Response to Healthcare Improvement Scotland on Healthcare and Forensic Medical Services for People who have Experienced Rape, Sexual Assault, or Child Sexual Abuse: Children Young People and Adults (Draft Final Indicators)

December 2019

We welcome the opportunity to submit our views in response to Healthcare Improvement Scotland's Healthcare and Forensic Medical Services for People who have Experienced Rape, Sexual Assault, or Child Sexual Abuse: Children Young People and Adults (Draft Final Indicators). We support the intention of the CMO Taskforce to develop key indicators to assist in the implementation and monitoring of the standards for anyone who has experienced rape, sexual assault or child sexual abuse.

Please note that we have not included Indicators 5-9 as these are not in our area of expertise.

Background

At CELCIS, we undertake a range of systemic, evidence-informed approaches to drive sustainable and positive change in systems, services and practices for children in need of care and protection and their families. Our work includes a Protecting Children Programme, which supports delivery of the national Child Protection Improvement Programme (CPIP), launched by the Scottish Government in 2016. CPIP aims to ensure that Scotland's child protection system puts children's wellbeing first, and keeps them safe from neglect and abuse. Official statistics indicate that there are 2,688 children on the child protection register in Scotland, and for 163 of these children, case conferences identified concerns relating to sexual abuse. [1] The true extent of child sexual abuse in Scotland is not, however, known and is difficult to estimate, as often sexual abuse is not disclosed or discovered for many years. The NSPCC estimate that as many as 7 out of every 8 children who experience sexual abuse do not come to the attention of services.[2]

These key indicators which support the monitoring of the standards will play a pivotal role in ensuring that children and young people access child centred and trauma informed health care services in a timeous manner. Article 12 of the UN Convention of the Rights of the Child (UNCRC) highlights the right of children and young people to have their views taken into account and we would emphasise the need for choice to be a central aspect of these key indicators.

[1] Scottish Government (2018) *Children's social work statistics 2017-2018.* Table 4.5 – Additional Tables. Edinburgh: Scottish Government.
[2] Galloway, S., Love, R. & Wales, A (2017) *The Right to Recover: Therapeutic services for children & young people following sexual abuse - An overview of provision in the West of Scotland*. NSPCC.

Article 39 states that all appropriate measures should be taken to promote the physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse. Full consideration of other UNCRC articles would also be important to ensuring a child's rights-based approach.

Our response is also informed by our lead role in the development and implementation of the Minimum Dataset for Child Protection Committees, which is an action of the Child Protection Improvement Programme. Critical to the Minimum Dataset's development has been the attention paid to the purpose of indicators, the clarity of their definitions and their presentation in a meaningful and accessible manner, and many of our comments relate to these themes.

Consultation questions

Indicator 1: Sex of sexual offences examiner

Rationale

In their research into sexual assault referral centres, Lovett et al and Chowdhury Hawkins et al noted that adult service users, regardless of sex, expressed a strong preference for female sexual offences examiners and they recommended that this should be the norm. Guidance from the Faculty of Forensic and Legal Medicine recommends that people are given the choice of sex of their sexual offences examiner, in line with recommendations from the Royal College of Emergency Medicine.

The Victims and Witnesses (Scotland) Act 2014 states that an individual must be given the opportunity to request the sex of the examiner.

In joint forensic medical examinations, children and young people under the age of 16 should be able to express a preference for the sex of their paediatrician in addition to the sex of the sexual offences examiner.

Relates to criterion 2.10 in the Healthcare Improvement Scotland 2017 standards.

1. Do you agree with the rationale?
No. Offering choice in the sex of the sexual offences examiner is the key issue for us. Choice is, however, undermined somewhat if there is reference to female sexual offences examiners becoming the norm and Indicator 1.3 measures the proportion of female sexual offences examiners. In short, it is not clear whether the data measures are designed to encourage genuine choice or to encourage female sexual offences examiners.

There is also an implicit gender assumption that the perpetrators of the sexual offences are male and the victims are female. Having the female sexual offences examiner indicator (1.3) reinforces this and does not acknowledge that females can be perpetrators and males can be victims. This does not fully align with the presumption of choice.

Indicators
Indicator 1.1 Proportion of people given the opportunity to express a preference about the sex of examiner before the start of the examination.

Indicator 1.2 Proportion of people who had this preference met:
a) without delay
b) with a delayed examination.

Indicator 1.3 Proportion of examinations undertaken by a female sexual offences examiner.

