

Clinical Pathway for Healthcare Professionals Working to Support Adults Who Present Having Experienced Rape or Sexual Assault

**FOR
CLINICIANS**



**Healthier
Scotland**

Summary Sheet of Taskforce Outputs

The **Adult Clinical Pathway** provides information about the healthcare and Forensic Medical examination (FME) for victims of rape or sexual assault; the steps that should be followed by the clinician undertaking the examination; and the requirements for follow up care and ongoing support. Further information about the purpose of this document can be found in [section 1.1](#).

Information about the requirements for NHS healthcare and FME facilities in the territorial NHS Health Boards in Scotland is provided in **the Health Board Service Specification document**¹.

The findings of the healthcare, FME and follow up assessment will be captured in the National Clinical IT System, Cellma. Cellma is a digital version of the previous paper-based National Form, and contains a healthcare element and a forensic element. All Health Boards should adopt the use of Cellma into their clinical practice for FME for victims of rape or sexual assault. Some of the data fields that will be completed in Cellma will make up the national adult data set. For more information, please refer to [Appendix C](#).

¹[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](#)

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List of Abbreviations

BASHH	British Association of Sexual Health and HIV
BBV	Blood Borne Virus
BHIVA	British HIV Association
CCTV	Closed Circuit Television
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CMO	Chief Medical Officer
CoE	Centres of Expertise
COPFS	Crown Office & Procurator Fiscal Service
CSE	Child Sexual Exploitation
Cu-IUD	Copper Intrauterine Device
DAQ	Domestic Abuse Questionnaire
DASH	Domestic Abuse, Stalking and Honour Based Violence
DNA	Deoxyribonucleic acid
DOB	Date of Birth
EC	Emergency Contraception
FFLM	Faculty of Forensic and Legal Medicine
FGM	Female Genital Mutilation
FME	Forensic Medical Examination
FSRH	Faculty of Sexual and Reproductive Health
GDPR	General Data Protection Regulation
GIRFEC	Getting it right for every child
GMC	General Medical Council

HIS	Healthcare Improvement Scotland
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IUD	Intrauterine Device
IRD	Inter-agency Referral Discussion
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
NES	NHS Education for Scotland
NHS	National Health Service
PEPSE	Post-exposure prophylaxis post-sexual assault
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RCPCH	Royal College of Paediatrics and Child Health
RIC	Risk Identification Checklist
SDM	Supported Decision Making
SOE	Sexual Offence Examiner
SIO	Senior Investigating Officer
SOLO	Sexual Offences Liaison Officer
SPA	Scottish Police Authority
STI	Sexually Transmitted Infection
UNCRPD	UN Convention on the Rights of Persons with Disabilities
WA	Welfare Attorney
WG	Welfare Guardian

Introduction and Background Information	
Section 1	<p>Introduction</p> <p>This section introduces the clinical pathway, including advice on how it should be used.</p>
Section 2	<p>Understanding and Responding to the Needs of People</p> <p>This section focuses on the societal and cultural context of gender based/sexual violence and abuse and outlines the need for services that respond appropriately to the needs of people who have experienced rape, sexual assault or sexual abuse.</p>
Section 3	Self-referral
Section 4	Service Models and Service Ethos
Clinical Pathway Process	
Section 5	<p>High Level Diagram of the Adult Clinical Pathway Flowchart Process</p> <p>This section provides a high level flow diagram showing the steps of the clinical pathway.</p>
Section 6	<p>Responding to Initial Disclosure</p> <p>This section provides information on dealing with the initial disclosure.</p>
Section 7	<p>Consent</p> <p>This section sets out the choices for individuals and the requirement to seek consent.</p>
Section 8	<p>Health and Psychosocial Needs Assessment</p> <p>This section sets out the processes for undertaking a healthcare medical examination, including:</p> <ul style="list-style-type: none"> • Healthcare examination • Psychosocial risk assessment
Section 9	<p>Forensic Medical Examination (FME)</p> <p>This section sets out the processes for undertaking a forensic medical examination, including:</p>

	<ul style="list-style-type: none"> • Preserving forensic evidence • FME • Role of colposcopy in FME • Assessing specific healthcare needs
Section 10	Follow Up Care and Ongoing Trauma-Informed Support
Corroboration	
Section 11	<p>Corroboration</p> <p>This section explains the requirement of corroboration and the role of witnesses and the disclosure of records.</p>
Appendices	
Appendix A	<p>Legislation and Policy Context</p> <p>This appendix sets out the legislation and policy context for the provision of services to people who have experienced rape or sexual assault and the legislative framework for prosecution of people who commit acts of rape or sexual assault.</p>
Appendix B	<p>Roles and Responsibilities</p> <p>This appendix outlines the key roles and responsibilities for the healthcare and other professionals working within this clinical pathway.</p>
Appendix C	<p>Cellma: The National Clinical IT System</p> <p>This appendix provides an overview of the use of the National Clinical IT System, 'Cellma'.</p>
Appendix D	<p>The Criminal Justice Process</p> <p>This appendix explains the criminal justice process.</p>
Appendix E	<p>Clinical Pathways Subgroup Membership</p> <p>This appendix provides a list of people who have been involved in the clinical pathways subgroup.</p>
Resources	

1. Introduction

1.1 What is the purpose of this guidance?

This clinical pathway and guidance is for healthcare professionals in Scotland working to support adults (16 years and over) who present having experienced rape or sexual assault. It outlines:

- The processes for supporting the immediate health and wellbeing of individuals
- The requirements for trauma-informed practice
- Guidance on how to assess and manage clinical risk, ongoing safety, and the provision of ongoing support and follow up
- Who can access self-referral FMEs
- The processes for collection of forensic evidence, if required
- The legal framework and policy context in Scotland
- The processes for providing evidence for criminal justice system purposes

Healthcare professionals should not make a judgement about whether the reported rape or sexual assault against a person did or did not take place. It follows that from a clinical, person-centred and trauma-informed perspective, that this pathway refers to a report of rape or sexual assault. Whether a rape or sexual assault has taken place is ultimately for a court to decide, if a police report is made a criminal case is subsequently brought forward.

1.2 Who should use this guidance?

This guidance should be used by NHS Health Boards and Integrated Joint Boards to inform the way in which services are structured and delivered locally. This guidance provides a minimum standard for service delivery, in line with the Health Board service specification².

Responsibility for the delivery of healthcare and forensic medical services sits with NHS Health Boards.

1.3 How should this guidance be used?

This document is split into chapters, for ease of reference. Where possible, for all resources referenced or referred to within this document, a link to the document is provided. This pathway should be used as part of a holistic healthcare approach, which delivers a person-centred, trauma-informed service provided by an appropriately trained workforce. Anything defined in the guidance is a general

²[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/rape-sexual-abuse-child-sexual-abuse-medical-services-guide-for-service-providers-december-2019/pages/115.aspx)

description of the term and is not referring to a statutory definition of the term, unless otherwise specified.

1.4 Who is this guidance applicable to?

This guidance is designed to support the healthcare and FME of adults aged 16 and above who disclose recent rape or sexual assault.

For those under 16, please consult:

- National Guidance for Child Protection in Scotland (Scottish Government 2021)³
- Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland (Child Protection Managed Clinical Networks 2017)⁴
- National Clinical Pathway for Children and Young People⁵

There may be occasions, due to capacity, other additional needs or vulnerabilities where it is appropriate for a person aged 16 or over to have a joint examination with a paediatrician. This should be decided at an Inter-agency Referral Discussion (IRD). For further guidance on support for young people, please refer to [section 2.4](#).

1.4.1 Delayed Disclosure

For those who disclose child sexual abuse in adulthood, the guidance below should be referred to:

- Working with Survivors of Childhood Sexual Abuse (Scottish Government 2008)⁶
- The Psychological Therapies Matrix (2015) – A Guide to Delivering Evidence-Based Psychological Therapies in Scotland (NHS Education for Scotland 2015)⁷
- Coping after a Traumatic Event (RCPCH 2016)⁸
- Childhood Sexual Abuse – Information booklet for women survivors (Glasgow and Clyde Rape Crisis Centre 2016)⁹
- Survivors UK¹⁰

³ [National guidance for child protection in Scotland 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/national-guidance-for-child-protection-in-scotland-2021/pages/1-1-introduction.aspx)

⁴ [Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland](#)

⁵ [National Clinical Pathway for Children and Young People](#)

⁶ [Yes You Can! - Working with Survivors of Childhood Sexual Abuse: Second Edition](#)

⁷ [Matrix - A guide to delivering evidence-based psychological therapies in Scotland \(scot.nhs.uk\)](https://scot.nhs.uk/matrix)

⁸ [Coping after a traumatic event | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/clinical/clinical-approach/coping-after-a-traumatic-event)

⁹ [Childhood Sexual Abuse Information Booklet for Women Survivors | Rape Crisis Scotland](#)

¹⁰ [SurvivorsUK | We challenge the silence to support sexually abused men](https://www.survivorsuk.org/)

1.5 What other documents should be consulted?

The guidance is intended to supplement but does not replace existing national guidance and standards such as:

- Health and Social Care Standards: My Support, My Life (Scottish Government 2017)¹¹
- Standards for Healthcare and Forensic Medical Services for People who have experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults (Healthcare Improvement Scotland 2017)¹²
- Indicators for Healthcare and Forensic Medical Services for People who have experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults (Healthcare Improvement Scotland 2020)¹³
- Compendium of Healthcare Associated Infection Guidance (Health Protection Scotland, 2018)¹⁴
- Recommendations from the Faculty of Forensic and Legal Medicine (Faculty of Forensic & Legal Medicine (FFLM), 2019), recognising that there are some important differences between the English and Scottish legal and justice systems¹⁵
- Clinical Guidance: Emergency Contraception (Faculty of Sexual and Reproductive Health 2017)¹⁶
- UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (British Association of Sexual Health and HIV (BASHH) 2021)¹⁷
- Gender based violence, Domestic abuse - What health workers need to know (NHS Health Scotland 2019)¹⁸
- Confidentiality: Reporting gunshot and knife wounds (General Medical Council 2018)¹⁹

¹¹[Health and Social Care Standards: my support, my life - gov.scot \(www.gov.scot\)](http://www.gov.scot)

¹²[Healthcare and forensic medical services for people who have experienced rape or sexual assault standards \(healthcareimprovementscotland.org\)](http://healthcareimprovementscotland.org)

¹³[Healthcare and forensic medical services for people who have experienced rape or sexual assault - Indicators \(healthcareimprovementscotland.org\)](http://healthcareimprovementscotland.org)

¹⁴[HPS Website - HAI Compendium: Guidance and resources \(scot.nhs.uk\)](http://scot.nhs.uk)

¹⁵[Recommendations for the Collection of Forensic Specimens from Complainants and Suspects - FFLM](#)

¹⁶[FSRH Clinical Guideline: Emergency Contraception \(March 2017, amended December 2020\) - Faculty of Sexual and Reproductive Healthcare](#)

¹⁷[UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021 \(bhiva.org\)](http://bhiva.org)

¹⁸[Gender based violence, Domestic abuse - What health workers need to know - Publications - Public Health Scotland](#)

¹⁹[Confidentiality - reporting gunshot and knife wounds - GMC \(gmc-uk.org\)](http://gmc-uk.org)

1.6 Who has developed the guidance?

The guidance has been developed by the Clinical Pathways Subgroup and approved by the Chief Medical Officer's Taskforce for the Improvement of Services for Victims of Rape and Sexual Assault²⁰.

A wide range of multi-agency professionals were members of the subgroup along with third sector organisations to represent the views of people with lived experience.

This document is currently held by the Chief Medical Officer's (CMO) Taskforce Unit within the Scottish Government who are responsible for reviewing and updating it on behalf of the Taskforce. This version is an update to the guidance published in November 2020. However, each consecutive iteration should be retained for audit and control purposes. The most up to date version can be found on the CMO Taskforce website.

1.7 Review of the pathway

The November 2020 version of the pathway has been updated to take account of the introduction of self-referral FMEs in accordance with health board responsibilities under the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021, which commenced on 1 April 2022. The pathway will be updated to reflect any future changes that are relevant to the guidance included in this document.

This pathway contains references to legislation that are relevant to forensic medical services. This pathway does not supersede or alter any duties or requirements imposed by legislation or legal obligations and principles arising from case law determined by the courts (more applicable to criminal justice matters). Legislation may have been amended before this document is next reviewed and this should not be considered a comprehensive description of the law in this area. Case law may also have changed. If needed, independent advice should be obtained on the accuracy of any references to legislation or reference to any other legal obligations or descriptions of the law. If legal advice is required in relation to the provision of care, this should be sought through the normal Health Board process.

1.8 What terminology is used in the guidance?

Terminology in the pathway has been used to align with Healthcare Improvement Scotland's Standards for Healthcare and Forensic Medical Services.

Wherever possible, generic terminology, which can be applied across all settings, has been used. The term 'person' or 'people' is used to refer to the person receiving

²⁰[Taskforce for the improvement of services for adults and children who have experienced rape and sexual assault - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/forensic-medical-services-victims-of-sexual-offences-act-2021/pages/introduction-and-when-it-commences/)

care or support. This emphasises that people have the same rights to care, irrespective of their sex or other distinguishing characteristic.

Throughout this document, we have used the phrase 'Sexual Offence Examiner' (SOE) to refer to the clinician carrying out the FME. It is acknowledged that, depending on the specific circumstances or the wishes of the person who has experienced rape or sexual assault, it may be that there is only a requirement for a healthcare assessment and associated follow up and this may be done by a range of healthcare professionals.

2. Understanding and Responding to the Needs of People

This section:

- Focuses on the societal and cultural context of gender based violence, abuse and sexual violence
- Outlines the need for services that respond appropriately to the needs of people who have experienced rape sexual assault or child sexual abuse

Key points

- ✓ The term gender based violence is used to describe violence, predominantly against women and girls, in the context of gender inequality
- ✓ Those most at risk of domestic abuse are those with multiple vulnerabilities. Perpetrators can be adept at targeting people with vulnerabilities
- ✓ Services must be designed with the person at the centre, so that the physical environment and care pathway has due regard for the impact of trauma
One of the challenges for the pathway is to provide age appropriate services. Services designed for older adults may not address the needs of young people

2.1 Gender Based Violence

Sexual violence can affect anyone in Scotland; it perpetuates inequality and prevents the achievement of potential, not only for those who directly experience it or those who fear it, but also their families, and communities (Scottish Government 2016).

