

Clinical Pathways and Guidance for Healthcare Professionals Working to Support Adults who Present Having Experienced Sexual Assault or Rape

Version 1.0

30 October 2018



Scottish Government
Riaghaltas na h-Alba
gov.scot

Version History

Version	Date of revision	Summary of changes	Changes marked
V0.1	3 August 2017	Initial draft meeting	N
V0.2	28 August 2017	Changes following LS work	N
V0.3	6 October 2017	Changes following comments from DW, FW and MM	N
V0.4	16 October 2017	Comments included from the Clinical Pathways Group meeting on 11/10/17 – still need to make full changes	Y
V0.5	27 December 2017	Comments included from the Clinical Pathways Group meeting and others	N
V0.6	3 February 2018	Comments made following clinical pathways meeting in January 2018	N
V0.7	4 May 2018	Comments made following clinical pathways meeting in April 2018	N
V0.8	13 July 2018	Comments made following clinical pathways meeting in June 2018	N
V0.9	18 July 2018	Comments from PMc and DW	N
V0.10	28 July 2018		
V0.11	17 th September 2018	Comments from Taskforce and subgroup	N
V0.12	27 th September 2018	Pathway updated as per Feedback	N
V0.13	12 October 2018	Updates made as per feedback. Proof read and cross check of references.	N
V0.14	15 October 2018	Updates made as per feedback and references updated	N
V0.15	23 October 2018	Updates made to appendices	N

V0.15	24 October 2018	Final updates made following Clinical Pathways Subgroup meeting	N
V1.0	30 October 2018	Final version for consultation	N

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List of abbreviations

A&E	Accident and Emergency
BASHH	British Association of Sexual Health and HIV
BBV	Blood Borne Virus
BHIVA	British HIV Association
CEDAW	Convention of Elimination of all Forms of Discrimination
CMO	Chief Medical Officer
COPFS	Crown Office & Procurator Fiscal Service
Cu-IUD	Copper Intrauterine Device
DNA	Deoxyribonucleic acid
DOB	Date of Birth
EC	Emergency Contraception
FP	Forensic Physician
FFLM	Faculty of Forensic and Legal Medicine
FGM	Female Genital Mutilation
FSRH	Faculty of Sexual and Reproductive Health
GDPR	General Data Protection Regulation
GP	General Practitioner
GMC	General Medical Council
GUM	Genitourinary Medicine
HMICS	Her Majesty's Inspectorate of Constabulary in Scotland
HMIP	Her Majesty's Inspectorate of Prisons
HIS	Healthcare Improvement Scotland
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IUD	Intrauterine Device
IRD	Interagency Referral Discussion
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
LMP	Last Menstrual Period
NAAT	Nucleic Acid Amplification Tests
NATSAL	National Surgery of Sexual Attitudes and Lifestyle
PEPSE	Post-exposure prophylaxis post-sexual assault
PPE	Personal Protective Equipment
PTSD	Post Traumatic Stress Disorder
UPSI	Unprotected Sexual Intercourse
RCEM	Royal College of Emergency Medicine
RCPCH	Royal College of Paediatrics and Child Health
RIC	Risk Identification Checklist
SARRA	Sexual Assault Response & Review Arrangements
SOLO	Sexual Offences Liaison Officer
SPA	Scottish Police Authority
STI	Sexually Transmitted Infection
WA	Welfare Attorney
WG	Welfare Guardian
WHO	World Health Organization

1. Introduction

1.1 What is the purpose of this resource?

This Clinical Pathways and Guidance is for Healthcare Professionals in Scotland working to support adults (age 16+) who present having experienced sexual assault or rape.

It outlines:

- processes for supporting the immediate health and wellbeing of individuals.
- processes for initiating recovery using trauma informed practice.
- guidance on how to assess and manage clinical risk, ongoing safety, and the provision of ongoing support and follow up.
- processes for collection of forensic evidence, if required.
- the legal framework and policy context in Scotland.
- processes for providing evidence for judicial purposes.

1.2 Who should use this resource?

This guidance should be used by NHS Boards and Health and Social Care Partnerships to inform the way in which services are delivered and structured locally. It in no way constrains NHS, Police Scotland, or associated partnerships should they wish to enhance the model with innovative elements of service delivery.

Responsibility for the delivery of clinical care and healthcare and forensic medical services sits with NHS Boards. Statutory responsibility for forensic medical services rests with Police Scotland / Scottish Police Authority.

Further detail on the ‘multi-agency approach to service delivery that will ensure all those working in the field of forensic medical examination, social work and third sector organisations can deliver the highest quality of care, treatment and support to survivors’ can be consulted within [Honouring the Lived Experience, Chief Medical Officer’s Taskforce to Improve Services for Victims of Rape and Sexual Assault Option Appraisal Report](#)

1.3 How should this resource be used?

It is not intended for this resource to be read from cover to cover, rather, this resource is split into the following chapters, for easy access. Where possible, for all resources referenced or referred to within this document, a hyperlink to the document is provided.

Section 1	How to use the resource
Section 2	Understanding and responding to the needs of individuals 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.
Section 3	Prevalence of rape and sexual assault This section sets out the numbers in relation to rape and sexual assault.
Section 4	Legislation and Policy Context This section sets out the legislation and policy context for the provision of services to people who have experienced rape and sexual assault and the legislative framework for prosecution of people who commit acts of rape and sexual assault.
Section 5	Service Models and Service Ethos
Section 6	Coordinated Multiagency Sexual Assault Response and Review Pathway
Section 7	Healthcare and Forensic Medical Examination This section sets out the processes for undertaking a healthcare and forensic medical examination. Including: <ul style="list-style-type: none"> • Healthcare examination • Psychosocial Risk Assessment • Preserving Forensic Evidence • Forensic Medical Examination • Role of Colposcopy in Sexual Assault Forensic Examination • Specific Healthcare Needs • Immediate and Long Term Follow Up
Section 8	Consent to Healthcare and Forensic Medical Examination
Section 9	Corroboration This section explains the requirement of corroboration and the role of witnesses and the disclosure of records
Section 10	Information Sharing

Section 11	<p>The Criminal Justice Process</p> <p>This section explains the criminal justice process,</p>
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1.4 Who is this guidance applicable to?

This guidance is designed to cover adults aged 16 and above who have experienced rape and sexual assault.

For those under 16, please consult:

- [National Guidance for Child Protection in Scotland](#) (Scottish Government 2014)
- [Child Protection Guidance for Health Professionals](#) (Scottish Government 2013)
- [Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland](#) (Child Protection Managed Clinical Networks 2017)
- Children and Young People’s Pathway – this pathway is currently being developed by the Clinical Pathways subgroup. Consultation on the Children and Young People’s Pathway will be scheduled upon completion of the consultation for the Adult Pathway.

There may be occasions, due to capacity or other additional needs or vulnerabilities where it is appropriate for a person over 16 to have a joint examination with a paediatrician. This should be decided at an Interagency Referral Discussion (IRD). For further details on Interagency Referral Discussions, see the Glossary.

1.5 What other documents should be consulted?

The guidance is intended to supplement but does not replace existing national guidance and standards such as¹:

- [Health and Social Care Standards: My support, my life](#) (Scottish Government 2017)
- [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)
- [Compendium of Healthcare Associated Infection Guidance](#) (Health Protection Scotland, 2018)
- [Recommendations from the Faculty of Forensic and Legal Medicine \(FFLM\)](#)
- [Clinical Guidance: Emergency Contraception](#) (Faculty of Sexual and Reproductive Health 2017)

¹ This list is not exhaustive.

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

1.6 Who has developed the guidance?

The Guidance has been developed by professionals who are part of the [Police Care Network](#) and members of the Chief Medical Officer's [Taskforce for the Improvement of Services for Victims of Rape and Sexual Assault](#).

The Police Care Network aims to support consistency in service quality and healthcare outcomes for individuals who receive services across Scotland, recognising that different NHS Boards will have differing service models in place which meet the needs of their population and geography. It has a role in developing guidance to support and improve service delivery, establishing data collection and quality improvement mechanisms, and supporting the workforce through peer support and exchanging good practice training and education. More information and resources can be found on the website - www.policecare.scot.nhs.uk.

1.7 What terminology is used in the resource?

To align with Healthcare Improvement Scotland's [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)

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 care or support.

Throughout this document, we have used the phrase 'Forensic Examiner' to refer to the professional carrying out the clinical forensic examination. It is acknowledged that, depending on 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 broader range of healthcare professionals.

2. Understanding and responding to the needs of people who have experienced rape and sexual assault

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.

2.1 Gender Based Violence and Domestic Abuse

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

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

- Domestic abuse
- Rape and sexual assault
- Childhood 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 significant impact on people who have been raped and can deter them from seeking help due to fear of judgment. Fear of judgement is particularly common among people with pre-existing vulnerabilities or criminal convictions for example sex workers, substance users or those living with domestic abuse. This results in significant under reporting (see section 3.3)

Sexual violence within relationships should always be considered within the wider context of domestic abuse. Those most at risk of domestic violence are those with co-vulnerabilities and perpetrators can be adept at targeting these individuals (see section 3.2). An assessment of ongoing risk should be undertaken with any individual of intimate partner violence and child protection issues (NHS Education Scotland 2017).

2.2 Responsive Services

Evidence demonstrates that a timely, person-centred service following sexual assault can positively influence a person's long term health, wellbeing, and recovery. Such a service also helps ensure continued engagement in any criminal justice process, as well as the collection of high quality evidence to support the criminal justice process.

The dual benefits of a dedicated service for the health and wellbeing of the person and the collection of evidence to support the delivery of justice are quite considerable. Emotional, practical, and clinical support; Wellbeing of the patient; and forensic evidence collection are key factors with rape and sexual assault investigations – as well as being central to health outcomes and maintaining the confidence of the complainant throughout the judicial process

(Lovett et al 2004; European Parliament 2013; Angiolini 2015)

For the individual, the long-term effects of sexual violence can have both immediate and longer term impacts on physical and mental health and wellbeing as well as on coping strategies which may bring their own health impacts. Effects can vary and can include depression, anxiety, post-traumatic stress disorder, psychosis, alcohol and drug misuse, self-harm and suicide, and obesity. Such outcomes have a higher prevalence reported amongst young people. Sexual violence may also affect personal economic ability and can worsen the impact of inequalities in women, the vulnerable and the disadvantaged, and is often linked to domestic violence (Department of Health 2012, Conaglen and Gallimore 2014). It also can have an impact on those close to them, including individuals dependent on them such as children and others.

