-genital findings have been summarised in chronological order in Table 5. The rationale for this approach is that it assists non medical audiences to view more clearly the inconsistencies which exist. In a child protection 'system' where the ano-genital examination forms a routine component of the service that is 'delivered' to children following alleged or suspected sexual abuse, it is important to establish the uncertainties and inconsistencies that exist in the 'evidence' base.

Table 5 Rate of positive genital findings

Author, year, country	Sample	Anogenital findings	Commentary
Cantwell 1983 USA *(see narrative re: inclusion of this 'historical' paper)*	202 girls, aged less than 13 years suspected of physical abuse or neglect (i.e. **not** suspected of sexual abuse)	22% of group of 'non sexually abused' girls had findings indicative of sexual abuse – based on size of vaginal opening.	Interpretation of physical signs appears to be based on personal opinion and therefore unreliable. This study suggests some positive findings may be normal variants However, sexual abuse may coexist in the physical and neglect cohort of children and a higher incidence of sexual abuse in this group is possible.
Hobbs and Wynne 1987 England *(see narrative re: inclusion of this 'historical' paper)*	608 children aged 0-15 years referred following disclosure of sexual abuse. 337 children were confirmed or probable cases of csa.	Of 243 girls with confirmed or probable sexual abuse, 58% had findings relevant to diagnosis of sexual abuse. Of 92 boys, 77 (83%) of boys with confirmed or probable sexual abuse, had signs of anal abuse based on anal dilatation sign.	More recent studies suggest significance of anal dilatation is uncertain in absence of other signs or history of abuse.

Author, year, country	Sample	Anogenital findings	Commentary
Berenson 2000 USA	192 girls aged 3-8 years who disclosed pre-pubertal penetration compared with 200 girls who denied prior abuse	2.5% of abused girls had specific anogenital findings Overall few differences between the 2 groups	Ethically unsound study but findings are in line with Heger et al (2002) Physical examinations not all undertaken within 7 days of alleged abuse which may contribute to low rate of positive findings.
Palusci and Cyrus 2001 USA	Girls aged 2-17 years referred for concern about sexual abuse (i.e. penetrative abuse not necessarily alleged)	17% positive findings	Similar sample to Heger et al but wide variation in rate of positive findings.
Heger et al 2002 USA	2384 pre-pubertal children referred for evaluation of possible sexual abuse (penetrative abuse not necessarily alleged)	4% positive findings 5.5% positive findings when penetrative abuse alleged.	Examination did take place within 7 days of last alleged incident of abuse.

Author, year, country	Sample	Anogenital findings	Commentary
Cheung 2004 Hong Kong	77 children 6 months – 2 years Acute and historic concerns	Findings were: Clearly abnormal 13% Concerning for abuse 13% Non-specific 29% Normal 45%	The timescale of the last incident of alleged abuse is not clear in this study and findings are therefore difficult to interpret.
Watkeys 2008 UK (Wales)	257 children 0-17 years who had disclosed penetrative sexual abuse	Abnormal findings in 56.6% when penetrative abuse disclosed. 50% positive findings in alleged vaginal abuse seen within 7 days of last event. When more than 7 days elapsed, 18% abnormal findings following penetrative anal abuse, 30.7% following penetrative vaginal abuse.	Authors used Adams (2001, 2004) classification system and yet results for non-acute (>7 days) presentations show wide variation with Berenson et al.

Author, year, country	Sample	Anogenital findings	Commentary
Kirk 2010 UK (Scotland)	848 children, 0-18 years, retrospective case records review 267 children referred following alleged sexual abuse,	2 children (<1%)had findings confirmatory of sexual abuse 22% had findings supportive of the allegation 39% had normal findings that did not support or refute the allegation.	Timing of examination not clear. This study concludes medical assessment is an important component in supporting or refuting an allegation and helps to identify other unmet health needs.
Hansen et al 2010 Denmark	482 children 0-15 years, (426 girls and 56 boys) retrospective case file review	38% girls and 20% boys had abnormal anogenital findings,	Where outcome known (440 cases), 43% were prosecuted in court. Of those cases taken to court, 87% were convicted. There was no relation between abnormal anogenital findings and legal outcomes; the highest conviction rate was achieved in the oldest children.
Campbell et al 2010 USA	203 children aged less than 14 years	39% had anogenital injury	This study reviews children examined by a paediatric forensic nurse examiner. Less experienced nurses were 'somewhat' more likely to document injuries.

Heger et al's (2002) prospective study in the USA of 2384 pre pubertal children referred for evaluation of possible sexual abuse is an important large scale study. The authors report only 4% of children had abnormal findings at the time of evaluation and even when the sample was divided to identify those children where the most severe forms of abuse were alleged (vaginal or anal penetration), the abnormal finding rate was only 5.5%. The professionals concluded that children were sexually abused if they gave a history of abuse, if there was an adult witness of the abuse, or if they had medical findings diagnostic of abuse (such as forensic evidence, sexually transmitted diseases, acute non accidental injuries and trauma). The study found that boys were statistically less likely to disclose their abuse than girls ($p<.001$). Most participants were evaluated within 7 days of the last event of alleged abuse, so this low rate of positive findings is unlikely to be associated with the timing of examination which it is suggested is influential (Watkeys et al 2008, Palusci et al 2006, Campbell et al 2010) in identifying significant clinical findings.

Heger et al (2002), in reviewing the available literature prior to their own study, undertook a review of 13 studies published between 1979 and 2000 and identified a wide variation in the range of reported abnormal genital findings. The lowest rate was 2.5% of girls (Berenson et al 2000). At the higher end, Hobbs and Wynne (1987) identified 83% of boys and 58% of girls with abnormal findings. Cantwell (1983) identified 74% of girls with positive genital findings within her study (although Heger et al misquote Cantwell and state that the findings applied to 84% of girls). To better understand this wide variation in reported findings, these three papers were scrutinised further. None of the papers had been included in the literature review inclusion criteria for this study, due to date of publication in the case of Hobbs and Wynne (1987) and Cantwell (1983) and because the focus was specifically anatomical changes in the case of Berenson et al (2000). These three papers have therefore been included as secondary sources and are discussed below.

Cantwell's (1983) USA paper relied on anatomical signs such as the diameter of the vaginal opening being greater than 4mm in girls aged less than 13 years. This finding is not suggested by either Adams et al (2007) or RCPCH (2008) as significant. The author stated that of 202 girls suspected of physical abuse or neglect (not sexual abuse), 22% (n=45) had vaginal findings indicating that sexual abuse had occurred and of these, 70% (n=33) confirmed they had been sexually abused. Although the relevant anatomical sign in this study is not recognised in current literature, the testimony of the girls does appear to demonstrate a high rate of coexistence of physical abuse and neglect with sexual abuse.

Scrutiny of Cantwell's paper shows that she suggests an enlarged vaginal opening correlates to occurrence of sexual abuse in about three out of four girls (70 out of 95 or 74%) who were

referred for medical examination due to concerns about sexual abuse, physical abuse , being 'left alone' or for 'shelter'. Heger et al (2002) cite Cantwell as quoting that this correlation existed for 84% of girls. This figure of 84% therefore appears to have been either misquoted or misprinted in Heger et al's paper. The figure of 74% having abnormal findings does however, remain the second highest rate quoted by Heger et al after Hobbs and Wynne's (1987) rate of 83% of girls.

Another of the older papers, by Hobbs and Wynne (1987), presents UK findings of 243 girls with 'confirmed' or 'probable' sexual abuse of whom 58% had positive findings suggestive of sexual abuse. Of the 94 boys, 83% had signs of anal abuse. There is no information in the paper to show on what evidence this statement is based but it is possible the reflex anal dilatation sign was a factor. This anatomical sign has subsequently been viewed as unreliable in the absence of other signs or disclosure supportive of abuse.

In contrast to Cantwell (1983) and Hobbs and Wynne (1987), Berenson et al (2000)'s study in the USA found a low rate of positive findings. The study is ethically unsound as it involved examination and photography of the external genitalia of two groups of children; one group were suspected to have been sexually abused (n=192) and the other group (n=200) were believed to be 'non-abused' and there was therefore no clinical indication for examination. It does however allow a comparison to be made between girls who had disclosed penetrative abuse with a group of similar race and age who denied prior abuse and where there were no indicators that abuse had occurred. Findings unique to the 'abused' girls were found in just 2.5% and the study does highlight that little is known about normal variants in non abused children. However, only 17 of the children were examined within 7 days of abuse, which may also explain the low rate of positive findings.

These three papers demonstrate the changeable and evolving nature of what has constituted either 'evidence' or ethical acceptability in the last three decades. Heger et al (2002) suggest that if the findings from older studies such as Cantwell (1983) and Hobbs and Wynne (1987) were revisited using the revised classification scale of Adams (2001) that positive findings more in keeping with Berenson's 2.5% may have been achieved.

Continuous review is an essential, but complex, task as other subsequently published papers showed similarly conflicting results to Heger et al (2002). Palusci and Cyrus's (2001) USA study found 17% had 'positive' findings even though their sample, similar to Heger et al's included those where there was a 'concern' (or suspicion) that sexual abuse had occurred and that penetrative abuse had not necessarily been alleged. In Hong Kong, Cheung et al (2004) studied children who were referred for colposcopic examination and using Adams (2001) classification system found

signs ‘concerning for abuse’ in 13% and clearly abnormal in 13%. Participants included children who presented for both acute and historic allegations of abuse but results from the two groups are not broken down and are therefore difficult to compare. Campbell et al (2010) in the USA reviewed findings in 203 cases of alleged sexual abuse and found 39% positive findings. This nursing study queries the significance of examiner experience and positive anogenital findings, as nurses with less experience were ‘somewhat’ more likely to document injuries.

More recent UK studies have found a variation in positive findings despite use of Adams’ (2001 and 2011) classification system. Watkeys et al’s (2008) study included participants who had made a direct allegation of penetrative sexual abuse. Positive findings were present in over 50% of children who presented within 7 days, but even when more than 7 days had elapsed following the last alleged incident of abuse, a rate of significant findings of over 30% was reported for those girls who had alleged vaginal penetration. These findings contrast with those of Berenson et al (2000) and Heger (2002) et al, although Watkeys et al’s (2008) sample included adolescents as well as pre-pubertal children. Watkeys et al’s findings are also dissimilar to those of Kirk et al (2010) in Scotland where 23% of children had findings confirmatory or supportive of sexual abuse allegations. These findings are, once again, difficult to compare due to differences in samples and methodologies.

This section of the literature review has highlighted the emergent nature of the evidence related to the identification and significance of positive genital findings post sexual abuse. The purpose of reviewing the state of knowledge in this field was to apply the findings to current practice in the Centre. While most of the papers in this section have been produced by medical professionals, it is essential for all professionals who provide care for victims to have an understanding of the status of the evidence base to enable sound judgements and decisions to be made in partnership with children, young people and their families. Reasons for the wide variation are unclear but demographic issues may be a contributory factor. Adams (2011) acknowledges the continued uncertainty in this area of practice and advocates a systematic review of published research and expert opinion to ‘help determine the diagnostic significance of specific acute genital and anal injuries, non-acute findings in adolescents and anal findings in both children and adolescents’ (p597).

2.3.3 Legal outcomes

Four studies that reported legal outcomes were also reviewed in an attempt to establish the impact of positive findings on subsequent legal proceedings. In Hansen et al (2010)’s study of legal outcomes in Denmark, where outcomes were known (n=440), 43% (n=190) of cases were

prosecuted in court and of those cases, 87% (n=165) were convicted. Significant predictors (using odds ratio) of legal outcome were perpetrator confession and age of child, as older children can usually give a more detailed history to the police. The lowest rate of conviction was for those who were alleged to have abused the 0- 3 years age group. The authors conclude that anogenital findings are not a significant predictor of prosecution or conviction in Danish courts.

A lower rate of cases proceeding to trial was found by Sugue-Castillo (2009) in the Philippines who found that of children (n=486) who underwent sexual abuse evaluation, 15% of cases went to trial of which 30% were convicted. Self-referral, penetrative abuse, acute evaluation and abnormal findings were influential in cases reaching court, but similarly to Hansen et al, the child's testimony appeared to be the most significant factor in obtaining a conviction. Walsh et al (2007) suggest doctors and nurses can, in the absence of medical evidence, provide expert testimony to explain why evidence may not have been obtained. Differing legal systems and requirements of professional and expert witnesses in the USA make it difficult to apply this finding to the UK. Walsh et al reviewed 907 cases and found that 40% of the children where offenders were charged had an examination, compared with 37% of cases where there was no offender charged (statistically insignificant).

Patterson and Campbell (2009) in the USA reviewed 95 cases of children referred to a paediatric forensic nurse examiner (PFNE) following alleged sexual abuse and compared them with a similar sample who had been examined in the 3 years preceding the inception of the PFNE programme. Of the PFNE cases, 36% progressed to plea bargaining or conviction, compared with 17% of cases seen in the comparator group. The authors acknowledge the flaw in this study due to the number of variables influencing the programme, and it cannot be suggested that there is a direct correlation between an increase in plea bargaining or conviction and the nursing input.

One of the most significant drivers for establishing SARCs in the UK is the desire to increase criminal convictions of sexual offenders. This review has found little evidence to demonstrate a relationship between forensic findings and conviction rates. It appears that the child's testimony is more influential in the outcome of court cases and this may, in part, explain why conviction rates are higher for older children who may be better able to provide an account of their experiences. These findings cannot be generalised to the UK due to differences in legal systems but they do provide an area of interest for the study.

2.3.4 Role of nursing in response to child sexual abuse

The concept of a specialist nursing role for victims of sexual assault is a relatively recent development in the UK and available literature largely focuses on the needs of adults. North America appears to have progressed further in terms of paediatric services and one study from the USA which evaluated the role of paediatric nurse examiners is reviewed in this section.

Patterson and Campbell's (2009) comparative study suggests that the Paediatric Forensic Nurse Examiners (PFNEs) provide medical services, crisis intervention, forensic examination and can help link victims and their families to law enforcement and social service agencies. Their study showed that PFNEs were more likely to assess younger children where it was unclear or ambiguous as to whether sexual abuse had taken place. They suggest that the specialist nurses may assist in discovering what has happened to a child, as opposed to hospital or private physicians in the comparator group who documented what had already been determined to have occurred.

Literature related to the nursing role within child sexual abuse health assessment services in the UK is sparse. In relation to adults however, Lovett et al's (2004) study established the gender of the examiner as important as the 'vast majority' of respondents (n=992) stated a preference for a female examiner. Regan et al (2004) conducted a study at one SARC in the UK and demonstrated that a forensic nurse examiner was able to conduct medical examinations independently and to prepare and present written statements for court.

The nursing literature in the UK and USA suggests there is potential for greater development of nursing in both adult and children's specialist services. These studies tentatively suggest that nurses, with appropriate training, can offer an approach that improves quality in relation to physical and psychological care, co-ordination with police and legal services, and in the case of children, with social care services. In relation to children, this approach is relevant not only for those where abuse has been alleged or witnessed, but also for younger or disabled children where circumstances are less certain. This concept of uncertainty in relation to the abuse is fundamental to the way in which sexual abuse services are designed and developed. Biomedical models of undertaking medical examination for the purpose of 'diagnosing' abuse or confirming that abuse has occurred may be helpful for medico legal purposes and are a key function for adult SARCs. However, an alternative approach is required for those children who may be younger or disabled and who, for a number of reasons, may be unable to clearly communicate about their experience.

2.3.5 Relevance of literature review to the study

In the absence of evidence relating to children's specialist centres, this review has assisted in identifying some of what might be considered 'established' knowledge in relation to child sexual abuse medical assessment, in four key areas:

- Studies that have attempted to 'measure' the extent to which children are distressed by undergoing medical examination following suspected sexual abuse have not produced generalisable findings. However, some studies show that a proportion of children found the experience to be negative or 'felt worse' after examination (e.g. Davies et al 2000). As medical findings were not found to be a significant factor in securing prosecution of perpetrators, a question must be raised regarding the purpose of medical examination following alleged child sexual abuse. Lack of generalisable findings may not be surprising given the multiple variables associated with reasons for referral, multiagency response, clinicians' attitude and individual resilience in children and young people.
- There is a large variation in rates of positive genital findings at medical examination which may not be entirely attributable to demographic or methodological differences. The evidence base is therefore emerging rather than established and the impact of this uncertainty in practice is unclear.
- Studies related to legal outcomes, where alleged perpetrators have been prosecuted, tentatively suggest that the testimony of the child may be a more significant factor in securing convictions of perpetrators than the forensic or medical evidence.
- The role of a specialist nurse within medical assessment services has been considered, and it is cautiously suggested there may be benefit for children and young people in extending this role. This may be in relation to the biomedical role of collecting forensic evidence and undertaking some examinations and also in crossing professional boundaries, for instance, through maintaining communication with criminal justice agencies and providing psychological support to children and families.

The findings from the literature review have identified significant gaps in the current knowledge base and underpinned the development of the research questions for this study.

2.4 Conclusion

This chapter has presented a critical review of papers relevant to this research study. There is an absence of evidence about the effectiveness of UK children's centres that provide services for children who are suspected to have been sexually abused. Findings from this critical review of

four related themes provide compelling support for the need to build greater knowledge about children's health, legal and social outcomes following attendance at a specialist sexual abuse centre. Greater insight is also needed into the experience of professionals who deliver the services as currently little is known about the way in which multiagency working impacts on children's experiences or outcomes.

Chapter 3: Research Methods

3.1 Introduction

This chapter presents the aim and design of the research study and the methods employed for each of the three research questions. A discussion about qualitative methods and constructivist inquiry is also presented. Initial stages of data analysis are also described although analysis and findings are more fully presented in chapters 4 and 5.

3.2 Research aim

The aim of the study is to explore the role of a specialist centre in providing a multiagency response to children and young people who may have been sexually abused. The intention is that findings should influence and improve practice in the Centre and they may also have utility within the wider NHS and multiagency arena. In order to gain an understanding of the day to day reality of the activity in the Centre, three research questions form the basis of the study.

3.3 Research questions

Simons (2009) and Stake (1995) as proponents of the case study approach, refer to research questions or issue questions rather than research 'objectives'. Simons' suggests 'presuppositions' influence decisions about research questions and provide a frame for the case. Three initial research questions were devised in response to professional and personal intuition and curiosity about the purpose of the Centre, which Appleton (2002) suggests can guide the inquiry process. The process of reviewing the literature also assisted in defining the research questions.

For this study the questions were:

1. What can be learnt about the children, young people and carers who access the Centre and their outcomes in relation to health, criminal justice and social care proceedings?

2. What are the practitioners' perspectives of working in, or with, the Centre? Do practitioners believe that interagency collaboration and co-ordination is improved? If inter-agency collaboration and co-ordination are improved, how do they believe that this impacts on the children and young people who have accessed the Centre?

3. What are children and young people's perceptions of their experience when accessing the services at the Centre?

Although these three research questions were posed separately for clarity, in reality a process of cross checking and triangulation took place continuously throughout the study design and data collection process.

3.4 The research paradigm

The constructivist 'paradigm', Appleton and King (1997:13) suggest, is a theoretical perspective on research inquiry that was previously referred to as 'naturalistic inquiry'. The paradigm or 'world view' guides the researcher's choice of ontological, epistemological and methodological approach. Lincoln et al (2011:100) suggest 'constructivism' is based on three basic beliefs:

- Realities are co-constructed (ontological)
- Findings are co-created and subjectivist (epistemological)
- Findings are dependent upon a hermeneutical approach in which an understanding of the meaning of the constructing is reached (methodological).

This study takes a more holistic approach to children, as opposed to a model in which child abuse is viewed as a medical 'disease' and which may more commonly be associated with the positivist paradigm. Denzin and Lincoln (2011) describe this (qualitative) approach to research inquiry as:

'Qualitative research consists of a set of interpretive, material practices that make the world visible. These practices transform the world'

(Denzin and Lincoln, 2011:3)

Lincoln et al (2011:97) suggest that the proliferation of research paradigms since the 1990s once caused conflict but more recently there has been a blurring of theories which now appear to inform one another. They suggest there are four potentially competing paradigms; positivism, post-positivism, critical theory and constructivism.

There is some lack of consistency in terminology in the literature. For this study, the term 'constructivism' is applied to both paradigm and methodology (Lincoln and Guba 1985, Appleton and King 1997). Methodology is concerned with 'the process of gathering knowledge about what exists in the world' (Appleton and King 1997:15) and is a term that is used to 'encompass aims, strategies and methods to gain knowledge about a particular phenomenon under investigation'. 'Methods', Appleton and King suggest, is a term used to describe specific data collecting and analysis techniques. In this study, consistent with Simons (2009), the terms case study 'methods' and 'approach' are used.

Constructivism does not provide a distinct set of rules by which a study should be conducted, but Appleton and King's (1997) framework for constructivist investigation in nursing research provides supportive and informative guidance. For this study an adapted version of Lincoln et al (2011) and Appleton and King's (1997) model was used and is presented in summarised form in Table 6.

Table 6 Framework of inquiry: adapted from Lincoln (2011) and Appleton and King (1997)

Item	Constructivist paradigm
Inquiry aim	Understanding; reconstruction Researcher is instrumental in the inquiry
Nature of knowledge	Individual or collective reconstructions coalescing around consensus Research design is tentative and researcher works with people who are being studied to construct understanding of the phenomena.
Knowledge accumulation	Informed and sophisticated reconstructions; lived experience. Alternative interpretations are sought.
Goodness or quality criteria	Trustworthiness, credibility, transferability and confirmability are the criteria against which truth value or quality may be judged. An auditable trail of decisions regarding: applicability, consistency and neutrality are kept. The research provides a catalyst for change.
Values	Personal intuitive experience guides the inquiry process. Researcher to be aware of pressure from others who may exert influence or manipulate the direction of the inquiry.
Ethics	Intrinsic – inquiry process tilts towards revelation. But, in health care settings, the people being studied are potentially vulnerable to exploitation through naive disclosure. Research governance processes are of paramount importance.
Voice	Researcher involved in 'passionate participation' as facilitator of multivoice reconstruction'
Hegemony	Seeks recognition, offers challenges to predecessor paradigms, aligned with democratic, postcolonial aspirations.

In relation to research findings, Lincoln et al (2011) suggest they are created, developed and further refined during the process of the study. This refinement of the data is a dynamic process through which the researcher makes connections and achieves an intuitive grasp and insight into the meaning of the data.

3.5 Case study design

Several authors (Stake 1995, Simons 2009, and Yin 1993) agree that a clearly defined 'case' is a pre-requisite for case study research. For this study, the Centre provides the case as it is a clearly defined, constant, physical environment within which dynamic activity of children, young people, carers and professionals is played out. Any attempt to focus the inquiry on selected components of the activity, or relationships within the Centre was felt to be restrictive and potentially misleading until knowledge about its wider functioning had been established. Gaining an understanding of the complex role of the Centre was felt to be an appropriate research aim and this approach was compatible with Stake (1995) who suggests that understanding the complexity of the case is the primary aim of case study research. He defines case study as:

'the particularity and complexity of a single case, coming to understand its activity within important circumstances.'

(Stake, 1995:xi)

In common with Simons (2009), Stake suggests that case study research is subjective and that the researcher, through direct interpretation, enables the complexity of the case to be understood. However, Simons (2009:14) suggests that case study should not simply be 'equated with qualitative research'. Two important distinctions should be made. Firstly, case study may share some characteristics of social research traditions but, as outlined above, it has distinctive features such as the requirement for a clearly bounded case, the particularity of which is the interest of the study. Secondly, some authors such as Yin (1995) are proponents of positivist approaches in which the researcher attempts to generalise findings to an existing theory. Appleton (2002:89) suggests that Yin does not recognise 'the importance of tacit knowledge and intuitive processes in data collection and analysis'. This positivist stance is not compatible with the constructivist paradigm that underpins this study. Appleton (2002) in her analysis of Yin (1993) and Stake's (1995) work suggests there is little detailed critique or comparison of their differing approaches. Furthermore, she suggests that researchers who have undertaken case study research have sometimes used Yin's positivist approach for qualitative studies and failed to consider the conflicting epistemology.

Stake (1995) defines three types of case study research, intrinsic, instrumental and collective. 'Intrinsic' case study, which has been used for this research, is where a case is studied for interest in the case itself. Simons (2009) extends the definition to include the purpose of the study and the research focus:

'Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, programme or system in a 'real life' context. It is research-based, inclusive of difference methods and is evidence-led. The primary purpose is to generate in-depth understanding of a specific topic (as in a thesis), programme, policy, institution, or systems to generate knowledge and/or inform policy development, professional practice and civil or community action'.

(Simons, 2009:21)

This definition builds upon Stake's and offers helpful additional context. However, Simons suggests that case study is almost synonymous with 'democratic evaluation'. Adopting an evaluative approach at the outset was avoided as this would imply that the 'success' or 'benefit' of the Centre could be measured in some way, when it was lack of knowledge and understanding about the role it plays that formed the rationale for the study. In order to make a judgement about the worth of a service, a set of criteria against which to make the judgement would have been necessary and until greater insight into the functioning of the Centre had been achieved this was felt to be a misguided approach.

In practice, it may be difficult to separate Stake's intrinsic case study research from an evaluative approach. As Simons asserts, as understanding or knowledge increase, judgements will be made and the study will fulfil an evaluative purpose for some audiences. Evaluation involves making a judgement, or valuing the worth or merit of something, and there are methodological choices to be made in determining who makes that judgement. She argues that case study evaluation is linked with the distribution of power, as individual or organisational interests may be served. Evaluative case study research, she maintains, should be impartial and:

'Inform stakeholders, participants and the public on the value of the policy or programme to enable them to contribute to informed policy making and debate'

(Simons, 2009:17)

As the findings from this study will be disseminated to these groups, it is important to be aware that the research may be used to make judgements about the value of the Centre. This was not the primary focus of the study but it is important to be aware of the 'political' dimension of the research. Having considered these approaches, Stake's intrinsic case study design has been adopted for this study, supported by the practical guidance of Simons (2009).

3.5.1 Insider status

This section outlines the relationships in the field and the way in which gaining access was achieved. As outlined in 1.3, my occasional experience of working as a nurse in the early days' of

the Centre and in the service that preceded it, was influential in the choice of research study. Although relatively fleeting, my practitioner role had prompted a 'puzzlement, a need for general understanding' (Stake 1995:3) about the way in which child protection services were being delivered.

When the study commenced, I had chosen to adopt an 'impartial observer' role (Simons 2009:37), but nevertheless had insider status as a relatively senior nurse within the health trust that hosted the services in the Centre, with previous experience of providing occasional clinical nursing care there. I was therefore familiar with some personnel who were 'gatekeepers' in terms of access to the field and to the data that I wished to study. Being aware of this potentially privileged position, I ensured that all ethical requirements were stringently adhered to and that my position was not used inappropriately to exert undue influence or control either within the NHS or other agencies involved in this study. The process of gaining formal ethical approval for the study is outlined in 3.5.4. This section focuses in greater depth on my relationship with the research study and those who participated in it over the course of several years.

At the time of applying for ethical approval (in 2011) and subsequently when accessing the 'field' for data collection, I was no longer involved in providing direct clinical care in the Centre and had no managerial responsibility for the nurses who worked there. However, personal and experiential knowledge of working in local child protection services had contributed to a level of expertise (Benner 1984) and insight which may have positively influenced my credibility as a potential researcher. Arguably, this level of expertise would not be present in a researcher who had had gained knowledge through scientific research alone (Rolfe 1998). Within the constructivist paradigm the researcher is acknowledged as being 'instrumental to the progression of fruitful inquiry' (Appleton and King 1997:16). Of particular relevance to a clinical doctorate is Rolfe's (1998) view that the validity of knowledge and theory generated through research is dependent on the usefulness of findings 'to help people to act more intelligently and skilfully' (p678). Certainly, a desire to facilitate useful knowledge for professionals who work in the Centre was an important motive in choosing this particular research topic.

When applying for ethical approval for this study I had a considerable degree of strategic oversight of local safeguarding services. As such, I was aware that I may have been viewed by some participants, particularly the nurse interviewees, as occupying a position of authority or 'power'. These were important issues to acknowledge in terms of negotiating entry to the field and I was sensitive to the risk of undue influence being exerted in requesting participation of

nurse interviewees and was conscious of the need to adhere rigidly to the formal processes outlined in section 3.5.4.

Simons (2009) suggests that researchers should not assume that access to the field (via gatekeepers for the services) equates with access to all potential participants. I had minimal or no contact with police and social worker participants and arguably my insider status was of little significance to them. There appeared to be little risk that they might feel coerced to consent to participate in the study. However, I had over several years, established a working relationship with the majority of nurses who contributed to the work of the Centre and I was a familiar member of the safeguarding team. This may have been influential in the nurses' agreement to participate as, when the initial information sheet was circulated to managers within each agency, they proved to be the group that responded quickly and enthusiastically to the invitation to participate. This response may have been influenced by my 'insider' status which Pelias (2011:662) suggests confers a 'shared cultural membership'. Certainly all the nurse interviewees appeared keen to talk about the service and changes that might be made to improve it. Stake (1995) suggests that:

'most people when asked to participate are 'generally co-operative, often pleased to have their story known and happy to help someone do their job although not optimistic that the research will be of benefit to them'.

