Clinical pathway for healthcare professionals working to support children and young people who may have experienced child sexual abuse

FOR

CLINICIANS

Contents

List of abbreviations

ACE	Adverse Childhood Experience
CMO	Chief Medical Officer
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
FFLM	Faculty of Forensic and Legal Medicine
FGM	Female Genital Mutilation
GDPR	General Data Protection Regulation
GIRFEC	Getting It Right For Every Child
GMC	General Medical Council
HIS	Healthcare Improvement Scotland
IJB	Integration Joint Board
IRD	Inter-agency Referral Discussion
JII	Joint Investigative Interview
JPFE	Joint Paediatric Forensic Examination
MCN	Managed Clinical Network
NES	NHS Education for Scotland
NHS	National Health Service
NSPCC	National Society for the Prevention of Cruelty to Children
PTSD	Post-Traumatic Stress Disorder
RCPCH	Royal College of Paediatrics and Child Health
UN	United Nations

<table>
<tr><td colspan="2">Introduction and Background Information</td></tr>
<tr><td>Section 1</td><td>Introduction

This section provides an introduction to the clinical pathway, including advice on how it should be used.</td></tr>
<tr><td>Section 2</td><td>Child Sexual Abuse

This section outlines the definition of child sexual abuse and child sexual exploitation.</td></tr>
<tr><td>Section 3</td><td>The Wider Child Protection Context in Scotland

This section details the multi-agency approach to supporting children and young people who experience sexual abuse.</td></tr>
<tr><td>Section 4</td><td>Aims of the clinical pathway

This section outlines the purpose of the clinical pathway.</td></tr>
<tr><td colspan="2">Clinical pathway process</td></tr>
<tr><td>Section 5</td><td>Clinical pathway

This section provides information on dealing with the initial concern / disclosure.</td></tr>
<tr><td>Section 6</td><td>Health assessment and medical examination for suspected child sexual abuse

This section sets out the purpose of the examination and details of the procedure, including obtaining consent.</td></tr>
<tr><td>Section 7</td><td>Post-examination care

This section describes follow up for health needs and on-going support.</td></tr>
<tr><td colspan="2">Appendices</td></tr>
<tr><td>Appendix A</td><td>Age of a child or young person

This appendix discusses the definitions of children and adults by age with regard to the relevant legislation and guidance.</td></tr>
<tr><td>Appendix B</td><td>Legal Context</td></tr>
</table>

	This appendix provides further information on the legal context surrounding Children and Young People who have experienced sexual abuse.
Appendix C	**Children and Young People Pathway Subgroup Membership** This appendix provides a list of people who have been involved in the Children and Young People Pathway Subgroup.
Appendix D	**Prevalence of Child Sexual Abuse** This appendix provides some context on the prevalence of child sexual abuse with caveats about under reporting and the difficulties of collecting accurate information.
Appendix E	**Roles and Responsibilities** This appendix details the roles and responsibilities of professionals involved in the clinical pathway.
Appendix F	**GIRFEC** This appendix outlines further information on the GIRFEC approach to supporting children and young people.
Resources	

1 Introduction

1.1 What is the purpose of the guidance?

The purpose of this guidance is to ensure a consistent approach to the provision of healthcare and forensic medical examination services for children and young people who may have experienced sexual abuse. It is intended to complement existing guidance, standards and legislation and should be read alongside those.

The pathway covers the journey of care and support for the child or young person, from initial concern through to their onward recovery. It describes the requirement for close working between the NHS, social work services, police and the third sector to ensure the provision of a holistic healthcare response.

This clinical pathway will be subject to review to take account of any changes to relevant guidance or legislation. This pathway does not supersede or alter any duties or requirements imposed by legislation or legal obligations and principles arising from case law determined by the courts (more applicable to criminal justice matters).

Healthcare professionals do not need to and should not make a judgement about whether the reported sexual abuse of a child or young person did or did not take place. It is important to recognise that it is for a court order to decide whether sexual abuse has taken place if there is a prosecution or other proceedings.

1.2 Who should use the guidance?

This guidance is for healthcare professionals working to support children and young people who may have experienced sexual abuse. It should also be a key reference document for police, social work services, Child Protection Committees, the third sector and Integration Joint Boards (IJBs) to support the effective planning and delivery of services. It is not prescriptive and is intended to support ongoing improvements to services.

1.3 How should the guidance be used?

The guidance has been designed to enable easy navigation to the appropriate sections. Where possible, footnotes are provided for all resources referenced or referred to in the document.

Anything defined in the guidance is a general description of the term and is not referring to a statutory definition of the term, unless otherwise specified.

1.4 Who is this guidance applicable to?

This guidance is applicable to the care and treatment of children and young people up to their 16th birthday (or up to 18th birthday for young people with vulnerabilities and additional support needs) who may have experienced sexual abuse.

Appendix A discusses the definitions of children and adults by age with regard to the relevant legislation and guidance.

The definition of a child in Scotland is dependent on the legal context. Appendix B summarises considerations that are relevant to the clinical pathway and multi-agency assessment and planning for children and young people who may have experienced sexual abuse. Further information on the applicable age of this pathway can be found in section 3.4.

1.5 What other documents should be consulted?

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

- Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland (Child Protection Managed Clinical Networks 2017)[1]
- Getting It Right For Every Child (GIRFEC)[2]
- Healthcare and Forensic Medical Services for People who have Experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults Standards (Healthcare Improvement Scotland 2017)[3]
- Healthcare and Forensic Medical Services for People to have Experienced Rape, Sexual Assault and Child Sexual Abuse: Children, Young People and Adults Quality Indicators (Healthcare Improvement Scotland 2020)[4]
- Service specification for the clinical evaluation of children and young people who may have been sexually abused (Royal College of Paediatrics and Child Health)[5]
- Faculty for Forensic and Legal Medicine (FFLM Guidance) (Royal College of Paediatrics and Child Health)[6]
- National Guidance for Child Protection in Scotland (Scottish Government 2014)[7]
- Child Protection Guidance for Health Professionals (Scottish Government 2013)[8]

1.6 Who has developed the guidance?

Under the remit of the CMO Taskforce, a Clinical Pathways Subgroup was established to develop a national clinical pathway for adults and a national clinical pathway for

[1] https://www.ermcncp.scot.nhs.uk/wp-content/uploads/Standards-QIs_for_Child_Protection_Medical_Examinations_v1.pdf
[2] https://www.gov.scot/policies/girfec/
[3] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx
[4] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_indicators.aspx
[5] https://www.rcpch.ac.uk/resources/service-specification-clinical-evaluation-children-young-people-who-may-have-been
[6] https://www.rcpch.ac.uk/resources/faculty-forensic-legal-medicine-fflm-guidance
[7] https://www.gov.scot/publications/national-guidance-child-protection-scotland/
[8] https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2012/12/national-guidance-child-protection-scotland-guidance-health-professionals-scotland/documents/00411543-pdf/00411543-pdf/govscot%3Adocument/00411543.pdf

children and young people. Both pathways have had detailed input from third sector organisations to represent the views of people with lived experience.

A wide range of multi-agency professionals were members of the subgroup including the Child Protection Managed Clinical Network (MCN) managers, paediatricians, Police Scotland, third sector and members of the Scottish Government child protection team.

