

[HOSPITAL / HEALTH AUTHORITY NAME]

SAFEGUARDING, ABUSE, NEGLECT, AND SEXUAL ASSAULT PATHWAY

Protocol 43: Children and Adults at Risk, Domestic and Intimate Partner Violence, Sexual Assault, Human Trafficking, Forensic Preservation, Mandatory Reporting, Safe Placement, and Coordinated Follow-up

DRAFT FOR EMERGENCY MEDICINE, PAEDIATRICS, OBSTETRICS / GYNAECOLOGY, NURSING, FORENSIC / SEXUAL ASSAULT SERVICES, SOCIAL WORK, CHILD PROTECTION, MENTAL HEALTH, INFECTIOUS DISEASES, PHARMACY, POLICE / SPECIAL VICTIMS LIAISON, LEGAL / RISK, AND CLINICAL GOVERNANCE

STATUS: This is a draft clinical-governance document. It must be adapted to current national law, mandatory-reporting duties, consent and capacity law, child-protection and adult-safeguarding pathways, sexual-assault forensic services, evidence-kit procedures, police / Special Victims Unit arrangements, STI and HIV prevention order sets, emergency contraception, pregnancy and abortion law, safe accommodation, interpreter access, data protection, and referral resources before implementation.

SURVIVOR-CENTRED SAFETY RULE: Treat urgent injury and illness first; provide privacy, choice, dignity and clear information; obtain consent for each examination, photograph, sample and information-sharing step; never require a police report as a condition of medical care unless a specific law applies; and never discharge a child or adult to a setting that the multidisciplinary team has identified as immediately unsafe.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Safeguarding and Child Protection / Nursing Services / Clinical Governance
Clinical leads	Emergency Medicine; Paediatrics; Obstetrics / Gynaecology; Nursing; Forensic / Sexual Assault Examiner; Social Work; Child Protection; Mental Health; Infectious Diseases; Pharmacy; Police / Special Victims Liaison; Legal / Risk
Applies to	Children, adolescents and adults presenting with suspected or disclosed physical, sexual, emotional or psychological abuse; neglect; domestic or intimate partner violence; coercive control; exploitation; human trafficking; harmful practices; caregiver failure; or a forensic concern associated with assault.
Interfaces	Protocol 1 Patient Journey; Protocol 2 Triage; Protocol 3 Resuscitation / Sepsis / Shock; Protocol 17 Altered Mental Status; Protocol 29 Poisoning / Intoxication; Protocol 31 Major Trauma; Protocol 32 Head / Spinal Injury; Protocol 34 Limb Injury; Protocol 35 Wounds / Bites; Protocol 37 Eye / ENT / Dental Emergencies; Protocol 38 Obstetric / Postpartum Emergencies; Protocol 40 Seriously Ill Child; Protocol 42 Mental-Health Crisis; Protocol 48 Airway; Protocol 51 Capacity / Refusal; Protocol 58 Security and Staff Safety.
Version / status	Draft 1.0 for local multidisciplinary validation
Review cycle	After any death or serious injury related to abuse, missed safeguarding opportunity, unsafe discharge, evidence-handling failure, breach of confidentiality, delayed HIV PEP or emergency contraception, unplanned re-attendance with harm, major legal / guideline change, or at least every 2 years.
Required approval	Emergency Department; Paediatrics; Obstetrics / Gynaecology; Nursing; Safeguarding / Child Protection; Forensic / Sexual Assault Service; Social Work; Mental Health; Infectious Diseases; Pharmacy; Police Liaison; Legal / Risk; Clinical Governance.

1. Purpose

To provide a standardized emergency-department pathway for recognizing and responding to abuse, neglect, sexual assault, intimate partner violence, exploitation and trafficking; treating urgent medical and psychological harm; protecting children and adults at risk; preserving forensic options; meeting lawful reporting duties; coordinating specialist assessment; and arranging safe admission, transfer or discharge.

The protocol aims to reduce missed abuse, repeated questioning, victim-blaming, avoidable loss of evidence, delayed preventive treatment, unsafe contact with an alleged perpetrator, inappropriate disclosure of confidential information, and discharge into continued danger.

2. Scope

This protocol begins at pre-alert or first ED contact and continues through private enquiry, emergency treatment, safeguarding assessment, forensic consultation, reporting, police or child-protection interface, observation, admission, transfer, discharge and follow-up. It applies whether abuse is disclosed, suspected from clinical findings, identified through collateral information, or discovered while treating another emergency.

It does not replace a specialist child-abuse medical assessment, forensic sexual-assault examination, police forensic interview, social-care investigation, adult-protection process, mental-health law, or jurisdiction-specific legal advice. Staff should ask only the questions needed for immediate clinical care and safety and should avoid conducting investigative interviews.

3. Core policy statements

- Safeguarding is part of emergency care. Staff must address immediate medical danger, the risk of further harm, the safety of children or dependent adults, and the need for specialist referral at the same time.
- Interview the patient alone whenever safe and developmentally appropriate. Do not ask about abuse in front of a partner, caregiver, employer, controller, accompanying police officer or family member who may be involved.
- Use a professional interpreter. Do not use children, alleged perpetrators, companions under suspicion, or persons who may control the patient as interpreters.
- Believe and validate the disclosure without promising outcomes: acknowledge that the person is not to blame, explain choices, and avoid disbelief, blame, interrogation or pressure to report.

- Obtain separate informed consent for medical examination, anogenital examination, photography, forensic samples, toxicology, release of information and police contact. Consent may be withdrawn at any time unless a specific lawful authority applies.
- Provide medical treatment even when the patient declines evidence collection or police involvement. A delayed presentation, uncertain memory, intoxication, previous consensual contact, continued relationship with the alleged perpetrator, or absence of visible injury does not invalidate the concern.
- Record spontaneous disclosures as closely as possible in the patient's own words. Distinguish observation, patient history, collateral information and clinician interpretation.
- Preserve evidence without delaying resuscitation, analgesia, wound care, hydration, toileting or other essential treatment. Patient welfare takes priority over evidence.
- Children and adolescents require developmentally appropriate communication, attention to assent and best interests, immediate mandatory reporting where the law requires it, and assessment of siblings or other children who may also be at risk.
- For competent adults, confidentiality and choice are the default. Share without consent only when authorized or required by law, when necessary to protect a child or adult unable to protect themselves, or when there is a serious and imminent threat that meets the local legal threshold.
- Do not discharge to an alleged perpetrator or unsafe caregiver solely because no alternative placement is immediately available. Escalate to safeguarding, social services, hospital leadership and police / legal partners as required.