2. Do you agree with Indicator 1.1?
Yes. It is not clear whether all children under the age of 13 are excluded from this measure, or only those who have been assessed as not having the legal capacity to consent to the examination. Our view is that no age limit is set to consent as all children should have the opportunity to express their preference.

3. Do you agree with the measurement note for 1.1?
No. The note refers to 'meaningful opportunity' but this term is not referred to in the indicator name. A clear definition of a 'meaningful opportunity' should be provided to support consistent reporting.
Paragraph 2: As above, we believe all children should have the opportunity to express their preference and not only when they indicate distress.

4. Do you agree with Indicator 1.2?
Yes. The denominator should be the numerator in Indicator 1.1 – i.e. of those that were given the opportunity to express a preference, and not all examinations.

5. Do you agree with the measurement note for 1.2?
No. It is not clear whether all children under the age of 13 are excluded from this measure, or only those who have been assessed as not having the legal capacity to consent to the examination.

6. Do you agree with Indicator 1.3?
No. If the gender preference of the examiner is met, does it matter whether the examiner is male or female? As outlined earlier, there is also an implicit gender assumption within this indicator that the perpetrators of the sexual offences are male and the victims are female. Having this indicator reinforces this and does not acknowledge that females can be perpetrators and males can be victims.

7. Do you agree with the measurement note for 1.3?
No. It is not clear whether all children under the age of 13 are excluded from this measure, or only those who have been assessed as not having the legal capacity to consent to the examination.

Indicator 2: Timing of forensic medical examination

Rationale

The principles of trauma-informed care should be applied throughout the process of a person's care, including in any communications with or about them. This will enable the individual to have as much sense of choice and collaboration about the examination and their subsequent care as possible, enhancing their sense of safety and trust.

The timing of the forensic medical examination should be person-centred and trauma-informed. It should be performed following discussions with the person, the sexual offences examiner, and others as appropriate, for example, a paediatrician, if the person is under 16 years of age. The forensic medical examination for adults should commence within three hours of the individual, or an individual with guardianship responsibility, agreeing to a forensic medical examination.

When an NHS board receives a referral for an acute sexual assault (within the seven day forensic window), a discussion with a paediatrician should occur within two hours, and the examination commenced within 12 hours. Examinations between 10pm and 8am should be avoided for children and young people, unless there is an urgent need. How quickly a non-acute case (outside the seven day forensic window, including historical cases), needs to be seen may vary according to clinical need. It is envisaged that such cases would be seen for paediatric assessment within two weeks of a decision being made that such an assessment is required.

Relates to criteria 2.11 and 2.12 in the Healthcare Improvement Scotland 2017 standards

8. Do you agree with the rationale?

Yes. Paragraph 3, we feel the rationale for the timescales should be given – e.g. that delay may lead to loss of evidence.

Indicators

Indicator 2.1 Proportion of forensic medical examinations of adults in acute cases which commenced within three hours of the person agreeing to an examination.

Indicator 2.2 Proportion of joint forensic examinations of children or young people in acute cases where:

a) an agreement about the timing of the examination is reached within two hours of an inter-agency referral discussion (IRD) being initiated

b) the examination is commenced within 12 hours of the IRD decision being made.

Indicator 2.3 Proportion of joint forensic medical examinations of children in

non-acute cases that are completed within 14 days of the IRD.

9. Do you agree with Indicator 2.1?
Yes.

10. Do you agree with the measurement note for 2.1?
Yes.

11. Do you agree with Indicator 2.2?
No. We do not believe Indicator 2.2 (a) is necessary if Indicator 2.2 (b) is met. Could the indicator be simplified to focus only on Indicator 2.2 (b)?

12. Do you agree with the measurement note for 2.2?
Yes.

13. Do you agree with Indicator 2.3?
Yes.

14. Do you agree with the measurement note for 2.3?
Yes.

Indicator 3: Examination support

Rationale

Adults, or a young person over 13 years, who have experienced rape or sexual assault should not be examined by a sexual offences examiner without another healthcare professional present. This is in line with the General Medical Council (GMC)'s guidance on intimate examinations and chaperones, which states that everyone should be offered a chaperone for intimate examinations.

The accompanying healthcare professional should be:

- familiar with the examination procedure being carried out
- sensitive and respect the individual's dignity and confidentiality
- present throughout the entirety of the examination
- positioned so they have a clear view of what the clinician is doing, as well as being able to clearly hear everything the clinician is saying
- present to reassure the person being examined if they show signs of distress or discomfort, and
- prepared to raise concerns if they are concerned about the clinician's

behaviour or actions.