The term 'gender based violence' is generically used to describe violence, predominantly against women and girls, in the context of gender inequality. Gender based violence encompasses:

- Domestic abuse including coercive control²¹
- Rape and sexual assault
- Child sexual abuse
- Commercial sexual exploitation
- Sexual harassment and stalking
- Harmful traditions and practices

The roots of gender based violence are deeply embedded within societal and cultural attitudes towards women and in notions of how men and women should behave, particularly in relation to sexual matters (Health Scotland 2018).

These attitudes can have a significant impact on people who have been raped or sexually assaulted and can deter them from seeking help due to fear of judgment.

²¹[Domestic Abuse \(Scotland\) Act 2018 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2018/42/section/1)

Fear of judgement is particularly common among people who are vulnerable at that time, for example those with experience of the care system; people with learning and/or physical disabilities; people who experience gender based violence; those who have been victims of human trafficking and exploitation for the purpose of commercial sexual exploitation; those with experience of the criminal justice system; people who misuse drugs and/or alcohol; and those living with domestic abuse. These factors contribute to significant under reporting.

Sexual violence within relationships should always be considered within the wider context of domestic abuse. It is also important to understand the full dynamics of domestic abuse. The Domestic Abuse (Scotland) Act 2018 criminalises not only physical abuse but other forms of psychological abuse and coercive and controlling behaviour. This new offence brings clarity for victims so they can see explicitly that what their partner or ex-partner has done to them is wrong and can be dealt with under the law.

Anyone who is a partner or an ex-partner (spouse, civil partner or in an intimate relationship) can be affected by domestic abuse. Those most at risk of domestic abuse are those with multiple vulnerabilities. Perpetrators can be adept at targeting people with vulnerabilities. An assessment of ongoing risk should be undertaken with any individual experiencing intimate partner violence, including child protection issues (NHS Education for Scotland 2017). This is included in the digitised National Form within Cellma, and is to be performed as part of the health assessment.

Female Genital Mutilation (FGM) is an illegal practice and an extreme violation of human rights. FGM reflects deep-rooted inequality between the sexes and constitutes a severe form of discrimination against women and girls. Perpetrators of FGM may seek to justify their behaviour by referencing various socio-cultural factors, including fixed gender roles that perceive women and girls as gatekeepers of their family's honour. FGM has been illegal in Scotland since 1985, when the Prohibition of Female Circumcision Act was passed. The Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 was passed on 19 March 2020. Work on the implementation of the Act is now recommencing. The Act creates a new type of Protection Order for women and girls at risk of, or who have experienced, FGM, and for the general purpose of reducing the likelihood that FGM offences will occur. An application for an FGM Protection Order can be made by the person who has had, or who is at risk of FGM; by a relevant local authority, Police Scotland, or the Lord Advocate; or with the permission of the court by any other person (for example, a family member or a charity).

2.2 Responsive Services

A timely, person-centred multi-agency coordinated approach following rape or sexual assault can positively influence a person's long term health, wellbeing and recovery,

and supports continued engagement, as well as the collection of high quality evidence to support any criminal justice process.

For the person, sexual abuse can have both immediate and longer term impacts on their physical and mental health and wellbeing. Effects can vary and can include depression, anxiety, post-traumatic stress disorder, psychosis, alcohol and drug misuse, eating disorders, self-harm and suicide. Sexual abuse may also affect personal and professional attainment, and can worsen the impact of inequalities in women, the vulnerable and the disadvantaged (Department of Health 2012, Conaglen and Gallimore 2014).

2.3 Person-Centred, Trauma-Informed Services

In accordance with the Healthcare Improvement Scotland Standards²² and national service specification document²³, services must be designed with the person at the centre, so that the physical environment and care pathway has due regard for the impact of trauma. Any staff in direct contact with the person should also have completed the NHS Education for Scotland (NES) training which incorporates the principles of the National Trauma Training Framework²⁴. The level of trauma training that staff working with people who have experienced rape and sexual assault will be expected to have is outlined in [Appendix B](#). Health Boards are responsible for ensuring that their employees are trained to the appropriate level in accordance with the trauma training framework.

NES on-line training resources²⁵ are available to help increase awareness, knowledge, capacity and capability among all sectors of the workforce to understand the impact of trauma and embed trauma-informed practice and responses. These are available for free and accessible to everyone in the Scottish workforce and include the key principles of safety, trust, choice, empowerment and collaboration. The importance of this approach is set out below.

First, it supports the recovery of those affected by trauma by providing them with a different experience of relationships, one in which they are offered safety rather than threat, choice rather than control, collaboration rather than coercion, and trust rather

²²[Healthcare and forensic medical services for people who have experienced rape or sexual assault standards \(healthcareimprovementscotland.org\)](https://www.healthcareimprovementscotland.org)

²³[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](https://www.gov.scot)

²⁴[National Trauma Training Framework \(transformingpsychologicaltrauma.scot\)](https://transformingpsychologicaltrauma.scot)

²⁵[NES Trauma Informed - National Trauma Training Programme Online Resources Summary \(transformingpsychologicaltrauma.scot\)](https://transformingpsychologicaltrauma.scot)

than betrayal. Each encounter provides an opportunity to reverse the association between trauma and relationships and is an important part of recovery.

Second, it minimises the barriers to receiving care, support and interventions that those affected by trauma can experience when memories of trauma are triggered by aspects of the service or interactions with staff. People affected by trauma can become highly sensitive to subtle (as well as obvious) reminders of their previous traumatic experiences and relationships. Such reminders and the distress that they may cause, is another reason why people affected by trauma may not engage with or drop out from the care, support and interventions that they need. Trauma-informed care allows workers and services to explicitly identify and adapt any aspects of their service that may trigger distress associated with trauma, in order to minimise it.

The Psychological Therapies Matrix²⁶ recommends empowerment to help support a person's recovery from the trauma they have experienced. The provision of services and the processes and policies which underpin them should all be viewed through a trauma-informed lens to ensure that the person is given choice and control over all aspects of their care. The person should be made to feel safe and that they can trust the people involved in providing their care.

Services should be alert to possible triggers. A trigger is a term commonly used to describe something that re-ignites the trauma response for a person and is highly personal to the individual's experience. The response is a subconscious action by the brain to engage safety systems to protect them from further harm. They cannot control this response and may not even be aware what has caused it. Something which is identified as a trigger for one person may not affect someone else. Whilst no list can be exhaustive, the Health Board Service Specification seeks to highlight factors in the delivery of the service which may unintentionally trigger a trauma response (for example sights, smells, sounds or processes).

²⁶ [Matrix - A guide to delivering evidence-based psychological \(scot.nhs.uk\)](https://www.scot.nhs.uk/matrix/)

Useful resources

NHS Education for Scotland (2017) Transforming Psychological Trauma: A knowledge and skills Framework for the Scottish Workforce²⁷

Rape Crisis Scotland (2017) I Just Froze²⁸

NHS Health Scotland (2018) Gender Based Violence²⁹

NHS Lanarkshire: Trauma and the Brain: Understanding Abuse Survivors Responses³⁰

2.4 Young People 16 and 17 Years Old

A young person aged 16 years is still developing emotionally, physically and sexually and their needs are therefore different from those of older adults. For young people aged 16 and 17, professional judgement should be used to decide whether the adult clinical pathway or the pathway for children and young people³¹ is most appropriate. In relation to a pathway for reporting rape or sexual assault, they should be considered potentially vulnerable based on age. The Adult Support and Protection (Scotland) Act 2007³² provides additional protection to adults at risk of harm or neglect. The Act defines 'adults at risk' as those (aged 16 years or over) who:

- Are unable to safeguard their own wellbeing, property, rights or other interests
- Are at risk of harm; and
- Are more vulnerable to being harmed because they are affected by disability, mental disorder, illness or physical or mental infirmity

An adult is at risk of harm if:

- Another person's conduct is causing (or is likely to cause) the adult to be harmed, or
- The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm

The Act places a duty on local authorities to inquire into and investigate cases where it knows or suspects that an adult is at risk and that it might need to intervene to protect, among other things, the person's wellbeing. A local authority has powers to

²⁷[Trauma – national trauma training programme | NHS Education \(scot.nhs.uk\)](#)

²⁸[I just froze](#)

²⁹[Gender based violence - Health topics - Public Health Scotland](#)

³⁰[Trauma and the Brain | NHS Lanarkshire](#)

³¹[Clinical pathway for healthcare professionals working to support children and young people who may have experienced child sexual abuse](#)

³²[Adult Support and Protection \(Scotland\) Act 2007 \(legislation.gov.uk\)](#)

visit and interview people, arrange medical examinations, examine records and apply for various types of protection orders. It must also consider if there is a need for advocacy and other services, such as help with medication, or support services.

The provisions of the Adults with Incapacity (Scotland) Act 2000³³ may be relevant for some young people aged 16 and 17 years. The Act concerns the welfare of adults with special needs who are unable to make decisions for themselves or are not able to communicate. This Act provides the framework for other people (such as carers) to act on the behalf of people with incapacity. For further information on Adult Support and Protection, see [section 6.1](#).

In addition, practitioners should be aware that a proportion of 16 and 17-year-old young people who present reporting rape or sexual assault may have been victims of sexual abuse whilst they were under the age of 16 years. This may or may not have been reported and may or may not have progressed through the criminal justice system. It is important to take account of the increased vulnerability of young people who have a history of abuse. This may include young people who experienced abuse from a young age which continued over many years and may have been perpetrated by someone close to them. These and other young people can continue to experience further abuse. Their early exposure to abuse means that many have an increased vulnerability to further abuse, be subject to grooming or at risk of sexual exploitation.

Young people who have experience of the care system are at a significantly greater risk of being in this position. A young person with a history of sexual abuse will therefore need any new incident or report to be assessed within the context of a chronology of adverse childhood events. They will also need a comprehensive and holistic assessment of their needs to inform the offer/plan for trauma sensitive support post disclosure/reporting. Particular attention should be paid to considering any ongoing risks to their safety and assessing general wellbeing concerns. One of the additional challenges that can arise in relation to offering follow up in this group is that young people will at times not identify or recognise what they have experienced as abusive. Some will also be concerned about the potential consequences of sharing their experience, either fearing reprisals for themselves or being keen to protect their abuser, who they may consider their partner.

Other young adults who may be particularly vulnerable with regard to rape or sexual assault and where resistance to the offer of follow up support will need to be sensitively explored include:

³³[Adults with Incapacity \(Scotland\) Act 2000 \(legislation.gov.uk\)](#)

- Those who have been trafficked and/or have been unaccompanied asylum seeking children
- Young people who have been victims of CSE and/or grooming and abuse in a coordinated way. This may be in part due to their age and a consequence of highly effective grooming, which can leave young people either believing that they are in a consensual relationship or in fear of the consequences of exposing their exploitation.

For these particularly vulnerable young people aged 16 and 17 years (and potentially up to 25 years if care experienced), although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting it right for every child (GIRFEC) may be engaged.

For the purposes of this pathway, child sexual abuse is defined as an act that involves a child under sixteen (or up to 18 years of age for young people with vulnerabilities and additional support needs) in any activity for the sexual gratification of another. For those aged 16 and 17 who may be victims of sexual abuse, child protection procedures should be considered; and must be applied when there is concern about sexual exploitation or trafficking.

CSE is defined as a *'form of child sexual abuse in which a person(s), of any age takes advantage of a power imbalance to force or entice a child into engaging in sexual activity in return for something received by the child and/or those perpetrating or facilitating the abuse.'*

As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act. 'Child' in this context means child or young person up to age 18. A child or young person of either sex may be a victim. A child protection response is required, the manner of which will be determined following an Inter-agency Referral Discussion (IRD). 'Disclosure' is not a pre-requisite for a child protection investigation or IRD.

Where information is received by police, health or social work that a child may have been abused or neglected and/or is suffering or is likely to suffer significant harm, an IRD must be convened as soon as reasonably practical.

The IRD process may have to begin out with core hours, with a focus on immediate protective actions and interim safety planning. A comprehensive IRD must be completed as soon as practical. This should normally be on the next working day.

The IRD is the start of the formal process of information sharing, assessment, analysis and decision making following reported concern about abuse or neglect of a child or young person in relation to familial and non-familial concerns; and of siblings or other children within the same context.

IRDs are required to ensure coordinated inter-agency child protection processes up until the point a Child Protection Planning Meeting (CPPM) is held; or until a decision is made that a CPPM is not required. An IRD is not usually a one-off discussion. It is a series of discussions between representatives of each of the core agencies as to what the coordinated response should be - a process where it may be necessary to reconvene the IRD as enquiries progress to review strategies and evaluate outcomes.

The situation with regard to these young people may be complicated by:

- The fact that some will not regard themselves as particularly vulnerable
- The fact that some care experienced young people choose not to identify themselves as such

The key principles and components of the IRD are defined in the National Guidance for Child Protection in Scotland 2021³⁴.

2.5 Corporate Parenting

The Children and Young People (Scotland) Act 2014³⁵ (“the 2014 Act”; part 9 which relates to Corporate Parenting) came into effect on 1 April 2015. The Act names 26 public bodies³⁶ and groups of bodies as corporate parents. Under the 2014 Act, Corporate Parents have a duty to promote the wellbeing of looked after children and care leavers to the age of 26.

The 2014 Act also inserts a new section 26A into the Children (Scotland) Act 1995. This section supports the provision of continuing care, meaning that a young person can remain in a foster care, residential care or equivalent placement until the age of 21. Corporate parenting duties for the 26 public bodies also apply to these young people.

The term corporate parenting is defined as: ‘An organisation’s performance of actions necessary to uphold the rights and safeguard the wellbeing of a looked after child or care leaver, and through which physical, emotional, spiritual, social and educational development is promoted’ (Statutory Guidance on Corporate Parenting, 2015).