(Stake, 1995:58)

Relationships with the other health trust employees, the paediatricians, were less clear. The 'moral authority', with which the medical profession is conferred (and further discussed in Chapter 6) to a great extent, negates the authority of a researcher who coincidentally is a senior nurse within the same health trust. Although I had worked alongside three of the paediatricians who consented to participate in the interviews, I did not share the same 'cultural membership' to which Pelias (2011) refers. My expertise within child protection medical practice did however, enable the paediatrician interviewees to speak freely without being misinterpreted, a risk that might exist for researchers who are not familiar with the research setting (Cresswell et al 2007).

I was professionally acquainted with two of the police officers who volunteered and subsequently consented to interview, but had not previously met any of the social work interviewees. I had fewer shared experiences with these groups and my nursing identity may have been of little importance to them. However, as the role of the researcher within qualitative case study research

is subjective and influential (Lincoln 2011), my connection and understanding of the health service issues became evident and is further discussed in chapter 7.

Organisational changes resulting from the Health and Social Care Act (HM Government 2012) impacted on my professional role (Table 2 page 15). The study continued, data collection was completed and from 2012 my contact with the interviewees and their managers became more distant and eventually ceased. My role within a commissioning organisation did however, involve ensuring there was adequate provision of specialist services for children who were suspected to have been abused. Knowledge and expertise gained through my previous professional role and through this research study was valuable in informing my day to day work within clinical commissioning but my 'visibility' among the participants in the study was greatly reduced.

Constructivist inquiry requires a reflexive approach, involving continuous internal dialogue and critical reflection (Berger 2015) on all aspects of trustworthiness and credibility of the study. A non-exploitative and compassionate approach to the research was consciously adopted and monitored in order to minimise any potentially negative effects of power within researcher-researched relationships (Berger 2015). Ethical implications of insider status were therefore managed through a process of reflexivity and several documents were maintained where auditable decision making trails were recorded. Reflexivity took place throughout the study and involved individual, personal reflection alongside academic and clinical supervision as well as maintenance of academic and professional diaries and logs.

3.5.2 Principles that underpin the study

Green and Thorogood (2004) suggest it is important to identify the 'macro' or large scale theoretical perspectives that frame the research as they involve particular assumptions about the way the world 'is' and how people behave within it. For this study, a set of overarching principles rather than a theory, provide the framework for the research. The principles relate to the status of 'childhood' within the contemporary world. Principles and standards that governments are required to promote are set out in the United Nations Convention on the Rights of the Child (United Nations General Assembly 1989). The treaty establishes the rights of children to live free from abuse and exploitation and to have access to education. These standards have been ratified globally (excluding the USA and Somalia) and provide the large scale 'world view' for the study.

The '*Butler-Sloss Report'* (1988), The Children Act [1989] and *'Working Together to Safeguard Children*' (HM Government 2013) provide the middle range principles that relate to state intervention in family life when there is concern that children will not be protected from abuse

and neglect. This combination of inquiry, legislation and statutory guidance has emerged from the theory that children require protection from harm, but that such protection should be balanced with 'being heard' and actively participating in making decisions that affect them. The 'no decision about me without me' principle has been further advocated by Lewis and Lenahan (2012) in the recent children and young people's health outcomes strategy commissioned by the Secretary of State for Health. This poses a challenge for professionals as children's ability to contribute to decision making is variable and it cannot be assumed that their wishes or feelings will be consistent with those of their parents. Professionals who manage child protection cases represent agencies with varying 'world views' and the study considers this complex interplay.

The 'position' of childhood within society combined with the largely accepted theory that interagency co-operation and collaboration is essential for effective child protection practice provide the key concepts or 'building blocks' of the study as described by Green and Thorogood (2004:30). Simons (2009:31) however, warns there is potential for a framework to lead to an overly structured, hypothesis testing research design, and advocates the use of theoretical 'pre suppositions' which support inductive reasoning rather than theory testing. It is intended the framework as described above therefore provided a flexible structure rather than rigid constraint.

3.5.3 Issues of rigour

In parallel with Simons' (2009) approach to addressing the rigour of the study, Appleton and King's (1997) framework for constructivist investigation in nursing research has been used. They highlight the potential for the researcher's views to be manipulated by the demands of others and suggest the use of an auditable decision trail in order to establish the truth value, applicability, consistency and neutrality of the research. This consideration has been addressed through regular clinical and academic supervision and the maintenance of a personal log throughout the development of the study.

To establish the worth and credibility of the study it is important, as Stake (1995), Simons (2009) and others concur, that the relevance and significance of an issue is tested out. This 'testing out' of perspectives must take place at an early stage of the study design so the research questions are integrated and not an 'ad hoc' set of issues (Simons 2009). Stake notes however, that issues continue to emerge and evolve as the study progresses and that the qualitative researcher should remain 'open to the nuances of increasing complexity' (p21).

3.5.4 Ethical issues

Research must be underpinned by the principle of doing no harm. Simons (2009) suggests that throughout the research process the researcher should build relationships that allow trust to be established through treating the participants with dignity and respect. Careful consideration of ethical issues has taken place throughout the research study, particularly the implications of being an 'insider' researcher, and the methods selected have, as a priority, been selected on the basis of minimising risk of disruption or harm to the people who are being studied. Following a process of internal university peer review, approval for the study was sought from the following:

- National Institute of Health Research via the Integrated Research Application System (IRAS version 3.1)
- University of Southampton Research Governance Department
- Relevant NHS Trust research governance department
- Senior managers in relevant constabulary and local authority standards department.

The researcher attended a paediatric specific ethics committee in March 2011 following submission of the research proposal via the IRAS system. Following extensive questioning by members the committee concluded, surprisingly, that ethical approval was not necessary for the study as they felt it resembled service evaluation (Appendix 3). The committee did, however, make some suggestions for minor amendments to the protocol and following discussion with academic supervisors, relevant changes were made which are described below in Table 7.

Table 7 Ethics Committee feedback

Ethics committee opinion	**Researcher's response**
As service evaluation there is no requirement to seek consent and provide a formal information sheet: this may add to young person's distress at time of attendance.	This view opened possibility of retrospective case file audit of total population of children and young people who had attended the Centre over an 18 month period.
Greater clarity required about information to be sought from the police and reasons for obtaining it.	The research protocol was revised to provide greater clarity regarding data that was to be requested from police authorities.
The Committee was of the view that the study represents a missed opportunity for undertaking research that might be of significant value to the Centre.	The validity and rigour of the study have been defended in this thesis and the merits of the study will be judged accordingly.
The Committee wished to point out the	The concepts of subjectivity and bias within the

applicant had made no provision for obvious bias.	qualitative research paradigm have been acknowledged and discussed within this thesis.
The Committee was concerned that educational supervisor was inclined to the view that the project was service evaluation rather than research but had encouraged the student to pursue the application for the experience.	It was judged by the researcher and academic supervisors that given the sensitive and confidential nature of the research study and the requirement to seek data from agencies outside the health service, that to fail to seek independent ethical approval would be an unacceptable omission.

Relevant university research governance standards were adhered to and the study received sponsorship and indemnity insurance. The relevant NHS trust research governance department approved and registered the study.

Issues of consent, confidentiality, anonymity and security are addressed within each research question below.

3.5.5 Research methods

Rosenberg and Yates (2007) suggest schematic representation of case study research design can provide procedural clarity and promote rigour in the conduct of case study research and a diagrammatic representation of the study is presented in Figure 1 below.

There are numerous and varying perspectives of the Centre that might have been explored in this study. However, following the process of 'testing out' potential research questions, three separate data sets were decided upon. These were judged to be those that might provide the greatest understanding of the case, as they provide a perspective of the children's journeys ('tracking' case files), the perspective of professionals (interviews) and finally the perspectives of children and carers' (questionnaires).

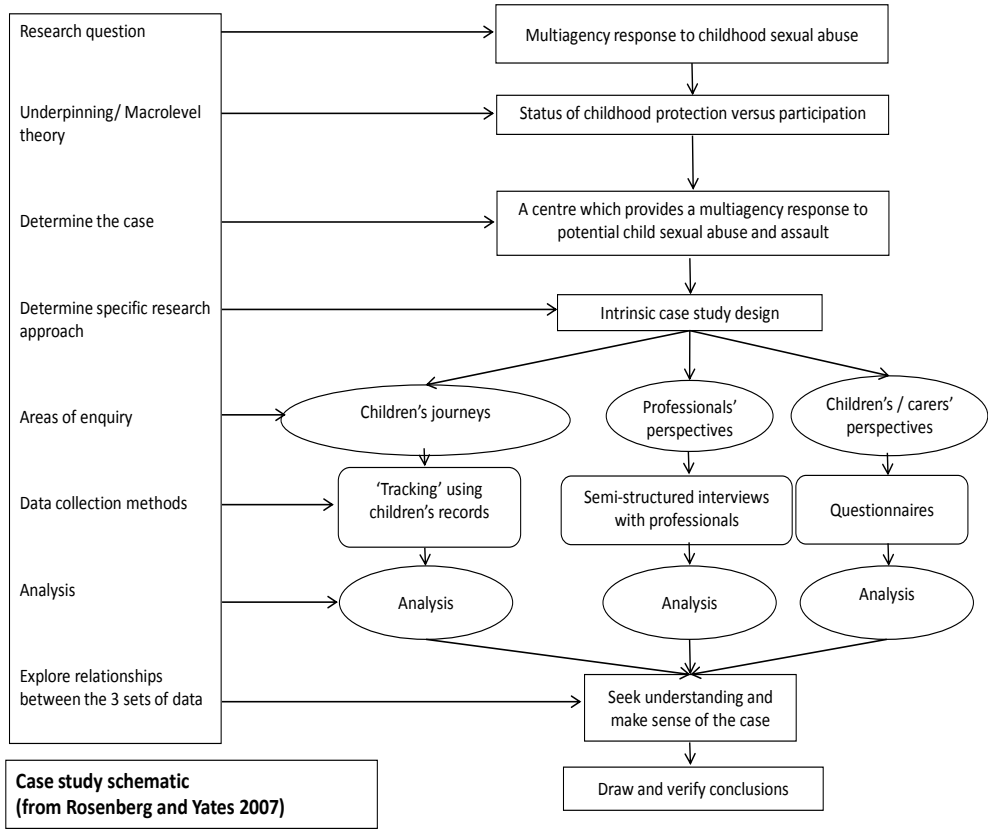
Simons (2009:63) suggests that formal document analysis can be used in case study 'to portray and enrich the context and contribute to an analysis of issues'. She refers to documents that might formally represent an organisation in additional to formal policies such as prospectuses, annual reports, audit reports or informal documents such as bulletins or memos which may contain clues about how an organisation envisages itself. For this study there was minimal formal or informal documentation. Although senior police and NHS personnel had worked closely to apply for available funding to support the development of the local children's SARC, prior to 2009, there was an absence of any specific policy or agreement regarding the on-going running of the Centre. Professionals who worked there continued to adhere to their 'own' agency's policy and

procedure. The impact of the absence of any integrated policy or procedure is discussed in chapter 6.

During the course of this study I maintained an academic research diary which has been valuable in writing up this study as it provides details of numerous decision made, issues that were encountered and problems that were overcome. Simons (2009:88) suggests that a researcher's diary assists in identifying 'values and subjective selves'. She advises researchers to refer to their diary when writing up reports to enable them to report on how values have influenced their interpretation. The academic diary has been referred to in writing up this thesis on numerous occasions, and the extent to which 'nursing values' have influenced the study is discussed further in chapter 7.

Annual professional appointment diaries and notebooks were also maintained throughout the course of the study. They have enabled me to provide the account of my changing professional roles over the past eight years during a number of significant NHS reorganisations. Reference to the diaries has enabled me to reflect upon the changing relationship between my professional and researcher roles and these are more fully discussed in chapter 7.

Figure 1 Schematic of study design



3.6 Research question 1: Tracking children's journey

What can be learnt about the children, young people and caregivers who access the Centre and their outcomes in relation to health, criminal justice and social care proceedings?

This element of the study was intended to gain insight into the circumstances which prompted children's attendance at The Centre and their progress through police, social care and health 'systems' until six months after their attendance. Prior knowledge of the researcher suggested that inter-professional and interdisciplinary (between doctors and nurses) compartmentalisation of service delivery rendered it difficult to gain a sense of how child or young person experienced their journey through 'the system'. This research question, through analysis of documentary evidence, 'examined some of the key variables which are important in determining the dynamics of a situation in order to provide detailed insight' (Appleton 2002:82) into the case.

Consideration of the available methods for gaining a wide angle lens perspective resulted in this 'tracking the journey' approach which has provided rich data for analysis. The underpinning constructivist paradigm is particularly significant for this element of the research as it may initially be viewed as a 'mixed methods' or 'pragmatic' study in which qualitative and quantitative methods are used. Teddlie and Tashakkori (2011) are proponents of pragmatism, which they suggest allows information from qualitative and quantitative approaches to be combined to highlight divergence or dissimilarity. However, in this study, results from the three research questions have been synthesised in a way that keeps the 'voice' of the people being studied central to the analysis and the approach is therefore congruent with the constructivist paradigm. The 'tracking' concept also resonates with the concept of the patient 'pathway' or 'journey;' terms that are commonly used within the NHS and also in Munro's (DfE 2011a, 2011b) review of child protection arrangements in the UK.

The data collection involved a retrospective review of 60 case notes; the total population of children and young people who attended the Centre between 1st May 2009 and 31st October 2010 as a result of an 'acute' referral (locally defined as the last alleged or suspected incident of sexual abuse having occurred within the preceding 7 days). This research question does not attempt to identify typical or representative cases or to seek statistically meaningful findings. Neither was the aim to treat the children who were being studied as passive research subjects, but rather to construct a picture of who they were and a sense of what they may have experienced. This may assist in enabling subsequent studies to focus on individual lived experience through interviews and conversations. A limitation of this element of the study is the reliance on documentary

analysis (through medical, social care and police records). The records were reviewed and the following information recorded:

- Reason for referral
- Details of the victim (age, gender, ethnic origin, disability)
- Details of alleged perpetrator (related, known, stranger).
- Type of examination conducted
- Presence of positive clinical findings
- Services involved at the time of examination (children's social care, voluntary organisations, other health services).
- Police action – (actions, arrests, outcomes)
- Legal process - final police classification, outcome of court case etc.
- Children's social care actions
- Outcome for child/young person 6 months post referral

As Simons (2009:118) asserts 'the data do not speak for themselves' and it was through further analysis and synthesis with data from the other 2 research questions that this element of the research began to 'tell a story'.

3.6.1 Method

The children were identified by accessing the NHS database of all children referred to the service. The medical records for the total population of children who were referred between 1st May 2009 and 31st October 2010 were accessed and the researcher recorded the anonymised data in a data collection book in the first instance. Medical files were accessed in the chronological order in which the children and young people had attended the Centre. The names of the children were subsequently stored on a secure NHS drive to which only the researcher has access. Anonymised data from the data collection book were subsequently transferred to an Excel spreadsheet with children identified via a case tracking number. Data were accessed predominantly from children's medical records but where information was not available about police or social care actions, additional data were obtained from senior police and social care personnel. Police information was returned electronically following request on secure email systems. Social care data were accessed by the researcher and a senior social worker reviewing the social care electronic child records together and the researcher recording results in the original handwritten data collection book. Data were transferred to and from this meeting in a locked case. The data collection book was stored in a locked filing cabinet when not in use.

3.6.2 Sample

The total population of all children accepted as acute referrals between 1st May 2009 and 31st October 2010 (60 children and young people). The size of the sample was sufficient to enable a broad view to be constructed and for understanding of the nature of some children's journeys to be demonstrated.

3.6.3 Confidentiality

Parahoo (2014:405) defines confidentiality as the assurance given by researchers that data collected from participants will not be revealed to others who are not connected with the study'. The children were originally identified via the data base held within the administrative department for the Centre. Having accessed these data, each child included in the study was assigned a reference number. The relationship between the identifying reference number and the child's name is known only to the researcher and the information is stored in the secure data base. No patient identifiable details have been released or published.

3.6.4 Data security

The child's medical records remained with the administrative department responsible for the Centre's client records where they were routinely stored and were accessed on site by the researcher when required. Information from police and children's social care was requested as and when needed, but the researcher was not responsible for the storage of any records. Data analysis

This element of the study is highly structured and by stipulating the categories of data to be studied in advance, the researcher adopted a relatively objective stance to the inquiry. Marshall and Rossman (2006:155) describe this as 'quasi-statistical analytic style'. Data were originally recorded by hand in a book, and were transferred subsequently to an Excel spreadsheet and categorised. Although it was not the intention of this study to seek statistical significance, it was acknowledged that for some audiences this may be of interest. Consequently, the opinion of an academic statistician was sought and it was confirmed that there are no statistically significant results.

3.7 Research question 2: Semi structured interviews with practitioners

What are the practitioners' perspectives of the role of the Centre? Do practitioners believe the Centre impacts on their own professional experience, or on children and young people's experience?

What role do nurses play in the Centre? Should any changes be made to any aspect of the service at the Centre?

Semi structured interviews are a widely used qualitative data collection method which Simons (2009:43) suggests serve four major purposes which have been summarised as: to document the interviewee's perspective on the topic; to actively engage the interviewer and interviewee in identifying and analysing issues; to provide flexibility in pursuing emergent issues and finally, the potential for uncovering unobserved feelings and events. Stake (1995:64) suggests that the interview is 'the main road to multiple realities'.

For this study, a semi structured approach was adopted to allow a level of interaction and equitable relationship between interviewer and interviewee. Structured interviews were considered, but were rejected on the grounds that they may overly constrain interaction. Unstructured interviews were also deemed unsuitable on the grounds that the study required a number of 'issue orientated questions' (Stake 1995:65) to be addressed.

All elements of case study research, Stake (1995) suggests, require the researcher to consider the role he or she plays. For this study the researcher attempted to adopt the role of 'neutral observer' (p103) whilst acknowledging thoughts, feelings and bias through the ongoing use of a reflective diary.

Participants were:

- Police officers from a specialist child abuse investigation unit who had participated in the management of the case of at least one child referred to the Centre following an acute referral.
- Children's social workers who had been actively involved in the management of a case and who had been present when the child accessed the Centre following an acute referral.
- Paediatricians who routinely contributed to the child sexual abuse rota at the Centre
- Nurses who had been involved in the care of children who had been referred to the Centre due to actual or suspected sexual abuse.

3.7.1 Method

Stake (1995) supports the use of a list of issue orientated questions (Appendix 4) rather than an interview schedule for case study research. This approach allowed me to guide the conversation, using prompts, without being constrained by a rigid structure. Stake suggests the role of the interviewer is to listen, whilst staying 'in control of the data gathering' (p 65). The schedule was

informally tested with colleagues to ensure that a conversational, interactive style of interview could be achieved (Kvale 1996). Following this informal testing, the schedule was finalised and interviewees were asked about their perception of: the role of the Centre; how the Centre impacts on inter-agency co-operation; how the Centre impacts on outcomes for children and young people. Interviewees were also asked if they felt the Centre had any effect on them as individuals or the agency they represent. Interviews were scheduled to last approximately 30 minutes, but one hour was allowed. Interviews were tape recorded and transcribed. All data was securely stored in locked cabinets in the researcher's employing organisation, to which the researcher and one administrator had access. Data stored on computer were password protected and coded (paediatrician 1, social worker 2, etc.) and was accessible only to the researcher and one administrator.

3.7.2 Sample:

Each professional group is presented separately.

- **Police:** Purposive sampling in the initial stage took place by contacting the senior police officer responsible for the child abuse investigation team. He identified relevant police officers who had experience of attending the Centre as part of an investigation of at least one case of 'acute', possible childhood sexual abuse case. He forwarded the information sheet directly to the relevant police officers, who were then asked to directly contact me if they were willing to consider being interviewed. Three police officers volunteered and following a further direct request, in person, to a group of police officers at a meeting, another volunteer was identified.

- **Social workers:** Purposive sampling in the initial stage took place by contacting the service manager in the children's social care department, responsible for the team whose members are most likely to be those involved in the social care management of children who had undergone medical assessment as part of a possible child sexual abuse investigation. He forwarded the information sheet directly to social workers with relevant experience. They were asked to contact me directly if they were willing to consider being interviewed. Four social workers contacted me to volunteer.

- **Paediatricians:** Purposive sampling took place in the initial stage by contacting the lead paediatrician for the community paediatricians who deliver the sexual abuse health assessment service at the Centre. She forwarded the information sheet to colleagues and asked volunteers to contact me directly. Three paediatricians volunteered. Following

discussion with academic supervisors, I contacted a recently retired paediatrician who remains actively connected to the service and she agreed to be interviewed.

- **Nurses**: Only five nurses had relevant experience to meet the criteria for being interviewed as part of the study and so the information sheet and an invitation to be interviewed was sent directly to all five nurses and four volunteered.

Therefore, purposive sampling was used to identify relevant groups of professionals with valid experience, or key attributes that would enable them to describe their perspective of the case. When the relevant groups of professionals had been identified, either by me, or by senior managers in other organisations, all were contacted with an invitation to participate in the research and the participants consequently constituted a volunteer sample. The exception to this was the retired paediatrician who was, as an individual, purposively sampled as she was felt to constitute a particularly rich source of insight into Centre. A total sample of 16 participants was achieved, with four representatives from each relevant profession. This sample size was selected to provide a varied range of perspectives to inform the study.

3.7.3 Consent

Following completion of formal ethical approval processes, assistance was sought from a senior police officer, a clinical lead for paediatricians, a health service manager and a senior social work manager, in order for me to make contact with potential volunteer interviewees.

It was agreed that I would send the information sheets (Appendix 5) directly to the total population of potential nurse volunteers (n=5). The lead clinician for the paediatricians disseminated the information sheets to colleagues who contributed to the child protection medical rota. For police and social workers, senior managers were requested to distribute the information sheets to relevant professionals within their teams. The information sheets were distributed with a request to contact me if recipients were willing to consider participation. Further communication took place by e mail or telephone and arrangements were made to meet for the interview. A consent sheet (Appendix 6) was signed by each interviewee prior to the interview taking place. No potential interviewees decided against proceeding with the interviews following this initial contact.

3.7.4 Confidentiality

The identity of interviewees was known only to the researcher. Confidentiality in the context of this study was discussed with each participant and it was made clear that any statements used in the thesis or other reports would be non-attributable and that participants would be assigned a pseudonym to protect their identity. However, where direct quotations have been used in Chapter 5, professionals have been ascribed numbers rather than names as ethical difficulties were encountered with the use of pseudonyms. The names of some interviewees reflected racial or cultural background and it was not possible to assign a pseudonym without either compromising confidentiality, or being insensitive to participants' identities. Numerical identification was therefore preferable.

Direct quotations have been used judiciously to ensure no specific individuals within professional groups can be identified. No requests were made by any interviewees for any information to be withheld from the study. Participants were made aware by the researcher that, as a research study, findings would be made available to a wider audience.

Original interview data (audio recordings and transcripts) are stored in a locked cabinet. These data will continue to be stored securely for a minimum of ten years as directed by university research governance policy for data storage (www.soton.ac.uk/blackboard).

3.7.5 Data collection

Sixteen interviews took place between September 2011 and June 2012 in offices in a variety of settings that included the Centre, a police station, clinics and offices. All interviews were conducted in quiet, private surroundings that minimised the risk of interruption or disturbance. Interviewees had all received the information sheet by e mail prior to the meeting and all were given an opportunity to ask for further information or clarification. Following this, interviewees were asked to sign the consent sheet (Appendix 6) and the interviews took place. Every interview was audio taped and subsequently transcribed. Most interviews lasted for approximately 30 minutes, with the longest lasting for 70 minutes, and the shortest lasting 17 minutes.

Respondent validation was considered, but as tapes provide evidence of what was said and as interpretation and meaning is assigned by the researcher, this was not judged to be appropriate. Participants were informed that they would be sent a summary of the key findings of the study.

3.7.6 Data analysis

Initially the audiotapes were replayed and salient themes and categories were noted. Every paragraph of the interview transcripts was numbered and notes were made where data revealed themes or issues of interest. In managing these issues of interest, Bogdan and Biklen's (1992) coding categories provided a helpful initial data management structure as outlined below:

1. Setting /context: information on surroundings that allow the study to be put into context;
2. Definition of the situation: how people understand, define or perceive the setting;
3. Perspectives: ways of thinking about their setting shared by people ('how things are done here');
4. Ways of thinking about people and objects: understandings of each other, of objects in their world;
5. Process: sequence of events, transitions, turning points, changes over time;
6. Activities: regularly occurring kinds of behaviour;
7. Events: Specific activities, especially ones occurring infrequently;
8. Strategies: ways of accomplishing things, tactics, methods, techniques for meeting their needs;
9. Relationships and social structure; unofficially defined patterns such as cliques, coalitions, friendships, enemies;
10. Methods: problems, joys, dilemmas of the research process;

In using these coding categories as a tool by which the data were more easily 'managed', it must be noted that Stake (1995) argues that intrinsic case study analysis differs from that of other qualitative research and he does not advocate the use of frameworks for analysis. He suggests the primary task of the researcher in intrinsic case study is:

> 'To come to understand the case. It will help us to tease out relationships, to probe issues, and to aggregate categorical data, but those ends are subordinate to understanding the case. The case is complex, and the time we have for examining its complexity is short. To devote much time to formal aggregation of categorical data is likely to distract attention to its various involvements, its various contexts'.
>
> (Stake, 1995:77)

He does however, suggest that in instrumental case study, where the researcher seeks to gain understanding of a phenomenon or relationships within it, that the need for categorical data and measurements is greater. Stake's view on the distinction between these approaches was somewhat problematic for this study, in which the Centre was studied for 'interest's sake' and yet it was necessary to illuminate the day to day reality of life in the Centre through examining the relationships and other variables that exist there. Therefore, a synthesis of data analysis methods were used in which Bogdan and Biklen's (1992) framework provided a relevant and clear structure (or tool) for initial data coding and management whilst 'the uniqueness and priority of the case' remained central to the analysis as advocated by Stake (1995:77). As coding progressed, patterns, linkages and explanations became apparent (Marshall and Rossman 2006).

Bogdan and Biklen's (1992) framework for coding was used following reference to Miles and Huberman (1994:61) who describe a number of methods for data management and analysis. Bogdan and Biklen's system provided a practical, but non-constraining means by which to undertake initial data management. They propose that it is helpful for the researcher, in the early stages of analysis, to identify 'coding categories' and use an analogy of a gymnasium filled with toys that must be sorted. In the same ways that toys might be sorted according to size, function or colour, qualitative data may also be 'sorted' into groups and labelled. The 'labels' are the 'coding categories' which do not have to be adhered to rigidly, but may provide the researcher with a means by data may be labelled and retrieved (Miles and Huberman 1994) more easily. It is important to emphasise that these coding categories were used to assist in managing the large volume of data that had been generated from 16 interviews and to provide a foundation on which my own analysis could be carried out subsequently. It is acknowledged that Stake (1995:17) is critical of the use of such coding tools which he suggests 'do not attend to the uniqueness and the priority of the case as case researcher must do'. However it was felt that these pre-defined codes, as Miles and Huberman (1994) suggest, are a useful tool that enables data to be managed prior to the interpretative process.

A recording sheet for each of Bogdan and Biklen's coding categories, for instance, 'Perspectives', was kept. Each transcript was read and re-read and with increased familiarity with the transcript data, it was possible to note correspondence between suggested coding categories and the transcript data. The transcripts were labelled according to the professional group of the interviewee (e.g. social worker 1 = SW1) and every paragraph was numbered. If SW1 described an issue related to relationships within the Centre, in paragraph 10; SW1 paragraph 10, would be noted on the 'Relationships' sheet. As each transcript was analysed in this way, the summary

sheets were filled and it became possible to note patterns within each coding category and to compare and contrast some of the data within and between professional groups.