4. Definitions and safeguarding framework

Term	Operational meaning
Child	A person below the locally defined age of majority. For Saint Christopher and Nevis child-protection law, the care-and-protection definition generally includes a person under 18 and certain older persons affected by serious illness or disability; obtain legal confirmation for implementation.
Adult at risk	An adult whose care, support, disability, illness, dependence, detention, isolation or circumstances may limit the ability to protect themselves from abuse, neglect or exploitation. Use the definition in current local law and policy.
Abuse	Physical, sexual, emotional, psychological or financial harm; coercive control; threats; humiliation; exploitation; harmful practices; or misuse of power, trust or dependency.
Neglect	Failure to meet essential health, nutrition, hygiene, shelter, supervision, medication, developmental or protection needs, whether deliberate, reckless or related to caregiver incapacity.
Sexual assault / abuse	Any sexual act, contact, exposure or exploitation without valid consent, including where age, coercion, intoxication, cognitive impairment, threat or abuse of power prevents valid consent. Legal definitions are jurisdiction-specific.
Intimate partner / domestic violence	Physical, sexual, psychological or economic abuse, threats, stalking, coercive control or deprivation of liberty by a current or former partner or family / household member.
Human trafficking / exploitation	Recruitment, transport, harbouring or control for exploitation through force, fraud, coercion or abuse of vulnerability. For children, proof of force or coercion may not be required under applicable law.
Forensic medical examination	A consent-based clinical examination that treats health needs and documents / collects potential evidence using trained personnel, approved kits, secure records and chain-of-custody procedures.
Mandatory report	A report required by law when a defined person has knowledge or reasonable grounds to suspect specified abuse or risk. The exact threshold, recipient, timing and documentation must be stated in local policy.

5. Roles and accountability

Role	Minimum responsibilities
Triage nurse	Identify immediate danger, separate the patient from unsafe companions, use neutral injury coding, begin privacy and evidence precautions, notify the senior clinician and safeguarding pathway.
ED clinician	Treat ABCDE threats, obtain minimum necessary history, document objective findings, assess capacity / consent, activate specialist services, provide prevention and follow-up, and ensure safe disposition.
Nurse in charge	Provide a private safe area, assign trained staff, control access and visitors, preserve clothing / evidence, coordinate medicines, observation and handover.
Paediatrics / child-protection clinician	Lead child medical assessment, developmental interpretation, injury work-up, consent / assent plan, sibling risk assessment, mandatory reporting and safe placement.
Forensic / sexual-assault examiner	Provide or direct the medical forensic examination, photographs, sample collection, evidence packaging, chain of custody, follow-up and court-quality documentation.
Social work / safeguarding lead	Assess immediate safety, dependants, housing, coercion, supports and placement; coordinate statutory and community agencies; document the protection plan.
Obstetrics / gynaecology	Manage pregnancy, genital injury, bleeding, emergency contraception, pregnancy-related risk and specialist examination when required.

Role	Minimum responsibilities
Mental health	Assess acute distress, self-harm, suicide, psychosis, trauma symptoms, capacity and need for crisis intervention without delaying medical or forensic care.
Police / Special Victims liaison	Receive reports under lawful processes, maintain safety, avoid contaminating clinical history, coordinate evidence transfer and preserve patient access to care. Police do not direct clinical consent.
Clinical governance / legal	Maintain current law, forms, service agreements, confidential record systems, evidence storage, training, audit and serious-incident review.

6. Required readiness

Capability	Minimum standard
Environment	Private interview / examination room with controlled access, chaperone option, safe exits, discreet registration, secure clothing and evidence storage, and no recording by unauthorized persons.
Response contacts	24-hour ED senior, paediatrics, child protection / Probation and Child Welfare Board contact, social work, forensic / sexual-assault examiner, obstetrics / gynaecology, mental health, infectious diseases / HIV advice, police / Special Victims Unit and safe accommodation.
Forensic supplies	Current sealed evidence kits, paper bags, labels, tamper-evident seals, chain-of-custody forms, swabs, blood / urine containers, sterile water, photo scale, body maps, secure camera and locked storage.
Medicines	Emergency contraception, pregnancy testing, HIV nPEP starter / full course pathway, hepatitis B vaccine and immunoglobulin access, STI prophylaxis / treatment, tetanus, analgesia, antiemetics and age / pregnancy-specific alternatives.
Documentation	Separate confidential safeguarding and forensic forms, consent forms, injury body maps, photograph log, evidence log, mandatory-report form, safety plan and transfer / discharge checklist.
Training	Private enquiry, LIVES first-line support, child disclosure response, minimal-facts history, capacity, mandatory reporting, forensic preservation, chain of custody, strangulation, trafficking, cultural safety and staff support.

7. Pre-alert, triage, and immediate danger recognition

Presentation / finding	Immediate response
Airway threat, severe bleeding, shock, reduced consciousness, seizure, major trauma, poisoning, burns, pregnancy emergency	Move to resuscitation and treat immediately. Preserve clothing and evidence only when this does not delay care.
Recent strangulation / suffocation with dyspnoea, voice change, dysphagia, neck swelling, neurological symptoms, loss of consciousness or collapse	Resuscitation-level assessment, airway and neurological monitoring, senior review and imaging / transfer according to the local strangulation pathway.
Child with serious injury, concerning bruising / burn, unexplained fracture, head injury, genital bleeding, poisoning, starvation / dehydration or caregiver obstruction	Immediate paediatric and safeguarding activation; control access; do not discharge pending specialist risk assessment.
Sexual assault within a possible HIV PEP, emergency contraception or forensic evidence window	Urgent private assessment and forensic consultation. Do not wait for police before offering time-sensitive medical care.
Patient accompanied by a controlling, threatening or answering companion; fearfulness, inconsistent identity / address, withheld documents, inability to speak alone	Separate safely using routine clinical reasons; notify security / safeguarding discreetly; do not confront the suspected controller.
Threat from alleged perpetrator, weapon, stalking at the hospital, attempted removal of patient / child	Activate security and police response, visitor restriction, confidential location and hospital lockdown / missing-patient pathway as appropriate.
Stable patient with possible abuse or neglect	Provide privacy, medical assessment, first-line support and timely safeguarding review. Reassess if waiting circumstances change.