Young people who have a corporate parent may form a disproportionately high proportion of young people age 16 and 17 on the adult pathway, due to their increased vulnerability. For these young people, and most others in the 16 and 17

³⁴ [National guidance for child protection in Scotland 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/national-guidance-for-child-protection-in-scotland-2021/pages/1-10-introduction-to-the-guidance.aspx)

³⁵ [Children and Young People \(Scotland\) Act 2014 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2014/20/part-9)

³⁶ [Statutory guidance on Part 9 \(Corporate Parenting\) of the Children and Young People \(Scotland\) Act 2014 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/statutory-guidance-on-part-9-of-the-children-and-young-people-scotland-act-2014/pages/1-10-introduction-to-the-guidance.aspx)

age group, it will be necessary to consider whether the GIRFEC approach should be used to provide support or augment support already in place for the young person.

When required, the GIRFEC approach will provide a holistic assessment of support needs for the child or young person and a personalised support plan when the child or young person needs a range of extra support to be planned, delivered and coordinated. This plan will explain what should improve for the child or young person, the actions to be taken and why the plan has been created. The plan is managed by a 'lead professional'; someone with the right skills and experience to make sure the plan is managed properly. The child or young person and parent/carer(s) will know what information is being shared, with whom and for what purpose, and their views will be taken into account.

2.6 Older people

Circumstances that make children vulnerable to abuse can also apply to older people. Some older people will become dependent on others, creating a power imbalance that may be taken advantage of. Older people have the same human rights as everyone else and the impact of sexual abuse on an individual does not diminish as people get older.

The subjects of consent and capacity, including disability, are dealt with in [section 7](#).

3. Self-referral

This section:

- Provides an introduction to self-referral services as defined within the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021³⁷ (FMS Act)
- Provides an overview of who can access self-referral FME, what considerations must be made before offering self-referral, and where to find further information

Key points

- ✓ The FMS Act places a statutory duty on Health Boards to provide self-referral FMS subject to professional judgement
- ✓ Self-referral services are available for people aged 16 and over, unless in their professional judgement there are vulnerabilities, including child protection, sexual exploitation or trafficking
- ✓ The Self-Referral National Protocol provides full guidance on self-referral services

The FMS Act requires consent information to be given to a person who has experienced rape or sexual assault prior to examination. More guidance on this can be found in the Self-Referral National Protocol

The Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021 (“FMS Act”), places a statutory duty on health boards to provide Forensic Medical Services (FMS) for victims of sexual offences and establishes a legal framework for consistent access to self-referral so a victim can access healthcare and request a FME without first having to make a report to the police. This service is called ‘self-referral’ and will be available to those aged 16 and over, subject to professional judgement.

Subject to that professional judgement, a self-referral service allows young people aged 16 and 17 years, who have experienced rape or sexual assault the opportunity to access appropriate support and healthcare services as well as a FME to collect any potential evidence, at a time when they do not feel ready to report to the police.

3.1 Self-referral and certain vulnerabilities

The Self-Referral National Protocol outlines and provides guidance on the requirements of Health Boards under the provisions of the FMS Act and The

³⁷ [Forensic Medical Services \(Victims of Sexual Offences\) \(Scotland\) Act 2021 \(legislation.gov.uk\)](https://www.legislation.gov.uk/ukpga/2021/12/section/1)

Forensic Medical Services (Retention Period) (Scotland) Regulations 2021 (“Retention Period Regulations”)³⁸ in relation to self-referral services.

The Protocol provides examples of potential indicators of vulnerability that should be considered for further discussion with partners, based on professional judgement. Every person is unique and particular consideration should be given to their presentation and the verbal and non-verbal cues they provide.

The following list, whilst in no way exhaustive, provides examples of potential indicators of vulnerability that should be considered for further discussion with partners, and based on professional judgement, could indicate the need for referral to child or adult protection procedures, including an IRD.

The young person self-referring:

- Lacks capacity to consent to the medical
- Is defined as a child for the purposes of the Children’s Hearings System
- Is a Looked After Child or is care experienced
- Self-referred previously
- Was under the influence of drugs or alcohol at the time of the offence
- Intimates that they may have been drugged
- Has other injuries such as bruising, which may indicate a violent assault
- Provides an address in a different area or locality, which may indicate they have been trafficked
- Displays any indicators of CSE or Child Criminal Exploitation³⁹
- Displays any indicators of Honour Based Violence or FGM⁴⁰

In addition, if a young person provides information about a perpetrator and these indicators are present, then Police Scotland should be contacted immediately:

- If the perpetrator is an adult with potential continued access to the young person or other children
- If the perpetrator is a sibling of the young person
- If the perpetrator holds a position of trust such as Teacher, Police Officer, Medical Professional, Social Worker, Youth Worker, Foster Parent, runs/is involved in a club or organisation that other children attend

³⁹ [National guidance for child protection in Scotland 2021 - part 4 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/national-guidance-for-child-protection-in-scotland-2021-part-4/pages/120-121.aspx)

⁴⁰ [National guidance for child protection in Scotland 2021 - part 1 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/national-guidance-for-child-protection-in-scotland-2021-part-1/pages/120-121.aspx)

4. Service Models

Key points

- ✓ Local services should be delivered as close as possible to the point of need supported by a regional centre of expertise
- ✓ The centres of expertise could take a number of forms e.g. a physical space or a virtual role

The Health Board Service Specification describes what should be provided for the delivery of safe and forensically secure person-centred healthcare and forensic medical services

A robust options appraisal process (informed by best practice and the views of people with lived experience) was carried out in 2018 under the remit of the CMO Taskforce. A wide ranging stakeholder event was then held to determine the optimal model and configuration of healthcare and forensic medical services for Scotland. These were agreed by the Taskforce in August 2018.

The clear preference from the options appraisal exercise was for local services to be delivered as close as possible to the point of need supported by a regional Centre of Expertise (CoE).

The role of the CoE may vary across Scotland. In some areas, it may be a physical space where multi-agency partners provide a wraparound service to people in their immediate area, as well as to provide a range of expert advice and support to the other Health Boards in the region. In other areas, the CoE may have a virtual role. Either way, Health Boards within a region should seek to maximise opportunities to collaborate. For further information on the CoE, please refer to the Health Board service specification document⁴¹.

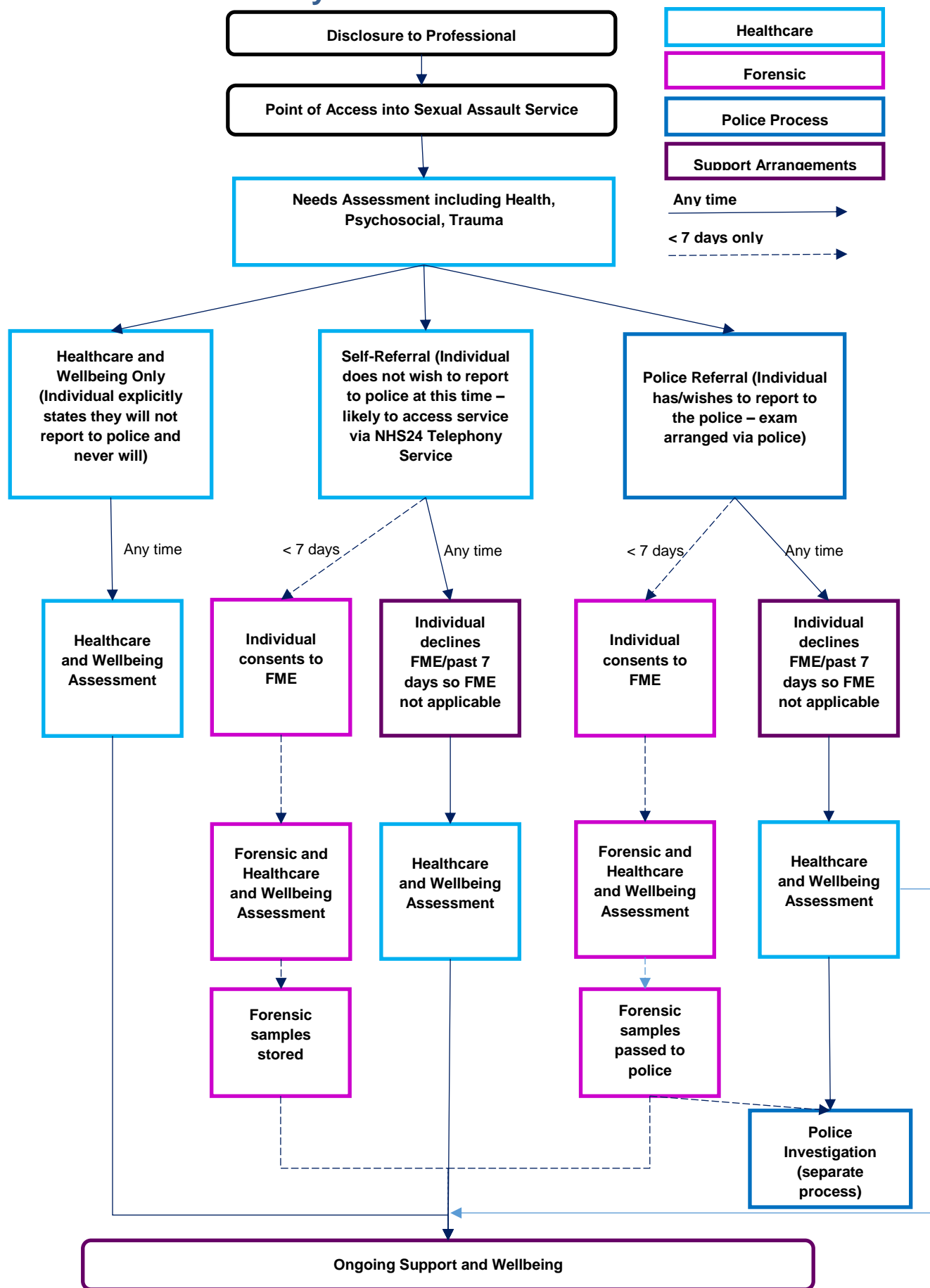
4.1 Health Board Service Specification

In addition to the multi-agency, coordinated services that are being implemented across the Health Boards, a service specification has been developed which describes what should be provided within a healthcare environment for the delivery of person-centred healthcare and forensic medical service provision following rape or sexual assault, and to ensure the forensic integrity of samples taken and stored. The service specification document is to be used as a control document and reference point for the development of service provision. It will currently be updated by the CMO Taskforce Unit to reflect significant changes. The first full version should be

⁴¹[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/rape-sexual-abuse-or-child-sexual-abuse-medical-services-guide-for-service-providers-december-2019/pages/112.aspx)

used as a baseline and each consecutive iteration should be retained for audit and control purposes.

5. Adult Clinical Pathway Flowchart



6. Responding to Initial Disclosure

Key points

- ✓ Responding appropriately to disclosure is a key step for recovery
- ✓ Early and appropriate multi-agency information sharing with the person's involvement, and preferably with their consent, should be considered in every case

Where appropriate, child and/or adult support and protection referrals should be made following local procedures in response to disclosures

As noted in section 1.4 this guidance has been designed to cover adults aged 16 and above who disclose a rape or sexual assault.

The points below should always be considered when responding to initial disclosure of rape or sexual assault whether it is historical or recent:

- Direct the person to locally available support services and provide clear and accessible information on these services as per the adult sexual assault - 7 day window considerations: guidance document⁴²
- Reassure the person that telling you is the right thing to do
- Document details of the consultation as soon as possible
- Use the person's own words as far as possible. Date and sign the documentation including details of anyone else present
- Discuss the options available for clinical care and forensic examination
- Discuss wider support, advocacy and follow up services (within the local context)
- Be alert to the impact on the person of disclosing, perhaps for the first time, whether the events are recent or not
- Make sure you know and follow your organisation's child and adult protection procedures for the involvement of police and social work services
- Provide information in a clear way which ensures the person has a full understanding
- Let the person know what you are documenting and why
- Where the initial disclosure takes place more than 7 days after the rape or sexual assault, local decision-making pathways should be followed
- Where an individual has made an appointment for a consultation and subsequently does not attend, the requirement to follow up on non-attendance is subject to professional judgement.

⁴²[Adult sexual assault - 7 day window considerations: guidance - gov.scot \(www.gov.scot\)](http://www.gov.scot/resources/documents/2015/06/Adult_sexual_assault_-_7_day_window_considerations_guidance.pdf)

6.1 Adult Support and Protection

Under the Adult Support and Protection (Scotland) Act 2007⁴³ (“the 2007 Act”), an ‘adult at risk’ is someone aged 16 or over who is unable to safeguard their own wellbeing, property, rights or other interests, is at risk of harm and because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The 2007 Act provides for adults who are at risk of harm if another person’s conduct is causing (or is likely to cause) that adult harm or the adult is engaging (or is likely to engage in) conduct which causes self-harm. The provisions of the 2007 Act are in place to support and protect any adults who are at risk of harm.

Where an employee of a Health Board knows or believes that an adult is at risk of harm, they are under a statutory duty to refer their person to and respond to information requests from the council or delegated agency. Please note that these duties are in addition to others you may have in terms of reporting a potential crime.

Harm is defined in the 2007 Act as all harmful conduct and in particular includes conduct (or unlawful conduct) which causes physical, psychological, financial and self-harm.

Where you believe a person lacks capacity regarding a specific task or issue refer to your local protocols regarding the Adults with Incapacity (Scotland) Act 2000 especially with regard to assessing mental capacity. Similarly, if you have concerns regarding the person’s mental health refer to your local protocols regarding the Mental Health (Care and Treatment) (Scotland) Act 2003⁴⁴.

Any conduct which constitutes rape or sexual assault is highly likely to come into the category of ‘behaviours that constitute harm’ and should be reported under local adult support and protection procedures as per the statutory duties outlined above. On such occasions the person who lacks capacity, and their Guardian, proxy or representative should be made aware a report will be made. There may be occasions where the healthcare provider is of the professional opinion that the information in relation to rape or sexual assault should be reported in the wider public interest without the need to obtain consent of the person, for example where a child or a vulnerable adult, other than the person themselves, is at risk. Disclosures without consent should be discussed with a senior clinician, Caldicott Guardian, or Data Protection Officer, and the decision to share and the justification clearly documented. The medical record should include the steps taken to seek the person’s consent for information sharing with relevant agencies, the information to be shared and the services involved or record the reasons for not informing the person of the decision to share information without their consent.