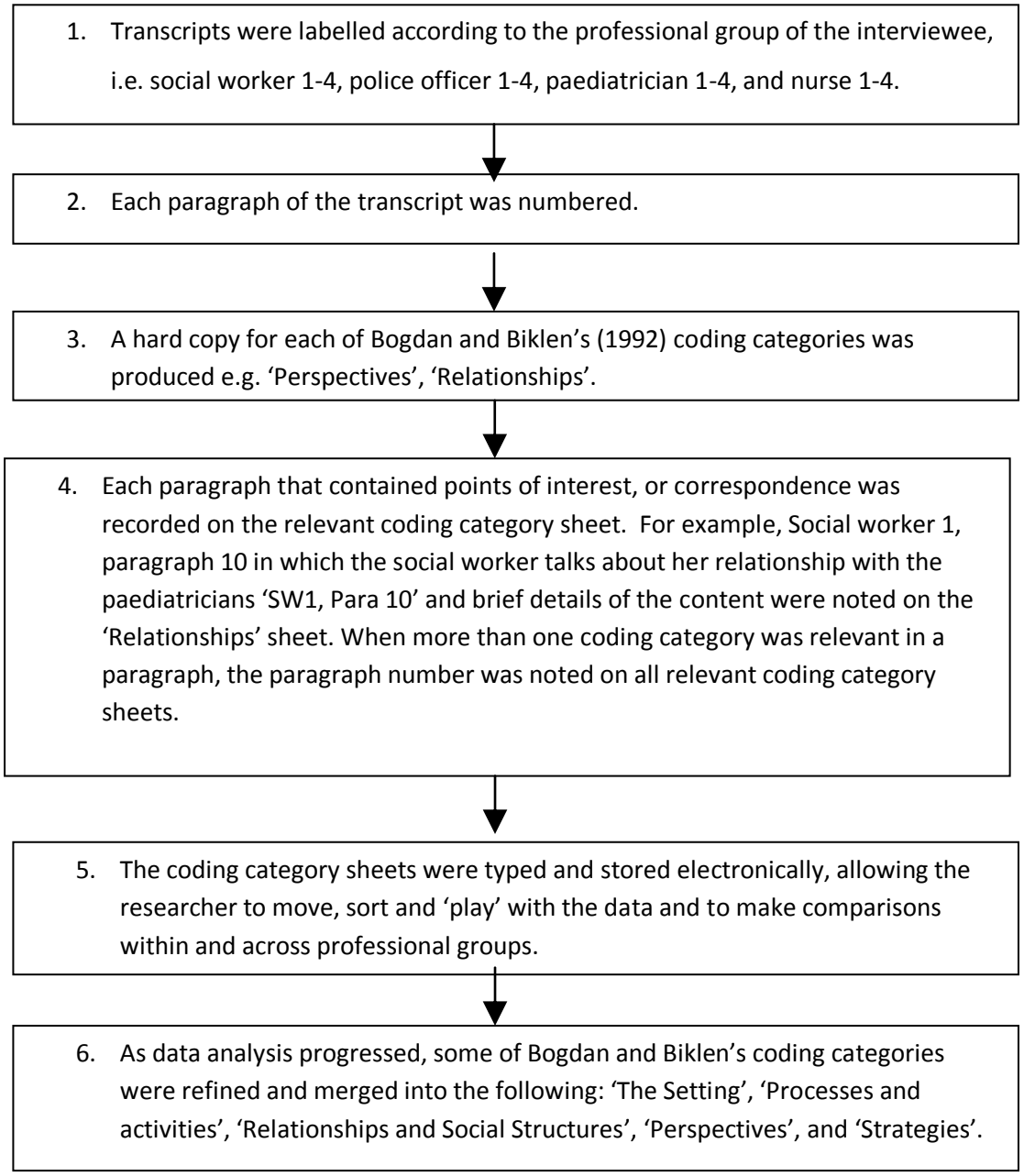
Although Bogdan and Biklen's coding categories provided a helpful structure for the researcher at this early stage, as analysis progressed their coding categories were modified. The reason for this was that some categories contained largely similar themes. For example, the 'setting / context' category, Bogdan and Biklen suggest, may contain information on surroundings that allow the study to be put into context. Data in this category was also relevant to the category 'Definition of the situation' which Bogdan and Biklen suggest may demonstrate 'how people understand, define or perceive the setting'. It was difficult, in practice, for data to be assigned to one or other of these categories and the researcher therefore modified Bogdan and Biklen's categories by merging 10 categories into five. The final five categories that were used by the researcher were:

- Definition of the situation (which also included the 'setting /context' category)
- Perspectives (including 'ways of thinking about people' category)
- Process: sequence of events (combined with 'events' category)
- Strategies (included 'activities')
- Relationships and social structures

One category ' methods' which involved consideration of problems, joys and dilemmas of the research process was not included in this section of analysis but these issues are considered by the researcher in the concluding chapter.

When all relevant data had been assigned to a coding category the data were checked again, to ensure no relevant data had been omitted or overlooked. Some data were omitted from the analysis as they were judged to be peripheral, or not relevant, to the focus of the research study. Data that were utilised for the study findings are presented in tabular forms in Chapter 4. A diagrammatic representation of the process is presented in Figure 2.

Figure 2 Process of coding data for research question 2



3.8 Research question 3: Evaluation forms

What are children and young people's (or parents' or carers') perceptions of their experience when accessing the services at the Centre?

3.8.1 Method

Questionnaires (Appendix 7) that sought to capture the patient experience at the Centre and were in routine use were analysed. Although questionnaires have limitations in terms of capturing lived experience, it was felt that by using an existing evaluation tool, the research would cause minimum disruption to the children, young people and carers and was therefore ethically acceptable. The findings from this study confirm the limitation of this particular method and the limitations are further discussed in chapter 7.

Questionnaires in current use may be completed by:

- Children and young people who access the Centre and,
- Parents or carers who attend the Centre with the child / young person

3.8.2 Sample

It was initially planned for the evaluation data routinely collected for the same time period as the case tracking of children's journeys to be analysed. However, it became apparent that during that time period, the purpose of the Centre was expanded to include assessment of children and young people who may have experienced physical abuse or neglect. It was therefore not possible to distinguish between the evaluation forms completed by children who had attended due to potential sexual abuse and those who attended due to concerns about other forms of abuse or neglect. From 1st September 2011 therefore, the evaluation forms were colour coded according to the probable reason for presentation and for this reason the sampling period started then. Only 18 of the evaluation forms colour codes for possible sexual abuse were completed between 1st September 2011 and 28th February 2013, of which 5 were completed by children or young people and 13 by parents or carers. These findings are therefore limited in their contribution to the research question.

3.8.3 Consent

The original questionnaire that was included in the research proposal contained a statement relating to its use for research studies. However, over the intervening period, the 'patient satisfaction survey' was revised by the health professionals in the Centre and the statement was excluded. The form no longer provides an explanation of its intended purpose, (although it may be argued that this can be deduced from the questions). Consent for the data to be used for research purposes, or even service evaluation, was implied rather than explicit.

3.8.4 Anonymity

Parahoo (2014:404) defines anonymity as the 'circumstances when respondents remain unknown to the researcher'. The revised questionnaire provides a space for insertion of the name and date of birth of the person completing the form and also contains a 'parent or carer' or 'child or young person' option to be circled or ticked. Although not all forms were fully completed, it was possible to deduce whether a parent or carer had completed the form (for example where the date of birth was completed on the questionnaire and the child was younger than 5 years, it was deduced that the parent or carer had probably completed the form). Where names or dates of birth or other identifying details had been recorded, these details were immediately redacted so that no patient identifiable information was known. No record was kept of the names that were redacted.

3.8.5 Data analysis

The paper questionnaire in current use combines a satisfaction scale using happy, sad or neutral facial expression diagrams. Against a series of positive statements the child or parent/ carer is required to record 'I agree' (happy face), 'Not sure' (neutral face) or 'I disagree' (sad face). The form also includes a section for children, young people and their accompanying caregiver to provide narrative comments. Analysis consisted of calculation of descriptive statistics and no inferential analysis was undertaken.

3.9 Data synthesis

In using three relatively detached data collection methods, it was important to be clear about how data would be merged, aggregated or synthesised to achieve understanding of the case. Miles and Huberman (1994) are proponents of having a transparent and structured approach to analysis in which methods are explicit. In contrast, Stake (1995) and Simons (2009) are proponents of creative and intuitive methods of aggregation.

Following significant reflection, this study used a 'middle ground' approach. A number of approaches were considered, one of which was Farmer et al's (2006) triangulation protocol which requires researchers to list findings from each component of the study and to consider where findings from each method are 'convergent', 'complementary', 'dissonant' or 'silent'. This method and terminology, (largely applied to mixed methods research) appeared helpful initially, possibly because the tool provided a means by which intuitive thought processes may be made more visible. However, in attempting to make the data 'fit' the tool, it was found to be an overly structured approach which placed a constraint on the creative methods advocated by Simons (2004), Stake (1995) and Wolcott (1994) and was therefore eventually rejected.

Frequency of findings within the data sets was not a primary consideration. At times it was tempting to assign greater meaning to those data that occurred frequently. Stake (1995) refers to the concept of 'correspondence' within instances and emphasises that meaning may be ascribed to a single instance, not only to those that occur frequently. This philosophy was confirmed during this study's data analysis as some findings were confirmed repeatedly within the data and yet provided least insight into the case. Findings that were both expected and unexpected were explored and the concept of correspondence with other data was pursued. This is not dissimilar to the method of Moran-Ellis et al (2006) who suggest that researchers may identify a key theme from one component and follow it across other components, a process they describe as 'following a thread'. This more accurately describes a creative process in which data can be identified, compared, contrasted, and their similarities, dissimilarities and issues of interest can be highlighted.

Hammond's (1978) cognitive continuum is of relevance as it is recognised that mental visualisation of multiple ideas and cues arise from the data. This may be viewed by some as an intuitive process, or equally, it may be argued that the researcher draws conclusions based on rapid, unconscious processing of cues (Hamm 1988). Demonstrating how these cues were processed does not need to constrain the creativity of the researcher but does provide greater transparency in how connections were made. Therefore, using Stake's terminology, 'correspondence' across data sets was noted, and in the later stages of analysis and interpretation, meaning could be assigned and sense made of the findings.

In order to demonstrate transparency, descriptive data are presented, or 'displayed' (Miles and Huberman 1994) in Chapter 4. This approach is not typical of case study research methods but it enabled the flexible nature of the research to be protected whilst ensuring rigour could be demonstrated, factors that Houghton et al (2013) believe to be important. O'Cathain et al (2010) and Farmer (2006) are also proponents of a systematic approach to aggregation and indeed, O'Cathain et al suggest that unless a degree of transparency can be demonstrated, some researchers may themselves feel that they have 'made things up' (p1149).

3.9.1 Terminology in relation to data synthesis process

Consistency in terminology is important in ensuring clarity when describing the data analysis process. In the initial planning stages it was noted that the terms, 'description', 'analysis', 'meaning' and 'interpretation' are sometimes vaguely described in the literature. Therefore an attempt has been made to clarify terminology and to use it consistently throughout this thesis. Wolcott's (1994) work was referred to as Simons (2009) suggests his methods may be helpful in

'transforming' qualitative data. He suggests the process of 'transformation' enables an 'intelligible' account (p1) to be presented and uses three key questions to assist in the process:

- Description - What is going on?
- Analysis – Why things work or why they don't (identifying key factors and relationships)
- Interpretation – What is to be made of it all? (explanation, understanding and, for this study, 'meaning' and implications for practice)

Wolcott acknowledges these stages are rarely distinct or discrete activities and the differences between analysis and interpretation can be difficult to define.

3.9.2 Conclusion

This section has presented the way in which data were collected and describes how initial stages of analysis were undertaken. In the next chapter the findings from each of the three individual research questions are presented with minimal analysis. This may not be considered strictly 'necessary' in qualitative case study research in which the emphasis is placed on the researcher's role in transforming data into meaning. However, as discussed in the next chapter, data from individual research questions may be of interest to some audiences and presenting it in this way assists in demonstrating rigour within the data transformation process. Using Wolcott's (1994) terminology, Chapter 4 thereby illustrates 'what is going on' in the Centre.

Chapter 5 subsequently presents the aggregated data from the individual research questions as a full and coherent case study story. Children's potential journeys through the multiagency response, starting at the point of referral and finishing six months' after their attendance, are considered. The case study story makes more apparent as to 'why things work and why they don't' (Wolcott 1994:12) in the Centre.

In Chapter 6 the interpretation of the findings are discussed in detail and implications for practice are presented as it becomes possible to address Wolcott's question; 'What is going on?'. Figure 3 below provides a diagrammatic representation of the process of transforming the data.

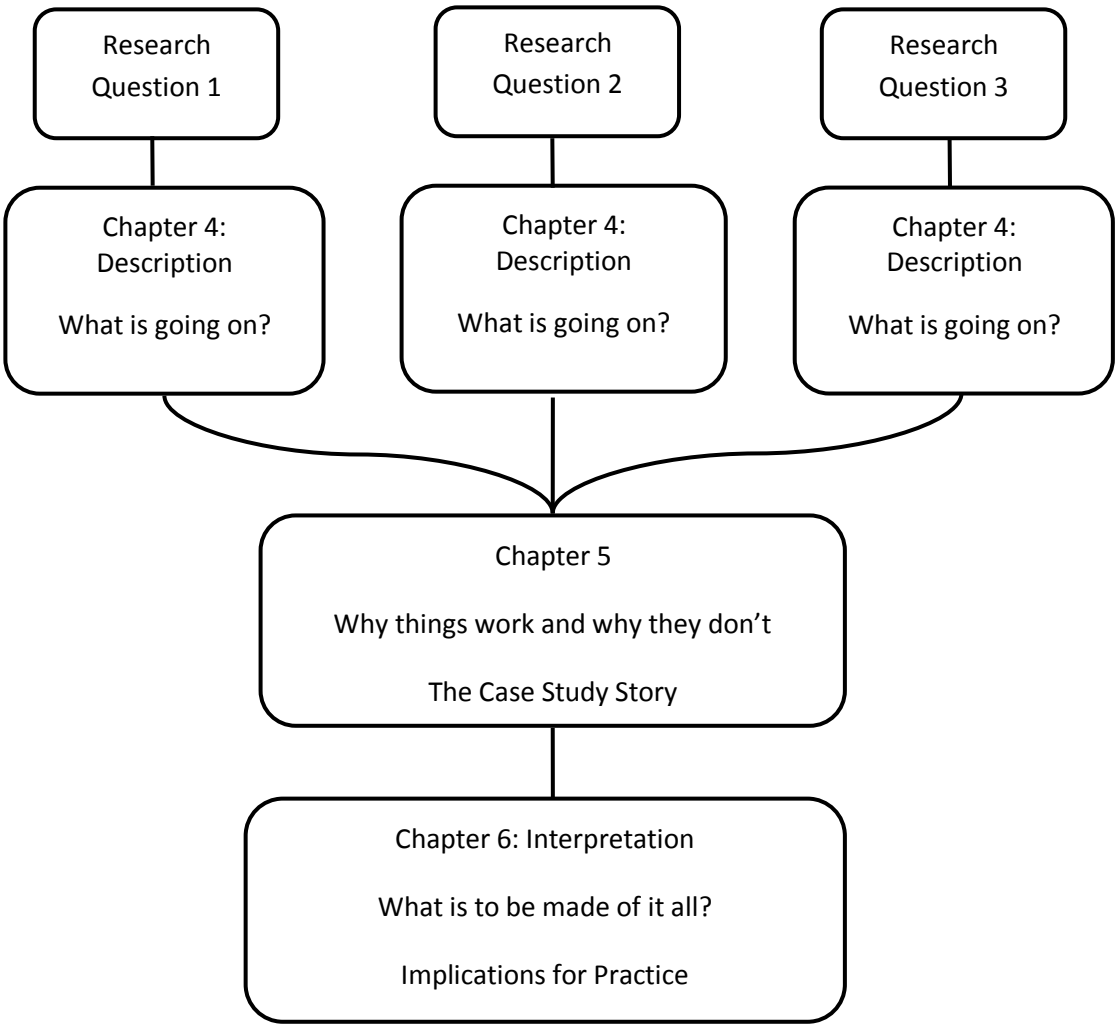


Figure 3 Diagrammatic representation of data analysis process (adapted from Wolcott 1994)

Chapter 4: Research Findings

4.1 Introduction

Chapter 3 described the research methods and the process for transforming the data into an intelligible account. In judging how best to present the findings of the study, case study methodologists Simons (2004) and Stake (1995) were referred to. They emphasise the researcher's creative and intuitive approach to 'transforming' data (Wolcott 1994) into a meaningful account but provide little detail about how original data might be presented (if at all).

Whilst recognising the relativist philosophy of qualitative research, Stake (1995) suggests that the value of interpretations vary, 'relative to their credibility and utility' (p102*).* In demonstrating those qualities within this study, it was felt to be important to 'display' data from the three individual research questions, thereby providing an audit trail of the process of aggregation. Miles and Huberman (1994:91) suggest this method of displaying qualitative data assists an audience to more easily see the 'variable orientated' view and the contextual findings as separate stages in qualitative research.

Therefore, this chapter presents findings as three distinct data sets with minimal interpretation. This approach enables those audiences who may have an interest in only one or two of the research questions rather than 'the case' to view a summary of the data collected for individual research questions. In Chapter 5 the aggregated findings are presented more fully as the 'story' of a child's journey through the Centre. This 'story' was produced from noting correspondence across all data sets, a process that is described later in this chapter.

4.2 Descriptive findings

4.2.1 Research question 1

Data relating to 60 children who attended the Centre between 1st May 2009 and 31st October 2010 were recorded. The rationale for this period being studied was that the Centre opened officially on 1st May 2009 (although children and young people had accessed the services prior to that date), and data collection started in May 2011. Therefore children who attended in October 2010 would have had a 6 month post attendance period.

The age profile of the children and young people who attended the Centre is presented in Figure 4 below and shows the high proportion of children within the younger age groups.

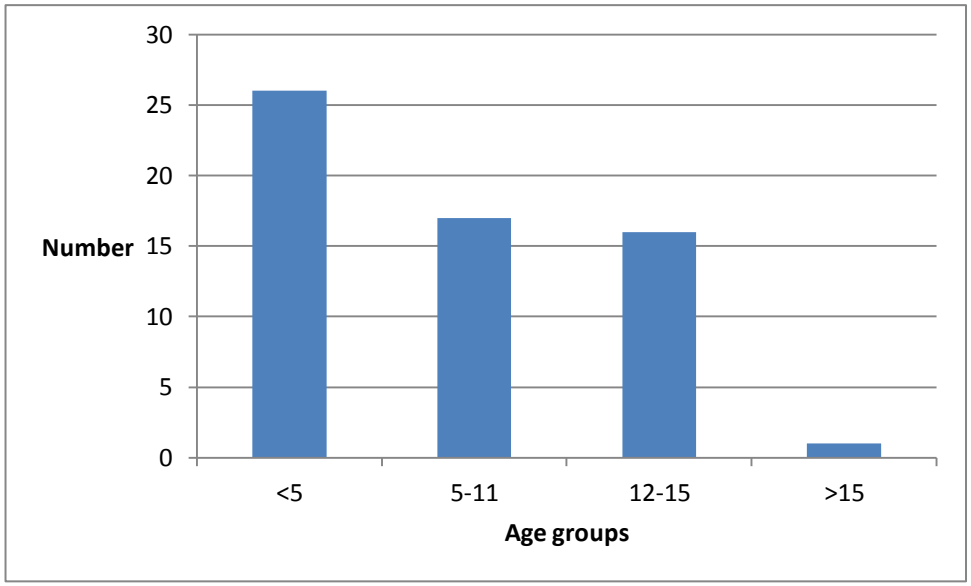


Figure 4 Age profile of children referred to the Centre

During the same 18 month period of data collection, six young people (all aged 13 years or over) accessed the local adult SARC which is available at weekends (and are not included in this data set). Disability was recorded for eight children who attended the Centre, with an additional four children who were described as having developmental delay. Four children were recorded as non white British, but for the majority of children, ethnicity was not recorded at all.

Police and social care are the statutory agencies to which child protection referrals are made but it is interesting to note the higher rate of referrals made by police compared to social care (see Figure 5 below). This may be linked to the expectation that medical examination will contribute to an investigatory process that may prove or disprove suspicions or allegations of abuse.

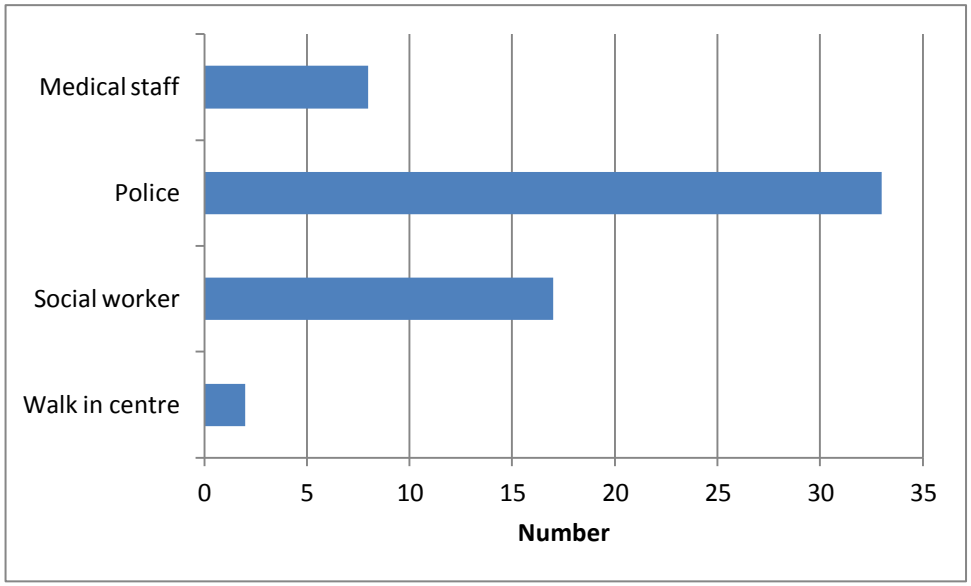


Figure 5 Source of referrals to the Centre

The reasons for referral to the Centre are shown in Figure 6 below.

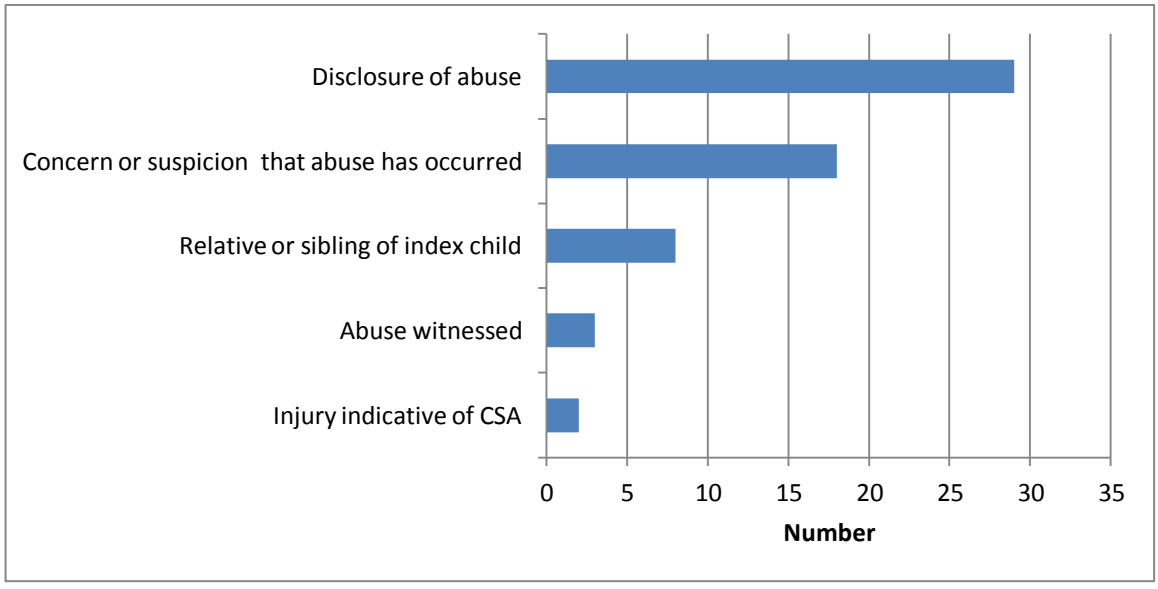


Figure 6 Reason for referral to the Centre

For some younger children, 'disclosures' were made unwittingly and had occurred several days or more after the suspected event. In a number of cases, parents had noted a change in the child's behaviour and / or physical symptoms which had prompted them to contact professionals.

The relationship between the children and alleged or suspected perpetrators of abuse are shown in Figure 7 below.

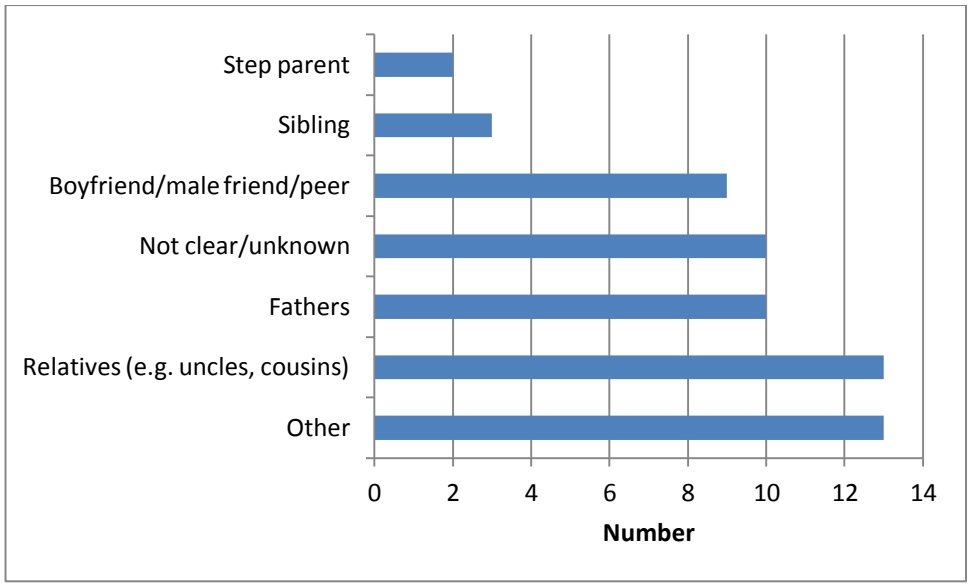


Figure 7 Alleged or suspected perpetrator

Where known, all the alleged or suspected perpetrators were male. The 'not clear' category includes those children where there was no verbal disclosure of abuse. The 'other' group included: family lodger (n=2) brother of friend (n=1), friend of parent (n=2), ex-partner of grandmother (n=1). Allegations were made against groups of young adult men in two instances but these were not indicative of organised exploitation.

The type of examination is shown in Figure 8 below and shows that of the 60 children and young people who attended the Centre, eight underwent forensic examinations. Of the eight forensic examinations, one was not completed at the requested of the child. Six non forensic examinations were not completed. Three children refused any type of examination at all.

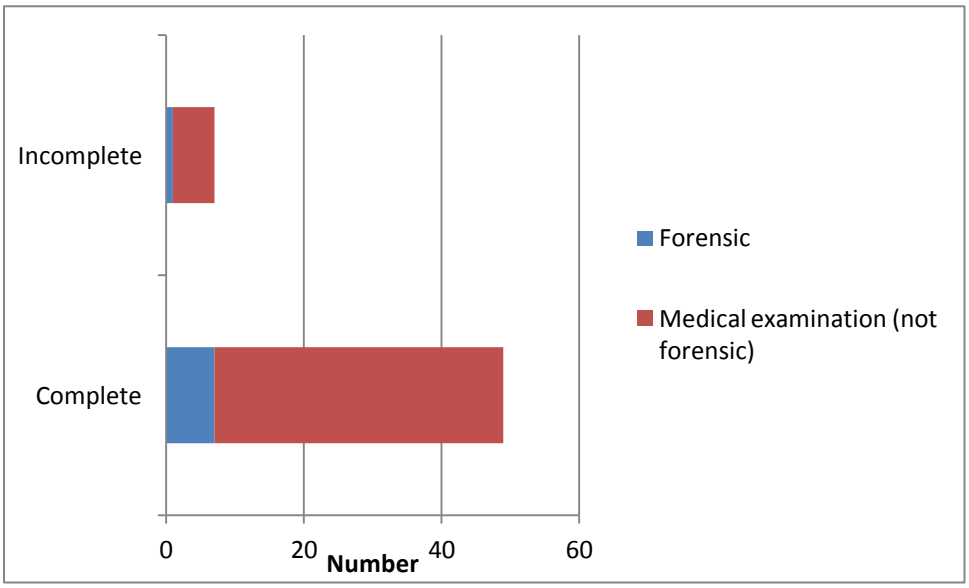


Figure 8 Type of examination

The findings at examination of all 60 children and young people are shown in Figure 9 below and demonstrate the numbers who had positive genital findings. Genital findings may be indicative that abuse may have occurred (e.g. bruising, lacerations) but also included children with nappy rash or hygiene issues that are clinically insignificant in terms of assessing the likelihood of sexual abuse but may be an indicator of neglect or other conditions.

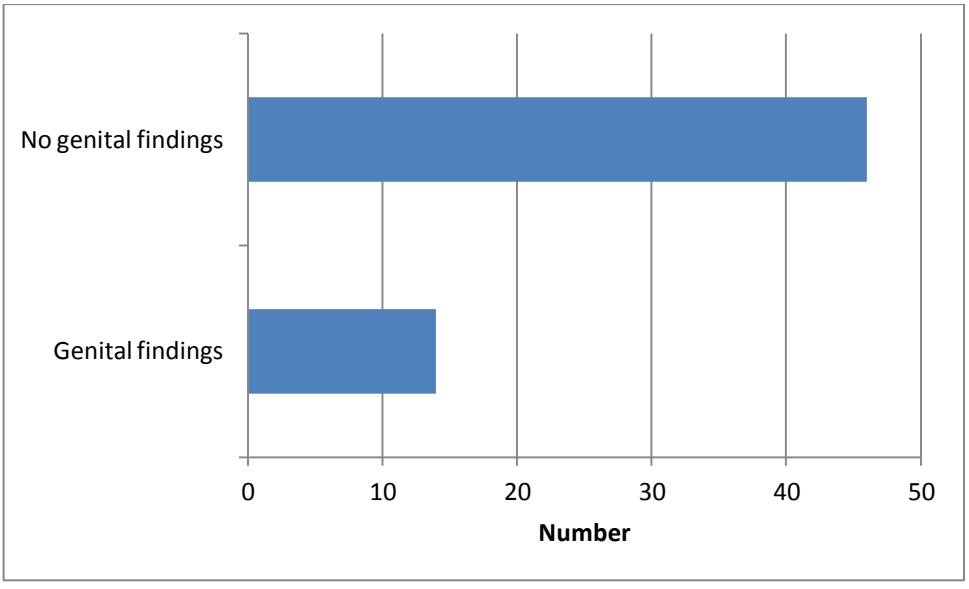


Figure 9 Genital findings at examination

Figure 10 below shows that 40 children had health needs (not related to genital findings) that required some follow up by health professionals. Follow up arrangements for children and young people were sometimes vaguely defined, and terms such as 'for GP follow up' were used. Most follow up arrangements appeared to be focused on 'medical' conditions such as enuresis, encopresis, skin conditions, heart murmur. Little detail was recorded of emotional or psychological health needs although several children were recorded as having behavioural problems.

