



HM INSPECTORATE OF CONSTABULARY IN SCOTLAND

Strategic Overview of Provision of Forensic Medical Services to Victims of Sexual Crime

March 2017



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HM Inspectorate of Constabulary in Scotland

HM Inspectorate for Constabulary in Scotland (HMICS) is established under the Police and Fire Reform (Scotland) Act 2012 and has wide ranging powers to look into the 'state, effectiveness and efficiency' of both the Police Service of Scotland (Police Scotland) and the Scottish Police Authority (SPA).¹

We have a statutory duty to inquire into the arrangements made by the Chief Constable and the SPA to meet their obligations in terms of best value and continuous improvement. If necessary, we can be directed by Scottish Ministers to look into anything relating to the SPA or Police Scotland as they consider appropriate. We also have an established role in providing professional advice and guidance on policing in Scotland.

- Our powers allow us to do anything we consider necessary or expedient for the purposes of, or in connection with, the carrying out of our functions.
- The SPA and the Chief Constable must provide us with such assistance and co-operation as we may require to enable us to carry out our functions.
- When we publish a report, the SPA and the Chief Constable must also consider what we have found and take such measures, if any, as they think fit.
- Where our report identifies that the SPA or Police Scotland is not efficient or effective (or best value not secured), or will, unless remedial measures are taken, cease to be efficient or effective, Scottish Ministers may direct the SPA to take such measures as may be required. The SPA must comply with any direction given.
- Where we make recommendations, we will follow them up and report publicly on progress.
- We will identify good practice that can be applied across Scotland.
- We work with other inspectorates and agencies across the public sector and co-ordinate our activities to reduce the burden of inspection and avoid unnecessary duplication.
- We aim to add value and strengthen public confidence in Scottish policing and will do this through independent scrutiny and objective, evidence-led reporting about what we find.

Our approach is to support Police Scotland and the SPA to deliver services that are high quality, continually improving, effective and responsive to local needs.²

This strategic review was undertaken by HMICS in terms of section 74(2) of the Police and Fire Reform (Scotland) Act 2012 and is laid before the Scottish Parliament in terms of section 79(3) of the Act.

¹ Chapter 11, Police and Fire Reform (Scotland) Act 2012.

² HMICS, [Corporate Strategy 2014-17](#) (2014).



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Our review

This review aims to **provide a strategic overview of the forensic medical services provided to adult and child victims of sexual crime, and to give a high-level assessment of these services in terms of their current delivery against national policies and standards.** It highlights strategic issues for consideration by key stakeholders, and is intended to inform future scrutiny of this area.

HMICS welcomes the commitment from the Cabinet Secretary for Justice, announced in February 2017, to introduce new nationwide standards to ensure consistent delivery of forensic medical examinations for victims of sexual violence. Healthcare Improvement Scotland has been commissioned to produce the standards, which are expected to be published before the end of 2017.

We believe the evidence in this review, which has been gathered over six months since August 2016, confirms the need for national standards, as well as highlighting wider issues affecting the quality of service delivered to victims of sexual crime. We have identified an urgent need to review the Memorandum of Understanding between the Police Service of Scotland and all geographic NHS Boards in Scotland (collectively described as 'NHS Scotland' for the purposes of the MOU) for the provision of Healthcare and Forensic Medical Services. There is also a need to provide greater clarity around the statutory responsibility for delivering these services. This will require an informed debate around where the appropriate balance lies between providing quality healthcare services to the victims of sexual crime and the need to obtain forensic evidence to support criminal justice processes.

This review highlights significant disparity in the forensic healthcare services currently being provided to the victims of sexual crime and supports the need for further investment in healthcare professionals, premises and equipment. There should be greater innovation in providing services across Scotland, especially in relation to rural and island communities and more collaboration is needed amongst health boards to share specialist staff and make them available to victims at the point of need within their own communities. We consider there are also opportunities to develop the role of specialist nurses in support of the victims of sexual crime, although recognise this will require more dialogue with the Crown Office and Procurator Fiscal Service.

Our review has identified an important gap in current service provision, where the victims of sexual crime seek support and medical attention after a crime but may not wish to report it to the police at that time. We believe that in such circumstances, victims should not only be able to obtain the medical attention and support they need, but that forensic evidence should also be secured and retained. This would allow the forensic evidence to be available should the victim subsequently decide to report the crime.

We have taken an opportunity to look at how services are provided to the victims of sexual crime in other countries and identified several models which may inform future provision in Scotland. These all focus on the health and wellbeing of victims within a supportive healthcare setting.



HMICS has engaged with a wide range of agencies and stakeholders to gather evidence for this review. Although our statutory duties primarily relate to Police Scotland and the Scottish Police Authority, we have included some wider recommendations to other key stakeholders, including the Scottish Government. These recommendations are offered as suggestions to inform the design of future provision and importantly, drive improvement in the services currently being provided to the victims of sexual crime across Scotland.

This review was led by Gill Imery, Assistant Inspector of Constabulary.

Derek Penman QPM

HM Chief Inspector of Constabulary in Scotland

March 2017



Key findings

- There are committed and dedicated professionals across the country working towards delivering high quality forensic medical examinations for victims of sexual crime.
- Significant variations in the provision of forensic medical services in Scotland persist, with issues of availability as well as geography making the quality of service offered to some victims of sexual crime unacceptable.
- A lack of strategic leadership and governance over the provision of forensic medical services has limited progress towards improvements.
- A better balance needs to be achieved between the responsibility of the Scottish Government portfolios of Justice and Health to deliver quality forensic medical services. This balance should reflect the fact that the priority of forensic medical examinations should be to address the immediate health needs and future recovery of patients, with the contribution to potential criminal justice proceedings being a secondary consideration.
- There is a need to clarify the legal responsibilities for both the function and delivery of forensic medical services in Scotland.
- 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.
- Minimum standards of service delivery were accepted in principle by Scottish Ministers in 2013, but not formally issued to NHS Boards.
- No audit or inspection process is in place to ensure quality service provision across Scotland.
- No quality performance indicators have been developed to monitor the standards of forensic medical services being delivered.
- Scotland is well behind the rest of the United Kingdom in respect of availability of dedicated healthcare facilities which meet both the health needs of victims and the necessary forensic requirements.
- The one dedicated service at Archway in Glasgow is not available for significant periods of time, particularly overnight and at weekends, which has resulted in a two-tier service being delivered to victims of sexual crime. The alternative service delivered in a police station is inadequate.
- Forensic physicians generally provide both healthcare services to people in police custody and forensic medical services to victims of sexual crime.
- The provision of forensic medical services is not currently recognised as a specialism by the General Medical Council. Some stakeholders suggested that more doctors would be attracted to the role of forensic physician if this position were to change.
- The majority of forensic physicians in Scotland are men.
- The role of forensic nurse examiners is under developed in Scotland.
- Adult victims of sexual crime continue to undergo forensic medical examinations in police buildings in many areas of Scotland. This is not victim-centred or considered effective practice.
- Lack of availability of services locally leads to delays and lengthy journeys for victims of sexual crime, who can be asked not to wash for a day or more after an assault.



- The options for victims to self-refer to services and to receive a forensic medical examination to secure forensic evidence before deciding to report the crime to the police, are limited in Scotland.
- The legal position relating to collecting and retaining forensic samples in the absence of a report to the police is not clear in Scotland, and no formal guidance exists for NHS Boards or Police Scotland.
- There is no consistent data collection on the provision of forensic medical services to victims of sexual crime in order to understand the volume and nature of demand across the country, and to inform decisions on policy and resources.
- The provision of essential equipment (including colposcopes) for forensic medical examinations is inconsistent across Scotland.
- Forensic cleaning regimes vary across the country and the Faculty of Forensic and Legal Medicine (FFLM) standards are not being met in some areas.
- Suspects of sexual crime are being examined and having forensic samples obtained in police custody settings, which are not always forensically secure environments.
- Children and young people suspected of being perpetrators of sexual crime are being examined and having forensic samples obtained in police custody settings.
- The paediatric component of forensic medical examinations of children who have been sexually abused is generally working well and is always delivered in a medical setting, however, sustaining sufficient numbers of paediatricians with the relevant experience is a challenge.
- Due to the lack of availability of paediatric services in some areas, children who have been sexually abused are having to travel significant distances to be medically examined.
- Adolescents can fall between adult and child services and, in the West of the country when Archway is unavailable, forensic medical examinations can be delayed.
- Opportunities exist to learn from well-established policy and practice in the rest of the United Kingdom, Europe and across the world relating to the provision of forensic medical services to victims of sexual crime.
- Interest is growing in models that provide holistic services to meet the healthcare needs of individuals, as well as secure evidence for potential criminal justice processes.
- The Children's House approach to providing services to children who have been sexually abused is being considered in Scotland. Whilst this holds the potential to improve criminal justice outcomes, the emphasis should be on the health, wellbeing and recovery of children and families affected by child sexual abuse.
- There are examples of good practice in Scotland for the provision of forensic medical services to victims of sexual crime, however victims are being let down by the standard of service available at some times and in some areas of the country.



Recommendations

Recommendation 1

The Scottish Government should review the legal basis for the current agreement between Police Scotland, the Scottish Police Authority and NHS Scotland to deliver healthcare and forensic medical services. This review should inform the nature and need for any refreshed national Memorandum of Understanding between the parties.

Recommendation 2

Police Scotland should work with the partners responsible for delivering the Archway service in Glasgow and the West of Scotland and strengthen its current governance arrangements to ensure the service is adequately resourced and meets the needs of the communities it serves.

Recommendation 3

The Scottish Government should engage with relevant agencies and stakeholders and bring forward proposals for establishing dedicated healthcare facilities across Scotland to meet both the healthcare needs of victims of sexual crime and the necessary forensic requirements. This should be informed by research and current best practice.

Recommendation 4

The Scottish Government should consider formally issuing the newly proposed national standards for the delivery of forensic medical examination for victims of sexual violence to all NHS Boards. These standards should be supported by a framework of publicly reported quality indicators and monitored through an effective audit and inspection regime.

Recommendation 5

Police Scotland should work with NHS Boards to urgently identify appropriate healthcare facilities for the forensic medical examination of victims of sexual crime. The use of police premises for the examination of victims should be phased out in favour of healthcare facilities as soon as is practicable.

Recommendation 6

The Scottish Government should work with relevant stakeholders and professional bodies including NHS Scotland, Police Scotland and the Crown Office and Procurator Fiscal Service to develop the role of forensic nurses in Scotland.

Recommendation 7

The Scottish Government should work with relevant stakeholders and professional bodies, including NHS Scotland, Police Scotland and the Crown Office and Procurator Fiscal Service to develop self-referral services for the victims of sexual crime. This should clarify the legal position for obtaining and retaining forensic samples in the absence of a report to the police and support formal guidance for NHS Boards and Police Scotland.

Recommendation 8

The Scottish Government should work with NHS Scotland to ensure that the existing healthcare ICT system (ADASTRA) is being used consistently for collating information on the volume and nature of forensic medical examinations across Scotland. This will inform future policy and decision making, including resourcing.



Recommendation 9

Police Scotland should work with the Scottish Police Authority and NHS Scotland to introduce standard operating procedures for the forensic cleaning of police premises which continue to be used for medical examinations. These should comply with current guidance.

Recommendation 10

Police Scotland should work with NHS Scotland to ensure suspected perpetrators of sexual abuse who are under 16 years old are not forensically examined within police custody facilities. The Criminal Justice (Scotland) Act 2016 defines a child as being a person under the age of 18 and consideration should be given to how this affects the treatment of child suspects in the context of forensic medical examinations.

Background and context

1. The Scottish Government has five strategic objectives³ that underpin its core purpose to create a more successful country, with opportunities for all of Scotland to flourish through increasing sustainable economic growth. Two of these strategic objectives, 'Healthier' and 'Safer and Stronger' are particularly relevant here:
 - Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to healthcare.
 - Helping communities to flourish, becoming stronger, safer places to live, offering improved opportunities and a better quality of life.
2. The Strategy for Justice in Scotland (2012)⁴ sets out a vision of a justice system that contributes positively to a flourishing Scotland, helping to create an inclusive and respectful society in which all people and communities live in safety and security, individual and collective rights are supported and disputes are resolved fairly and swiftly.
3. The Route Map to the 2020 Vision for Health and Social Care (2013)⁵ sets out the vision for the delivery of healthcare services in Scotland, asserting that *'whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.'*
4. The Police and Fire Reform (Scotland) Act 2012⁶ introduced the national Police Service of Scotland (referred to in this report as 'Police Scotland'), which became operational on 1 April 2013. The main policing principle under the Act is to improve the safety and wellbeing of people, localities and communities in Scotland. The police service should police in a way that is accessible to and engaged with local communities.
5. Police Scotland's Code of Ethics⁷ is based on the understanding that *how* policing is delivered is as important as *what* is delivered in terms of the impact on communities, and their trust and confidence in the police. A fundamental aim of Police Scotland is to provide equity of access to specialist services across the country.
6. Following the creation of Police Scotland, the responsibility for the delivery of healthcare and forensic medical services for people in police care transferred from the police to NHS Boards. The Scottish Police Authority (SPA) has assumed responsibility for forensic medical services under Section 31 of the Police and Fire Reform (Scotland) Act 2012 however the delivery of forensic medical services was passed to NHS Boards.
7. The transfer of responsibility from police to NHS was based on an agreement that the NHS should look after the healthcare needs of people in police custody. The requirement to provide forensic medical services was less well defined. However, at the point of transfer, there was an expectation that Police Scotland and NHS Scotland would work together to define the service and establish effective delivery across Scotland.

³ <http://www.gov.scot/About/Performance/scotPerforms/objectives>.

⁴ <http://www.gov.scot/Topics/Justice/justicestrategy>.

⁵ <http://www.gov.scot/Topics/Health/Policy/Quality-Strategy/routemap2020vision>.

⁶ [Police and Fire Reform \(Scotland\) Act 2012.](http://www.gov.scot/Topics/Justice/Police-and-Fire-Reform-Scotland-Act-2012)

⁷ <http://www.scotland.police.uk/about-us/code-of-ethics-for-policing-in-scotland/>.



8. Police Scotland, the Crown Office and Procurator Fiscal Service (COPFS), the Scottish Courts and Tribunals Service, the Scottish Prison Service, and the Parole Board for Scotland, established standards of service for victims and witnesses⁸ in April 2015. These standards include:
 - Ensuring fair and equal access to services throughout and being treated with dignity and respect at all times.
 - Working together and in partnership with victim and witness support organisations to ensure the best possible service is delivered.
9. The common factor of national policy for health and justice is that services should be delivered as far as possible to meet the needs of the individual, and should be accessible to everyone regardless of where he or she lives.
10. In this review, HMICS considered the extent to which adult and child victims of sexual crime in Scotland receive a consistent, professional, and sensitive forensic medical service to meet their healthcare needs as well as to retrieve evidence in support of potential criminal proceedings.
11. HMICS used a range of tools to gather information to inform this strategic overview, including:
 - Meetings with key stakeholders from Police Scotland, Scottish Government, SPA, Healthcare Improvement Scotland, COPFS, Rape Crisis Scotland, and Children 1st.
 - Attendance at relevant NHS Regional Planning and Network Board meetings.
 - Document review of legislation, policy and guidance in Scotland.
 - Information request to all Police Scotland Public Protection Units.
 - Presentation to and consultation with members of the Adult Sexual Assault Forensic Delivery Sub Group and the Paediatric Forensic Service Delivery Sub Group (both sub groups of the National Co-ordinating Network Board).
 - Questionnaire circulated to all forensic physicians.
 - Questionnaire circulated to all paediatricians involved in forensic medicals for child sexual abuse.
 - Questionnaire circulated to Children 1st, National Society for the Prevention of Cruelty to Children (NSPCC), Barnardos, Aberlour Child Care Trust, Child Protection Committees, Social Work Children and Families.
 - Visit to Archway SARC in Glasgow.
 - Desktop research into approaches in England and Wales, including legislation and guidance relating to models of service delivery that could provide potential solutions for Scotland.
 - Desktop research into European and international approaches.
 - The perspective of service users was gained through access to the anonymised feedback collated by Rape Crisis Scotland, views of Police Scotland's Sexual Offences Liaison Officers (SOLOs), experiences of those who attended Archway (contained in Archway review report),⁹ and the feedback from organisations who support children and young people.

⁸ <https://www.scotcourts.gov.uk/about-the-scottish-court-service/scs-news/2015/04/30/standards-of-service-for-victims-and-witnesses>.

⁹ Review of Archway, Axiom Consultancy (January 2016).

Prevalence of sexual crime

12. The Scottish Crime and Justice Survey 2014-15¹⁰ found that almost 3% of adults had experienced at least one form of serious sexual assault since the age of 16. Over 8% of respondents had experienced at least one form of less serious sexual assault since the age of 16. Only 17% of those respondents who had been subjected to 'forced sexual intercourse' had reported the crime to the police.
13. The NSPCC conducted a study¹¹ in 2011 that estimated the rates of contact sexual abuse to be as high as 7% of girls aged between 11 and 17 years. Overall the study estimated that one in 20 children in the UK had been sexually abused. The NSPCC 'How Safe Are Our Children?' report in 2016¹² provides an overview of child protection in the UK. The report shows that calls to its helpline relating to sexual abuse have more than doubled from 3,867 in 2009-10 to 8,805 in 2014-15. The report includes Scottish Government statistics on sexual crimes against children, and notes an upward trend with approximately three sexual offences per 1,000 children under 16.
14. Tables 1, 2 and 3 below show Police Scotland figures for sexual crime and rape over the past three years.

Overall figures for sexual crime in Scotland

Table 1 – Comparison of Group 2 Crime (including rape) from 2013 to 2016 (adult and child victims)

Fiscal year (April to March)	Total Group 2 crime (sexual crime including rape)	Number of reported rapes
2013-14	8,767	1,700
2014-15	9,671	1,810
2015-16	10,273	1,692

15. While Table 1 shows increasing levels of overall sexual crime (Group 2), the number of reported rapes has remained relatively stable. Arguably, this provides opportunities to assess and plan services to meet future demand. Increases in overall sexual crime are largely attributable to non-contact offending, such as communicating indecently with children, and taking, distributing and possessing indecent images of children, which has implications for cyber-crime and cyber forensics, but not for forensic medical services.
16. The most up-to-date figures available are until the end of December 2016. From 1 April to 31 December 2016, the overall Group 2 figure is 8,017, up 5.1% on the same period the previous year. The number of rapes recorded in Scotland is 1,319, up 2.6% from the same period the previous year.
17. The proportion of rapes reported within seven days of being committed is important as it indicates those cases where forensic evidence is most likely to be gleaned from a forensic medical examination.