Appendix C includes a list of people who were involved in the Children and Young People Pathway Subgroup.

1.7 Review of the pathway

The pathway will be kept under review and will be updated to reflect any changes that are relevant to the guidance included in this document.

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

1.8 Background to the pathway

In March 2017, Her Majesty's Inspectorate of Constabulary in Scotland published a report[9] which provided a strategic overview of forensic medical services for victims of sexual crime and made a number of recommendations to improve these. The Chief Medical Officer for Scotland was asked by the then Cabinet Secretary for Health and Sport and the Cabinet Secretary for Justice to chair a Taskforce to provide national leadership for the improvement of these services.

The Taskforce vision is for consistent, person-centred, trauma-informed healthcare and forensic medical services and access to recovery for anyone who has experienced rape, sexual assault, or child sexual abuse in Scotland.

In December 2017, Healthcare Improvement Scotland (HIS) published National Standards[10] to ensure consistency in approach to the delivery of these services across

[9] https://www.hmics.scot/sites/default/files/publications/HMICS%20Strategic%20Overview%20of%20Provision%20of%20Forensic%20Medical%20Services%20to%20Victims%20of%20Sexual%20Crime.pdf
[10] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx

Scotland. These standards are underpinned by Quality Indicators[11] published in March 2020.

1.9 What terminology is used in the guidance?

Terminology within this document is aligned with Healthcare Improvement Scotland's National Standards[12].

[11] http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/sexual_assault_indicators.aspx
[12] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx

2 Child Sexual Abuse (CSA)

2.1 Definition of CSA

Within this pathway child sexual abuse (CSA) is defined as an act that involves a child less than 16 years of age in any activity for the sexual gratification of another person, whether or not it is claimed that the child consented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening (draft National Child Protection Guidance 2020). For those who may be victims of sexual offences aged 16-17, see section 3 of the pathway.

There are situations between young people under 16 that may not require child protection processes, but where immediate support is needed in relation to sexual risks, development and relationships. This may be addressed either on a single agency or multiagency basis, depending on needs and circumstances. Child protection concerns arise when the impact of under-age sexual activity could cause significant harm.

With childhood sexual abuse children are often too young to know how to express what is happening and seek out help. The identification of concerns or disclosure tends to be a process rather than a single episode and is often initiated following a medical complaint or a change in behaviour.

Children can be sexually abused by adults or other children who are by virtue of their age or stage of development in a position of responsibility, trust, or power over the child. Online technology and the internet can be vectors of non-contact activity leading to contact sexual abuse.

Not all child abuse is familial. As young people grow and develop, they are influenced by a whole range of environments and people outside their family including in school or college, in their local community, in their peer groups and/or online. Children and young people may encounter risk in any of these environments. Sometimes the different contexts are inter-related and can mean that children and young people may encounter multiple risks.

There are various circumstances within which abuse can occur which is why health professionals also have a role, with partners, in the response to extra-familial forms of abuse. Contextual safeguarding looks at how we can best understand these risks, engage with children and young people and help to keep them safe.

Some groups of young people may be particularly vulnerable with regard to rape, sexual assault or CSA, and resistance to the offer of follow up support will need to be sensitively explored. These include those who have been trafficked and / or are an unaccompanied asylum seeker or who have been victims of child sexual exploitation and/or grooming and abuse in a coordinated way. Reluctance to accept help and support may be due to their age and a consequence of highly effective grooming,

which can leave young people either believing that they are in a consensual relationship or in fear of the consequences of exposing their exploitation. For these particularly vulnerable young people aged 16 and 17 years, professional judgement *may* determine that it is more appropriate for the young person to follow the adult clinical pathway. However, the requirements in relation to GIRFEC must still be considered[13] and child protection procedures must be followed for victims of child sexual exploitation or trafficking.

The Sexual Offences (Scotland) Act 2009[14] (2009 Act) outlines types of offences against younger children (under the age of 13) and older children (aged 13-15). In all cases of suspected child sexual abuse there should be an Inter-agency Referral Discussion (IRD) (see Section 5.2).

Younger children

Children under the age of 13 cannot consent to sexual activity so in every case in which a child of that age is subjected to sexual activity it is very likely that a criminal offence has been committed. Accordingly, concerns **must** be raised in accordance with local child protection procedures.

Older children

If a child aged between 13 and 15 years has been subjected to non-consensual sexual activity then, in the accordance with the law in relation to adults, it is very likely that a criminal offence has been committed due to the absence of consent. Cases in which children aged between 13 and 15 years have disclosed non-consensual activity must also follow child protection procedures.

If a child aged between 13 and 15 years engages in apparently consensual sexual activity with a person aged 16 or older it is likely that a criminal offence has been committed by the person aged 16 or older. For example, if a male aged 16 or older penetrates the vagina, anus or mouth of a 13-15-year-old female with his penis with her consent he commits an offence in terms of section 28 of the 2009 Act. In these circumstances, it may be necessary to share information to ascertain if the child is a victim of exploitation or grooming. There will be many circumstances in which consensual sexual conduct involving a child aged 13-15 should be investigated by the police and subsequently prosecuted.

Older children, aged between 13 and 15 who engage in sexual activity with one another both commit a criminal offence in terms of section 37 of the 2009 Act only if: a) the activity involves penile penetration of the vagina, anus or mouth or touching of the vagina, anus or penis with the mouth; and b) both parties consent to the activity. Again, depending on the particular circumstances it may be necessary to share

[13] https://www.gov.scot/policies/girfec/
[14] https://www.legislation.gov.uk/asp/2009/9/contents

information to determine if one or both or the children are being, or have been, exploited.

2.2 Child Sexual Exploitation

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

The victim may have been sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact. It can also occur using technology. As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act. 'Child' in this context means child or young person up to age their 18th birthday. A child or young person of any sex may be a victim. A child protection response is required, the nature of which will be determined following an Inter-agency Referral Discussion (IRD). 'Disclosure' is not a pre-requisite for a child protection investigation; the clinicians may have concern about abuse and exploitation necessitating an IRD (see section 5.1). Children who are trafficked across borders or within the UK may be sexually abused.

3 The wider child protection context in Scotland

The pathway is intended to inform the health care and recovery pathway for children and young people who may have experienced sexual abuse. The pathway sits within a wider policy and practice landscape which covers all forms of child abuse including physical abuse, sexual abuse and exploitation, emotional abuse, female genital mutilation (FGM), neglect, fabricated and induced illness.

Female Genital Mutilation (FGM) is an illegal practice and an extreme violation of human rights. FGM reflects deep-rooted inequality between the sexes and constitutes a severe form of discrimination against women and girls. FGM has been illegal in Scotland since 1985, when the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation (Protection and Guidance) (Scotland) Act 2020 was passed on 19 March 2020. At the time of publication, not all sections of this Act have been brought into force.