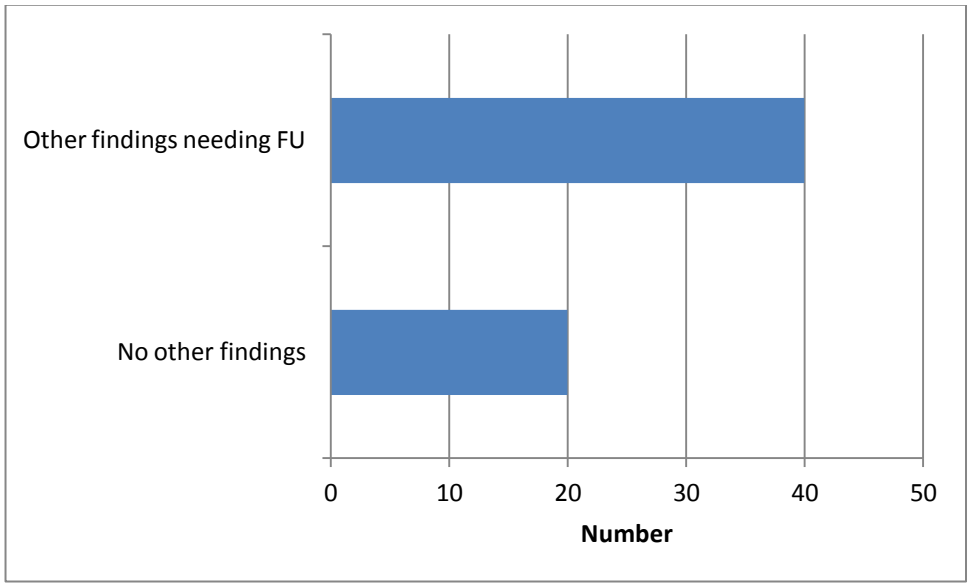


Figure 10 Health findings requiring follow up

Figure 11 below shows outcomes of criminal justice processes. The 'no further action group' includes those children whose alleged or suspected perpetrator was interviewed or arrested, but where police or crown prosecution service decided to take no further action (for a number of reasons). Some of these outcomes had been recorded in the child's health records, but the majority were not. In those cases where police action had been taken, two of the children had undergone forensic examination, but it is not known if the forensic findings were influential in securing a conviction.

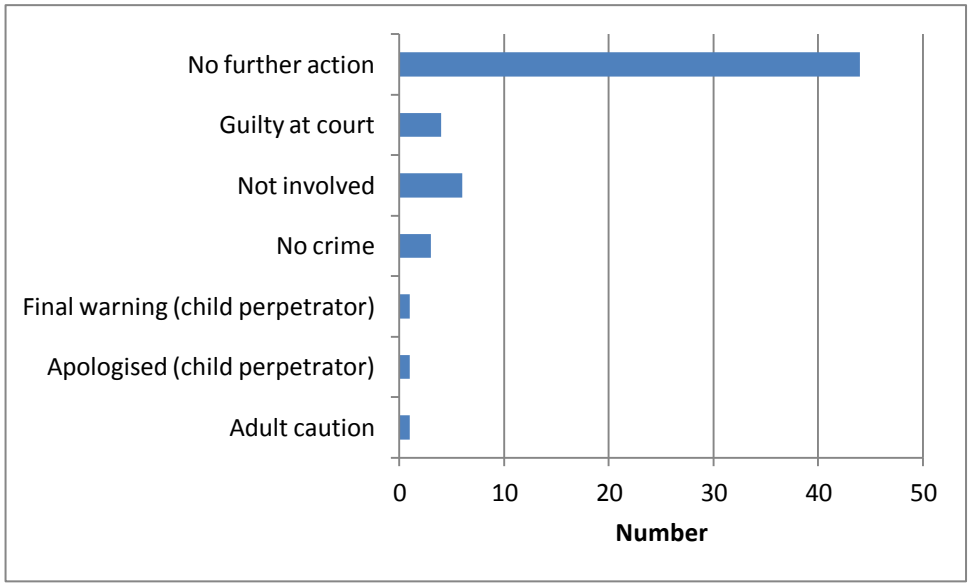


Figure 11 Criminal justice outcomes

Data relating to health outcomes were difficult to capture as children, parents or carers may access health services in a variety of organisations and the study had access to just one set of records within one health trust. However, no children or young people were being followed up by either a paediatrician or nurse at the Centre six months after their attendance. Some children had been referred to GPs for follow up of symptoms, two had nurse follow up at the Centre which had ceased by six months and three children had been referred to the community paediatrician for longer term follow up.

Social care outcomes (Figure 12 below) showed that 28 (46%) children and young people within the cohort were in foster care or subject to social care intervention six months post attendance and confirms that this is a vulnerable cohort.

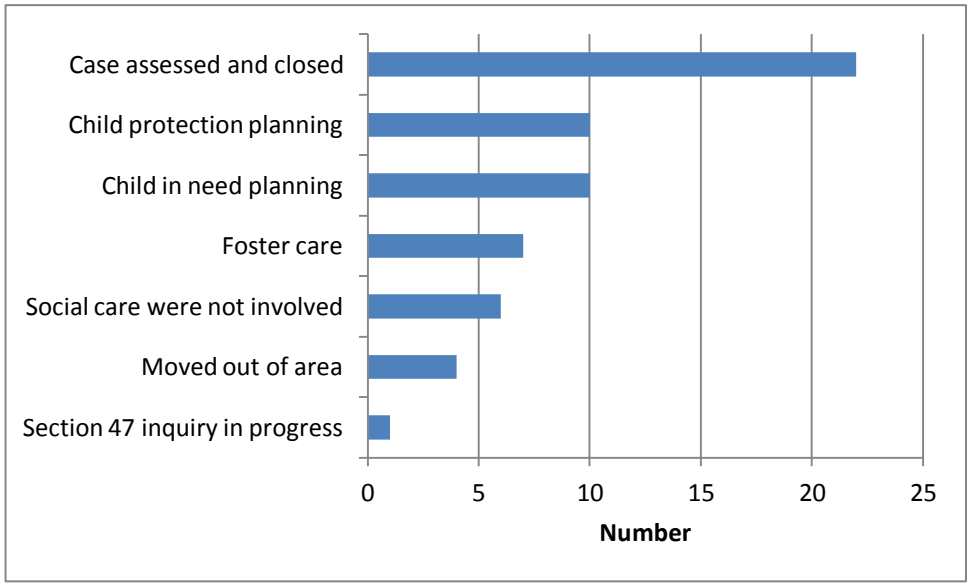


Figure 12 Children's social care outcomes 6 months after attendance

Some children had moved out of area (n=4) and it was therefore not possible to track their progress. Those where there had been no social care involvement (n=6) had been referred by other health professionals where 'second opinion' was required for genital injury e.g. genital injury (n=2) and where a parent or carer had appropriately reported concerns about their child's possible abuse by a non-family member to the police (n=4).

This section has presented the original, uninterpreted data from research question one. These data when aggregated with those from research questions two and three are presented in the case study story in chapter 5.

4.2.2 Research Question 2

The interview schedule (Appendix 4) was used to guide the interviews and to ensure consistency of opportunities for interviewees to express their views. The schedule was not adhered to rigidly and interviewees were encouraged to pursue and explore areas of individual interest and curiosity as part of a conversation.

As discussed in Chapter 3, a modified form of Bogdan and Biklen's (1992) coding categories was used to provide initial structure for coding interview data. A summary of interview data is presented using those modified categories in this section which allows data to be 'displayed'. It is recognised, as Miles and Huberman (1994:61) suggest, that unless categories are meaningfully interrelated, findings may resemble a catalogue. This section is presented in tabular form to enable a summary of data to be presented and for transparency and rigour to be demonstrated.

Table 8 Definition of the setting

Theme	Commentary
Is the Centre a building or a service?	One paediatrician posed this question which prompted further exploration of the relationship between the physical environment and professional behaviours in the case study story.
'One stop shop'	All police interviewees used this terminology.
Physical environment is child friendly, private and welcoming	Cross professional agreement on the positive contribution of the environment of the Centre
Primary purpose of the Centre: forensic facility versus paediatric facility	All police interviewees viewed the primary purpose of the Centre as a forensic facility that was also child focused. Paediatricians and nurses all viewed the Centre as a children's facility that was also able to provide forensic facilities.

Table 9 Processes and activities

Theme	Commentary
Police officers feel responsible for 'leading' the activity in the Centre	Reasons for police interviewees' sense of leadership appeared to reflect the clear protocol to which they worked, but also a shortage of appropriately trained social workers who could share the role of interviewing children and young people.
Paediatricians and nurses are not routinely included in strategy discussions	Some paediatricians felt strategy meetings are 'police led' and described a sense of detachment / isolation from decision making (although police and social care are the statutory decision makers).
Paediatricians and nurses are not routinely involved in observing video interviewing processes	Several professionals across all groups believed it would be valuable for paediatricians / nurses to observe the interview. There was no obvious reason for them being excluded.
The Centre is 'time saving'	Time-saving for police (due to reduced requirement to travel between venues) but this also reduced 'thinking time' for one police officer.
The Centre is 'time consuming'	Two social workers commented that medical processes in the Centre are slow and expressed concern that there is unnecessary information gathering by paediatricians.

Absence of feedback to professionals about outcomes for children and young people or the standard of professional work.	Disquiet among paediatricians /nurses who are rarely informed about the outcomes of police investigations. A social worker described his anxiety about not knowing what has happened to children with whom he has been involved into the Centre (as he then passes their case management to a colleague). A paediatrician also noted absence of feedback on her work, for instance the quality of forensic samples.
Absence of coordinated follow up care for children, young people and parents post attendance at the Centre	Cross professional group consensus on this issue – one nurse described families as 'left floundering'.
Children and families confusion and anxiety.	Social workers predominantly raised this issue explicitly, but other groups referred to families being distressed or angry. Two social workers believed that lack of explanation for families on why they had been asked to attend the Centre may contribute to this distress.

Table 10 Relationships and social structures

Theme	**Commentary**
Professional silos, tribes, hierarchies and differences	All paediatricians and nurses referred explicitly to their relationships with non-health professionals. For police and social workers it was less clearly stated but there was tacit acknowledgement by every professional that differences, based on professional roles, exist.
Separate to, but on the site of an acute hospital	Paediatricians valued proximity to other medical facilities and 'opinions' if required
Dedicated centre enhances multiagency working	Every interviewee referred to the aim of the Centre being to enhance multiagency working.
Emotional impact of working with distressed children and families	All groups referred to this issue
Nurses are 'human'	Nurses, police officers and social workers expressed this view
Familiarity with other professionals	Police officers noted that they felt comfortable to approach a paediatrician with whom they had a relationship to say 'this isn't working very well'.

Table 11 Perspectives

Theme	Commentary
Paediatricians' anxiety and worry	Every paediatrician referred to sources of anxiety in their role at the Centre. Several causes of this anxiety were identified: • making judgements that might impact on child's future with their family; • perceived variable levels of competence and commitment of some colleagues; • finding a balance with 'normal' paediatrics; • absence of good follow up; • feeling isolated from statutory child protection decision making processes. • expectation of other professionals that medical examination will confirm or refute abuse has occurred Although paediatricians expressed concerns about their role most clearly, other groups referred to some emotional impact of their work
The child protection examination provides reassurance for children and young people and / or parents.	Paediatricians expressed this view. Little differentiation was apparent between parents' views and children and young people's views.
Paediatricians and nurses referred to collectively as 'Health'	Social workers and police interviewees frequently referred to paediatricians and nurses collectively as 'Health'. Reflects participation of the health service as a partner agency and does not differentiate between individuals or their roles.
Child protection services are the 'Cinderella' service of the NHS	One paediatrician expressed this view.

Table 12 Strategies, tactics and methods

Themes	Commentary
Coping strategies for managing distress associated with the work.	All professional groups referred to some form of personal or informal coping mechanism
'Obtaining' a disclosure from a child.	One police officer used this term which illustrated the presence of organisational priorities. Highlighted the aim of the centre is viewed as supporting the aims of the criminal justice system.

This section has presented a summary of themes raised by interviewees with minimal commentary by the researcher. In their current format it is acknowledged that these data have limited impact. However, they may assist in demonstrating an audit trail that leads from the interview data to the case study story.

4.2.3 Research question 3

What are children and young people's (and parents' or carers') perceptions of their experience when accessing the services at the Centre?

Questionnaires in current use may be completed by:

- Children and young people who access the Centre and,
- Parents or carers who attend the Centre with the child / young person

Completed questionnaires for the period 1st September 2011 and 28th February 2013 were analysed. 18 questionnaires had been completed out of a possible 43 attendees (response rate 41%). Five questionnaires appeared to have been completed by children or young people and 13 by parents or carers. Where the date of birth was completed on the questionnaire and the child was younger than 5 years, it was deduced that the parent or carer had completed the form, although this cannot be stated with certainty.

Findings from both the face scale and narrative sections of the evaluation form were analysed and results are shown in Table 13.

Table 13 Responses to patient satisfaction questionnaire

	I agree	Not sure	I disagree
I knew why I was coming to the Centre	17		1
I understood what was going to happen	18		
I felt the doctor/ nurse listened to me	18		
I felt I could be honest and say what I needed and/ or wanted to	18		
I felt I was given a choice about being examined	16 (1 not applicable)	1	
I felt the examination was better than I had thought it would be	18		

The narrative sections on the form contain the following questions. Three forms had some narrative recorded.

Question	Response
Is there anything we did today that you didn't feel comfortable about?	'No' x3 responses
Is there anything we did today that you thought was really good?	3 responses were recorded: 'The examination was fun' 'Friendly and gentle with ... and explained everything to me' 'Sellotape test'
Is there anything we could do better?	'No' x 2 responses
Any other comments?	No comments were recorded

4.3 Examples of correspondence across data sets

As described in section 3.9, in order to aggregate the data from the three research questions, 'correspondence' (Stake 1995) between data sets was identified. This was largely a creative and

intuitive process and yet the credibility of the study may be enhanced by demonstrating the way in which such correspondence was noted. In a similar way to Moran- Ellis's concept of following a thread, Table 14 below provides two examples of the way in which the method was used. As discussed previously, the concept of correspondence is not synonymous with congruence as dissonance and incongruence within the data are equally significant in making sense of the 'whole' case.

Table 14 Examples of noting correspondence

Research question 1	Research question 2	Research question 3	Correspondence between data sets
High rate of alleged perpetrators were known to, or related to the victim	Distress / anger of parents and children was noted by some interviewees	Positive evaluations completed by parents and carers of their experience at the Centre	The impact of an abuser being a friend or family member may compound the distress experienced by children and families. High levels of distress among attendees were described by professionals at interview. Correspondence in this case relates to incongruence between data sets 1 and 2 with those from data set 3. This leads to the researcher's hypothesis that data from research question three does not reflect all attendees' perceptions or experience. It also leads to a recommendation that children, young people and families should be actively involved in developing evaluative methods.
45 of 60 attendees had no positive genital findings on examination.	Paediatricians feel pressurised to provide an opinion on the likelihood of abuse having occurred. Police offers and some social workers demonstrated an	Minimal data were available about children's or parents' perceptions or understanding of this issue.	The literature review shows absence of genital findings does not confirm that sexual abuse has not occurred. This provides insight into paediatricians' expressed unease and

	expectation that paediatricians will confirm or refute that abuse has occurred.		highlighted a lack of understanding and unrealistic expectations within the multiagency partnership. Children and parents' expectations of the medical examination remain unclear. This may suggest a passive role within the Centre's 'system'.

4.4 Conclusion

This chapter has presented findings from individual research questions and illustrated the method by which data aggregation was undertaken. In the next chapter, a child's potential journey through the Centre provides the focus of the 'case study story'. This format may assist audiences to see more clearly 'what works and what doesn't?' (Wolcott 1994).

Chapter 5: The Case Study Story: The Child's Journey

5.1 Introduction

This chapter presents the aggregated findings from the three research questions and also 'follows the thread' (Moran-Ellis et al 2006) of connections with some findings from the literature review. Simons (2009) considers it important to develop a means by which findings can be presented clearly to outside audiences and suggests that data need to be 'woven into a coherent story' (p147). For a clinical doctorate this is a pertinent issue as providers and commissioners of health services and other multiagency audiences may not be familiar with the subject area. Finding an appropriate means by which to influence leaders is an important consideration for graduates of clinical doctorates and Simons suggests storytelling is an effective means by which insights may be communicated and wisdom imparted to such an audience. Stake (2005:127) however, states that case study reporting is not simply storytelling, and that the report should follow one of the following three paths:

- A chronological or biographical development of the case
- A researcher's view of coming to know the case
- Description, one by one, of several major components of the case.

For this chapter, a combined approach that uses Simons' (2009) term 'story' as well as Stake's (1995) concept of chronological development has been adopted. Rather than reflecting the development of the case itself (the Centre) the narrative is presented in a way that portrays the sequence, or chronology, of events that is most commonly experienced by children and young people who access the Centre. This approach was adopted, not only in view of Simons' and Stake's suggestions, but also because it helps to illustrate the analogy of a child's 'journey' through a 'system' used by Munro (DfE 2011a, 2011b). The story starts at the point at which a child is referred to the Centre and ends six months after their attendance. For audiences who may not be familiar with the 'child protection system' this approach is intended to provide a reflection, if not of the lived experience of the participants, then at least of the sequence of events and the complex interaction between children, their families and multiagency professionals within the Centre.

5.1.1 Referral to the Centre

Prior to the children and young people arriving at the Centre a number of processes and activities had already taken place. Thirty three (55%) of children and young people's referrals to the Centre were made by police officers and 17 (28.3%) by social workers (with the remainder from health

professionals). For some children whose referral had arisen as a result of parental concern, the parents were actively seeking investigation. For others where parental involvement in abuse was implicated or suspected, police and social workers had used statutory or legal powers (under the Children Act 1989) to undertake an investigation. The legal status of arrangements for undertaking the inquiry at the point of referral may have been influential in the way that children, young people and their parents perceived their experience in the Centre as some were actively seeking input from police, social care or health services. Others may have been reluctant attendees due to statutory child protection investigations. However, exploration of this issue was beyond the scope of this study.

Among the professionals who work in the Centre, a fundamental difference in perspectives was evident among interviewees regarding the purpose of referring children to the Centre. All paediatricians and nurses spoke about their role in helping children to have wider health needs identified. They believed the availability of forensic facilities to be an important, but at times, secondary consideration. When asked about her view of the role of the Centre, one nurse stated:

'I think the police probably see a lot of it as a place to gain evidence in preparation for court and in relation to the perpetrator but from a health perspective I see it as very much a place for support for them [children and young people] where they hopefully get all the tests that they need to get done in relation to their abuse and a way of reassuring them in a supportive way.'

Nurse 3

Police interviewees affirmed the nurse's view that they believe the Centre to provide a 'one stop shop'. They all referred to the availability of video interviewing and medical examination facilities on one site leading to a reduction of trauma for children as there was no longer a requirement to travel between venues. They believed the physical facilities and availability of specialist paediatric opinion to be the fundamental and most important role of the Centre. A police officer, when asked if forensic evidence was helpful in supporting the prosecution case in court, replied 'it will often lead to a guilty plea'. He described a potential scenario where the defence barrister may say:

'Members of the jury, we're not saying this poor child hasn't been sexually abused and raped, however it wasn't my client, it was somebody else, this child just thinks it's my client.'

He continued:

'If we have forensic evidence that's half their argument gone'.

Police officer 1

This very clear vision of the purpose of the Centre and its associated role in the criminal justice processes was evident among all police officers. However, as findings from research question one demonstrated, the majority (86.7%) of children did not fall within the group where forensic examination was indicated and frequently more complicated circumstances tended to prevail.

For those families who had not 'self-referred' to the police or social care, one social worker explained, the referral might be a sudden event, for which neither child, young person nor carers had time to prepare. Another social worker said that she felt that explanations given to families about why a child protection referral was necessary were often inadequate and consequently families attended the Centre with little understanding of why they had been 'sent there'.

This set of circumstances was likely to be compounded by the alleged or suspected perpetrator, in common with national findings, being a friend, relative, parent, sibling, half sibling or step parent. Of 60 children, the alleged perpetrator was known to 50 of them (84%). During interview, two paediatricians volunteered this as a factor that caused them apprehension. One of them described her anxiety in participating in child protection work because 'you've got to remember that there are families at stake here' and the other referred to the role involving working with 'dysfunctional families' and their 'immense emotional distress'. Other interviewees did not refer to experiencing specific difficulties relating to suspected abuse occurring within the family or perpetrated by people known to them, and yet all interviewees made reference at some point in their interview to child protection being an inherently challenging field of practice. Complexity associated with a suspected or potential abuser being a family member or friend, it may be hypothesised, contributes to high levels of distress for some families and this distress was a theme frequently referred to by interviewees from all groups. It may be a contributory factor to a situation described by one paediatrician who referred to the reluctance of some paediatricians to undertake the work.

'It's a national problem and one of the principal things I think is the fear and I think it is fear around not wanting to acknowledge this happens and not wanting to face up to it and finding it probably painful and too distressing. There is a group ...who just can't accept that this happens, it's too horrific and it's too emotional for them'.

Paediatrician 4

Just under half of the children and young people (n=29, 48.5%) referred to the Centre, had made a disclosure of abuse, and three (5%) had been witnessed being abused. For the others there was a concern that abuse had occurred, an injury indicative that abuse may have occurred, or the child was the relative or sibling of the 'index' child. The Centre appears therefore, to accept referrals of

children who present in a similar way as those in Heger et al's (2002) study (where there may be uncertainty about the history or timescales of events) compared with those studies that included only those children who had made a clear allegation of sexual abuse. Forty three (71.6%) children who were referred were aged less than 12 years and for this young age group (and possibly for older children who may have communication difficulties) there may be inherent challenges for professionals in the Centre in accurately establishing events and timescales. The level of uncertainty posed by a lack of clear history can be a cause of anxiety, not only for families but also for paediatricians. A paediatrician described her concerns:

'The children I worry about are the ones where there's a sort of covert disclosure if not a complete disclosure. There are normal findings and because there's very little to go on, the case is very quickly closed and the family are left in limbo with a huge flurry of activity that happened because somebody's pounced on something that the child's said or that grandma's seen after an access visit, or behaviour that the nursery have seen and then it all fizzles out and I think that can be very difficult for parents'.

Paediatrician 3

Children's tendency to present with uncertain or vague histories highlights a key difference between the demands placed on children's services and those of adult SARCs. Most adult victims, whilst being supported by Police, are able to contribute to decision making over events such as providing a statement, agreeing to medical examination and deciding whether to pursue a complaint. If a victim does not wish to pursue the case immediately, forensic samples may be stored for future use (Lovett et al 2004). For children, who may not be aware that they have been abused, or who are unable to describe it clearly, professionals may face a dilemma in terms of assessing which actions may be in the best interests of the child. Additionally, whilst a parent or carer who is known or suspected to have committed abuse would be prevented from attending the Centre, there may be no clarity about the identity of a suspected perpetrator. Children may consequently, in some instances, be accompanied by an adult who has either perpetrated abuse themselves or been complicit in its occurrence. Therefore, at the point at which a child's referral is accepted by the paediatrician or nurse at the Centre, the potential exists for distress and conflict for all involved.

5.1.2 Arrival at the Centre

Children's referrals had been discussed on the telephone with either a nurse or a paediatrician prior to their arrival in the Centre. A sense of the Centre providing a serene backdrop to potentially complex and highly charged events was portrayed by interviewees from all professional groups. Paediatricians and nurses were described by one police officer as having a 'lovely' attitude that contributed to the Centre providing a 'welcoming' environment.

Professionals from all groups expressed very positive feelings in relation to the Centre and there were numerous comments about it being 'private', 'calm' 'low key' and 'cosy', findings that were similar to Lovett's et al's (2004) evaluation of adult SARCs. All interviewees referred positively in some way to the environment and space provided by the Centre enabling them to talk and plan, not only as a multiagency group of professionals, but also with children, young people and parents. The benefit, of the 'child friendliness' of the Centre in promoting police organisational priorities (obtaining a disclosure that may be used for criminal investigation) was described by a police officer who stated:

'I feel more comfortable going in there …… it makes them [children and young people] feel more comfortable, you are going to get a better disclosure from them than if you go somewhere where they don't feel comfortable' .

Police officer 3

The position of the Centre, on a hospital site and yet separate from the main facilities, was felt by one paediatrician to provide a level of confidentiality for children which may not exist if they were seen entering 'the abuse room' as she felt the previous facility in the main hospital had become known. Some paediatricians valued the proximity of their colleagues in the main hospital in case advice or onward referrals were necessary.

The concept of 'familiarity' was referred to as advantageous, both inter-professional and between the family and professionals. Two police officers described how they felt that knowing one another can impact on the management of a child's case:

'If you are talking face to face with someone, you know the way they work, you know what their strengths and weaknesses are, and you can provide a much better service'.

Police officer 2

'It provides professionals with almost a comfort blanket that they know that they have to go to one place and they can speak to all the right people with the right expertise and be supported with a familiarity that can back up that service'.

Police officer 2

Equally, a lack of familiarity was described as a constraint to processes running well. One nurse and one paediatrician commented that processes ran more smoothly when families were accompanied by a social worker with whom they were familiar. A social worker said she felt that some families were inadequately prepared for their visit to the Centre and believed this sometimes contributed to angry or defensive behaviour. She stated:

'They don't know how to behave or what to do because they are worried and they have only had short notice in terms of being there – they haven't had an appointment for a week, knowing they are going there, they have normally been told hours or an hour before, maximum'.

Social worker 4

Another social worker described how some families may feel intimidated by medical professionals:

'The people we work with, they're not quite anti- professional but they go up there and have paediatricians just asking questions and I think it can feel a bit intimidating for families.....sometimes I think crikey those paediatricians do make you feel a little inferior, if you like, not intentionally, it's just their manner'.

Social worker 3

For those children where a statutory child protection inquiry was being jointly conducted by social workers and police officer a strategy discussion had usually been held, prior to their arrival at the Centre, involving professionals from those two agencies. No health professional referred to being involved in this discussion and one paediatrician felt this reflected the role that health services are perceived to fulfil by police officers and social workers.

'We never seem to get involved in strategy meetings, even to this day. It's going back to are we part of this decision making team or are we just there to tick boxes and say that's not accidental or that's accidental, you don't have to do something about that one? That's not really what we should be about; it's much more intricate and involved than that really'.

Paediatrician 1

As all police interviewees were highly complimentary about the professionalism of paediatricians, their lack of involvement in some key operational procedures may be a reflection of the relatively strict protocols under which police officers conducted their investigations. This rigidity of processes contrasted with the position of paediatricians and nurses who appeared to use individual and professional judgement about appropriate actions, although a locally developed child protection medical examination pro forma was referred to as providing structure for assessment of children's physical and emotional needs.

5.1.3 Children and young people's interviews

Video interviewing of children is a core part of the investigatory process (Ministry of Justice 2011). As previously described, a number of children were deemed too young to be video interviewed. For 21 (35%) of children medical records showed that the child or young person had been video interviewed but data for this aspect of the children's journey often lacked clarity and it was difficult to ascertain from medical records (the primary source of data) what type of interview had been completed. The timing of the interview was a potential source of inter-professional tension

and a paediatrician stated there had been two cases 'where the police have really pushed me to do the forensic before they've interviewed the child' (implying that the examination might reveal injuries that would confirm abuse). A social worker acknowledged potential dilemmas in planning the timing of a child's interview and medical examination:

'There's been a time when we've asked for a medical to be done but we've gotten into an argument, I guess with health, about when the interview would be done ...this was a very grey kind of case without a clear disclosure being made. The Police are pretty hesitant to do a full ABE [Achieving Best Evidence] interview without knowing that some sort of crime has been committed..... In that case we decided, police hadn't spoken with the little girl yet, it had been social workers so we decided we would use the interview suite for an informal chat as we call it. Then if there was further information at that point we would have an interview and do the medical but she didn't say anything more than what had happened already anyway'.

She went on to say:

'I have found a lot of the different professionals are able to kind of navigate those decisions when the time comes'.

Social worker 4

As well as the timing of children's interview, a number of issues associated with the way in which video interviews were conducted were referred to by all professional groups. The process involves the child or young person being invited to sit in a comfortable 'sitting room' which contains a small video recorder mounted in the corner. A monitoring room is situated in the adjacent room in which the child's interview can be viewed via a one way screen. Children are accompanied by a supportive adult (usually a non-abusing parent, carer or social worker).