2.3 Trauma Informed Services

2.3.1 Trauma Informed Practice

A trauma informed examination takes into account the impact that sexual violence may have on a person and seeks to ensure that their experience of trauma is not repeated or triggered in the examination. It offers them a very different relational experience from the assault or rape, one which may help to start the healing process rather than hinder it.

Principles of trauma informed practice:

- Realise the prevalence of trauma
- Recognise the impact of trauma
- Respond using trauma informed principles, both personally and as an organisation
- Resist re-traumatisation through offering choice and collaboration, power and control, safety and trust.

2.3.2 Understanding the impact of trauma

The human response to threat – fight, flight and freeze – is designed to ensure survival. In the context of sexual assault most individuals will exhibit the freeze

response. If the freeze function is unsuccessful, the body will move to a 'flop' state, changing from predominantly sympathetic to parasympathetic activation. This will result in reduced muscle tension and reduced cortical functioning in order to 'lessen the impact'. Individuals who exhibit this will be submissive and make little or no outward protest to what is happening to them. Complete emotional and physical detachment while experiencing the assault (dissociation) can enable a person to endure horrifying experiences beyond their control, however may lead to long term issues affecting their physical and mental wellbeing.

Useful resources

Dr Caroline Bruce, Clinical Psychologist and Dr Julie Cumming, Sexual Offences Examiner: [*Trauma Informed Practice in the Forensic Setting: A conversation*](#)

NHS Education Scotland (2017) [*Transforming Psychological Trauma: A knowledge and skills Framework for the Scottish Workforce*](#)

NHS Health Scotland (2018) [*Gender Based Violence*](#)

NHS Lanarkshire: [*Trauma and the Brain: Understanding Abuse Survivors Responses*](#)

NHS Education Scotland (2018) Opening Doors: Trauma Informed Practice for the Workforce <https://vimeo.com/274703693>

3. Prevalence of rape and sexual assault

This section sets out the numbers in relation to rape and sexual assault.

Key Points for Service Provision

- ✓ People find it hard to report rapes and sexual assaults
- ✓ Services need to be accessible to all, ensuring that physical or perceived barriers are acknowledged and addressed, in terms of access, financial inclusion, travel arrangements, translators, free phone call number etc.
- ✓ It is important that already marginalised communities are afforded equal access to services and efforts are made to ensure that confidential access and reporting mechanisms are in place.
- ✓ Staff should have the relevant training to be able to deliver sensitive and inclusive services.
- ✓ Knowledge of local communities and geography also helps to plan services, particularly community healthcare and social services.

3.1 Prevalence

No formal needs assessment of people requiring healthcare and forensic medical services for sexual offences examination in Scotland has been undertaken. The information outlined here has therefore been compiled from publicly available secondary literature sources.

The [Scottish Crime and Justice Survey 2014-15](#) (Scottish Government 2016) found that:

- 2.7% of adults had experienced at least one form of sexual assault since the age of 16 (89% were female and 11% were male).
- More than half of respondents said that they had experienced their first (or only) incident of serious sexual assault between the ages of 16 and 20.
- Serious sexual assault was most commonly carried out by someone known to the individual
- Almost nine-in-ten (87%) said they knew the offender in some way.
- Over half (55%) said that the offender was their partner.

The [British National Survey of Sexual Attitudes and Lifestyles](#) (Natsal) includes questions about the experience of rape or sexual assault. Participants who reported having had heterosexual intercourse or sex with someone of the same sex were asked: ‘*Since the age of 13 years, has anyone tried to make you have sex with them against your will?*’ Those who answered ‘yes’ were defined as having experienced ‘attempted rape or sexual assault and were then asked, ‘*Has*

anyone actually made you have sex with them, against your will?’ which was used to define the experience of ‘completed rape or sexual assault.

These questions were asked in the self-completion part of the interview.

[Natsal Key Findings from Scotland](#) (Fuller et al. 2015) found that:

- A higher proportion of women than men reported having experienced rape or sexual assault.
- Around one in five women (19%) reported that someone had tried to make them have sex against their will.
- About half of these (10%) went on to report completed rape or sexual assault.
- Amongst men, 4% reported that someone had attempted to have sex with them against their will.
- 2% went on to report completed rape or sexual assault.

The levels of reporting of attempted and completed rape or sexual assault were similar across the three countries. As in England and Wales, women in Scotland were more likely than men to report that someone had attempted to have sex with them against their will and to report that an attempt had been completed (Fuller et al. 2015).

3.2 Social Factors

3.2.1 Socio-economic

The [2014/15 Scottish Crime and Justice Survey: Sexual Victimization and Stalking](#) found that the risk of serious sexual assault since the age of 16 varied by neighbourhood deprivation: 4% of those living in the most deprived areas of Scotland reported abuse, compared to 2.5% of those living in the rest of Scotland (Murray 2016).

Analysis from the Youth Justice Liaison and Diversion pathfinder scheme data-set suggests that young women in gangs have some of the highest health and social vulnerabilities including sexual assault (x11) compared to the broader group (x2) (Department of Health 2012).

3.2.2 Health

The relatively high prevalence of sexual violence in young women is worse for those with pre-existing vulnerabilities and for some, may be associated with several other life risks.

A [Report of the Independent Review into the Investigation and Prosecution of Rape in London](#) by Rt. Hon Angioloni DBE QC found that 56% of clients in London reported with vulnerabilities including mental health and substance misuse (Department of Health 2012, Angioloni 2015).

3.2.3 Men

Regardless of sexual orientation or gender identity rape is a crime of power and aggression and not sexual attraction, however societal expectations of men as being non-passive make it difficult for them to report this crime. Men may struggle afterwards with issues surrounding their sexual orientation and how this will be perceived by others (NHS Education Scotland 2018). The [Stern Review on Rape Reporting in England and Wales](#) found that male rape was under-reported and men experience additional socio-cultural barriers to reporting rape and sexual assault (Government Equalities Office and Home Office 2010). Services therefore need to be set up to support the needs of men.

Resources: For further information on the impact of sexual violence on men: [Male Sexual Abuse – The Myths & The Realities](#) Survivors UK.

3.2.4 Black and Ethnic Minorities

Rape amongst people from ethnic minorities is underreported and stigmatised. The maintenance of virginity may be an issue and the opportunity to marry after a rape may be affected. This is complicated by language barriers, cultural issues, social isolation and family pressures (BASHH 2012).

A study undertaken with asylum seeking women in Scotland found that:

- 26% of those interviewed (n 46) reported forced or coerced sex, and had experience this multiple times.
- 11% experienced this in the past 12 months.

(Zimmerman et al. 2009).

An issue that has been raised with Rape Crisis Scotland is around immigration status and sexual violence. If someone has no recourse to funds because of their asylum status, this is a barrier to disclosure and to accessing services.

3.2.5 LGBTI

Many large-scale surveys on sexual violence do not take into consideration participants' sexual orientation or gender identity. This makes it difficult to gauge the full extent of sexual violence experienced by LGBTI (lesbian, gay, transgender/, bisexual, and intersex, individuals and communities).

Research suggests that members of LGBTI may face significant levels of abuse, harassment and violence (Fileborn 2012).

[The Hate Crime Report: Homophobia, biphobia and transphobia in the UK](#) surveyed people from the LGBT community regarding their experiences of hate crime. They found that:

- 1 in 10 LGBT people said the hate crime they experienced involved some form of sexual violence (9%).

- Trans people were most likely to have experienced sexual violence as part of a hate crime (16%), followed by bisexual people (10%), lesbian women (8%) and gay men (7%).
- This group were slightly less likely to be satisfied with the outcome of reporting (43% compared with 49% in general).
- They were also more likely to say they thought they would not report next time they experience hate crime (21% compared with 11% in general).
- The main reason given for this was their fear that it would not be treated seriously (66% compared with 44% in general) (Antjoule 2016).

LGBTI individuals are likely to face additional barriers to disclosure such as fear of judgement, stigmatisation and 'outing' of their sexual orientation or gender identity.

3.2.6 People in Prison

There has been limited research on sexual abuse in prisons and the nature and extent of the problem in Scotland is unknown. Her Majesty's Inspectorate of Prisons (HMIP) data for England and Wales demonstrate that 1% of the prisoners reported being sexually abused in prison. Extrapolating from this data, the Howard League for Penal Reform's [Coercive sex in Prison](#) briefing estimates that between 850 and 1650 prisoners in England and Wales could be individuals of sexual abuse whilst in prison. The Howard League for Penal Reform suggests that the number of sexual assaults could be many times higher as evidence indicates that some individuals are assaulted several times, with gay and transgender prisoners at higher risk of sexual assault than heterosexual prisoners (Howard League for Penal Reform 2015).

3.2.7 Reporting of sexual crimes to Police

Recorded sexual crimes have been on a long-term upward trend since 1974, and have increased each consecutive year since 2008-09. Police Scotland has advised that the increase in recorded sexual crime may in part be due to increased reporting, including that of non-recent crimes. The successful outcome of cases featuring historic offending may have highlighted to survivors that cases will be listened to by the police, regardless of how long ago they occurred. Media coverage has also led to the identification of further survivors who previously may not have reported crimes to the police.

Sexual crimes account for 5% of all crimes recorded in Scotland in 2016-17.

During 2016-17 Police Scotland recorded 1,878 recorded crimes of rape and 4,281 recorded crimes of sexual assault. This includes children as well as adults (Scottish Government 2017, Recorded Crime in Scotland 2016-17). For those who did report to the police;

- 32% did so within 7 days.
- 39% reported between 7 days and 1 year.
- 28% reported over a year from the incident taking place.