TRIAGE PRIVACY RULE: Do not write sensitive details on public tracking boards, wristband notes, waiting-room slips or discharge paperwork that may be seen by the alleged perpetrator. Use the locally approved confidential alert and access-control system.

8. The first 10 minutes

1. Treat immediate ABCDE threats, severe pain, bleeding, hypoglycaemia, intoxication, pregnancy complications and mental-health emergencies.
2. Separate the patient from accompanying persons using a neutral clinical explanation. Ensure the alleged perpetrator or controller cannot access the interview, examination, record or discharge destination.
3. Introduce one lead clinician, confirm preferred name and communication needs, offer a trained interpreter and explain confidentiality and its limits before detailed enquiry.
4. Use first-line supportive care: listen without pressure, inquire about immediate needs, validate the experience, enhance safety and connect the person with practical support.
5. Ask only the minimum questions needed to guide urgent treatment, time-sensitive prevention, evidence options and immediate safety. Record spontaneous words verbatim.
6. Identify dependent children, siblings, older persons or others who may be at risk and establish their current location and safety.
7. Contact the senior ED clinician and safeguarding / social-work lead. Add paediatrics, forensic examiner, obstetrics, mental health, infectious diseases or police according to need and law.

8. Explain medical and forensic choices. Obtain consent step by step; the patient may accept some elements and decline others.
9. Preserve potential evidence when feasible: minimize handling, retain clothing in separate paper bags, document pre-hospital washing / changing, and initiate chain-of-custody records.
10. Document the immediate safety plan, legal / reporting actions, observation, visitor restrictions, responsible clinician and time of next review.

9. Survivor-centred communication and first-line support

LIVES element	ED application
Listen	Give full attention, avoid interruption, do not demand a complete chronology and allow pauses.
Inquire about needs and concerns	Ask what the person needs now: treatment, privacy, support person, safe contact, food, clothing, child care, police, shelter or time.
Validate	State that the person is not to blame, that help is available, and that the response is understandable. Do not question why they stayed, returned, used substances or delayed reporting.
Enhance safety	Assess immediate danger, perpetrator access, threats, weapons, strangulation, stalking, separation, pregnancy, dependants and a safe destination.
Support	Offer advocacy, social work, child protection, forensic care, mental health, sexual-health follow-up, practical resources and a clear return route.

- Ask permission before touch, examination, photography or moving clothing. Explain what will happen and stop when asked unless life-saving care is required under lawful emergency authority.
- Allow the person to choose the sex of examiner or chaperone where feasible, and record when this preference cannot be met.
- Use non-gendered, inclusive language and do not assume the identity of the assailant, type of contact, sexual orientation, gender identity, disability, immigration status or relationship.
- Provide accessible communication for cognitive, hearing, visual, developmental or literacy needs. Confirm understanding with teach-back.
- Do not leave a distressed child or vulnerable adult alone with a person who may be implicated.

10. Receiving a disclosure and obtaining the minimum necessary history

Do	Avoid
Use open prompts: "Tell me what happened that made you come today" and "What are you worried about now?"	Leading, suggestive, repetitive or accusatory questions.
Clarify timing, body areas affected, penetration / exposure needed for treatment, strangulation, loss of consciousness, bleeding, pregnancy risk and substances.	Demanding a detailed sexual or assault narrative before pain relief, safety or consent.
Record exact words for key statements and identify who was present.	Paraphrasing a disclosure into legal terminology the patient did not use.
Ask a child only enough to establish immediate safety and medical need; thank them and explain what happens next.	Promising secrecy, asking the child to repeat the account to multiple staff, or confronting the alleged offender.
Use collateral information from EMS, records and caregivers while labelling the source.	Blending collateral allegations with the patient's account or documenting speculation as fact.
Stop when the necessary clinical information is obtained and defer investigative detail to trained interviewers.	Conducting a police-style forensic interview in the ED.

DISCLOSURE RULE: A calm, limited, non-leading clinical history protects the patient and preserves later investigative interviewing. Do not repeatedly ask "why," test consistency, or attempt to determine credibility.

11. Child abuse and neglect

Concern	Examples requiring senior paediatric / safeguarding review
Physical abuse	Injury inconsistent with developmental ability or history; bruising in a non-mobile infant; patterned injury; multiple injuries of different ages; concerning burns; unexplained fracture; oral injury; abdominal injury; head injury; delay in seeking care.
Neglect	Failure to provide food, hydration, shelter, hygiene, supervision, medicines, essential treatment, safe sleep, education or protection; repeated preventable emergencies; caregiver intoxication or incapacity.
Emotional / psychological abuse	Persistent humiliation, threats, rejection, exposure to severe domestic violence, coercion, terrorizing, isolation or exploitation with developmental / behavioural impact.
Sexual abuse / exploitation	Disclosure, genital / anal injury or bleeding, pregnancy, STI, sexualized exploitation, online grooming, exchange sex, trafficking, exposure to pornography or contact with an alleged offender.
Fabricated or induced illness	Symptoms or test abnormalities induced, falsified or exaggerated by a caregiver; repeated unexplained presentations; discrepancy between observed child and reported history.
Harmful practices	Forced marriage, genital cutting, ritual injury, punishment or other practices causing or threatening physical or psychological harm.

- Complete a head-to-toe examination with consent / assent, growth and hydration assessment, developmental context, skin and oral inspection, neurological status and documentation of all injuries. Use a body map.
- Treat pain and injury. Obtain imaging and laboratory tests according to paediatric and child-protection guidance; involve specialists before skeletal survey, occult-injury work-up or interpretation of healing age.
- Consider abusive head trauma, occult abdominal injury and poisoning when findings or history indicate. A normal initial examination does not remove concern.
- Assess the safety of siblings and other children in the household or care setting. Record names, ages and locations and communicate them in the report.
- Do not allow discharge until the senior paediatric / safeguarding clinician confirms the protection plan and the person authorized to receive the child.

LOCAL LEGAL NOTE - SAINT CHRISTOPHER AND NEVIS: Section 14 of the Children (Care and Adoption) Act requires persons providing health care to children, and relevant managers, who know or have reasonable grounds to suspect that a child needs care and protection to report without delay to the Board or to a police officer who reports to the Board. Local legal services must verify that the current consolidated law and contact pathway remain in force before approval.