⁴³[Adult Support and Protection \(Scotland\) Act 2007 \(legislation.gov.uk\)](http://legislation.gov.uk)

⁴⁴[Mental Health \(Care and Treatment\) \(Scotland\) Act 2003 \(legislation.gov.uk\)](http://legislation.gov.uk)

More information, including guidance on specific steps and processes on this area, can be found in The Code of Practice for the Adult Support and Protection (Scotland) Act 2007⁴⁵.

Useful Resources

A survivors guide to the criminal justice system (Rape Crisis Scotland) ⁴⁶

Little Green Book (Edinburgh woman's rape or sexual assault centre, 2016)⁴⁷

Unlocking sexual abuse and learning difficulties(Enable 2009)⁴⁸

⁴⁵[Adult Support and Protection revised Code of Practice - gov.scot \(www.gov.scot\)](http://www.gov.scot)

⁴⁶[A survivors guide to the criminal justice system](#)

⁴⁷[Little Green Book](#)

⁴⁸[Unlocking sexual abuse and learning difficulties](#)

7. Consent

Key points

- ✓ Consent is a dynamic process. For adults with capacity, subject to the other points set out below, no examination should be undertaken without the person's consent
- ✓ Accessible information should be provided to ensure that a full understanding is gathered before and throughout the examination
- ✓ An adult's consent should be given freely, be specific and without coercion - providing that they have the capacity to consent
- ✓ For a small proportion of people, there may be a need to formally assess capacity and to document the reasons for making a particular decision at that time in the person's best interests
- ✓ The person is entitled to be accompanied by a supportive person of their choice, for example a friend or carer, during any such discussion

Health Boards must ensure that the processing of any personal data is done in compliance with the Data Protection Act 2018 and, where relevant, the General Data Protection Regulation (GDPR). Independent advice on how to comply with any duties or obligations should be taken if needed

7.1 Consent to Assessment, Examination and Treatment

A Doctor, Forensically Trained Nurse (FTN) or other appropriately trained healthcare professional may be involved in sharing information with the person at different points in the person's care. For the purpose of this section, the term healthcare professional is used to capture anyone who may be involved in the person's care.

Sexual Offence Examiners (SOE) are expected to follow the detailed guidance on consent produced by the General Medical Council (GMC). The GMC guidance states that doctors must be satisfied that they have consent (or other valid authority) before:

- Carrying out any examination or investigation
- Providing treatment
- Involving patients in teaching or research

Doctors must consult the most up to date guidance on consent from the GMC.

A fundamental ethical principle guiding medical practice is that no examination, investigation or treatment of a competent adult should be undertaken without the person's consent. In order for consent to be 'valid' the individual must have been given sufficient, accurate and relevant information. They must be given the information in plain English or via an interpreter with sufficient time to consider the decision they are making. The individual must have the competence to consider the

issues and to reach a decision and that decision must be voluntary in terms of not being coerced (Faculty of Forensic and Legal Medicine, 2017). If there is doubt about a person's capacity to consent, please refer to [section 7.4.1](#)

Where a person has a disability, this does not mean that they are not able to give consent. The approach taken should be in line with the principles of supported decision making.

When seeking consent to provide a FME, the question of whether the information given to a person is adequate is judged from the perspective of a reasonable person in that person's position. Doctors have a duty to take reasonable care to ensure that people are aware of 'material risks'.

The purpose of a FME should be explained to the person in a way that they can understand and in plain English. For those whose first language is not English see [section 7.4.1](#).

Local pathways should be in place for use of interpreters including British Sign Language interpreters to provide support for those who are deaf or hard of hearing and those with additional communication needs.

The clinician must provide all information in a clear way and give as much time as the person requires to understand the process and the choices available to them. A patient information leaflet setting out what an examination involves can be provided to aid understanding and decision making. Information on what the FME involves and what will happen following a report to the police, can also be found in the video by Rape Crisis Scotland⁴⁹.

The person should be provided with accessible information to ensure they have a full understanding of what will happen before, during and after the examination and during follow up. It is important that the clinician is aware and is conscious of how information is framed and the potential power imbalances that may exist between the healthcare professional and the person who has experienced trauma.

It is also important that to ensure a truly trauma-informed approach is taken, individuals should feel empowered to express their views and clinicians should be aware of cultural/religious sensitivities which may have an effect on a person's response to an examination. There should be no indication, even in body language, that the time available is limited. The person should be fully informed throughout the process, allowing them to make informed choices about their care. An adult's consent should be given freely, voluntarily and without coercion providing they have capacity to consent. The person is entitled to be accompanied by a supportive person of their choice, for example a friend or carer, during any such discussion.

⁴⁹[RCS Survivors Guide to the Scottish Justice System 2019](#)

Consent is an ongoing process and an individual can withdraw consent at any stage during the consultation and examination and their wishes must be respected.

7.2 Data Protection and Confidentiality

In a healthcare setting, patient data is held under a duty of confidentiality. Health Boards should process personal data in line with Data Protection legislation and in line with Health Board data processing protocols.

7.3 Refusal of any Elements of the Examination

Every adult with capacity is entitled to refuse medical intervention and their refusal must be respected. A person cannot be deemed to lack decision making capacity simply because there is a risk that they might make what appears to be an unwise decision.

If a person chooses not to have a FME, then they should do so with a clear understanding of the implications of the choice they are making including the potentially detrimental effect this could have on any future police investigation or prosecution and that choice should be respected. The person should be offered healthcare even if they do not consent to the FME. There may also be particular aspects of the examination they do not feel able to undertake but some aspects they feel they can proceed with.

7.4 Adults with Incapacity

For a small proportion of people, there may be a need to assess their capacity to make a particular decision at that time. This does not mean they lack capacity to make any decisions at all or will not be able to make similar decisions in the future. See GMC: Consent Guidance: Assessing capacity⁵⁰.

In Scotland, the Adults with Incapacity (Scotland) Act 2000⁵¹ (“the 2000 Act”) defines individuals as incapacitated if they cannot act, make decisions, or communicate them, understand or remember their decisions. In line with the principle of Supported Decision Making (SDM), substitute decision making by another person should be a last resort. Where SDM applies, the SOE (see [Appendix B](#), Roles and Responsibilities) should, following initial assessment, act in accordance with the principles of the 2000 Act, only act in ways that are for the benefit of that individual person and take full account of the person’s wishes and feelings. If the person has difficulty formulating or communicating wishes and feelings, communication must be facilitated so far as is feasible in the circumstances. The impairment may be due to a mental disorder or a physical inability to communicate in any form. Under the UN Convention on the Rights of Persons with Disabilities⁵², disabled people have a right

⁵⁰[Decision making and consent - GMC \(gmc-uk.org\)](#)

⁵¹[Adults with Incapacity \(Scotland\) Act 2000 \(legislation.gov.uk\)](#)

⁵²[OHCHR | Convention on the Rights of Persons with Disabilities](#)

to exercise their legal capacity and must be provided with the support necessary to enable them to do so. Article 12.4 contains safeguards as follows:

States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.

The UN Convention has been ratified by the UK Government, along with the related complaints mechanism. Article 12.3 can be said to support the principle of SDM which is the process of assisting a person with cognitive impairment to build and exercise their capacity to make and communicate decisions for themselves. The Scottish Government is committed to the implementation of domestic human rights legislation and international instruments including the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which the UK Government ratified in 2008.

7.4.1 Factors Which May Affect Capacity or Ability to Consent

The SOE should be cognisant of other impairments or language barriers which may affect an individual's ability to consent.

Use of interpreters or sign language interpreters may be appropriate and NHS Health Board guidance should be consulted. Interpreters may be provided by other agencies such as local authorities. Family members, friends or partners of the person should not be used.

7.4.2 Temporary Loss of Capacity Due to Intoxication

People who are intoxicated due to alcohol or drugs may temporarily lose their capacity. In such circumstances, the assessment should normally be deferred until the person's capacity has returned.

The period for deferment will depend on the type, amount and quantity of the substances that have been consumed. It may be necessary to assess the person repeatedly over a period to determine if the person's capacity has returned.

Clear and precise reasons for deferring a FME should always be recorded.

7.4.3 Person with Serious Injury / Unconscious Person

On occasions people are seriously injured during a rape or sexual assault and the ensuing injuries may result in a loss of capacity (for example where the person is unconscious). The FFLM's recommendations on consent for patients who may have

been seriously assaulted⁵³ advise that any attendance in an acute care setting to carry out a FME on a seriously ill or unconscious person should be with the prior knowledge and permission of the consultant in charge of that person's medical care who should also be informed of the nature and purpose of the proposed examination to ensure that they have no objections to it being undertaken (FFLM 2014).

Each person and their condition should be evaluated on an individual basis with consideration always given to the rights of the person namely:

- The right to life
- The right to bodily integrity
- The right to privacy
- The right to self-determination
- The right not to be discriminated against based on disability (including people with a learning disability)

The SOE must act on the basis of good professional practice and a FME should be undertaken with consideration of the will and preference of the person and their right to exercise legal capacity (the principle of SDM). The rationale behind any decisions, the factors considered and the judgements made may need to stand up to future scrutiny. All steps taken and decisions made must be clearly documented.

In understanding the will and preference of the person, the SOE should consider speaking to people close to the person about the nature and purpose of the proposed examination in order to determine the person's past and present wishes or feelings, beliefs and values so that these can be considered.

The SOE must be mindful that in some cases it may be a member of the family or a close 'friend' who is the perpetrator.

In other cases, there may be sensitive information about an incident that the person would not wish to be disclosed to friends and/or family. Therefore, the SOE must endeavour to understand the will and preference of the person and gain their consent before speaking to any friends or family members about the person.

The SOE should also ascertain if the person has made an advance directive relating to their future medical care to ensure that their wishes are respected. Those close to the person and/or a legally appointed Welfare Attorney (WA) or Welfare Guardian (WG) should be consulted in these circumstances.

The SOE should ensure that the person is informed what has been done and why, as soon as the person is sufficiently recovered to understand.

⁵³[Recommendations - Consent from patients who may have been seriously assaulted - FFLM](#)

In complex cases further advice and guidance should be sought from appropriate senior colleagues.

Useful Resources

General Medical Council (2008) Consent: patients and doctors making decisions together⁵⁴

General Medical Council (2018) Five things to know about our Confidentiality guidance and the GDPR⁵⁵

Faculty of Forensic and Legal Medicine (2014) Consent for patients who may have been seriously assaulted ⁵⁶

Information Commissioner (2018) Guide to the General Data Protection Regulation (GDPR)⁵⁷

⁵⁴[Decision making and consent - GMC \(gmc-uk.org\)](#)

⁵⁵[Five things to know about our Confidentiality guidance and the GDPR - GMC \(gmc-uk.org\)](#)

⁵⁶[Recommendations - Consent from patients who may have been seriously assaulted - FFLM](#)

⁵⁷[Guide to the UK General Data Protection Regulation \(UK GDPR\) | ICO](#)

8. Health and Psychosocial Needs Assessment

8.1 Healthcare Assessment and Aftercare

This section sets out the processes for undertaking an assessment of the person's healthcare needs, wellbeing and ongoing aftercare. Assessment for STI testing including consideration of Blood-Borne Virus (BBV) prophylaxis and pregnancy risk should be undertaken and managed in line with current guidelines and HIS Quality Indicator 5. It is important to note that should the person wish to have a FME, this should be done as soon as reasonably possible in order to preserve as much forensic evidence as possible. For details and guidance on the FME, refer to [section 9](#).

Key Points

- ✓ Supporting the healthcare needs of individuals is essential
- ✓ Health Boards must ensure that healthcare is made available to all who have experienced rape or sexual assault irrespective of whether the individual chooses to report to the police and/or undergo a FME
- ✓ A person centred, trauma-informed approach should take account of specific individual cultural and healthcare needs.
- ✓ The most appropriate method of contraception should be offered and provided as soon as possible. Refer to Faculty of Sexual and Reproductive Health (FSRH) for current guidance for Emergency Contraception (EC)⁵⁸
- ✓ Assessment of the possibility of existing pregnancy should be undertaken when indicated
- ✓ When the risk of Human Immunodeficiency Virus (HIV) infection is assessed as sufficient to recommend prescribing Post Exposure Prophylaxis following Sexual Exposure (PEPSE), starter packs should be commenced as soon as possible and within 72 hours of an assault. See British Association of Sexual Health and HIV (BASHH) HIV PEPSE guidance⁵⁹ for current guidelines
- ✓ Hepatitis B vaccine is highly effective at preventing infection if given shortly after exposure and should be offered to all who may be at risk - see BASHH or local sexual health guidelines for current guidance on prescribing
- ✓ Human Papilloma Virus (HPV) vaccination should be offered to those who do not have a complete vaccination history in line with current national guidance⁶⁰
- ✓ Offer Sexually Transmitted Infection (STI) screening after appropriate incubation periods to allow exclusion of STIs associated with the incident. See BASHH guidance for management of STIs

⁵⁸[FSRH Clinical Guideline: Emergency Contraception \(March 2017, amended December 2020\) - Faculty of Sexual and Reproductive Healthcare](#)

⁵⁹[UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021 \(bhiva.org\)](#)

⁶⁰[Human papillomavirus \(HPV\): the green book, chapter 18a - GOV.UK \(www.gov.uk\)](#)

- ✓ Due to increasing antibiotic resistance, STIs should be treated only after a positive test result. Prophylactic antibiotics should be considered in some circumstances when an individual is at increased risk e.g. multiple assailants and requiring an IUD as EC

Healthcare for victims of all sexes and gender identities must meet both immediate and ongoing health needs in a clinically appropriate sequence including:

- Treating physical injuries that have resulted from the assault
- Safety assessment
- Emergency contraception (where indicated)
- Testing and arranging treatment for sexually transmitted infections, post exposure prophylaxis against blood borne viruses and bacterial STIs
- Psychosocial assessment and support

The findings and observations from the assessments detailed below will be recorded in the immediate after care/medical examination follow up section of the digitised National Form within Cellma.