(Scottish Government 2017, Scottish Government 2016)

In the Crime and Justice Survey 2015-16, of those who reported that they had experienced forced sexual intercourse, 17% said the police were informed about the most recent incident (Murray 2016).

3.2.8 Conviction rates

The [Criminal Proceedings in Scotland Statistical Bulletin](#) shows that in 2016-17 the number of convictions for sexual crimes in Scotland totalled 1,037 and has remained relatively static from 1,156 convictions in 2015-16, although it should be noted that this is still 37% higher than the conviction rate in 2010-11. The number of proceedings in court for sexual crimes has remained relatively static in 2016-17 with 1,510 proceedings in comparison to 1606 in 2015-16. Although this has been static over the previous 2 years there is still a 62% rise since 2010-11, likely related to an increased level of reporting in the wake of high profile cases.

Further to the above, conviction rates for rape and attempted rape saw a slight decrease in 2016-17 with a total of 98 convictions compared to 105 in 2015-16 and further to this saw an increased number of proceedings, 251 in comparison to 216 in 2015-16. Due to the complex nature of high court cases it should be noted that figures may be underestimated due to delays in recording information.

Although the number of convictions and proceedings for sexual crimes have remained relatively static it is important to highlight that rape / attempted rape and sexual assault in 2016-17 saw the highest acquittal rates at 59% and 35% respectively.

3.3 Social and Economic Costs

Estimates of the social and economic cost of reported crime have been produced by Scottish Government (Scottish Government [Cost of the Criminal Justice System in Scotland](#) 2018)².

The total cost is estimated at £1.6million. This total includes estimates of economic and social costs of crime including costs for:

- the anticipation of crime (e.g. defensive expenditure such as household alarms and insurance administration);
- the consequences of crime (e.g. value of property stolen/damaged, lost output and emotional or physical impact of crime) and;

² The figures are developed from various sources of crime data such as the Scottish Crime and Justice Survey, which publishes data on the actual levels of crime experienced by the public, not just those crimes that are reported to the police. Costs for particular crime types are based on UK Home Office estimates of economic and social costs of crime, adjusted to 2015-16 prices.

- responses to crime (e.g. police, health services, prosecution, court, legal aid, criminal justice social work, and prisons).

Useful resources

Antjoule, N., (2016) [*The Hate Crime Report: Homophobia, biphobia and transphobia in the UK*](#)

Angiolini, A., DBE QC (2015) [*Report of the Independent Review into the Investigation and Prosecution of Rape in London*](#)

Fuller et al. (2015) [*Natsal Key Findings from Scotland*](#)

Government Equalities Office and Home Office (2010) [*Stern Review on Rape Reporting in England and Wales*](#)

The Howard League for Penal Reform's [*Coercive sex in Prison*](#)

Murray (2016) [*2014/15 Scottish Crime and Justice Survey: Sexual Victimisation and Stalking*](#)

Scottish Government (2016) [*Scottish Crime and Justice Survey 2014-15*](#)

Scottish Government (2016) [*Criminal Proceedings in Scotland Statistical Bulletin*](#)

Scottish Government (2018) [*Cost of the Criminal Justice System in Scotland*](#)

Survivors UK: [*Male Sexual Abuse – The Myths & The Realities*](#)

Zimmerman, C., et al. (2009) [*Asylum-Seeking Women, Violence & Health: Results from a Pilot Study in Scotland and Belgium*](#), London School of Hygiene & Tropical Medicine (LSHTM) and Scottish Refugee Council (SRC)

4. Legislation and Policy Context

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

Sexual violence is predominantly a crime against women, children, and vulnerable adults which may be contextualised in gender, equality, and inequalities policies. 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](#) (Council of Europe 2014).

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 Elimination of all Forms of Discrimination against Women](#) (CEDAW) (United Nations Entity for Gender Equality and the Empowerment of Women (1979).

These are reflected in the Scottish Government's strategy [Equally Safe, Scotland's Strategy For Preventing and Eradicating Violence Against Women and Girls](#). 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 2016d).

Recent acts of rape and sexual assault are crimes that are governed by the [Sexual Offences \(Scotland\) Act 2009](#). The Act defines 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. Definitions of 'rape' and 'sexual assault' and consent can be found within the Act.

The [Victims and Witnesses \(Scotland\) Act \(2014\)](#) legislates that people who have experienced sexual crime should be offered the choice of gender of examiner.

In April 2017 the Scottish Government established a [Chief Medical Officer Led Taskforce for the Improvement of Services for Victims of Rape and Sexual Assault](#). The Taskforce provides the necessary leadership so that NHS Boards are supported to provide services to better meet the needs of individuals.

Scottish Government policy aims to tackle the significant inequalities that people often experience as a result 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 Scotland 2017) 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 Priorities](#) 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).

All information provided is also in line with the [Human Rights Act](#) 1998.

Useful resources

[Chief Medical Officer's Taskforce for the Improvement of Services for victims of rape and sexual assault.](#)

Council of Europe (2011) [Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence](#)).

[Human Rights Act](#) (1998)

NHS Education Scotland (2017) [Transforming Psychological Trauma: A knowledge and skills Framework for the Scottish Workforce](#)

Scottish Government (2016) [Equally Safe, Scotland's strategy for preventing and eradicating violence against women and girls](#)

Scottish Government (2017) [Justice in Scotland: Vision and Priorities](#)

Scottish Government (2009) [Sexual Offences \(Scotland\) Act 2009](#).

United Nations Entity for Gender Equality and the Empowerment of Women (1979) [Convention Elimination of all Forms of Discrimination against Women](#)

5. Service Models and Service Ethos

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

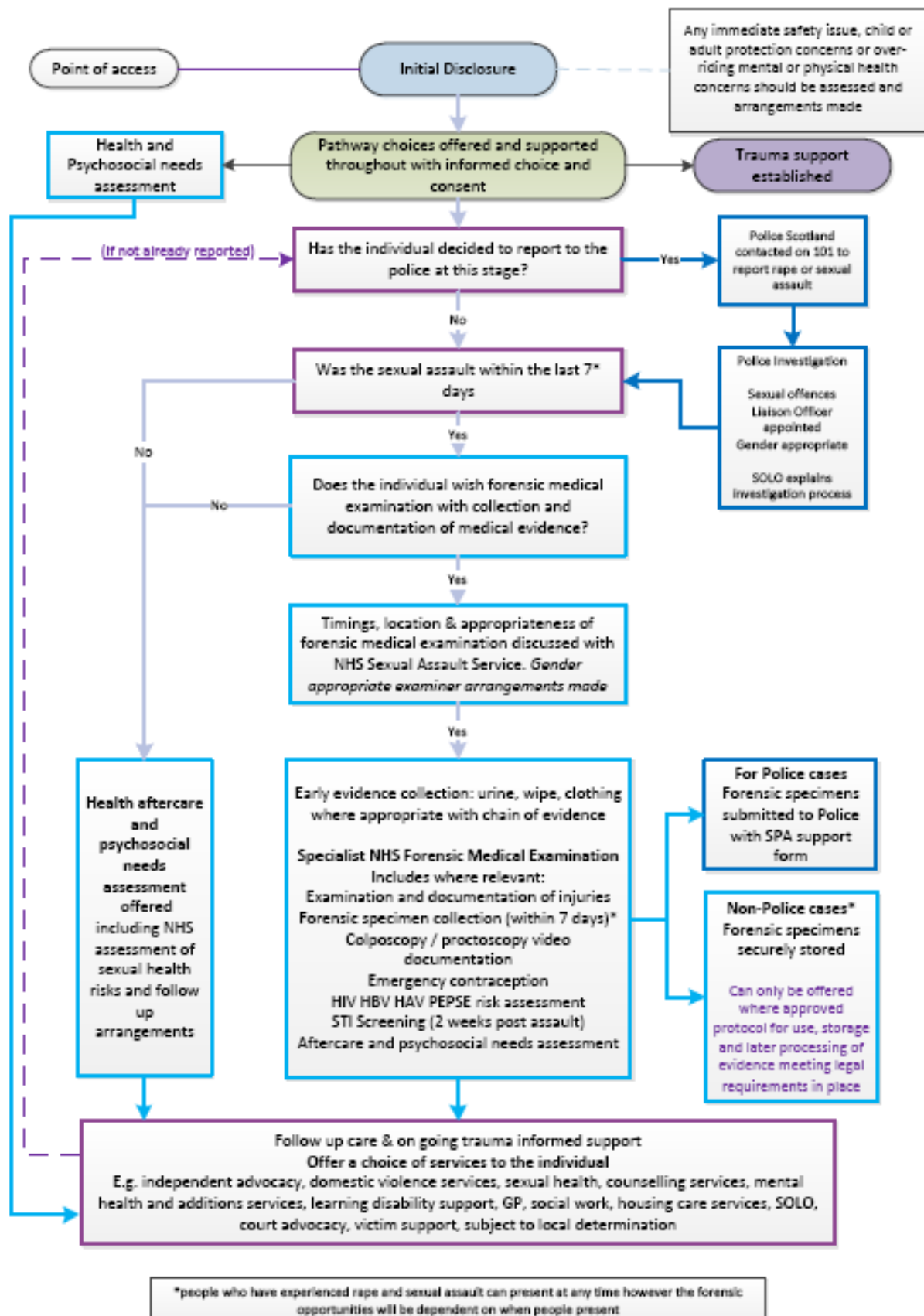
The recommended model of service delivery is for multi-agency co-ordinated services for adults, children, and young people who have experienced rape and sexual assault.

This option provides greater opportunities to co-locate health services with other agencies and partners to help deliver a holistic, smooth pathway and the highest quality of care, treatment, and support (which meet the Healthcare Improvement Scotland standards). For example, social care, criminal justice, advocacy, and third sector services for the individual and their family all under the one roof. All services should aspire to deliver this model in a way that is both sustainable and best meets the needs of their locality. This may mean a co-ordinated, multi-agency service but not necessarily delivered from the same physical space.