12. Child and adolescent sexual abuse

Principle	Required action
Urgency	Immediate specialist assessment for major bleeding, severe pain, acute injury, strangulation, intoxication, pregnancy concern, suicidal crisis, suspected recent assault or possible time-sensitive evidence / prophylaxis.
Consent and assent	Use the lawful consent route and seek the child's assent according to development. If a parent / guardian is implicated, unsafe, unavailable or refuses necessary care, obtain senior safeguarding and legal advice.
Examination	Use a trained clinician. Avoid forced examination. A prepubertal child should not undergo internal vaginal or anal examination unless medically necessary and performed by an appropriately skilled specialist.
History	Obtain minimal facts for health and safety. Do not ask the child to demonstrate acts, identify legal elements or repeat the disclosure unnecessarily.
STI / pregnancy	Testing, prophylaxis and follow-up are individualized by pubertal status, type and timing of exposure, symptoms and ability to follow up. Positive results in children require expert interpretation and confirmatory processes.
Forensic evidence	Use the paediatric forensic pathway and kit. Do not assume that elapsed time or washing makes examination useless; consult the specialist.
Mental health	Assess acute distress, self-harm and caregiver response. Provide trauma-focused follow-up; do not compel immediate detailed therapy or disclosure.
Safety	Mandatory report, alleged offender access restriction, sibling assessment and a documented safe placement are required before discharge.

13. Adults at risk: abuse, neglect, and exploitation

Domain	Assessment priorities
Capacity and communication	Assess capacity for each decision; treat delirium, pain, hypoxia and intoxication; use communication aids and interpreters; seek independent advocacy.
Care dependence	Who provides food, medication, hygiene, mobility, finances, transport and communication? Is care being withheld, unsafe or conditional?
Injury / neglect	Pressure injury, dehydration, malnutrition, poor hygiene, untreated illness, medication omission / overuse, restraint, burns, bruises, fractures and delayed presentation.
Financial / property abuse	Unexplained transactions, missing benefits, coerced signatures, theft, forced transfer of property or dependence on the alleged abuser for access to money.
Institutional / caregiver context	Staffing, restraint, seclusion, medication, repeated injuries, home-care arrangements, caregiver stress and access by the suspected person.
Protection decision	For an adult with capacity, support informed choice and safety planning. If capacity is absent or serious legal thresholds are met, use best-interest / protective processes and document authority.

- Do not assume that disability, age, psychiatric diagnosis or dependence removes capacity. Equally, do not accept a caregiver's refusal when urgent treatment or protective assessment is lawfully required.
- Consider self-neglect, caregiver burnout and resource failure while still assessing for deliberate abuse or exploitation. These may coexist.
- When the alleged abuser is also the essential caregiver, arrange an alternative care plan rather than returning the person because no replacement is immediately obvious.

14. Intimate partner and domestic violence

Assessment area	Ask / assess privately
Immediate danger	Do you feel safe leaving? Is the person waiting, monitoring your phone or able to reach you today?
Escalation	Has violence become more frequent or severe? Are there threats to kill, suicide threats, weapons, stalking or forced sex?

Assessment area	Ask / assess privately
Strangulation	Any pressure to the neck, choking, smothering, voice change, swallowing difficulty, loss of consciousness, incontinence, confusion or neurological symptoms?
Coercive control	Isolation, surveillance, financial control, threats to immigration / employment, forced medication, deprivation of sleep / food, or restriction of health care.
Separation / pregnancy	Recent or planned separation, pregnancy, postpartum period, new partner, legal proceedings or protection-order breach.
Children / dependants	Direct harm, exposure to violence, threats, abduction risk, unsafe caregiver, pets used as threats and current location.
Safe communication	Safe phone number, time, words to avoid in messages, whether printed information or voicemail could increase danger.

- Do not confront the alleged perpetrator or mediate the relationship in the ED. Do not share the patient's location, room, findings or discharge plan without consent or lawful authority.
- Offer police, advocate, social-work and shelter contact, but do not pressure a competent adult to report unless law requires action. Explain the limits of confidentiality before sharing.
- Develop a practical plan: safe destination, transport, medicines, identification, children, emergency contacts, code word, device safety and what to do if the perpetrator arrives.
- Use discreet information. A visible brochure, text message or discharge diagnosis may increase risk.

15. Sexual assault in adolescents and adults

Step	Clinical standard
Stabilize	Treat injury, bleeding, pain, intoxication, strangulation, head injury, pregnancy emergency and acute mental-health risk first.
Explain options	Medical care only; medical forensic examination; photographs; evidence collection; STI / pregnancy prevention; police report now, later or not at all where law permits; advocacy and follow-up.
Consent	Obtain consent separately for each part. The patient may pause or stop. Intoxication or cognitive impairment requires capacity assessment and a plan to preserve options until valid consent is possible.
History	Medical forensic history by trained clinician: timing, sites of contact, condom / ejaculation, cleansing, clothing change, consensual contact relevant to evidence, injuries, strangulation, substances and post-assault activities.
Examination	Head-to-toe injury assessment and indicated anogenital examination using trauma-informed positioning and chaperone. Absence of injury neither proves nor disproves assault.
Evidence	Collect according to the approved kit and case circumstances. Do not use an arbitrary time cut-off without consulting the forensic service.
Prevention	Pregnancy test, emergency contraception, STI testing / prophylaxis, hepatitis B prevention, HPV vaccination when eligible, HIV nPEP assessment and follow-up.
Support	Advocate / support person, crisis and mental-health assessment, safe discharge, written choices, follow-up and a named results owner.

CARE WITHOUT REPORTING: Unless a specific law applies, a competent adolescent or adult may receive medical care and, where local systems permit, have evidence collected / stored without making an immediate police report. Local policy must state the available reporting and storage options clearly.

16. Non-fatal strangulation and suffocation

High-risk feature	Response
Airway / breathing	Dyspnoea, stridor, dysphonia, aphonia, dysphagia, odynophagia, neck swelling, subcutaneous emphysema or respiratory distress: resuscitation, airway expertise and urgent imaging / transfer.
Neurological	Loss of consciousness, confusion, seizure, focal deficit, severe headache, visual symptoms, amnesia or collapse: urgent neurological and vascular assessment.
Circulatory / injury	Petechiae, significant neck tenderness, bruising, ligature mark, chest pain, arrhythmia or associated blunt trauma: senior review and targeted investigation.
Pregnancy / child	Lower threshold for specialist assessment and observation; assess fetal / obstetric status and child-protection implications.
Delayed risk	Symptoms can evolve after presentation. Provide observation when indicated and explicit return instructions for breathing, voice, swallowing, neurological or worsening neck symptoms.
Documentation	Record the patient's words, method and duration if known, loss of consciousness, incontinence, neurological symptoms, voice / swallow findings, photographs with consent and serial examinations.