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

- Domestic abuse including coercive control[15]
- Rape and sexual assault
- Child sexual abuse
- Commercial sexual exploitation
- Sexual harassment and stalking
- Harmful traditions and practices including female genital mutilation

The wider policy context in Scotland includes:

- The intention to incorporate the United Nations Convention on the Rights of the Child (UNCRC) into Scots law. The convention includes a provision that everyone up to the age of 18 years is entitled to all the rights and protections provided for children
- A refresh of the Getting It Right for Every Child (GIRFEC) approach to improving the wellbeing of children and young people
- A Scottish Government commitment to consider how the Barnahus concept for immediate trauma-informed support for child victims of serious and traumatic crimes can operate within the context of Scotland's healthcare and justice systems
- The Vulnerable Witnesses (Criminal Evidence) (Scotland) Act 2019 which requires pre-recording of evidence of child witnesses (aged under 18 years) for certain types of case heard in a jury trial and increased use of pre-recorded evidence by vulnerable witnesses in other proceedings

[15] https://www.legislation.gov.uk/asp/2018/5/contents/enacted

- A model for police and social work to video record child interviews (Joint Investigative Interview (JII)). Section 6.3 details the purpose of a JII.

3.1 Adverse Childhood Experiences

We know that Adverse Childhood Experiences (ACEs)[16] such as sexual abuse can create harmful levels of stress which can affect brain development, resulting in long term detrimental effects on learning, behaviour and health outcomes. It is not inevitable that ACEs will cause these negative outcomes and protective factors such as supportive relationships and appropriate care can mitigate their effects. The ideal is to prevent ACEs happening in the first place but once the traumatic events have occurred the aim is to ensure that children and young people affected by childhood adversity and trauma have the right support in place where and when needed to improve their health and life outcomes. Steps to attain this aim include:

- Strengthening multi-agency and multi-disciplinary working across the children's workforce to deliver integrated care for children and young people so they are experienced as coordinated by those who use the services
- Providing tailored support for families with the most complex needs to ensure children and young people can be safely cared for at home and in their communities, to prevent children and young people from entering the care system and/or experiencing multiple disadvantage
- Creating improved communication and coordination between child and adult services to enable adult services to better take account of and support the needs of affected children and enable children's services to address the needs of non-abusing parent(s)/carer(s)

The care and support set out in the pathway should be delivered by a trauma-informed multi-agency workforce to help reduce the negative impact of ACEs on children and young people.

3.2 Trauma-informed care

Scotland has a commitment to develop a trauma informed workforce to respond to people who have experienced trauma at any age. A trauma informed workforce will provide opportunities for empowerment to individuals and ensure that physical and emotional safety, choice, collaboration and trustworthiness is offered. There is a knowledge and skills framework for psychological trauma[17], led by NHS Education for Scotland and support for implementation through the National Trauma Training Programme[18]. The level of trauma training that staff working with children and young people who have experienced sexual abuse will be expected to have is outlined in Appendix D. Health boards and other agencies are responsible for ensuring that their

[16] http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces
[17] https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf
[18] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx

employees are trained to the appropriate level in accordance with the trauma training framework.

The National Trauma Training Programme was established in 2018 in response to survivors of abuse whose experiences of frontline services was often re-traumatising and stigmatising, leading them to disengage from the services that were set up to support them. The Programme provides dedicated training support for the entire workforce (health service, social care and police) through the following:

- Service Level Agreements within every Health Board across Scotland to facilitate and co-ordinate trauma training activities
- A suite of high quality trauma training resources available at all practice levels including animations, e-modules, webinars, face to face sessions and train the trainer models
- Scottish Trauma-Informed Leadership Training facilitated by NES
- A Knowledge and Skills Framework and Trauma Training Plan which sets out the core competencies required at each practice level (from basic awareness to specialist) and a practical step by step guide on how to deliver and embed trauma informed principles in the workplace
- Dedicated support from clinical psychologists at NES to develop bespoke training packages for staff working in maternity services, victim support and people working with looked after children

Since 2019, the right to trauma-informed care and practice has been embedded within the Charter of Patient Rights and Responsibilities, as well as the guidance for local authorities and health boards on exercising the functions conferred by Part 3 of the Children and Young People (Scotland) Act 2014[19].

3.3 Revised National Guidance for Child Protection in Scotland

This clinical pathway anticipates and provides a bridge in some key respects to the National Guidance for Child Protection in Scotland which is currently under revision[20] to reflect developments in legislation, systems and practice since 2014. For example, it will provide additional detail to support consistency in approach to Inter-agency Referral Discussions (IRD), which are outlined in section 5.2 of this pathway. The current child protection guidance for health practitioners (2013) will be integrated within the revised National Guidance for Child Protection in Scotland. Among other changes, the revised National Guidance for Child Protection will provide additional detail about multi-agency child protection assessment and about the need to assess intersecting risks arising from different forms of abuse (including child sexual abuse, exploitation, trafficking, internet-enabled sexual abuse and harmful sexual behaviour by children and young people). It recognises that children and young people who cause harm to others may themselves have experienced abuse.

[19] https://www.legislation.gov.uk/asp/2014/8/contents/enacted

[20] At time of publication of the CYP Pathway (November 2020), the draft National Guidance for Child Protection in Scotland was out for public consultation and is expected to be published in early 2021

In anticipation of the revised National Guidance for Child Protection in Scotland, this pathway stresses general principles that underpin the consideration and conduct of investigative activities in relation to children and young people who may be harmed and those who may cause harm to others. These are summarised below:

Rights: The child's present feelings, views and future rights are respected and protected at every stage.

Safety: Processes are both careful and robust, promoting the safety of those involved by determining the truth within the most harmful circumstances.

Wellbeing: The wellbeing of the child is the lens through which all decisions and actions are taken. A child's wellbeing, as defined by the wellbeing indicators, is a key part of the National Practice Model which underpins assessment and individual child centered planning for children in Scotland.

Preparation: Processes include early discussion between the lead agencies, coordination and partnership with those responsible for the child's care.

Understanding: Each stage and any change or decision is explained in a way that makes sense to each child and those responsible for their safe care, taking in to account culture, capacity, age and stage.

Support: Support will be provided for children and young people and non-abusing parent/carer(s) involved in these processes.

Skill: Professionals involved are afforded the training and supervision that ensures a coordinated and child-centered process.

Pace: Preparation and pace of exploration is patient and attuned to the impact of trauma upon the needs and feelings of each child.

Place: Investigative processes are conducted in an environment which is child-friendly and amenable to those attending for the child's support.

Improvement: Processes will be evaluated in line with HIS standards ensuring adherence and continuous improvement.

The 'Promise' (Independent Care Review 2020)[21] emphasised the importance of the 'voice' of the child being heard. This is echoed in this current pathway as it will be in future National Guidance for Child Protection in Scotland.

[21] https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

Useful resources

NHS Education Scotland (2017): Transforming Psychological Trauma: A knowledge and skills Framework for the Scottish Workforce[22]

NHS Health Scotland (2018): Gender Based Violence[23]

NHS Lanarkshire: Trauma and the Brain: Understanding Abuse Survivors Responses[24]

NHS Education Scotland (2018): Opening Doors: Trauma-Informed Practice for the Workforce[25]

NHS Health Scotland (2018): Adverse Childhood Experiences (ACEs)[26]

3.4 Young people 16 and 17 years old

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

There may be multiple reasons for considering a young person aged 16 or 17 to be vulnerable or have additional support needs. Children with communication impairments, behavioural disorders, learning disabilities and sensory impairments may be additionally vulnerable to abuse and neglect. The most common forms of abuse experienced by disabled children are neglect and emotional abuse, although they may experience multiple abuses including sexual abuse. Disclosing abuse can be more difficult for children who have a wide range of communication needs, and this can be more problematic if a perpetrator is also in a trusted role.