8.1.1 Assessment of Need for Emergency Contraception (EC)

Rape or sexual assault may place some individuals of reproductive age at risk of unwanted pregnancy. The healthcare professional should assess the need for, offer and provide EC.

The FSRH Clinical Guidelines on EC (2017)⁶¹ recommends that all individuals requiring EC after sexual assault should be offered all methods of EC including a Copper Intrauterine Device (Cu-IUD) if within the appropriate timeframe as it is the most effective method of EC. Following sexual assault, antibiotic cover for STI should be considered if an individual opts for Cu-IUD insertion.

The option of a FME should be discussed with the individual, with consideration of the timeframe for collection of forensic samples. If an individual accepts the offer of a FME, it should be explained that Cu-IUD insertion should be deferred until after a forensic examination has taken place in order to maximise potential for capture of assailant DNA. Some individuals may choose to prioritise pregnancy risk reduction and Cu-IUD insertion above a FME if there is to be a delay in arranging the examination. Clinicians should ensure that they provide adequate information to allow an individual to make an informed choice in this regard, dependent on their own priorities; it is important that their decision is respected.

If an individual opts to have a Cu-IUD inserted for EC after a forensic examination, their EC provider should arrange for Cu-IUD insertion to be carried out without delay after forensic examination has taken place. Oral EC should be offered in the interim

⁶¹[Emergency Contraception - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](https://www.fsrh.org/clinical-guidelines/emergency-contraception/)

in case the Cu-IUD cannot be inserted or the individual later changes their mind about Cu-IUD insertion.

Individuals who decline Cu-IUD insertion for EC after a rape or sexual assault should be offered oral EC as soon as possible, if within the appropriate timeframe.

Healthcare professionals should ensure that they provide adequate information to allow a person to make an informed choice in this regard, dependent on their own priorities; it is important that their decision is respected.

8.1.2 Oral Emergency Contraception (EC)

People who choose and are eligible for oral EC after a rape or sexual assault should be offered it as soon as possible. There are two hormonal preparations licensed for use in the UK. Consult local guidance or FSRH guidance on EC Clinical Guidelines on Emergency Contraception (2017)⁶².

Follow up arrangements for pregnancy testing and provision of ongoing contraception should also be discussed.

Those clinicians who choose to opt out of providing particular procedures because of their personal beliefs and values must make sure that arrangements are made without delay for another suitably qualified colleague to advise, treat or refer the person.

Useful Resources

GMC (2013) Personal Beliefs and Medical Practice⁶³

Nursing and Midwifery Council (2018) The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates⁶⁴

FSRH (2017) Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception⁶⁵

8.1.3 Assessment of Pregnancy Risk and Pregnancy Diagnosis

It may become apparent that current pregnancy as a result of a rape or sexual assault is a possibility. Testing for this should be undertaken with consent either as a baseline or for diagnosis. This should include consideration of a repeat pregnancy test at an appropriate interval if required.

⁶²[Emergency Contraception - Faculty of Sexual and Reproductive Healthcare \(fsrh.org\)](#)

⁶³[Personal beliefs and medical practice - GMC \(gmc-uk.org\)](#)

⁶⁴[Professional standards of practice and behaviour for nurses, midwives and nursing associates](#)

⁶⁵[Guidance for those undertaking or recertifying FSRH qualifications whose personal beliefs conflict with the provision of abortion or any method of contraception - Faculty of Sexual and Reproductive Healthcare](#)

Both practical and emotional support for the person should be offered. There should be pathways in place to access services which support a person's choice, both for continuing with any pregnancy and options relating to termination, where appropriate.

In cases where the person is pregnant at the time of the rape or sexual assault, it is important that they are seen at the appropriate antenatal service following the examination for any follow up care. This support should be organised by the nurse coordinator or equivalent - see [Appendix B](#) for further information on the nurse coordinator role.

8.1.4 Testing for, Prevention Against, and Management of Sexually Transmitted Infection

Rates of STI following a rape or sexual assault vary depending on the population studied, risk factors for STIs and the sensitivity of the test used for identifying the STI. STIs are identifiable at varying periods of time post-exposure depending on the incubation period of the infection.

It is important that there are appropriate care pathways with testing timeframes and defined protocols for management of any STIs. BASHH produce guidance on prevention, screening and management of STIs. Sexual Offence Examiners should consult the most up to date publications at: www.bashh.org/guidelines .

8.1.4.1 Testing for Sexually Transmitted Infections

Due to incubation periods samples for bacterial STIs should be undertaken with consideration of appropriate incubation periods (BASHH guidelines). Any screening samples for bacterial STIs (Chlamydia, Gonorrhoea and Trichomonas) taken at the time of a forensic examination should be taken **after** forensic samples.

In circumstances where a positive screening sample may be of forensic significance (where a minimal chance that the person could have acquired infection from anyone other than the assailant can be evidenced, usually in child cases or people without any previous sexual activity), baseline samples maybe taken at the time of examination and again 14 days' post incident and forwarded with an accompanying chain of evidence form. This is dependent on local facilities and is only possible where the service infrastructure allows for the testing of STI and management of results as STI screening tests are performed in NHS laboratories rather than by the Scottish Police Authority (SPA).

Any follow up samples should be coordinated by the Nurse Coordinator or equivalent.

Consider further advice from local genitourinary medicine, sexual and reproductive health clinician, microbiologist (NHS Education for Scotland 2017).

Testing for some STIs (HIV, syphilis and hepatitis) is by blood testing. In recently disclosed incidents a serum save sample should be offered at the time of the FME

and stored. Arrangements should be made to screen for BBV infections after appropriate incubation periods.

If any of the above mentioned blood tests are positive at follow up following incubation periods, the serum save sample can be tested to assess whether the infection may pre-date the incident. A negative serum save sample may indicate an association between the disclosed assault and the suspect as the source of infection.

Some individuals may opt to have opportunistic baseline BBV screening rather than a serum save whilst awaiting subsequent testing to exclude the possibility of infection related to the incident.

It is important to understand that the identification of an STI in the immediate period after sexual assault is seldom useful in court. Any request from the Crown Office & Procurator Fiscal Service (COPFS) for medical notes/STI screening should be explored and a court order provided. Further information on the sharing of personal sensitive information for court proceedings can be found in the communication released⁶⁶ by the CMO in 2016.

8.1.4.2 HIV Post Exposure Prophylaxis (PEPSE)

In cases of sexual assault, risk assessment for HIV transmission is required. Guidance on this is available in: UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (BASSH 2021)⁶⁷ and in local NHS Health Board protocols.

When the risk is assessed to be sufficient to recommend prescribing of PEPSE, starter packs should be commenced as soon as possible and within 72 hours of an assault.

Baseline blood and urine testing, including HIV testing, should be undertaken before PEPSE is prescribed. Treatment should continue for 28 days if the baseline HIV test is negative. Prescribing clinicians should check for interactions with prescribed or over the counter preparations on www.druginteractions.org. Appropriate follow up should be in place as recommended in the most recent BASHH/BHIVA guidelines.

8.1.4.3 Hepatitis A

At the time of publication, given the prevalence of this virus amongst men who have sex with men, consider the risk of Hepatitis A under these circumstances.

Hepatitis A vaccine can be given up to 14 days after exposure provided the exposure was within the infectious period of the source case during the prodromal illness or first week of jaundice (unlikely to be known in cases of sexual assault).

⁶⁶[Letter from the CMO](#)

⁶⁷[UK Guideline for the use of HIV Post-Exposure Prophylaxis 2021 \(bhiva.org\)](#)

Immunoglobulin is also an option if given in an appropriate timeframe when there is a history of jaundice in the contact source (unlikely to be known in a sexual assault setting).

Immunoglobulin given within a few days and up to two weeks offers protection after contact with an infectious source. It may reduce symptoms if given within up to four weeks of contact.

See: 2017 Interim update of the 2015 BASHH National Guidelines for the Management of the Viral Hepatitis (BASHH 2017)⁶⁸.

8.1.4.4 Hepatitis B

Hepatitis B testing is recommended for all people who present after rape or sexual assault (BASHH 2017).

Where there is a known risk of Hepatitis B transmission, refer to local protocols and clinical pathways (Public Health England: June 2017)⁶⁹.

8.1.4.5 Hepatitis C

There is some evidence in high risk situations (known HCV positive source) that early treatment may be effective if there has been parenteral exposure and this should be discussed with local specialist genitourinary medicine or infectious diseases clinicians. There is currently no vaccine.

8.1.4.6 Human Papilloma Virus (HPV)

There is a Scottish vaccination programme in place for young women and for men who have sex with men up to the age of 45.

Vaccination should be considered for eligible people who have not commenced the vaccination schedule or with an incomplete vaccination history and arrangements should be made with local vaccination services.

Opportunistic cervical cytology may be considered if cervical screening is overdue at the time of a FME. Women may be less likely to engage in cervical screening following sexual violence and it may be helpful to provide information on local services.

8.1.4.7 Bacterial Sexually Transmitted Infections

In the interests of antibiotic stewardship offer testing for STIs after the appropriate incubation period and treat only if present.

Sampling methods are fairly non-invasive with the option of self-taken swabs and therefore tolerance of examinations need not be a deciding factor.

⁶⁸[BASHH National Guidelines for the Management of the Viral Hepatitis](#)

⁶⁹[The Green Book on Immunisation - Chapter 18 Hepatitis B \(publishing.service.gov.uk\)](#)

Consideration should be given to providing prophylactic treatment against bacterial STIs (Chlamydia, Gonorrhoea and Trichomonas), using a pragmatic approach based on the individual clinical picture and circumstances, for example if someone is likely to default from clinical follow up. The antibiotics provided should be informed by local resistance patterns. The default position of screening and treating only as required is preferable.

Local protocols will depend on local prevalence of infection and patterns of antibiotic resistance. See: British Association of Sexual Health and HIV (BASHH) (2012) UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault (BASHH 2012)⁷⁰

Testing and prophylaxis for bacterial STIs and blood borne viruses after disclosure of rape or sexual assault		
<i>Immediate needs - disclosure within 14 days of assault</i>	<i>Disclosure after 14 days</i>	<i>Presentation over 3 months</i>
<ul style="list-style-type: none"> • Baseline HIV and hepatitis tests or save serum sample • Commence HIV PEPSE if appropriate (within 72 hours) • Commence hepatitis B vaccination (and hepatitis B immunoglobulin if assailant likely or known to be surface antigen carrier) • Determine need for HPV vaccination • Arrange appropriate testing, completion of PEPSE treatment and vaccination schedules • Consider option for prophylaxis against bacterial STIs if IUD as emergency contraception or high risk of no future engagement with services 	<ul style="list-style-type: none"> • Offer screening for bacterial STIs • Adapt the follow-up schedule accordingly: <ul style="list-style-type: none"> ○ HIV serology – testing at 4 weeks after risk will identify majority of HIV positive ○ Hepatitis B serology ○ Hepatitis B vaccination (if less than 2 weeks since sexual assault/rape) ○ Hepatitis C serology (minimum of 4 weeks post incident) ○ Syphilis serology (minimum of 4 weeks post incident) ○ Arrange appropriate testing, completion of vaccination schedules and any treatment of existing STIs identified 	<ul style="list-style-type: none"> • Offer tests for bacterial STIs • Offer syphilis, hepatitis B and C and HIV serology • Determine need for completion of vaccination schedules depending on personal and clinical circumstances of any ongoing risks of exposure.

⁷⁰ [The Management of Adult and Adolescent Complainants of Sexual Assault \(bashhguidelines.org\)](http://bashhguidelines.org)

Useful resources

British Association of Sexual Health and HIV (2012) UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault

British Association of Sexual Health and HIV (2015) United Kingdom National Guideline on the Management of the Viral Hepatitides A, B and C⁷¹

British Association of Sexual Health and HIV (2015) UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure⁷²

British Association of Sexual Health and HIV (2017) 2017 Interim update of the 2015 BASHH National Guidelines for the Management of the Viral Hepatitides⁷³

Faculty of Sexual and Reproductive Health (2017) Clinical Guidance: Emergency Contraception⁷⁴

Faculty of Forensic and Legal Medicine (2016) Guidance on paternity testing⁷⁵

Public Health England (June 2017) The Green Book Hepatitis B: chapter 18⁷⁶

8.2 Psychosocial Risk Assessment

8.2.1 Assessment

It is important to ascertain the immediate and future safety of people who have experienced rape or sexual assault.

This should include:

- Mental health and psychological needs
- Risk of suicide and use of harmful coping strategies (refer to the Applied Suicide Intervention Skills Training (ASIST)⁷⁷ for more information)
- Any previous self-harm or recent suicidal ideation
- Safety and ongoing risk particularly in people who at that time are at risk. This should include stalking. Their home may be a crime scene and/or the

⁷¹[UK National Guideline on the Management of the viral hepatitis A, B and C 2015 \(bashhguidelines.org\)](https://www.bashhguidelines.org/)

⁷²[UK guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure, 2015 \(bashhguidelines.org\)](https://www.bashhguidelines.org/)

⁷³[Viral Hepatitides A, B & C \(bashhguidelines.org\)](https://www.bashhguidelines.org/)

⁷⁴[FSRH Clinical Guideline: Emergency Contraception \(March 2017, amended December 2020\) - Faculty of Sexual and Reproductive Healthcare](#)

⁷⁵[Guidance on Paternity Testing - FFLM](#)

⁷⁶[Hepatitis B: the green book, chapter 18 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/hepatitis-b-the-green-book)

⁷⁷[ASIST: Applied Suicide Intervention Skills Training - Suicide Prevention Training - Grassroots \(prevent-suicide.org.uk\)](https://www.prevent-suicide.org.uk/)

perpetrator may know where the person lives and they may feel at ongoing risk as a result

- Domestic abuse, including coercive control
- Alcohol and drug history
- Child protection issues (for further details on this, please see national guidance)⁷⁸
- Consideration of the safety and wellbeing for those who are cared for by the person who has experienced rape or sexual assault

In cases associated with domestic abuse, a Risk Identification Checklist (RIC) should be used. The third sector organisation Safe Lives has developed the Safe Lives DASH risk checklist which should be completed and appropriate information sharing and referral undertaken. Guidance and further information can be found on the Safe Lives⁷⁹ website.

The Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment forms part of the clinical record and is not part of the forensic documentation.

Where there is police involvement, they will use a Domestic Abuse Questionnaire (DAQ). Where issues of risk are identified, this should be shared appropriately between agencies, according to local protocol, to avoid duplication and aid management.

Alternative safe accommodation may need to be sourced with assistance from investigating police officers, violence against women services (e.g. Women's Aid) or local authority social work or homeless services.

Legislation, as outlined in the Adult Support and Protection (Scotland) Act 2007, may require sharing information in particular circumstances with social work. The Act defines 'adults at risk' as those (aged 16 years or over) who:

- Are unable to safeguard their own wellbeing, property, rights or other interests
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected

An adult is at risk of harm if:

- Another person's conduct is causing (or is likely to cause) the adult to be harmed

⁷⁸ [National guidance for child protection in Scotland 2021 - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/national-guidance-for-child-protection-in-scotland-2021/pages/1-1-introduction-and-what-is-child-protection-in-scotland.aspx)

⁷⁹ [Dash risk checklist quick start guidance FINAL.pdf \(safelives.org.uk\)](https://safelives.org.uk/wp-content/uploads/2019/03/Dash-risk-checklist-quick-start-guidance-FINAL.pdf)

- The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm

It is important to consider if child protection is an issue. If the person affected by sexual violence is the main carer of children and their psychological wellbeing is affected, they may require additional support. Check current support resources in place. Where there are concerns and a lack of current support systems, discuss additional support options with social work to allow for child protection procedures to be followed⁸⁰.

8.2.2 Support and Psychological Care

Contact by a Nurse Co-ordinator in the days following the FME offers the opportunity to discuss with the person any aftercare needs and identify any new health or social care needs or concerns. If support mechanisms are in place to monitor whether normal coping mechanisms fail to resume, then timely referral to further support services or counselling can take place. See [section 10.1](#) for more details on the Rape Crisis Advocacy Project.

People should have information about how to get back in touch with services if they wish to re-engage or require more support and should be given information about what their follow-on care may entail.

Anxiety and depression after a rape or sexual assault can appear early and are common. The majority of people recover whilst a minority will go on to develop Post-Traumatic Stress Disorder (PTSD).

Further information on follow up care and ongoing support can be found in section 10.

Individuals should have control in determining their own needs and arrangements for follow up care and support should be made. The person should be discharged to a safe environment, ideally accompanied by a family member, guardian, friend or support person. Consent to contact the person to remind them of future appointments and arrangements should be confirmed and the preferred method documented prior to discharge. If not already in contact, consent for contact from a Nurse Coordinator and Rape Crisis Advocacy Worker should be obtained. Information about support services should also be provided in an appropriate format. Support should be provided in order to ensure that referrals are carried out as well as providing additional information for people who may face barriers in accessing these services.

⁸⁰ [National guidance for child protection in Scotland 2021 - gov.scot \(www.gov.scot\)](#)

Useful Resources

The Safe Lives Dash Risk Identification Checklist⁸¹

General Medical Council (2018)

Rape Crisis Scotland (2019) Supporting LGBTI survivors of sexual violence⁸²

Scottish Government (2016) Scotland's National Action Plan to Prevent and Eradicate FGM⁸³

Equality and Human Rights Commission (2019) Protected Characteristics⁸⁴

⁸¹[Dash risk checklist quick start guidance FINAL.pdf \(safelives.org.uk\)](https://safelives.org.uk)

⁸²[Support resources | Rape Crisis Scotland](#)

⁸³[Scotland's national action plan to prevent and eradicate FGM - gov.scot \(www.gov.scot\)](https://www.gov.scot)

⁸⁴[Protected characteristics | Equality and Human Rights Commission \(equalityhumanrights.com\)](https://equalityhumanrights.com)

9. Forensic Medical Examination (FME)

This section sets out the processes for undertaking a FME. It is important to note that should the person wish to have a FME; this should be done as soon as reasonably possible in order to preserve as much forensic evidence as possible.

Key points

- ✓ The primary purpose of the FME for rape or sexual assault is to support the health and wellbeing of individuals and identify the healthcare needs of the person
- ✓ FME and evidence collection supports the judicial process
- ✓ Early evidence kits assist with the preservation of forensic evidence while a FME is awaited.
- ✓ It is important to minimise the number of times a person is asked about the incident. Obtain details from other professionals e.g. police, if already given, to avoid the risk of re-traumatisation

The Self-Referral National Protocol provides detailed guidance on providing self-referral FMEs. The primary purpose of the FME for rape and sexual assault is to support the health and wellbeing of individuals and identify the healthcare needs of the person. The secondary purpose is to collect evidence that would support any criminal investigation and future prosecution.

Should the person wish to have a FME, the options available for FME and evidence collection should be communicated to them. In exceptional cases, it may be appropriate to prioritise emergency medical care despite the possibility of some compromise of forensic evidence.

The introduction of the FMS Act means that people can request a FME without first contacting the police. Section 3 of the pathway provides an outline of the self-referral service and the Self-Referral National Protocol provides further guidance.

The principles of trauma-informed care should be at the forefront before, during and after the examination, offering the person flexibility and choice and ensuring that they have control of all parts of the process they have consented to.

9.1 Preserving Forensic Evidence

For both self-referral and police referral cases, the FME should be carried out in appropriate NHS healthcare facility, which is managed in line with the National DNA Decontamination Protocol⁸⁵ to ensure the forensic integrity of evidence is

⁸⁵[Forensic medical examinations: DNA decontamination guidelines - October 2019 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/documents/2019/10/Forensic_medical_examinations_DNA_decontamination_guidelines_-_October_2019_-_gov.scot.pdf)

maintained. Further guidance is available in the Self-Referral National Protocol and the Health Board service specification document⁸⁶.

The forensic examination findings should be recorded by the SOE within the national clinical IT system, Cellma.

9.1.1 Early Evidence Kits

Early evidence kits assist with the preservation of potential forensic evidence while FME is awaited. They are used by police officers soon after the time of the initial police report. This may include the taking of mouth samples to allow the person to drink without risk of loss of evidence and urine bottles and forensically secure toilet tissue if needing to urinate before being examined.

When a FME is carried out, the SOE should be informed whether an early evidence kit has been used and which samples/items were taken.

Information on the role of the Sexual Offence Liaison Officer (SOLO) is available at [Appendix B](#).

9.1.2 For All Types of Rape/Sexual Assault

- The type of seat the person sits on should be 'wipeable'. For further information, see the Health Board service specification document⁸⁷
- The person should be asked to avoid baths/showers/douching/changing clothes until after an examination
- If a condom was used, it should be retained
- Where possible the person should be asked to avoid eating, drinking, including alcohol or smoking if the assault included oral penetration

For further information, refer to current FFLM Recommendations.

9.1.3 Vaginal and Anal Rape/Sexual Assault

If possible:

- Any sanitary protection worn at the time of the assault or afterwards should be saved
- It is preferable to remove a tampon as part of forensic examination after external genital swabs have been taken. However, the person may prefer to remove the tampon themselves
- Document the order of swabs taken in relation to any tampons removed during the course of the examination

⁸⁶[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](#)

If possible, the person should avoid passing urine and/or opening their bowels before forensic examination. However, if they need to, offer to retain samples and tissue used to wipe as potential evidence.

Refer to the most current FFLM guidelines⁸⁸ on sampling recommendations and guidance on personal protective clothing to maximise the opportunity for forensic capture and minimise the risk of DNA transfer.

9.1.4 Oral Rape/Sexual Assault

If possible, the person should avoid:

- Brushing their teeth or using mouthwash
- Taking fluid or food
- Smoking

If appropriate, offer to take toothbrushes/cigarette ends as potential evidence as appropriate.

9.1.5 Clothing

For both self-referral and police referral cases, in a forensically secure environment:

- The person should change out of the clothes worn at the time of the rape/sexual assault as soon as possible. If the person is wearing the same clothing and/or has not washed since the incident they should be asked to stand when undressing on a paper ground sheet to allow recovery of body fluids or foreign particles that may fall from clothing or body during examination.
- The person should be given a DNA free modesty gown to wear.
- Each item of clothing should be placed in a separate paper evidence bag (not plastic)
- All items should be labelled immediately with identifying details, date and name of the person labelling
- Underwear worn at the time of or after the incident, should also be collected and placed in a separate paper evidence bag

Ideally professionals should avoid handling clothing; if this must happen, it should be done with double gloves.

If clothing has to be cut:

- It should be cut along the seams of the item
- Do not cut through any damaged areas or breaks in a garment; which may be the result of the assault or use of weapons

⁸⁸ [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects - FFLM](#)

- Do not cut through blood, semen or fluid marks

9.1.6 Wounds and Blood/Saliva/Semen Stains

Blood, saliva or semen stains and injuries should have forensic swabs taken prior to cleansing wherever possible.

9.1.7 Collection of Firearms Residue and Trace Samples

For collection of items e.g. weapons, restraints, tape, bullets, paint, glass, soil:

- Contact the on call forensic scientist for advice
- Wear PPE to collect items of potential evidence as per FFLM guidelines⁸⁹

9.2 Examination

9.2.1 Introduction to the forensic medical examination

Using trauma-informed principles:

- Ensure safety and build trust
- Consider any person specific needs depending on age, sex, religion, sexual orientation, language requirements etc.
- Offer choice and control where possible
- Maintain the person's privacy and dignity at all times
- Minimise re-traumatisation by avoiding identified triggers. For further information on triggers, refer to the Health Board service specification document⁹⁰
- Keep the person informed of processes and changes

This examination may include:

- A detailed head to toe examination
- Documenting the presence or absence of injuries and their interpretation
- Dealing with any injuries requiring immediate medical treatment
- Identifying any medical conditions that may affect interpretation e.g. skin conditions, bleeding disorders
- Developing an opinion on timing, mechanism and causation of injury
- Documenting and interpreting any forensically relevant features or injuries
- Collecting appropriate forensic specimens in accordance with FFLM (2018) guidelines

For police reports, incident details should be provided by investigating officers and recorded in Cellma prior to commencing the examination.

⁸⁹ [Recommended Equipment for Obtaining Forensic Samples from Complainants and Suspects - FFLM](#)

⁹⁰ [Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](#)

9.2.2 Key Elements in a Forensic Medical History

The purpose of taking a history as part of a FME is to obtain any information that may assist with both assessing the healthcare needs of the person and to aid interpretation of forensic findings. This should be documented as recommended in the digitised National Form in Cellma.

9.2.3 Forensic Examination Procedure

The SOE and the corroborating witness, normally the FTN, should put on the recommended PPE in the correct order. It is important to ensure the examination room has been decontaminated in accordance with the National DNA Decontamination Protocol⁹¹.

PPE should be donned in the following order:

- Face mask and beard snood (if applicable)
- Mob cap
- Disposable gloves (pair 1)
- Gown/coveralls or disposable sleeves
- Disposable gloves (pair 2)
- Safety glasses or goggles (optional)

A video containing more information on the PPE that should be worn is available⁹².

In addition to the examiner wearing the recommended PPE including facemask, powder free double gloves (nitrile) should be worn throughout the sampling process and when handling samples (including tamper-evident bags) with the top pair of gloves changed between sampling each different body area.

The clothing and ground sheet should be submitted as evidence. Similar consideration may be given to submitting any couch cover or seat cover if deemed likely to be relevant.

Any condoms, sanitary wear (tampons or pads) or incontinence pads should be submitted as appropriate.

The person should be given a DNA free modesty gown to wear.

The SOE should undertake a detailed top to toe external examination to ascertain the presence of any injuries and their sequence. These should be measured and documented on body maps in the digitised forensic examination form in Cellma, using recognised terminology for the type of injury and their position detailed relevant to anatomical landmarks.

⁹¹[Forensic medical examinations: DNA decontamination guidelines - October 2019 - gov.scot \(www.gov.scot\)](https://www.gov.scot/resources/documents/2019/10/Forensic_medical_examinations_DNA_decontamination_guidelines_-_October_2019_-_gov.scot)

⁹²[Forensic Decontamination Protocol](#)

Detailed genital and ano-genital examination should be undertaken with additional lighting. This may include colposcopy digital video documentation - see [section 9.3](#)

The Recommendations for the Collection of Forensic Specimens from Complainants and Suspects⁹³ should be followed.

The history and nature of the assault and timing of exposure or contact will determine which forensic samples are relevant.

9.2.4 Forensic Sampling and Sequence

Appropriate clothing and biological samples, for forensic examination, should be collected, packaged and stored as per FFLM guidelines.

National, standardised forensic kits should be available to assist with the samples, which should be taken in the sequence listed. In general, non-intimate samples are taken before intimate samples and at the time of top to toe examination followed by the genital examination.

On completion of the forensic evidence collection:

- Double gloves are worn until the tamper-evident bag is sealed
- Check each sample is correctly labelled
- Check the person's name
- Check the person's date of birth
- Date and time sample was taken
- Sample description e.g. if related to a swab - Endocervical (1)
- The SOE signs each sample
- Each sample should also be signed by the corroborating witness, normally a FTN and the SOLO if present
- All specimens are packed in the tamper evident bags provided in the kit (except toxicology specimens)
- The SOE should complete all relevant information relating to productions in the forensic examination form
- Tamper-evident bags to be labelled appropriately
- Keep the toxicology specimens separated from the Sexual Offences Examination Kit i.e. they are not packaged together
- In police referral cases, the SOE and corroborating witness should provide witness statements to the police
- Facility for the individual to wash/shower after examination should be offered. Food, drink and additional clothing should be offered. For further details, refer to the Health Board Service Specification⁹⁴

⁹³[Recommendations for the Collection of Forensic Specimens from Complainants and Suspects - FFLM](#)

⁹⁴[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](#)

- The SOE should complete the forensics section of the digitised National Form within Cellma along with the Summary of Findings report.

The medical assessment should be undertaken during the time at the healthcare facility and the findings and outcomes should be recorded in the health section of the digitised National Form within Cellma. This will form part of the individual's health record and will not be shared with the police. Details of this assessment can be found in section 8 of the pathway.