¹⁰ [Scottish Crime and Justice Survey 2014/15.](#)

¹¹ [Radford,L.,Corral,S.,Bradley,C.,Fisher,H.,Bassett,C.,Howat,N.,Collishaw,S.,\(2011\) Child Abuse and Neglect in the UK today, London: National Society for the Prevention of Cruelty to Children.](#)

¹² [How Safe Are Our Children? NSPCC \(2016\).](#)

18. From 1 April to 31 December 2016, 415 rapes were reported within seven days of commission (31.46% of all reports). For the same period the previous year, the number was 430, which is 33.46% of all reports.
19. Non-recent reports are also significant, with many being reported over a year after the crime. From 1 April to 31 December 2016, 531 rapes were reported more than one year from date committed (40.2%). For the same period the previous year, the number was 496 (38.5%).

Table 2 – Reported rape cases within seven days and more than one year after commission (adult and child victims)

YTD	Total Group 2 (sexual crime including rape)	Number of reported rapes	Number of rapes reported within 7 days of commission	Number of rapes reported more than one year after commission
1 April-31 December 2016	8,017	1,319	415	531
1 April-31 December 2015	7,626	1,285	430	496

Child victims of sexual crime in Scotland

20. The Sexual Offences (Scotland) Act 2009 defines a young child as being under the age of 13 and an older child as not having attained the age of 16.
21. While Table 3 shows increasing levels of overall sexual crime (Group 2) involving victims under the age of 16 years, the increases are largely attributable to non-contact, internet-enabled offending. The number of reported rapes with victims under the age of 16 years has remained relatively stable, which provides opportunities to assess and plan services to meet future demand.

Table 3 – Proportion of Group 2 Crime (including rape) where victims are under 16 years of age from 2013 to 2016


Fiscal year (April to end March)	Total Group 2 (sexual crime including Rape)	Number of victims of sexual crime aged under 16 years	Total number of reported rapes	Number of victims of rape aged under 16 years
2013-14	8,767	3,183 (36.3%)	1,700	288 (16.9%)
2014-15	9,671	3,886 (40.1%)	1,810	347 (19.2%)
2015-16	10,273	4,495 (44.7%)	1,692	328 (19.4%)

Impact of sexual crime

22. The effects of sexual violence on the individual cannot be underestimated and include depression, anxiety, post-traumatic stress disorder, substance misuse, self-harm and suicide.¹³ The wider impact for society is that sexual violence perpetuates inequality, prevents the achievement of potential, not only for those who experience it directly, but also their families and communities.¹⁴

¹³ [Violence Prevention: A Public Health Priority, Glasgow \(2014\).](#)

¹⁴ [Scottish Government, Safer Lives: Changed Lives-A Shared Approach to Tackling Against Women in Scotland, Edinburgh \(2009\).](#)

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23. The Scottish Government has produced estimates of the social and economic cost of reported crime. The cost of rape and attempted rape has been calculated at £529 million per year based on data for 2010-11.¹⁵ Each rape is thought to cost £88,731.¹⁵
 24. A study for the NSPCC¹¹ shows that all forms of abuse in childhood were generally associated with poorer outcomes in terms of mental and physical health, as well as influencing behaviour such as being involved in crime and substance misuse, all of which have wider implications for the individual and society. A literature review by the NSPCC estimated the economic cost of child sexual abuse in the UK as £3.2 billion based on costs to health, criminal justice, children's services, and to the labour market in lost productivity.¹⁶
 25. There is evidence that a victim-centred response to sexual crime can have a positive effect on the long-term health and recovery of an individual, continued engagement in any criminal justice process, as well as improved quality of evidence to support any criminal proceedings.¹⁷
 26. A sensitive and professional service to victims of sexual crime delivers benefits in terms of the individual's health as well as the delivery of justice. Forensic recovery, medical support and the wellbeing of the victim are key factors in rape investigation and central to health outcomes and maintaining the confidence of the victim through the judicial process.¹⁸ There are also significant positive implications for future service demand on the wider health system.¹⁹

¹⁵ Perman, J., Economic and Social Costs of Crime, Application in Criminal Careers, Crime and Justice User Day, Scottish Government (2012).

¹⁶ [Saied-Tessier, A. \(2014\) Estimating the Cost of Child Sexual Abuse in the UK, London: NSPCC.](#)

¹⁷ [Sexual Assault Referral Centres Developing Good Practice and Maximising Potentials, Home Office Research Study 285 \(2004\).](#)

¹⁸ [Report of the Independent Review into the Investigation and Prosecution of Rape in London \(2015\).](#)

¹⁹ [National Institute for Health and Clinical Excellence 2014 Domestic Violence and Abuse: How Health Services, Social Care and the organisations they work with can respond effectively.](#)



Transfer of function from police to NHS Boards

27. In 2011, the Director General of NHS Scotland, NHS Board Chief Executives and representatives of the Association of Chief Police Officers in Scotland (ACPOS) agreed to move towards a partnership arrangement for custody healthcare and forensic medical services, whereby the services previously provided by police forces under the Scottish Home Department Circular 7362 (1950), should be jointly provided by Police and Health and delivered by NHS Boards.
28. The Cabinet Secretaries for Health and Social Care and for Justice agreed the general approach to transfer funding and responsibility for the provision of healthcare and forensic medical service, based on a number of proposals, including:
 - Responsibility for the healthcare in police custody, as a function of health boards under the terms of the Health Service (Scotland) Act 1978, will be the *function and responsibility* of health boards.
 - Forensic medical services should be *delivered* by health boards but remain a *function and responsibility* of the Scottish Police Authority (SPA) under Section 31 of the Police and Fire Reform (Scotland) Act 2012.
29. This agreement relies heavily on an interpretation of who has the statutory responsibility for custody healthcare and forensic functions. It is now accepted that the legal responsibility for custody healthcare is covered by the National Health Service (Scotland) Act 1978 and is properly the function and responsibility of health boards. This acknowledges that those who are temporarily held in police custody may have healthcare needs that are best met by the NHS, especially in terms of continuity with pre-existing treatment and throughcare after release. This is intended to improve individual health outcomes.
30. Similarly, there is an acceptance that the statutory responsibility for forensic services is covered by Section 31 of the Police and Fire Reform (Scotland) Act 2012 and is properly the function and responsibility of the SPA. This is a very short section in the Act, which simply states, '*The Authority must provide forensic services to the Police Service, the Police Investigations and Review Commissioner and the Lord Advocate and procurators fiscal.*' The legislation provides no guidance or interpretation of 'forensic services' and makes no reference to the legacy arrangements for forensic medical examiners or the specialist forensic healthcare services such as paediatrics that had historically been delivered by health boards.
31. Legacy police forces had a mixture of arrangements in place to provide both custody healthcare and forensic medical services. These included direct employment of 'police surgeons', local partnership agreements with NHS and some outsourced private services. The combined budget spent by legacy police forces on custody healthcare and forensic medical provision was calculated at approximately £7.6m and was transferred in full to NHS Scotland at the time of transfer of functions in 2014. It is estimated that around 95% of the £7.6m was allocated to custody healthcare provision, with little remaining for the forensic medical service to victims of sexual crime. While the arrangements for custody healthcare were better understood, the requirements for forensic medical services were less well defined. However, it was envisaged that partners including Police Scotland and NHS Scotland would work together to develop the service requirement over time.
32. The current agreement creates a narrow distinction between the legal responsibility for providing forensic healthcare and its actual delivery. If accepted, this distinction defines the actual relationships between the SPA and NHS Scotland and would suggest the former has

outsourced its statutory responsibility to deliver forensic healthcare to the latter. Despite this, there is little evidence of the SPA recognising any legal responsibility for outsourcing forensic healthcare or providing any strategic leadership, governance or scrutiny over the agreement between Police Scotland and NHS Scotland.

National Memorandum of Understanding between the Police Service of Scotland and all geographic NHS Boards in Scotland²⁰

33. A national Memorandum of Understanding (MOU) was agreed between Police Scotland and NHS Scotland, which covers the transfer of function to deliver both custody healthcare and forensic medical services. The agreement establishes a common purpose to deliver integrated healthcare and forensic medical services based on good practice, value for money and the statutory requirements of the Scottish Government, working towards best practice. However, this MOU is not legally binding and has relied largely on the goodwill of all parties to adopt standards and agree the level of service to be provided. It has been subject to regional variations and has also led to practical difficulties in holding parties to account for effective delivery.
34. Forensic medical services are defined in the MOU and include:
 - Undertake relevant examination and collection of forensic samples from alleged perpetrators in police custody.
 - Undertake relevant examination and collection of forensic samples from complainants (reported victims) of crime.
 - Undertake relevant examination and collection of forensic samples from children suspected to have suffered abuse including sexual offence.
 - Facilitating the training and support of colleagues to deliver forensic medical services.
35. The common purpose and common values are described in the MOU. The values refer to the provision of open, consistent and accountable public services, and quality person centred services for people who report crimes to the police.
36. The principal responsibilities of partners are listed in the MOU. NHS Boards are responsible for the delivery of forensic medical services for people referred by police to their care. If the terms of the MOU are accepted, namely that Police Scotland has strategic responsibility and oversight of forensic medical services, then it begs the questions how this responsibility is being governed through the SPA and how effective is it when the inconsistencies in standard of service persist?
37. HMICS considers that the initial agreement between the Cabinet Secretaries for Health and Social Care and for Justice has relied upon an unduly narrow interpretation of the legislation. There is now an urgent need to review the legal basis for the agreement between Police Scotland, the SPA and NHS Scotland to deliver healthcare and forensic medical services. Whilst this may ultimately require specific legislation to clarify the statutory function and responsibility for delivering forensic medical services, it is necessary to provide the much-needed certainty upon which improved services and standards can be built.
38. Any decision around the legal basis for the agreement between Police Scotland, SPA and NHS Scotland is likely to impact on the nature and perhaps need for any national MOU between the parties. If the statutory function and responsibility to deliver forensic healthcare is seen to be NHS Scotland, then the MOU could be replaced by nationally agreed service

²⁰ [National Memorandum of Understanding Between the Police Service of Scotland and all Geographic NHS Boards in Scotland for the Provision of Healthcare and Forensic Medical Services for those in the care of the Police Service of Scotland \(v.1.2\).](#)

standards and a supporting performance management regime. Police Scotland and the SPA would become key stakeholders in setting and monitoring these standards. However, should the statutory function and responsibility be held by the SPA and delivery outsourced to NHS Scotland, then there will be a need to replace the current MOU with some form of binding and enforceable agreement. This would specify the roles and responsibilities for delivering forensic medical services and would require the development of new and more robust leadership and a governance arrangements to monitor performance and hold parties to account when the required standard of service is not delivered.

Recommendation 1

The Scottish Government should review the legal basis for the current agreement between Police Scotland, the Scottish Police Authority and NHS Scotland to deliver healthcare and forensic medical services. This review should inform the nature and need for any refreshed national Memorandum of Understanding between the parties.

National Guidance on the delivery of Police Custody Healthcare and Forensic Medical Services²¹

39. This guidance accompanies the national MOU, and states there should be clear management, accountability and clinical governance arrangements. Any model of delivery must promote equity of access, patient centred delivery and patient dignity and respect not compromised by physical, language, cultural, social, economic and other barriers.

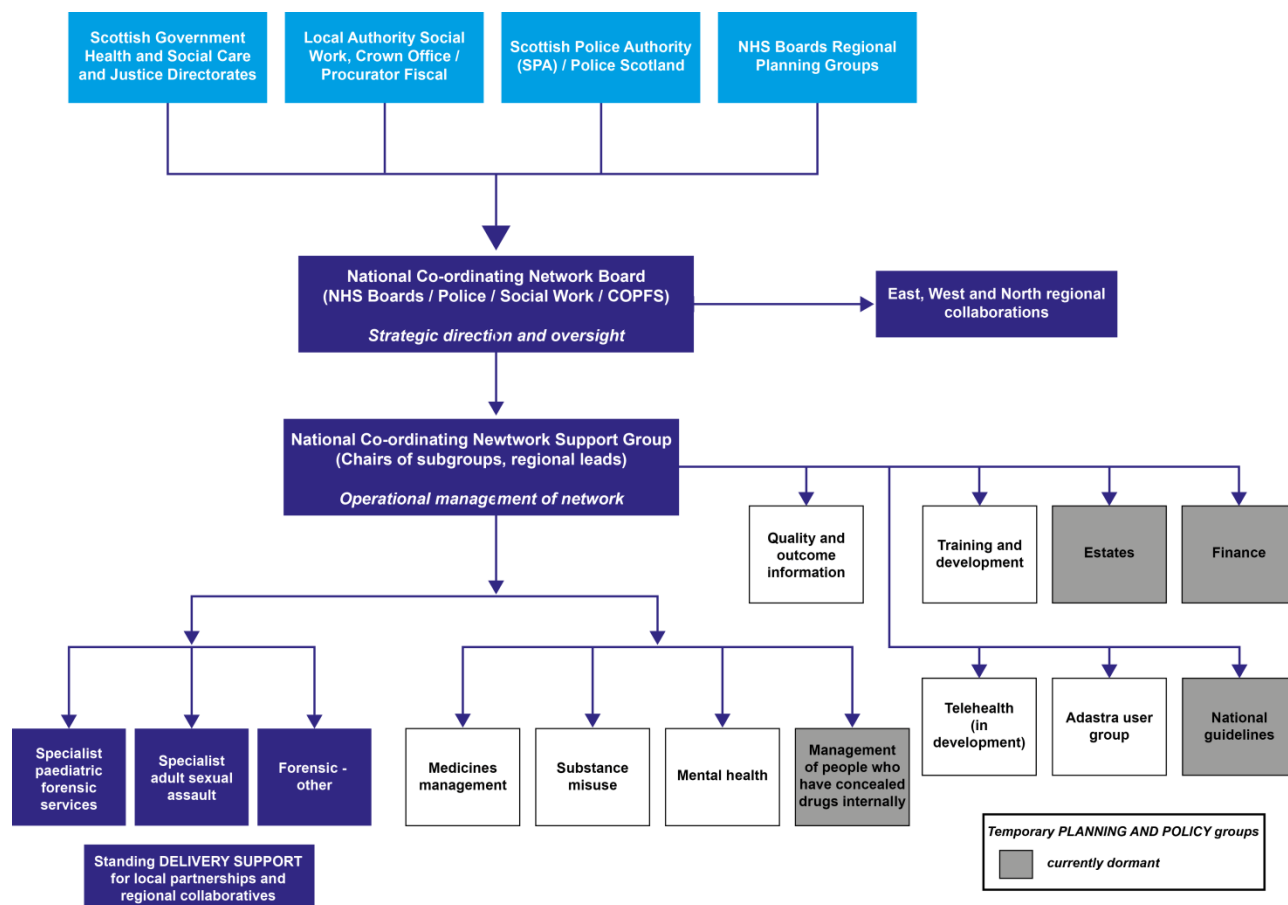
The National Co-ordinating Network for Healthcare and Forensic Medical Services for People in Police Care²²

40. In 2012, the National Co-ordinating Network for Healthcare and Forensic Medical Services for People in Police Care was established to work with NHS Boards and Police Scotland to support and facilitate the transition to the new arrangements in April 2014. A National Co-ordinating Network Board was formed, with a remit to provide strategic direction and oversight for all healthcare and forensic medical services for people in police care. This included healthcare and forensic services provided to adult victims of sexual assault, and to child victims of sex abuse and serious physical abuse.

²¹ National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services (v.2.0 June 2015).

²² [Police Care – National Co-ordinating Network for Healthcare & Forensic Medical Services for People in Police Care.](#)

Diagram 1 – Governance structures for the National Co-ordinating Network



41. The National Co-ordinating Network Board has a remit to monitor service delivery to ensure that it meets needs and is delivered efficiently, effectively and equitably across Scotland. It also oversees the Network’s objectives and directs action to ensure they are met.
42. Although the Network has made considerable efforts to achieve improvements in forensic estate, to introduce standardised forensic kits, and to ensure provision of essential equipment such as colposcopes, challenges continue to be experienced in delivering to a consistent standard across the country. NHS Boards and Regional Collaboratives have worked hard towards delivering high quality, person-centred services, however significant variations in standards persist.
43. The 2015-16 annual report of the Network sets out a Vision for 2020. The following elements relate to healthcare and forensic medical services for adult victims of sexual assault and child sexual abuse and non-accidental injury.
 - Healthcare and forensic medical services should be embedded within existing healthcare services and be situated in forensically sound healthcare or social care facilities.
 - Services should include an immediate clinical needs assessment and healthcare follow up with access to sexual and reproductive health services, support, advocacy, trauma care and safety planning.
 - Examinations should be timed appropriately to meet the needs of the victim and both evidential and therapeutic needs.



- Services should refer to other NHS services as well as support services provided by local authorities and third sector organisations if appropriate.
- Everyone should have access to healthcare and forensic medical services regardless of whether they choose to report to the police and proactive steps will be taken to ensure access to services for disadvantaged groups.

44. The annual report goes on to add that this vision is aspirational, and investment would be required to achieve this, specifically with regards to ensuring locations for forensic medical examinations are in healthcare or social care settings.

National arrangements

45. In the decision making to arrive at the current arrangements, it was felt that a clear separation of the provision of healthcare and forensic medical services was difficult and impractical, however HMICS suggest this needs to be re-visited. There would be real benefits in separating the service for those in custody from those who are victims of sexual crime. Currently, forensic physicians in the main carry out duties across the full range of healthcare provision for people in custody and for forensic medical services, which is a wide remit requiring very different skills. Dealing with what one forensic physician described as *'generally young violent males with drug and alcohol problems'* in police custody is a very different role from providing sensitive support to the victim of rape or serious sexual assault. HMICS believes separating these roles should be considered, and a remit for providing forensic medical services to victims is likely to be more attractive to a wider pool of doctors, including women.

46. There are no audit and inspection processes in place across health boards to ensure forensic medical services are delivered to a consistent standard. There are opportunities for Healthcare Improvement Scotland to undertake this role at a national level.