STRANGULATION RULE: Minimal external marks do not exclude significant internal or neurological injury. Do not downgrade risk because the neck looks normal.

17. Human trafficking, sexual exploitation, and forced labour

Indicator	Trauma-informed response
Control by companion	Companion answers, refuses privacy, holds documents / money / medicines, monitors phone or insists on leaving: separate safely and notify safeguarding / security.
Restricted freedom	Patient cannot leave work / housing, is transported and watched, owes a debt, or fears punishment / deportation: ask privately about safety and options.
Exploitation	Forced sex, labour, begging, criminal activity, domestic servitude, repeated assault, unsafe work, withheld pay or threats to family.
Health pattern	Repeated injuries, untreated infection, pregnancy, STI, malnutrition, sleep deprivation, substance control, branding / tattoos, dental neglect or delayed care.
Children	Any suspected child trafficking or commercial sexual exploitation is a child-protection emergency and requires mandatory reporting.
Action	Do not confront the controller. Treat health needs, preserve confidentiality, assess immediate danger, use professional interpreters, involve trained safeguarding / trafficking resources and create a safe contact plan.

- The goal of enquiry is safe care and empowerment, not obtaining a disclosure. A person may deny trafficking because of fear, surveillance, debt, loyalty or threats.
- Do not automatically contact immigration or law enforcement for a competent adult unless law or immediate danger requires it. Explain available options and likely consequences honestly.
- Use only safe contact methods. Do not leave voicemail, text, portal messages or printed material that a controller may see unless the patient confirms it is safe.

18. Medical assessment and treatment

Domain	Minimum assessment / treatment
ABCDE and injury	Full vital signs, pain, head-to-toe examination, pregnancy status where relevant, wound care, imaging, tetanus, fracture / burn / head-injury pathways and serial review.
Neurological / toxicological	GCS, pupils, focal signs, seizure, strangulation, intoxication, withdrawal, poisoning, drug-facilitated assault and head injury.
Sexual / reproductive	Bleeding, pelvic / abdominal pain, genital or anal injury, pregnancy risk, contraception, STI symptoms, urinary symptoms and reproductive coercion.
Infection prevention	HIV exposure assessment, hepatitis B status, STI testing / prophylaxis, wound infection, blood-borne virus testing and immunization according to current orders.
Mental health	Acute stress, dissociation, panic, psychosis, self-harm, suicidal thoughts, substance use, sleep and ability to use the safety plan.
Basic needs	Food, fluids, clothing, hygiene, medicines, mobility aids, child care, shelter, phone access, transport and safe communication.

Investigations are guided by injuries, exposure, age, pregnancy, symptoms and follow-up feasibility. Do not order tests solely to prove or disprove assault. Explain that baseline STI or HIV results generally reflect pre-existing status and do not establish when infection occurred.

19. Consent, forensic examination, photography, and evidence preservation

Element	Required safeguard
Consent	Document capacity and consent for each component. Explain purpose, discomfort, limits, possible disclosure in legal proceedings, storage and who may access the evidence.
Medical priority	Resuscitation and treatment come first. Evidence preservation must never delay life-saving care, analgesia or necessary hygiene.
Clothing	Handle minimally; place each dry item separately in a labelled paper bag. Air-dry wet items only in a secure approved area. Do not use plastic for damp biological evidence.
Swabs / samples	Use the current sealed kit and forensic service instructions. Label, seal and document every transfer. Do not improvise without specialist advice.
Photographs	Separate consent; use approved secure equipment, identification and measurement scale; take overview and close-up images; maintain a photograph log; never use personal devices.
Body maps	Record size, colour, shape, location, tenderness and patient explanation. Avoid estimating injury age beyond expertise.
Chain of custody	Record collector, date / time, item, seal number, storage location, every transfer and recipient signature. Lock evidence immediately.
Declined component	Document what was offered, information provided and what was declined without judgement. Offer medical care and follow-up.

EVIDENCE RULE: Do not tell a patient that washing, urinating, changing clothes or elapsed time means there is "no evidence." Consult the forensic service because useful examination, documentation or collection may still be possible.

20. Suspected drug-facilitated assault

- Consider when there is unexpected amnesia, altered consciousness, severe intoxication inconsistent with reported intake, rapid incapacitation, unexplained injuries or concern that a substance was administered without consent.
- Treat poisoning and airway risk first. Obtain blood and urine as early as possible with informed consent and the correct clinical / forensic chain-of-custody process; urine often offers a longer detection opportunity than blood.
- Explain that many substances clear rapidly; routine hospital toxicology may not detect all agents, a negative result does not exclude drug-facilitated assault, and prescribed / recreational substances may also be identified.
- Document reported drinks / medicines / substances, timing, symptoms, vomiting, urination and samples collected. Use the designated forensic laboratory pathway rather than relying only on routine screens.

21. Sexual-health, pregnancy, and infection-prevention care

Intervention	Operational standard
Pregnancy testing	Offer according to reproductive potential and timing, with privacy and informed consent. A negative early test does not exclude pregnancy from the assault.
Emergency contraception	Offer as soon as possible when pregnancy is possible and within the effective window of an available method. Discuss the most effective locally available option, contraindications, interactions and follow-up pregnancy testing.
HIV nPEP	Assess urgently. When indicated, give the first dose as soon as possible, ideally within 24 hours and no later than 72 hours, without waiting for laboratory results; use the current local age / weight / pregnancy / renal order set for a 28-day course and arrange early follow-up.
STI prophylaxis / testing	Use the current approved sexual-assault order set. Adult / adolescent empiric prevention commonly addresses gonorrhoea, chlamydia and trichomoniasis, with pregnancy-specific alternatives; individualize for children and allergies.
Hepatitis B	Verify vaccination and source status if available without delaying care; provide vaccine and immunoglobulin according to current post-exposure guidance.
HPV vaccine	Offer or arrange according to age and national immunization policy.
Follow-up	Name the service responsible for results, repeat HIV / syphilis / hepatitis / pregnancy testing, vaccine completion, nPEP tolerance, STI treatment and counselling.