Useful Resources

Faculty of Forensic and Legal Medicine Recommendations for the Collection of Forensic Specimens from Complainants and Suspects⁹⁵

9.2.5 Submitting Specimens to the Police

For police reports, once taken and labelled, specimens should be passed to the SOLO who will sign samples and bags.

9.3 Role of Colposcopy in Forensic Medical Examination

Magnification and lighting provided by colposcopes may increase the rate of injury detection. Colposcopy allows recording and imaging for peer review purposes and has the potential to be used to facilitate further expert medical opinion.

9.3.1 Storage and Retention of Digital Images

In line with Guidance for best practice for the management of intimate images that may become evidence in court⁹⁶ from the Royal College of Paediatrics and Child Health and the Faculty of Forensic and Legal Medicine, intimate images form part of the medical record and are retained by the Health Board (RCPCH and FFLM 2020). Health Boards are generally the data controller for the images. Images, including intimate images should be shared and stored in line with data protection legislation and in line with local Health Board protocols. Sharing of intimate images that form part of the medical record should only be done in certain circumstances for example where there is appropriate informed consent or there is a court order.

9.3.2 Forensic Photography

Photography of injuries is a useful addition to body map documentation and the description of findings. In all cases in which the person presents with non-genital injuries, they should be asked to consent to relevant photography for use as part of the clinical and/or forensic record. When seeking consent, it should be made clear

⁹⁵[Recommendations for the Collection of Forensic Specimens from Complainants and Suspects - FFLM](#)

⁹⁶[Guidance for best practice for the management of intimate images which may become evidence in court - FFLM](#)

that photography is an important part of the investigation and prosecution process and may be used in any subsequent court proceedings.

In police referral cases, SPA photographers should be requested to take photographs of non-genital injuries observed during a FME of an adult or a Joint Paediatric Forensic Examination of a child or young person. However, if in exceptional circumstances an SPA photographer is not available to take the photographs, it is acceptable for the examining clinician to perform that role using an approved NHS digital device. The use of personal devices/smart phones is prohibited.

In the case of self-referral for adults, it is also acceptable for the examining clinician to perform that role, or they can request a medical illustrator to take photographs of non-genital injuries if deemed appropriate.

The reason why the photographs were not taken by a trained photographer should be recorded in the national form.

The requirements for photographs taken as part of a self-referral FME, include:

- clear, high-resolution, colour photographs of all non-genital injuries observed
- a close up view so that the detail of the non-genital injury can be analysed and;
- a wide angle to provide a perspective about the location and size of each non-genital injury is needed.

All photographs must be stored securely in line with Health Board procedures in a way that ensures that they are available when requested by Police Scotland or COPFS.

10. Follow Up Care and Ongoing Trauma-Informed Support

Key points

- ✓ Services should ensure access to a broad range of relevant services and expertise where required
- ✓ It is not appropriate to expect people to coordinate multiple appointments themselves
- ✓ Follow up appointments should be organised by the nurse coordinator, including with other agencies such as housing, social work and third sector organisations
- ✓ All healthcare staff have a responsibility to act to make sure that all children and young people are protected from harm. This responsibility includes acting on concerns about a child or young person even if the child or young person is not your patient

If the person has previously been engaging with social work then, with the person's permission, a referral is made through their allocated social worker to help facilitate continuity of care

10.1 Referrals and Follow-up Care

Services need to have systems in place to enable people to have access to a broad range of multi-agency services e.g. sexual health, gynaecology, mental health social work, housing and third sector support and advocacy services (such as Rape Crisis Scotland).

Follow up appointments should be organised by the nurse coordinator and support should be available to facilitate attendance at follow up appointments. It is not appropriate to expect people to coordinate multiple appointments themselves.

Local arrangements will need to be developed, depending on the service model described above.

People with particular needs, e.g. homelessness or adults requiring support and protection, should be referred, with their consent, to the appropriate social work department. If the person has previously been engaging with social work then, with their consent, a referral is made through their allocated social worker to facilitate continuity of care.

If concerns exist regarding domestic abuse/stalking/human trafficking/ongoing sexual violence/interpersonal violence it is vital that they are provided with a place of safety if required and information on their local support services including social work services, police and sexual violence services.

After assessment and relevant examination an immediate treatment plan which includes timescales should be made jointly with the individual for their return to a safe environment, ideally accompanied by a family member, guardian, friend or support person – this is a multi-agency responsibility. Consent to contact the person to remind them of future appointments etc. should be confirmed and the preferred method documented prior to discharge.

Healthcare should meet both immediate and ongoing health needs including:

- Treating physical injuries that have resulted from the assault
- Safety assessment
- Emergency contraception where appropriate
- Testing and arranging treatment for sexually transmitted infections and post exposure prophylaxis against BBV and bacterial STIs
- Psychosocial assessment and support
- Ongoing trauma support – see the International Trauma questionnaire⁹⁷ for a tool to assess needs
- Contact details so that people can seek future support, even if they decline immediate follow up arrangements

Rape Crisis Advocacy Project

The National Advocacy Project provides support and advocacy to anyone engaging or considering engaging with the justice system after a sexual offence. Advocacy workers are based in rape crisis services across Scotland, and can provide support, information and assistance around reporting to the police and the resulting justice processes. Workers can accompany survivors to meetings, as well as be a supporter in court. Referrals can be made directly to local rape crisis centres, or through the national rape crisis helpline on [08088 01 03 02](tel:08088010302).

This project has 3 main aims:

- To improve the support available to survivors of rape and serious sexual crime
- To improve the experience of the criminal justice process for survivors of rape and serious sexual crime
- To improve the development of a better understanding of survivors' motivations to proceed or not to proceed with the criminal justice process and the difference advocacy support makes to this decision
- More information: [National Advocacy Project | Rape Crisis Scotland](#)

⁹⁷[International Trauma questionnaire](#)

10.2 Domestic Abuse Services

If it becomes apparent that domestic abuse has occurred, referral should be made to the relevant local services.

10.3 Feedback

Feedback routes are very important for performance monitoring and continuous improvement. Where appropriate, feedback should be sought regularly both from those using services but also those agencies engaged in each stage of the pathway. For further information on feedback routes, refer to the Health Board service specification⁹⁸.

Useful Resources

Scottish Women's Aid⁹⁹

Hemat Gryffe¹⁰⁰

Rape Crisis Scotland¹⁰¹

International Trauma Questionnaire¹⁰²

⁹⁸[Rape, sexual abuse or child sexual abuse medical services: guide for service providers - December 2019 - gov.scot \(www.gov.scot\)](#)

⁹⁹[Scottish Women's Aid](#)

¹⁰⁰[Hemat Gryffe](#)

¹⁰¹[Rape Crisis Scotland](#)

¹⁰²[International Trauma questionnaire](#)

11. Corroboration

Key points

- ✓ There is a legal requirement that there must be corroborated evidence for key elements of a criminal charge
- ✓ Corroboration is a requirement in all FMEs

In Scotland, there is a legal requirement that there must be corroborated evidence for key elements of a criminal charge. This means that there must be two sources of evidence in order to prove certain key facts.

Accordingly, it is necessary that all FMEs are witnessed by a person other than the clinician conducting the examination.

Examination should be performed by a clinician who at a minimum, has undertaken the required NES training in a FME ¹⁰³.

11.1 Types of Witnesses

The examination must be witnessed, preferably by a forensically trained health professional, who must be able to speak to the particulars of the examination including the taking of all swabs and samples and the presence of any injuries.

There are two types of witness in a case:

A witness of fact: may give evidence about what they observed. An example would be a member of the public who was in a shop during a robbery and describes what the perpetrator did and what they looked like.

A skilled witness: may give evidence not only about what they observed but, subject to the court assessing that they have the necessary skills, qualifications and experience, they may also offer considered opinion evidence regarding conclusions which they have drawn from their observations. An example would be a medical professional who observes an injury and offers an opinion regarding the likely age and likely causes of that injury.

For more information see: GMC Ethical Guidance¹⁰⁴.

When using the digitised National Form within Cellma it is important to ensure information is presented in a manner that supports both the ongoing investigation and any future prosecution process.

¹⁰³[Training for examiners of victims of rape and sexual assault - gov.scot \(www.gov.scot\)](http://www.gov.scot)

¹⁰⁴[Acting as a witness in legal proceedings - GMC \(gmc-uk.org\)](http://gmc-uk.org)

It is imperative that all relevant information is disclosed in the report and that the report writer does not stray beyond their area of competence or expertise.

11.2 Disclosure of Records

A contemporaneous record of the FME should be made in the forensic section of the digitised National Form in Cellma.

In police referral cases, a printed and signed copy of the form is provided to the police together with any evidence obtained.

For self-referrals, the printed and signed copy should be retained, stored and destroyed by the health board in accordance with the Self-Referral National Protocol and GDPR. A copy should be provided to the police if and when, the person decides to make a police report.

The health assessment is separate from the forensic form to ensure confidentiality of the person's health records and this will be retained as part of the person's medical record. It should not be shared with the police.

However, it must be made clear to the person from the outset that their health record may be disclosed during any criminal investigation if requested by the courts and active acknowledgement of this understanding sought.

Disclosure of the health record to non-health bodies must be carried out in accordance with any data protection legislation and any other legislation governing the processing of this information.

Useful Resources

Sharing of Personal Sensitive Information (Medical / Clinical Records) For Court Proceedings¹⁰⁵

¹⁰⁵[Sharing of Personal Sensitive Information for Court Proceedings](#)

Appendix A – Legislation and Policy Context

This section sets out the legislation and policy context for the provision of services to people who have experienced rape or sexual assault and the legislative framework for prosecution of people who commit acts of rape and sexual assault.

As noted above, this pathway contains references to legislation that are relevant to forensic medical services. This pathway does not supersede or alter any duties or requirements imposed by legislation or legal obligations and principles arising from case law determined by the courts (more applicable to criminal justice matters). Legislation may have been amended before this document is next reviewed and it should not be considered a comprehensive description of the law in this area. Case law may also have changed. If needed, independent advice should be obtained on the accuracy of any references to legislation or reference to any other legal obligations or descriptions of the law. If legal advice is required in relation to the provision of care, this should be sought through the normal Health Board process.

Sexual violence is predominantly a crime against women, children and vulnerable adults that may be contextualised in gender, equality and inequalities policies; however, the Sexual Offences (Scotland) Act 2009¹⁰⁶ is drafted in gender neutral language. The obligation to provide accessible and integrated services to all individuals of sexual violence is affirmed in Articles 24 and 25 of the Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence (“Istanbul Convention”; Council of Europe 2014)¹⁰⁷.

The UK Government became a signatory of the Convention in June 2012. The UK Government is obliged to observe other international obligations to take actions to mitigate violence against women including the Convention on Elimination of all Forms of Discrimination against Women (CEDAW) (United Nations Entity for Gender Equality and the Empowerment of Women (1979)¹⁰⁸.

These are reflected in the Scottish Government’s strategy Equally Safe, Scotland’s strategy for preventing and eradicating violence against women and girls¹⁰⁹. The strategy sets out the following vision:

A strong and flourishing Scotland where all individuals are equally safe and respected, and where women and girls live free from all forms of violence and abuse – and the attitudes that help perpetuate it and aim to work collaboratively with key partners in public, private and third sectors to prevent and eradicate all forms of violence against women and girls (Scottish Government 2016).

¹⁰⁶[Sexual Offences \(Scotland\) Act 2009](#)

¹⁰⁷[Council of Europe Convention on preventing and combating violence against women and domestic violence](#)

¹⁰⁸[Convention on the Elimination of All Forms of Discrimination against Women](#)

¹⁰⁹[Equally Safe: Scotland's strategy to eradicate violence against women](#)

Rape and sexual assault are statutory offences under the Sexual Offences (Scotland) Act 2009¹¹⁰. The Act creates certain sexual offences against adults, older children (13-15) and younger children (under 13). Younger children are deemed to have no capacity to consent to sexual activity. The conduct which consists of the crime of 'rape' and 'sexual assault', as well as what is meant by consent to sexual activity is also found within the Act.

Scottish Government policy aims to tackle the significant inequalities that people often experience because of trauma and abuse. There is emerging evidence that trauma-informed systems can have better outcomes for people affected by trauma. Transforming Psychological Trauma: A knowledge and skills Framework for the Scottish Workforce (NHS Education for Scotland 2017)¹¹¹ involves recognising the need for trauma related knowledge and skills across the whole workforce, not just for those with a remit to respond directly to the needs of those affected by trauma.

The Justice in Scotland: Vision and Priorities¹¹² was published by Scottish Government in 2017 and set out 4 outcomes for a just and resilient Scotland:

- We live in safe, cohesive and resilient communities
- Prevention and early intervention improve wellbeing and life chances
- We deliver person-centred, modern and affordable public services
- Our system and interventions are proportionate, fair and effective

One of the six priority areas is to improve the experience of people who have experienced rape or sexual assault and witnesses, minimising court attendance and supporting them to give best evidence (Scottish Government 2017).

¹¹⁰[Sexual Offences \(Scotland\) Act 2009](#)

¹¹¹[National trauma training programme](#)

¹¹²[Justice in Scotland: vision and priorities](#)

Useful Resources

Equality and Human Rights Commission (2018) Human Rights Act (1998)¹¹³

Equality and Human Rights Commission (2019) Protected Characteristics¹¹⁴

Scottish Government (2007) Adult Support and Protection (Scotland) Act 2007¹¹⁵

Scottish Government (2015) Statutory Guidance on Corporate Parenting of the Children and Young People (Scotland) Act 2014¹¹⁶

Scottish Government (2019) Getting it right for every child¹¹⁷

Scottish Government (2019) Violence Against Women and Girls (VAWG)¹¹⁸

The Independent Review of Learning Disability and Autism in the Mental Health Act (2019) Stage One Report¹¹⁹

UK Government Adults with Incapacity (Scotland) Act 2000¹²⁰

¹¹³ [The Human Rights Act](#)

¹¹⁴ [Protected characteristics](#)

¹¹⁵ [Adult Support and Protection revised Code of Practice](#)

¹¹⁶ [Statutory guidance on Part 9 \(Corporate Parenting\) of the Children and Young People \(Scotland\) Act 2014](#)

¹¹⁷ [Getting it right for every child \(GIRFEC\)](#)

¹¹⁸ [Violence against women and girls \(VAWG\)](#)

¹¹⁹ [The Independent Review of Learning Disability and Autism in the Mental Health Act \(2019\) Stage One Report](#)

¹²⁰ [Adults with Incapacity \(Scotland\) Act 2000](#)

Appendix B – Roles and Responsibilities

All staff members working with people who have experienced rape or sexual assault should have completed the relevant NHS Education Scotland training which incorporates the principles of the national trauma training framework. In addition, details on the desired level of trauma training for each role are noted below.