47. The Archway centre in Glasgow is the only Sexual Assault Referral Centre (SARC) in Scotland. It was formed in 2006, and was initially a partnership between NHS Greater Glasgow and Clyde, Strathclyde Police, Glasgow City Council, COPFS, and Rape Crisis.
48. It was created to offer a range of services to people over the age of 13, who have been raped or sexually assaulted in the previous seven days. The service includes forensic medical examinations, forensic sample storage, sexual health screening, emergency contraception, support and counselling. The service aims to:
 - Increase the rate of disclosure of rape and sexual assaults
 - Increase the rate of reporting to the police
 - Reduce levels of attrition (from the criminal justice process)
 - Reduce short and long term effects of rape and sexual assault
49. The service was developed to provide forensic services to victims who self-present or present via the police or other agencies, and was initially available 24 hours a day, seven days a week, with support and advocacy for up to 12 weeks. Over the years issues with medical and nursing cover meant Archway's hours of operation reduced to 9am to 5pm Monday to Friday, with forensic physicians largely providing the out of hours cover. The original Archway service was set up as a pilot and there is a view that the budget was not sufficient from the outset therefore it is not surprising that challenges in sustaining a 24 hour service quickly emerged.
50. The geographic area the Archway service covers has expanded from Glasgow to include people from NHS Lanarkshire, NHS Ayrshire and Arran, and parts of NHS Highland.
51. The arrangements for funding have changed to reflect the geographical expansion as well as the changes to the forensic medical provision more widely (i.e. from the police to health). Therefore Archway is funded from the Scottish Government Health and Social Care Directorate revenue allocation for provision of forensic medical services to people in police care; Glasgow City Council, and NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Ayrshire and Arran, and NHS Highland. The level of funding has not altered significantly since its inception in 2006.
52. Due in part to these changes, and challenges in terms of staffing the service, a review of the Archway service was commissioned by its management, and reported in January 2016.²³
53. The review notes that whilst the geographic area covered has increased since the service's inception, its annual budget has remained fairly static. In 2014-15 the budget was £587,389. The report goes on to show the budget as an allocation per person based on the population of the areas served, which shows Archway receiving £0.27 per head of population, in contrast with St Mary's SARC in Manchester, which receives £0.59 per head of population served (the annual budget for St Mary's is £1.6m).
54. While figures based on population are of interest, so is the volume of activity. Figures provided in the review of Archway show that the number of cases seen by Archway has reduced from its peak in 2011 (396 cases) to 222 'cases seen' in 2015. By contrast, St Mary's in Manchester saw some 1,600 clients in 2014-15, 65% of which involved a forensic medical examination. The staff complement at Archway has also reduced over the years, with a team of 29 in 2015, comprised of 10 doctors and 19 nurses.

²³ Review of Archway, Axiom Consultancy (January 2016).



55. The bulk of funding is for staff costs (£495,000 approximately for pay), and has remained relatively unchanged despite a reduction in the number of staff. The service is no longer available 24 hours a day, seven days a week.
56. Figures provided by Archway for the service provided since the review in January 2016, show that between 1 January 2016 and 31 October 2016 (305 days), 151 cases were seen at Archway. Over that period, an Archway doctor and nurse were available for 86 days. Forensic physicians covered 188 days. For 60 of those days, an Archway nurse was available.
57. There were only 15 occasions over those 10 months when forensic physicians used the premises. The review notes that due to lock up and decontamination requirements, it is difficult to give police or forensic physicians access to the building unless someone from Archway is present. The Archway nurses clean the forensic rooms after use. Out of hours, neither the police nor the forensic physician can wait on the premises while this takes place, therefore nurses would be left on their own, which is not considered to be safe.
58. The review includes a section on stakeholder perspective, and all interviewees valued the service very highly, and expressed support for the ethos of a SARC. One issue highlighted by almost all interviewees was the concern that the holistic nature of the SARC approach was being compromised by the way the out of hours service was being delivered. Due to difficulties in maintaining the Archway staff on call rota, forensic physicians are increasingly relied on to fill the gaps. This means that examinations are carried out in police stations by male doctors.
59. The review reported concerns about the service provided by forensic physicians, whose focus is the retrieval of forensic medical samples, and not the provision of emergency contraception or support for victims.
60. On the forensic physicians' part, there is considerable frustration at the lack of availability of the Archway service, and the extent to which they are having to fill the gaps in out of hours provision for forensic medical examinations of victims of rape and serious sexual assault. All of the forensic physicians affected who responded to the HMICS questionnaire expressed serious concerns about the standard of the alternative facilities in a police station, the lack of basic equipment, inadequate cleaning regime, and most importantly the service they are able to provide to the victim. HMICS is aware that since this review Police Scotland and the Archway service have put measures in place to address the situation however it is too early to say if these have proved successful.
61. It is estimated that forensic physicians carrying out around 108 forensic medical examinations each year in the area covered by Archway. Figures from Archway show that its staff dealt with 222 cases in 2015. Indications are that the number of cases dealt with by Archway is decreasing and is likely to have been around 180 by end of December 2016. forensic physicians report significant gaps in Archway availability, with staff withdrawing from rostered shifts at short notice. HMICS is aware that Archway cannot always accommodate clients after 3pm due to the lengthy nature of forensic medical examinations. The out of hours rota is limited, with forensic physicians providing the bulk of the cover overnight and at weekends.
62. Although it is difficult to provide exact figures, Archway would appear to have conducted approximately 67% of all examinations within its area in 2015. This will include victims who have not been seen immediately after reporting a rape or sexual assault. However, in the month of November 2016, Archway dealt with six out a total of 19 forensic examinations in its area, meeting approximately 31% of the demand.²⁴

²⁴ This data was compiled by Police Scotland at the request of HMICS as part of this Review.

63. The Archway review report offers a number of short, medium and long term actions. Archway staff report that since the review, an Executive Implementation Group has been established to progress these recommendations. Archway has committed to providing cover Monday to Friday 9am – 5pm, with efforts being made to improve the out-of-hours provision. A feasibility study is being undertaken for new premises. Despite this, there remains a degree of scepticism amongst some forensic physicians that this will result in any real improvement.
64. HMICS found that police public protection officers and SOLOs very much value the services offered at Archway. However, it is apparent that a two-tier service is in place in Glasgow and the West of Scotland and the quality of approach is dependent on when a victim reports to the police. Officers in Glasgow estimate about half of all forensic medical examinations of adult victims are carried out at Baird Street police station.

Comments from forensic physicians include:

- When the SARC (Archway) is not open, *'complainers are still seen '1980s' style by male doctors alone in unsuitable, forensically insecure premises'*.
 - If the SARC at Archway is unavailable, *'patients will be seen by a male doctor in wholly unsuitable premises... the forensic physician will have no nurse assistance, the room has poor lighting and is not stocked'*.
 - *'The minimum standards are certainly not being met for adult victims when the SARC is closed (which can be up to 70% of the time). Examining a victim on police premises, in a room wholly unsuitable for the examinations without a gender choice is dreadful. The room is not forensically cleaned. The victims should not be put through further trauma by being subject to an intimate examination in such woefully bad conditions'*.
 - *'...it is a lottery as to whether patients will be able to access the services of Archway. If they present between 0800 and 1500 Monday to Friday they probably, but by no means always, will be seen there by a female doctor with nurse assistance in a forensically cleaned room. If outwith these hours, they will be seen by a male FME in wholly unsuitable premises adjacent to the custody cells as no access is permitted to the Archway premises'*.
65. The Archway review recommended that the previous multi-agency steering group with representatives from the relevant NHS Health Boards, Police Scotland, COPFS, and Rape Crisis Scotland, be reinstated. This does not appear to have been achieved and HMICS has concerns about the availability of the Archway service, and the extent to which current governance arrangements ensure that the service meets the needs of the communities it serves.
66. The feedback about the service at Archway is overwhelmingly positive from professionals and service users alike. However, as the Archway service is not available for significant periods of time, in particular overnight and at weekends, a two-tier service has developed where victims receive a very different service depending when they come forward to report a rape or sexual assault. The alternative arrangements when Archway is unavailable are not acceptable. HMICS considers that more work is required to address the current lack of availability for Archway and seek to provide a service 24 hours a day, seven days a week. Suitable alternative arrangements should only be used as a contingency as part of a business continuity plan.



Recommendation 2

Police Scotland should work with the partners responsible for delivering the Archway service in Glasgow and the West of Scotland and strengthen its current governance arrangements to ensure the service is adequately resourced and meets the needs of the communities it serves.

67. There are 43 SARC's in England, four in Wales, and one in Northern Ireland. A variety of models are in operation elsewhere in the UK, some with a centralised SARC, others with a hub and spoke model, dependent on local context. Whilst there are local variations in the delivery model, all the SARC's work to a set of agreed standards. HMICS considers Scotland to be significantly behind the rest of the UK in its provision of a fully functioning SARC, available 24 hours a day, seven days a week, functioning independently of a rota for forensic physicians. SARC's are discussed in more detail later in this report (paragraphs 238 - 261).
68. There is a consensus amongst professionals and agencies supporting the victims of sexual crime that dedicated healthcare services for adults and children, which meet both the healthcare needs and the necessary forensic requirements should be available across Scotland. These should be multi-agency facilities that are not co-located on police premises and should be developed in partnership with all the relevant agencies and stakeholders. Given the challenges around geography and rural communities across Scotland, consideration should be given to developing a 'hub' and 'spoke' model. This would provide for dedicated facilities to be established in more densely populated areas, with skilled staff working within these centres being available to travel to more remote and island areas and deliver a high-quality service in suitable local healthcare premises. This will require political will, additional investment and strategic leadership across a number of agencies to supplement and realign existing resources into a new national delivery model for Scotland.

Recommendation 3

The Scottish Government should engage with relevant agencies and stakeholders and bring forward proposals for establishing dedicated healthcare facilities across Scotland to meet both the healthcare needs of victims of sexual crime and the necessary forensic requirements. This should be informed by research and current best practice.

Adult services

Minimum standards

69. At the start of 2013, the Cabinet Secretaries for Health and Justice approved the establishment of a Short Term Working Group comprising representatives from Health Boards, Police Scotland, Scottish Government, COPFS, Victim Support, SPA Forensic Services, forensic physicians, Archway, and Rape Crisis Scotland, with a remit to develop minimum standards for the provision of forensic examinations in sexual offences cases in Scotland.
70. In 2013, Scotland had no minimum standards in place despite considerable variation and gaps across the country, principally in relation to:
- Gender of forensic physician. In most areas, complainers were more likely to be examined by a male doctor.
 - Location of examination. Police stations being used for examinations, an environment which is not suitable for victims, and may lack specialist equipment and forensic integrity.
 - Timescale of examination. Sometimes unacceptable delays in arranging medical examinations, which can heighten victims' distress since they are not permitted to wash until after the examination takes place.
 - After care. Variability in provision of post-assault support and healthcare.
 - Availability of Archway. Archway SARC in Glasgow provides a service where victims are guaranteed a female doctor in an appropriate setting. Archway is not able to provide 24-hour service and victims have to be examined by forensic physicians in a police station when it is closed.
 - Self-referral. Few facilities available for victims to have a forensic medical examination in order to preserve evidence before deciding to report to the police.
71. The report from the Short Term Working Group was produced in May 2013.²⁵ The report stated that the standards should be implemented across Scotland. Whilst the group considered it acceptable to have regional variation in how services were delivered, taking account of local geography and arrangements, the group was clear that it was not acceptable for the quality of the service being provided to differ markedly.
72. The Minimum Standards were agreed in principle by both the Cabinet Secretaries for Justice and Health, but not widely consulted on, nor formally issued to health boards. The Ministers' expectation was that discussions amongst partners would be able to give effect to the recommended standards in practice. In summary, the Minimum Standards are:
- The NHS will ensure there is a care pathway in place to meet the victim's care and support needs.
 - Victims must have access to a forensic examiner of the gender of their choosing.
 - Examinations must take place outwith police stations in facilities for this purpose.
 - Examinations must take place within two hours of being requested.
 - Forensic examiners must have undertaken specialist training.
 - Nurses involved in forensic examinations must have undertaken specialist training.

²⁵ Report from the short term working group established to develop minimum standards for the provision of forensic examinations to victims following a sexual offence (May 2013).



- Individuals must have access to forensic examinations on a self-referral basis to ensure forensic evidence is not lost due to delay caused by uncertainty as to whether to report.
 - Views of the victim must be sought in relation to arrangements for examination.
 - Standardised forms for forensic reporting must be used.
 - All NHS staff involved in the care of victims of sexual crime must have received training in provision of services to people with additional needs.
73. The group recommended that a process of peer review and audit at both local and national levels be developed to ensure quality of provision. NHS Healthcare Improvement Scotland should be involved to develop quality performance indicators as a means of monitoring implementation of the standards.
74. In April 2014, it emerged that the implementation of the Minimum Standards was not progressing in some areas.
75. In the summer of 2014, the joint Scottish Government/COSLA *'Equally Safe – Scotland's Strategy for Preventing and Eradicating Violence Against Women and Girls'* was published.²⁶ As part of the Equally Safe Strategy, a Justice Expert Group was established in 2015 to further the aims of Equally Safe within a justice system context.
76. In April 2015, the Adult Sexual Assault Services Delivery Group (a sub-group of the National Co-ordinating Network Support Group) asked NHS Boards and Police Scotland to consider the extent to which their services were meeting the minimum standards. The information was collated and an action plan²⁷ developed to help partnerships with working towards the standards. The main issues where service was not meeting the standards related to lack of choice regarding gender of forensic examiner; examinations being carrying out in police stations; length of time to arrange medical, and lack of services to self-refer.
77. A short paper on police custody healthcare and forensic medical services was tabled at an NHS Board Chief Executives meeting in August 2015. Shortfalls were identified in relation to achieving the Minimum Standards across the country, and a lack of funding, resources, and capacity on the part of NHS Boards seemed to make progress unlikely.
78. In December 2015, the Justice Expert Group agreed a paper raised by Rape Crisis Scotland, recommending that a sub-group be convened to consider the provision of services across Scotland for victims of rape and sexual assault. It was reported to the meeting that progress towards the Minimum Standards was slow in some areas, and victims were being adversely affected.
79. A proposal was made by the sub-group to the Justice Expert Group for a national post to work with health boards for two years to support them to work towards the implementation of key parts of the Minimum Standards. The proposal was agreed by Ministers in March 2016, with the funding coming entirely from the Violence Against Women Justice budget. This post was filled in the summer of 2016.

²⁶ [Equally Safe-Scotland's Strategy for Preventing and Eradicating Violence Against Women and Girls \(2014 updated March 2016\).](#)

²⁷ High level action plan for Adult Sexual Assault Services (July 2015).

80. HMICS found there was good awareness of the Minimum Standards amongst forensic physicians responding to the HMICS consultation exercise, however most stated the standards are not being met in their areas. The following statement highlights the frustration of some forensic physicians:

'Despite short life working groups and national sub groups over the last 10 years, work convened and plans developed, reports written and minimum standards and mandatory policies, procedures and practices agreed, almost nothing has changed.'
(forensic physician, January 2017).

81. Looking back at the issues that led to the formation of the Short Term Working Group in 2013, HMICS is disappointed to note that many of the same issues are still relevant today, and progress has been limited despite the efforts of the National Network Board.
82. Contrary to the recommendation of the Short Term Working Group, there is no process of peer review and no audit process in place at local or national levels to ensure quality of service provision. The Short Term Working Group also recommended that Healthcare Improvement Scotland develop quality performance indicators as a means of monitoring implementation of the standards, however this did not happen.
83. In order for the Minimum Standards to be successful, they must be supported by a process of audit and inspection, and robust governance processes to hold parties to account for delivery. Either the Minimum Standards need to be articulated in a legally binding contract, which contains sanctions in the event of failure to deliver, or there needs to be legislation to make the delivery of Minimum Standards for forensic medical examinations a statutory function of NHS Health Boards.
84. The National Network has worked hard to understand where the challenges lie and to identify how to achieve progress, as demonstrated by the high-level action plan of the Adult Sexual Assault Services Delivery Group. The intention of this HMICS review is not to simply restate those challenges, rather it seeks to stimulate debate and inform changes that will support the efforts to achieve improvements.
85. The lack of clarity about the status of the Minimum Standards, the absence of a contract or legislation to ensure that parties deliver against clearly stated objectives, and the absence of any inspection regime, combine to create an environment where identified shortcomings in service persist, to the detriment of victims, their families, and wider society.
86. HMICS welcomes the commitment from the Cabinet Secretary for Justice, announced in February 2017, to introduce new nationwide standards to ensure consistent delivery of forensic medical examinations for victims of sexual violence. We also acknowledge the important role of Healthcare Improvement Scotland to produce these standards, which are expected to be rolled out before the end of 2017. However, in order to be effective, we believe that these new minimum standards should be formally issued to NHS Boards and supported by a framework of publicly reported quality indicators. We also believe that the standards need to be monitored through an effective audit and inspection regime.

Recommendation 4

The Scottish Government should consider formally issuing the newly proposed nationwide standards for the delivery of forensic medical examination for victims of sexual violence to all NHS Boards. These standards should be supported by a framework of publicly reported Quality Indicators and monitored through an effective audit and inspection regime.

87. The following sections will address each of the Minimum Standards in turn.

Care pathways

88. The national guidance states that health boards will have a care pathway in place which, at a minimum, will include immediate clinical needs assessment including emergency contraception and healthcare follow up including sexual health, access and referral to support, advocacy, trauma care, and safety planning.
89. The service provided at Archway exceeds the minimum standard in relation to care pathways to meet the victim's care and support needs, however is only available for people in some areas of Scotland and only for some of the time.
90. HMICS obtained feedback from Public Protection Units in all local policing divisions, which indicates that for all other areas of Scotland, and when Archway is not available, the care pathway is limited to advice provided by forensic physicians and police officers about the support and sexual health services available locally.
91. From the responses of NHS Boards to the survey by the Adult Sexual Assault Service Delivery Group in 2015, it was clear that immediate clinical needs were being met by the healthcare and forensic medical service in the majority of areas, with advice and information leaflets also being provided. Referrals to other agencies were made, however formal referral pathways were not in place in all areas and dependent on the individual forensic physician. With the exception of Archway and NHS Western Isles, all Boards noted there was no process for referral to advocacy services.
92. HMICS notes that the majority of areas are not providing a co-ordinated, holistic service which addresses the health and support needs of the victim at the point of presentation and subsequently, meaning that the benefits for the individual and for future demand on health and other public services, are not being realised. This issue is linked to the dual purpose of the forensic medical examination: one to address the clinical and health needs of the victim, the other to collect forensic samples in support of a potential criminal investigation. HMICS believes that both elements should be delivered by one doctor, whether that be a forensic physician with a nurse or a SARC doctor with a nurse, as happens at Archway when it is available, and happens in all of the SARCs in the rest of the UK.