For some young people aged 16 and 17, professional judgement should be used to decide whether the adult clinical pathway or the pathway for children and young people is most appropriate. In doing so, consideration should be given to the person's capacity and whether there is a need for adult support and protection measures to be put in place.

[22] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx
[23] http://www.healthscotland.scot/health-topics/gender-based-violence
[24] https://vimeo.com/126501517
[25] https://vimeo.com/274703693
[26] http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

Not all young people aged 16 and 17 years interpret abuse as abuse. Some are at heightened risk because of vulnerabilities, effective grooming and / or because of fear of the consequences of speaking out. They may fear reprisals for themselves or someone close to them or are keen to protect their abuser, who they may consider to be their partner. In addition, health professionals should be aware that a proportion of 16 and 17-year-old young people who present reporting rape or sexual assault may have been victims of sexual abuse whilst they were under the age of 16 years. This may or may not have been reported and may or may not have progressed through the criminal justice system. It is important to take account of the increased vulnerability of young people who have a history of abuse. This may include young people who experienced abuse from a young age which continued over many years and may have been perpetrated by someone close to them.

3.4.1 Adult support and protection

The provisions of the Adults with Incapacity (Scotland) Act 2000[27] may be relevant for some young people aged 16 and 17 years.

Under the Adult Support and Protection (Scotland) Act 2007[28] ("the 2007 Act"), an 'adult at risk' is someone aged 16 or over who is unable to safeguard their own wellbeing, property, rights or other interests, is at risk of harm and because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

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

The 2007 Act places a duty on local authorities to inquire and investigate cases where it knows or suspects that an adult is at risk and that it might need to intervene to protect, among other things, the person's wellbeing. A local authority has powers to visit and interview people, arrange medical examinations, examine records and apply for various types of protection orders. It must also consider if there is a need for advocacy and other services, such as help with medication, or support services.

The Act concerns the welfare of adults (for the purposes of this pathway, young people aged 16 and 17) with special needs who are unable to make decisions for themselves or are not able to communicate. This Act provides the framework for other people (such as carers) to act on the behalf of people with incapacity. For further information on Adult Support and Protection, see page 26 of the adult clinical pathway.

3.5 Care experienced young people

Young people who have experience of the care system are at a significantly greater risk suffering abuse. A young person with a history of experiencing sexual abuse will

[27] https://www.legislation.gov.uk/asp/2000/4/contents
[28] https://www.legislation.gov.uk/asp/2007/10/contents

therefore need any new incident or report to be assessed within the context of a chronology of adverse childhood events. As in all cases, they will need a comprehensive and holistic assessment of their needs to inform the offer / plan for trauma-informed support. Particular attention should be paid to considering any ongoing risks to their safety and assessing general wellbeing concerns.

3.6 Corporate parents

The term corporate parenting is defined as: 'An organisation's performance of actions necessary to uphold the rights and safeguard the wellbeing of a looked after child or care leaver, and through which physical, emotional, spiritual, social and educational development is promoted' (Statutory Guidance on Corporate Parenting, 2015)[29].

The Children and Young People (Scotland) Act 2014[30] ("the 2014 Act"; part 9 which relates to Corporate Parenting) came into effect on 1 April 2015. The Act names 26 public bodies[31] and groups of bodies as corporate parents. Under the 2014 Act, corporate parents have a duty to promote the wellbeing of looked after children and care leavers to the age of 26.

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

The 2014 Act also supports the provision of continuing care, meaning that an eligible young person can remain in their foster care, residential care, formal kinship care or an equivalent placement until their 21st birthday. Corporate parenting duties for the 26 public bodies also apply to these young people.

[29] https://www.gov.scot/publications/statutory-guidance-part-9-corporate-parenting-children-young-people-scotland/
[30] https://www.legislation.gov.uk/asp/2014/8
[31] https://www.gov.scot/publications/statutory-guidance-part-9-corporate-parenting-children-young-people-scotland/pages/5/

4 Aims of the clinical pathway

This section outlines the healthcare response that should be provided for a child or young person following disclosure of sexual abuse or where, through other interactions, there are concerns that sexual abuse has occurred. The steps should be taken in collaboration with partner agencies to ensure a holistic pathway of care which supports the health, wellbeing and recovery of the child or young person and their non-abusing parent / carer(s). Health services providing clinical care for children and young people who may have suffered sexual abuse should:

- Work in partnership across agencies with a shared commitment to the best interests of the child. This includes listening to and taking the child seriously
- Be focused on the reduction of further harm and promotion of the recovery of the child and non-abusing parent / carer(s), whether or not there is an ongoing criminal justice process
- Provide appropriate and timely access to holistic health care, emotional, mental health and social support
- Balance confidentiality with the need to share information to safeguard the child or young person, or other children and young people at risk of harm
- Promote health, wellbeing and recovery, and maintain a focus on safeguarding
- Offer a holistic and trauma-informed approach to therapeutic support (further information about the principles of trauma-informed care is available in section 3.2)
- Ensure that the examination meets the forensic standards (HIS)[32] required to support any future criminal justice process including the requirement that facilities used for forensic medical examination are appropriately maintained and comply with forensic decontamination processes and procedures
- Work to ensure that all children and young people who may have suffered sexual abuse are provided with the minimum standard of care outlined in this pathway

[32] http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/sexual_assault_indicators.aspx