Sexual Offence Examiner

The term Sexual Offence Examiner (SOE) is used to refer to the healthcare professional carrying out the forensic examination. It is good practice for a female Sexual Offence Examiner to be available at all times. Standards for Healthcare and Forensic Medical Services for People who have experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults (Healthcare Improvement Scotland 2017)¹²¹.

At present in Scotland, Sexual Offence Examiners are medically trained. All doctors fulfilling this role for people who have experienced rape or sexual assault should have completed the NES Essentials in Sexual Offences Forensic Examination and Clinical Management (Adults & Adolescents) - Best Practice for Scotland training course. Trauma-informed principles underpin the approach to clinical and forensic management decisions following disclosure of sexual violence. In terms of trauma training, SOE's should be trained to a *trauma-skilled* level.

Forensically Trained Nurse

A forensically trained nurse (FTN) (who has attended the NES training) can provide trauma-informed support and expertise and is able to fulfil the requirements of a chaperone. However, they are not trained to carry out an examination. In some areas, the forensically trained nurse has the responsibility for coordinating the follow up care and support for the person and to help them to navigate the healthcare system, including onward referrals to other services as required. In terms of trauma training, FTNs should be trained to a *trauma-skilled* level.

Chaperone

In line with the GMC's Guidance on Intimate Examinations and Chaperones¹²², everyone should be offered a chaperone for intimate examinations.

The chaperone should be:

- A healthcare professional
- Familiar in general terms with the examination procedure being carried out
- Sensitive and respect the individual's dignity and confidentiality
- Present throughout the entirety of the examination

¹²¹[Healthcare and forensic medical services for people who have experienced rape or sexual assault standards \(healthcareimprovementscotland.org\)](https://www.healthcareimprovementscotland.org)

¹²²[Intimate examinations and chaperones - GMC \(gmc-uk.org\)](https://www.gmc-uk.org)

- Present to reassure the person being examined if they show signs of distress or discomfort
- Prepared to raise concerns if they are concerned about the clinician's behaviour or actions.
- Trained to a *trauma-skilled* level

The role of the chaperone is to safeguard both the individual and the SOE, and to provide additional support and reassurance to an individual where they are being examined by a sole SOE.

The CMO has asked Health Boards to ensure an appropriately trained nurse is available to fulfil this role.

Nurse Coordinator

The Nurse Coordinator is responsible for coordinating the follow up care and support for an individual and to help them to navigate the healthcare system, including onward referrals to other services as required. The Nurse Coordinator may also fulfil the role of FTN and chaperone during the examination. However, the coordinator role could also be undertaken by other staff groups. A Nurse Coordinator should be trained to a *trauma-skilled/enhanced* level.

Corroborating Witness

All FMEs should be witnessed, preferably by a healthcare professional who is a forensically trained witness in accordance with the requirements of the Scottish Criminal Justice System. The forensically trained witness should be appropriately positioned to observe the full examination including the taking of all swabs and samples and observation of any injuries. Ideally this role is undertaken by a FTN.

The witness should be able to confirm that the examination took place at a specific time, by whom, the samples that were taken and the presence or absence of injuries.

A healthcare professional acting as a chaperone, who is not forensically trained, should only corroborate the examination if no other forensically trained healthcare professional is available.

Both the SOE and the forensically trained corroborating witness should:

- Provide the police with witness statements
- Label and sign all productions taken during the examination in accordance with Forensic Regulator guidance¹²³

¹²³[Forensic Science Regulator legal guidance](#)

- In police referral cases, ensure that the productions are passed to the SOLO in attendance
- In self-referral cases, ensure that the productions are stored securely
- Be prepared to attend court to give evidence if cited

A corroborating witness should be trained to a *trauma-informed* level.

Sexual Offences Liaison Officer

The Sexual Offence Liaison Officer (SOLO) provides the critical link between the victim, Senior Investigating Officer (SIO) and the enquiry team in all rape investigations and serious sexual crime cases including other penetrative sexual offences i.e. sexual assault by penetration.

The SOLO must be deployed within 24 hours of the incident being reported to police. They have an important role in key processes including providing time critical updates to the SIO to identify the locus, significant witnesses, suspects and investigative opportunities. They also have a role in gathering vital information to inform a victim risk assessment, victim safety plan and victim strategy. Due to the role of the SOLO during the process, SOLO's should be trained to a *trauma-skilled* level.

The role of the SOLO is wide and varied and this specially trained officer forms an integral part of the investigation team. Their duties include:

- Obtaining a full statement from the victim
- Requesting the FME (in cases where a police report has been made ahead of examination)
- Briefing the attending health professionals
- Attending the FME
- Seizing clothing for evidential purposes
- Seizing forensic samples for evidential purposes
- Ensuring the police and RCS referral procedures are completed
- Providing information to victims on referrals to external agencies
- Providing enquiry updates to the victim
- Supporting the victim during any other police process (e.g. suspect identification)
- Photographing evidence when the SPA photographer is unavailable

The SOLO's attendance at the FME is primarily to support the criminal investigation; ensure the chain of evidence is recorded and protect the forensic integrity of productions seized from the forensically trained nurse or healthcare professional corroborating the examination.

Administrative and Clerical Staff

The Administrative and Clerical staff may be the first point of contact for someone when they access the service. Administrative and clerical staff will prepare forensic medical reports and assist with data collection and monitoring. Staff in these roles should be trained to a *trauma-skilled* level.

Future Developments

Work to develop the role of forensic nurse examiners in Scotland is being progressed under the remit of the CMO Taskforce Workforce and Training Subgroup.

Appendix C – National Clinical IT System, ‘Cellma’

The National Clinical IT System, ‘Cellma’, will be used by medical and forensic staff to support clinical care and forensic assessment. Cellma provides a digital version of the adult National Form which was previously developed by the CMO Taskforce Clinical Pathways Subgroup. This builds on previous work to ensure consistent documentation of the clinical and forensic elements of immediate care for people who have experienced rape or sexual assault, to improve the quality of clinical care, forensic assessment, and progress through the justice system for those who choose to engage with the police. Health professionals and representatives from Police Scotland, COPFS and the Scottish Police Authority Forensic Services have worked collaboratively to develop the digital version of the National Form within Cellma.

The digitised National Form within Cellma includes certain pieces of information that make up the National Dataset for Adults. A ‘mini assessment’ for Children and Young People is used to record the National Dataset for this age group as well. It allows services to monitor quality of services and plan service improvements. Work is ongoing to fully digitise the children and young people’s pro forma, which is completed to record the findings from a Joint Paediatric Forensic Examination.

The National Dataset in Cellma will be routinely exported and sent via secure link to Public Health Scotland. This will be used for regular performance management reports for local use. The National Dataset will also be used to produce an annual report as required by the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Act 2021. For further information please contact, phs.rsa-data@phs.scot.

Appendix D: The Criminal Justice Process

Key points

- ✓ A police investigation is likely to involve gathering evidence from a range of sources including the FME
- ✓ In the majority of cases which involve a report of rape, the accused will be reported to the Procurator Fiscal whilst held in police custody assuming that there is sufficient evidence to prove the charge
- ✓ Trials in all cases which involve a charge of rape and in which a prosecution is raised take place in the High Court of Justiciary

Outline of the Criminal Justice Process

On receipt of a report that an offence of rape or sexual assault has been committed, the police will carry out an investigation into the circumstances. Increased access to self-referral services may mean that there will increasingly be cases where a police report is not made prior to forensic examination. Police investigation is likely to involve: statements being obtained from the person who has experienced rape or sexual assault and witnesses; FME of the person who has experienced rape or sexual assault; exploration of relevant technological evidence (e.g. CCTV footage, social media messages) and arrest and interview of the suspect if they are identified.

The Senior Investigating Officer (SIO) is the person in charge of the inquiry. If the SIO forms the view that there is sufficient evidence that an offence has been committed and that the accused person committed it, a report will be submitted to the Procurator Fiscal. In the majority of cases, which involve a report of rape, the accused will be reported to the Procurator Fiscal while held in police custody.

The Procurator Fiscal will consider the content of the report in order to decide: if the report identifies that a crime has been committed; if there is sufficient admissible, credible and reliable evidence; and if prosecution is in the public interest. If all three questions are answered affirmatively then the accused person will appear in court. If any of the questions is answered negatively then it is very likely that the accused person will not appear in court. Further investigations may be carried out by Police Scotland and/or the Procurator Fiscal before a final decision about what should happen to the case.

In cases involving a report of rape or particularly serious sexual assault, accused persons will firstly appear 'on petition' in the Sheriff Court with jurisdiction over the place where the offence is alleged to have taken place. If the accused person is granted bail the prosecutor is required to serve an indictment on the accused person within 10 months and the trial must commence within 12 months. If the accused person is remanded in custody the indictment must be served within 80 days and the

trial must commence within 140 days. These timescales may extend dependant on court adjournments under Section 65 of the Criminal Procedure (Scotland) Act 1995.

All trials that include a charge of rape are required by law to be heard in the High Court of Justiciary. A jury of 15 members of the public will decide if the accused person committed the offence. If the accused person is convicted the judge will pass sentence on the offender. The offence of rape carries a maximum sentence of life imprisonment.

Trials that involve a charge of serious sexual assault may be heard in the Sheriff Court by a sheriff sitting with a jury. The jury will decide if the accused is guilty and the sheriff will pass sentence. The maximum sentence that can be imposed by the Sheriff Court is 5 years' imprisonment.

Other trials that involve a charge of sexual assault may be heard in the Sheriff Court by a sheriff sitting alone. If an accused person is remanded in custody when they first appear in court the trial must commence within 40 days. The sheriff will decide if the accused person is guilty of the offence and will pass sentence. The maximum sentence that can be imposed is 12 months' imprisonment. Other sentencing powers include Community Payback Order, Fine, Compensation Order, Admonishment at his/her disposal, and these apply equally in the High Court, Sheriff, Jury Court and Sheriff Summary Court.

Increased access to self-referral services may mean that there will increasingly be cases where a police report is not made prior to forensic examination. Further information on self-referral can be found in [section 3](#).

Rape Crisis Scotland has produced an online video resource featuring NHS, police, COPFS, which provides information for people who have experienced rape or sexual assault of the journey through the justice process, including the FME¹²⁴

¹²⁴[Rape Crisis Scotland - journey through the justice system](#)

Appendix E – Clinical Pathways Subgroup Membership

Name	Role and Organisation
Edward Doyle	Chair - Senior Medical Adviser Paediatrics, Scottish Government
Hilary Ansell	Clinical Lead, Lead Forensic Physician, South East and Tayside Healthcare and Forensic Medical Services
Sandie Barton	Director of Operations, Rape Crisis Scotland
Rod Finan	Professional Social Work Adviser, Office of the Chief Social Work Adviser/Getting li right for every child team, Scottish Government
Bruce Henderson	Forensic Medical Examiner, NHS Ayrshire and Arran
Kranti Hiremath	Forensic Physician, South East Scotland
Robin Jamieson	Forensic Medical Examiner, NHS Greater Glasgow and Clyde
Jane Johnstone	Professional Social Work Advisor, Scottish Government
George Laird	Manager West of Scotland Sexual Health Managed Clinical Networks & Child Protection Managed Clinical Networks, NHS Greater Glasgow & Clyde
Jamie Lipton	Principal Procurator Fiscal Depute, Policy & Engagement Division, Crown Office & Procurator Fiscal Service
Pauline McGough	Consultant in Sexual and Reproductive Health, NHS Greater Glasgow and Clyde
Katherine McKay	Consultant Paediatrician/Lead Paediatrician for Child Protection NHS GGC
Stephen Morris	Public Protection Support, Police Scotland
Barry Muirhead	Clinical Service Manager, People in Police Care, NHS Lothian
Vicky Norris	Project Manager, NHS National Services Scotland
Chloe Poole	Deputy Head of Unit, CMO Taskforce, Scottish Government
Oladimeji Popoola	Project Support Officer, NHS National Services Scotland
Sarah Tait	Regional Manager, South East Child Protection Manage Clinical Network
Deborah Wardle	Lead Clinician Archway, NHS Greater Glasgow and Clyde Associate Post Graduate Dean, NHS Education for Scotland Forensics

Resources

British Association of Sexual Health and HIV (2015) UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure¹²⁵ [cited 27 October 2020]

British Association of Sexual Health and HIV (2015) United Kingdom National Guideline on the Management of the Viral Hepatitides A, B and C¹²⁶ [cited 27 October 2020]

British Association of Sexual Health and HIV (2017) 2017 Interim update of the 2015 BASHH National Guidelines for the Management of the Viral Hepatitides¹²⁷ [cited 27 October 2020]

Council of Europe (2014) Convention on Prevention and Combating Violence against Women and Domestic Violence (CAHVIO)¹²⁸ [cited 27 October 2020]

Edinburgh woman's rape and sexual assault centre (2016) Little Green Book¹²⁹ [cited 27 October 2020]

Enable (2009) Unlocking sexual abuse and learning difficulties¹³⁰ [cited 27 October 2020]

Faculty of Forensic and Legal Medicine and Royal College of Paediatrics and Child Health (2011) Consent for patients who may have been seriously assaulted¹³¹ [cited 27 October 2020]

Faculty of Forensic and Legal Medicine (2016) Guidance on paternity testing¹³² [cited 27 October 2020]

Faculty of Forensic and Legal Medicine (2019) Recommendations for the Collection of Forensic Specimens from Complainants and Suspects¹³³ [cited 27 October 2020]

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¹²⁵ [UK guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure, 2015](#)

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