Forensic physicians – gender

93. There are around 81 forensic physicians in Scotland, about 63 of whom are involved in forensic medical examinations for sexual crime. Only 19 of these forensic physicians are female. All nine doctors at Archway are women. Examinations are carried out at Archway by a female doctor accompanied by a female nurse.
94. Police Public Protection Units reported to HMICS that although victims are generally being asked their preference in respect of the gender of examining forensic physician, there is rarely any choice available. There are very few female doctors available, and in some areas there are none. If there is a female doctor covering the area, it will be chance if that person happens to be the on call forensic physician on the rota at the time a report is received. This process was described by some stakeholders as a 'lottery'. Where a person does insist on having a female doctor, police officers have to make a request to other areas, causing delays while arrangements are made and resulting in long journeys. This causes further distress to victims, as well as affecting the quality of evidence that can be gained from the medical. Female police officers, trained as SOLOs, are often asked to be in the room when the medical examination is being carried out in order to provide support.



95. Comments provided to HMICS from SOLOs are clear that the victim should be able to specify gender of doctor without this impacting on when the medical will be carried out. SOLOs are aware of situations when the victim has requested a female doctor and been told they can either be examined by a male doctor straight away, or wait for a day or two to get a female doctor and asked not to wash. This leads to victims consenting to an examination in circumstances where they are uncomfortable, simply to get it over with.
96. Section 8 of the Victims and Witnesses (Scotland) Act 2014²⁸ provides that victims and witnesses can specify the gender of the interviewing officer. Section 9 relates to a similar provision for choosing the gender of the examining doctor, however this section has not yet been enacted due to the practical challenges in meeting the requirement.
97. Most of the forensic physicians who responded to the HMICS questionnaire agreed it is not possible to provide a gender choice due to lack of female doctors prepared to undertake the role. Some areas report having no female forensic physicians, others have one or two.
98. The feedback from victims gathered by Rape Crisis Scotland is overwhelming negative about having to be examined by a male doctor following a rape. This issue has attracted negative media reports on numerous occasions, which is at risk of discouraging other victims to come forward and report a rape. One victim who wrote about her experience,²⁹ describes the impact of the examination by two male doctors *'I felt like a piece of meat, not a live human being who has just been through extreme trauma. I did not want any man anywhere near me and certainly not touching me. Because I wanted all this to be over, I didn't feel able to voice this'*.
99. HMICS found there to be a general acceptance that this standard could not be met due to lack of women wanting to perform the role of forensic physician, however there is little evidence of any different thinking about how to address this issue. HMICS is aware that the Cabinet Secretary for Justice has asked NHS Education Scotland to conduct a survey of women doctors to gain a better understanding of why so few women are willing to undertake the role of forensic physician. HMICS has identified several factors, which could improve the achievement of this standard including:
 - Developing the role of the forensic nurse in Scotland.
 - Securing greater use of the evidence of forensic nurses as witnesses in Scottish courts.
 - Changing the role of forensic physician and separating the duties for custody healthcare from those for forensic medical examinations, given that custody settings can be regarded as less attractive working environments (see paragraph 45).
100. HMICS believes that progress can be made in relation to all of the above factors, which will have a positive impact on the gender choice for victims.

Location of examinations – must not be in police stations

101. There is no standard approach to facilities across Scotland, and the use of police premises in a number of areas is not in line with the Minimum Standards. The following table shows the facilities across Scotland per health board area and police division for the examination of adults.

²⁸ [Victims and Witnesses \(Scotland\) Act 2014.](#)

²⁹ [A Woman's Story, Rape Crisis, Edinburgh \(May 2016\), relates to experience in December 2012.](#)



Table 4 – Forensic Healthcare Facilities across health board areas

Health board	Police division	Examination suite	Out of hours facility
NHS Grampian	A - North East	Forensic medical suite, Heath Village, Aberdeen	Forensic medical suite, Heath Village, Aberdeen
NHS Forth Valley	C - Forth Valley	Falkirk Police Station	Falkirk Police Station
NHS Tayside	D - Tayside	Medical suite, Police Station, West Bell Street, Dundee	Medical suite, Police Station, West Bell Street, Dundee
NHS Lothian	E - Edinburgh	Royal Victoria Hospital, Edinburgh	Royal Victoria Hospital, Edinburgh
	J - Lothians	Royal Victoria Hospital, Edinburgh Medical suite, Police Station, Civic Centre, Livingston	Royal Victoria Hospital, Edinburgh Medical suite, Police Station, Civic Centre, Livingston
NHS Borders	J - Borders	No facility – travel to Edinburgh	No facility – travel to Edinburgh
NHS Greater Glasgow & Clyde	G - Glasgow	Archway, Sandyford Clinic, Glasgow (not 24/7)	Medical suite, Baird Street Police Station, Glasgow
NHS Greater Glasgow & Clyde	K - Renfrewshire & Inverclyde	Archway, Sandyford Clinic, Glasgow (not 24/7)	Medical suite, Baird Street Police Station, Glasgow
NHS Greater Glasgow & Clyde	L - Argyll & West Dumbartonshire	<u>Sub-division – West Dunbartonshire</u>	<u>Sub-division – West Dunbartonshire</u>
		Archway, Sandyford Clinic, 2 Sandyford Place, Glasgow (not 24/7)	Medical Suite, Baird Street Police Station, Glasgow
NHS Highland	N - Highlands and Islands	Victim Medical and Interview Suite, Dalneigh Crescent, Inverness (police building)	Victim Medical and Interview Suite, Dalneigh Crescent, Inverness (police building)
		Medical Suite, Wick Police Station	Medical Suite, Wick Police Station
		Health Centre, Stornoway Western Isles	Health Centre, Stornoway Western Isles
		Gilbert Bain Medical Centre	Gilbert Bain Medical Centre
NHS Western Isles		No service provided	No service provided
NHS Shetland			
NHS Orkney			
NHS Fife	P - Fife	Forensic Medical Suite, Divisional Police HQ, Glenrothes	Forensic Medical Suite, Divisional Police HQ, Glenrothes
NHS Lanarkshire	Q - Lanarkshire	Archway, Sandyford Clinic, Glasgow (not 24/7)	Medical Suite, Baird Street Police Station, Glasgow
NHS Ayrshire & Arran	U - Ayrshire	Archway, Sandyford Clinic, Glasgow (not 24/7)	Medical Suite, Baird Street Police Station, Glasgow
NHS Dumfries & Galloway	V - Dumfries & Galloway	Loreburn Street Police Station, Dumfries	Loreburn Street Police Station, Dumfries

102. HMICS found that only two police divisions (North East and Edinburgh divisions) out of 13 had no issues with appropriate accommodation. When the facility is in a police station, there is rarely an option for discreet access to the area.
103. Feedback is positive about the facilities and service provided by Archway in Glasgow and the Royal Victoria Hospital in Edinburgh. The latter offers a range of facilities, which include provision for victim interviews, statement noting, visually recorded interviews, and access to police computer systems. Unfortunately the Royal Victoria Hospital has recently closed and

although the medical suite for forensic medical examinations is still in use, urgent work is underway to identify new premises.

104. In some divisions, forensic medical examinations are conducted in police buildings, which are not operational police stations. Police Scotland say that the buildings are adapted houses, which are not recognisable as police property, and victims feel more comfortable in these surroundings.

105. Forensic physicians in the West expressed very strong negative views about the police facilities that are used when Archway is unavailable. The room is described as wholly unsuitable, adjacent to custody cells, with poor lighting, inadequate stocks of forensic examination kits, and no forensic cleaning regime.

'Too small, not forensically cleaned between cases and lacks the most basic equipment for taking the most rudimentary and essential samples (the stocking of which continues to remain firmly within the remit of Police Scotland).'

106. The examination suite in Highland (Inverness) was described as 'grossly inadequate' (collective forensic physician response). Facilities in Tayside (Dundee) are described as being much better than those in the West of the country in that the room is stocked, deep cleaned after each use, and there is often a nurse assistant available. The forensic suite is managed by NHS Tayside and maintained to Archway standards. There are six female custody nurses who assist at forensic examination and act as chaperones. However, the criticisms of the Dundee facility are that it is in a police station and there is no colposcope.³⁰ There is good provision in Aberdeen, where there is a dedicated, purpose built suite, available 24 hours a day, seven days a week, not on a police site, described by a forensic physician as 'great premises'.

107. In the National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services, it is accepted that police premises are not a suitable venue for victim examination. However it is also accepted that currently *'there are a number of reasons why these may still require to be used until other premises are available and have been agreed'*.

108. HMICS cannot see any reasons why police premises still require to be used. There are examples of good facilities being provided at NHS locations, such as the Aberdeen Health Village, the Royal Victoria Hospital in Edinburgh, and the Health Centre in Stornoway, which show that it can be done and indeed should be done in all areas.

109. The National Guidance goes on to say that examination facilities should provide the opportunity for the victim to relax and prepare for the examination and have facilities to wash and change clothing. Agreement may be reached between individual health boards and Police Scotland on suitable locations, which may be healthcare premises such as a hospital, GP surgery or health centre, or suitable jointly agreed and maintained facility. Health boards and the police should work together to ensure that the examination is carried out in the most appropriate location, with a view to ceasing the use of operational police offices for examinations. HMICS believes health boards and Police Scotland have had ample time to arrive at agreements, but in the absence of any contract, legislation, robust governance or inspection regime with sanctions for failure to meet the standards, there is no means of ensuring the necessary action is taken at a local level.

³⁰ A colposcope is an illuminated, magnified instrument, which allows closer internal examination to identify and photograph injuries or marks. See paragraph 162.

110. HMICS considers the continued use of police stations for forensic medical examinations of victims of sexual crime to be unacceptable. Good practice in some areas of Scotland show that providing facilities for forensic medical examinations in appropriate health settings, can be achieved. HMICS suggest that urgent consideration should be given to using existing health facilities, be they hospitals or health centres, for forensic medical examinations. This would not only provide a more sensitive environment for victims, but would also have the potential to include a wider pool of NHS doctors and nurses already providing 24/7 services, which would overcome some of the challenges in terms of staff resilience, and gender mix. While HMICS would hope that any future service will involve dedicated facilities across Scotland, there is still a pressing need to identify appropriate healthcare settings for forensic medical examinations and decommission police premises as soon as practicable.

Recommendation 5

Police Scotland should work with NHS Boards to urgently identify appropriate healthcare facilities for the forensic medical examination of victims of sexual crime. The use of police premises for the examination of victims should be phased out in favour of healthcare facilities as soon as is practicable.

Examinations to take place within two hours

111. In setting the standard that examinations should take place within two hours, the Short Life Working Group (SLWG) which produced the standards in 2013, did make allowance for geography, however it is clear that distance is not the only issue. Clearly delays may also result in the loss of vital forensic evidence capture.

112. The issues that cause delays for medical examinations include:

- Geography is predictably an issue in the North of the country where cases occurring on any island other than the Western Isles can involve delays of 12 to 24 hours, and on the mainland over three hours. The absence of a forensic medical service on Orkney, and the limitations of the service on Shetland (one male forensic physician) leads to lengthy journeys in difficult circumstances.
- This issue is not restricted to the North however. People from the Scottish Borders, East Lothian and Midlothian have to travel to Edinburgh, which entails sitting in a car with police officers for several hours. There are no facilities in Campbeltown, Lochgilphead or Oban, necessitating travel to Glasgow. People from areas such as Ballantrae in Ayrshire also travel to Glasgow for examinations. Depending on weather and traffic conditions, these journeys can result in significant delays.
- Room availability. In some areas where there is only one room (for example, in Falkirk police station), adult victims will have to wait until it is free.
- Doctor availability. Some SOLOs report it is a frequent occurrence that victims have to wait a number of hours for a forensic physician to attend. An example was given of a request for a forensic physician being made in the morning for the examination of a teenage girl with learning difficulties. No doctor was available all day and the girl had to be sent home and asked not to wash, and was told to come back at 7pm, which caused much distress.
- When a doctor is not available locally, there does not seem to be flexibility in arranging for a doctor from another area to travel to the victim's location. Invariably the victim is expected to travel to the doctor accompanied by police officers.
- Variations in the level of information required before medical. The police Initial Briefing Report is designed to be sufficient to inform forensic medical examination but in some areas forensic physicians are reluctant to proceed before a full statement is noted, which can take a considerable length of time.



- Archway availability. If a victim does opt to wait until Archway is open, this can and does lead to delays. Victims are being asked to return the following day, and not to wash in the interim.

113. HMICS is aware that some NHS Boards query how the two hour timeframe was decided. The high level action plan for Adult Sexual Assault Services makes it clear that exceptions to the two hour standard should be based on geographical challenges rather than availability. At present, the failure to meet the standard is as much to do with availability as it is to do with geography.
114. The lack of specialist service in Orkney and Shetland has been highlighted by Rape Crisis, and has attracted negative media attention in early 2017. Reports refer to victims having to make lengthy journeys to the mainland for a forensic examination, travelling by boat or aeroplane with police officers, which is very visible in a small island community. Victims are advised not to wash during the time between the rape and the examination, which can be over a day later. Not only does this compound the trauma of the victim, but it can also deter other victims from coming forward.
115. HMICS believes this could be improved by separating out the custody healthcare responsibility from the forensic medical examination, which would increase the pool of forensic physicians, and by introducing a process where those doctors would travel to where the victim is, using existing local health facilities for examinations.

Specialist training for forensic physicians

116. All clinical staff should have undertaken the introductory course on clinical forensic medicine that has been developed by the Faculty of Forensic and Legal Medicine. Forensic physicians must have undertaken specialist training and have specified professional competencies, as set out in the Quality Standards in Forensic Medicine issued by the Faculty of Forensic and Legal Medicine. Training must include not only forensic capture, but also immediate clinical needs assessment and appropriate and timely referral for follow up care, as well as the impact on trauma and how to respond sensitively to victims of sexual violence.
117. Levels of specialist training vary across the country. In the response to the Adult Sexual Assault Service Delivery Group survey in 2015, the majority of NHS Boards indicated the training standards are being met for most staff and that continuous development sessions are provided locally. The National Network has delivered two days for stakeholders to share best practice across Scotland. The stakeholder event in August 2016 was attended by 71 people and included a session on delivering person centred, effective sexual assault services with inputs from Rape Crisis Scotland and Police Scotland's National Rape Task Force.
118. HMICS found that individual forensic physicians have taken responsibility for their own continuous professional development and have undertaken a variety of courses on a proactive basis. There is evidence of Archway delivering Sexual Offence Examination training to forensic physicians.
119. In its annual report 2015-16, the National Network refers to a range of training provided by NHS Education Scotland (NES). NES has a Forensic Medicine section on the Knowledge Network.
120. There is a four-day, multi-professional *course 'Introduction to the role of the Forensic Medical Examiner'*, developed by NES with significant input from a faculty of Scottish experts. It is accredited for continuous development purposes by the Faculty of Forensic and Legal Medicine. The course was run in March and May 2013 with 37 attendees, in October and November 2014 with 45 attendees, in April and May 2014 with 41 attendees and October and November 2015 with 32 attendees. The NES course is based entirely and appropriately on the Scottish legal system and legislation.



121. Another course, *'Essentials in Sexual Offences Examination and Clinical Management (Adults and Adolescents) – Best Practice for Scotland'*, was developed following recognition by the National Network of the need for a course based on the Scottish context. In 2014-15 there were 22 attendees and in 2015-16 there were 21 attendees. There is also a *'What's new in forensics?'* course first run by NES in 2015 with over 100 attendees and a number of sessions relevant to forensics in sexual assault cases. The course ran again in 2016 with 41 attendees.
122. The provision of forensic medical services is not considered a specialism by the General Medical Council, and some stakeholders have suggested that the role of forensic physician would be more appealing if forensic medical services were recognised as a specific skill, and separated from the duties in relation to custody healthcare. HMICS is aware that an application to the GMC is underway by the Faculty of Forensic and Legal Medicine to have the provision of forensic medical services recognised as a specialism.

Forensic nurses

123. Nurses involved in the provision of forensic examinations must have undertaken specialist training and have specified professional competencies, as set out in the Quality Standards for Nurses in Sexual Offence Medicine. Training must include not only forensic capture but also immediate clinical needs assessment and appropriate and timely referral for follow up care as well as the impact of trauma and how to respond sensitively to victims of sexual violence.
124. From the NHS Board responses to the survey by the Adult Sexual Assault Service Delivery Group in 2015, in the majority of cases nurses were not participating in forensic medical examinations. In Dundee, three of the six female custody nurses have an MSc in Forensic Nursing, one postgraduate diploma in Forensic Nursing and one postgraduate certificate in Forensic Nursing.
125. All police divisions reported that nurses are not involved in forensic examinations, other than at Archway and in Dundee.
126. In its annual report 2015-16, the National Network refers to the formation of a short life working group to look at the extended role of nurses within forensic medical services. The National Network has worked with COPFS to look at how the role could be expanded, and COPFS has agreed that suitably trained and experienced forensic nurses are able to take penile swabs from suspects for sexual crime and take bloods for the purposes of Section 5 of the Road Traffic Act 1988.
127. COPFS considers the use of forensic nurses to be a complex issue, particularly in terms of offering medical opinion about injuries. Discussions have taken place between COPFS, Police Scotland, and other relevant parties for many years in order to change this position, to no avail.
128. If colposcopes were routinely used during examinations, the images captured could be used in court and be subject to medical opinion at that stage, negating the need for forensic nurses to offer opinion. HMICS is aware that COPFS has identified difficulties in using and disclosing images of intimate parts of the body, however HMICS maintains the view that there is merit in exploring options for using digitally recorded images and telemedicine, particularly to support the service in remote areas of the country.
129. Sexual Assault Nurse Examiners (SANEs) and forensic nurse examiners are used in England to conduct the forensic and therapeutic medical examination of victims of rape and sexual assault. SANEs were introduced in 2001, and are used to collect forensic evidence in medical examinations of victims of rape.

130. In Scotland, the primary duties undertaken by forensic nurses are in relation to custody healthcare. Dundee is the only area, other than Archway, where forensic nurses assist in the forensic examinations for victims of sexual crime by acting as a chaperone and helping the forensic physician with general tasks such as setting up the examination room and labelling forensic samples. Of the eight forensic custody nurses in Tayside, seven have undertaken further training and education in forensic medicine, examination, documentation of injuries and the taking of samples.
131. HMICS believes there is real potential to expand the role of forensic nurses in the forensic medical examinations of victims of rape and sexual crime in Scotland. Practice elsewhere in the UK and internationally shows nurses are being used to a greater extent, and HMICS has found no examples of criminal cases being compromised due to the medical evidence being provided by a nurse as opposed to a doctor. There is no evidence of cases where the quality of the examination has jeopardised a prosecution.
132. The expansion of the role of forensic nurses would go some way to assist with the lack of female forensic physicians.
133. HMICS is aware that the Expert Advisory Group on Sexual Crime continues to work on the Crown's requirements for corroboration and clarity on the involvement of forensic physicians and forensic nurses in medical examinations. HMICS believes that COPFS needs to review its position on the role of forensic nurses as a matter of urgency.