Two police officers expressed uncertainty about whether they could routinely use the Centre for video interviewing. One said:

'I'm a bit unclear on whether we can use it as a general suite or whether it's only if you are having an examination there. I'm a bit unclear on that one'.

Police officer 4

A social worker said that she had been involved in one case where the child had been interviewed at a police facility eight miles away and then transported to the Centre for medical examination because 'that's the way the police set it up'. This resonated with comments made by police officers and a paediatrician that the system works best when professionals are familiar with one another and the facilities of the Centre. A social worker felt that 'most of them [police officers] don't know it [the Centre] exists'.

There was a degree of consensus that health professionals should be more closely involved in the video interviewing process at the Centre when it does occur. One nurse who routinely 'sat in' on the interview stated:

'I usually sit in on the interview in the monitoring room and make notes so that they don't have to go through the whole thing again with the doctor'.

Nurse 1

However, this did not appear to be routine practice as three police officers and two paediatricians suggested that it would be helpful for the paediatrician or nurse who was going to undertake the medical examination to view the interview. It was not clear why this was not routine practice as no resistance was detected on the part of any professional group. A police officer inferred it might be associated with time constraints, saying 'I know that consultants are busy'.

Not all interviews took place in the Centre. Some were recorded as 'informal interview' (i.e. not video interviewed) and took place in other venues such as the child's home or school when this had been judged to be more appropriate for the child. Some children were too young, or were unwilling or unable to be interviewed but again, data in relation to this aspect were not always recorded or clear in the medical records.

There were some examples of professional conflict impacting on children's experiences. Although many professionals professed to want to deliver a child centred service, there was little recorded information in medical files of the way in which children were enabled to actively participate in decision making. One example was provided by a nurse who described a situation where the child appeared to have become 'an object of concern' (Butler Sloss 1988):

''Health' wanted to support the child and make them as comfortable as possible, but from the police perspective it was a forensic investigation and their aim felt very much that they wanted to get the evidence as quickly as possible to maintain that forensic viability……for the child sitting there and hearing the difference of opinion from two professionals .. I think that was quite a difficult situation really'.

Nurse 2

This example was not typical of experiences articulated by interviewees but does highlight the potential for professional conflict. This potential was acknowledged by several interviewees but there was a pervasive sense that professionals felt responsible for managing and minimising conflict. A paediatrician described her feelings about relationships with other professional groups and her comments again emphasised the issue of familiarity:

'It's kind of natural tribalism, we all get stuck in our little tribes and I think the more you have contact with other agencies and work with other agencies and have discussions with other agencies you can kind of see

where each other are coming from, see what the constraints are on each other's services, then you can all kind of work together. I do think that works, the more you do it, the more it works'.

Paediatrician 2

The issue of 'tribalism' was not usually described in terms of professional conflict, but all interviewees referred in some way to belonging to a professionally distinct group which had its 'own' priorities.

5.1.4 The medical examination (or health assessment)

The medical examination of children and young people usually took place when interview processes were complete. Only one interview was documented as taking place after the examination. The previously discussed open acknowledgement of variance among police and health interviewees about the purpose of children attending the Centre largely centred on perceptions of the 'status' of the medical examination. One nurse stated:

'They [police and social care] are expecting an outcome that says yes or no and sometimes it's not like that is it?'

Nurse 4

This was a common theme where divergence of expectations and understanding among professional groups was clearly triangulated within the data. Social workers' views about the medical examination were more nuanced than those of police interviewees and yet there was an expectation that the paediatricians would be able to contribute to decisions about the likelihood of abuse having occurred. A social worker felt that 'the examination might be the deciding factor' (in assessing a child to be at risk of abuse) and he expressed frustration at a perceived lack of decisiveness by paediatricians as he felt that 'health services hover around' and suggested:

'I'm sure you could at least give an idea' (of whether abuse has or has not occurred).

Social worker 2

However, another social worker said that she found the role of health professionals in sharing responsibility for decision making in the Centre supportive:

'The staff are supportive, working with us and taking some of that pressure off us. You know very often the family focus on the social worker but they (paediatricians) own their part in terms of medical findings so I think it's really good'.

Social worker 4

Police were frequently perceived by other professionals to introduce a degree of urgency into the proceedings, possibly due to a need to gather forensic evidence as quickly as possible to avoid deterioration in its quality. Police interviewees did express the pressure they felt and one talked about the way in which his mind is 'racing' during a child abuse investigation. Although all police interviewees referred to advantages of a 'one stop shop' a sense of time pressure was also described. A police officer talked about how he had previously used travelling time between venues to think:

'You can do a lot of thinking in the car – you've got a lot of time to think and discuss in the car – 'right we'll do this or we'll do that', but if you haven't got that it's often straight there and do it'.

Police officer 1

Of the 60 children, examinations under forensic conditions were commenced with eight (13.3%). One child declined to be examined and seven examinations were completed. Forensic conditions require the medical examination room to be cleaned to a required standard and the police 'scene of crime' officer to work with the medical examiner to obtain swabs and samples. All police officers, a nurse and a paediatrician commented on how 'smoothly' processes ran when a forensic examination was required. One stated:

'It works really slickly when there's a forensic case, the forensic cleaners come in and there's often a bit of a time lapse trying to sort out the CSI [crime scene investigator] to come in at the same time, especially now that they've made cuts in the police, that's quite difficult, but it does work really, really well'.

Nurse 1

Only one child within the group where forensic examination was conducted was aged less than 12 years and this may be a factor in a number of positive comments made about how smoothly forensic examinations tended to proceed as older children may be more capable of providing an account of their experience which may better inform professionals' actions. This group of children and young people may also contribute more readily to consent and decision making processes.

As previously discussed the large number of children aged less than 12 years who attended the Centre may account for low numbers of forensic examinations being carried out, as this group may be less able to provide a clear account of their experience. However, another reason was suggested by a police officer:

'The majority of child sexual offences are reported outside the forensic window, because children don't generally talk about it straight away, they probably are most likely to discuss it with friends before they discuss it with parents'.

Police officer 2

Paediatricians and nurses frequently referred to the medical examination component of the children's 'journey' as fulfilling a role, not only in identifying genital changes or injuries, but even in the absence of such findings, in providing either 'reassurance' or 'support'. A paediatrician said:

'Only in a few circumstances do we find any abnormalities that support the child's allegation. I think that could be argued both ways because a lot of the time, your 'normal' is therapeutic in itself and reduces, to some extent, the sense of violation. 'If he's done this to me am I different from other people?' and to be able to say 'I've looked and nobody would know that anything had ever happened previously', can be very therapeutic and very reassuring'.

Paediatrician 3

The concept of all children and young people feeling distressed, either about their experience or about attending the Centre, and thereby requiring 'reassurance' was not supported by one police officer:

'It's 'uncanny how some of them go along to the Centre and it's just like a normal day for them, maybe a day out even'.

Police officer 3

The extent to which younger children, who may have attended the Centre as a result of parental concern over behavioural or genital signs, may be 'reassured' by the examination was not considered by any interviewees. Although parents may be reassured about their child's 'normality', one social worker described her observation that this may not be without some reservation on their part:

'One or two have been really upset to think their child has to go through an examination that would include a sexual examination, I can't always figure out where their anxiety is coming from and I think it might often have to do with something they have been through in the past. .....Afterwards I've heard that parents have thought, 'oh that wasn't that bad''.

Social worker 4

A paediatrician acknowledged a tension in frequently being unable to confirm abuse has occurred and her sense of being able to provide reassurance:

'If you feel sure something's happened and you feel that justice isn't going to be done that can be frustrating, but I suppose the flip side of that is that you know that's not our job to convict people. It's our job to say what we see and to examine the child in a way that is child centred and potentially therapeutic by being able to ...say to the child and the mum you know everything is whole and healthy and OK down there'.

Paediatrician 2

This comment resonated with findings from Research Question 3 and showed that for some children and parents the medical examination, including video colposcopy of the ano-genital area,

was less traumatic than might be anticipated. The literature review suggested that some parents find the medical examination of their child a 'reassuring' exercise (Allard Dansereau 2001, Jones et al 2007, Marks et al 2009). However there was no conclusive evidence that children were reassured in the studies that explored their perceptions (Davies et al 2000, Jones et al 2007, Marks et al 2009, Scribano 2010).

Physical examination was not deemed necessary for one child who attended the Centre, but the remaining 59 children and young people were offered a medical examination. Three children were documented as having refused and six examinations were commenced but were not completed at the child's request or refusal. Of the 50 medical examinations that were completed, seven were carried out under forensic conditions and the remaining 43 were medical examinations that included video colposcopy of the anogenital area.

The outcome of analysis of forensic samples collected during the medical examination was not included in medical records and one paediatrician's comments suggest that this may have been due to absence of a feedback mechanism from the police rather than a recording issue:

'If we know that the forensic evidence we have collected is of poor quality then we need to do something about it, if we know that it's of good quality then that's reassuring. It's not nosiness, it's actually 'did we do a good report so that we didn't have to go to court?' There's lots of learning we can get from that, it's not just prurient interest'.

Paediatrician 1

This comment highlighted a difference between adult SARCs where a 'case tracker' is responsible for keeping in touch with victims, liaising with criminal justice authorities such as the Crown Prosecution Service, sexual health and mental health support services (Lovett et al 2004).

The time taken to undertake the medical examination was a source of irritation to one social worker who felt that the history that is routinely collected as part of the medical examination was an unnecessary duplication of information already held on other health records (such as the GP or safeguarding nursing team). She said:

'We go up to the Centre, we meet the family or we take them up there sometimes, we go into the office with the paediatricians, they are now completing another great big wodge of information a lot of which I'm sure they have on record anyway.... they go through the whole lot with the parents, so you can be sitting there for a good hour going through all this paperwork and then there's the medical'.

Social worker 3

Patient evaluation forms are available in the waiting room in the Centre and during informal discussions with the paediatricians and nurses a system of inviting children and young people and /or their parents and carers to complete a form was described. One paediatrician said (outside the interview) that she felt it was more likely that 'co-operative' parents were invited to complete the questionnaires. The positive responses received do however illustrate that for some children and parents that the experience at the Centre is not necessarily distressing.

5.1.5 Children's health outcomes

Of the 50 children who underwent a medical examination, 'health' findings showed 13 (26%) had positive genital findings. Some genital findings were indicative that abuse may have occurred (for example bruising or lacerations) but they also included nappy rash or hygiene issues that were clinically insignificant in terms of assessing the likelihood of abuse having occurred, but were nevertheless important factors to be considered in the overall assessment of the child's health needs. It is beyond the remit of this study to interpret the potential significance of genital findings but paediatricians' reports were clear that in few cases would their findings confirm or refute that abuse had occurred. As many of the children had presented as a result of vague histories of abuse and the timing of any alleged assaults may also have been unclear, (although with a possibility of it having occurred in the preceding seven days) it is difficult to make comparisons with the findings from the literature review.

Forty (66%) children had findings that required follow up by health services post examination. These included: 'severe neglect', enuresis, encopresis, untreated head lice, abdominal pain, behaviour problems including sexualised behaviour, anxiety, sleep disturbance, outstanding immunisations, heart murmur, skin conditions, dental decay, developmental delay, hearing problems, small head, sparse hair, alcohol dependency and poor hygiene. Few of these conditions were already being treated. Two children were noted to be under the care of a community paediatrician, and one was already receiving care from child and adolescent mental health services. Some children had more than one, or several of the conditions outlined above. This finding was consistent with that of Kirk et al (2010) where 63% of children who were referred for medical assessment of possible sexual abuse had other health concerns identified.

Following examination, two children were referred for specific medical follow up from specialist hospital services for reasons that were unrelated to their possible sexual abuse. However, follow up was most frequently requested from GPs and health visitors. There was no clear mechanism by which children's attendance at follow up services could be checked by paediatricians and nurses in the Centre. Therefore, for those families that were 'sign posted' or given information about

other services it was not known if they had been accessed. Paediatricians or nurses had, as part of a systematic check at three to six months post attendance, accessed the medical case files to ensure all 'health' actions were complete and any outstanding issues addressed. Formal referrals to medical services such as cardiology had clearly recorded feedback communications via hard copy letters in the child's file. However, health problems such as head lice or bedwetting where families were advised to see their GP or health visitor were not routinely followed up by the paediatricians or nurses in the Centre.

Medical records rarely provided information about police or social care actions although it was notable that where police outcomes were recorded, it was as a result of those police officers who were more familiar with the Centre and well established in the local team that had phoned and provided the relevant information to a nurse, a paediatrician or administrative support staff. There did not appear to be any system for routine feedback to health professionals from police, social care or other health professionals. A paediatrician stated:

'Unless there had been a case conference, we don't get told when the case is closed and we don't necessarily know whether any other points that we've highlighted that need doing are enacted'.

Paediatrician 3

The specialist clinical nurse in the Centre was identified as providing follow up contact with those children and young people who required further screening for sexually transmitted diseases and clear pathways for this specific issue were in place. In terms of mental health needs, some young people had been provided with details of voluntary organisations such as Rape Crisis. However there was consensus among all professionals that psychological aftercare was, as one paediatrician described 'terribly hit and miss'. As Radford et al 2011 suggest, the children and families who access the services of the Centre are more likely to be vulnerable due to a range of factors. Some paediatricians and a nurse described unease at the concept of 'signposting' to support services which required a proactive approach on the part of families.

For the seven children who entered the care of the local authority (commonly referred to as 'foster care') following their attendance at the Centre, statutory health requirements (DH 2009) provided a degree of structure for further input from health professionals. For these 'looked after' children, a local specialist paediatrician and nursing team was in place to ensure their health needs were comprehensively assessed, monitored and appropriate services put in place. For those children who remained with their family but became subject to child protection planning, child protection conferences were recorded as having taken place and GPs, health visitors and school nurses appeared to be the lead health professionals. Outcome of the medical examination

at the Centre was fed in to the child protection conference via the child's social worker. It was not recorded that any paediatrician or nurse had attended a child protection conference although one nurse stated that, when possible and when there are relevant findings that require explanation, they do try to attend. For those children for whom there were no statutory processes in place, there was no mechanism for follow up at the Centre other than for screening for sexually transmitted diseases and pregnancy. One nurse highlighted her concerns about the difficulties in providing follow up care:

'It's good to keep in touch when they are discharged from the clinic just because there's nothing more to be doing from a genital examination, there's still so much emotional baggage that goes on, not just for the child but for the whole family as well. The under 12s can't go to Rape Crisis and have counselling....behavioural changes come up and I feel that a lot of the children are just sort of left floundering'.

Nurse 1

This issue was also raised by a police officer who stated:

'Social services don't always keep it (the child's case) open do they? It if was a 14 year old that has been sexually assaulted by a bloke round the corner and the family are believed to be as protective as possible, police might drop the case due to lack of evidence, social services might not see any role for them because the family have tried to be protective, so you end up with a young person out there, with no one. They come here, have their examination and like 'thanks but nothing here for any of us so off you go...''.

In terms of police support for victims he explained:

'If it looks like it's going towards a police prosecution, they have victim support involvement but obviously that doesn't continue if the police decide to end the investigation'.

Police officer 2

The sense that children and families are 'left floundering' in terms of both their physical and possibly to a greater extent, psychological needs, was evident. The concept of children and young people experiencing a 'flurry of activity' that 'fizzles out' was apparent among all professional groups. Several expressed personal frustration at not knowing what had happened to children and young people following their attendance. A nurse said:

'What happens to them in the long term? We have snippets of information about these young people and maybe had the experience of doing the medical and then never knowing what happens to them in the long term'.

Nurse 3

Some professionals described their personal strategies for coping with the emotional demands of their role. A paediatrician said:

'I have to separate work and home quite clearly and when the ignition goes off in the car and the key comes out, that's it'.

Paediatrician 2

A social worker whilst describing the curiosity he feels about what has happened to children who have passed through his professional life, described how he could track their progress by looking at the social care electronic recording system, but he refrains from doing so, not only because he does not want to 'get involved' but also due to concern that he may not agree with the subsequent management of the child's case.

5.1.6 Children's outcomes – police and legal

Of the three children's cases where a perpetrator was found guilty at court, two young people had undergone a forensic examination, (although one had undergone the examination at an alternative venue and had attended the Centre for an associated issue). One had significant genital findings, suggesting that abuse had occurred but had not undergone forensic examination.

Of the eight forensic examinations that were attempted, seven were for young people aged 12 years or over, further suggesting that forensic medical examination is more commonly undertaken in the older age cohorts where a verbal account of what has occurred may be more easily obtained.

In the eight cases where perpetrator conviction or confession was the outcome, victims were aged three years to 15 years. Of the eight confirmed perpetrators, seven were aged 12 to 19 years. Formal outcomes included: apology by (child) perpetrator (x1), a final warning (x1), formal caution (x1) and five custodial sentences.

For the majority of children and young people (n=44), no further action was taken and for six children, police had not been involved at all. 'No further action' included those cases where children may have been interviewed and where suspects, or alleged perpetrators, may have been interviewed by police or arrested. Legal processes were pursued beyond this stage in only eight cases with the outcomes shown in Figure 11 in Chapter 4.

As one police officer pointed out above, the child or young person did not receive further input from the police unless a case was to be pursued through criminal proceedings and this group constituted a small minority of children.

5.1.7 Children's social care outcomes

The vulnerability and risk associated with those children and young people who accessed the services of the Centre was demonstrated in the number who had continuing social care involvement six months after their attendance. Ten children (16.6 %) were subject to child protection planning (those who were assessed to be at risk of 'significant harm'), 10 (16.6%) were subject to child in need planning (those who were assessed to need input from children's social care to achieve their potential). Eight children (13.3%) were in the care of the local authority (commonly known as foster care). For only eight (13.3%) children there had been no social care involvement (possibly those where health professionals had requested a second opinion, or where a 'stranger' was the potential perpetrator and parents were deemed to be protective of their child).

These data combined with the numbers who had unresolved health needs suggest, as national research has demonstrated (Radford et al 2011), that these children and young people constitute a vulnerable group on the basis of their health and social care needs notwithstanding unconfirmed concerns about possible sexual abuse.

5.2 Perceptions of the role of nursing in the Centre

Although the role of nursing in the Centre is not a stage in a child's journey, this is an etic issue that has been highlighted as an area of interest of the researcher, and there is some literature suggesting that this is an area worthy of greater exploration. The potential contribution of the nursing profession to the NHS response to childhood sexual abuse, was, when the study was initially planned, a vaguely defined concept and yet an etic issue of specific interest. For the purpose of the case study story it may be presented as the narrator's voice, or commentary. As the study progressed, the potential for nursing to enhance the service became more distinctly visible and a case for developing the nursing role is made in chapter six. However, it may be helpful at this stage of the 'story' to present the accounts of interviewees who were all, usually towards the end of the interviews, asked for their perceptions of the role that nurses, as opposed to any other type of professional, play in the Centre.

Nurses themselves had a number of views about their professional contribution and one nurse was clear about the potential for development:

'Some doctors will come and ask me to go through the DVD (from the video-colposcopy) with them and ask my opinion, which is really invaluable and it makes you feel worthwhile. What we are doing here is not rocket science, you obviously have to be very careful with wording and the way that you express your

report because it's potentially going to be used in court, but I fail to see why you couldn't have a nurse who has been trained actually carrying out the assessment and examinations'.

Nurse 1

While some interviewees focused on the technical or medical aspects that might be adopted by nurses, others saw potential for nurses in terms of observing family interaction in order to inform assessment processes, providing a friendly face and support, and in the provision of more co-ordinated follow up for children post attendance. One nurse felt that paediatricians viewed her and her colleagues as the 'backbone of the medical' and being reliant on them to 'know the running order and be able to cope with police and social services'. This comment about 'coping' with multiagency work was a pertinent reminder that the nurses were all from a safeguarding team in which working with police and social care was routine. For some paediatricians (not necessarily the interviewees in this study), this may be a less familiar concept.

Although no nurse interviewees referred specifically to the existence of a medical and nursing hierarchy, interesting comments were made that highlighted the way in which families may respond differently to paediatricians and nurses:

'I'm not saying a nurse has got any less ability, she's still a professional, but I think people can relate to nurses more than doctors possibly'.

Social Worker 3

This view was echoed by a police officer:

'I would say that the nurses bring in the human element to the whole process because they talk to, not that the doctors don't, because some of the experienced doctors do, they talk to the parents on their level. Nurses make that difference, sometimes doctors can be very clinical in their approach, not necessarily always'.

Police officer 2

and a social worker said:

'I think nurses bring in the human angle to it'

Social worker 2

In terms of the 'human angle', one nurse felt that she was more likely to understand the terminology used by some children and young people. The use of language she perceived to be a significant factor, not only in being able to establish a relationship with some children and young people, but also in terms of being able to gather an accurate picture of events that have occurred. For instance, she felt she had learnt many of the colloquial terms used to describe sexual activity

and this was an important factor in establishing what had happened to the child. Some paediatricians, she felt, used more formal language that was not always understood by some children and young people. The perception of nurses being more human or approachable may be linked to their professional status, particularly in relation to the medical profession.

The most positive comments about the role of nurses in the Centre arose in the paediatricians' interviews. One paediatrician felt it was 'incredibly helpful' to work with nurses who she perceived to have 'complementary and overlapping skills'. She believed the ability of nurses to build an 'amazing rapport' with the children and see them through the examination, can assist in the technical aspects of the medical examination such as 'seeing what you need to see and getting the images you need'. She also valued debriefing with the nurse, and 'sharing the experience' as part of a 'coping' strategy.

Another paediatrician expressed concern that there might be a cultural barrier to overcome with social care and police if nurses were to undertake examinations and provide opinions although she felt personally that nurses can be 'highly competent' in this area of practice and that any such resistance was therefore ill founded. Yet another paediatrician believed the clinical nurse to have superior technical skills with the colposcope and was therefore a valuable source of support to the paediatricians. The main strength she believed however was the way in which nurses were able to pick up cues from children and families, making sure families accessed follow up services and maintaining telephone contact with them after their attendance.

The potential role of nursing to improve the quality of care is more fully explored in the implications for practice in Chapter 6. However, at this stage it may be helpful to note a sense that the nurses were tentatively exploring their role in the Centre. Although paediatricians expressed an inherent tension between their therapeutic and forensic functions, their role is formally established within multiagency policy (HM Government 2013) and Royal College of Paediatrics and Child Health guidance (2011). In contrast, nursing roles are not defined in national statutory or professional guidance and appear to be evolving in response to the demands of the service. One specialist nurse had clearly established a role in contributing to the technical aspects of examination including interpretation of findings. She also took a more proactive approach to follow up care but this appeared to be an informal arrangement, dependent on the capacity of the service, rather than a formally recognised role. The contribution of nursing appeared to be largely based on traditional nursing roles of assisting the doctor, and 'supporting' the child and family. However, all nurses appeared comfortable working as part of a multiagency team and demonstrated awareness of the intricacies of the child protection system. Explicit analysis of the

potential contribution of nursing to improve the experience of children and young people and families is required.

5.3 Conclusion of case study story

In answering the 'what works?' question, a clear view of the environment of the Centre was constructed in terms of space, equipment and ambience. There was a sense that, for several professionals, the existence of the Centre emphasised, or in some cases reminded them of a responsibility to work constructively with multiagency representatives in a way that might not be as apparent in other settings. Professionals frequently referred to the concept of working together in the best interests of the child and this principle appeared to be embedded in the culture of the Centre.

The provision of comfortable waiting areas for families to sit also contributed to professionals' view that the Centre was 'child friendly' and also that they felt enabled to communicate with greater ease than they had prior to the Centre being developed. From the researcher's experience of working in the facilities prior to the Centre being established this view was understandable as professionals' conversations used to take place in a busy hospital corridor. The waiting area for children and families had consisted of an alcove on the same corridor and it is therefore apparent why space in the Centre, which might appear a basic requirement for child sexual abuse services, was so frequently acknowledged by interviewees.

There was an acknowledgement that the Centre has the specialist equipment (colposcope, forensic medical examination room, video interviewing facilities, and viewing room) to enable a specialist service to be delivered. The provision of appropriate equipment and professionals who were knowledgeable about its use was valued, particularly by police interviewees.

In considering 'what doesn't work?' a number of areas of interest arose, some with great clarity, others more subtle. The experience of the children and young people was not clearly captured whereas the concept of a journey through a 'system' was more apparent. Many professionals referred to the child focused services they delivered and yet, in some instances, were themselves perplexed by the demands of the 'system' which they felt was more focused on organisational priorities than the experience of the children. Although individual professionals stated or inferred that they attempted to make their contribution to each stage in the child's journey run as smoothly as possible, there was scant evidence of the journey being overseen in its entirety by anyone other than children and families.

The patient questionnaires that were completed suggested that a small number of children and some parents or carers, felt that attendance at the Centre following possible sexual abuse was not as distressing as might be imagined. There were however, references made in interviews to the distress, anger or anxiety that some families displayed and little was ascertained about the reasons for this although some interviewees referred to a possible lack of explanation or preparation on the part of those who had asked the families to attend the Centre.

Disparity of expectations among professionals about the Centre's primary purpose was a fundamental difference and the consequences of this divergence are discussed more fully in the next chapter. However, to summarise, it appears that if professionals do not share a view of the rationale of the Centre, there may be an impact on those who access its services. The focus on criminal justice processes and social care activity post attendance was easily defined, but the absence of clear pathways for children with unmet health needs (other than for sexually transmitted diseases) was an area that this study indicates requires greater consideration.

Paediatricians' unease in their role in the evaluation of sexual abuse in the Centre was clearly identified and this could be linked to a number of diverse factors. The demands of dealing with angry and distressed families, a sense of responsibility in making decisions that may impact on families' lives (depending on clinical findings) and also being isolated from the police and social care discussions and planning were areas that were clearly highlighted in the study. Feelings of professional isolation appeared to be compounded by a sense among some of the paediatricians that their roles are poorly understood not only by multiagency partners but also within their own profession and employing organisation.

Narrating the story in a chronological format was not without challenge, as data collection and analysis were not linear, consecutive processes. To present findings in sequenced sections therefore required 'weaving' of the data and it was essential to remain reflexive throughout the process, to ensure that important findings were included in the story even though, on occasion, it was difficult to make them 'fit' in an orderly and sequenced manner. Data divergence as well as convergence has been highlighted as this assists in understanding the complexity of the case and in demonstrating credibility of the study findings. The case study story is intended to assist the audience in understanding the day to day reality of the Centre and to show 'why things work and why they don't' (Wolcott 1994). Not all available data were used in telling the story, as Stake (p121) urges researchers to 'ruthlessly winnow and sift' in order to 'tell what is needed and leave the rest to the reader'. A discussion of the findings and links to the wider literature are presented in Chapter 6 which addresses the question 'What is to be made of it all?'

Chapter 6: Discussion

6.1 Introduction

In the last chapter, the analyses of findings were presented to assist the reader in answering 'why things work and why they don't', in the context of a child's journey through a child protection 'system'. This chapter focuses largely on addressing 'what is to be made of it all?' which Wolcott (1994) suggests is the interpretative stage of data analysis. As previously discussed, for this study, interpretation involves making sense of the whole narrative; the interrelationship of the parts with the whole.

6.2 Children's rights in the UK

The overarching global philosophy of children's rights underpins delivery of services in the Centre and was discussed earlier in this thesis as it provided a framework of principles on which the study was constructed. As the study progressed it became clear these principles are of primary interest within the findings.

The United Nations Convention on the Rights of the Child (UN General Assembly 1989), ratified by the UK in 1991, requires the state to act in the best interests of the child and to actively promote the participation of children in achieving their rights. UK legislation and statute have promoted this principle and, of particular relevance to this study, the Children Acts of 1989, 2004 and HM Governments' successive versions of statutory guidance '*Working Together to Safeguard Children'* (DHSS 1986, 1988, DH 1991, 1999, HM Government 2001, 2006, 2010, 2013) have promoted an approach within England that supports the aims of the UN convention. The influence of these principles in relation to children's participation and multiagency working in the Centre are considered in the following sections.

6.2.1 Children and young people's participation

Active 'participation' of children and young people is commonly referred to in relation to children and young people achieving their rights, and although it is often considered to be a process by which they 'may influence decisions about their lives' (Davey et al 2013:8), the exact definition remains contested (Lansdown 2009). Enabling children and young people's participation, appropriate to their individual age and understanding, is a challenging task. This study demonstrated that, on occasion, potentially competing organisational priorities (such as timing of interviews and medical examination) became the focus of professional attention, potentially to the detriment of ensuring children's views were actively sought. A statement in the concluding

chapter of the *Report of the Inquiry into Child Abuse in Cleveland 1987* (Butler Sloss 1988) has resonance:

'There is a danger that in looking to the welfare of the children believed to be the victims of sexual abuse the children themselves may be overlooked. The child is a person and not an object of concern'.

(Butler Sloss, 1988:245)

There was evidence within the findings of all professionals attempting to deliver a child centred service. However, on occasion, the demands of the 'system' in which they worked detracted from their intended focus.

