*Response to Equally Safe: A consultation on legislation to improve forensic medical services for victims of rape and sexual assault from Children 1st*

*Response submitted by Mark Ballard, Policy Manager Children 1st, 83 Whitehouse Loan, Edinburgh EH9 1AT 0131 446 2300 mark.ballard@children1st.org.uk*

*1. Should a specific statutory duty be conferred on Health Boards to provide forensic medical services to victims of rape and sexual assault, for people who have reported to the police as well as for those who have not?*

*Yes No Don't know No answer*

*Please provide reasons for your response in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

Children 1st recognises the issues with the current model provision of forensic medical services to victims of rape and sexual assault. We therefore support the proposal that there should be statutory duties on Health Boards to provide these services. Such a duty would replace the current Memorandum of Understanding between Police Scotland and the territorial Health Boards which has been in place since 2013. However, it is important to recognise that as well as forensic medical services to victims of rape and sexual assault, the Memorandum of Understanding also covers examination and collection of forensic samples from children suspected to have suffered abuse – including, but not limited, to sexual offences.

We believe that in any discussion of potential new duties on Health Boards it will be crucial to give greater and more specific consideration to the particular issues around provision of forensic medical services to children and young people who have experienced sexual abuse, alongside but separately to consideration of the needs to adults who have experienced rape or sexual assault. Children who have experienced sexual abuse have a very distinct set of needs, and will follow separate pathways and process after disclosure of abuse. We would therefore suggest that consideration is given to having two separate duties – one for forensic medical services for adult victims of rape and sexual assault, and a separate duty around forensic medical services for children and young people suspected to have suffered abuse – again including, but not limited to, sexual offences.

Over recent years a great deal of work has been put in to the development of standards of service provision and quality indicators for the medical component of Child Protection in Scotland. Again, these standards cover all children where there are child protection concerns, not just sexual abuse. It is crucial that any new duties in law do not undermine or cut across this work.

The HMICS report into Provision of Forensic Medical Services to Victims of Sexual Crime (https://www.hmics.scot/publications/strategic-overview-provision-forensic-medical-services-victims-sexual-crime) highlighted that there has been good collaboration between the three Managed Clinical Networks to arrive at the standards and quality indicators, and there has been consultation with paediatricians across the country. However, several areas reported shortages in paediatricians to the inquiry, and difficulties in gaining and maintaining experience due to low numbers of examinations. The shortages in paediatrician availability locally can result in lengthy journeys and delays, which HMCIS considered unacceptable.

Work undertaken by Children 1st was cited in the HMICS report, which indicates that a child might need to speak to over 14 different people from disclosing abuse to a teacher, through to a court case. Anonymised case studies show that children are having to wait for hours for a medical examination and when it takes place there can be up to five professionals in the room, talking to each other and not to the child.

The CMO taskforce option appraisal (https://www.gov.scot/publications/honouring-lived-experience-chief-medical-officers-taskforce-improve-services-victims/) which followed the HMCIS report highlighted the discussion that took place during the appraisal process of a number of issues around children and young people and their specific needs. In particular, the need to link the proposed work to improve services for victims of child sexual abuse with developments around the ‘barnahus’ model were highlighted. This was linked to the need to ensure that secure and trusting relationships are built wherever possible between abused children and the professional (s) involved in their care. However, a large number of comments focussed on the need to link whatever was proposed to the wider child protection system.

Relevant comments listed from the Option Appraisal Event included:

* “Reassurance required that whatever is recommended would not unpick the

work going on around children. We need to be very aware of the risk around

children and make sure that any decisions don’t undermine the work that has

gone over the past decade.”

* “A plea that any option going forward for consideration will sit with the wider

child protection sphere, it’s not just the crown but can also be called to a child

protection hearing. We’re meant to be protecting children.”

* “Reassurance that models put forward won’t dissemble, be detrimental to any

current structures for children, will only build on them.”

