Response to the Health and Sport Committee's Call for Views on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill

30th January 2020

Children 1st is Scotland's national children's charity. We have over 130 years of experience of working alongside families to provide relationship- based recovery support when they need it and to help children and families to recover from the trauma associated with childhood adversity.

Children 1st recognises the issues with the current model provision of forensic medical services to victims of sexual offences and welcomes the Chief Medical Officer's commitment to developing consistent, person centred, trauma informed healthcare and forensic medical services and access to recovery for anyone who has experienced rape or sexual assault in Scotland. The 2017 Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime report produced by HM Inspectorate of Constabulary in Scotland (the HMCIS report) found major issues in the support available for those who have experienced rape or sexual assault in Scotland, and we agree with Rape Crisis Scotland and other organisations that there is a need for continued leadership and significant, ongoing investment to bring services in Scotland up to the standards which survivors need and deserve.

What are the key advantages and disadvantages of placing the examination of victims of sexual offences (and harmful sexual behaviour by children under the age of 12) by health boards on a statutory basis?

We support the proposal that there should be statutory duties on health boards to provide these vital services. However, as we stated in our response to the Scottish Government pre-legislative consultation, there are a number of specific considerations regarding how the distinct needs of the children and young people are recognised in the legislation.

These issues were also raised by a range of other organisations during the pre-legislative consultation period. Indeed, the Scottish Government's analysis of responses to the pre legislative consultation states in its conclusion: "a large majority (of responses) support the introduction of a statutory duty for health boards and advocate for special provisions to be made for children and young people." We are therefore disappointed that it does not appear that this has not been taken into account in the drafting of this Bill.

We have set out key issues where the specific needs of children need to be addressed below:

1. **Children who are victims of other offences who require forensic examinations.**

   We understand that the duty contained within the Bill will replace the provisions within the current Memorandum of Understanding between Police Scotland and the territorial health boards relating to sexual offences, which has been in place since 2013. In addition to forensic medical services for 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. However, this legislation only covers the examination and collection of forensic samples from children who are victims of sexual offenses.

   Therefore while we welcome the replacement of part of the Memorandum of Understanding with the new duty, we are thoughtful about the impact of a new duty and subsequent guidance or Pathway documents that will not cover all situations where a child might require a forensic examination. This could inadvertently create a two-tier system of forensic examinations,

where some forensic examinations of children who have been abused are covered by statutory duties and different guidance and others are not.

The Child Rights and Wellbeing Impact Assessment (CRWIA) accompanying the Bill states that, *"the Bill does not require to legislate any wider than is proposed because wider medical examinations can (and are) carried out under the National Health Service (Scotland) Act 1978 and the 2014 Memorandum of Understanding between health boards and Police Scotland.*"

However, the HMCIS report found that "*The Memorandum of Understanding between Police Scotland and NHS Scotland for the transfer of function to deliver forensic medical services from the police to the NHS is confusing and ineffective. The MOU is not legally binding, which results in difficulties in holding parties to account for delivery*."[1] We therefore do not believe that the 2014 Memorandum of Understanding is sufficient as it stands for either child victims of sexual offences or child victims of other offences who require medical examination.

In order to address this, we suggested in our response to the pre-legislative consultation that one option could be legislation that created a separate duty around forensic medical services for children and young people suspected to have suffered abuse—including, but not limited to, sexual offences. It appears that the title of the Bill presented to Parliament would now preclude this option, given the legislation is now focussed only on the provision of forensic medical services to victims of sexual offences. Children 1st, however, remain concerned that children require consistent high quality provision of forensic medical examinations for other purposes and encourage the Committee to consider further how this duty will work in relation to provision for examinations of children in connect to other offences.