It is unlikely that this finding is unique to the Centre, and certainly in considering a much wider context of child protection in England, Munro (2011a, 2011b) highlighted similar issues. The current version of *'Working Together to Safeguard Children'* (HM Government 2013:10) reflects her findings and requires professionals to deliver child centred services that reflect children's requests for:

'• Respect: to be treated with the expectation that they are competent rather than not

• Information and engagement: to be informed about and involved in procedures, decisions, concerns and plans

• Explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response

• Support: to be provided with support in their own right as well as a member of their family

• Advocacy: to be provided with advocacy to assist them in putting forward their views.'

(HM Government, 2013:10)

Findings from this study suggest that individual professionals attempted to meet these requirements when they led their agency's component part of the child's journey (for example the police led interview, or the paediatrician led examination). However, there was little evidence of a co-ordinated approach across police, health and social care agencies that enabled or encouraged children and families to actively contribute to the 'whole' of their journey in the Centre.

In navigating a complex system, the study showed that the professionals in the Centre engaged in intricate negotiations not only with one another, but also with children and families, some of whom were referred to as 'distressed'. The extent to which families 'normalise' certain

behaviours such as anger can be difficult to assess in such circumstances, but it poses additional demands on the process of professional assessment. It is known that domestic abuse, mental ill health and substance misuse and other adverse circumstances are prevalent in families where children have died or been seriously harmed as a result of abuse of neglect (Brandon et al 2012). However, the extent to which parents present as angry or aggressive in a deliberate attempt to deflect professional attention from the role they may themselves have played in a child's sexual abuse (or other form of abuse) is difficult to assess, particularly when they spend just a few hours in the Centre.

Schofield and Thoburn (1996) suggest that participation may be perceived as a finite entity where one party's inclusion will diminish the role of another. They argue that debate is enhanced and better informed when all parties participate and that those whose lives may be permanently affected by the outcome must be included. For the multiagency group of professionals in the Centre this appeared to be made more difficult in the absence of an integrated decision making process. Several interviewees referred to occasional feelings of powerlessness associated with being excluded from decision making and it may be suggested that some children and families may have shared that experience.

Lack of recorded data relating to children's ethnicity and disability further compounded the sense of children and young people occupying a passive position within their own 'journey'. With some exceptions it was difficult to ascertain a sense of children and families' language, religious or cultural needs from medical records (police and social care records were not directly accessed). Disability and developmental delay had been recorded for some children, but where it was not recorded it was not clear whether it was due to an omission of record keeping or the absence of disability. Collecting accurate data within the Centre is fundamental to ensuring that practice is non discriminatory (Equality Act 2010) and that all children regardless of age, race, disability, gender, sexual orientation or religion have equal access to care and treatment in the Centre. Walsh et al's study (2007) in the USA demonstrated that white girls were more likely than other groups of children to undergo forensic examination. No explanation for this finding is provided but it does raise concern regarding discriminatory practice. It is known that children with disability and other forms disadvantage are more likely to be victims of abuse (Radford et al 2011, Murray and Osbourne 2009).

6.2.2 Multiagency working and the concept of 'integration'

The degree to which children can actively participate in the Centre appears linked to the way in which professionals 'work together'. The requirement is reflected in health, police and social care policy and protocol (e.g. HM Government 2013, Ministry of Justice 2011) and this multiagency philosophy underpinned the development of the Centre. As Horwath and Morrison (2007) suggested, terminology in relation to the concept of 'working together' is often loosely defined, and contested terms, which are subtly different may be used interchangeably. This study found professionals demonstrated an expectation that multiagency work in the Centre would involve working co-operatively with colleagues from 'partner' agencies. Some also acknowledged the potential for inter-professional tension and 'tribalism' and described situations where conflict had arisen. It seemed however, that largely constructive attempts had been made to overcome tensions when they arose. This is in contrast to the findings of the Butler Sloss Report (1988) which described inter-professional conflict as a significant factor in the events that impacted deleteriously on children and their families in Cleveland. Professionals' commitment to multi-agency working in the Centre also provides encouraging evidence that the physical environment of a specialist centre may enhance willingness and ability to work co-operatively.

In further exploring the continuum of levels at which 'working together' occurs, and using Horwath and Morrison's (2007) terminology, it appears 'communication' and 'co-operation' have been achieved in the Centre and multi-professional actions are, to a great extent, co-ordinated. It was difficult to find evidence of a multiagency 'coalition' (or alliance) although the paediatricians and nurses as 'health professionals' might be perceived as an 'interagency coalition', particularly by social care and police professionals who frequently referred to both groups collectively as 'Health'.

Literature frequently refers to the importance of 'shared mental models' (e.g. McComb and Simpson 2013) or 'shared vision and collaboration' in promoting multiagency working (Carter et al 2007:527) but few authors have addressed the inherent tension in a multiagency service such as the Centre where professional interests may verge on conflict. Much multiagency working focused on establishing an environment that is supportive for children and families. As the police must focus on detecting crime, there is an intrinsic challenge and it is not perhaps surprising that practice in the Centre does not appear to have achieved what is considered the 'pinnacle' of collaborative working, 'integration'.

The term 'integration' is used commonly to describe a variety of arrangements which Frost and Stein (2009) suggest have their origins in the late 20th century when politicians started to

advocate 'joined up thinking' and promoted the concept in government policy as a means by which organisational 'silos' may be overcome. Silo working, they suggest, describes arrangements in which organisations become 'stuck' working with 'their' client group and 'their' way of working. This study provides some examples of professionals focusing on their own organisational priorities from which others felt excluded. For example, paediatricians and nurses experienced being excluded from strategy discussions or meetings where the plans for management of a child's case were discussed. Similarly, a focus on obtaining evidential material (either in interviews or medical examination) does not sufficiently consider children's wider health or social care needs. These examples confirm that placing professionals from diverse agencies together in a centre does not reliably overcome the potential for fragmented service delivery and that greater focus on integrated working within the Centre is indicated. Integration, Frost and Stein argue, is widely believed to be the means by which children will receive holistic services that improve their outcomes and yet they identify a number of challenges for services in achieving it, not least the required leadership and workforce development. Several leadership programmes that focus on organisational culture and working across 'systems' are available (e.g. The Kings Fund) and these might usefully be accessed by those who manage or work within the Centre to address these challenges.

6.2.3 Children's outcomes

A further interrelated issue is the concept of improved 'outcomes' for children. The term 'outcome', Frost and Stein (2009) propose, can be used simplistically to describe the 'effect or result of a service which can be attributed to it' (p316). It was not clear from this study what, if any, mutually agreed outcomes for children and young people had been agreed or aspired to when the Centre was set up. At the time of its establishment, the development of a well-equipped and staffed specialist centre may in itself have been perceived as the desired outcome. It is not clear if improved health outcomes (other than for sexually transmitted conditions) were an agreed priority and this may be an influential factor in the divergence of expectations that were identified between police and health professional groups.

A focus on outcomes for children has continued to gain national momentum since this study was conceptualised and is of relevance. The recently published '*Better health outcomes for children and young people: Our pledge'* (Children and Young People's Health Outcomes Forum 2013) provides insight into developments in this area. The document promotes the concept of the health outcomes that matter most to children, young people and their families taking priority (p3), and 'The Pledge' commits to integrated health services with care coordinated around the

individual rather than the health care 'system'. This appears to provide a response to Kennedy's (2010) '*Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs'.* Kennedy suggests professional and managerial cultures can introduce a degree of incompatibility but, even when this is overcome at senior manager level, it does not necessarily apply to frontline practice. It is perhaps unsurprising that where professional cultures conspire against integration within the NHS, an even greater challenge might be expected in a multiagency context. The Centre was developed as a result of senior managers and professionals in the NHS and police working together but this study suggests greater attention is needed to understand inter-professional barriers at frontline practice level.

Potential complexities in identifying and defining desired outcomes for children are suggested by Frost and Stein (2009:317):

- 'It is difficult to disentangle the impact of services from contextual and interpersonal factors that shape the life chances of children and young people.
- The contested nature of what outcomes can, or should, be measured and attributed to services
- Outcomes may vary and change between official measurement periods
- The separation of outcome areas (for the Centre, this may constitute police, social care and health outcomes)
- Who should define outcomes – managers, commissioners, or service users?'

It is recommended that these prompts should form the basis for discussions in the Centre, with the aim of developing a set of mutually agreed, multiagency outcome criteria. This may assist in building a child centred approach, with a shared understanding of the purpose of the Centre and thereby promote greater integration of professional groups.

6.3 The role of the medical examination

As the review of the literature demonstrated, the medical examination is a potentially contentious part of the 'service' that a child receives in the aftermath of suspected sexual abuse or assault. This study assists in illuminating some of the debates that exist regarding; variable rates of positive findings (Heger et al 2002, Kirk et al 2010, Cheung et al 2004, Palusci et al 2006, Walsh et al 2007, Watkeys et al 2008); perceptions of children and families of medical examination (Hornor et al 2009, Jones et al 2009, Marks et al 2009, Allard-Dansereau et al 2001, Mears et al 2003); outcomes of legal proceedings (Hansen et al 2010, Patterson and Campbell 2009, Sugue- Castillo 2009) and the role of nursing within the child protection medical

examination (Campbell et al 2010). The inter-relationship between these themes is complex and may differ for individual children and families. In this section, further consideration is given to these issues in the light of findings from this study.

6.3.1 Children's needs

As already established, the national drive for the development of specialist centres arose largely within criminal justice agencies, and funding was made available for centres for children and young people, based on adult SARCs, to be developed. Parallels are difficult to draw in terms of adults' and children's ability to assist professionals in obtaining a clear history of events that will be used to inform the inquiry process. Most adults, with assistance where required, can provide some details about the abusive event or events that have occurred. For children attending the Centre this was not the case as 44% were aged less than 5 years (n=26). Although chronological age is not a good indicator of a child's ability to accurately describe their experiences, Marchant (2014) suggests that children aged as young as two years may contribute reliably to witness interviews. In the Centre, some children were deemed 'too young' for an interview to be considered (the age was not clearly defined, but appeared to apply to children aged three years or under) and data from research question one showed that some older children were unable to provide an account of their experience even in the presence of skilled professional interviewers. For those children where an interview may be possible, the complexity of dynamics within the extended family may contribute to a reluctance to make a disclosure that might adversely affect the perpetrator or their own family members. For 84% (n=50) of children in this study the suspected perpetrators was known by, or related to, the child and for some there was a lack of certainty about the degree of protection provided by their parent or carer. A reluctance to make a disclosure of abuse in these circumstances is understood by those who are trained to interview children in these circumstances.

Some children's sexual abuse referral centres in the UK have not traditionally accepted referrals for younger children, or for those who have not made a clear disclosure of genital penetration. If these criteria had been applied to children referred to the Centre, a large cohort would not have received a service. This study's findings show this group of children may be vulnerable due to a number of factors and suggests the provision of sensitive, supportive services that may help them to manage distress and prevent re-victimisation should be welcome. The form that such services should take remains an area for further discussion.

6.3.2 Criminal justice system

It was not within the remit of this study to focus specifically on the part that child protection medical findings played in the outcomes of criminal justice proceedings but it is notable that the proportion of children whose cases proceeded to formal proceedings was small (n=8, 13%). Research undertaken at a combined children and adult SARC in Manchester (White 2014) although not yet published in full, has similar findings. In the retrospective case file review of 365 children aged seven years or less who had disclosed rape, sexual assault or assault by penetration, the author states 'it is clear many cases do not progress very far in the criminal justice system' (p10). The author, in this interim publication, has suggested that it is 'the holistic needs of the child are paramount and not just a focus on the forensic aspects of any evaluation' (p10).

In terms of the criminal justice system some controversy exists regarding the role of the child's witness interview. As previously discussed Marchant (2014) suggests children as young as two years can give reliable and accurate evidence that can be tested at trial. Pillai (2005) argues however, that paediatricians and forensic examiners are encouraged to place great emphasis on 'unquestioning support for the evidential strength of a child's statement' (p61) and that only if it is 'entirely spontaneous and free from contamination' can it be 'reasonably regarded as highly reliable' (p62). Unless great care is taken to ensure compliance with procedural requirements (i.e. '*Achieving Best Evidence'* Ministry of Justice 2011), Pillai suggests that objectivity may be lost and legal processes can be jeopardised. This differing perspectives may constitute a further source of complexity for the paediatricians who work in the Centre as they are required to balance the evidential demands with those of ensuring children are actively encouraged to participate in discussions.

This study highlighted the need for routine feedback to paediatricians and nurses in the Centre about outcomes of police and crown prosecution service decisions and subsequent court proceedings. As a paediatrician pointed out, it provides a contribution to the evaluative process for the quality of the medical examination. It is a complex task to ascertain the precise value of medical evidence as decisions about whether to proceed to criminal proceedings may be influenced by the fact that such evidence is known to exist (even if the case does not proceed to court). Similarly, suspected perpetrators' pleas may be influenced by the availability of medical evidence. It is therefore not possible to draw conclusions about the link between medical evidence and criminal prosecution outcomes within this study. However, findings suggest a formal mechanism for data collection and data sharing between health services and criminal justice services may better inform the service that is delivered in the Centre.

6.3.3 Children's social care

In pursuing their statutory functions in relation to child protection, children's social care departments are required to satisfy differing criteria to those of police and criminal justice agencies. Where criminal justice systems are required to satisfy 'beyond reasonable doubt' that a crime has been committed, children's social care are required to act on the balance of probability that abuse or neglect has occurred (Children Act 1989). It should be acknowledged therefore, that where prosecution of alleged or suspected perpetrators was not pursued by police, decisions by social workers about children's risks may have been based on findings from medical examination. This study, in common with Kirk et al (2010), found that although the medical examination may not have been confirmatory of sexual abuse, in a high percentage of children there were other unmet health needs, some of which may have been indicative of childhood neglect. Forty six per cent of the children in this study were subject to children's social care input six months after attending the Centre, but the extent to which potential neglect contributed to the safeguarding concerns was not within the remit of this study. Farmer and Lutman (2014) argue that childhood neglect is about an accumulation of concerns, whereas professionals operate within a system that is 'incident-led' (p270) and therefore often miss opportunities to intervene. They conclude that local authorities should work 'in collaboration with health services to chart children's weight gain, developmental and other progress, or lack of it, so that workers can be clear about when to take action'. This view supports the recommendation from this study that attendance at the Centre due to suspected sexual abuse should not be viewed as an isolated event as it may be part of a long-term situation in which a child's needs are not being met. This recommendation also links with that of ensuring that all relevant information about the child's needs is effectively communicated from the Centre to those professionals who are working with the child and family in the community.

6.3.4 Principles of medical examination and health assessment

The purpose of the medical examination as a component of the child's journey in the Centre also requires further exploration in light of this study. Medical examination and collection of evidence to support potential legal proceedings may be a priority for some children, but this should not be assumed to be the case. In adult SARCs, there is a focus on victims' choice of when to undergo medical examination and the way in which potential findings might be used (Lovett 2004). Fifty nine of the 60 children who were included in this study were invited to undergo medical examination, suggesting a universal approach for all children. Three children refused any form of examination and seven were not fully completed due to the child's reluctance or inability to proceed.

This statistic suggests that critical analysis of the role of the medical examination in individual circumstances in the Centre may be lacking. The medical examination (including ano-genital examination) is a tangible, measureable response to suspected sexual abuse. Given the low rate of positive genital findings, both in this and in larger scale studies, such as Heger at al (2002), some doubt may be expressed about the acceptability of this approach. Greenhalgh et al (2014), in discussing the evolution of evidence based medicine away from strict adherence to guidelines or protocols, advocate 'individualised evidence and shared decisions through meaningful conversations in the context of a humanistic and professional clinician patient relationship' (p21). In the Centre this approach might involve a discussion about the likelihood of positive genital findings and their significance. The suggestion by some interviewees that medical findings, and ano-genital findings in particular, are an influential factor in subsequent legal proceedings was not upheld in this study and, as previously discussed, Hansen et al (2010) and Sugue-Castillo (2009) suggest that the child's testimony may be a more significant factor in legal outcomes. The extent to which either medical findings or children's testimonies impact on UK legal proceedings remains unclear.

This study highlights risks associated with children undergoing medical examination and interview for the purpose of obtaining evidence for criminal justice proceedings, which they may (or may not) find unpleasant or distressing. Where a case is pursued through the criminal justice system, there appears a small chance of achieving a conviction. Equally however, to deny any child the right to access services which may be beneficial for them is unacceptable. Therefore, the concept of Greenhalgh et al's (2014) 'meaningful conversations' involving children, families and professionals appear to constitute to the best approach to ensuring individualised care in the Centre.

Some paediatricians and nurses in the Centre expressed doubt about the appropriateness of the biomedical approach (although this doubt sometimes co-existed with the view that the medical examination is a reassuring activity). Barriers to making changes to the existing 'system' were not explored in interviews, but may be linked to Foucault's (1973) observation of the medical world. In identifying the relationship between power and knowledge, he suggests the medical profession's 'clinical gaze' through which problems are diagnosed and treated, infers a socially constructed moral authority. This authority appeared, in the Centre, to equate to a belief among many professionals, that the medical examination was the means by which abuse may be 'diagnosed'.

The medical files that were reviewed for this study showed that examinations were consistent with the principle of holistic health assessment as described by paediatrician and nurse interviewees. Comprehensive histories were documented and included consideration of a wide range of psycho-social factors that might impact on the child or family functioning. For example, wider environmental factors such as housing or schooling were documented as were conditions that might impact on parenting capacity such as domestic abuse or substance misuse. The findings from children's health assessments were documented on a pro-forma which, when completed, contained a rich source of health data that might inform future planning. As discussed, two thirds of children had an unmet health need identified that was not directly associated with sexual abuse.

The child protection medical files were stored in such a way that they remained accessible only by paediatricians and nurses who work within the Centre. Important information was not therefore available (and its existence would possibly be unknown) to health professionals working in other services who may subsequently have contact with that child. Therefore, in addition to concerns regarding children's degree of participation and the management of unmet health needs, a concern existed regarding the 'holism' of the approach as information that had the potential to inform health professionals in other settings might remain hidden or inaccessible. Children's health assessments thereby constituted an isolated 'event' with little capacity for informing other relevant services. The concept of 'holistic assessment' as an 'ongoing process which can be updated and changed as a person's choices and preferences change' (SCIE 2015) was lacking. In the Centre the risk existed that, having undergone a time consuming assessment that touched upon sensitive areas of family life, minimal information was made available to health professionals working with the family in the longer term. Although referral letters were written to specialist services and a summary of the outcome of the Centre's involvement was routinely sent to GPs, a wealth of information remained in the child protection medical file and there was no apparent means by which this could be used to its potential to inform health care planning. The Centre is not the only service where this situation exists and it was noted by Laming (HM Government 2003:379) to be a contributory factor in failed communication in the Victoria Climbié Inquiry. He recommended that, 'within any given location, health professionals should work from a single set of records'. As electronic recording systems are increasingly implemented in health services this situation may be addressed in the future but sustained efforts are needed to ensure this important aspect of holistic health care is not overlooked.

For those children or young people where there was an uncertain history of abuse and whose case was therefore unlikely to progress to criminal proceedings, there was an assumption on the

part of some professionals that undertaking a medical examination, including genital examination, provides 'reassurance' for the child. This theory appeared to have gained credibility among paediatricians and nurses and was frequently stated. The extent to which children underwent examination because they were encouraged to do so by parents (who may be anxious), or by professionals who believed it to be a reassuring exercise is not known. Pillai (2005), in referring to forensic examination specifically, urges examiners to ensure that it is in the child's best interests not the interests of any other party. Given the concern expressed by some interviewees about families' distress, and reports that they themselves have sometimes felt pressure to comply with 'the system', some disquiet about this issue may be justified.

Further research into children's experience of the medical examination may be indicated but, importantly, professionals should be explicit with children and families about the purpose of the proposed examination and the limited likelihood of medical findings being used to inform legal proceedings. This approach might enable children, young people and parents to contribute more actively (and thereby provide better informed consent) to decision making about whether the medical examination serves a useful purpose for them as individuals and if it does, the optimum timing. Christian (2011) suggests that although it may seem intuitive that medical examination should occur as soon as possible after recognition of potential abuse, 'it should be weighed against the emotional needs of the child, and the limitation of the examination to prove sexual abuse' (p507). The optimum timing of medical examination therefore requires further debate.

6.4 Early help and prevention

This section reviews the circumstances for those children where abuse was not confirmed at the time of attending the Centre. Although some children when they were initially referred to the Centre were subject to a level of statutory intervention requiring compulsory intervention in family life (Children Act 1989), in the subsequent weeks, 22 children had their care closed by children's social care. Given the difficulties described in this study of obtaining an unequivocal history from some children and the limited role of medical examination in confirming sexual abuse, the needs of this group of children and their families are considered in this section.

In common with Kirk et al's (2010) finding, this study found 66% of attendees had an unmet health need and for a proportion of the children where sexual abuse was not confirmed, the possibility that abuse had occurred was a reality. As Radford et al (2011) and others established, children who have been abused may also be at greater risk of multiple forms of disadvantage. The possibility therefore exists that for some within this group, a risk of re-victimisation and poor

health outcomes remained, and yet there was no clear means by which they might be followed up or supported by any agency.

In this study inadequate follow up services for children who had attended the Centre was an area that was consistently referred to by professionals from all groups. This concern applied to all groups of children, even those where abuse had been confirmed. However, it appears children who did not continue to receive input from the statutory services were at greatest risk of being 'lost' within the follow up period. For adults who attend SARCs, post attendance 'support, counselling and advocacy' (Lovett et al 2004) is promoted.

Munro (DfE 2011a) refers to the need for provision of 'early help' to prevent escalation of need to a level requiring statutory social care intervention (HM Government 2013). The term refers to intervention that takes place at a threshold above that at which universal health services are able to respond effectively. The threshold is therefore set at a level where few children would be eligible for services, particularly if abuse cannot be confirmed. Preventative public health initiatives aimed at reducing health inequalities (Institute of Health Inequalities 2010) are relevant however, and attendance at the Centre may provide a mechanism by which health professionals can work with families to explore their health and social needs.

The potential advantage of constructing the Centre as a preventative as well as responsive facility is an important finding within this study. Although medical examination and the collection of evidence may be an important component of the journey for some children, Heger's (2002:655) assertion that the medical examination (when necessary) should take place with the expectation that findings will be normal may need to be promoted among children, families, police and social workers. This may also contribute to a lesser expectation of the medical examination serving a purpose in 'diagnosing' sexual abuse.

For children who were not assessed as being at risk of significant harm, GPs, health visitors and 'signposting' to voluntary organisations were the most frequently identified follow up arrangements. For those parents who were described by interviewees as 'floundering', or who may themselves have had histories of abuse (in common with Davies et al's 2000 study) it may not be easy to actively seek help without further assistance. Moreover, the extent to which all GPs or health visitors feel able to respond to concerns related to childhood sexual abuse is not known, and this remains an area that may benefit from greater exploration through further research.

6.4.1 Strengthening Families

For parents who attend the Centre and who have not been involved in either abusing or failing to protect their children, but who may not feel confident in addressing their children's needs, an approach that is based on building resilience within the family may offer benefit. A number of government funded initiatives have aimed to achieve this, albeit with differing foci. 'Think Family' (Department of Children, Schools and Families 2010) aimed to improve support to vulnerable families to prevent escalation of need, and the more recent 'Troubled Families' (Department of Communities and Local Government 2011) is aimed at improving outcomes for those families where non school attendance, adult worklessness and antisocial behaviour coexist. These initiatives indicate a growing policy directive aimed at 'whole family' approaches to improving children's outcomes, whether in terms of health, education or criminal justice systems. Several interviewees referred to the distress of parents and, because 50% of attendees do not have continued statutory agency follow up, this study suggests that an approach that is more firmly aimed at enabling parents to support their children in the aftermath of actual or suspected sexual abuse requires greater consideration by professionals working in the Centre.

6.5 Insight into paediatricians' and nurses' roles

Whilst focusing on a multiagency area of practice, it was interesting that the greatest insight into professional roles was gained in relation to paediatricians and nurses. Potential reasons for this are explored more fully in chapter 7. This section examines the findings that were specifically related to health professionals in the Centre.

6.5.1 Role of paediatricians

Whilst all paediatricians were clear that they attempted to deliver a child focused, multiagency service in the Centre, interviewees in this group described notable levels of disquiet about their role which requires further exploration. Pillai (2005) and Kelly et al (2005) allude to a degree of conflict that may be encountered by medical examiners in their forensic role, as the needs of the patient and the demands of the justice system coexist, but may not be entirely compatible. This conflict may underpin some interviewees' comments about their anxiety. The responsibility for managing parental expectations and demands, sometimes in the context of a parent being a suspected abuser, or having failed to prevent their child's abuse, is significant. For paediatricians this challenge is further compounded, as the literature review demonstrated, by the status of the emerging knowledge and evidence base regarding genital findings, with some areas being contested. These issues appeared to place a significant pressure on paediatricians, some of whom described misgivings about their role. Participating in child protection work in general (not just

child sexual abuse) appeared, for some interviewees, to be motivated by a moral imperative in which they believed it to be the ethically correct thing to do. This imperative appeared to be accompanied by misgivings about a perceived lack of understanding on the part of fellow professionals, within the NHS as well as the multiagency arena, about the purpose and complexity of their role. This perceived lack of understanding may indicate a need for further dialogue about not only the role of the medical examination (as discussed in 6.3.4), but also about the need for professional supervision mechanisms for paediatricians who play a central, but seemingly poorly understood role, in the Centre.

Paediatricians' sense of separation from social care and police processes were compounded by their regular exclusion from key activities such as the strategy discussion. Statutory guidance requires social workers to discuss with 'police and health' (HM Government 2013:29) plans for immediate safeguarding action and the need for information giving to parents and families. This strategy discussion had frequently already taken place when children and young people attended the Centre, and paediatricians were regularly denied an opportunity to contribute. This was a cause of frustration as the health needs of the child appeared to be considered of secondary importance, and this practice emphasised the relatively remote part played by paediatricians in the events preceding medical examination.

Another factor requiring consideration is that of paediatricians' familiarity with multiagency systems. Although all paediatrician interviewees in this study were highly experienced and familiar with multiagency demands, a nurse interviewee commented that some paediatricians who work in the Centre on a less frequent basis may be less familiar with multiagency processes as their primary roles do not significantly include child protection work. This factor may link to observations about variable levels of competence among paediatricians that were made by a social worker and by paediatricians themselves.

Several interviewees referred to the importance of professionals' familiarity with one another in being able to work co-operatively and yet also constructively challenge one another when needed. There remains a question therefore, as to whether paediatricians who work in the child sexual abuse arena should be a small, stable, specialist and highly competent workforce who are well placed to build relationships with colleagues from other agencies. The risks associated with not 'staying sane' and lack of exposure to 'normal' paediatrics was highlighted as a disadvantage to this approach by one paediatrician. There was no clear consensus among interviewees about this issue but Adams' (2011) suggests that specialist paediatric roles are advantageous. She undertook a survey of knowledge about child sexual abuse medical findings in the USA in 2007.

Findings, when multiple regression analysis was used, showed that child abuse paediatricians scored 'significantly higher' (p596) than non-expert paediatricians, advanced nurse practitioners or sexual abuse nurse examiners. However, the child abuse paediatricians were required to carry out more than five cases a month of child sexual abuse evaluation, undertake case review with an expert in child sexual abuse and stay up to date with published literature. This remains an area that requires further debate and exploration, particularly as the frequency of exposure to paediatric sexual abuse cases among the nursing cohort in Adams' study was not cited in the article. These findings do however further support the case for professional training and supervision for paediatricians and others who engage in this area of work.

Findings in this study also suggest that paediatricians' isolation may be compounded by the view of some other professionals who perceive doctors to occupy a superior position in a perceived hierarchy (although it should be noted that none of the paediatricians inferred this to be the case). It was not clear in the study the extent to which paediatricians were aware of the tacit, or informal, networks in the Centre in which police officers, social workers and the perceived 'human' nurses appeared to engage and this remains an area for further exploration.

This study's findings tentatively suggest that a number of ill-defined factors may impact on paediatricians in the Centre. The evidence base with which they work continues to emerge and uncertainty about the likelihood of sexual abuse having occurred, based on medical findings, is a legitimate conclusion in the majority of cases (Heger et al 2002). Unrealistic expectation of the outcome of the medical examination on the part of some other professionals (and potentially families) may provide an additional pressure for them. This, combined with the distress of some families, a lack of natural 'fit' in the informal professional networks that exist, and an absence of routine, constructive professional supervision, appear to contribute to their unease in the Centre.

6.5.2 Role of nurses

It may be argued that until the 'what is going on?' and 'what is to be made of it all?' questions have been addressed either nationally or locally that nurses who are immersed in delivering a service may find it difficult to visualise their potential contribution to leading change and influencing developments. The DH (2012) '6 Cs' (care, compassion, competence, communication, courage and commitment) are relevant to this study's findings as nurses are urged to 'shape and lead a caring culture' (p11). This issue is reviewed in this section.

It is notable that, within this study, the nursing profession's 'identity' and contribution to the child's journey within the Centre was the least clearly defined of any professional group. Some

other professionals viewed the nurses as providing the 'human' face of health services. Paediatricians valued a fellow health professional for debriefing purposes (as well as a 'pair of hands') and this implied that nurses were able to build rapport with children, families and professionals alike. However, there was little commentary about the contribution made by nurses to children's journeys. Discussions during interviews about potential development of nursing roles were largely associated with technical and forensic skills and were in keeping with the biomedical model of service delivery. This may be a further reflection of the relatively recent development of specialist sexual abuse centres for children in which medico-legal considerations dominate.