Recommendation 6

The Scottish Government should work with relevant stakeholders and professional bodies including NHS Scotland, Police Scotland and the Crown Office and Procurator Fiscal Service to develop the role of forensic nurses in Scotland.

Self-referral

134. Individuals must have access to forensic examinations on a self-referral basis to ensure that forensic evidence is captured and retained for future use should the person decide to report to the police. Everyone should have access to health and support services, regardless of whether or not they have reported to the police.
135. The National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services acknowledges that some victims are unsure about whether or not to report to the police in the aftermath of a sexual assault. In these circumstances, victims should have access to a forensic examination on a self-referral basis to ensure forensic evidence is not lost. Health boards should develop processes to assist self-referral.
136. The only facilities for self-referral are at Archway in Glasgow (NHS Greater Glasgow and Clyde, NHS Lanarkshire, NHS Ayrshire and Arran) and in Tayside (Women's Rape and Sexual Abuse Centre). There is a willingness to develop self-referral in other areas (Aberdeen, Forth Valley, and Edinburgh).
137. HMICS believes that the legal position in respect of NHS Health Boards retrieving and storing forensic medical samples in circumstances where no report of a crime or offence has been made to the police (and therefore without an instruction from police or the procurator fiscal), must be clarified and, if necessary, primary legislation brought forward to provide a clear legal basis for this practice. There should be national guidance on how to provide a self-referral service, including protocols for storage and retention of forensic samples.

138. In England in 2015, the Home Office counting rules for recorded crime³¹ included guidance on the recording of crime reported by third parties or from SARCs. The rules make provision for circumstances where the victim wishes to remain anonymous, does not seek a police investigation, however forensic samples are taken in case the victim wishes to pursue the case at a later date. A procedure has been introduced whereby such a report would be recorded as 'reported incident of rape' (classification N100).
139. There is no such provision in Scotland. The Scottish Crime Recording Standard covers third party reporting, and the name of a complainer is required in order to raise a crime report. The Scottish Crime Recording Standard could be easily changed if needed.
140. HMICS considers the provision of services on a self-referral basis in Scotland to be poor. Victims from most areas of Scotland are not being provided with the opportunity to access a forensic medical examination unless they make a report to the police. Clearly the development of a model similar to SARCs across Scotland would address this important gap in current service provision, although there is also a need to clarify the legal position for obtaining and retaining forensic samples in the absence of a report to the police and formal guidance would need to be issued to NHS Boards and Police Scotland.

Recommendation 7

The Scottish Government should work with relevant stakeholders and professional bodies, including NHS Scotland, Police Scotland and the Crown Office and Procurator Fiscal Service to develop self-referral services for the victims of sexual crime. This should clarify the legal position for obtaining and retaining forensic samples in the absence of a report to the police and support formal guidance for NHS Boards and Police Scotland.

Views of victim to be sought

141. All police divisions recognise the importance of the views of the victim, and the SOLO explains the process and asks what the victim's preferences are in relation to the gender of interviewer and gender of examining doctor. Nonetheless, most divisions pointed out that there are very few choices available to the victim in terms of location or timing of examination, or gender of doctor. So whilst views are sought, it is often not possible to meet the victim's requests.

Standardised forms

142. The Adult Sexual Assault Delivery Group has been working with the National Network Board on standardised forms for forensic reporting since 2014. The national proforma for sexual offences has had input from the scientists at the SPA's Forensic Service, however has yet to be agreed by all stakeholders. HMICS considers the lack of agreement on a basic form to be symptomatic of the absence of an option to instruct the relevant parties to comply with a standard.

Issues other than those relating to Minimum Standards

Data collection

143. HMICS has found there is no consistent system for collating information on the volume and nature of forensic medical examinations being carried out in Scotland. There is no central register of forensic physicians, how many there are, which types of examinations they carry out, and which areas of the country they are able to cover. There are managers of service in each of the health board areas, however the extent to which they co-ordinate the activities of forensic physicians is limited. The regional governance structure in SEAT (in this context only

³¹ [Home Office Counting Rules for Recorded Crime in England and Wales - Counting Rules for Sexual Offences.](#)

NHS Lothian, NHS Borders, NHS Fife and NHS Forth Valley are managed under this governance structure) appears to be the most effective in terms of information gathering and co-ordination of services.

144. The National Network has made significant progress in improving data collation, and for the first time it has been able to provide a full year of activity within healthcare and forensic medical service in its annual report for 2015-16. This covers almost the whole of the country, however there are three out of 14 health boards (NHS Orkney, NHS Highland and NHS Shetland) who are still not using the national healthcare and forensic medical IT system called ADASTRA (funded by the Scottish Government). NHS Grampian only started to use the system in December 2016. HMICS considers it helpful for all NHS health boards to use the national IT system, which would be an enabler for improved collaboration between boards, particularly for sharing resources more effectively around the country.
145. For the year 1 April 2015 to 31 March 2016, 167 intimate samples were recorded on ADASTRA, which will relate to samples taken from suspects in a custody setting. The figures do not show national data relating to forensic medical examinations of adult or child victims of sexual crime due to inconsistencies in recording and data not being inputted for the majority of adult and paediatric examinations that take place on NHS premises (the exception was the South East area where standardised recording of data has been achieved). Further work will be done in 2016-17 to develop consistent data collection with the aim of providing more comprehensive national activity data.

Recommendation 8

The Scottish Government should work with NHS Scotland to ensure that the existing healthcare ICT system (ADASTRA) is being used consistently for collating information on the volume and nature of forensic medical examinations across Scotland. This will inform future policy and decision making, including resourcing.

Number of forensic physicians

146. HMICS has made repeated efforts to obtain a definitive list of forensic physicians who carry out forensic medical examinations in Scotland. No national list exists, however queries with each of the NHS Boards have resulted in an estimate of 81 doctors across Scotland who undertake the role of forensic physician, 63 of whom are involved in the forensic medical examinations of children and adults. In one area, the examination of children is separate from that of other patients, and the figure of 63 includes the four Child Medical Examiners. Of the 63 forensic physicians, 19 are women.
147. Many of the forensic physicians who engaged in the HMICS consultation have been undertaking the role for many years. Several forensic physicians expressed concerns about recruiting and retaining doctors to replace those who will be retiring. Out of hours work is increasingly unpopular, and the role of forensic physician is difficult to balance with a 'day job' as a general practitioner, and not financially viable as an alternative in its own right.
148. Many of the forensic physicians who responded had not been selected through any formal recruitment process, but had either expressed an interest or been approached locally due to the impending retirement of other doctors. Most learned through accompanying more experienced colleagues and then as they went along.
149. There are concerns about the number of forensic physicians on rotas serving particular areas, with some police divisions reporting that there is only one forensic physician locally. When the doctor is unavailable, approaches have to be made to other areas further away which causes delays. There is no forensic physician cover at all on Orkney, and only one



male forensic physician on Shetland, therefore alternative arrangements involve a lengthy journey to the mainland to access a medical examination. The police are acutely aware of the impact on the victim in terms of having to leave the island accompanied by a SOLO to travel by public flight or ferry, with the delay in being able to wash, compounding an already traumatic experience. The police division has highlighted numerous examples of the impact of gaps in service within Highland and lack of service on the Islands to the National Network since 2014.

- 150. Most divisions felt the service provided by forensic physicians was of a good standard. However, some raised specific concerns about the manner and empathy displayed by forensic physicians.
- 151. Views have been sought from a sample of SOLOs specifically due to their first-hand experience of being present at forensic medical examinations. These officers reported good professional relationships with forensic physicians, whom they found to be helpful and supportive. A preference was expressed for using Archway, where the doctors and nurses are described as excellent. One SOLO reported having been instructed by a forensic physician to be on the same side of the curtain as the victim when swabs were collected.

Barriers to recruiting new forensic physicians (collated from forensic physicians)
On call
Out of hours, unsocial
Unpredictability of work
Lone working
Training haphazard
Custody perceived as an aggressive environment, too confrontational, high risk
Link to custody healthcare puts people off – suggest recruit separately, through sexual health services
Police facilities not adequate
Court duties – anxiety, disruption to life and other work, absence from GP practice
Citations and treatment of doctors by COPFS and defence
Service model – health boards either employ forensic physicians, who are generally GPs and self-employed, or contract out the forensic medical service to a group of doctors who have joined together to deliver the service.
Lack of awareness during training at medical school (work of forensic physician not mentioned)
Lack of specialty recognition

Variations in level of information required before medical

- 152. Police officers report that there are occasions when forensic physicians are reluctant to carry out medicals until the full SOLO statement has been noted. Once an initial account has been taken, the medical is often the main priority to allow the victim to wash and rest prior to providing a full statement, which is often a lengthy process. It is not always practical to note a statement immediately, and agreement on what is required prior to a medical taking place would be helpful.
- 153. Some forensic physicians believe a full statement should be noted prior to medical examination so that they can form an opinion on injuries noted. They are aware of not being trained in interview techniques and the potential for this to be questioned in court.
- 154. Similarly, there was a view that forensic physicians should be consulted earlier to discuss the arrangements and timing of a medical examination, and not solely contacted once that decision has already been made.

Number of forensic medical examinations being carried out by forensic physicians

155. HMICS has found it challenging to establish the volume of medical examinations being carried out across Scotland. Responses from individual forensic physicians did not provide sufficient information for a national perspective, therefore managers in NHS Boards were contacted who were able to provide further information. Table 5 shows the figures for examinations carried out by forensic physicians between November 2015 and November 2016:

Table 5 – Examinations by forensic physicians (November 2015 to November 2016)

Health board	Number of victim examinations	Adults	Under 16 years
*			
NHS Borders	11	4	7
NHS Lothian	179	95	84
NHS Fife	75	38	37
NHS Forth Valley	59	39	20
**			
NHS Dumfries & Galloway	12	12	0
NHS Tayside	45	38	7
NHS Grampian	74	74	0
NHS Highland	No figures provided	–	–
NHS Western Isles	7	7	0
NHS Shetland	0	0	0
NHS Orkney	No forensic medical service	–	–

* NHS Borders, Lothian, Fife and Forth Valley have been provided by South East collaborative – total number of examinations is 324, of which 148 are described as under 18 years.

** Forensic physicians in Highland estimate they conduct around 8 to 10 examinations each of adults per year (Five forensic physicians, therefore 45-50 examinations per year).

NHS Greater Glasgow and Clyde, NHS Ayrshire and Arran, NHS Lanarkshire, are covered by the West consortium. Difficulties in data recording mean it is not possible to provide current accurate figures. From April 2014 to February 2016, there were 210 examinations carried out (adults), which is about nine per month. Other figures for two months in 2016, October and November, show 16 examinations, which is roughly consistent with the monthly average. This would mean forensic physicians in the West of the country are carrying out around 108 examinations per year.

156. Police Scotland do not routinely record the number of forensic medical examinations carried out across the country. However, at the request of HMICS, a manual record was kept for the month of November 2016, which shows the number across all local policing divisions.

Table 6 – Adult victim examinations – figures provided by Police Scotland for November 2016

Division	Adult victim examinations
A - North East	4
C - Forth Valley	5
D - Tayside	6
E - Edinburgh	7
G - Greater Glasgow	7 (3 at Archway)
J - Lothians & Scottish Borders	1
K - Renfrewshire & Inverclyde	2
L - Argyll & West Dumbartonshire	0
N - Highlands & Islands	5
P - Fife	5
Q - Lanarkshire	5 (3 at Archway)
U - Ayrshire	5
V - Dumfries & Galloway	0
Total	52

157. Whilst not entirely accurate, an extrapolation of these figures would show around 624 medical examinations of adult victims of sexual crime take place over the course of a year.

Sharing best practice about forensic medical examinations

158. Forensic physicians from most areas refer to meetings with colleagues and peer review events however this is not formalised. There does not appear to be any process for recording the number of examinations being carried out by forensic physicians, and using this data to anticipate demand and inform decisions about future resource requirements.

Availability of equipment – colposcope

159. The colposcope is an illuminated, magnified instrument, which allows closer internal examination in order to identify injuries or marks that would otherwise not be noticed. The colposcope also provides the facility to visually record images on DVD, and the images can be used in evidence. Colposcopy evidence is of a higher quality than that achievable by the naked eye, and therefore has a positive impact on the supportive evidence in serious assault cases, including rape. The use of colposcopes is regarded as best practice for adults and essential for children.
160. In the National Guidance, which supports the MOU, it states that the DVD recording from video colposcopy provides the best quality forensic evidence in relation to intimate examinations and enables the Crown to obtain, where necessary, the opinion of a medical expert not present at the examination. It affords defence medical experts an opportunity to view the recording and prevents need for repeated examinations.

Table 7 – Availability of colposcopy across Scotland.

Health board	Police division	Colposcope available	Location
NHS Grampian	A - North East	Yes	Forensic Medical Suite, Heath Village, Aberdeen
NHS Forth Valley	C - Forth Valley	Yes	Falkirk Police Station
NHS Tayside	D - Tayside	No	Medical suite, Police Station, West Bell Street, Dundee
NHS Lothian	E - Edinburgh	Yes	Royal Victoria Hospital, Edinburgh
	J - Lothians & Borders	Yes	Royal Victoria Hospital, Edinburgh
		Yes	Medical Suite, Police Station, Civic Centre, Livingston
NHS Borders	J - Lothians & Borders	No facilities	No facilities
NHS Greater Glasgow & Clyde	G - Glasgow	Yes	Archway, Sandyford Clinic, Glasgow (not 24/7)
		No (when Archway is closed)**	Medical Suite, Baird Street Police Station, Glasgow
NHS Greater Glasgow & Clyde	K - Renfrewshire & Inverclyde	Yes	Archway, Sandyford Clinic, Glasgow (not 24/7)
		No (when Archway is closed)**	Medical Suite, Baird Street Police Station, Glasgow
NHS Greater Glasgow & Clyde	L - Argyll & West Dumbartonshire	Yes	<u>Sub-division – West Dumbartonshire</u> Archway, Sandyford Clinic, Glasgow (not 24/7)
		No (when Archway is closed)**	<u>Sub-division – West Dumbartonshire</u> Medical Suite, Baird Street Police Station, Glasgow
NHS Highland	N - Highlands & Islands	Yes	Victim Medical and Interview Suite, Dalneigh Crescent, Inverness (police building)
NHS Western Isles		No	Medical Suite, Wick Police Station
NHS Shetland		Yes	Health Centre, Stornoway, Western Isles
NHS Orkney		No	Gilbert Bain Medical Centre
NHS Orkney		No service provided	No service provided
NHS Fife	P - Fife	Yes	Forensic Medical Suite, Divisional Police HQ, Glenrothes
NHS Lanarkshire	Q - Lanarkshire	Yes	Archway, Sandyford Clinic, Glasgow (not 24/7)
		No (when Archway is closed)**	Medical Suite, Baird Street Police Station, Glasgow
NHS Ayrshire & Arran	U - Ayrshire	Yes	Archway, Sandyford Clinic, Glasgow (not 24/7)
		No (when Archway is closed)**	Medical Suite, Baird Street Police Station, Glasgow
NHS Dumfries & Galloway	V - Dumfries & Galloway	No	Loreburn Street Police Station, Dumfries

** Archway is currently unavailable for significant periods of time (see paragraph 56)

161. This shows gaps in provision across the country. If Archway is not available, none of the divisions on the West has access to a colposcope for examinations of adult victims of sexual crime. No colposcope is available to forensic physicians carrying out adult victim examinations in Tayside.



162. A colposcope costs between £20,000-£35,000 depending on specification, plus an annual maintenance contract of £2,000. The funding for existing equipment is provided by a mixture of NHS and police budgets, with no consistency across the country. Previous evidence has been provided to the National Network Board in the form of briefing papers to highlight the need for funding and governance requirements in relation to this essential specialist equipment, however gaps continue to exist.
163. In terms of wider equipment, forensic physicians comment that the facility used when Archway is unavailable is not properly stocked, and feedback from SOLOs mentions kits being out of date. An example was given of an occasion when, due to the kits being out of date, a forensic physician refused to proceed with the medical and had to be persuaded to stay while the correct supplies were located and brought to the medical room. The SOLO felt this added to the distress of the victim, who had suffered a prolonged and violent assault and rape.
164. The MOU states NHS Boards are responsible for supplying medical supplies, sundries and consumables for custody and those coming into contact with Police Scotland for healthcare purposes. Police Scotland is responsible for the supply of all agreed forensic consumables and kits. Police Scotland and SPA Forensic Services are working on standardised module kits for forensic medical examinations, however progress on finalising a national requisition process has been slow, which has caused frustration on the part of NHS Boards.
165. The national guidance states that health boards will '*supply and maintain equipment for therapeutic purposes*'. Calibration and maintenance of equipment is the responsibility of the health board. Police Scotland will '*supply any forensic kits/equipment*'. Health boards and Police Scotland should work together towards provision of colposcopy and suitable facilities for examination.
166. HMICS considers the lack of provision of basic equipment in the form of colposcopes to be unacceptable. The lack of a colposcope undermines the quality of findings of a medical examination and consequently the quality of evidence available for a criminal case.

Faculty of Forensic and Legal Medicine (FFLM) standards

167. All facilities being used for forensic medical examinations must adhere to FFLM anti-contamination guidelines. The premises that are not meeting the required standard are in police buildings and, with the exception on the examination of suspects, there should be no forensic examinations taking place in these locations in the future. In the meantime, the Adult Sexual Assault Forensic Services Delivery Group has been working with Police Scotland and the SPA Forensic Services to produce Forensic Medical Examination Suite Guidance. Despite having been in draft form for some time, this guidance has yet to be finalised.
168. The SPA and Police Scotland have the responsibility for the implementation of consistent cleaning regimes across police locations where medical examinations are carried out. Police Scotland admits that progress towards achieving this consistency has been slow. Local divisions have different legacy arrangements for cleaning contracts, which vary in service provision.
169. The National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services describes the requirements for cleaning custody medical examination rooms and rooms or suites used for forensic medical examinations. HMICS has been informed by Police Scotland and forensic physicians that these are not being met consistently across the country.