Children 1st has always been clear that any proposals to strengthen and improve forensic medical examinations for children, while welcome, must align effectively with wider child protection process, where the forensic examination often forms a part of a holistic multiagency approach to the protection needs of a child. These are often considered at a child protection case conference or within a children’s hearing setting, so such examinations need to be able to inform wider safety and risk assessments of child, as well as being used to report to Police and referral on to the Crown Office Prosecution service. The forensic examination must therefore be seen as fully supporting both the child protection and justice processes – both protecting the child victim as well as providing evidence for potential prosecution

Therefore, as previously stated, it seems logical and appropriate to consider having two separate duties – one for forensic medical services for adult victims of rape and sexual assault, and a separate duty, aligned with child protection policy and practice, around forensic medical services for children and young people suspected to have suffered abuse – again including, but not limited to, sexual offences.

Successfully developing and delivering this would involve more analysis and understand of children’s current experiences of the interaction between child protection and health. The consultation document makes specific reference in para 23 to the need to consult and integrate the views of those with lived experience of presenting having experienced sexual abuse or rape. It is not clear from the consultation to what extent the views of children who have experienced sexual abuse, and the different pathways of care and support they have received, have been considered.

This is particular important because we know that some young people who disclose abuse may have immediate protection needs, leading to what can be complicated post–disclosure situations. Any new duty would therefore need to take account of the complex and distinct needs of children around their safety and protection. For example, Children 1st have worked with a number of young people who found they were not believed by their immediate family or circle of friends after their disclosure of abuse. This led to them needing to be looked after and accommodated either for care or safety reasons, or sometimes both.

*2. Do you have any views on how a legislative framework for the taking and retention of samples, personal data and other evidence in the case of police referral should operate?*

*Yes No Don't know No answer*

Please provide reasons for your response in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.

Any consideration of a potential legislative framework for the taking and retention of samples, personal data and other evidence needs to take into account the very different context and existing legislative principles and requirements for children and young people.

Although Paragraph 36 of the consultation document makes reference to the fact that that there are particular issues for victims of child sexual abuse around taking and retention of samples and the sharing personal data, these issues are currently not fully addressed in the consultation. Paragraph 61 of chapter 5 of the consultation does make reference to different legal requirements around consent for children of different ages, there is no mention of how any potential legislative framework for the taking and retention of samples, personal data and other evidence would apply to children and young people.

It is therefore important that the proposed Data Protection Impact Assessment gives specific and separate consideration to the situation of children and young people. The consultation document also suggests that one option would be enact new legislative provisions around data sharing of material gathered through forensic medical examinations. Again, for children and young people any discussion around data sharing in child protection cases (which would include all cases of potential child sexual abuse) must be viewed separately to the situation for adults, and aligned with existing policy and practice.

There are particular issues around children’s capacity, and their rights to refuse to consent to the taking and retention of samples, personal data and other evidence. As is highlighted in paragraph of the consultation, children under 16 are only deemed have legal capacity to refuse to consent to a medical procedure where a qualified medical practitioner deems them capable of understanding the nature and possible consequences of the procedure or treatment. As the National Child Protect Guidance makes clear, even where a child is subject to a Child Protection or Assessment Order may still withhold their consent to examination or assessment if they are deemed to have legal capacity.

There are also particular issues around the safe storage of information pertaining to children. Children 1st has experience of a number of very difficult and complex situations where parents have sought to conduct a Subject Access Request to see their child’s records, and any information held about them in the records. This has included a parent seeking access to the full medical records of a forensic examination which was undertaken due to report of potential harm by that parent. Because these records were no longer part of an ongoing Police inquiry or live justice processes, the records were shown in full on the ground that this was what the legislation required. This is highly concerning in relation to the impact this has on the right to privacy of children who are forensically examined; as a parents ability to request full access their child’s records means that whilst measures can be taken to securely hold the sensitive data gathered under forensic examination, for those cases where there is no ongoing or open criminal investigation (which is a significant proportion of cases, if not majority) a SAR request could end up with the sensitive data being provided to the requesting parent, even in cases where a child would not wish this to happen.

Children 1st are aware of cases where request were made by parents who did not have care of their children and where it is clear that the children would have been upset to know that the information would be shared. In such cases, where the children were under 11, their ability to withhold consent could have be legally challenged, with the parent submitting the subject access request often expressing the view that despite the child having withheld consent and being considered capable of informing this decision, the child was being influenced unduly by the other parent.