In 1988, '*The Butler Sloss Report'* referred to nurses as a group of professionals who 'had to cope with some of the worst effects of the crisis when it was at its peak and were unable to do anything to change the situation' (p125). Although the report made numerous recommendations regarding police, social care and medical input the potential role of nurses within the child abuse system at that time was not recognised. Nursing roles have advanced since then(DH 2010, RCN 2012), and are believed to be fundamental to improving the quality (i.e. patient safety, experience and clinical effectiveness) of care, but the paucity of nursing research specifically in this area of practice is notable.

It is not disputed that technical skills are within the capability of nurses and are an important consideration. However, this study suggests attention is paid both by paediatricians and nurses to the clinical medical examination component of the child's 'journey' at the expense of less well defined areas of psychosocial and health care needs. The development of advanced nursing roles compatible with the DH (2010) guidance '*Advanced level nursing: a position statement*' provides a framework through which the improvement of care in the Centre might be enhanced. In four key headings the document outlines the means by which advanced nursing can impact on practice. The themes are:

- Clinical/ direct care practice
- Leadership and collaborative practice
- Improving quality and developing practice
- Developing self and others

Whilst there is a clear role for an advanced nurse to undertake physical examination of children, the ability to engage and influence nursing and medical colleagues as well as those from other agencies may be fundamental to achieving a more child centred approach in the Centre. Stepping out of a traditional 'supporting the medical model' roles require individual knowledge and

expertise, but is also dependent upon an organisational culture that supports transformational change as described by Goleman (2002) and others.

The potential for advanced nursing roles as outlined by the DH in 2010 is further supported by the RCN (2010, 2012) and the development of competences and standards for educational establishments to enable practitioners to access relevant programmes of education. Gobbi's (2004) construct of nurses as intellectual and technical bricoleurs, who use the domains of philosophy, psychology, sociology and anthropology to meet the needs of individual patients assists in visualising the many ways in which advanced nurse practitioners may be of value, not only when families attend the Centre, but also to assist those who were described as 'floundering' following their attendance.

In the USA Patterson and Campbell (2009) explored paediatric forensic nurse examiner roles and it is interesting that they suggest nurses may be valuable in establishing a comprehensive health history (including when it is not clear if sexual abuse has occurred), carrying out health assessments and 'tracking' children through a multiagency pathway post attendance to ensure their needs are addressed in a coordinated way. This study has highlighted these as important areas requiring attention as many children and young people presented with vague histories where preceding events were not immediately clear. Nurses who are skilled in enabling children to feel at ease, obtaining a history (whilst not compromising any police or social care processes), liaising with other professionals and, in the post attendance period, ensuring children and families receive a co-ordinated response, may assist in overcoming some difficulties highlighted in this study.

A focus on preventing escalation of need in a potentially vulnerable group of children and families is consistent with a public health, preventative role as discussed in 6.4. In summary, development of advanced nursing roles for this sphere of practice appear to be a largely untapped resource in terms of potential to ensure children and families' needs are responded to sensitively and effectively.

6.6 The emotional impact of the work

The cumulative impact of working with vulnerable children and families was evident for several professionals who described a number of techniques they had developed for managing emotional demands. This is not unusual for professionals who are engaged in front line protection work. Figley (1995:7) describes secondary traumatic stress as 'the stress resulting from helping or wanting to help a traumatized or suffering person'. Despite acknowledgement of the stressful

nature of the work in the Centre, none of the interviewees appeared to be feeling any sense of 'burnout' which Maslach (1982:3) describes as 'a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind'. Conrad and Kellar-Guenther (2006) suggest that 'compassion fatigue' is a form of secondary traumatic stress which may be mitigated by 'compassion satisfaction' where workers experience satisfaction and benefits from the work they undertake and this may be a factor that sustains professionals in the Centre.

None of this study's interviewees described any form of professional support provided by their employing organisation, although one paediatrician did refer to the important role of peer review (an essentially educational forum for paediatricians to discuss and learn from clinical cases). The interview schedule did not contain a prompt on this issue and it was not a subject that was specifically discussed during interviews. However, there were no apparent mechanisms by which practitioners who work in the Centre received supervision on a multiagency basis. Neither was there evidence of any formal system through which the emotive nature of the work was acknowledged. Much has been written about the importance of clinical supervision within the NHS (e.g. Care Quality Commission 2013) and Munro (DfE 2011a) emphasised its important role in maintaining frontline social workers. The extent to which individual professionals accessed supervision was not explored, but it was notable that informal, personal mechanisms were described by several interviewees.

In terms of alleviating the emotional demands, the principles of normative, formative and restorative supervision (Driscoll 2002) appear to provide a reflective model through which some of the difficulties encountered by the multiagency professional forum might be addressed. Use of such a model enables a focus on emotional resilience through the restorative function, a focus on professional development needs through the formative function and the normative function might helpfully assist the more formal procedural and practice difficulties to be considered and addressed.

6.7 Conclusion

This chapter has presented a discussion of the findings to assist in understanding 'what is to be made of it all?' (Wolcott 1994). In the final chapter, the conclusions, implications for practice, impact, strengths and limitations of the study are discussed. Also, the method by which findings will be disseminated and areas for further research are presented. Personal reflections on the research are also discussed.

Chapter 7: Critique of the research approach and conclusion

7.1 Introduction to the chapter

This study aimed to explore the role of a specialist centre in providing a multiagency response to children and young people who may have been sexually abused. Through the use of case study research and greater clarity about the reality of its day to day functioning this has been achieved. In this chapter the conclusions from the study and implications for practice are considered. The local application of the study, and the way in which findings have, or will be disseminated are discussed. Personal reflections on the study are presented in the context of the clinical doctorate programme which requires researchers to influence clinical practice in the light of new knowledge and to provide leadership within the field. Unsurprisingly, given the complex role of the Centre, additional questions have been identified which might usefully be the subject of research in the future. Bogdan and Biklen (1992) refer to the problems, joys and dilemmas of the research process, and this phrase usefully encapsulates some of the issues included in this final chapter.

7.2 Conclusions from the study

The aim of the study, to explore the role of the Centre in providing a multiagency response to children and young people who may have been sexually abused, has been achieved. Through the application of case study methods it has been possible to answer the research questions that were posed. Stake (2005) and Simons (2010) acknowledge that within case study research, as clarity is achieved about some aspects of the case, new questions emerge. Hence, recommendations for further research are made in section 7.6.

This study has demonstrated the complex demands of a child protection 'system' in operation. Professionals, whilst attempting to work together and maintain a focus on the best interests of the children who attend the Centre, are nevertheless required to complete 'their' part of the process. Review of the literature and findings from this research suggest that some component parts of that process require greater critical scrutiny.

This study, in common with others (e.g. Hansen et al Patterson and Campbell2009, Sugue-Castillo 2009), found that a small proportion of cases proceeded to court and when they did, it was not clear to what extent, if at all, findings from the medical examination were influential. The medical examination (including ano-genital examination) did, however, form a routine component of every child's attendance at the Centre. The primary function of the Centre to serve medico-legal purposes was therefore questionable. This study suggests that a much greater focus on the health needs of the child and his or her family functioning is indicated. Two thirds of the children (n=60)

who attended the Centre had an unmet health need identified during their health assessment, and 46% of the children were still 'open' to the children's social care department six months after their attendance. This finding suggests that childhood neglect is a significant risk for the children who attend the Centre following suspected or actual sexual abuse. Attendance should not therefore be viewed as an isolated event, but one which is considered in the light of the family's known history and functioning, and which prompts health and social care professionals to work with families to prevent children experiencing further escalation of risk or need. To assist this process, the documented findings from the comprehensive health assessment that takes place in the Centre should be available to those health professionals who continue to work with the family in subsequent months.

To achieve this approach, whereby the visit to the Centre is viewed as an opportunity to initiate preventative work as well as an abuse 'diagnostic unit,' may take a radical cultural change for professional agencies. This study demonstrated inherent tensions between professionals who believed a 'medical examination' would confirm or refute that sexual abuse had occurred, and those who believed their primary role to be the delivery of an holistic health assessment in order to identify the child's health needs.

The evolution of children's centres based on adult SARCs may account for this tension. The focus on ensuring compliance with police forensic requirements was a predominant concern when the Centre opened. If criteria set by some SARCs had been introduced in the Centre, whereby referrals are limited to those children who have made a clear verbal disclosure of sexual abuse, a large number of children who were assessed in the Centre would have been denied a service. By accepting referrals of very young children and children where there may be vague or unsubstantiated concerns about sexual abuse, it is implied that the Centre will respond appropriately to their needs. To ensure that services are appropriate for all children's needs will require all partners who work in or with the Centre, from strategic leaders to frontline workers, to develop a shared, integrated vision for its future.

7.3 Implications for practice

As Rolfe (1998) argues, valid research should assist nurses to work more intelligently and skilfully in practice, and it is intended that this thesis should inform and thereby improve clinical practice. As the study focused on a multiagency area of practice, it identifies some issues for professionals from all agencies involved with the Centre. As a health sciences doctorate, undertaken by a nurse, the greatest insight is perhaps into the potential for enhanced nursing practice. In this section the implications for practice as discussed in the sections above are summarised:

1. The physical environment of the Centre provides a 'child friendly' facility that promotes interagency co-operation and it should continue to be developed and improved.
2. Whilst in the Centre, children, young people and families should be actively enabled to participate in informed multiagency decision-making. Their participation should be actively enabled in a way that is cognisant of the diverse nature of the community and therefore responsive to cultural and racial identity and issues of physical or learning disability. Children's needs are paramount but, it also recognised that in some circumstances, the welfare of children is promoted through supporting parents and carers.
3. Many of the difficulties encountered by professionals may be reduced by an integrated approach to improving outcomes for children. This may be assisted through the development and routine use of shared, multiagency outcomes measures in the Centre. This should include the following principles:
    - Health and social care outcome measures should be included (not just criminal justice)
    - Children, young people and families should be involved in the development of the measures
    - Routine multiagency data collection and information sharing processes should be introduced to better inform professionals about the outcomes of their work (e.g. outcomes of legal proceedings).
4. There should be greater transparency by professionals about the purpose of the medical examination (or health assessment). The likelihood of medical evidence being obtained and its potential uses should be explained, as should the concept of the examination being carried out to provide 'reassurance'. The optimum timing of the examination (in the child's best interests) should also be considered.
5. Holism of health assessment will be achieved only if findings are used effectively to inform longer term health care planning.
6. The role of the medical examination (or health assessment) following suspected childhood sexual abuse may be poorly understood, not only by police officers and social workers, but also non specialist health professionals. This topic may therefore be usefully included in induction or education programmes for professionals, particularly those whose role will bring them into contact with the Centre.
7. Post attendance follow up should be co-ordinated. Where children and young people do not meet the criteria for on-going input from police or social care agencies, their needs should nevertheless be assessed to enable the provision of preventative intervention. The

nature of such interventions will be dependent on levels of unmet health or social care need, but all interventions should be based on the 'strengthening families' approach.

8. The potential for developing advanced nurse roles to lead co-ordinated services that support the longer terms needs of children and families should be explored.
9. A multiagency supervision model should be introduced to meet the needs of the professionals who work in the Centre. This should acknowledge and respond to the emotional demands of the role, identify professional development needs and also assist in resolving day to day practice difficulties.

In addition to the implications for practice that arose directly from the study, some additional contextual factors were identified. Prevalence rates of childhood sexual abuse (Radford et al 2011) indicate that the NHS should adopt a systematic approach in its response, not only to the long term mental health sequelae (e.g. Allnock and Haynes 2011) but also to children and young people who are suspected of being 'acute' victims of sexual assault. The important role that non specialists play (such as GPs and health visitors in the NHS or school teachers in education services) both in making referrals to police or social care and in the post attendance period was visible. However, experience suggests that training and education about sexual abuse in children is scant among non-specialist NHS staff and may be similarly limited in other agencies. This study suggests education and awareness of all professionals who work with children is important in ensuring they receive skilled, well informed care at this stage of their experience.

Data obtained from the patient satisfaction questionnaire for research question 3 were limited in value although they did indicate that, for some children, the attendance at the Centre was not as negative as might be envisaged by outside audiences. In developing ways that children and young people's participation may be encouraged in the Centre, more creative use of technology could be explored. With an exponential increase in the use of technology during the 21st century, it may be argued that children and young people themselves should advise the Centre on the optimum use of information technology and other means of communication and engagement. In considering such issues, those children who may have additional language or communication needs should be included.

7.4 Local application

Almost inevitably, given the time taken to complete the study, as well as successive reorganisations of the NHS, my role changed during the course of the research. Having moved from a 'provider trust role' into a 'commissioning role' (albeit in a 'safeguarding children advisory role') there may have been an inclination if this research had not been completed, to accept the

Centre as a positive development in providing a specialist multiagency response to children at a time of need, without greater scrutiny of its complex role. As a commissioner it is essential to acknowledge that practitioners, such as the interviewees for this study, who work 'in the front line' are a source of expertise who are well placed to advocate on behalf of their clients or patients (as described by Rolfe 1998).

The concept of clinician driven commissioning underpinned the development of clinical commissioning groups in the Health and Social Care Act (HM Government 2012). However it is important to ensure that the contribution of nurses, other professional groups and service users is not lost in the potentially medically dominated structure of clinical commissioning groups. This section provides a review of local commissioning activity which has been influenced by this study.

The drive for 'integration' of services might once have appeared to be a national initiative unlikely to yield the benefits claimed by its proponents. However, this study has provided an illustration of how working in professional silos may impact not only on those who receive services, but also on those who deliver them. In practice, several recent local developments have confirmed that it is possible to overcome silo working and to share multiagency outcome measures. For example, the multiagency safeguarding children hub and a newly developed framework for the delivery of services for victims of domestic violence service have both been predicated on the principle that service users require a 'joined up' approach from professionals, regardless of their employing organisation. The success of these services will be judged on service user feedback and jointly agreed outcomes, a concept that only a few years ago might have been thought impossible. It is timely therefore that this study is being concluded as the service specification for the Centre requires review and renewed agreement between the provider trust and commissioning organisations. Knowledge gained from this study in terms of involving front line staff, developing shared multiagency outcome measures and a much greater focus on children and families' participation in the Centre will be applied to that process.

Godar (2013), in reviewing the commissioning of services for children and families suggests:

'The skills required of commissioning teams include those required of social researchers: those knowledge and skills that support the application of research findings and methods to investigate new research questions. Where commissioning teams go beyond the work of researchers is in applying those findings to real-world situations in which the decisions taken are funded by the public purse and have an impact on the lives of children and families. It is even more important then that commissioning teams have a clear set of values that guide their work alongside technical knowledge and skills'

(Godar, 2013:10)

This study has emphasised two important values that commissioners must apply to all services. Firstly, children must be enabled to actively participate in making decisions that will affect them and are in their best interests. Secondly, multiagency working is a complex phenomenon which cannot be achieved simply by locating professionals in a building together and asking them to 'work together'. To ensure these values remain central to health service activity will require sustained focus as a process of democratisation takes place and children and families play a leading role in influencing service design.

Clinical commissioning organisations have potential to influence these developments. For example, requirements for NHS organisations to ensure participation of children and families and to demonstrate evidence of the way in which this has been achieved may be included in service specifications and contracting arrangements between commissioners and provider organisations. To avoid tokenistic approaches, performance measures for participation must be developed. Importantly though, as Godar (2012:80) points out, it is necessary to be aware that tensions may arise between the aspirations of commissioners to achieve this aim and the realities of service delivery, particularly at a time of continued 'austerity' for health services.

Pressures within day to day frontline practice are apparent in many NHS services. Godar (2013) suggests commissioners should set out clearly the local intentions for services and define their desired outcomes and preferred model of practice. In asking organisations that deliver services to undergo a change process, she suggests it is important to engage with frontline staff and to offer assistance such as training and support for innovation, or for reaching 'hard to reach' groups. As a multiagency facility, achieving change within the Centre will require engagement with professionals at a senior strategic level as well as those who work in frontline practice in police, social care and health services. As Fulton (2012) suggested, the clinical doctorate, in developing 'credible leadership', may assist in facilitating this process which will require influencing decisions made by senior managers as well as demonstrating insight into the day to day reality of the Centre. As the Health Foundation (2012) suggests, an approach based on 'quieter' leadership in which inclusion, explanation and general education are promoted, is effective in overcoming tribalism within organisational contexts. Case study research methods, it may be argued, can be applied in day to day practice to support this leadership style.

Financial considerations arising from these recommendations are minimal, although some specific training and educational programmes may need to be commissioned. To further develop advanced nursing roles within the Centre will require financial investment. Enabling professionals

to promote meaningful participation by children and families may also require additional development programmes to be funded.

Although a recent requirement by the LSCB for all member agencies to adopt and implement a set of 'Safeguarding Supervision Principles' arose following several local serious case reviews, the importance of 'maintaining' practitioners who work in the front line has been demonstrated through this study. In order to promote safe and effective practice, clinical commissioners of health services will further emphasise the importance of reflective supervision by including requirement for adherence to these LSCB principles in contractual arrangements with health provider organisations.

Electronic recording systems have been introduced within recent years for some health services that are delivered by the trust that hosts the Centre. Child protection medical files continue to consist of paper records but there is a means by which the existence of the file can now be flagged to health visitors and school nurses on the electronic system. This does not enable the content of the record to be directly accessed and is therefore of limited value, but does mark a small degree of progress. Commissioning organisations will continue to promote the use of a single patient record.

7.5 Disseminating findings

Findings from the study will be disseminated in a number of ways as it is important to continue to remember Simon's (2009) assertion that audiences have differing interests and curiosities.

A brief summary of key findings from the study will be provided to interviewees who participated in the study. Similar summaries of findings will be presented to local audiences both within the NHS and in multiagency forums such as the LSCB. In some situations the purpose of sharing findings is 'for interest' but for the LSCB (and the policy and practice committee in particular) there are important policy issues to be addressed. Some findings within this study (such as the need for greater focus on children's experiences and the drive for greater service integration) are reflective of numerous other studies. It is intended that this specific study with its local focus will provide some impetus to local multiagency partnerships to drive the required changes forward.

An abstract for the British Association for the Prevention of Child Abuse and Neglect (BASPCAN) congress in 2015 has been accepted and a relevant paper will be submitted for publication in Child Abuse Review, the organisation's academic journal. The choice of the congress of the British Association for the Prevention of Child Abuse and Neglect to present the findings is significant. As an interdisciplinary organisation that reflects the diverse professional make up of its members, it

assists in overcoming the discipline specific nature of child protection practice. However, as previously discussed, it is possible that the medical profession's 'moral authority' that appeared to contribute to some professional isolation for paediatricians, may also contribute to judgements being made about the role of a nurse researcher in challenging established medical practice. It will be important therefore to be aware of potential challenges.

7.6 Areas for further research

The study identified a number of areas that may benefit from further inquiry. Most obviously, research that is based on children's and families' experience of the multiagency response to childhood sexual abuse is indicated. A project designed to enable participation of children and their families, and conducted by researchers representing multiagency and multidisciplinary professionals has the potential to provide deep and rich insight.

Ethical debates about participation of children and young people in research studies continue. Spencer et al (2014) undertook a small scale study in England which explored young people's views of participating in clinical research. The study demonstrated that young people do wish to participate in research studies with the provisos that researchers adopt a personalised approach and recognise their individuality; keep them fully informed throughout the course of the study and value their contributions. The authors debate the difficulties associated with children's competence to provide informed consent (as opposed to passive assent) and degrees of autonomy. The vulnerabilities of those children who attend the Centre contribute to additional levels of complexity in undertaking research with children in this sensitive area of practice. Arguably, children's wishes as identified by Spencer et al (to be treated as individuals, to be kept informed and to have their contributions valued) provide valid guidance for all professionals who work with children, not just potential researchers.

As discussed in 6.3.2., it is difficult to ascertain the role that medical evidence (or its potential availability) plays in criminal justice proceedings for alleged child sexual abuse. White (2014) suggests in a summary of early findings from a review of children who have undergone medical and forensic evaluation, that it is the holistic needs of the child that are paramount, not just the focus on forensic aspects. Greater understanding of the relationship between medical examination, findings and criminal justice outcomes for children is required in order to advance knowledge in the field and a collaborative approach to this area of work across the UK should be advocated.

The extent to which non specialist professionals, particularly GPs, health visitors or school nurses have the required level of knowledge or expertise to feel competent to talk to children and families about sexual abuse remains an area of interest at both local and national level. While a recommendation has been made that training and education should be made available to this important group of health professionals, research that explores this might inform the development of effective education programmes on this subject would be of value.

7.7 Strengths and limitations of the research approach

This section critically analyses the strengths and limitations of the case study approach for this study. Case study research as a means to explore 'what is going on?' was a credible approach and findings have usefully enabled the unique nature of the case, a clear aim of intrinsic case study (Stake 1995), to be better understood. The approach was also valuable, as a study of clinical practice, in addressing the 'what is to be made of it all?' question (Wolcott 1994). Sufficient clarity was achieved to enable recommendations, intended to enhance practice to be made.

Critics of the case study approach cite 'subjectivity' as a problem. The subjective nature of qualitative inquiry in general and Stake's intrinsic case study approach in particular, has been discussed in this thesis. The view that phenomena that are experienced subjectively should be researched in a way that promotes subjective ways of knowing is well established, but not without critics. In conducting a study that would allow 'depth, detail, richness, completeness and within-case variance' (Flyvbjerg 2011:314) to be its strength, I consciously rejected a positivist approach that might have attempted statistical significance or generalisation across several settings. However, in making this decision I was aware of a continuum of subjectivity and wished to avoid constructing meaning that might only have personal relevance. As previously described, I had experience of working as a nurse within child protection services and had 'insider' status due to employment within the health trust that provides services in the Centre. I was aware that although it can be valid to conduct a 'personalistic' study, Stake (1995:46) suggests some researchers can fail to apply 'stiff enough tests' to 'subjective misunderstandings'. Aware of the audiences which I hoped would be interested in (and possibly influenced by) the study, I judged a highly personalised study, written solely from my own perspective, to constitute a politically naive choice that risked alienating those whom I most sought to influence. Acknowledging my own subjectivity, in which personal intuitive experience and knowledge were motivating factors in undertaking the study and guiding its progress (Lincoln 2011), I aimed to position myself as 'impartial observer' (Simons 2009:37) in relation to the research. Throughout the course of the study reflective diaries and discussions assisted in maintaining a balance between the subjectivity

of personal, professional interests and perspectives with that of being 'open' to the experiences and understanding of others who participated in this study. I also wished to avoid adopting an overtly subjective stance which might invite participants to concur with critics who suggest that case study has 'a tendency to confirm the researcher's pre-conceived notions' (Flyvberg 2011:309).

The decision to adopt an impartial observer role (Simons 2009) continued to feel appropriate as the study progressed and was completed. It was designed in a way that might help to overcome the discipline specific nature of some of the research community and this has been achieved. Appropriately however, given the subjective nature of the constructivist paradigm the nursing 'stance' is clearly apparent throughout the study. The relationship between the researcher and the case cannot be entirely impartial and should a police officer, social worker or paediatrician replicate the study design in the future, their findings may equally reflect their unique professional interests.

One limitation of this study was the difficulty in accessing the views of children and families due to complex ethical considerations. It is difficult to find a balance between a non-paternalistic, inclusive approach to research with children and families where abuse has occurred, and the risk of causing emotional distress to participants. Higgs and Finlay (2014) undertook a study aimed to investigate young people's views on being copied in to physician's correspondence following a child protection medical examination. They believed the restrictions placed on their study by the ethics committee to be influential in the low response rate (17.1%) that was achieved with no responses received from young people at all. The authors suggest that a wider debate about such complex ethical issues is required and also comment that several members of the Research Ethics Committee stated that 'they felt 'anxious about child protection research' per se' (p380).

Whilst planning the design for this study the ethical difficulties associated with approaching children with a view to asking them to participate in an interview about their experience at the Centre were debated with supervisors and academic staff, and it was agreed that the risks of causing harm were too great. The decision to use the patient satisfaction questionnaire as a means by which relevant data may be gathered was therefore, a pragmatic choice. However, as the study progressed it became apparent that positive comments contained in questionnaires did not triangulate with data from interviews with professionals in which the distress and anxiety of some families was described. Neither did the patient satisfaction form reflect views of those who may have had language or communication barriers which, as evidence suggests, may be a group that is over-represented among those who attend the Centre.

Also, as section 3.8.2 describes, there were some difficulties in the initial stages of the study when the role of the Centre was expanded to provide services to children where any form of maltreatment (not just sexual abuse) was a concern. This change in function of the Centre impacted on the availability of data for research question three as it was not possible to ensure that completed evaluation forms reflected the views of children whose reason for attendance was principally in relation to potential sexual abuse. Although the evaluation forms were subsequently colour coded to enable the reason for attendance to be distinguished, the newly designed forms no longer contained a statement about their potential use for research purposes and consent was therefore implied rather than explicit. These difficulties highlighted the importance of ensuring that the practicalities of the study are considered and that effective communication takes place with professionals and other staff working within the service.

As Simons (2009) suggests, some audiences may perceive this study as an evaluative tool. The desired outcomes for children and young people are problematic to define, let alone measure and the decision to avoid an evaluative approach was, on reflection, correct. Nevertheless, in studying the Centre for interest's sake, a number of areas in which improvements in practice might benefit children and young people have been made. These areas may not have been identified if an evaluative approach, in which those factors that are most easily 'measured' (such as criminal justice or medical outcomes) had been the specific focus. Case study research is accessible to researchers whose principal role sits outside the research community. Parlett (1980) argues the accessibility of case study methods contribute to the democratisation of research practice in the same way as knowledge acquired through research itself. This accessibility, combined with the principles that underpin clinical doctoral study, have been enabling factors in generating knowledge that has value for day to day practice. The skills gained through undertaking a study of this nature have also enhanced my professional identity. This may be an influential factor in the process of implementing recommendations, where the credibility of the researcher (Fulton 2012) to speak and act authoritatively is important.

7.8 Personal reflections

This clinical doctorate pathway commenced in the autumn of 2006 and to provide a succinct account of the influential events, advances and setbacks that occurred over a period of eight years presents a challenge. However, the researcher plays a central role within qualitative research and it is important to demonstrate the reflexive nature of the research process and to consider not only the impact of the researcher on the study, but also the impact of the study on

the researcher. This section therefore presents a reflective account of the research process itself and the relationship with the modular elements of the programme.

A striking change that occurred slowly and imperceptibly over a period of time was the change in my attitude to the research study. Initially I perceived it to be an endless set of separate tasks that must be completed and 'ticked off'. It was not possible to see how any 'task' related to another. A specific example of this is the application process for ethics approval from an external committee which I perceived to be a bureaucratic, administrative task to enable me, as the researcher, to achieve my aim of undertaking the study. As data collection and analysis stages progressed the nurse researcher's duty to protect the confidentiality, privacy and dignity of 'participants' became very clear. My privileged position as a professional researcher became apparent as did the relative powerlessness of not only children and families, but also some professionals. Consequently, the potential for nurse researchers to act as advocates for participants became evident during the course of the study and it is hoped that this thesis reflects that change.

The personal change has not therefore solely consisted of gaining additional knowledge and research skills, although their value is inestimable particularly when combined with those acquired through in- depth study of leadership, governance and decision making models. The modular elements of the clinical doctorate pathway are valuable in enabling researchers to apply new knowledge in the 'real world'. The complex, political nature of the health service poses inevitable challenges for those who wish to influence or lead change for the benefit of service users. The knowledge that complexity is inevitable combined with a focus on my own leadership style, has contributed to the development of greater professional confidence and resilience. That resilience has enabled some potentially difficult challenges to be overcome in my professional life as a member of a clinical commissioning group.

The '6Cs' (DH 2012), as outlined in section 6.5.2, had equal resonance for my research and commissioning roles and increasingly the boundary between these roles has become blurred. Competence and confidence that have developed through the clinical doctorate programme are applied to my day to day commissioning role. Commissioners are frequently required to plan or re-design service provision with little or no contextual information to enable informed decisions to be made. Recently I have had opportunities to apply principles of qualitative case study research methods to several small scale case studies that have been the subject of commissioning attention. The value of seeking differing perspectives and actively listening to the views of, not just children and families who receive services but also the professionals who deliver them, has

been invaluable. Frequently however, this approach requires me to challenge the status quo of established health service delivery. The requirement for all of the 6Cs, but most particularly 'courage' to be employed in both my day to day commissioning role and in my nurse researcher role has become apparent. Practising openly and advocating on behalf of patients to improve their quality of care therefore requires a set of personal values and attributes. These personal values have parity with the knowledge and skills gained through undertaking the clinical doctorate programme. Simons (2009:82) refers to the meaning of self as 'that inner sense of knowing who we are and how we define what is important to us – those values, emotions and the ways of thinking and being that affect how we live and act'. As she describes, it is not possible to separate the 'research self' and the 'personal self'.