An appropriately trained forensic nurse can provide trauma-informed support and reassurance to the person during the examination; cover the GMC requirement for a chaperone; and may also corroborate evidence in court.

Relates to criterion 2.13 in the Healthcare Improvement Scotland 2017 standards

15. Do you agree with the rationale?
Yes.

Indicators
Indicator 3.1 Proportion of people who were examined by a sexual offences examiner without any other appropriate healthcare professional present.

Indicator 3.2 Proportion of people who were supported by a forensically trained nurse throughout their examination.

16. Do you agree with Indicator 3.1?
No. Indicator 3.1 has a 'negative direction' in that 0% is 'good' and 100% is 'bad'. By rewording the indicator to 'Proportion of people who were examined by a sexual offences examiner with another appropriate healthcare professional present' switches the direction of the indicator so that it is in line with the other indicators (thereby is easier to present and report on).

18. Do you agree with Indicator 3.2?
Yes.

19. Do you agree with the measurement note for 3.2?
Yes

Indicator 4: Assessed support needs and ongoing safety planning

Rationale

Individuals who have experienced rape or sexual assault are at high risk for suicide and self-harm 18 and should be assessed for immediate safety, suicidality, and social support. Psychological First Aid is preferred to psychological debriefing in the immediate period after a person has experienced trauma, both for adults and children 19. Adults and children who have experienced rape, sexual assault or child sexual abuse may be at risk of other forms of domestic, gender-based and/or intimate partner violence 20, 21 and should be screened and referred to services accordingly. Individual needs and

preferences are central to trauma-informed care. This enables individuals to regain a sense of control over their environment and ongoing recovery 18, 22.

A comprehensive needs assessment should include assessment of additional support needs due to disability or existing vulnerability, cultural or language barriers, existing or ongoing safety planning, housing needs, social work referrals, legal and advocacy services, and immediate crisis services. NHS Boards should have existing guidance on safeguarding, in addition to local public protection procedures.

For children and young people, a comprehensive social, emotional and wellbeing support assessment must be made, in line with Royal College of Paediatrics and Child Health guidelines, Scottish child protection guidance, and Faculty of Forensic and Legal Medicine guidelines 5, 23. Prior to obtaining consent, an assessment should be made of language, learning or communication needs. This is essential for providing responsive, appropriate and person-centred support. A person must be given the opportunity to fully understand the process of the examination and its implications 24.

Relates to criteria 1.1, 1.3 and 2.6 in the Healthcare Improvement Scotland 2017 standards

20. Do you agree with the rationale?
Yes. Paragraph 3: we believe mention of family, cultural and LGBTi factors should also be included alongside language, learning or communication needs.

Indicators

Indicator 4.1 Proportion of people who underwent a trauma-informed psychosocial risk assessment.

Indicator 4.2 Proportion of people who were referred to all required services identified during a psychosocial risk assessment.

Indicator 4.3 Proportion of people who were referred to

a) sexual health services

b) a support worker

c) Rape Crisis Scotland

d) mental health services, or

e) their General Practitioner.

Indicator 4.4 Proportion of people who received follow-up contact from a nurse coordinator within 14 days of the examination.

21. Do you agree with Indicator 4.1?
Yes.

22. Do you agree with the measurement note for 4.1?
Yes.

23. Do you agree with Indicator 4.2?
No. This would be a hard indicator to get consistently accurate data on. How can practitioners be confident of what 'all required services' are? Can 'all required services' be identified in a (single) psychosocial risk assessment? Perhaps an indicator on a/any referral could be an alternative?

24. Do you agree with the measurement note for 4.2?
Yes.

25. Do you agree with Indicator 4.3?
No. All the other indicators can be said to be targets – e.g. to achieve 100% - but this indicator appears to be more about intelligence around future provision/pathways. As such, is it a target?

Are the five options mean to be an exhaustive list? Should people be referred to all of these?

26. Do you agree with the measurement note for 4.3?
Yes.

27. Do you agree with Indicator 4.4?
Yes.

28. Do you agree with the measurement note for 4.4?
Yes.

Please note that we have left Indicators 5-9 blank as these are not in our area of expertise.

About CELCIS

CELCIS is a leading improvement and innovation centre in Scotland. We improve children's lives by supporting people and organisations to drive long-lasting change in the services they need, and the practices used by people responsible for their care.

Thank you for providing us with this opportunity to respond. We hope the feedback is helpful; we would be happy to discuss any aspect in further detail.

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