The recommended configuration of services was for local services delivered as close as possible to the point of need, supported by a Centre of Excellence. The clear principle is that services should firstly be accessed locally in a facility appropriately equipped to provide the highest quality of service to meet the national Healthcare Improvement Scotland standards and as far as possible, in line with the model of service delivery outlined above (i.e. multi-agency approach).

Whilst it has not yet been decided what the services will be called, it is envisaged that a 'Centre of Excellence' would provide a dedicated specialist team (although not necessarily in one location) that can provide forensic medical and healthcare services to its locality, as well as support for services in surrounding localities / health boards in relation to education/training, peer review and support, best practice advice and guidance for example. Work is underway to determine the exact detail of what that support will look like.

6. Coordinated Multiagency Sexual Assault Response and Review Pathway



7. Healthcare and Forensic Medical Examination

This section sets out the processes for undertaking a healthcare and forensic medical examination.

The primary purpose of the healthcare and forensic medical examination for rape and sexual assault is to support the health and wellbeing of individuals and identify the health care needs of the patient (European Parliament 2013). The secondary purpose is to collect evidence that would support investigation and prosecution of crime.

The options available for forensic examination and evidence collection should be communicated to the patient. Should the patient wish to have a forensic medical examination this should ideally be carried out first in order to preserve as much forensic evidence as possible. In certain cases it may be appropriate to prioritise emergency medical care despite the possibility of some compromise of forensic evidence.

7.1 Healthcare Assessment and Aftercare

Key Points

- ✓ Supporting the healthcare needs of individuals is essential.
- ✓ Healthcare should be 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 forensic medical examination
- ✓ A person centred, trauma informed approach should take account of specific individual cultural and health care needs
- ✓ Should the patient wish to have a forensic medical examination this should ideally be carried out first in order to preserve as much forensic evidence as possible.
- ✓ Copper Intrauterine Device (Cu-IUD) is the most effective method of emergency contraception and should be offered to all patients when clinically indicated
- ✓ Oral emergency contraception should be given as soon as possible after unprotected sex.
- ✓ Ulipristal acetate is more effective than Levonorgestrel but there are clinical situations in which Levonorgestrel is more appropriate.
- ✓ When the prescribing of post exposure prophylaxis following sexual exposure (PEPSE) is recommended, starter packs should be commenced as soon as possible and within 72 hours of an assault.
- ✓ Hepatitis B vaccine is highly effective at preventing infection if given shortly after exposure and should be offered to all who present within 6 weeks of exposure.
- ✓ HPV vaccination should be offered to those who do not have complete vaccine history, using current national guidance
- ✓ Offer STI screening at appropriate incubation periods to allow exclusion of STIs.
- ✓ Consider prophylaxis against bacterial STIs.

Healthcare should meet both immediate and on-going 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 post exposure prophylaxis against blood borne viruses and bacterial STIs.
- Psychosocial assessment and support.

7.1.1 Assessment of Need for Emergency Contraception

Sexual assault may place women and trans-men of reproductive age at risk of unwanted pregnancy. The healthcare professional should assess the need for and provide emergency contraception. Whether emergency contraception is required and the most suitable method will depend on:

- Nature of the sexual assault.
- Time since assault.
- Any current pre-existing method of contraception.
- Menstrual status, cycle and last menstrual period (LMP).
- Other episodes of Unprotected Sexual Intercourse (UPSI) in current cycle.
- Co-existing medical conditions and medications.

Copper Intrauterine Device

- The Faculty of Sexual and Reproductive Health (FSRH) [Clinical Guidelines on Emergency Contraception](#) (2017) recommend that all people at risk of pregnancy after sexual assault are offered a Copper Intrauterine Device (Cu-IUD) if within the appropriate timeframe as it is the most effective method of emergency contraception.
- If fitted within 5 days after UPSI or ovulation, the pregnancy rate is extremely low.
- Antibiotic cover for STI should be considered if a person opts for Cu-IUD insertion.
- If a person accepts the offer of forensic examination it should be explained that clinical examination and Cu-IUD insertion should be deferred until after forensic examination has taken place in order to maximise potential for capture of assailant DNA.
- Some people may choose to prioritise pregnancy risk reduction and Cu-IUD insertion above forensic examination if there is to be a delay in arranging the latter.
- 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.

- If a woman opts to have a Cu-IUD inserted after forensic examination, the Forensic Examiners should arrange for Cu-IUD insertion to be carried out without delay after the forensic examination has taken place.
- Oral EC should be offered in the interim in case the Cu-IUD cannot be inserted or the person later changes their mind about Cu-IUD insertion.

Oral Emergency Contraception

- People who choose and are eligible for oral emergency contraception after sexual assault should be offered it as soon as possible.
- There are two hormonal preparations licensed for use in the UK:
 - Ulipristal acetate licensed up to 120 hours after UPSI.
 - Levonorgestrel licensed to use up to 72 hours after UPSI.
 - Ulipristal acetate is more effective than levonorgestrel but there are some circumstances in which Levonorgestrel may be most appropriate; consult local guidance or FSRH guidance on emergency contraception (The Faculty of Sexual and Reproductive Health (FSRH) [Clinical Guidelines on Emergency Contraception](#) (2017)).

Follow up arrangements for pregnancy testing should also be discussed.

7.1.2 Assessment of Pregnancy Risk and Pregnancy Diagnosis

It may become apparent that current pregnancy as a result of 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.

Both practical and emotional support for the individual should be offered. There should be pathways in place to access services which support patient choice, both for continuing with any pregnancy and options relating to termination.

A discussion regarding the forensic significance of a child or products of conception from a miscarriage or termination of any pregnancies resulting from rape can be considered if and when appropriate. The ethics and legalities in such a situation are complex and advice should be sought. Further information is available from the FFLM (2016) [Guidance on paternity testing](#).

If products of conception are seized for DNA analysis these should be in a plain container and frozen and **not placed in formalin** as is usual practice following termination.

Sharing of such sensitive clinical information with the investigating police team should be as appropriate, with the patient's knowledge and with the patient's consent.

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

Rates of Sexually Transmitted Infection (STI)s following sexual assault vary depending on the population studied, known 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.

The British Association of Sexual Health and HIV (BASHH) produce guidance on prevention, screening and management of STIs. Forensic Physicians should consult the most up to date publications at: <https://www.bashh.org/guidelines>

7.1.3.1 Testing for Sexually Transmitted infections

- Any screening samples for bacterial STIs (Chlamydia, Gonorrhoea and Trichomonas) should be taken **after** forensic samples. Due to incubation periods samples for bacterial STIs are not usually undertaken until 14 days after the incident. (BASHH guidelines)
- In circumstances where a positive screening sample is likely to be of forensic significance (where 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 than previous sexual activity), baseline samples should be taken at time of examination and again 14 days post incident
- Only samples of potential forensic significance should be sent with the chain of evidence form (see local standard operating procedures).
- Consider further advice from local Genitourinary Medicine, Sexual and Reproductive Health clinician Microbiologist (NHS Education Scotland 2017).
- Testing for some STIs (HIV, Syphilis and Hepatitis) is by blood testing. Serum samples saved immediately, or soon after the disclosure of sexual assault, can be tested after 3 months if any of the above mentioned blood tests are positive at follow up, as negative saved serum may indicate an association between the alleged assault and the acquisition of infection.

It is important that there are appropriate care pathways for testing and defined protocols for management of any STIs. See: BASHH (2012) [UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault](#).

It is important to acknowledge that the identification of an STI in the immediate period after sexual assault is seldom useful in court and wrongly risks adverse inference on the individual's character. Any request from COPFS for medical notes/ STI screening should be explored and a court order provided. Unless there is relevance to the crime on trial for the testing / result it should not be disclosed. Further information on the sharing of personal sensitive information for court proceedings can be found in the [communication released](#) by the CMO in 2016. Information sharing is being explored further by the Information Governance Group under the Taskforce.

7.1.3.2 HIV Post Exposure Prophylaxis (PEPSE)

In cases of sexual assault, risk assessment for HIV transmission is required. A risk assessment should include:

- Nature of sexual assault.
- Time since exposure.
- Current HIV status and previous exposure.
- Details of assailant if known – i.e. risk that they will be HIV positive.

Further guidance on this is available in: [UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure](#) (BASSH 2015) and in local Board protocols.

- When the prescribing of post exposure prophylaxis following sexual exposure (PEPSE) is recommended, 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.
- Advice should be given on:
 - the lack of conclusive data about the efficacy and long-term toxicity of HIV PEPSE;
 - potential risks and side effects;
 - the need to continue treatment for 28 days if baseline HIV test is negative;
 - the need for a follow up HIV test at 8-12 weeks (dependent on local protocol);
- 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.

7.1.3.3 Hepatitis A

- Given the prevalence of this virus amongst men who have sex with men consider the risk of Hepatitis A.
- Hep. A vaccine can be given up to 14 days after exposure provided the source was in the infective period (likely to be unknown in cases of sexual assault).
- Immunoglobulin is also an option if given in appropriate timeframe if history of jaundice in the contact source (unlikely to be known in sexual assault setting).
- Immunoglobulin within a few days and up to 2 weeks offers protection if in contact with infectious source. It may reduce symptoms if given up to 4 weeks.

See: [2017 Interim update of the 2015 BASHH National Guidelines for the Management of the Viral Hepatitides](#) (BASHH 2017)

7.1.3.4 Hepatitis B

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

See: [United Kingdom National Guideline on the Management of the Viral Hepatitides A, B and C](https://www.bashhguidelines.org/media/1161/viral-hepatitides-2017-update-18-12-17.pdf) (BASHH 2015) updated 2017
<https://www.bashhguidelines.org/media/1161/viral-hepatitides-2017-update-18-12-17.pdf> Where there is a known risk of Hepatitis B transmission, refer to local protocols and clinical pathways.

Vaccine

- Hepatitis B vaccine is highly effective at preventing infection. Ideally immunisation should commence within 24 hours of exposure, although it should still be considered up to 6 weeks after exposure.
- A booster vaccination should be given to people who have been vaccinated and there is a history of contact with a high risk source.