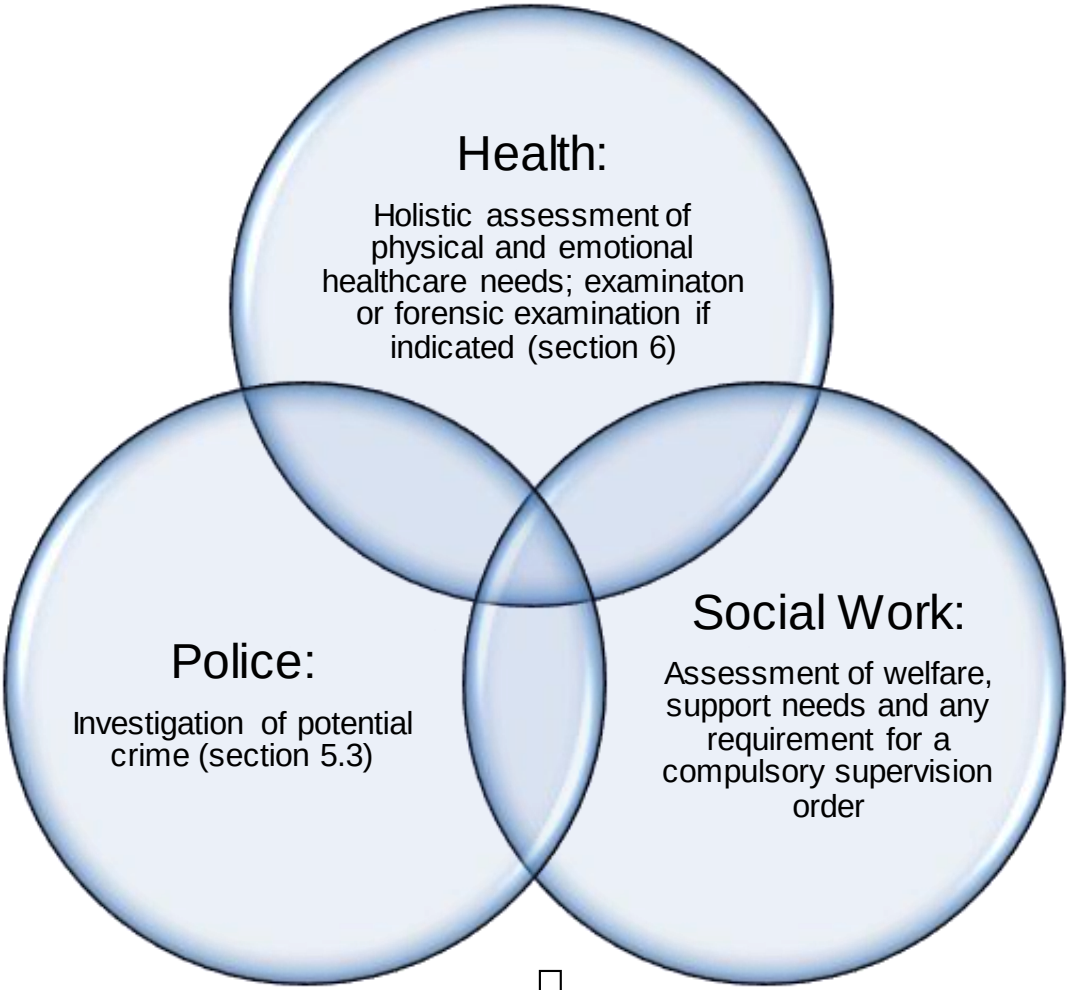
5 Clinical pathway

The diagram below provides a high level summary of the clinical pathway and the specific steps to take during the process. Details on each step are provided in the sections of the pathway following the diagram.

Disclosure by child / young person, suspicion of abuse by a professional or other adult, or indication from clinical presentation (section 5.1)

⇩

Interagency Referral Discussion (section 5.2) and Child Protection Procedures



⇩

Interagency Child Protection Procedures and safety plan
Where Multi-agency support is put in place (section 5.4)

5.1 Disclosure of / cause for concern about child sexual abuse

Any disclosure of sexual abuse by a child under 16 years of age must be considered as a child protection concern. For those who may be victims of sexual offences aged 16 and 17, child protection procedures should be considered and must be applied when there is concern about sexual exploitation or trafficking.

Initial concerns about the sexual abuse of a child or young person may arise in many ways or concerns may be raised from their behaviour or presenting symptoms. Often it can take some time for a disclosure to become apparent (NSPCC)[33]. It is important that there is a robust, timely, trauma-informed and consistent response to cases recent sexual abuse as well as to concerns about or disclosures of non-recent abuse.

At all points in the pathway, the primary focus is the child or young person and their immediate and future wellbeing, informed by the GIRFEC[34] principles and values. Services should ensure that appropriate support is put in place for non-abusing parent / carer(s) and other people close to the child.

Sexual abuse in children and young people may present in a number of ways including but not limited to:

- Disclosure by the child of previous or ongoing abuse
- A clear allegation may not be made at an early stage in the process as the abuser may groom and / or threaten the child. If the child alleges recent sexual abuse urgent action is required
- Pregnancy or sexually transmitted infection in a child under 16 years – this should always prompt further enquiry and exploration
- Behavioural change including sexualised behaviour
- Unexplained genital bleeding with an injury or history not compatible with symptoms and examination
- Any sexual activity in a child who is under 13 years
- Foreign body present in vagina or anus
- Recurrent or new onset wetting or soiling
- A child suspected of sexually abusing another child who may be, or may have been, a victim themselves

There may be no overt symptoms or signs.

[33] https://learning.nspcc.org.uk/research-resources/pre-2013/sexual-abuse-public-health-challenge
[34] https://www.gov.scot/policies/girfec/

5.2 Inter-agency Referral Discussion (IRD)

An IRD including police, social work and health (and education as appropriate), usually occurs within the first 24 hours after an initial concern / disclosure being received by any agency.

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

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

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

Where there is a risk to the life of a child or the likelihood of immediate risk or significant harm, intervention must not be delayed pending information gathering / sharing. Police and social work must use their statutory child protection powers and act immediately.

An IRD will include consideration of the following:

- Immediate safety of the child and any other children living within the house
- Collection of early evidence by police / health services if required
- Timing, sequence and site of joint interview and whether a medical examination is required
- Consent for medical examination and how this will be obtained

The priority considerations above will lead to decisions about:

- Immediate safety and wellbeing of the child
- The need for a joint child protection investigation (social work and police)
- The rationale for a single agency investigation and follow-up or for no further investigation
- Whether a Joint Investigative Interview (JII) is required and, if so, the arrangements for this; including who will carry it out, location of interview and in what timescales. It is also essential to ensure whether any additional supports e.g. advocacy are required to facilitate the child or young person's engagement with the JII
- Whether a medical examination is required. Not all cases of non-recent sexual abuse require an examination. If one is required, this may be a comprehensive

medical examination, a specialist medical examination or a joint paediatric forensic examination. A comprehensive medical examination is performed by a single paediatrician if there are concerns about chronic neglect or abuse. A specialist paediatric examination is a single paediatrician examination performed when a specialist paediatric assessment is required. A joint paediatric forensic examination is carried out by a paediatrician and a forensic physician and will usually be required in cases of recent suspected child sexual abuse

- Whether a compulsory supervision order might be necessary leading to early referral to the Principal Reporter[35].

For further information on the roles and responsibilities of professionals involved in the clinical pathway, see Appendix E.

5.3 Police and social work

Joint Investigative Interview (JII)

JII is the formal interview process carried out by police and social work investigative interviewers for evidential purposes and to assess whether the child (or any other child) needs protection.

These are formal interviews conducted by trained police officers and social workers where there is a concern that a child is a victim of, or witness to, criminal conduct, and where there is information to suggest that the child has been or is being abused or neglected, or may be at risk of significant harm.

The interview is conducted in a way that treats the best interests of the child as a primary consideration and includes the gathering of evidence when it is suspected a crime may have been committed against or witnessed by the child. The purposes of a JII include:

- To learn the child's account of the circumstances that prompted the enquiry
- Gather information to permit decision making on whether the child in question, or any other child, is in need of protection
- Gather sufficient evidence to suggest whether a crime may have been committed against the child or anyone else
- Gather sufficient evidence which may lead to a ground of referral to a children's hearing being established

Information obtained during the JII is fed back into the IRD process to allow further discussion and decision making. The joint investigation can also provide evidence for court proceedings, such as a criminal trial or a Children's Hearing proof.

[35] https://www.chip-partnership.co.uk/wp-content/uploads/2016/02/Guidance-on-Referral-to-Reporter-.pdf

5.4 Interagency child protection procedures and safety plan

All local authority areas have their own interagency child protection guidelines – please refer to them for further information. These are based on a national framework within which agencies and practitioners can understand and agree processes for working together to support, promote and safeguard all children[36].

Immediate safety planning involves all professionals sharing information and collaboratively working with non-abusing parent / carer(s) and children to develop and implement a safety plan that leaves everyone confident that the child is safe. It will involve monitoring and reviewing this plan to be satisfied that the plan is working and should include further subsequent follow up which includes addressing health and emotional needs.