In these instances medical records that do not show signs of physical trauma can be used by the parent for whom there is a child protection concern as proof that the disclosure was false. However, Children 1st have found that for many children a lack of medical ‘proof’ of abuse can in fact be entirely consistent with the nature of the sexual abuse they have disclosed, as not all sexual abuse results in physical evidence or trauma. For this reason it is particularly important that the forensic examination data is recognised as being only part of the ‘disclosure and story’ of a child’s abuse and that the potentially highly sensitive medical data needs to be covered by the data protection measures and guidance which is designed with these kinds of contexts and situations for children in mind.

Data should also be held for a significant period to enable a child to come back to this in future years if they choose to revisit a disclosure. Recognising that disclosure of sexual abuse can often happen over a period of time, sometimes years apart, forensic examination undertaken at one time should be considered as potentially ‘evidentially significant’ despite there being lack of evidence based on the examination for this to proceed at that particular time. Again, Children 1st have experience of young people and adults who have returned a number of years after previous contact and shared that they now recognise that what they experienced in childhood was grooming and abuse, in a way they had been unable to understand or communicate when first asked by a professional when younger. In these cases not all young people or adults want to subsequently make a further disclosure, however the option to do so would be made stronger if forensic examination data collected from initial disclosures had been retained, and is therefore available for the adult to draw on in event they choose to make another disclosure. Retaining forensic examination data over a longer period in this way also reflects the lived experience of adult survivors of childhood sexual abuse, and processes that they go though as the nature of their childhood experiences of abuse becomes clear to them.

This practice could also be potentially for helpful for young people over a shorter period of a few months or years, where they may be subject to organised abuse or sexual exploitation, but where this abusive element of this is not initially clear to them. These young people may have several forensic examinations of injuries but be unwilling to cooperate with the police investigative process initially, sometimes out of loyalty to their ‘abuser’ or fear of the consequences. Recent experience of organised Child Sexual Exploitation cases shows that when young people are supported by a professional who offers consistent, sensitive support that goes at the pace of the child or young person, those who have previously seen their ‘abuser’ as a boyfriend, have come to recognise the elements of coercive control and abuse that they have been subjected. As a result some go on to report this to the Police, and any forensic data from previous examinations would enable a fuller case to be compiled by Police at that time.

*3. Do you have any views on how a legislative framework for the taking and retention of samples, personal data and other evidence in the case of self-referral should operate?*

*Yes No Don't know No answer*

*Please provide reasons for your response in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

The kinds of self referral situation described in this section are not applicable to children under 16 since if they disclose sexual abuse, they will automatically be considered within a child protection pathway.

However, we support the position of Rape Crisis Scotland and others that informed consent must be central to any legislative framework for the taking and retention of samples, personal data and other evidence in the case of self-referral by adults. This should reflect the shock and distress that those subject to sexual violence are likely to feel, and take this into account in the provision of information. Clear and accessible written information should be provided setting out the position with samples, retention times, what to do and who to contact should they wish to report to the police. In cases where an individual has self-referred, a check in should be built into the clinical pathway to ensure the individual understands what is happening with their samples, how long they will be kept for and to see how they feel now about the prospect of reporting.

*4. More generally, do you have any views on potential impacts of the proposals in the Chapters of this paper on data protection and privacy (the handling of personal data including “special category” data about health)?*

*Yes No Don't know No answer*

*If yes, please outline possible impacts in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

Again we would highlight the different context and legislative provisions for children and adults, and the need for any consideration of data protection and privacy for children undergoing forensic medical examinations in cases of potential child sexual abuse to be discussed within the wider context of data protection and privacy for children in the child protection system. As previously mention, the particular considerations about parents ability to request access to their child’s records. Any legislative provisions specifically around data sharing of material gathered through forensic medical examinations must take account of the specific situation for children.