Immunoglobulin

- Hepatitis B immunoglobulin is used after exposure to give rapid protection until the vaccine becomes effective.
- As the vaccine alone is highly effective, the use of Hepatitis B immunoglobulin in addition to the vaccine is **only** recommended in high-risk situations or in a known non-responder to vaccine.
- When necessary, Hepatitis B immunoglobulin should also be given at the same time as vaccine, ideally within 24 hours of vaccine, although it may still be considered up to a week after exposure (Public Health England 2017).

(See: [The Green Book Hepatitis B: chapter 18](#) Public Health England: June 2017)

7.1.3.5 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 should be discussed with local specialist genitourinary medicine or infectious diseases clinicians. There is currently no vaccination.

7.1.3.6 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 vaccination schedule or with incomplete vaccination history.

The vaccine should be administered at the time of the initial examination, and follow-up dose administered at 1–2 months and 6 months after the first dose.

7.1.3.7 Bacterial Sexually Transmitted Infections

- In the interests of antibiotic stewardship, offering testing for STIs after the appropriate time frame - rather than antibiotic prophylaxis - should be the default.
- Sampling methods are fairly non-invasive with the option of self-taken swabs and therefore tolerance of examinations need not be a deciding factor.

- 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.
- 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).

7.1.4 Timelines for testing for STIs and offering vaccination

Testing and prophylaxis for bacterial STIs and blood borne viruses after disclosure of rape or sexual assault		
Immediate needs - disclosure within 14 days of assault	Disclosure after 14 days	Presentation over 3 months
<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) • Consider eligibility 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 of baseline testing for 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 6 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 ○ Carefully consider prophylaxis for bacterial STIs 	<ul style="list-style-type: none"> • Offer tests for bacterial STIs • Offer Syphilis, Hepatitis B and C and HIV serology • Consider eligibility for vaccination schedules depending on personal and clinical circumstances of any ongoing risks of exposure.

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 C](#)

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

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

Centre for Disease Control and Prevention (2015) [Sexual Assault and Abuse and STDs](#)

Faculty of Sexual and Reproductive Health (2017) [Clinical Guidance: Emergency Contraception](#).

Faculty of Forensic and Legal Medicine (2016) [Guidance on paternity testing](#)

Public Health England: (June 2017) [The Green Book Hepatitis B: chapter 18](#)

7.2 Psychosocial Risk Assessment

7.2.1 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.
- Any previous self-harm or recent suicidal ideation.
- Safety and ongoing risk particularly in vulnerable patients. This should include stalking. Their home may be a crime scene and / or the 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.
- Risk to others
- Child protection issues (for further details on this, please [see national guidance](#)).

In cases associated with domestic abuse a risk identification checklist should be used, such as the one developed by Third Sector Organisation SafeLives Risk Identification Checklist (RIC) should be completed and appropriate information

sharing and referral undertaken. This is included in Appendix B. Guidance and further information can be found on the [Safe Lives](#) website.

The RIC forms part of the clinical record and is not part of the forensic documentation.

Where there is police involvement, Police Scotland 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 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 an adult at risk as are adults who-

- are unable to safeguard their own well-being, property, rights or other interests.
- are at risk of harm.
- 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, or
- 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 out 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 followed. [See national and local guidance for child protection.](#)

7.2.2 Support and psychological care

Contact by a support worker in the days following the forensic consultation offers the opportunity to discuss with the patient any aftercare needs and identify any new health or social care needs or concerns. Timely referral to further support or counselling can take place if support mechanisms are in place to monitor when normal coping mechanisms fail to resume.

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

Resources

The [Safe Lives](#) Dash Risk Identification Checklist

7.2.3 Consideration of specific health care needs

It is beyond the scope of this pathway to include consideration of all conditions that may require consultation and examination to be adapted to suit the individual's needs. All individual specific health care needs should be assessed, managed and supported in accordance with all respective guidance and pathways.

Local pathways should be in place for use of interpreters including British Sign Language interpreters, for support for those with learning difficulties. See Section 8 for information specific to adults with incapacity.

Useful Resources

General Medical Council (2018) [Transhealthcare](#)

Rape Crisis Scotland (2014) [Supporting LGBTI survivors of sexual violence](#)

Scottish Government (2016) [Scotland's National Action Plan to Prevent and Eradicate FGM](#)

7.3 Preserving Forensic Evidence

Forensic examination and evidence collection supports the judicial process. The options available for forensic examination and evidence collection should be communicated to the individual.

Should the individual wish to have a forensic medical examination this should ideally be carried out before health care examination in order to preserve as much forensic evidence as possible. See section 7.1 for examples of health care needs that might require prioritisation in particular clinical circumstances (treatment of wounds, emergency contraception). The forensic medical element of the examination will depend on whether the person consents to samples being taken and tested, for criminal justice purposes.

While awaiting forensic medical examination and collection of forensic evidence, depending on individual circumstances, this guide should be followed as closely as possible providing there is no interference with the individual's safety and they feel able to consent. The length of time productions with personal information will be held for should be in line with local policies and GDPR.

Where forensic medical examination is planned, every effort should be made to preserve forensic evidence and avoid contamination. There may however be situations where immediate clinical needs override this, in which case Forensic Physicians should be informed that this has occurred, and this should be recorded.

Consult: [FFLM Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) (July 2018).

If a police SOLO has been appointed they will take care of all the elements below. This limits the potential for contamination and ensures that the chain of evidence requirements is met.

If there is no police involvement, these principles should be followed to maintain forensic integrity of any productions that are to be stored in case of later police involvement. Further guidance will be developed for the management of people who wish forensic examination but have not chosen police involvement.

7.3.1 For All Types of Rape / Sexual Assault

- The type of seat the person sits on should be 'wipeable'.
- The person should be requested to avoid baths/showers/douching.
- If a condom was used, it should be retained.
- Where possible the person should be asked to avoid eating, drinking, including alcohol or smoking after the assault if it included oral penetration.

7.3.2 Vaginal & 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 the tampon as part of forensic examination after external genital swabs taken.
- The person may prefer to remove the tampon themselves.
- If the person opts to remove before examination begins, explain that the forensic evidence on the skin may be lost.
- Document the order of swabs in relation to any tampons removed during the course of examination.

If possible, the person should not:

- Pass urine and/or open their bowel before forensic examination.
- Wipe the genital/anal area if they have to go to the toilet.

7.3.3 Oral Rape/Sexual Assault

If possible, the person should avoid:

- Brushing their teeth or use gargle in their mouth.
- Taking fluid or food.
- Smoking.

7.3.4 Clothing

If possible, the person should:

- Change out of the clothes worn at the time of the rape/sexual assault as soon as possible.
- Place each item of clothing in a separate paper bag (not plastic).
- Label immediately with identifying details, date and name of person labelling.
- Underwear, worn at the time of or after the incident, should also be collected and placed in a separate paper bag.

Healthcare professionals should avoid handling clothing. If clothing must be handled by health professionals it should be with double gloved hands.

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.
- Do not cut through blood, semen or fluid marks.

7.3.5 Wounds and Blood/Saliva/ Semen Stains

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

7.3.6 Collection of firearms residue and trace samples

E.g. Weapons, Restraints, Tape, Bullets, Paint, Glass, Soil:

- Do not talk, cough or sneeze over any specimens.
- Do not handle specimens, but if specimen must be handled then do so with double gloved hands.
- If bullets are handled then use double gloved hands – metal forceps should **not** be used.
- Contact forensic scientist on call for advice.

7.3.7 Early Evidence Kits

Early Evidence Kits - where made available - assist with the preservation of forensic evidence both for DNA (saliva and mouth swabs where oral sex has occurred) and for toxicology (collection of urine specimen in cases of suspected drug or alcohol facilitated sexual assault while forensic medical examination is awaited).

Usual content for Early Evidence Kits include:

- DNA free Gloves.
- Face mask.
- Mouth swab module.
- Mouth rinse module.
- Urine kit for toxicology.
- DNA free wipe.

- Paper evidence bags for collection of clothing.
- Chain of custody labelling & form.

Where appropriate Police, or in cases without Police involvement, certain healthcare professionals trained in evidence collection, should retrieve early evidence in all cases with consent while forensic medical examination is being arranged.

If / when a Forensic Medical Examination is carried out on the individual, the Forensic Examiners should be informed that the Early Evidence Kit was used and whether urine and/or oral swabs have been taken.

7.4 Forensic Medical Examination

7.4.1 Introduction to the forensic medical examination

Using trauma informed principles:

- Ensure safety and build trust.
- Offer choice and control where possible.
- Maintain the individual's privacy and dignity at all times.
- Minimise re-traumatisation by avoiding identified triggers.
- Keep the individual informed of processes and changes.

This examination may include:

- a detailed head to toe examination.
- identifying the presence or absence of injury – any injuries requiring immediate medical treatment.
- identifying any medical conditions that may affect interpretation e.g. skin conditions, bleeding disorders.
- contributing to informing an opinion on timing, mechanism and causation of injury.
- documenting and interpretation of any forensically relevant features or injuries.
- collection of appropriate forensic specimens in accordance FFLM [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) (FFLM 2018).

It is important the clinician does not re-traumatise the individual by re-interviewing or straying into the role of investigator.

Should the patient wish to report to the Police, the full history of the incident and recording of the statement is the remit of Police Scotland, not the Forensic Physician.

The following information should be recorded prior to commencing the examination:

- Date and time when healthcare services contacted.
- Date and time (24 hour clock) of the examination.

- Date and time (24 hour clock) of incident.
- Time interval from incident until examination.
- Location of the examination.
- Name of any other person present (e.g. interpreter).
- Where the police are involved – the SOLO's details.

7.4.2 Key elements in a forensic medical history

The purpose of taking a history in forensic medical examination is to determine any information that may assist with both assessing therapeutic needs of the individual and to aid interpretation of forensic findings.