[36] https://www.gov.scot/publications/national-guidance-child-protection-scotland/#res450733

6 Health assessment and examination

Prior to undertaking an examination or any follow up treatment, a number of points must be considered.

6.1 Purpose of the examination

The type of examination to be performed will be determined by the needs of the child or young person, whether or not the suspected sexual abuse is recent or non-recent and the likelihood of forensic findings being present. The purpose of an examination is:

- To establish what immediate treatment the child may need
- To gather relevant forensic evidence (joint paediatric forensic examination)
- To provide a specialist medical opinion on whether or not child sexual abuse is a likely or unlikely cause of the child's presentation
- To support multi-agency planning and decision-making
- To establish if there are unmet health needs, and to inform any ongoing healthcare (including mental health), investigations, monitoring and treatment that the child may require
- To listen to and to reassure the child
- To listen to and reassure the family as far as possible in relation to longer term health needs

The decision to carry out a medical examination of a child will be made by a paediatrician with child protection expertise. The decision to conduct a medical examination may:

- Follow from an IRD and inter-agency agreement about the timing, type and purpose of examination
- Follow from a presentation of concern to health services

A medical examination should be carried out in a location which is age appropriate and child-centred, with access to clinicians with relevant expertise including the management of children and young people with complex conditions or additional needs[37].

In accordance with the Standards of Service Provision for the Paediatric Medical Component of Protection Services in Scotland, a joint paediatric forensic examination should be carried out jointly by a paediatrician and a forensic physician. The paediatrician is responsible for assessing the child's health, wellbeing and development and ensuring that appropriate arrangements are made for further medical investigation, treatment and follow-up. The forensic physician is responsible for the forensic element of the examination. The presence of two doctors in a joint

[37] https://www.gov.scot/publications/rape-sexual-abuse-or-child-sexual-abuse-medical-services-guide-for-service-providers/

paediatric forensic examination is important for the corroboration of medical evidence in any subsequent criminal or children's hearings proceeding. In some cases, both the paediatrician and the forensic medical examiner may be cited to give evidence at a proof or trial.

The wishes of the child in respect of choice of sex of examiner for the examination will be considered and supported if possible[38].

6.2 Preparation

As far as can be achieved in the circumstances, the examining doctor must have:

- All relevant information about the cause for concern
- Information on previous concerns about abuse or neglect
- The inter-agency plan to meet the child's needs at this stage
- Relevant known background of the family or other relevant adults
- Information from a JII if available
- A preparatory discussion with the relevant social worker and police officer
- A preparatory meeting with non-abusing parent / carer(s) and child

Social work services or the police should ensure that the child and non-abusing parent / carer(s) have the opportunity to hear about what is happening, why and where so that they have an opportunity to ask questions and gain reassurance.

6.3 Consent

Written consent must be obtained for the examination before it takes place. Consent must be obtained in one of the following ways:

- From a parent or carer with parental rights (Section 1 (1) and 2(1) of the Children (Scotland) Act 1995)[39]
- An adult who does not have parental rights and responsibilities but does have care and control of the child (Section 5 of the Children (Scotland) Act 1995)
- From a young person assessed to have capacity to give informed consent
- Through a court order

The Age of Legal Capacity (Scotland) Act 1991[40] allows a child under the age of 16 to consent to any medical procedure or practice if, in the opinion of the qualified medical practitioner, the child is capable of understanding the nature and possible consequences of the proposed examination or procedure. Children and young people who are assessed as having capacity to consent can withhold their consent to any part of the medical examination, for example, the taking of blood, or a video recording and consent can be withdrawn at any time during the examination in accordance with the

[38] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx
[39] https://www.ermcncp.scot.nhs.uk/wp-content/uploads/Consent-for-JPFE-of-Children-and-Young-People.pdf
[40] https://www.legislation.gov.uk/ukpga/1991/50/contents

GMC and MCN guidance. Consent must be documented within medical notes and must reflect which parts of the process have been consented to and by whom[41,42].

When considering consent, a child or young person's capacity to consent may depend on their condition at the time (e.g. intoxicated). This may lead to a delay but must be taken into consideration when obtaining consent.

In order to ensure that the person providing consent to an examination is properly informed, the examining doctor, assisted if necessary by the social worker or police officer, should provide information about any aspect of the procedure and how the results may be used. Where a joint paediatric forensic examination is thought necessary for the purposes of obtaining evidence in criminal proceedings but the non-abusing parent / carer(s) refuse their consent, the Procurator Fiscal may consider obtaining a warrant for this purpose. However, where a child who has capacity to consent declines to do so, the Procurator Fiscal will not seek a warrant. If the local authority believes that a medical examination is required to find out whether concerns about a child's safety or welfare are justified, and the non-abusing parent / carer(s) refuse consent, the local authority may apply to a Sheriff for a Child Assessment Order or a Child Protection Order with a condition of medical examination.

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

6.4 Timing of examination

Timing of the examination is agreed jointly by the paediatrician, the forensic physician in the case of a joint paediatric forensic examination and the other agencies involved[43,44].

In recent sexual abuse (up to seven days):

- The immediate health needs of the child are paramount; these include the management of acute injuries, assessment of need for emergency contraception and post-exposure prophylaxis for blood-borne viruses
- Examination should occur as soon as appropriate to increase the likelihood of recovering any available forensic evidence as the likelihood of recovering forensic evidence decreases exponentially with time and the genital area heals extremely quickly

[41] https://www.ermcncp.scot.nhs.uk/wp-content/uploads/Consent-for-JPFE-of-Children-and-Young-People.pdf
[42] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent#:~:text=Consent%3A%20patients%20and%20doctors%20making%20decisions%20together%20Working,with%20your%20patient%20about%20their%20treatment%20and%20care.
[43] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_indicators.aspx
[44] https://www.rcpch.ac.uk/resources/faculty-forensic-legal-medicine-fflm-guidance

- Early evidence kits may be used by the police on children and young people (mouth / throat swab or mouth rinse) if the examination will be delayed until the following day
- These requirements need to be balanced with consideration of the wellbeing of the child, their ability to consent (for example if the child is intoxicated) and their general best interests
- The timing of the examination should be agreed as part of the IRD process and it is not usually in the best interests of the child for this to take place between 20.00 and 08.00 unless there are medical needs of the child which require immediate attention

In non-recent sexual abuse:

- The referral should be assessed in the IRD according to the clinical need of the child or young person and requirements of the child protection process
- The timing of the medical examination should be decided by the best interests of the child in a trauma-informed way
- In some cases, when there is no forensic urgency, it may be a priority that the child has time to rest and prepare which may also allow more information to become available
- The majority of cases arise in working hours, and a comprehensive medical examination can be carried out locally and quickly
- Local arrangements must be in place for medical examinations out of hours where these differ from daytime and weekday arrangements

6.5 Photographic evidence

Images form part of the medical record and are retained by the NHS Boards. Therefore, NHS Boards are the data controller for the images. Images should be stored in line with legislative requirements set out in the Data Protection Act (2018) and the General Data Protection Regulation (GDPR). All images should be coded and stored securely with password protection. Informed consent to share photographs with criminal justice agencies should be sought on every occasion that photographs are taken. Sharing of images that form part of the medical record should only be done where there is informed consent or an order from a judge.