170. National Guidance goes on to stress the importance of following the FFLM Recommendations for the Collection of Forensic Specimens from complainants and suspects, and being aware of cross contamination issues. Examinations of victims should be carried out in different locations from suspect examinations, and by different forensic physicians. HMICS is aware this is not happening in some areas of Scotland.
171. The Forensic Science Regulator (FSR) is a Home Office appointment, with no statutory powers in Scotland. The authorities in Scotland have agreed to be partners with the FSR in setting quality standards for the Scottish justice system. In the Forensic Science Regulator Annual Report 2016,³² high priority areas of work include producing substantive standards for SARCs and custody suites in respect of collecting forensic evidence. Due to the level of concern about contamination related issues in England, the FSR published interim guidance on anti-contamination measures for both SARCS and police custody as a matter of priority in 2016. The concerns raised with the FSR include the same medical practitioner being asked to examine multiple suspects within a custody setting and to examine both the victim and the suspect within the same case. There was also an example of DNA having been recovered from one victim examined at a SARC being detected on the intimate swabs from another victim examined in the same facility. HMICS is concerned that the risks that gave rise to the FSR's interim guidance are evident in Scotland now, particularly in relation to examinations of victims and suspects that take place within police buildings, which are not consistently forensically clean, and in relation to the use of the same doctor to examine both the victim and the suspect.
172. The FSR's interim guidance³³ states that the following conditions should apply to prevent cross-contamination:
- The practitioner undertaking the forensic medical examination of a complainant should not provide any medical examination or any other service to the alleged suspect in the same case, for example, where the suspect is in custody.
 - Where the provider of the forensic medical practitioners delivers services to both the SARC and custodial settings, there should be two separate rotas in operation to ensure that the forensic medical practitioner available for sexual offence forensic medical examinations of complainants is not used for custody medicine at that time.
 - In the event that multiple complainants from the same crime attend the SARC at the same time, or multiple suspects from the same alleged crime are in custody at the same time, staff should ensure that they do not have contact with multiple individuals linked to the same crime, in order to prevent cross-contamination.
 - Police officers shall already have general forensic awareness training to maintain and record separation of potentially conflicting or cross-contaminating activities to ensure that suspects and complainants are transported separately and that each individual is dealt with by different staff. If it becomes apparent that this practice has been breached, then appropriate information shall be documented, brought to the attention of the appropriate personnel and disclosed in any subsequent report or statement.
173. All healthcare professionals working in SARCs should have undergone training and assessment of competency in the forensic areas within which they are working. This includes personnel with responsibility for the decontamination cleaning of the forensic areas of the facility. This is in place at Archway in Glasgow and in Dundee, but less consistent in other areas.

³² [Forensic Science Regulator Annual Report 2016.](#)

³³ [DNA Anti-Contamination - Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities \(Interim Guidance July 2016\).](#)

174. As a minimum, the interim guidance applies to any room or area used for receiving persons for examination, medical examination and/or sample collection/storage. The interim guidance provides specific instructions in relation to the accommodation and environment required.
175. The Forensic Science Regulator interim guidance has been issued to SPA Forensic Science Services and communicated to Police Scotland. There are no agreed standard operating procedures for forensic cleaning procedures in Police Scotland buildings. HMICS considers that no Police Scotland location should be used for forensic medicals other than for adult suspects. However, where these take place on police premises, they should be cleaned in accordance with the relevant guidance.

Recommendation 9

Police Scotland should work with the Scottish Police Authority and NHS Scotland to introduce standard operating procedures for the forensic cleaning of police premises which continue to be used for medical examinations. These should comply with current guidance.

Forensic examination of suspects

176. Where suspects are being examined, the same FFLM standards as applied to victims, need to be adhered to. In April 2015, Dame Elish Angiolini completed her review of 'The Investigation and Prosecution of Rape in London'³⁴ which included a finding that forensic examinations of rape suspects to retrieve forensic evidence were being undertaken in a medical room of a custody suite by a doctor or forensic nurse, and this environment was not always forensically cleaned after each examination. Recommendation 7 of her report states:

'The forensic integrity of the environment in which forensic examinations are undertaken should be of the same standard for suspects as it is for complainers'

177. The following table shows locations where suspects of sexual crime are medically examined and samples obtained.

³⁴ [Report of the Independent Review into the Investigation and Prosecution of Rape in London \(2015\).](#)

Table 8

Health board	Police division	Custody examination suite
NHS Grampian	A - North East	Custody suite, Kittybrewster, Aberdeen
NHS Forth Valley	C - Forth Valley	Custody suite, Falkirk Police Station Custody suite, Stirling Police Station (weekends only)
NHS Tayside	D - Tayside	Forensic medical suite, Police Station, West Bell Street, Dundee
NHS Lothian	E - Edinburgh	Custody suite, St Leonard's Police Station, Edinburgh
	J - Lothians	Dalkeith, Livingston and St Leonard's Police Station, Edinburgh
NHS Borders	J - Borders	Custody suite, Hawick
NHS Greater Glasgow & Clyde	G - Glasgow	Various custody suites within Glasgow
NHS Greater Glasgow & Clyde	K - Renfrewshire & Inverclyde	Custody suites in Clydebank, Govan or Greenock
NHS Greater Glasgow & Clyde	L - Argyll & West Dumbartonshire	<u>Sub division – West Dunbartonshire</u> Custody suite, Clydebank Police Station
NHS Highland		<u>Sub division – Argyll & Bute</u> Custody suites in Oban, Lochgilphead, Campbeltown, Dunoon and Rothesay
NHS Highland	N - Highlands & Islands	Various police custody suites
NHS Western Isles		
NHS Shetland		
NHS Orkney		
NHS Fife	P - Fife	Various police custody suites
NHS Lanarkshire	Q - Lanarkshire	Various police custody suites
NHS Ayrshire & Arran	U - Ayrshire	Various police custody suites
NHS Dumfries & Galloway	V - Dumfries & Galloway	Custody suite, Loreburn Street Police Station, Dumfries

178. HMICS received comments from SOLOs that rape suspects are being medically examined in the custody suite medical room, which is not a forensically sterile environment and is not stocked with the correct kit for forensic medical examinations. The same room is used by forensic physicians and custody nurses to examine, treat and medicate a variety of persons in police custody during every shift. The potential for cross contamination is obvious.
179. Forensic physicians also raised cross contamination as an issue due to the shortcomings of medical rooms for examining suspects. Forensic physicians report being put under pressure by police to examine both the victim and the suspect in the same case. This can be due to a shortage of doctors (only one forensic physician on call to serve the health board area), and/or the location of the examination (in police station e.g. Dundee).
180. In one area, the forensic physician reported having to conduct the medicals for victim and suspect, travelling home between medicals to shower and change and come back. In the North, gaps in forensic physician cover mean a victim and suspect from same incident require to be transported from Fort William for examination in Inverness by the same forensic physician.



181. With the advances in DNA extraction capabilities available to the SPA forensic services, it is essential that the same safeguards are in place for examinations of suspects. To prevent any legal challenge, it is essential that all examination rooms where suspects may be subject to forensic sampling are cleaned to the same standards outlined in the interim guidance. The lack of forensic integrity could be exploited in criminal proceedings.

Services for male victims of sexual crime

182. This chapter has not specified gender and it is worth making it clear that the services for forensic medical examinations are delivered to both men and women. In her review of rape investigation in London in 2015, Dame Elish Angiolini highlighted that male victims of rape felt isolated, and this was compounded by the emphasis in sexual violence terminology on Violence Against Women and Girls, a term approved by UK and Scottish Governments and the United Nations. The barriers to reporting are even greater for gay and transgender victims of rape, and the review called for more support and understanding of the issues. HMICS believes the consideration of services for men, gay men, intersex and transgender people to be under developed in Scotland.

User focus – adults

183. Rape Crisis Scotland has an information sharing agreement with Police Scotland to share anonymised feedback from service users about their experience of the police response to a report of rape. Specific feedback was sought about the forensic medical examination and indicated a clear preference for a female doctor.

- *‘Even though he was very nice, I would have been much more comfortable with a female doctor, but I know this wasn’t possible’.*
- *‘The examination was conducted by two men which the caller felt awful about. She feels this is totally wrong and that she was re-traumatised’.*
- *‘The caller would have preferred a female examiner but felt comfortable enough with the male examiner and trusted him’.*

184. The experience of victims has regularly been reported by the media, with the lack of women doctors and the lack of local services featuring most highly. The absence of any service on Orkney and limited service on Shetland have attracted negative headlines, with local support services reporting that victims are deterred from reporting rapes due to the requirement to travel long distances, accompanied by police officers, in order to access a forensic medical examination, and not being able to wash until that examination has taken place.

185. A review of victim care in the justice sector in Scotland by the former Solicitor General, Lesley Thomson, was published in January 2017.³⁵ The report notes that COPFS has created a highly specialist approach to the investigation and preparation of cases of sexual crime, and Police Scotland has *‘transformed its response with the creation of specialist Sexual Offences Liaison Officers’*. Despite this progress in Scotland around the response to rape and serious sexual crime, this remains one of the most contentious areas in respect of responding to victims’ needs. During the review, improvements were welcomed but concerns about long standing issues, such as the potential impact of cross examination of the victim in court, were reiterated as well as some new issues which have emerged.

³⁵ [Review of Victim Care in the Justice Sector in Scotland, Dr Lesley Thomson QC \(January 2017\).](#)



186. The review describes factors that might discourage victims from reporting rape or serious sexual crime, many of which relate directly to the response victims believe they will receive from the justice system if they decide to report to the police. The report highlights the importance of having a criminal justice system that instils confidence in the public by providing a response that is sensitive to the needs of victims.
187. The review acknowledges that rape continues to be under-reported, pointing to Rape Crisis statistics that only about 48% of its clients choose to report the crime to the police, yet sexual crime now accounts for about 70% of COPFS work in High Court cases.
188. The report highlights that one recurring issue in the review was the fact that issues around victims do not lie exclusively in the Scottish Government's Justice portfolio. There are significant cross overs to Health where pertinent issues about forensic examination and recovery of evidence are located, and Education which has responsibility for in care survivors. Wider equality rights lie largely with Communities.

Children's services

189. The Children and Young People (Scotland) Act 2014 defines a child as someone under 18 years old, or until they have left school, whichever is the latest. NHS Scotland committed to hospital based children's services to the upper age limit of 16 years (with flexibility of up to 18 years). The Royal College of Paediatrics and Child Health consider paediatrics up to the age of 18.
190. In Scotland, forensic medical services for paediatrics should cover children up to the age of 16 years and up to the age of 18 for those considered vulnerable (e.g. looked after children, or children lacking capacity). The Criminal Justice (Scotland) Act 2016 defines a child as a person under the age of 18 years. There is a clear direction of travel in policy and legislation that provision should be made for young people's needs to be considered up until the age of 18.
191. In 2012, the Scottish Government established a SLWG to consider minimum requirements to deliver a safe, sustainable clinical service for the examination of children who have suffered physical abuse, neglect and sexual abuse. The SLWG reported its findings in November 2012,³⁶ and made recommendations regarding the provision of service for child sexual abuse in children, including:
- All NHS Boards to provide access to competently trained paediatrician who can carry out examinations with video colposcopy for child sexual abuse examination with forensic physician within four hours of referral as clinically and forensically appropriate in cases of acute sexual assault in children and young people under 16 years old to comply with Royal College of Paediatrics and Child Health (RCPCH) standards of clinical care and gathering forensic samples. Maximum waiting time should not exceed 12 hours.
 - All NHS Boards to provide facilities to record high quality images using colposcopic equipment in all cases of child sexual abuse which should be similar in make and model across Regions. These images should be digitally recorded and may be sent for specialist opinions when required.
 - In NHS Boards where general paediatricians who are competent and skilled carry out two doctor examinations, the provision of access to specialist paediatric forensic opinion will be developed across network areas to provide specialist medical opinion and a Stage 2 medical report.
 - All NHS Boards will ensure a national medical report template will be used by all paediatricians and forensic physicians conducting forensic examinations for child sexual abuse.
 - All NHS Boards will ensure standardised cleaning and decontamination policies for the child friendly examination suites which are adopted by all NHS and police premises with a protocol agreed by police, COPFS and NHS Boards.
192. The report by the SLWG on Forensic Paediatrics is listed in the National Network guidance document as informing the content of the guidance.

³⁶ [Forensic Paediatrics, A Report by the Short Life Working Group \(November 2012\).](#)



193. The SLWG report referred to the three regional Managed Clinical Networks for child protection, and noted positive signs of collaboration between them. The report stated there was an appetite for overall governance of child protection networks across Scotland, and indeed the Managed Clinical Network leads themselves had suggested a forum to report to the Scottish Government's Children and Young People Health Support Group would be helpful.
194. The report noted shortcomings in consistent data collation across the country, and found the figures for single and joint medical examinations were not routinely collected.
195. During the HMICS engagement with Managed Clinical Network (MCN) leads for child protection in 2016, there was a clear feeling that awareness of the 2012 report was low and any questions about it would cause confusion.
196. In February 2013, the Children and Young People's Health Support Group undertook an audit of health boards to ascertain the medical workforce situation within Specialist Child Protection Services in Scotland. Responses indicated low numbers of specialist paediatricians for child protection services and resultant gaps in the provision of local and regional services.
197. The findings were issued to NHS Board Chief Executives and invited discussion with key professionals within the services to scope possible solutions. The Child and Maternal Health Division of Scottish Government hosted two events in 2014 where attendees included regional MCN managers, lead clinicians, senior clinicians, service managers from NHS Boards, and a representative from RCPCH.
198. A subsequent national action plan was agreed, to be monitored by the Children and Young People's Health Support Group based on reports from the Children and Maternal Health Branch of the Scottish Government.
199. The first set of actions in the national action plan refer to the need for a set of standards and quality indicators for the medical component of child protection services. The Scottish Government hosted a series of meetings in 2015 which brought together MCN managers, lead clinicians and a representative from RCPCH to develop standards.
200. In November 2016, the three Managed Clinical Network leads produced a draft document detailing standards of service provision and quality indicators for the paediatric medical component of child protection services in Scotland, which has now been agreed with each of the Regional Planning Groups.³⁷
201. The MCN document builds on the RCPCH UK service specification for the clinical evaluation of children and young people who may have been sexually abused.³⁸ Scotland was represented on the RCPCH UK and Faculty of Forensic and Legal Medicine working group to arrive at the service specification and accompanying guidance. The RCPCH Scotland Child Protection Committee has been involved in the development of the MCN document, which includes 14 standards and accompanying quality indicators, which can be seen below and will be discussed in the next section:
 - **Standard 1:** All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies 2) available to provide immediate advice

³⁷ Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland (February 2017).

³⁸ [Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused, FFLM and Royal College of Paediatrics and Child Health \(RCPCH\)\(September 2015\).](#)

and subsequent assessment, if necessary, for children and young people under 16 years of age where there are child protection concerns. This should be extended to 18 years of age in specific circumstances e.g. known to paediatrics with additional needs/vulnerability factors. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.

- **Standard 2:** In response to notification of concerns that relate to child protection, an Interagency Referral Discussion (IRD) should take place between key agencies. Within the IRD, agencies will consider further information to inform the decision to initiate a child protection investigation and to explore the need for a medical examination. A paediatrician will be responsible in deciding if a medical assessment is required and will agree with police and social work colleagues the nature, timing and venue for the examination.
- **Standard 3:** A Joint Paediatric Forensic (JPF) examination is usually conducted by a paediatrician and a forensic physician. The JPF examination combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate photographs of injuries or specimens. If two professionals, or more, are involved they need to determine in advance of the assessment what skills they bring to the examination and who will undertake which component of the examination. It may be necessary to involve another complementary medical professional such as a genitourinary physician, orthopaedic surgeon, or family planning doctor, if the case demands it.
- **Standard 4:** If there are multi health professional specialists involved in a complex case, a round table discussion is required after assessments are completed. The identified Lead Clinician for the case should produce a summary of the discussion which clearly documents areas of agreement and disagreement.
- **Standard 5:** All child protection examinations, including examinations of underage suspected perpetrators, must take place in a suitably age appropriate space with a waiting area, appropriate toys and distraction for the examination and have appropriate clinical facilities. Age appropriate information resources should be available for children undergoing examination.
- **Standard 6:** For Joint Paediatric Forensic (JPF) examinations, all NHS Boards should ensure standardised cleaning and decontamination policies are adopted. This should be done as agreed by each NHS Board and Police Scotland, but should take into account nationally agreed procedures and standards along with any recommendations from the Scottish Police Authority (SPA) Forensic Service.
- **Standard 7:** For Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault NHS Boards should provide access to both a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photo documentation.
- **Standard 8:** When a child protection referral for an acute sexual assault comes into the NHS Board a discussion between the referrer and a paediatrician should occur within two hours. The timing of an examination will be determined by the examining doctor(s) after discussion with appropriate parties based on the clinical and forensic needs of the case and in the best interests of the child/young person.
- **Standard 9:** As part of any child protection examination there should be consideration of the ongoing healthcare, monitoring and treatment that the child may require. This should address any unmet health needs and appropriate onward referral to specialists, including consideration of access to the screening and treatment of sexually transmitted infections, risk assessment for post-exposure prophylaxis, emergency contraception and pregnancy testing, mental health services and therapeutic support for the child and family.

- **Standard 10:** Consent from the appropriate person with parental responsibility, or the child if appropriate, should be obtained in writing by the examining doctor(s) before the examination takes place. The examining doctor(s) must ensure adequate information about the procedure, and how the results may be used, is provided to children and their families in order that properly informed consent is given.
- **Standard 11:** All examining doctor(s) must make comprehensive contemporaneous notes using standardised documentation to cover the components of the examination that they are responsible for (as agreed prior to the assessment).
- **Standard 12:** After a child protection examination a report, the content of which is outlined in the *Child Protection Guidance for Health Professionals*, should be provided by the examining doctor. For Joint Paediatric Forensic (JPF) examinations there should be a joint interim report at the time of examination with a more detailed joint report available within 3 to 4 weeks. Less experienced doctors should have their reports checked by their supervising consultant or a more experienced colleague.
- **Standard 13:** Agreed data sets for the service provision of the paediatric medical component of child protection services should be collected and reported across each MCN region in order to capture standardised information on activity and performance against quality indicators.
- **Standard 14:** Provision of the paediatric medical component of child protection services and timely access to expert child protection advice is best provided through a managed clinical network arrangement.