General History

- Past relevant medical/surgical/psychiatric/family history
- Allergies
- Medications
- Social history:
 - alcohol intake/cigarettes
 - drug use, including illicit and prescription substances
- Vulnerabilities
 - learning/ developmental disabilities
 - Sexual orientation / identity
 - Cultural issues
 - Harmful coping strategies
- Home circumstances, with a view to discharge planning
- Menstrual cycle
- Date of last menstrual period
- Tampon/sanitary pad use
- Obstetric history (including details of multiple and still births and miscarriages)

The patient is asked if they had sexual intercourse within the last 7 days

If yes:

- Type and frequency of sexual experience.
- Use of a condom.
- Contraceptive use.
- Possibility of current pregnancy.

Forensic History

- Number and identity of the reported attacker(s), if known.
- Date and time of the incident and the time lapse from the incident.
- Location where incident took place.

Type of sexual acts that the patient reported occurred:

- For a female: contact with the vagina/anus/mouth/breasts and other locations on the body.

- For a male: contact with the mouth/anus/genitalia or other parts of the body
- Consideration as to whether and where ejaculation took place.
- Use of a condom.
- Use of objects to achieve penetration.
- Reported use of weapons or restraints.
- Any bites or other wounds.
- Any bleeding:
 - Menstrual bleeding.
 - Bleeding due to genital/anal injury.
 - Tampon/pad in place during incident.
 - Tampon/pad worn after incident.
 - Bleeding from any other part of the body at the time of the incident.
- After the incident, document whether the patient has:
 - Eaten/brushed teeth/washed out mouth (If the oral cavity was involved).
 - Bathed/showered.
 - Changed clothes, including panties/underpants.
 - Opened their bowel (If anal involvement).
 - Passed urine, if yes, how many times since the incident and the time they last urinated.
- Actual, threatened or perceived violent behaviour used in the course of the incident.

7.4.3 Forensic examination procedure

- The forensic examiner and the corroborating witness on the recommended personal protective equipment (PPE) in order.
- 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)

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 the tamper proof bags) with the top pair of gloves changed between sampling each different body area.

- If the examinee is wearing the same **clothing** and/or has not washed since event the individual being examined is asked to stand on the paper **ground sheet** provided when undressing to allow recovery of body fluids or foreign particles that may fall from clothing or body during examination.

- The clothing and ground sheet are then 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 examinee is given a DNA free modesty gown to wear.
- The Forensic Examiner undertakes a detailed top to toe external examination to ascertain the presence of any injuries or their sequence. These should be measured and documented on body diagrams using recognised terminology for the type of injury and position detailed relevant to anatomical landmarks.
- Detailed genital and ano-genital examination should be undertaken with additional lighting and magnification ideally with colposcopy digital video documentation - see section 7.5.
- The [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) should be followed.
- The history and nature of the assault and timing of exposure or contact will determine which forensic samples are relevant to take.
- On Completion of the Forensic Evidence Collection:
 - Double Gloves are worn until the tamper evidence bag is sealed.
 - Check each sample is correctly labelled.
 - Patient's name.
 - Patient's Date of Birth (DOB).
 - Date and time sample was taken.
 - Sample description e.g. If related to a swab - Endocervical (1).
 - The Forensic Examiner signs each sample.
 - Each sample should also be signed the corroborating witness, or Police Scotland SOLO if present.
 - All specimens are packed in the tamper evident bags provided in the kit (except toxicology specimens).
 - The Forensic Examiner should complete all relevant information on the SPA support form and the form is signed and dated.
 - The form is attached to the outside in a sealed bag, with the patient's name, DOB identifiers and the date and time of examination on the outside.
 - Keep the toxicology specimens separated from the Sexual Offences Examination Kit i.e. they are not packaged together.
 - The Forensic Examiner 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 may need to be offered.
- 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 with Care Coordinator and Rape Crisis advocacy worker should be obtained.
- Information about support services should also be provided in an appropriate format.
- Detailed documentation is completed and report prepared.

7.4.4 Forensic sampling and sequence

Materials such as clothes and samples such as hair, blood, saliva, or sperm should only be taken if they can be used and processed according to available laboratory and legal requirements; if this is not possible then samples should not be taken

In general terms - relating to swabs for DNA, semen, blood, other body fluids or debris - two plain swabs should be taken from each relevant site, labelled with the two swabs numbered sequentially in the order taken as (1) or (2).

Follow the table outlined in the most recent [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) (FFLM 2018).

Swabs from dry areas e.g. skin: the first swab to be taken should be moistened with sterile water and with moderate pressure rolled over the skin for 10 -15 seconds followed by the second dry swab rolled over the same area for 10 – 15 seconds. The swabs are then placed in the swab sleeve / tube and into the tamper evident bag.

National, standardised forensic kits should be available to assist with the following samples, which when taken should be done so 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.

Useful resources

Faculty of Forensic and Legal Medicine (2018) [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#).

7.5 Role of Colposcopy in Sexual Assault Forensic Examination

An [Overview of the worldwide best practices for rape prevention and for assisting women victims of rape](#) undertaken by the European Parliament (2013 pg. 61) advises that ‘forensic evidence collection should include colposcope examination’. In Scotland, the *National Guidance on the delivery of police custody healthcare and forensic medical services*, developed in partnership between the NHS, Police Scotland and the Crown Office and Procurator Fiscal Services states that:

“Colposcopes should be used where consent has been provided. The DVD recording from video Colposcopy provides the best quality of forensic evidence in relation to intimate examinations and enables the Crown to obtain, where necessary, the opinion of a medical expert not present at the examination. It also affords any defence medical experts an opportunity to view the recording”

Superior magnification and lighting provided by colposcopes increases the rate of injury detection. Colposcopy allows recording and imaging for peer review purposes and the potential to be used for second expert medical opinion and/or defence medical opinion. Colposcopes should therefore be available in every location where a forensic medical examination for individuals who have experienced sexual assault takes place. Colposcopic images cannot in themselves provide corroboration of the findings of forensic medical examinations.

Storage and Retention of Digital Images

In line with [Guidance for best practice for the management of intimate images that may become evidence in court](#) 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 NHS Boards (RCPCH and FFLM 2014). NHS Boards are therefore the Data Controller for the images. Images are stored in line with legislative requirements set out in the Data Protection Act 2018 and GDPR. All images should be coded and stored securely with password protection. Sharing of intimate images that form part of the medical record should only be done in circumstances where there is appropriate informed consent, or they are ordered to by a Judge or there is a public interest.

Further work on the storage and retention of digital images is being developed at this time and will be updated within the pathway once information is available.

Photographic Evidence

Photography of injuries may be useful addition to body map documentation and description of findings.

Consideration should be given to relevant photography by a trained individual if the examinee gives consent for their use as part of the clinical and/or forensic record. When seeking consent it should be made clear that photography is an important part of the investigatory process. When there is police involvement, photography will be undertaken by SPA photographer.

Consent to Photographs for use as Evidence

Before photographic evidence is taken, the patient must have given written consent and must be fully aware that the photographs may be shown in any subsequent court proceedings although this is unlikely. COPFS do not disclose copies of intimate photographs to the defence; disclosure would be facilitated by allowing the defence to come to a Procurator Fiscal's office to view the images.

7.6 Immediate and Long Term Follow Up

Key Points

- ✓ Services should have access to a broad range of immediately available services/expertise.
- ✓ It is not appropriate to expect people to coordinate multiple appointments themselves.
- ✓ Follow up appointments should be organised by the Service, including to 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.

7.6.1 Referrals and Follow-up Care

Services need to have systems in place to enable patients to have access to a broad range of immediately available services/expertise, should the need arise e.g. Emergency Departments, gynaecology and mental health services, support and advocacy services, housing services.

Follow up appointments should be organised by the Service and support should be available to facilitate attendance at follow up appointments. Local arrangements will need to be developed, depending on the service model described above.

A multi-agency response may include agencies such as Housing, Social Work services, and third sector specialist services such as Rape Crisis. People with particular needs, e.g. homelessness or adults requiring support and protection, should be referred, with consent, to the appropriate Social Work Department. If the patient has previously been attending Social Work, then with the patient's permission the referral is made through their allocated Social Worker, to facilitate continuity of care.

It is not appropriate to expect people to coordinate multiple appointments themselves.

If concerns exist regarding domestic abuse/stalking/ongoing sexual violence/interpersonal violence, it is vital that as well as being provided with a place of safety if required, the patient should also be given information on their local support services including, but not limited to social work services, Police and sexual violence services.

After assessment, relevant examination and immediate treatment, a plan should be made with the individual for return to a safe environment, ideally accompanied by a family member, guardian, friend or support person. Consent to contact the patient to remind them of future appointments etc. should be confirmed and the preferred method documented prior to discharge.

7.6.2 Summary of attendance given to the individual

Information Leaflet in appropriate format which should include: <ul style="list-style-type: none"> • Date of attendance. • Tests/procedures performed. • Medications given. • Follow-up appointment date and time, and what will take place at that appointment.
Contact details for the service, and Police Scotland (where appropriate)
Instruction on the care of any injuries.
Medication instructions, if applicable.
Information re: Social Work referral.
If the patient consents a letter is provided for the G.P.
Letter for work, college, school, if required.
Phone number and printed information leaflet from Rape Crisis Scotland (in relevant accessible format).
Relevant information about relevant services, tailored to the person's needs, e.g.: <ul style="list-style-type: none"> • Domestic abuse • Interpersonal violence • Drug and Alcohol programmes

7.6.3 Where children are involved

Where concerns are raised about the potential significant harm to a child or young person they should be considered child protection concerns. 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 (Scottish Government 2013).

Appropriate referrals to social services should also be made for children who may be indirectly affected by an adult's attendance, e.g. where a child has witnessed a

sexual assault, alcohol and drug use in the home, children of patients with mental health concerns, or any child identified as being at risk by a perpetrator of sexual violence.

Children and young people living with domestic abuse are at increased risk of significant harm, both as a result of witnessing the abuse and being abused themselves. Children can also be affected by abuse even when they are not witnessing it or being subjected to abuse themselves. Domestic abuse can profoundly disrupt a child's environment, undermining their stability and damaging their physical, mental, and emotional health.