6.6 Documenting the examination

The national pro-forma must be used to document a full medical history, developmental history and examination. This includes the use of line diagrams to document the extent, description and measurement of injuries[45].

Formal reports should be produced within 28 days[46] and should include a clear summary of findings, interpretation of these findings in light of current evidence and a clear final opinion. Good practice is that a joint forensic report should be written and

[45] https://www.nature.com/articles/sj.bdj.2008.579
[46] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx

agreed by the paediatrician and forensic physician. Prior to that, the paediatrician and / or forensic physician may be contacted for information before the report is produced e.g. by the Reporter. There will also be a clinical letter to the child or young person's General Practitioner summarising the examination including indications, findings, investigations and suggestions for ongoing care.

7 Post-examination care

7.1 Follow up for health needs and other support

Sexual health screening and blood borne virus prophylaxis should be arranged by the attending paediatrician and communicated to the General Practitioner with appropriate consent from the child or young person, if that child is considered to be able to provide informed consent, and if not, their non-abusing parent / carer(s). Referral for follow up of healthcare or other needs and / or referral to the Reporter can take place throughout the process[47]. It is best practice to give a brief written summary of findings and outcome as well as a clear list of contacts for follow up at the end of the examination to the child / young person and their non-abusing parent / carer(s).

Children and young people who have suffered sexual abuse and their non-abusing parent / carer(s) should be supported to access any follow up healthcare services or support they may need. The General Practitioner and school nurse have an important role in helping with access to the necessary services.

7.2 Ongoing care to support recovery

Every child and young person who has experienced sexual abuse should be offered a trauma-informed and holistic needs assessment to consider whether they and/or their non-abusing parent / carer(s) need support[48]. The needs of each child and young person and non-abusing parent / carer(s) are unique. This may be provided directly by the NHS Board responsible for their care or through a statutory or third sector partner. The role of General Practitioners and school nurses as ongoing points of contact may be particularly important in this regard.

For some, the investigation of an allegation of sexual abuse results in relatively short-term contact with professionals. Others will go on to have a Child's Plan (GIRFEC) and/or be identified as needing additional support. Others find that they need to wait approximately 18 months for the case to come to court. For further information on GIRFEC, see Appendix F.

Access to trauma-informed support should be in place for every child and young person and their non-abusing parent / carer(s) following sexual abuse. This includes access to mental health services if required. This should be accessible from 0-16 years regardless of age or location. Children and young people and their non-abusing parent / carer(s) should have the ability to access therapeutic support in the future, even if they have previously not taken up an offer of support. Acknowledging that support plans are individual, the types of support required usually fall into the following categories:

Immediate Support for Young Person: Children and young people who have disclosed abuse can show signs of distress in a wide range of ways. Many have

[47] https://www.chip-partnership.co.uk/wp-content/uploads/2016/02/Guidance-on-Referral-to-Reporter-.pdf
[48] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx

difficult relationships with their peers, within their family, poor school attendance or difficulty coping in school in general. Some young people put themselves or others at risk of harm.

Immediate support post-disclosure can help children and young people to 'normalise' their daily life. Focusing on bringing positive changes to their particular issues – e.g. family relationships, school etc. enables the young person to get back to feeling more in control, more 'normal' and generally happier within themselves.

Immediate Support for Families: This may be particularly important when children and young people disclose familial abuse, there is often a need for immediate support to their non-abusing parent / carer(s) to help them consider safety issues and to deal with the consequences of the alleged abuse within their family. An allegation of familial sexual abuse is usually devastating for parents and can lead to crisis within the extended family.

It is not unusual for a young person who discloses familial abuse to find themselves in a family that is at breaking point. Some feel a strong sense of guilt and blame, especially where siblings are affected. Support for a non-abusing parent / carer(s) can help them to support their child(ren), offer guidance and empower them in careful decision making at what is an immensely stressful time. Support mechanisms for families are important, particularly for cases involving younger children.

Medium to Longer Term Recovery Support: Some children, young people and families will need support, to help them to make sense of their experiences and move on positively from familial sexual abuse. Some need this shortly after disclosure, whilst others find that they need this later in their life e.g. when they enter puberty or begin to have their first intimate relationships. Support to recover from the impact of childhood sexual abuse needs to be available when the young person needs it, for as long as they need it.

Local services must ensure sufficient continuity and coordination of planning and support for each vulnerable young person at risk of harm as they make their individual transitions to adult life and services. 'Transitions' may be considered by services to be a 'handover' between services, and yet for a young person they are multi-dimensional.

Advocacy Support: A child or young person and their non-abusing parent / carer(s) should be signposted to child advocacy services where these are available in the local area. A child's journey following suspected abuse is often hugely complex and confusing with them needing to move between different agencies and disciplines, telling and re-telling their traumatic experiences. They can be subject to a range of interviews and procedures, in a range of settings, by multiple professionals. Dedicated advocacy support for a child and their family provides a consistent source of information about what is happening and what to expect. In addition, advocacy ensures that the young persons are given the chance to say what they want to happen in decisions that affect them and ensures that families understand the process they

are involved in. Services vary between areas and may be provided by local authorities, health boards or third sector or a combination of providers. The need for advocacy is particularly important if a case proceeds to court for support to navigate the criminal justice process, e.g. help with providing a statement and attending court, and emotional support during the process.

8 Appendix A – Age of a child or young person

While child protection procedures may be considered for a person up to their 18th birthday, the legal boundaries of childhood and adulthood are variously defined. There are overlaps which are relevant when considering multi-agency plans and clinical pathways for a child or young person who may have experienced sexual abuse.

In Part 1 of the Children (Scotland) Act 1995, which deals with matters including parental rights and responsibilities, a child is generally defined as someone under the age of 18, but most of the provisions apply only to children under the age of 16. Chapter 1 of Part 2 deals with support for children and families and includes local authorities' duties in respect of looked-after children and children "in need". For these purposes, a child is also defined as someone under the age of 18.

The Children's Hearings (Scotland) Act 2011 contains provisions about the Children's Hearings system and child protection orders. Section 199 states that, for the purposes of this Act, a child means a person less than 16 years of age. However, this section provides qualifications.

- In the ground for referral to a hearing under section 67(2)(o) (failure to attend school), "child" means a person who is of school age, and school age has the definition in section 31 of the Education (Scotland) Act 1980.
- "Child" includes any child who has turned 16 after being referred to the reporter, until the reporter makes a decision not to arrange a hearing, or a hearing makes a decision to discharge a referral.
- Children who are subject to a Compulsory Supervision Order under the Act on or after their 16th birthday are also treated as children until they reach the age of 18, or until order is terminated if this occurs first.
- Where a sheriff remits a case to the Principal Reporter under section 49(7)(b) of the Criminal Procedure (Scotland) Act 1995, then the person is treated as a child until the referral is discharged, any compulsory supervision order in place is terminated, or the child turns 18, whichever occurs first.

Under the (Sexual Offences (Scotland) Act 2009 an adult is someone aged 16 years of age and over, an older child is defined as someone between the ages of 13 and 15 and a younger child refers to someone under the age of 13.