*5. How might legislation help safeguard victims’ rights to respect for their dignity?*

*See below Don't know No answer*

*Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

We welcome the Government commitment taking a human rights based approach to the development of any legislation. We also welcome the specific reference to article 24 of the UNCRC in the consultation document, the right every child to the best possible health and health care. However, we would also highlight the importance of Article 16 (the right of children to privacy) and Article 19 (the right of children to be protected from violence, abuse and neglect) as well as the paramount principle, as enshrined in GIRFEC that best interests of the child must be the priority in all decisions and actions that affect children.

Helpful reference is made to the Scottish Government Commencing section 9 of the Victims and Witnesses Act in this chapter. Under section 9 children and young people must always be considered to have protection needs.

However the research cited in this chapter around preferences for the gender of the medical examiner was carried out among women who were victims of rape and sexual assault aged over 16, so it may be appropriate to conduct additional evidence gathering around preferences among children and young people, as part of wider investigations in to children and young peoples lived experience of the child protection and justice system. The issue of choice of examiner is often based on the experience of adult female victims who cite a preference for female examiners – undertaking specific consultation with children and young people, would provide invaluable feedback and guidance into the particular needs and preferences of young males and females, as well as those young people who allege abuse by a female.

*6. More generally, do you have any views on potential impacts of the proposals in the Chapters of this paper on human rights (including economic, social and cultural rights such as the right to the highest attainable standard of physical and mental health)?*

Yes No Don't know No answer

If yes, please outline possible impacts in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider. For example, any particularly relevant general comments, recommendations or other guidance by treaty monitoring bodies on the interpretation and implementation of treaties – and any relevant international obligations not mentioned in this consultation paper.

Please see our answer to question 5

*7. Should special provisions be included in legislation to reflect the distinct position and needs of children and young people? Do you have any views on how such special provisions should operate?*

*Yes No Don't know No answer*

*Please provide reasons for your response in the box below and, if Yes, outline what special provisions might be required. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

As previously discussed Children 1st believes it would be appropriate to consider having two separate duties – one for forensic medical services for adult victims of rape and sexual assault, and a separate duty around forensic medical services for children and young people suspected to have suffered abuse including, but not limited to, sexual abuse. We believe this would be the best way to ensure the distinct position and needs of children and young people.

We welcome the reference to the Barnahus approach in paragraphs 59 and 60. The Barnahus concept was established in Iceland in 1998, and has now been replicated in a nationally appropriate fashion in another ten countries across Europe. It seeks to provide an immediate trauma-informed response to child victims and witnesses of serious and traumatic crimes in a familiar and non-threatening setting. Internationally, the concept is seen as having four key principles:

• Respect for the participatory rights of the child by ensuring he/she is heard and receives information and support to exercise these rights;

• Multidisciplinary and interagency collaboration during investigations and procedures with the aim of avoiding re-traumatisation and securing outcomes that are in the best interests of the child;

• Comprehensive, accessible services to meet the complex, individual needs of the child and their non-offending family or caregivers; and

• Ensuring high professional standards, training and resources for those working with child victims and witnesses.

We believe that a separate duty on Health Boards around the provision of forensic medical services for children and young people suspected to have suffered abuse including, but not limited to, sexual abuse could be linked to the delivery of the Barnahus model. This would support the delivery of the commitments made by the Scottish government around the delivery of the barnahus approach. In particular on 5th February 2019, during the Scottish Parliament stage 1 debate on the Vulnerable Witnesses (Criminal Evidence) bill, Humza Yousaf, the Cabinet Secretary for Justice, reaffirmed that the adoption of a Barnahus approach, tailored to the Scottish context, was the Scottish Governments preferred destination, and confirmed during the stage 2 discussion of that bill on March 12th that “after the bill has received royal assent, there will be a review of the progress that has been made by the Government and Government agencies towards implementing the principles of a Scottish version of the Barnahus model”.

The 2018-19 Programme for Government committed the Scottish Government to exploring how the Barnahus concept could operate within the context of Scotland’s child protection, justice and health systems. This builds on the commitment made in the 2017 Equally Safe Delivery Plan that the Scottish Government will “work in partnership with Children 1st to consider the application of lessons from various international examples of the Barnahus concept for child victims in criminal justice cases and how these could potentially apply within the Scottish context.” We therefore look forward to exploring how any duty or duties around the provision of forensic medical services for children and young people could support and uphold this commitment.