Problematic parental substance use can involve alcohol and/or drug use (including prescription as well as illegal drugs). It is important that all practitioners working with parents affected by problematic drug and/or alcohol use know the potential impact that this has on children, both in terms of the impact on the care environment through direct exposure to alcohol and/or drug use, and also the potential practical and emotional challenges presented in terms of the recovery process.

Each NHS Board / Local Authority should have policies and guidance in place for the identification, assessment and management of children affected by parental problematic alcohol and/or drug use.

For further information see:

- [National Guidance for Child Protection in Scotland](#) (Scottish Government 2014)
- [Child Protection Guidance for Health Professionals](#) (Scottish Government 2013)

Health Scotland defines Adverse Childhood Experiences (ACE's) as stressful events occurring in childhood including:

- domestic violence.
- parental abandonment through separation or divorce.
- a parent with a mental health condition.
- having experienced abuse (physical, sexual and/or emotional).
- having experienced neglect (physical and emotional).
- a member of the household being in prison.
- growing up in a household in which there are adults experiencing alcohol and drug use problems.

Further information on ACE's can be found on the [Health Scotland website](#).

7.6.4 Feedback

An anonymous feedback mechanism should be in place, whereby the person who has experienced a rape or sexual assault is given a feedback form (usually at the follow-up visit). If the patient wishes to participate in giving feedback regarding the

care they received, they may post back or deposit the completed feedback form in a designated collection box.

Useful Resources

Scottish Government (2014) [*National Guidance for Child Protection in Scotland*](#)

Scottish Government (2013) [*Child Protection Guidance for Health Professionals*](#)

8. Consent to Healthcare and Forensic Medical Examination

8.1 Consent

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

- carrying out any examination or investigation;
- providing treatment; or
- involving patients in teaching or research.

See: GMC (2008) [*Consent: patients and doctors making decisions together*](#).

Clinicians must consult the most up to date guidance from the GMC.

A fundamental ethical principle guiding medical practice is that no examination, diagnosis 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. 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 (FFLM 2017).

When seeking consent to treatment, the question of whether the information given to a patient is adequate is judged from the perspective of a reasonable person in the patient's position. For the purposes of consent, the ruling from Montgomery in 2015 replaces the previous tests founded in Bolam and refined in Sidaway. Doctors have a duty to take reasonable care to ensure that patients are aware of 'material risks'.

Under new legislation from the General Data Protection Regulation (GDPR) consent must be a freely given, specific, informed and unambiguous indication of the individual's wishes. There must be some form of clear affirmative action. GMC guidance is that doctors can still rely on implied consent as long as the conditions set out in the guidance are met (GMC 2018 [*Five things to know about our Confidentiality guidance and the GDPR*](#))

Consent must also be separate from other terms and conditions, and healthcare professionals need to provide simple ways for people to withdraw consent. Further information is available on the Information Commissioner's [website](#).

The purpose of a forensic medical examination should be explained to the patient in a way that they can understand. The patient should be fully informed throughout the process, allowing them make informed choices about their care. A person's consent should be given freely, voluntarily and without coercion providing that s/he is of the legal age and has the mental capacity to consent. The patient is entitled to be accompanied during any such discussion by an advocate / support worker of their choice. Consent is voluntary and is an on-going process and the patient can

withdraw consent at any stage. An example consent form can be found in Appendix D.

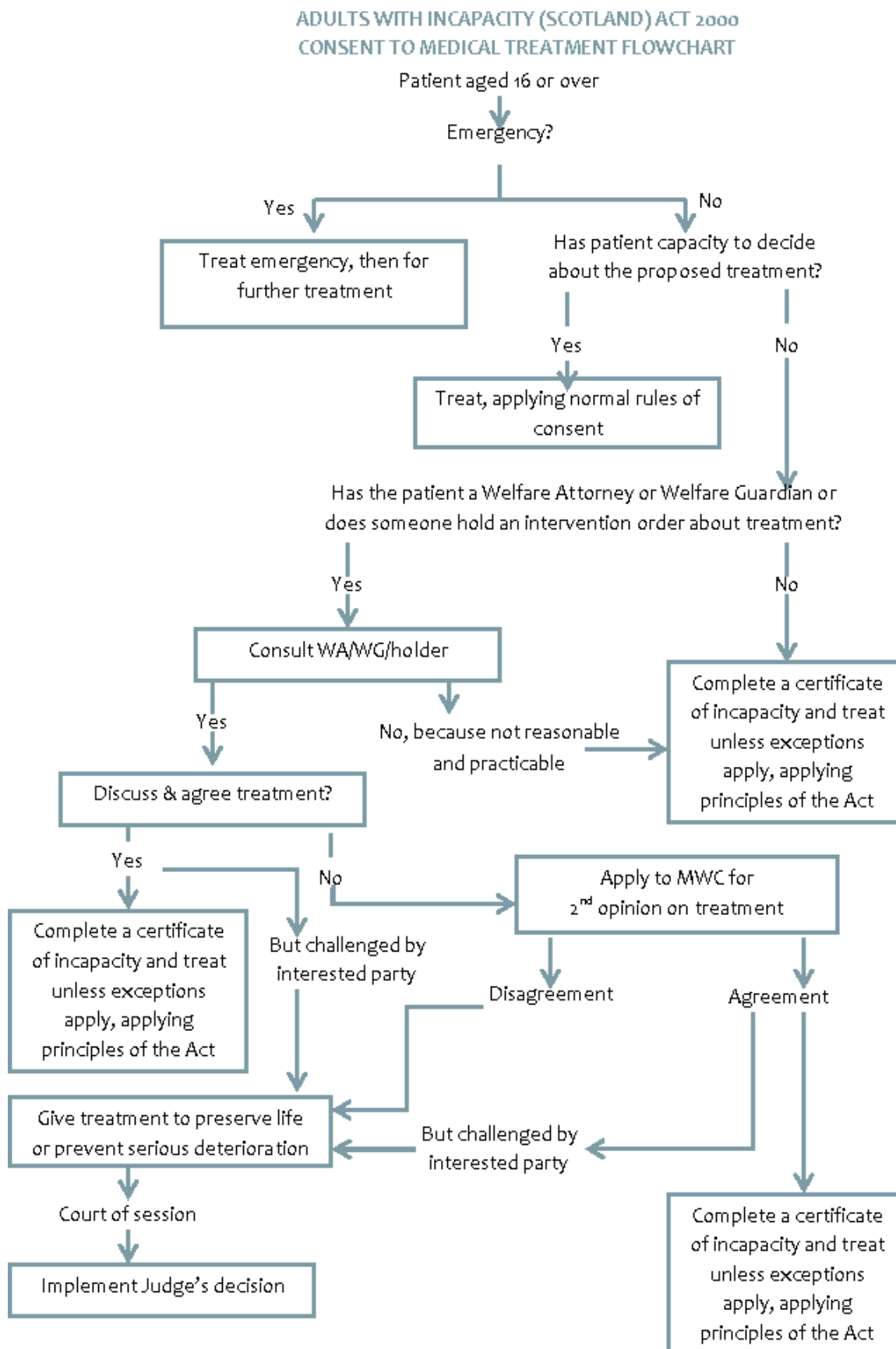
8.2 Adults with Incapacity

In Scotland the [Adults with Incapacity \(Scotland\) Act 2000](#) and any recent updates, defines individuals as incapacitated if they cannot make decisions, or communicate them, or remember their decisions. Where this applies, the FP should take account of the best interests of the patient following initial assessment. The impairment may be due to a mental disorder or a physical inability to communicate in any form.

Doctors must assess a patient's capacity to make a particular decision at the time it needs to be made. Doctors must not assume that because a patient lacks capacity to make a decision on a particular occasion, 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 capacity](#)

The flow chart below outlines the process for the provision of medical care for Adults with Incapacity under the Adults with Incapacity (Scotland) Act 2000.

Flow chart 1: Adults with (Scotland) Act 2000 – Consent to Medical Treatment Flowchart



8.2.1 Areas Which may Affect Capacity or Ability to Consent

Forensic Examiner 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 Board guidance should be consulted. Interpreters may be provided by other agencies such as Local Authorities. **Family members, friends or partners of the patients should not be used.**

8.2.2 Temporary Loss of Capacity Due to Intoxication

Patients who are intoxicated due to alcohol or drugs may temporarily lose their capacity. In such circumstances, the forensic assessment should normally be deferred until the patient'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 patient repeatedly within a given period to determine if the patient's capacity has returned.

Clear and precise reasons for deferring a forensic medical examination should always be recorded.

8.2.3 Patient with Serious Injury/Unconscious Patient

On occasions patients are seriously injured during a rape or sexual assault and the ensuing injuries may result in loss of capacity (for example where the patient is unconscious). The FFLM's recommendations on [Consent for patients who may have been seriously assaulted](#) advise that any attendance in an acute care setting to carry out a forensic medical examination on a seriously ill/unconscious patient should be with the prior knowledge and permission of the Consultant in charge of that patient's medical care who should also be informed of the nature and purpose of the proposed examination to ensure that he / she has no objections to it being undertaken (FFLM 2014).

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

- The right to life
- The right to bodily integrity
- The right to privacy
- The right to self-determination

The Forensic Examiner must also act on the basis of good professional practice and forensic medical examination should be undertaken if it is considered to be in the best interests of the patient. The rationale behind any decisions, the factors considered and the judgements made need to stand up to any future scrutiny. All steps taken and decisions made must be clearly documented.

In assessing best interests, the Forensic Examiner should consider speaking to people close to the patient 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 taken into account.

The Forensic Examiner 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 Forensic Examiner must decide whether it is in the patient's best interest to speak to the available family.

The Forensic Examiner should consider obtaining the views of other people who are close to the patient as well as consulting any legally appointed welfare attorney or welfare guardian attorney.

The Forensic Examiner should ensure that the patient is informed what has been done and why as soon as the patient is sufficiently recovered to understand.