TIME-CRITICAL PREVENTION RULE: Do not delay HIV nPEP or emergency contraception while waiting for police, forensic examination, source testing or specialist attendance. Give the first indicated treatment and continue coordination.

22. Mental-health and psychosocial care

- Assess current safety, suicidal thoughts, self-harm, severe dissociation, panic, psychosis, intoxication, sleep deprivation and ability to care for dependants.
- Normalize common immediate reactions without predicting long-term outcome. Avoid forced psychological debriefing or repeated detailed retelling.
- Offer a trained advocate or trusted support person selected by the patient. For children, ensure the support person is safe and not implicated.
- Arrange trauma-informed follow-up, crisis contacts and return instructions. Activate Protocol 42 when there is mental-health crisis, agitation, impaired capacity or suicide risk.
- Recognize staff vicarious trauma and arrange confidential debrief / support without discussing identifying patient details outside authorized channels.

23. Information sharing, confidentiality, and mandatory reporting

Situation	Information-sharing principle
Child abuse / neglect	Report immediately to the statutory child-protection authority or police according to current law and local pathway. Explain to the child and safe caregiver what will be shared unless doing so increases danger.
Adult with capacity	Seek consent for referral and police contact. Share without consent only under a defined legal duty or serious-risk exception; disclose the minimum necessary information and document the basis.
Adult lacking capacity	Use capacity / best-interest law and adult-protection procedures; involve an independent advocate and avoid relying on the suspected abuser as decision-maker.
Serious threat to another person	Obtain senior and legal advice and follow the jurisdiction's threshold for protective disclosure.
Police request	Confirm identity and legal authority. Clinical staff do not release records, samples or results solely because police ask; use consent, warrant / order or statutory authority and document the transfer.
Family / employer / school	Share only with consent or lawful safeguarding authority. Do not confirm attendance, location or details to an alleged perpetrator or controller.
Electronic record	Use restricted-access notes / flags where available; avoid unsafe portal release; follow policy for confidential adolescent records and forensic images.

REPORTING RULE: A mandatory report transfers information; it does not transfer clinical responsibility. The ED must continue treatment, observation and safety planning until a safe handover or placement occurs.

24. Police, statutory agency, and forensic-service interface

- Clarify who leads medical care, forensic examination, child-protection investigation, police interview and placement. These functions overlap but are not interchangeable.

- Police questioning should not delay urgent treatment, analgesia, sleep, food, toileting, nPEP or emergency contraception. The treating clinician determines clinical fitness for interview / custody and may pause access when necessary for care.
- Do not hand clothing, samples, photographs or original records to an unauthorized person. Use the evidence log and obtain signed receipt.
- When the alleged perpetrator is a caregiver, staff member, police officer, clinician or institutional representative, escalate outside the implicated reporting line and protect the patient from contact or retaliation.
- For children, coordinate to minimize repeated interviews and examinations and to ensure that the statutory agency knows the location and status of every child at risk.

25. Observation, admission, transfer, and safe placement

Disposition	Minimum criteria / indications
Resuscitation / ICU / surgical care	Airway or breathing threat, shock, severe bleeding, major trauma, strangulation complications, poisoning, reduced consciousness, severe infection or post-sedation monitoring. Safeguarding continues in parallel.
Medical / paediatric / obstetric admission	Ongoing treatment, pain or injury, pregnancy complication, inability to complete assessment, unsafe home, need for protected observation, child-protection work-up or placement delay.
Forensic / specialist transfer	Accepting clinician and facility confirmed; time-sensitive medicines given; stability for transport assessed; evidence, records, legal status, guardian / escort and chain of custody handed over.
Protected placement / shelter	Social work and statutory agency confirm destination, transport, confidentiality, medicines, children / dependants and whether the alleged perpetrator knows the location.
Discharge	Medical care complete; capacity / consent addressed; mandatory reports made; safe destination and transport confirmed; perpetrator access plan; prevention and follow-up arranged; written information is safe to carry; teach-back completed.
Patient wishes to leave	Immediate senior review, capacity and legal duties, unresolved child / adult risk, safe contact, time-critical treatment, confidential follow-up and documentation. Do not use unlawful detention or coercion.

- While awaiting placement or transfer, continue active medical review, nutrition, hydration, medicines, privacy, observation and protection from visitors. A bed or transport delay does not justify return to danger.
- For a child, discharge only to the person and place authorized by the child-protection / safeguarding plan. Record identity verification and handover time.
- For an adult, do not reveal the destination in routine discharge paperwork, portal messages or verbal handover to an unsafe companion.

26. Discharge care and follow-up

- Provide a clear, individualized plan for wound / injury review, pregnancy testing, emergency contraception follow-up, HIV nPEP supply and tolerance, STI / hepatitis / HIV testing, vaccination, forensic results, mental health and safeguarding.
- Name the clinician or service responsible for every pending result. State how the patient will be contacted safely and what happens if contact fails.
- Give return instructions for breathing or swallowing difficulty, voice change, neurological symptoms, worsening neck pain, severe headache, fainting, bleeding, abdominal / pelvic pain, fever, vomiting, pregnancy symptoms, medication adverse effects, suicidal crisis or renewed danger.
- Provide medicines and documents discreetly. Ask whether packaging, labels, phone messages or appointment letters could increase risk.
- Arrange early follow-up after HIV nPEP initiation and the locally required repeat testing schedule. Confirm access to the full course before discharge.
- Offer advocacy and practical support even when the patient declines police involvement or forensic examination.

27. Documentation and handover

- ☐ Arrival time, accompanying persons, privacy achieved, interpreter / chaperone, visitor restrictions and security concerns.
- ☐ Patient's spontaneous words and minimum necessary clinical history; collateral sources separately identified.
- ☐ ABCDE findings, complete vital signs, pain, mental state, pregnancy status, intoxication, strangulation and serial observations.
- ☐ Head-to-toe findings and body map; size, colour, shape, location and tenderness; relevant negative findings without implying assault did not occur.
- ☐ Capacity, explanation and separate consent / decline for examination, anogenital assessment, photographs, samples, toxicology, prophylaxis and information sharing.
- ☐ Every photograph, sample, clothing item, label, seal, storage location, transfer and recipient signature.
- ☐ Treatment: analgesia, wounds, tetanus, emergency contraception, STI care, hepatitis B, HIV nPEP first dose / supply, pregnancy and mental-health care.
- ☐ Children / dependants / siblings at risk, their locations, mandatory-report recipient, time, person contacted, advice and protection plan.
- ☐ Adult safeguarding / domestic violence / trafficking assessment, capacity, consent, legal basis for any disclosure and safe communication method.
- ☐ Police / forensic / specialist contacts, accepting clinician, transfer details, evidence handover and unresolved actions.
- ☐ Safe destination, transport, perpetrator access plan, medicines, follow-up dates, pending-results owner, return advice and teach-back.