Status of MCN standards and quality indicators

202. A summary of the indicators for each standard is below but the guidance document contains a full description of these. There is no measure allocated for standards 4, 9 or 10.

Table 9

1	A paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) is available at all times to provide immediate advice and subsequent assessment, if necessary, for children and young people where there are child protection concerns.
2	% of episodes where children have an Interagency Referral Discussion (IRD) before a Joint Paediatric Forensic (JPF) examination is carried out.
3	% of episodes where it has been agreed that a Joint Paediatric Forensic examination should take place and subsequently the examination involves at least a paediatrician and a forensic physician.
5	Facilities used for child protection examinations, including for under age suspected perpetrators, are age appropriate.
6	Cleaning and decontamination policies are in place, that take into account nationally agreed procedures and standards, to ensure Joint Paediatric Forensic (JPF) examinations are carried out in appropriate facilities.
7	Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases include both a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photo documentation.
8	% of cases of acute sexual assault where a discussion with a paediatrician occurred within 2 hours of the case being referred to the NHS Board.
11	% of episodes where examining doctors make comprehensive contemporaneous notes using standardised documentation during child protection examinations.
12	% of episodes where a detailed joint report, produced by the examining paediatrician and forensic physician, is available within 3 to 4 weeks following Joint Paediatric Forensic (JPF) examinations.



203. The majority of paediatricians are aware of the service specification for the clinical evaluation of children and young people who may have been sexually abused (RCPCH UK, September 2015), and feel their service generally meets these standards, albeit in a Scottish context. For example, there is frequent mention of the SARC model, which is not widely available in Scotland.
204. There are good levels of awareness and support for the MCN standards, which most paediatricians who responded have been consulted on or directly involved in their development.
205. 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. Whilst the Specialist Paediatric Sub Group of the National co-ordinating Network Board did not meet during the consultation period, the Chair for the Sub Group was involved in initial meetings and the Clinical Leads for the Managed Clinical Networks are members of the Sub Group. It is important to avoid the difficulties experienced with delivering the national Minimum Standards discussed earlier in this report, due to the fact these were not issued formally to NHS Boards in 2013, nor were they subject to any audit or inspection regime. HMICS is encouraged that the new standards and quality indicators are to be issued formally to health boards with arrangements for these to be audited annually. HMICS believes there should also be sanctions available in the event of failure to meet the required standards.

Issues relating to Managed Clinical Network standards

Availability of paediatrician with child protection experience

206. Several areas reported shortages in paediatricians, and difficulties in gaining and maintaining experience due to low numbers of examinations. In Fife, the situation regarding paediatric provision was described as 'at crisis point'. In Highland, the out of hours service was described as poor and only exists due to the goodwill of the available paediatrician. In Greater Glasgow and Clyde, there is concern about workforce resilience due to a range of workforce issues including the anticipated retirement of experienced paediatricians.

Involvement in Interagency Referral Discussions (IRD)

207. Paediatricians from all areas report being involved in Interagency Referral Discussions, although the process is relatively new in Greater Glasgow and Clyde. Several areas commented that the police sometimes need to be reminded that the decision about whether or not a medical examination is required needs to be informed by medical opinion. On occasion, the police put too much emphasis on the investigation, and less on what is in the best interests of the child, particularly in terms of the timing of any medical examination. None of the forensic physicians who responded to the HMICS survey said they were involved in IRD discussions.

Joint paediatric forensic examinations

208. Relationships between paediatricians and forensic physicians are generally good across the country.

Location of examinations

209. Medical examinations of children, including suspects, must take place in a suitably age appropriate space and have appropriate clinical facilities. The following table shows the location where children are examined in all health board areas:



Table 10 – Locations where children are examined in health board areas

Health board	Police division	Examination suite	Out of hours facility
NHS Grampian	A - North East	Aberdeen Royal Children's Hospital	Aberdeen Royal Children's Hospital
NHS Forth Valley	C - Forth Valley	Children's Ward, Forth Valley Royal Hospital, Larbert	Children's Ward, Forth Valley Royal Hospital, Larbert
NHS Tayside	D - Tayside	Medical suite, Seymour House, Dundee (co-located with Social Work Department)	Medical suite, Seymour House, Dundee (co-located with Social Work Department)
		Police Public Protection Unit	Police Public Protection Unit
NHS Lothian	E - Edinburgh	Royal Hospital for Sick Children, Edinburgh	Royal Hospital for Sick Children, Edinburgh
	J - Lothians	Royal Hospital for Sick Children, Edinburgh	Royal Hospital for Sick Children, Edinburgh
		St John's Hospital, Livingston, West Lothian	Civic Centre, Livingston, West Lothian
NHS Borders	J - Borders	Borders General Hospital, Melrose	Borders General Hospital, Melrose
NHS Greater Glasgow & Clyde	G - Glasgow	Royal Hospital for Children, Queen Elizabeth University Hospital, Glasgow	Royal Hospital for Children, Queen Elizabeth University Hospital, Glasgow
NHS Greater Glasgow & Clyde	K - Renfrewshire & Inverclyde	Royal Hospital for Children, Queen Elizabeth University Hospital, Glasgow	Royal Hospital for Children, Queen Elizabeth University Hospital, Glasgow
NHS Greater Glasgow & Clyde	L - Argyll & West Dumbartonshire	<u>Sub division – West Dunbartonshire</u> Royal Hospital for Children, Queen Elizabeth University Hospital, Glasgow	<u>Sub division – West Dunbartonshire</u> Royal Hospital for Children, Queen Elizabeth University Hospital, Glasgow
NHS Highland		<u>Sub division – Argyll & Bute</u> Dependent on location of paediatrician in Oban or Lochgilphead in NHS premises.	<u>Sub division – Argyll & Bute</u> Dependent on location of paediatrician in Oban or Lochgilphead in NHS premises.
NHS Highland	N - Highlands & Islands	Victim Medical and Interview Suite, Dalneigh Crescent, Inverness (police building)	Victim Medical and Interview Suite, Dalneigh Crescent, Inverness (police building)
		Health Centre, Stornoway, Western Isles	Health Centre, Stornoway, Western Isles
		Medical Suite, Wick Police Station, Wick	Medical Suite, Wick Police Station, Wick
NHS Fife	P - Fife	Victoria Hospital, Kirkcaldy (not 24/7)	Royal Hospital for Sick Children, Edinburgh
NHS Lanarkshire	Q - Lanarkshire	Medical suite, Wishaw General Hospital	Medical suite, Wishaw General Hospital
NHS Ayrshire & Arran	U - Ayrshire	Ward 1A, Paediatric Ward, Crosshouse Hospital, Kilmarnock	Ward 1A, Paediatric Ward, Crosshouse Hospital, Kilmarnock
NHS Dumfries & Galloway	V - Dumfries & Galloway	Medical suite, Wishaw General Hospital	Medical suite, Wishaw General Hospital
		Ward 1A, Paediatric Ward, Crosshouse Hospital, Kilmarnock	Ward 1A, Paediatric Ward, Crosshouse Hospital, Kilmarnock

Children and young people as suspects

210. Several paediatricians reported concerns about suspected perpetrators of sexual abuse who are under 16 years old. The paediatricians identified them as a vulnerable group and as potentially being victims of abuse themselves. Only one area reported having seen a child suspect in a clinical setting, others had no involvement in these examinations, nor any knowledge of where or how these were conducted. Police officers in all divisions report that juvenile suspects for sexual crime are examined in police custody suites by forensic physicians. The medical rooms in police custody suites are not forensically secure environments.
211. HMICS considers it unacceptable that intimate samples are being obtained from children in police custody environments.
212. The national healthcare and forensic medical IT system, ADAstra, does not record the age of suspects from whom intimate samples are obtained. For 2015-16, some 167 intimate samples were recorded on ADAstra, however it is not possible to establish the number relating to suspects in police custody who were under the age of 16.

Recommendation 10

Police Scotland should work with NHS Scotland to ensure suspected perpetrators of sexual abuse who are under 16 years old are not forensically examined within police custody facilities. The Criminal Justice (Scotland) Act 2016 defines a child as being a person under the age of 18 and consideration should be given to how this affects the treatment of child suspects in the context of forensic medical examinations.

Colposcope

213. Colposcopes are available at all the locations where child sexual abuse examinations are carried out. In one area, comment was made about the need to replace equipment, which is rapidly deteriorating. (see paragraphs 159 - 166).

Timescale

214. The shortages in paediatrician availability locally can result in lengthy journeys and delays. Children and young people from Fife can have to travel to Edinburgh for the out of hours service, which sometimes results in refusals to be examined. An example was given of requesting a paediatrician in the afternoon, however there was no availability in Fife. The child was in North East Fife, in easy driving distance to Dundee, however it was not possible to secure assistance and the child had to travel two hours each way to Edinburgh. In Highland, from Caithness to Brora, children and carers are having to travel 113 miles to Inverness for a medical. 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.
215. HMICS has found the delays for examinations of children in these circumstances to be unacceptable. 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.

Reports

216. There is some variation in how Paediatric Forensic Examination Reports are prepared. In some areas, there are joint reports with a forensic physician. In others the report is prepared by the paediatrician and signed by the forensic physician. Only one area has a standardised format (South East including Tayside).

Data

217. The data set for service provision of paediatric medical services is not consistently collated. Whilst some areas have been collecting data on child protection examinations for a number of years, a standardised minimum data set for all regions was only introduced in January 2017. It has proved difficult to obtain figures with any degree of confidence. Responses from paediatricians direct are as follows:

Table 11 – Examinations for child sexual abuse (under 16) – January to December 2015

January to December 2015	
All examinations for child sexual abuse (under 16)	
NHS Borders	15
NHS Lothian	90
NHS Fife	32
NHS Highland	3
NHS Tayside	12
NHS Grampian	35
NHS Lanarkshire	21
NHS Ayrshire and Arran	12
NHS Greater Glasgow and Clyde*	26
Total	246

* Figures relate to 1 – 13 years old

Table 12 – Examinations for child sexual abuse (under 16) – January to October 2016

January to October 2016	
All examinations for child sexual abuse (under 16)	
NHS Borders	14
NHS Lothian	78
NHS Fife	21
NHS Highland	6
NHS Tayside	7
NHS Grampian	27
NHS Lanarkshire	12
NHS Ayrshire and Arran	18
NHS Greater Glasgow and Clyde*	30
Total	213

* Figures relate to 1 – 13 years old

These figures indicate that approximately 20 medicals of children per month in 2015 and 21 per month in 2016, are being carried out by the paediatricians

218. Police Scotland do not collate data on examinations, however at the request of HMICS, all divisions manually recorded the numbers for the month of November 2016. The table below shows 30 examinations of children in November which, if extrapolated, would indicate around 360 medical examinations of children over the course of a year.

Table 13 – Child victim examinations – figures provided by Police Scotland for November 2016

Division	Child examination
A - North East	4
C - Forth Valley	4
D - Tayside	1
E - Edinburgh	2
G - Greater Glasgow	1
J - Lothians & Scottish Borders	3
K - Renfrewshire & Inverclyde	1
L - Argyll & West Dumbartonshire	0
N - Highlands & Islands	0
P - Fife	5
Q - Lanarkshire	7
U - Ayrshire	2
V - Dumfries & Galloway	0
Totals	30

Adolescents

219. The Archway service is offered to anyone aged 13 years and over. They consider young people aged 13 to 16 years, as well as those 16 to 18-year-olds who are looked after or accommodated young people, to be adolescents. The Archway review report states it is essential that the service for adolescents improves. It refers to examples where adolescents have had to attend a police station to have a forensic medical examination or have been seen by a male forensic physician because an Archway doctor has not been available.
220. As part of this review, staff at Archway identified adolescents as a vulnerable group who fall through the cracks if not seen at Archway. The issue arises when there is no Archway doctor available, and adolescents are examined by a forensic physician (in the West of the country, this is likely to be a Child Medical Examiner) and a paediatrician.
221. At Archway, an adolescent is examined by an Archway doctor and a nurse, and the service includes emergency contraception, and follow up for sexually transmitted infection, support and counselling. If not seen at Archway, the staff who will conduct follow up services are dependent on information being passed on by Child Medical Examiners (forensic physicians) about the cases they see, but this generally does not happen.
222. Over the period 1 January 2016 to 31 October 2016, there were 21 medical examinations of adolescents at Archway. HMICS has been unable to establish accurate figures for the number of adolescents examined by forensic physicians and paediatricians. Aberlour Child Care Trust identified a gap in provision for medical examination of adolescents and in particular follow up care when Archway is not available.
223. The NSPCC commented that *'a great deal of the young people that Archway sees are vulnerable young people, who can present at Archway several times. Repeat victimisation is not uncommon after childhood sexual abuse'*.
224. Police Public Protection Units told HMICS that arranging the medical examination of adolescent victims out of hours can cause challenges, however all the divisions report that medical examinations of the 13 to 16 age group do take place in a medical setting when Archway is not available. This is in contrast to the Archway review report, which referred to specific examples of adolescents having been medically examined in police stations by male forensic physicians when its service was unavailable.



225. HMICS believes the service for adolescents, those young people aged 13 and over, but under 16, and those looked after children up to the age of 18, needs to be reviewed. The risks of child sexual exploitation are increasingly better understood and it is vital that professionals are trained to recognise the signs of exploitation and to do all that is possible to ensure that where young people do disclose and present at services and that the response is as sensitive and supportive as it can be in order to encourage the young person to remain engaged with services.

User focus – children and young people

226. HMICS has engaged with a range of services offering support to and working with children and young people in Scotland. These services include:

- Children 1st
- National Society for the Prevention of Cruelty to Children (NSPCC)
- Barnardos
- Aberlour Child Care Trust
- Child Protection Committees
- Social Work Children and Families

227. There was general agreement that very real differences exist in terms of service provision. In some areas, children and young people can face journeys of two to six hours round trip to attend forensic medicals which are long distances from their home area. There was understanding that different models of service would be required for urban and rural environments, however the quality should be of the same standard.

228. Services felt that decisions about the timing of an examination should be made in the best interests of the child, taking into account the individual needs of a child, including family and emotional support, rather than to meet an arbitrary target. Several service providers raised concerns that about the vulnerability of abusers who are children and young people.

229. Comments were made about the availability of forensic physicians, and children and young people not having a choice in terms of the gender of the examining doctor.

230. Child Protection Committees Scotland commented that vulnerable children are being negatively affected by the current disparity of service provision across the country.

231. Social Work Scotland made the point that social workers are often involved to support children and young people through the medical examination, however they are rarely involved in policy making about the forensic medical service.

232. Work undertaken by Children 1st to map the current process as experienced by a child, 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.

233. The NSPCC stress the importance of language to reflect children's very different experience of sexual crime. The word 'assault' suggests a one off incident, and whilst children do experience this, many are likely to have experienced ongoing trauma caused by child sexual abuse.

234. The NSPCC are undertaking research in conjunction with the West of Scotland child protection MCN into the provision of and access to therapeutic support for children and young people across the West of Scotland MCN area. Early findings indicate there is confusion amongst professionals regarding the assessment of children's emotional health and well-being needs following sexual trauma before, during and after a forensic medical examination. The extent to which health is involved in health needs assessment for therapeutic support following an examination is highly variable. Early assessment of children begins at the IRD stage, however health is not involved in some local authority areas. There is a clear referral pathway between Archway and Sandyford Young People's Sexual Health Service and to the Sandyford Young People's Counselling Service, however young people outside Glasgow will generally not continue to travel for counselling support.

Parentline/Children 1st research

235. Children 1st is a national charity which seeks to provide advice and support to children and families. It supports survivors of abuse, neglect, and other traumatic events in childhood, to recover.

236. A joint initiative³⁹ between the South East and Tayside (SEAT)⁴⁰ regional Managed Clinical Network for Child Sexual Abuse, NHS Lothian Children's Services, and Children 1st used ParentLine, a national helpline administered by Children 1st to engage with users of the service. The aim was to engage with parents and carers whose child had undergone forensic medical examination following a report of child sexual abuse in order to understand better their experience of the process and to identify the support needed for parents, carers and children.

237. The project found that the experience of undergoing a forensic medical examination can be extremely challenging and distressing for both the child or young person and their parents or carers. The parents and carers views about the medical staff involved throughout the examination experience was generally very positive. There were issues about the experience before the examination, for example waiting to be seen, the presence of police officers in the waiting room, and confidential information discussed there. These circumstances heightened the anxiety of parents and carers and the child or young person. The location for the medical examination was not always found to be 'child friendly'. Some parents and careers found the amount of information given to them difficult to cope with and on occasion it was inconsistent. Parents and carers felt that an information leaflet would help them to support their child or young person after the examination.

³⁹ A study to identify the experience and support needs of parents/carers involved in child sexual abuse investigations, Children 1st/ParentLine/NHS Lothian (February 2016).

⁴⁰ in this context SEAT is something of a misnomer – project covers NHS Lothian, NHS Borders, and NHS Fife.

Learning from others

Sexual Assault Referral Centres (SARCs) in England

238. SARCs provide services to victims of rape or sexual assault regardless of whether the person chooses to report the crime to the police at that time. The services include conducting a forensic medical examination, providing healthcare and follow up support.
239. The first UK Sexual Assault Referral Centre (SARC) opened in 1986 in Manchester. St Mary's SARC was established to improve the experience of reporting rape for victims, particularly forensic medical examination and aftercare. St Mary's was influenced by similar developments in North America in the 1970s and its establishment and others in the West Yorkshire and Northumbria Police areas around that time drew on a number of recurring criticisms of police responses to rape victims:
- Low levels of reporting of rape
 - Delays in locating a forensic doctor
 - Lack of female forensic doctors
 - Environment in which forensic examinations took place
 - Manner in which examinations were conducted
 - Inconsistency of evidence gathering
 - Absence of medical follow-up and support
 - Lack of co-ordination between agencies
 - Limited support services for victims
240. HM Crown Prosecution Service Inspectorate and HM Inspectorate of Constabulary in England and Wales conducted a joint thematic inspection into rape investigation, which was published in 2002.⁴¹ It identified dedicated SARCs as good practice.
241. In 2004 the Home Office evaluated the SARCs at St Mary's in Manchester, REACH in Northumbria, and STAR in West Yorkshire, and concluded that the integrated model of providing forensic examinations on site along with support services was the preferred model.¹⁷
242. A national SARC steering group and SARC advisory group were created and in 2005 came the joint publication of Department of Health and Home Office National Service Guidelines for developing SARCs.⁴² The guidance included recommended minimum elements of service for SARCs.
243. The guidance highlighted evidence that victims seen at a SARC were less likely to withdraw from an investigation than those victims dealing only with the police. Although all SARCs aimed to meet the recommended minimum elements, there were regional variations in delivery models. A number of different examples were provided for different approaches. The guidance introduced the Government aim of providing access to a SARC for all victims of rape in England and Wales and set out an expectation that every police force area would develop a SARC.