2. Distinct needs of children and young people.

As it stands, the Bill does not differentiate between a child and an adult and applies to examinations carried out on victims of sexual offences irrespective of age. The evidence is that children represent a significant proportion of those affected by sexual crime in Scotland. For example, in 2015-16 44.7% of recorded victims of sexual crime were aged under 16 years and 19.4% of recorded victim of rape were aged under 16 years.[2] HMICS found it challenging to establish the volume of medical examinations being carried out across Scotland, but figures for NHS Borders, Lothian, Fife and Forth Valley, provided by the South East collaborative, showed that 324 examinations were carried out in these areas during 2015/16, of which 148 (46%) involved children under 18 years.[3]

We recognise that for many child victims forensic medical examination is not needed or appropriate, especially given that many children do not disclose sexual abuse within the seven- day 'DNA capture' window. We also recognise that some of the most common sexual offenses against children do not involve contact between the perpetrator and the child, such as internet enabled offending. In addition, a forensic medical examination should only ever be varied out when it is in the best interests of the child. However, those children who do require forensic examinations will have a very distinct set of needs compared to adults and are covered by different legislative and policy provisions.

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[1] P.5, Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime, HM Inspectorate of Constabulary in Scotland, March 2017
https://www.hmics.scot/sites/default/files/publications/HMICS%20Strategic%20Overview%20of%20Provision%20of%20Forensic%20Medical%20Services%20to%20Victims%20of%20Sexual%20Crime.pdf

[2] P.12, Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime, HM Inspectorate of Constabulary in Scotland, March 2017
https://www.hmics.scot/sites/default/files/publications/HMICS%20Strategic%20Overview%20of%20Provision%20of%20Forensic%20Medical%20Services%20to%20Victims%20of%20Sexual%20Crime.pdf

[3] P.37, Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime, HM Inspectorate of Constabulary in Scotland, March 2017
https://www.hmics.scot/sites/default/files/publications/HMICS%20Strategic%20Overview%20of%20Provision%20of%20Forensic%20Medical%20Services%20to%20Victims%20of%20Sexual%20Crime.pdf

Children 1st believes that the Bill needs to take proper account of these different provisions and legislation that apply to children (such as the legislation relating to children's capacity to consent to medical examinations). The Bill also contains provisions relating to what information is relayed to a 'person' and makes reference to 'professional judgement' regarding examinations taking place, which requires further thought relating to children and young people and their rights.

We would also highlight the need for different skills and qualifications of key professionals involved in arranging and undertaking examinations and the often complex support and recovery needs of children. While these may be covered within specific guidance or a Pathway document, we would welcome further consideration of what may be appropriate to place on the face of the Bill to ensure consistent statutory provision to address some of the issues highlighted in the HMICS report.

The Children and Young People (Scotland) Act sets out in Part 3 requirements for heath boards to work with other statutory agencies on the development of a children services plan, covering how children's services will be provided in each local authority area in Scotland. Such plans must set out how the provision of children services in an area meet certain criteria, including being as integrated as possible from the point of view of the child. It is unclear whether the services that are required to be provided by health boards as result of this legislation, insofar as they related to children, meet the definition of a 'children's service' in the 2014 Act and if they are, how they will meet the specific criteria it lays out.

It is also worth highlighting the upcoming recommendations of the Care Review, and the particular needs of care experienced children, which should be considered as this Bill continues its journey through Parliament.

3. Alignment with child protection processes.

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 children, as well as being used to report to Police and referral on to the Crown Office and Procurator Fiscal Service. The forensic examination must therefore be seen as fully supporting the child protection as well justice processes – both protecting the child victim as well as providing evidence for potential prosecution. However the legislation currently is not clear how this will work in practice.

4. Implementation

We are clear that while a statutory duty is welcome, effective implementation in terms of ensuring that forensic medical examinations are not compounding trauma and preventing recovery should be the biggest priority. The Child Rights and Wellbeing Impact Assessment (CRWIA) accompanying this Bill has highlighted the importance of a child- centred approach and referred to the consultation on the draft Clinical Pathway for Children and Young People who have disclosed sexual abuse. In summer 2019 we responded to the pathway consultation expressing our concerns about the current proposals for the Pathway and the way in which it potentially cuts across the ongoing work with respect to a Barnahus approach for child victims and witnesses in Scotland (see below). Our understanding is that this Pathway is due to be published in after the publication of the Barnahus standards. It is important for the Committee to consider how it can ensure that an integrated, rights- based,

child- centred approach required for effective implementation of this legislation can be delivered through the Pathway.