7.9 Conclusion

The vulnerability of children to sexual abuse has become increasingly clear to non-professional audiences in recent years as the media has provided coverage of celebrity 'scandals' and sexual exploitation of children by gangs and groups. Arguably, this type of high profile publicity may distract from the day to day reality for many children of being sexually abused by parents, siblings, family associates and relatives.

This study provides insight into the multiagency activity in a specialist children's centre that provides services for these children. It demonstrates some limitations of modelling children's services on those that have been positively evaluated for adult victims. Children may present with unclear histories of sexual assault and are less able, for a number of reasons, to contribute to decision making about their care and management. Their legal status and potentially complex relationships with family and friends may contribute to circumstances in which they appear relatively powerless. Although policy drivers place great emphasis on encouraging children and young people's participation in decision making about their own care, this study suggests that professionals may, at times, become distracted by the demands of the multiagency system within which they operate. It is important that the advantages of multiagency working do not, in themselves, hinder the provision of child centred services.

Recommendations for practice arising from this study have been presented. Although the study involved a single site, some findings may be of value for other similar services. In common with numerous other studies, the need for a relentless focus on children's experiences has been highlighted. This message accords with policy directives that were in place at the time this study commenced and yet it continues to prove problematic for professionals to implement. As the

national focus on the integration of services continues to gain momentum, this study may make a contribution to the growing body of evidence that supports that aim.

A need to develop greater knowledge of the needs of children in the acute aftermath of suspected abuse is indicated. The current 'medicalised' or 'diagnostic' focus of the NHS with a particular emphasis on interpreting ano-genital findings for children seen at the Centre appears to contribute to meeting only a small proportion of children's needs. In attempting to provide an integrated and holistic approach to children and families, both in the acute phase and in any follow up period, nursing roles may provide a currently untapped resource. However, all service development should be predicated on the views and experience of children and families, and dogmatic recommendations have been deliberately avoided.

The study has achieved what it set out to do, which was largely to understand 'what is going on?' in a specialist centre and importantly, in addressing 'what is to be made of it all?' implications for practice have been presented. Professionals' understanding of the experience of children for whom sexual abuse is a reality must continue to be developed. It is hoped that this study will support improvements in the response to those children and their families.

Appendix 1: Significant events in relation to child sexual abuse in England

1948 Children Act and Children's Departments were formed

1962 Kempe et al published evidence relating to 'the battered child'

1974 Maria Colwell inquiry following her death from physical abuse, which later resulted in the formation of Area Review Committees whose function it was to co-ordinate child protection work, assessment of children at risk by means of case conferences and registers of children considered to be at risk of abuse.

1973-

1981 26 inquiries into child deaths and serious abuse.

1985 Jasmine Beckford Inquiry Report (Brent 1985) resulting in draft guidelines for improving inter-professional co-ordination. Statutory responsibility placed on local authorities to act on behalf of children. Social work departments were given the main responsibility for co-ordinating work to protect children. There was a steep rise in the numbers of children whose names were placed on child protection registers.

1987 Cleveland – 121 children taken into care following paediatricians' diagnosis of anal abuse, using the reflex anal dilatation test. Police and police surgeons refused to work with social workers who they believed were overzealous in removing children from their families, with no supporting social evidence. Children were sometimes medically examined on several occasions as medical staff disagreed about significance of findings.

1988 The Report of the Inquiry into Child Abuse in Cleveland (Butler-Sloss 1988). Acknowledged child sexual abuse is a widespread phenomenon and must remain on the social policy agenda.

1989 The Children Act (HM Government 1989). Provides the framework for the care and protection of children. Principle of the child's welfare being paramount was embedded in law.

1991 New Working Together Guidelines (Department of Health 1991). Agencies and professionals to work together in a measured, planned and co-ordinated manner.

The Orkney case – children removed from their family following suspicions of ritual or satanic abuse. No contact allowed with their parents for a further 6 weeks and subjected to repeated interviews. Concerns about 'over zealous' social workers.

1992 Memorandum of Good Practice (Home Office 1992). Police and social workers should jointly investigate allegations of serious abuse. Video interviewing should be used to reduce requirement for children to appear in court.

1997 Sexual Offenders Act (HM Government 1997): convicted offenders need to register with the Police and keep them informed of their whereabouts.

1999 Working Together to Safeguard Children (Department of Health 1999): updated version.

2002 Royal College of Child Health and Paediatrics and Association of Police Surgeons (RCPCH&APS 2002) guidance on paediatric forensic examinations in relation to possible child sexual abuse published.

2003 Publication of Victoria Climbié Inquiry Report (HM Government 2003): resulted in a complete overhaul of child protection services from practitioner level to Government.

Sexual Offences Act (HM Government 2003): made 'grooming' an offence as well as paying for the sexual services of a child or causing or inciting child prostitution.

2004 Children Act (HM Government 2004): underpins the Every Child Matters programme and requires Local Safeguarding Children Boards to be established.

Royal College of Paediatrics and Child Health and Association of Forensic Physicians (RCPCH&AFS 2004) Guidance on paediatric forensic examinations in relation to possible sexual abuse guidelines published.

2006 Working Together to Safeguard Children (HM Government 2006) published – children's involvement in the production of on line images is included in the definition of child sexual abuse.

Child Protection Companion (RCPCH 2006) published.

2007 Cross Government Action Plan on Sexual Abuse and Violence published (HM Government 2007) requiring agencies to prioritise working together to improve services and outcomes for child and adult victims of sexual crime.

Royal College of Paediatrics and Child Health (RCPCH 2007): interim guidance on interpreting signs of sexual abuse in pre-pubertal children published.

2008 Royal College of Paediatrics and Child Health (2008) guidelines regarding best practice regarding physical signs of child sexual abuse published.

2009 Laming Report on the state of child protection in England published following the death of 'Baby P'

2011 Munro Report on the child protection system in England published

2012 Celebrity abuse becomes a prominent subject e.g. Jimmy Savile receives media attention

2013 Sexual exploitation of children by gangs is highlighted in the media e.g. Oxford, Rochdale.

2014 Independent inquiry into scale of historic sexual abuse announced by Home Secretary

Appendix 2: Literature review – summary of all papers

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
Adams et al	2007 USA	To develop guidelines for performing and interpreting findings of medical evaluation undertaken as part of child sexual abuse assessments.	Expert physicians critically analysed research studies, medical and laboratory findings and participated in focus group discussions.	Established 'best available evidence' at that time. Contributed to consistency in terminology for some clinicians. Recommendations made about required competencies in the field of child sexual abuse evaluation.	Requires continuous revision in the light of new research findings.
Allard-Dansereau et al	2001 Canada	To study maternal perceptions of children's responses to medical evaluation of alleged sexual abuse.	50 children (38 girls, 12 boys) aged between 4 and 12 years were medically examined following allegations of sexual abuse. Their mothers were interviewed 6 months after the examination and rated their perceptions on a 3 point Likert scale.	Mothers reported a negative influence on their child in 24.5% and a strong negative influence in 6.1%. Pain associated with examination, child's age, gender and fear of ordinary medical visit did not contribute significantly to the prediction. Fear of hypothetical second examination increased with fear related to the examination and	Authors suggest medical examination may provide reassurance. Video-colposcopy may provide comfort and 'demystification' as the child can observe the monitor. Physician's empathy is an important factor in reducing stress. Children were not directly

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
				decreased with a perceived higher kindness of the doctor. 62% of mothers felt reassured about physical integrity of their child.	interviewed.
Campbell et al	2010 USA	To examine the role of paediatric forensic nurse examiners' rate of documenting anogenital injury and to identify what factors predict the presence of such injuries.	Records of 203 children aged less than 14 years who had received a forensic medical examinaitn by a forensic nurse examiner for sexual assault /abuse were retrospectively reviewed.	39% of cases had anogenital injury. Those victims who had suspected vaginal or anal assault were more likely to have injury. Inexperienced nurses were more likely to document positive findings.	Raises issue of training and competence of examiners.
Cheung et al	2004 Hong Kong	To examine relationship between colposcopic anogenital findings and overall assessment of CSA	Prospective study of 77 children aged 6 months-16 years, mean age 6.5 years. Colposcopic findings categorised as normal/non-specific/concerning for abuse/clearly abnormal and correlated with likelihood of	Anogenital findings were normal for 45% of patients, non- specific in 29%, concerning for abuse in 13% and clearly abnormal in 13%. Clearly abnormal findings are helpful in confirming definite abuse.	The sample included historic and acute referrals for colposcopic examination and so results are difficult to compare.

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
			abuse: no evidence of abuse/possible abuse/probable abuse/definite abuse.		
Davies et al	2000 New Zealand	To ascertain children's and non-offending parents perceptions of the child sexual abuse investigation process including social work intervention, early police responses, evidential video units, medical examinations, access to therapeutic services and the way the interventions linked together.	51 children who had made clear disclosures of sexual abuse and 124 primary carers were interviewed. The interviews recorded perceptions of social work intervention, early police responses, video units and medical examination, access to therapeutic services and the way these interventions link together.	The majority reported positive experiences but some reported problems with delays, interagency collaboration and provision of information, support and therapeutic services. Many carers had difficulty in supporting their children without support for themselves, particularly those with a commitment to the alleged perpetrator or where they had their own history of abuse.	Small sample size and non specific reporting of results are a limitation of this study.
Hansen et al	2010 Denmark	To examine the influence of medical findings for sexually abused children on police investigation and legal outcome	482 children's medical records, police reports and court decisions were retrospectively reviewed.	482 children's cases were reviewed. 440 children's legal outcomes were known. Abnormal findings were present in 38% of girls and 20% of boys.	Perpetrator confession, older age of victim and duration of abuse appear to be more significant predictors for legal

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
				190 cases were prosecuted in court and 165 of the accused were convicted.	outcomes than medical findings.
Heger et al	2002 USA	To compare rates of positive medical findings in children referred for evaluation of possible CSA, with two decades of research.	Case files of 2384 children who were evaluated for possible CSA were retrospectively reviewed. They were referred following disclosure of abuse, behavioural changes, exposure to an abusive environment and because of possible medical problems.	96.3% of children referred did not have abnormal findings.	Authors suggest research indicates that medical, social and legal professionals have relied too heavily on the medical examination in diagnosing child sexual abuse. History from the child remains the most important diagnostic feature. Even with a history of several abuse such as vaginal or anal penetration, the rate of abnormal medical findings is only 5.5 %
Hornor et al	2009 USA	To compare children's anxiety immediately preceding and immediately after the medical	175 children completed the Multidimensional Anxiety Scale for Children.	83% of children did not report clinically significant anxiety but those that did were more likely to	Clinicians should take steps to reduce children's anxiety.

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
		examination following suspected child sexual abuse		have a cognitive disability, to have experienced penetrative abuse or to have a chronic medical or mental health diagnosis. Also those without medical insurance were more likely to be anxious.	
Jones et al	2007 USA	To examine whether CACs improve caregivers and children's satisfaction with investigations	Caregivers and children were interviewed and completed Investigation Satisfaction Scale. 229 care givers and 90 children at CAC sites compared with 55 care givers and 30 children at non CAC sites.	Caregivers expressed greater satisfaction with CAC sites. Children expressed moderate to high satisfaction rates with both CAC and non CAC sites.	Where children did express dissatisfaction, areas such as feeling scared, receiving inadequate explanation or having to explain things too many times were cited. Limitation in sampling procedures as discretion of frontline practitioners was used to approach participants for involvement in study.
Kirk et al	2010 UK (Scotland)	To identify how medical assessment contributes to the	Case review of 848 children referred for medical examination following	67% of physical abuse cases had positive findings, 23% of sexual	Similar findings to this current research study, suggesting that attention

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
		diagnosis of child abuse	suspected abuse (both physical and sexual)	abuse cases had positive findings. 63% of children who were referred for possible sexual abuse had other health concerns identified.	should be given to unmet health needs of children who are suspected to have been sexually abused.
Marks, Lamb and Tzioumi	2009 Australia NSW	Aim to study the expectations and emotional responses of children and their parents to the medical examination. (personal beliefs that the examination further traumatises the child is the controversy that they wished to explore)	Prospective study of parents (stress) and children (pain scale) at tertiary referral centre. Children were aged >3yrs but upper age limit not provided. 71 children and parents consented. (64 girls, 7 boys) 35 aged less than 12 yrs, 36 aged 12 or older.	57% of parents expected the medical to be significantly stressful for their children and 17% found it to be so. 87% thought their child would feel pain, and 48% thought it was painful. 99% parents thought it would be stressful for their child. 66% of children reported feeling scared before the medical – if abused by someone within the family or living in the home, or going to be examined by a paediatric trainee then less scared.	Staff attitudes explanations and relationship between doctor and child has implications for training. Medical is less stressful than expected. Medical assessment for all children following allegations of sexual abuse are recommended. Not clear if anxiety scales used in the study was a validated tool.

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
Mears et al	2003 USA	To examine adolescents' responses to a medical examination including the use of video colposcopy conducted during an investigation of possible CSA.	77 girls aged 11-18 years participated. Prior to medical examination participants were assessed regarding anticipations of the examination, level of anxiety (using the State-Trait Anxiety Inventory), response to stressful situations using Miller Behavioural Style Scale and knowledge of reproduction and genital anatomy.	Post examination perceptions were significantly more positive than pre-examination anticipation although some aspects were embarrassing, painful or 'scary'. Anxiety significantly decreased post examination. Information avoiding coping styles were associated with positive anticipation of the examination but toward negative association with perception of video-colposcopy. There were no differences in relation to knowledge of reproduction from pre-examination to three month follow-up.	Adolescents generally reported the medical examination was beneficial. Feelings about the examination were significantly more positive afterwards.
Palusci and Cyrus	2001 USA	To clinically assess children's reactions to viewing videocolposcopy monitor during anogenital examination following	227 children completed the Genital Examination Distress Scale and	GEDs is a useful tool in identifying children's anxiety. Viewing monitor during anogenital examination may help	Findings regarding viewing videocolposocpy largely inconclusive.

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
		possible child sexual abuse		some children. Children who had positive findings were less likely to view the monitor.	
Palusci et al	2006 USA	To compare findings from children referred urgently to a community child advocacy centre with those seen non-urgently following possible CSA.	190 children under 13 years of age who were referred for urgent medical examination compared with those seen non-urgently with regard to physical findings, sexually transmitted infections, forensic evidence, gender, pubertal development, type of contact, reported ejaculation, bathing, changing clothes, time lapse before examination, gender, age, and relationship of alleged perpetrator.	Those seen urgently were younger, had more disclosures and more positive physical findings. Most children were female and had normal or non-specific physical examinations. Female children over 10 years who report ejaculation or genital contact without bathing have the highest likelihood of positive examinations or forensic findings.	There are potential benefits of early examination but the needs of the child and other factors need to be considered when determining the timing of medical assessment for CSA.
Patterson and Campbell	2009	Compare prosecution outcomes for child sexual abuse cases examined in a	None equivalent groups were compared. 157 children treated in the FNE group, 90	Prosecution rates higher in the FNE group. Penetration cases more likely to be prosecuted.	Useful commentary about quality of care issues when service delivered by nursing

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
	USA	FNE programme to comparison sample examined by non FNE (prior to FNE programme being introduced)	met sampling criteria. 58% of the group involved penetrative assaults. 52% of the group was not charged.		i.e. it is not just prosecution rates that improve (although prosecution rates for FNE likely to be higher due to the patient group that they work with)
Regan et al	2004 UK	To provide guidance for professionals who have a role in commissioning, organising or directly providing forensic examination for those who have reported rape or sexual assault.	A range of data were collected to evaluate the effectiveness of forensic nurse provision in improving responses to reported rape.	Forensic nursing can provide a cost-effective option to address delays in the provision of forensic examinations, increase the availability of female forensic examiners and also has potential to enhance professional standards.	Adult focused study and caution must be taken in applying findings to children.
Scribano	2010 USA	To evaluate anxiety during anogenital examination following suspected child sexual abuse	Multidimensional anxiety scale and genital examination distress scale completed by 175 children prior to and after medical examination. Medical professional's perception of the child's	17.1% of children reported significant anxiety prior to examination and 15.4% afterwards. Parental anxiety and the medical professional perception of the child's anxiety were also measured. The authors	Authors advise that parental and clinician reports should not be substituted for children's self reported feelings.

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
			anxiety was also measured.	suggest that the validated measures (Multidimensional Anxiety Score for Children and the Genital Examination Distress Scale) are useful in enabling clinicians to identify and respond to anxiety.	
Sugue-Castillo	2009 Philippines	To examine the legal outcome and factors associated with cases reaching court for children seen in hospital for sexual abuse examination.	486 children's cases were reviewed using qualitative and quantitative methods. Data were obtained by chart review, in depth interviews and analysis of legal documents.	30% convicted, 46.5% unresolved and 21.8% acquitted. Self referral, disclosure of penetrative abuse, presence of anogenital injury, urgent assessment were associated with perpetrator conviction.	This study has limited value in the UK due to varying legal and cultural factors.
Walsh et al	2007 USA	To examine the impact of Children's Advocacy Centres (CACs) and other factors such as child's age and type of alleged abuse on the use of forensic medical examination.	Review of retrospective case record data relating to 1,220 children who attended CAC and non CAC sites.	Children who attend a CAC site are two times more likely to receive an examination than in a non CAC site. Females, younger children and those with injuries or suspected penetrative abuse were more likely to be examined. Non	Authors query the 'optimum' level of medical input when abuse may have occurred. Comparisons between CAC and non CAC sites

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
				penetrative presentations were 4 times more likely to be examined in a CAC site. Legal outcomes from a subset of 907 cases were examined and medical examination was found to be statistically insignificant in influencing legal outcomes.	problematic due to lack of standardisation of facilities. Testimony of doctors and nurses in court, explaining why medical evidence of abuse had not been obtained may be helpful in supporting victims in the legal process.
Watkeys et al	2008 UK	To ascertain frequency of significant anogenital signs at medical examination following sexual abuse in relation to the timing of the examination	Prospective study of 257 children, 114 of whom seen within 7 days of the abuse, 23 of whom alleged penetrative anal abuse. 92 girls alleged penetrative vaginal abuse within previous 7 days,	13 of the anal abuse 23 had abnormal findings (56.5%) compared with 9 (18%) of the 50 who were seen more than 7 days after the abuse. Of vaginal penetration group, 46 (50%) had abnormal findings. If seen within 7 days compared with 30.7% seen more than 7 days after the alleged abuse. Abnormal findings were more	Authors suggest that sexual abuse within preceding 7 days should be viewed as a paediatric emergency – especially for adolescents. So, all acute paediatric departments should be resourced to respond to this situation.

Author/s	Year of publication Country	Aims / Objectives of study	Method/Methodology	Result	Comments, Limitations & Recommendations
				common in post pubertal girls.	

Appendix 3: Feedback from ethics committee

NHS
National Research Ethics Service
Berkshire Research Ethics Committee
Building L27
University of Reading
London Road
Reading
RG1 5AQ

Telephone: 0118 918 0550/1
Facsimile: 0118 918 0559

28 March 2011

Mrs. Lindsay Voss
Trust Headquarters
Oakley Road
Southampton
SO16 4GX

Dear Mrs. Voss

Full title of study: **Multiagency response to child sexual abuse: A case study that explores the role of a specialist referral centre.**

REC reference number: **11/H0505/10**

The Research Ethics Committee reviewed the above application at the meeting held on 15 March 2011.

It was noted that as this research falls outside the remit of Research Ethics Committees as set out in the Governance Arrangements for NHS Research Ethics Committees (GAfREC).

However, the Committee was happy to review the ethics of the research on a voluntary basis and to offer the following opinion.

Ethical opinion

Mrs Voss was invited to join the meeting to discuss the study and thanked for attending. She was asked by the Chair to clarify the following issues:

1. The researcher was asked why the Centre was not listed in the PIS; why there is no mechanism to correlate results from the two questionnaires and why the potential for recruitment bias from the sample of professionals had not been considered. The researcher confirmed that the study had been discussed with their supervisor, the limitations identified by the Committee had been identified and the study design was not intended to provide generalisable results. The researcher does not plan to link the feedback to the child's journey.
2. The researcher was asked whether the data collected is for research purposes or is collected as standard. It was confirmed that all the paperwork is standard apart from the follow up at six months. The researcher is introducing a new questionnaire at six months.
3. The researcher was asked to clarify the six month follow up and it was explained that access is via data from Police and Social Care records. The researcher will contact the Police to check if the child is still being seen.
4. The Committee questioned whether the researcher will ask whether court proceedings are being pursued. The researcher confirmed this will be checked and the researcher will ask whether the child is having a medical examination and

whether this will be used for legal purposes. The researcher confirmed that if the quality of the examination in the report is very good, this often results in more convictions. The researcher confirmed that the purpose of speaking to the Police is to obtain information about the examination and its usefulness with regard to legal proceedings.

5. The researcher was advised that some amendments to the PIS were required if the project were to progress as research and these would be provided in writing.
6. The Committee had questioned whether the study should be classed as service evaluation. The only reason the researcher needs to obtain consent is due to the inclusion of the six month questionnaire. The researcher explained that more detail is likely to be evident in the analysis. The Committee explained that the six month questionnaire could be carried out anonymously, so the study could be classed as service evaluation. The researcher confirmed that it had been a University requirement to complete a REC application. It was confirmed that the applicant had been told by her supervisor that ethical review by an NHS REC was probably not necessary but that the 'experience would be worthwhile'
7. The Committee informed the researcher that the project did not raise any concerns with regard to the Mental Capacity Act.

The Committee concluded that the project was service evaluation but was happy to review ethics on a voluntary basis and to offer the following opinion:

1. As a service evaluation there would be no requirement to seek consent and provide a formal information sheet; indeed attempts to do so might add to the young person's distress at the time of assessment in the Centre
2. The applicant should be clearer about what information she intends to seek from the police and the reasons for obtaining it
3. The Committee was of the view that, in its current form, this study represents a missed opportunity for undertaking research that might be of significant value to the Centre, the model it exemplifies and young people who use the service
4. The Committee wished to point out that the applicant had made no provision for obvious bias- the data provided by professionals working in the Centre would be of limited value.
5. The Committee was most concerned to learn that the limitations of the project had been identified by the educational supervisor and that they had been inclined to the view that the project was a service evaluation rather than research but had nevertheless encouraged the student to pursue the application for 'the experience'. This is a waste of a valuable resource.
6. This project raises no concerns with regard to mental capacity legislation.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Interview Schedules/Topic Guides	App 8, v1	07 January 2011
Questionnaire	App 12, v1	07 January 2011
REC application	1	16 December 2010
Participant Consent Form: children and young people (over 12 years)	App 6, v1	07 January 2011
Participant Consent Form: Parents	App 7, v1	07 January 2011
Participant Consent Form: Professionals	App 11, v1	07 January 2011
Case Study Schematic	App1, v1	07 January 2011
Email from Lindsay Voss		20 January 2011

Participant Information Sheet: children and young people	App 4, v1	07 January 2011
Participant Information Sheet: Parents/ Carers	App 5, v1	07 January 2011
Participant Information Sheet: Professionals	App 10, v1	07 January 2011
Protocol	1	07 January 2011
Evidence of insurance or indemnity		06 January 2011
Investigator CV		07 January 2011
Investigator CV	Dr Helen Rushforth	20 January 2011
Covering Letter		08 January 2011
Letter from Sponsor		06 January 2011
Letter of invitation to participant:children and young people	App2, v1	07 January 2011
Letter of invitation to participant: parents	App 3, v1	07 January 2011
Letter of invitation to participant:professionals	App 9, v1	07 January 2011

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

11/H0505/10	**Please quote this number on all correspondence**

Yours sincerely

[redacted]

Enclosures: Attendance at Committee meeting on 15 March 2011

☐

Appendix 4: Interview questions

1. What do you consider to be the role of a specialist centre for children who have been sexually abused?

2. What do you think is the impact of the Centre on children and young people?

3. What is the impact on your professional experience (i.e. as a police officer, social worker, paediatrician or nurse?)

4. Do you have a view on the role of nursing within the Centre?

5. Are there any aspects of the service at the Centre that you would like to change?

Appendix 5: Information sheet for professionals

Title of research study: Multiagency response to childhood sexual abuse: a case study that explores the role of a specialist referral centre

I am carrying out a research study which is intended to improve our understanding of the experience of children, young people, their parents or carers and professionals' experience of attending, or working with the XXXX Centre.

I would like to invite you to participate in this research project. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Before you decide whether you want to take part it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please let me know if there is anything that is not clear or if you would like more information.

Research Aims

I am interested in building a picture of the role that the Centre plays in the lives of the children who attend and would like to know more about the following:

1. How do children and their families or carers feel about the Centre when they attend?

2. Why do children attend the Centre, what happens to them while they are there and what happens to them during the 6 months after they have attended?

3. How do the people who work at the Centre feel about it? Does it help medical staff and other professionals such as social workers and the police work better together?

This information sheet is relevant to research aim 3 above.

Who has been asked to take part?

I am asking paediatricians, nurses, social workers and police officers to participate. I will use a sample of 4 paediatricians, 4 nurses, 4 police officers and 4 social workers who have been involved in multiagency cases at The Centre. During the same time period I will be gathering information from the user evaluation forms that are completed by children/young people and their families. I will also be 'case tracking' a sample of 60 children and young people who have attended The Centre.

What will you have to do?

I would like to ask you to consent to take part in a semi-structured interview which will be scheduled to last for approximately 30 minutes but up to one hour will be allowed. The interview will be tape recorded and transcribed. You may choose a pseudonym that will be used in the transcription. On completion of the study a summary of the findings will be produced and you will be asked if you would like to receive a copy.

Are there any risks in giving consent for my information to be used in a research study?

I do not believe there are any risks in taking part in this research, but if you are concerned at any point you may contact the researcher (or leave a message for when she is available).

Are there any benefits involved in participating?

The results from the study will help us to understand how we might improve our services for children and young people.

How will your privacy and confidentiality be maintained?

If you agree to participate, you will be assigned a pseudonym (or you may choose your own). The pseudonym will replace your name, and any other identification, although your profession will remain known.

All data will be securely stored in locked cabinets in the researcher's employing (NHS) organisation to which the researcher and one administrator will have access. Data that are stored on computers will be password protected and accessible only to the researcher.

When the research study is complete, findings may be used by health professionals, police, social care and other researchers. They will not be able to link you to any of the findings.

Who is organising the research?

The research is being organised by Lindsay Voss, Designated Nurse for Safeguarding Children, employed by Solent NHS Trust. She is completing a clinical doctorate which is being overseen by academic supervisors from the University of Southampton. Some National Institute of Health Research funding is supporting the study.

What if I have questions about the project?

Please contact Lindsay Voss on xxx or mobile xxx or e mail at Lindsay.voss@ xxx

It is up to you to decide if you wish to take part. If you do decide to take part you are still free to withdraw at any time without giving a reason. If you decide to withdraw you may ask for any data that has been previously collected to be discarded.

Thank you for taking time to read this information sheet.

Appendix 6: Consent Form

CONSENT FORM

Title of study: Multiagency response to childhood sexual abuse; A case study that explores the role of a specialist referral centre.

Name of researcher: Mrs. Lindsay Voss

	Please tick
I confirm that I have read and understood the information sheet for the above study.	
I have had the opportunity to ask questions and have had these answered	
I understand that participation is voluntary and that I am are free to withdraw at any time without giving a reason.	
I agree to take part in the research study	

Name	Date	Signature

Appendix 7: Patient evaluation form

Parent or carer / Child or young person

PATIENT SATISFACTION SURVEY

Name……DoB…… Male / Female

Please answer the following questions;

	I agree 	Not sure 	I disagree 
I knew why I was coming to the Centre			
I was told what was going to happen by the doctor/nurse			
I understood what was going to happen			
I felt the doctor/nurse listened to me			
I felt I could be honest and say what I needed and/or wanted to			
I felt I was given a choice about being examined			
I was given a choice about who was with me during the examination			
I felt the examination was better than I had thought it would be			

Is there anything we did today that you didn't feel comfortable about?

.....

.....

.....

.....

Is there anything we did today that you though was really good?

.....

.....

.....

.....

Is there anything you think we could do better?

.....

.....

.....

.....

Any other comments

.....

.....

.....

Glossary

Information about forensic medical examination:

The Royal College of Paediatrics and Child Health and Association of Forensic Physicians (2007:1) state a 'comprehensive assessment considering the physical development and emotional well being of the child or young person against the background of any relevant medical, family or social history must be undertaken'.

If the alleged abuse has taken place more than one week earlier it is not usually possible to collect forensic evidence but physical findings may be present. Therefore a detailed history and medical examination including the genitalia takes place. There may be genital signs but some children who have been sexually abused may have no physical signs at all (RCPCH 2007).

Forensic sampling, if necessary, takes place in liaison with the police to ensure samples are handed to them using the chain of evidence procedure (RCPCH 2007). Assessment and sampling should be performed according to the child's developmental stage and the available history. In younger children 'consideration needs to be given to what is absolutely necessary' (RCPCH 2007: 86).

In adolescents, specimens may include the following: saliva, mouth swab, mouth washings, skin swabs, head hair, pubic hair, vulval swab, vaginal swab (low and high) endocervical swab, penile swab, perianal swab, rectal swab, anal canal swab, fingernails, buccal scrapes, blood, urine.

For the purpose of this research study (and to reflect current practice within the Centre), the term 'acute' is used to describe abuse or assault that has potentially taken place in the preceding 7 days.

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