⁴¹ [A Report on the Joint Inspection into the Investigation and Prosecution of Cases involving allegations of Rape, HMCPSP \(April 2002\).](#)

⁴² [National Service Guidelines for developing Sexual Assault Referral Centres \(SARCS\) Home Office, Department of Health \(2005\).](#)



244. In 2005, the Association of Chief Police Officers (ACPO) Rape Working Group published, *'Sexual Assault Referral Centres – Getting Started'*,⁴³ which was based around two linked imperatives for service provision by a SARC following sexual assault:
- Forensic examination so that evidence can be collected for use in the investigation of crime
 - Care of the victim to minimise the risk of subsequent physical and mental difficulties and to promote recovery
245. The Home Office *'Tackling Violence Action Plan'* (2008) set an expectation that a SARC would be available in each police force area by 2011, and the National Service Guidelines for SARCs were revised in 2009.⁴⁴ By this time, the business case and benefits to be derived from a SARC were clear.
246. The 2009 revised National Guidance for SARCs⁴⁴ addressed in more detail how to establish a SARC in different settings, and mapped out the challenge for SARC providers and for commissioners working in partnership to improve individual health and wellbeing, as well as to achieve positive criminal justice outcomes. The guidance pointed out that the commissioning of SARCs should be undertaken jointly by the key public sector agencies including partners in the NHS and third sector, and that the process would be best informed by a clear assessment of local needs and services.
247. The key elements of a SARC were updated aimed at ensuring equity of service across England and Wales. These key elements include:
- 24 hour access, including self-referral, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.
 - Appropriately trained crisis workers to provide immediate support to the victim throughout the examination process.
 - Choice of gender of physician wherever possible.
 - Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.
 - Dedicated, forensically approved premises and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a robust chain of evidence.
 - The medical consultation includes a risk assessment of harm/self-harm, together with an assessment of vulnerability and sexual health, immediate access to emergency contraception, post exposure prophylaxis or other acute, mental health, or sexual health services and follow up.
 - Access to support, advocacy and follow-up provided through an independent sexual violence adviser (ISVA) service, including support throughout the criminal justice process.
 - Co-ordinated interagency arrangements to support the SARC to deliver care pathways.
 - The SARC has a core team to provide 24/7 cover for services, which meets the NHS standards of clinical governance and the European Working Time Directive
 - A minimum dataset and appropriate data collection procedures in each SARC.

⁴³ [Sexual Assault Referral Centres 'Getting Started' Guide, ACPO \(2005\).](#)

⁴⁴ [Revised National Service Guidelines: A resource for developing Sexual Assault Centres, Department of Health, Home Office \(2009\).](#)



248. Baroness Stern led an independent review into how rape complaints are handled by public authorities in England and Wales, and reported in 2010.⁴⁵ She concluded that implementation of policy was patchy and must be improved, and that SARCs be put on a firm basis as part of mainstream provision.
249. In 2010, the Department of Health launched the NHS Taskforce report by Sir George Alberti, *'Responding to violence against women and children – the role of the NHS'*.⁴⁶ This recommended that forensic physicians should be employed by the NHS with better access to high-quality training, be an integrated part of the new NHS clinical governance framework and commissioned in sufficient numbers to meet the needs of victims of rape.
250. A key recommendation in the Stern report and an endorsement of a recommendation in the Alberti taskforce report, was that funding and commissioning of forensic medical services should be transferred from the police to the NHS. This recommendation was aimed at addressing unacceptable variation in service provision, particularly in areas not served by a SARC. The Stern review report recommended that both the health service and the police should take responsibility for monitoring the performance of forensic physicians.
251. In 2013, as a result of the Health and Social Care Act 2012, NHS England and Public Health England were established. NHS England took over the lead commissioning role for sexual assault services commissioning on 1 April 2013 as part of a larger body of responsibilities transferred to NHS England under the Public Health Section 7A agreement.
252. In 2013, NHS England published Specification Number 30 in relation to SARCs.⁴⁷ This document was revised in 2016⁴⁸ and incorporated the service specification for forensic medical examinations, the model for service provision, minimum elements and quality standards.
253. In 2015 a commissioning framework was published⁴⁹ by NHS England, which states that the SARC would be commissioned by NHS England in partnership with the police, local authorities and clinical commissioning groups.
254. As at December 2016, there were 43 SARCs across England. Many of these services are located in urban areas with high population densities and good access to public transport. Some are based in separate police-owned customised facilities, others are located in NHS premises such as hospitals, primary healthcare centres, or premises in residential areas. In rural or semi-rural areas, the low volume of demand might not justify the establishment of a SARC, and in these situations regional SARCs operate via a hub and spoke model, where the SARC forms the hub, connected to local services, which operate as an extension of that hub. A SARC may also be networked to other services such as sexual health clinics, genitourinary medicine centres, paediatrics, social care and victim support services.
255. The workforce of SARCs varies greatly. Forensic medical examinations are usually undertaken by medically qualified forensic physicians, but might be undertaken by other clinical professionals such as forensic nurse practitioners, forensic paediatric examiners, and supported by Independent Sexual Violence Advocates (ISVA). The latter have been incorporated into the SARC model of service delivery since 2006 and are trained support workers who provide assistance and advice to victims of sexual violence.

⁴⁵ [Independent Review into how rape complaints are handled by Public Authorities in England and Wales, Baroness Vivien Stern CBE \(2010\).](#)

⁴⁶ ['Responding to violence against women and children – the role of the NHS' \(March 2010\)](#)

⁴⁷ [Public Health functions to be exercised by NHS England. Service specification No.30 Sexual Assault Services 2013.](#)

⁴⁸ [Public Health functions to be exercised by NHS England. Service specification No 30 Sexual Assault Services 2016.](#)

⁴⁹ [Commissioning Framework for Adult & Paediatric Sexual Assault Referral Centres \(SARC\) Services, NHS England \(2015\).](#)



256. The specification and commissioning framework make reference to the SARC indicators of performance, and SARCs are required to report on these performance indicators to inform the national commissioning assurance.⁵⁰ SARC providers must produce activity reports in line with the SARC Indicators of Performance (SARCIP) at least quarterly to the service commissioners.

257. The Care Quality Commission has the responsibility to inspect SARCs in England.

SARCs – Wales

258. New Pathways is a registered charitable company that provides a range of specialist counselling and advocacy services for women, men, children and young people who have been affected by rape or sexual abuse. New Pathways opened its first SARC in Wales in 2005, and has since introduced three more. The service is accessible 24 hours a day, every day of the year including all public holidays. The SARCs provide immediate support to recent victims of rape or sexual assault including access to a forensic medical examination and the opportunity to speak to the police if they wish to do so. The service is client focussed and designed to ensure that clients receive the right information to enable them to make informed decisions. Clients can choose to self-refer and have a forensic medical examination without having to make a report to the police. Forensic evidence is gathered, stored and retained for several years to support a potential criminal case should the client decide to report the crime to the police. There is a dedicated police interview room with full audio and visual recording facilities. The interview takes place after the forensic medical examination giving victims the opportunity to wash and potentially rest before being interviewed.

SARC – Northern Ireland

259. The Rowan is the SARC for Northern Ireland and is located in a purpose built facility in hospital grounds. The team provides a range of services 24 hours a day, 365 days of the year to women, men, children and young people who have been sexually abused, assaulted or raped. The services offered include a forensic medical examination and the retention of forensic samples until a person decides whether or not to report the crime to the police. People can access the services on a self-referral basis, through another agency, or via the police.

What does this mean for service provision in Scotland?

260. HMICS considers that Scotland is well behind the rest of the UK in terms of provision of dedicated healthcare facilities, accessible 24 hours a day, seven days a week, and available at appropriate locations within reach of communities across the country. Whilst Scotland does have challenges of geography to provide services to remote and rural communities, so do other areas of the UK. Amongst the 43 SARCs in England, there are a range of delivery models. Some are dedicated facilities, often in NHS premises including hospitals and health centres, in urban areas, and some are delivered on a regional basis using a hub and spoke model. The SARC forms the hub, with local services operating as extensions of the hub. What all the SARCs share, regardless of their model, are the key elements of service that must be delivered. These elements (or standards) form the SARC Indicators of Performance, which are reported on a quarterly basis to the service commissioners. SARC providers are required to demonstrate that an equitable and consistent standard and delivery of services are being provided to service users.

⁵⁰ [Commissioning Framework for Adult & Paediatric Sexual Assault Referral Centres \(SARC\) Services, NHS England \(2015\).](#)



261. Looking at how policy and practice have evolved over the years in the rest of the UK provides lessons from which Scotland can learn. HMICS highlights the following points, which it considers to be particularly useful:

- Clear direction and leadership from Government that SARCs are good practice and an expectation that every area should have one.
- Legislation (The NHS Public Health Functions Agreement, Section 7A made under the NHS Act 2006, as amended by the Health and Social Care Act 2012), which details the specific responsibilities of NHS England for commissioning certain services, including sexual assault services, as part of the wider system design to drive improvements in population health.
- A Service Specification for Sexual Assault Referral Centres, which makes it clear that NHS England is specifically responsible for commissioning the public health services elements of SARC services, and explaining the roles of other partners in local authorities and criminal justice system (police and Police and Crime Commissioners) as co-commissioners for other elements of the response to sexual violence and rape.
- Agreed Key Elements (or standards) that must be provided, but variations in delivery model depending on local circumstances.
- SARC Indicators of Performance, which are part of the management information template for all SARCs.
- Inspection regime.

International models of delivery

262. In 2013, the Department of Health published an overview of sexual violence services across several countries including America, Canada, Australia, New Zealand, South Africa, and the Nordic countries.⁵¹ Many of these countries have introduced 'one-stop-shop' models, which are usually hospital based or closely linked to a hospital, and provide a full range of support and services for victims of sexual crime. Centre of Excellence models are favoured by the Nordic countries and are similar to the one-stop-shop co-location model, but also include undertaking research and development of national strategy and policy.

Sexual Assault Response Teams (SARTs)

263. In America in the 1970s, responses to sexual assault began to evolve towards holistic and collaborative partnerships to better serve victims and to bring offenders to justice more effectively than the previously fragmented approach. These multi-disciplinary, interagency teams were called SARTs, who shared resources and worked together to provide an integrated response to victims. There was a recognition of differences between areas, but a desire to ensure victims would receive the same level of care no matter where the sexual assault took place, so a collaborative victim response system with state-wide standards was established. Each county uses these standards to create its own SART response. The SART includes forensic medical professionals who can be Sexual Assault Nurse Examiners (SANEs) or Sexual Assault Forensic Examiners (SAFEs), who are specially trained to address the victim's healthcare needs, facilitate the collection of evidence, document physical findings, and give evidence in court as accredited forensic experts. This SART model exists across America, much of Canada, and Australia.

⁵¹ [Sexual Violence Services International Overview, Department of Health \(2012\).](#)

Family Justice Centres

264. The Family Justice Centre approach is based on the San Diego Family Justice Centre model, which opened in 2002 as a one-stop-shop for services to victims of family violence. In 2007, there were 20 Family Justice Centres across America, with more planned. The model is a co-location of a multi-disciplinary team of professionals who work together to provide a range of services, including responses to sexual crime. The National Family Justice Centre Alliance helps communities develop centres across America and around the world.
265. Nine Family Justice Centres have been developed in Europe since 2013, in countries including The Netherlands, Sweden, Belgium, Italy, Germany, Poland, Northern Ireland, and England. They are united in the European Family Justice Centre Alliance. The Family Justice Centre in London opened in Croydon in 2005, which was the first of its kind in Europe. The One Safe Place Project is planned for Derry in Northern Ireland to co-locate over 20 agencies to provide a full wrap around service for victims of domestic and sexual violence.

Children's Advocacy Centres and Children's Houses

266. The Child Advocacy Centre began in Alabama in 1985 with the aim of improving the response to child sexual abuse, which at the time lacked co-ordination across the system and led to children undergoing repeat interviews and being re-traumatised. The multi-disciplinary team includes law enforcement, child protection services, forensic medical professionals, mental health practitioners, and advocates for children and families. The first centre in Alabama became the National Child Advocacy Centre, and has served as a model for centres across America, and there are now over 800 Child Advocacy Centres.
267. The National Child Advocacy Centre has become a role model and supported the development of similar centres internationally. It is an international training centre and has an online library of child abuse literature and information on best practice.
268. The Barnahus (Children's House) Model was inspired by the Child Advocacy Centre approach in America and was introduced in Iceland in 1998. The model works on a collaborative approach with child protection, welfare, health, police and prosecutors all having key roles from the initial forensic medical examination through to interview, court testimony, future support and therapy. It has shown some compelling results in terms of convictions of perpetrators of abuse and improved therapeutic outcomes for children and families. The services delivered by Barnahus include the forensic medical examination of children, as well as interviews of children, which can be used as court testimony.
269. In Sweden the Children's House model was introduced in 2005, and there are now 31 across the country. In Norway, Children's Houses were established in 2007, and there are now houses operating in at least 10 cities in Norway. Denmark has also introduced this model. A common feature is that the Barnahus premises are homely, child friendly and non-threatening, which is in contrast with police stations and hospitals, which can have negative associations for children and families.
270. In 2014, The Havens (a SARC that is part of King's College Hospital NHS Foundation Trust, London) was commissioned by NHS England to review the existing services that help children and young people following sexual assault in London. The report,⁵² which was published in March 2015, recommended a significant change in the way cases of child sexual abuse are investigated. The review recommended that the Children's House model be the vision for the care of children and young people following acute and historic sexual assault.

⁵² [Review of pathway following sexual assault for children and young people in London \(March 2015\).](#)



271. A report by the Children's Commissioner in England in June 2016⁵³ highlighted that the current system is not child centred and does not achieve the best results either for children or the criminal justice system. The report identified the Barnahus (Children's House) as a truly child centred approach to child sexual abuse and stated that it was time for commissioners in England to look at how the model could be piloted in England to help improve rates of prosecution and, ultimately, outcomes for children.
272. In September 2016, the UK Government Home Secretary announced that two Children's Houses would be established in London by 2017. The project is being led by the Home Office Police Innovation Fund, NHS England and London Mayor's Office for Police and Crime, with funding of £7.2 million (it is worth remembering that the budget allocation for 2017/18 to NHS Boards in Scotland combined is £7.03 million to cover the full range of custody healthcare and forensic medical services). Also in September 2016, the Ministry of Justice approved a court reform to allow vulnerable victims and witnesses to give their evidence before a trial starts with any cross examination being conducted in advance, sparing the victim the need to recount traumatic events in court.

Evidence and procedure review

273. The Evidence and Procedure Review Report was published by the Scottish Court Service in March 2015.⁵⁴ The Review was chaired by the then Lord Justice Clerk, Lord Carloway, and explored ways in which greater use could be made of pre-recorded evidence in order to modernise trial procedures given the technology now available. A whole chapter was devoted to Children and Vulnerable Witnesses, and considering approaches in other jurisdictions in order to support and protect child witnesses. Most of the areas investigated, including Australia, Canada, England and Wales, Ireland, New Zealand and the USA, have provision for screens in court, a support person and/or live links to an out-of-court location. Of particular interest was the extent to which some jurisdictions supplemented these standard measures with the use of pre-recorded testimony.
274. In other jurisdictions, steps have been taken to remove the child from the trial hearing altogether by pre-recording their evidence, including cross-examination or its equivalent. The Report of the Advisory Group on Video Evidence, issued by the Home Office as far back as 1989, and commonly referred to as 'the Pigot Report', laid the ground for reform not just in England but in other common law jurisdictions such as Australia and New Zealand.
275. The Evidence and Procedure Review Report presented case studies of approaches in other areas, including Norway. It noted that there are 11 Barnehus (State Children's Houses) across Norway, which provide custom designed facilities for the hearings and other services to support child witnesses. The Barnehus at Oslo is part of a network across Norway, introduced in 2009. The facility provides a safe environment for children to be interviewed and assessed. The child witness undergoes a forensic interview with a single interviewer in a purpose built facility, under the guidance of a judge and with the mediated participation of the relevant legal representatives. The focus in the Evidence and Procedure Review Report is on the benefits in terms of supporting a criminal trial process by obtaining an interview that is recorded and can be used as evidence in chief. The access to therapeutic and medical support is mentioned, but in the context of helping to ensure the interview was as effective as possible.

⁵³ [Barnahus: Improving the response to child sexual abuse in England, Children's Commissioner \(June 2016\).](#)

⁵⁴ [Evidence and Procedure Review Report, Scottish Court Service \(March 2015\).](#)



276. In the Evidence and Procedure Review – Next Steps report,⁵⁵ published February 2016, the Norwegian Barnehus model is highlighted again with a focus on obtaining testimony from a child witness, albeit the other aspects of the Norwegian system, including forensic medical examination suites and on-going family therapy, are mentioned.
277. The Next Steps report's principal recommendation is that there should be a systematic approach to the evidence of children in which it should be presumed that the evidence in chief of a child witness will be captured and presented at trial in pre-recorded form and the subsequent cross examination of the child will also be recorded in advance of the trial. Features of that approach should include securing the most appropriate environment for the taking of witness statements in recorded form with a view to their being used as evidence in chief. The Review's experience of the Norwegian model suggests that a multi-agency hub environment is likely to provide the best means of providing support to a witness who has been traumatised. The availability of 'wrap around' services is likely to minimise the risk of further traumatisation.
278. HMICS is aware of work being carried out by the Scottish Government, Scottish Court Service, and Police Scotland to consider the benefits of the Barnahus model and its potential application in Scotland. Children 1st have also been involved in this work, and are strongly in support of the introduction of a similar model in Scotland for the benefits to children who have been abused. The focus of the Evidence and Procedure Review - Next Steps is largely on the court process and the potential benefits of recording an interview of a child or vulnerable witness that can be used as evidence in chief. There is less emphasis on the forensic medical examination and the ongoing healthcare needs of the child.
279. HMICS believes it is vital that the work being led by Justice in relation to the improving the support for child witnesses in court, is joined up with the work the National Network Board and the Managed Clinical Networks are doing to improve the forensic medical examinations of children.

⁵⁵ [Evidence and Procedure Review - Next Steps, Scottish Court Service \(February 2016\).](#)



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