8. *More generally, do you have any views on potential impacts of the proposals in the Chapters of this paper on children and young people including their human rights or wellbeing?*

*Yes No Don't know No answer*

*If yes, please outline possible impacts in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider. For example, any particularly relevant general comments or other publications by the International Committee on the Rights of the Child.*

We welcome the Scottish Government’s Commitment to conduct a Child Rights and Wellbeing Impact Assessment, which will also be crucial in ensuring that the distinct needs of children and young people are recognised and understood.

As previously highlighted, Article 3 of the UNCRC, which is enshrined in the GIRFEC, states that the best interests of the child must be the priority in all decisions and actions that affect children. For children therefore, the question must always be asked whether a forensic medical examination of a child or young person is in the best interests of c a child. Even where it is in the best interests of the justice system to carry out such an examination, it may not be in the best interests of the child and this needs to be reflected in any new duty on Health Boards.

*9. Do you have any views on potential impacts of the proposals in this paper on equalities (the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation)?*

*Yes No Don't know No answer*

*If yes, please outline possible impacts in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

Again we would highlight the need for a different approach to ensuing appropriate services are available for children and young people, who by virtue of their protected characteristic of age, will require specific support.

*10. Do you have any views on potential impacts of the proposals in this paper on socio-economic equality (the Fairer Scotland Duty)?*

*Yes No Don't know No answer*

*If yes, please outline possible impacts in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

*11. Do you have any views on potential impacts of the proposals in this paper on people in rural or island communities?*

*Yes No Don't know No answer*

*If yes, please outline possible impacts in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

Ensuring the local availability of forensic examinations and related services across the geography of Scotland is vital to a child centred approach. The shortages in paediatrician availability locally can result in lengthy journeys and delays .The HMICS Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime (2017) found that in Highland children and carers from Caithness to Brora are having to travel 113 miles to Inverness for a medical. Meanwhile there is no service in Orkney at all, so children have to travel to the mainland where they will not be examined until the following day at the earliest. Children from Orkney and Shetland travel to Aberdeen for forensic medical examination and children from the Western Isles travel to Glasgow to be examined. The HMICS found these delays for examinations of children to be unacceptable. They recognised there are occasions when it would make more sense for a paediatrician to travel to where the child is instead of the child, carer and police officers making a journey that compounds the distress of the child and carers, as well as being a poor use of public resources. Again, this needs to be considered as part of particular consideration of the needs of children and young people.

*12. Do you have any views on the financial implications of the proposals in this consultation paper for NHS Scotland and other bodies?*

*Yes No Don't know No answer*

*If yes, please outline possible implications in the box below. Please be as specific as you can and in*clude any resources or references to evidence on this topic that we should consider.

Again, we welcome the references to the barnahus approach in the consultation paper, and suggest that aligning the proposals in this consultation paper with the development of the barnahus approach would be the cost cost-effective way forward for NHS Scotland. We recognise that the delivery of barnahus, although likely to generate significant preventative spend savings in the long term, is likely to require capital investment, and this should be coordinated with work to improve provision of forensic medical services to victims of child abuse.

*13. Finally, do you have any other comments that have not been captured in the responses to the other questions you have provided?*

*Yes No Don't know No answer*

*If yes, please provide comments in the box below. Please be as specific as you can and include any resources or references to evidence on this topic that we should consider.*

Particular consideration need to be given to the surroundings in which forensic medical interviews take place. In our experience surroundings that may be entirely suitable and appropriate for an adult, may not be appropriate for children. This is, in practice, increasingly recognised, and a number of Health Boards have done a significant amount of work to make sure spaces used for work with children fell child friendly. However we are also aware that there have been situations where adults have felt unconformable having forensic medical interviews in in surrounding that are too obviously designed to be child friendly. Again, this highlights to us the importance of ensuing that consideration is given to the distinct needs of adult victims of rape and sexual abuse and child victims of sexual abuse.