28. Quality indicators and audit

Indicator	Suggested measure
Privacy and first response	Percentage interviewed privately when safe; interpreter use; documentation of supportive response and confidentiality limits.
Child protection	Mandatory report completed without delay; paediatric / safeguarding review; sibling risk and safe placement documented.
Time-critical care	Time to emergency contraception and first HIV nPEP dose; percentage receiving indicated prevention without waiting for police / forensic attendance.
Consent	Separate consent / decline recorded for examination, photographs, samples, toxicology and information sharing.
Forensic quality	Correct kit, labels, seals, paper-bag use, secure storage, photograph log and uninterrupted chain of custody.
Strangulation	Screening, airway / neurological assessment, serial review, imaging / transfer decisions and return advice documented.
Safe disposition	Destination, transport, alleged-perpetrator access, dependants, confidential contact and follow-up confirmed.
Equity	Review access and outcomes by age, sex, gender, disability, language, migration status, geography, custody and socioeconomic barriers.
Serious incidents	Missed abuse, unsafe discharge, repeat harm, death, evidence loss, confidentiality breach, coercive examination or delayed prevention reviewed through multidisciplinary learning.

29. Training and implementation

- All ED staff require recurrent training in recognizing abuse and neglect, private enquiry, LIVES first-line support, child disclosure response, consent, capacity, mandatory reporting, evidence preservation, strangulation, trafficking and safe documentation.
- Only trained clinicians should perform sexual-assault forensic examinations and specialized child anogenital assessments. Maintain a 24-hour call and transfer plan when no local examiner is available.
- Run multidisciplinary simulation for child injury with caregiver obstruction, sexual assault requiring nPEP, strangulation with delayed symptoms, trafficking with controlling companion, adult neglect with impaired capacity and evidence chain-of-custody failure.
- Audit forms and actual cases with survivor-centred, paediatric, legal and forensic expertise. Include feedback from advocacy and community partners while protecting confidentiality.
- Provide staff with confidential support after distressing cases and protect against retaliation when staff raise safeguarding concerns.

30. Local configuration before approval

Local element	Complete before approval
Current child-protection law, mandatory reporter categories, threshold and recipient	_____
Probation and Child Welfare Board / Child Protection 24-hour contact	_____
Police / Special Victims Unit 24-hour contact and reporting process	_____
Adult safeguarding definition, lead agency and emergency contact	_____
Sexual-assault / forensic examiner and transfer pathway	_____
Evidence-kit location, expiry checks, secure storage and chain-of-custody recipient	_____
Approved injury photography device, storage, access and release policy	_____
HIV nPEP order set, stock, first-dose target, full-course access and follow-up clinic	_____
STI prophylaxis / testing, hepatitis B and HPV pathway	_____
Emergency contraception options, pregnancy follow-up and legal / referral pathway	_____
Non-fatal strangulation imaging / observation / transfer pathway	_____
Safe shelter / protected placement / transport contacts	_____
Professional interpreter and disability communication services	_____
Confidential electronic-record, portal and adolescent privacy rules	_____
Adult capacity / consent / information-sharing legal advice contact	_____
Clinical incident reporting, evidence failure and serious-case review process	_____

31. Source guidance for local adaptation

Source	Use in local adaptation
World Health Organization. Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. 2020; and CMRIPV training curriculum for health workers. 2025.	Survivor-centred clinical care, LIVES first-line support, consent, safety, medical treatment and referral.

Source	Use in local adaptation
World Health Organization. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. 2017.	Child-centred, trauma-informed care, autonomy, safety, examination, mental health and follow-up.
National Institute for Health and Care Excellence. Child abuse and neglect. NICE guideline NG76. 2017, current online version.	Recognition, response, therapeutic relationship, multi-agency assessment and child-centred practice.
U.S. Department of Justice, Office on Violence Against Women. A National Protocol for Sexual Assault Medical Forensic Examinations, Adults / Adolescents, Third Edition. 2024.	Consent, patient choice, medical forensic history, examination, evidence collection, photography, documentation and coordinated response.
Centers for Disease Control and Prevention. Sexually Transmitted Infections Treatment Guidelines: Sexual Assault and Abuse. 2021, current online version.	STI testing, empiric treatment, hepatitis B and HPV prevention, follow-up.
Centers for Disease Control and Prevention. Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV. 2025.	HIV nPEP indication, urgent initiation, 72-hour limit, 28-day course, testing and follow-up.
World Health Organization Regional Office for Europe. Addressing human trafficking through health systems: a scoping review. 2023.	Trauma-informed identification, health-system responsibilities, safe enquiry and multisectoral response.
Faculty of Forensic & Legal Medicine. Recommendations for the documentation of injuries. 2024; paediatric sexual offence medicine quality standards. 2024.	Objective injury description, photography, child forensic quality and documentation.
Saint Christopher and Nevis. Children (Care and Adoption) Act, Cap. 12:01, revision date 31 December 2017.	Best interests, child in need of care and protection, mandatory reporting and emergency protection. Verify current consolidated law.
Saint Christopher and Nevis. Probation and Child Welfare Board Act, Cap. 12:12; Domestic Violence Act, Cap. 12:04, and 2022 amendment.	Statutory child-welfare reporting / investigation and domestic-violence protection framework. Verify current law and operational contacts.
REFERENCE CONTROL: The clinical protocol, sexual-assault medicines order set, evidence kit, legal contact list and reporting forms must be version-controlled together. A change in law, HIV nPEP guidance, STI treatment, emergency contraception or forensic kit instructions triggers immediate review.	