Additionally, the HMICS report found that 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.

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 report found that in Highland children and carers from Caithness to Brora had at that point to travel 113 miles to Inverness for a medical. Meanwhile there they found there was no service in Orkney at all, so children had 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, these challenges needs to be considered as part of particular consideration of the needs of children and young people.

Additionally, particular consideration needs to be given to the surroundings in which forensic medical examinations 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 feel more child friendly. However, we are also aware that there have been situations where adults have felt unconformable having forensic medical examinations 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. As we describe below, European best practice in the delivery of forensic medical examinations is in a Barnahus or child's house, where the forensic medical examination is integrated into a single process of assessing and examining child victims of violence of abuse. Given the Scottish Government commitment to introducing the Barnahus model of support for all child victims and witnesses to violence and abuse in Scotland, this needs to be reflected in the implementation plans for the legislation.

5. Links to Barnahus.

As the Committee will be aware, the Scottish Government has been clear that their 'preferred destination' for child victims and witnesses across Scotland is the Scandinavian 'Barnahus' or Child's House model.[4] The Barnahus concept was established in Iceland in 1998, and has now been replicated in a number of other countries across Europe. It seeks to provide an immediate, trauma- informed response to all child victims and witnesses of serious and traumatic crimes in a familiar and non- threatening setting where the health (forensic examination), protection (social work), justice (interviews) and recovery (support for the victim and their family) is provided under one roof. Healthcare Improvement Scotland and

[4] https://www.children1st.org.uk/media/6701/trauma-free-justice-care-and-protection-for-scotlands-children.pdf

the Care Inspectorate are currently in the process of developing professional standards setting out the criteria for delivering a Barnahus approach in Scotland.

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." During the passage of the Vulnerable Witnesses (Criminal Evidence) (Scotland) Bill, Ash Denham, the Minister for Community Safety reiterated Scottish Government support for Barnahus, stating "As the cabinet secretary has said to the Parliament throughout the passage of the bill, a Scottish version of the Barnahus concept is the Scottish Government's intended destination and the bill is an important initial step towards that destination. We are committed to making progress towards a truly trauma-informed, recovery-focused response to child victims."[5]

As we have previously highlighted, we are concerned that this Bill may cut across some of this work and may have unintended consequences that impact on the progress of a Barnahus approach. The Barnahus model seeks to provide holistic support, including medical examinations, to all child victims of violence and abuse, whereas, as set out above, this Bill creates a duty only for medical examinations and only for child victims of sexual offences.

Although the Child Rights and Wellbeing Impact Assessment states that "the Bill supports multi-agency working and is therefore 'Barnahus ready' and can "support the Scottish Government's wider moves towards developing a Scottish version of the Barnahus concept" we are not clear how the bill will in practice support multi-agency working and how it will align to Barnahus provision. For example, our understanding is that many health boards are looking at significant investment into new forensic examination suites for both adults and children who have experienced sexual assault. However, delivery of Barnahus will probably require forensic examination facilities with the Barnahus for child victims of all forms of abuse. It is not clear how this will be reconciled.

What are the key benefits of providing forensic examination on a self-referral basis (whereby victims can undergo a forensic medical examination without first having reported the incident to the police)? What problems may arise from this process?

Children 1st 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.

Are there any issues with the proposal to restrict self-referral to people over 16 years old?

[5] http://www.parliament.scot/parliamentarybusiness/report.aspx?r=12083

Our understanding is that self- referral is not applicable to children under the age of 16 since if they disclose sexual abuse, they will automatically be considered within a child protection Pathway.

We also wish to highlight that the UNCRC defines a child as up to the age of 18 years, not 16 but different pieces of legislation view 16 and 17 year olds differently. The Committee may wish to consider this issue further.

Are there any issues with the health board storing and retaining evidence gathered during self-referred forensic examinations?

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.

Do you have any other comments to make on the Bill?

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 initial 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.

All legislation must be viewed through the lens of children's rights, in particular given the upcoming incorporation of the United Nations Convention on the Rights of the Child into Scots Law this year.