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

8.3 Refusal of any Elements of the Examination

Every adult or adolescent with capacity is entitled to refuse medical treatment, and their refusal must be respected. A person cannot be deemed to lack decision making capacity simply because there is a risk that he or she might make what seems an unwise decision.

If a patient chooses not to have a forensic medical examination, then they should do so with a clear understanding of the implications of the choice they are making and that choice should be respected.

Individual may consent to the healthcare elements of the examination or vice versa and if individual refuses for they should still be offered health aftercare.

Useful Resources

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

General Medical Council (2008) [*Consent: patients and doctors making decisions together.*](#)

General Medical Council GMC: [*Consent Guidance: Assessing capacity*](#)

General Medical Council (2018) [*Five things to know about our Confidentiality guidance and the GDPR*](#)

Faculty of Forensic and Legal Medicine (2014) [*Consent for patients who may have been seriously assaulted*](#)

Information Commissioner (2018) [*Guide to the General Data Protection Regulation \(GDPR\)*](#)

9. Corroboration

The necessity of having corroborated evidence has lain at the heart of the criminal justice system in Scotland. Its stated purpose, in criminal cases, is to prevent an accused from being wrongly convicted on the basis of a single witness, who may be either fallible or dishonest.

The requirement for corroboration was cited in *McLean (2009)* as one of several elements in the criminal justice system that contributed to the overall fairness of the trial procedure.

Corroboration is a requirement in all forensic medical examinations.

- Examination should be performed by a clinician who has undertaken suitable training in forensic medical examination techniques.
 - [Training for examiners of victims of rape and sexual assault](#)
 - [Police Care Network](#)
- The corroborating witness requires to be able to confirm: the date and place of the examination; the name of the person who has experienced rape or sexual assault, the taking of all swabs and samples; and the presence of any injuries.
- A subgroup of the CMO Taskforce undertaking some scoping of the appropriate skills and training required by corroborating witnesses in the context of sexual offences examinations. This may have a bearing on the role of chaperones (see Appendix A)

For more information see: The Carloway Review: Report and Recommendations (Scottish Government 2011)

9.1 Types of Witnesses

There are two types of witness in a case:

Witness of Fact: A witness of fact comments on what they saw occur. An example might be a member of the public who was in a shop during a robbery, or a doctor looking at a bruise. A professional witness of fact must offer clear and concise written and oral evidence, based as far as possible on clinical records and notes made at the relevant period of time. Professional witnesses of fact may include **some opinion** about findings but it should be made clear what is factual evidence and what is opinion based on professional judgement and experience.

Expert Witness: This witness must comment on what they saw and how to interpret that information. For example, a forensic scientist commenting on fingerprints or a doctor commenting on what could have caused the bruise or the age of a bruise. An expert witness is able to consider **all** the evidence available, including statements and reports from the other parties to the proceedings, before forming and providing an opinion to the court.

For more information see: [GMC Ethical Guidance](#)

When using the standardised national form (within appendix C), it is important to ensure information is presented in a manner that supports both the ongoing investigation and any future prosecution process.

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

9.2 Disclosure of Records

Reports are generally written with reference to the contemporaneous medical notes taken at the time of forensic medical examination. There may however be occasions where the court requires the original medical record as a production (evidence) in addition to the healthcare professional's report.

It is good practice to document the health assessment separately from the forensic element so non-relevant information may be protected. However this cannot be guaranteed and consent must be clear with the patient being informed from the outset that in addition to a report being prepared all notes may have to be disclosed during the criminal investigation and active acknowledgement of this understanding sought.

Any disclosure of the medical record should be with the patient's consent or on the direction of a court order.

Resources

[Sharing of Personal Sensitive Information \(Medical/ Clinical Records\) For Court Proceedings](#)

10. Information Sharing

The CMO Taskforce has convened an Information Governance Delivery Group. The role of the Taskforce is to improve services for adult and child victims of rape and sexual assault and the scope of the IG Delivery Group aligns with this. The current Information Governance Sharing Toolkit and other relevant material will be used by the Group as a foundation to provide a national approach that can also be used locally. The framework produced will aim to bring clarity and consistency to those working with victims of rape and sexual assault in Scotland. This section will be updated in line with the outcomes of the work.

11. The Criminal Justice Process

11.1 Outline of the Criminal Justice Process

On receipt of an allegation that an offence of rape or sexual assault has been committed the Police Service of Scotland will carry out an investigation into the circumstances. That investigation is likely to involve: statements being obtained from the person who has experienced rape or sexual assault and witnesses; forensic medical examination 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 accused person.

If the investigating police officers form the view that there is sufficient evidence to prove that the offence has been committed and that the accused person committed it, a report (known as an SPR2) will be submitted to the Procurator Fiscal. In the majority of cases, which involve an allegation of rape, the accused will be reported to the Procurator Fiscal whilst held in police custody.

The Procurator Fiscal will consider the content of the SPR2 in order to decide: if the report discloses a crime known to the law of Scotland; 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.

In cases involving an allegation 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.

All cases, which involve an allegation of rape, are 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 accused person. The offence of rape carries a maximum sentence of life imprisonment.

Cases, which involve an allegation of serious sexual assault, are likely to be heard in the Sheriff Court by a Sheriff sitting with a jury. Again the jury will decide if the accused is guilty and the Sheriff will pass sentence. The maximum sentence that can be imposed is 5 years imprisonment.

Other cases, which involve an allegation of sexual assault, are likely to be heard in the Sheriff Court by a Sheriff sitting alone. If an accused person is remanded in custody when he/she first appears in court the trial must commence within 40 days. The Sheriff will decide if the accused person is guilty of the offence and will also

pass sentence. The maximum sentence that can be imposed is 12 months imprisonment.

Appendix A - Roles and Responsibilities

Forensic Examiner

The phrase forensic examiner is used to refer to the professional carrying out the clinical forensic examination. It is noted that for good practice, a female forensic examiner should 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)

At present in Scotland, forensic examiners are medically trained. Work to develop the role of forensic nurse examiners in Scotland is being progressed under the remit of the CMO Taskforce workforce and training sub group.

Nurses

Where an appropriately trained nurse is available to be present during a forensic medical examination, their role is to provide trauma informed, person centered care and support to the individual and to help ensure that their immediate and on-going health and wellbeing needs are being met. Work to further develop the role of nurses in this context is being progressed under the remit of the CMO Taskforce workforce and training sub group.

Follow up care / co-ordination

Services have responsibility 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. At present this role is undertaken in a variety of ways; exploration of what constitutes best practice will be explored further under the remit of the CMO Taskforce workforce and training sub group.

Chaperones

In summary a chaperone should:

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

The chaperone has an important role in forensic medical examination. As well as witnessing the conduct of the examination the chaperone offers support to the individual during examination and reduces risk of them feeling vulnerable. The chaperone may be used to corroborate evidence collection in Scotland, within the parameters detailed in Section 9 therefore the chaperone must be prepared to sign labels of productions seized during the examination, provide the police with a witness statement and attend at court to give evidence if cited to do so.

[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).

Standard 2.1.3 'A suitably trained, impartial chaperone is offered for all forensic examinations where there is a sole clinician present.'

The General Medical Council (GMC) guidance on [Intimate Examinations and Chaperones](#) (2013) states: *When you carry out an intimate examination, you should offer the patient the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the person.*

A corroborating witness requires to be able to confirm: the date and place of the examination; the name of the complainer; the taking of all swabs and samples; and the presence of any injuries. Hence, a forensically trained healthcare professional is the preferred option.

The chaperone role should not be undertaken by sexual offences liaison officers (SOLOs).

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. The role of the SOLO will be 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
- arranging the forensic medical examination
- briefing the attending health professionals
- attending the forensic medical examination
- seizing clothing for evidential purposes
- seizing forensic samples for evidential purposes
- ensuring PSoS and RCS referral procedures are completed
- providing external agency referral information to victims
- providing enquiry updates to victim
- supporting the victim during any other police process (i.e. identification / VIPER parades)

- corroborate the forensic medical examination if a health care professional is not available

The SOLOs attendance at the forensic medical examination is primarily to support the criminal investigation; ensure the chain of evidence is recorded and protect the forensic integrity of productions seized. The SOLO should not have an active role in the forensic medical examination itself and corroboration should be provided by the 2nd health professional in attendance.

Rape Crisis Scotland National Advocacy Project

1. To improve the support available to survivors of rape and serious sexual crime
2. To improve the experience of the criminal justice process for survivors of rape and serious sexual crime; and
3. 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.

Appendix B – Risk Identification Checklist (RIC) SafeLives

[SafeLives Risk Identification Checklist](#)

Appendix C – National Form

Please see the consultation page for a copy of the National Form. Please note, the body maps have been removed for the purpose of consultation; however they are available on request.

The National Form is intended to be used by medical and forensic staff, to support clinical care and forensic assessment. Guidance for use is included in the body of the form. This form has been developed by a subgroup of the CMO Taskforce Clinical Pathways Group, building on previous work to ensure consistent documentation of the clinical and forensic elements of immediate care for people who have experienced sexual violence, to improve the quality of clinical care, forensic assessment, and progress through the justice system for those who choose to engage with Police Scotland. Professionals from Police Scotland, SPA, COPFS, and forensic services in all regions of Scotland have developed this form. The working version of the National Form also contains sections for specific documentation of clinical findings on body maps. These have been omitted from this version of the Form.

It is important that the National Form contains the core data set to support immediate clinical care, forensic assessment and documentation of care planning. It is also important that it allows services to monitor quality of services and plan service improvements. Work is ongoing within the Quality Improvement subgroup of the CMO taskforce, who have been developing a list of Key Business and Technical Requirements for an ideal National Clinical IT System to support healthcare and forensic medical examinations and to support the improvement of services for victims of rape, sexual assault and child sexual abuse. An Outline Business Case is also being developed. In order that the National Form aligns with future IT system developments, there may need to be further amendments to the format of this document.

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Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-333-5 (web only)

Published by The Scottish Government, October 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS478366 (10/18)

W W W . G O V . S C O T