Annex A. One-page safeguarding emergency workflow

Step	Action
1. Stabilize	ABCDE, injury, pain, bleeding, strangulation, pregnancy, poisoning, intoxication and mental-health crisis.
2. Separate safely	Private room, professional interpreter, safe chaperone, alleged perpetrator / controller excluded, access restricted.
3. Support	Listen, inquire about needs, validate, enhance safety and connect with support. Explain confidentiality and limits.
4. Minimal facts	Ask only what is needed for treatment, time-sensitive prevention, evidence options and immediate protection. Record exact words.
5. Activate team	Senior ED, safeguarding / social work; add paediatrics, forensic examiner, obstetrics, mental health, infectious diseases, police / statutory agency.
6. Consent and choices	Separate consent for examination, photographs, samples, toxicology, treatment and information sharing. Medical care is not conditional on reporting.
7. Preserve options	Approved kit, paper bags, labels, seals, secure photographs / evidence and uninterrupted chain of custody.
8. Prevent harm	Emergency contraception, HIV nPEP, STI / hepatitis prevention, tetanus and follow-up without avoidable delay.
9. Protect	Mandatory child report, adult-protection action as lawful, dependent / sibling safety, visitor restrictions and safe placement.
10. Close the loop	Named results owner, confidential contact, follow-up dates, safe transport / destination, return advice and documented handover.

Annex B. Child safeguarding assessment and report checklist

- ☐ Child seen and spoken with in a developmentally appropriate manner; safe caregiver / advocate identified.
- ☐ Exact spontaneous disclosure recorded; only minimal non-leading questions asked; persons present documented.
- ☐ Full vital signs, pain, growth / nutrition / hydration, development and head-to-toe examination completed.
- ☐ All injuries described and body-mapped; photographs obtained only with lawful consent and approved equipment.
- ☐ History and injury assessed for developmental compatibility, delay, changing account and prior presentations.
- ☐ Head injury, occult abdominal injury, fracture, poisoning, burns, sexual abuse, neglect and mental-health risk considered.
- ☐ Siblings / other children identified with names, ages, locations and immediate safety concerns.
- ☐ Mandatory report made without delay to: _____ Time: _____ Recipient: _____
- ☐ Paediatric / safeguarding lead: _____ Advice / plan: _____
- ☐ Person authorized to receive child and safe destination verified; alleged offender access addressed.
- ☐ Follow-up, pending results, transport and handover documented.

Annex C. Sexual-assault medical and forensic care bundle

- ☐ Immediate injury, strangulation, intoxication, pregnancy emergency and mental-health risk treated.
- ☐ Privacy, interpreter, advocate / support person and chaperone preference addressed.
- ☐ Options explained: medical care, forensic examination, photographs, evidence storage / reporting, police and follow-up.
- ☐ Capacity and separate consent / decline documented for each component.
- ☐ Medical forensic history by trained clinician; post-assault washing, urination, eating, changing and consensual contact documented without judgement.
- ☐ Head-to-toe and indicated anogenital examination completed; body map and photographs logged.
- ☐ Kit number: _____ Seal numbers: _____ Collector: _____

- ☐ Clothing individually bagged in paper; all samples labelled, sealed, stored and entered in chain of custody.
- ☐ Pregnancy test and emergency contraception offered / provided / declined.
- ☐ HIV nPEP risk assessed; first dose time: _____ Full course / access plan: _____
- ☐ STI testing / prophylaxis, hepatitis B, HPV and tetanus addressed using current order sets.
- ☐ Safe destination, confidential contact, named results owner and follow-up appointments confirmed.

Annex D. Non-fatal strangulation record

Assessment area	Record
Event	Patient's words; hands / forearm / ligature / object / smothering; duration if known; repeated episodes; associated assault.
Consciousness / neurology	Loss of consciousness, amnesia, confusion, seizure, incontinence, headache, visual symptoms, weakness, numbness, speech / gait change.
Airway / swallowing	Dyspnoea, cough, voice change, stridor, dysphagia, odynophagia, drooling, neck swelling or tenderness.
Examination	Vitals, oxygen saturation, GCS, voice, oral cavity, neck, chest, eyes / petechiae, neurological examination and serial findings.
Investigations / disposition	Imaging, airway / ENT / trauma / neurological consultation, observation, admission or transfer and rationale.
Forensic documentation	Body map, photographs with consent, associated injuries and evidence transfer.
Return advice	Breathing, swallowing, voice, neck swelling, severe headache, fainting, confusion, seizure, weakness, visual change or worsening pain.

Annex E. Evidence and chain-of-custody log

Item / sample	Collected by / date-time	Seal / label	Storage / transfer and recipient signature
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

- ☐ Kit intact and within expiry before use; kit number documented.
- ☐ Each item packaged separately and appropriate container used; damp items not sealed in plastic.
- ☐ Patient identifiers and date / time verified on every item; tamper-evident seals initialled.
- ☐ Evidence never left unattended or in an unlocked area.
- ☐ Photographs stored in approved restricted system; no personal device used.
- ☐ Every handover has date / time, names, signatures and destination.

Annex F. Domestic violence / trafficking immediate safety plan

Area	Plan
Immediate danger and perpetrator access	_____
Safe destination and transport	_____
Children / dependants / pets	_____
Safe contact number / time / words to avoid	_____
Documents, medicines, money and essential items	_____
Police / protection order / advocate / shelter options	_____
Device, location-sharing and portal safety	_____
Emergency code word / trusted person	_____
What to do if danger recurs	_____

Annex G. Safeguarding transfer and discharge checklist

- ☐ Medical treatment complete or accepted by receiving service; physiology stable for destination and transport.
- ☐ Child / adult safeguarding assessment, capacity, consent and legal / reporting duties completed.
- ☐ Mandatory report / statutory referral made; recipient, time and advice documented.
- ☐ Alleged perpetrator / controller access, visitor restrictions, confidentiality and destination secrecy addressed.
- ☐ Safe person, placement and transport verified; child handed only to authorized recipient.
- ☐ Forensic evidence sealed, stored / transferred with complete chain of custody; copies retained according to policy.
- ☐ Emergency contraception, HIV nPEP, STI / hepatitis / HPV / tetanus care completed or scheduled.
- ☐ Medicines supplied discreetly; full HIV nPEP course access and early tolerance contact confirmed.
- ☐ Named clinician owns pending results; safe contact method and follow-up dates verified.
- ☐ Mental-health / crisis needs and dependants addressed; written information is safe to carry.
- ☐ Return signs explained with teach-back; direct ED return route provided.
- ☐ Clinical and safeguarding handover completed and responsibility transfer documented.

END OF PROTOCOL 43 - DRAFT 1.0 FOR LOCAL MULTIDISCIPLINARY VALIDATION