The Human and Exploitation (Scotland) Act 2015 defines a child as a person under 18 years in relation to the crime of trafficking. When s38 of this Act is implemented there will be a statutory duty on certain public bodies to notify Police Scotland about possible victims of human trafficking. The sexual abuse of trust offence applies to persons 18 and over who are in a defined position of trust (such as teachers, care workers and health professionals) intentionally engaging in sexual activity towards a person under 18 years (Sexual Offences (Scotland) Act 2009, s42). The Protection of Children and

Prevention of Sexual Offences (Scotland) Act 2005 also defines a child as a person less than 18 years in relation to sexual exploitation of children under the age of 18 through prostitution or pornography.

Under the Children and Young People (Scotland) Act 2014, a “child” is defined, for the purposes of all Parts of that Act, as someone who has not yet attained the age of 18. The individual young person’s circumstances and age will dictate what legal measures can be applied. For example, the Adult Support and Protection (Scotland) Act 2007 can be applied to over-16s when the criteria are met.

Under the sections 32(3) and 33(2) and (4) of the Education (Scotland) Act 1980, a person is of school age if he has attained the age of five years and has not attained the age of sixteen years.

Where a young person aged 16 and 17 requires support and protection, services will need to consider which legal framework best fits each persons’ needs and circumstances. Consideration must be given to the issue of consent. While it is inherently unfair to ask for consent for information sharing or an action when this must occur anyway, it is always appropriate to seek the views of the person, and to take these into account. In the vast majority of areas, the Mental Health (Care and Treatment) (Scotland) Act 2003 follows the Children (Scotland) Act 1995 in considering a child to be under the age of 18 but there are some specific provisions which define a child as being someone who has not reached the age of 16. This does not affect a young person’s ability to consent to medical treatment (see below), but this legislation ensures that additional safeguards are in place when a person aged under 18 needs compulsory care and treatment in relation to their mental health.

The Adults with Incapacity (Scotland) Act 2000 safeguards people who do not have capacity in relation to making decisions about their welfare and/or finances. This legislation applies to those aged 16 and over.

The Adult Support and Protection (Scotland) Act 2007 also applies to those aged 16 and over. An "adult at risk" is someone who:

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

An adult is at risk of harm if another person is causing (or is likely to cause) the adult to be harmed, or the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm. The entirety of a person’s particular circumstances can combine to make them more vulnerable to harm than others. This legislation primarily places an emphasis on support but also provides a framework for intervention if someone requires protection.

When it comes to a medical procedure or treatment, the Age of Legal Capacity (Scotland) Act 1991(section 2(4)) gives medical practitioners authority to make a judgement about the level of understanding of a child: "*A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.*"

Section 67 of The Children and Young People (Scotland) Act 2014 inserted a new section, 26A, into the Children (Scotland) Act 1995. From April 2015, a young person born after 1 April 1999 who is looked after in foster, kinship or residential care is eligible to remain in their current care placement until they turn 21. This is called Continuing Care.

9 Appendix B – Legal context

The links below provide further information on the legal context surrounding Children and Young People who have suffered sexual abuse:

Age of Legal Capacity Act 1991[49]

Children (Scotland) Act 1995[50]

Children's Hearings (Scotland) Act 2011[51]

Sexual Offences (Scotland) Act 2009[52]

Children and Young People's (Scotland) Act 2014[53]

Vulnerable Witnesses (Criminal Evidence) Scotland Act 2019[54]

Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill[55]

Adults with Incapacity (Scotland) Act 2000[56]

Female Genital Mutilation (2005): Prohibition of Female Genital Mutilation (Scotland) Act 2005[57]

Equally Safe: Scotland's strategy to eradicate violence against women[58]

Victims and Witnesses (Scotland) Act 2014[59]

Taskforce for the improvement of services for adults and children who have experienced rape and sexual assault[60]

National Trauma Training Framework[61]

Justice in Scotland: vision and priorities[62]

Scottish Government (1991) Age of Legal Capacity (Scotland) Act 1991[63]

Scottish Government (1995) Children (Scotland) Act 1995[64]

[49] https://www.legislation.gov.uk/ukpga/1991/50/contents
[50] https://www.gov.scot/publications/scotlands-children-children-scotland-act-1995-regulations-guidance-volume-1-support-protection-children-families/pages/1/
[51] https://www.legislation.gov.uk/asp/2011/1/contents
[52] https://www.legislation.gov.uk/asp/2009/9/part/4/enacted
[53] https://www.legislation.gov.uk/asp/2014/8/contents/enacted
[54] https://www.legislation.gov.uk/asp/2019/8/enacted
[55] https://www.gov.scot/policies/violence-against-women-and-girls/forensic-medical-services-for-rape-victims/
[56] https://www.legislation.gov.uk/asp/2000/4/contents
[57] https://www.legislation.gov.uk/asp/2005/8/contents
[58] https://www.gov.scot/publications/equally-safe-scotlands-strategy-prevent-eradicate-violence-against-women-girls/
[59] https://www.legislation.gov.uk/asp/2014/1/contents
[60] https://www.gov.scot/groups/taskforce-to-improve-services-for-rape-and-sexual-assault-victims/
[61] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx
[62] https://www.gov.scot/publications/justice-scotland-vision-priorities/
[63] https://www.legislation.gov.uk/ukpga/1991/50/contents
[64] https://www.legislation.gov.uk/ukpga/1995/36/contents

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Scottish Government (2009) Sexual Offences (Scotland) Act 2009)[66]

Scottish Government (2012) Child Protection Guidance for Health Professionals[67]

Scottish Government (2014) Victims and Witnesses (Scotland) Act 2014[68]

Scottish Government (2014) Children and Young People (Scotland) Act 2014[69]

Scottish Government (2017) Getting It Right for Every Child (GIRFEC)[70]

Scottish Government (2019) Vulnerable Witnesses (Criminal Evidence) Scotland Bill[71]

[65] https://www.gov.uk/government/publications/ms-no42018-council-of-europe-convention-on-the-protection-of-children-against-sexual-exploitation-and-sexual-abuse
[66] https://www.legislation.gov.uk/asp/2009/9/contents
[67] https://www.gov.scot/publications/national-guidance-child-protection-scotland-guidance-health-professionals-scotland/
[68] https://www.legislation.gov.uk/asp/2014/1/section/9/enacted
[69] https://www.legislation.gov.uk/asp/2014/8/contents/enacted
[70] https://www.gov.scot/policies/girfec/
[71] https://www.parliament.scot/parliamentarybusiness/Bills/108702.aspx

10 Appendix C – Children and Young People Pathway Subgroup Membership

Name	Role and Organisation
Debbie Ambridge	Service Manager, Archway, NHS Greater Glasgow and Clyde
Isla Barton	Regional Clinical Network Manager, North of Scotland Planning Group
Sandie Barton	Director of Operations, Rape Crisis Scotland
Detective Inspector Morag Bruce	Child Protection, Police Scotland
Vicky Carmichael	CMO Taskforce Deputy Unit Head, Scottish Government
Dr Marianne Cochrane	Joint Clinical Lead, North of Scotland Managed Clinical Network for Child Protection
James Cox	Children and Families Lead Social Work Scotland and Professional Adviser Scottish Government Child Protection Team
Angela Cunningham	Head of Service for Tayside Forensic and Custody Healthcare
Lucy Dexter	CMO Taskforce Deputy Unit Head, Scottish Government
Dr Edward Doyle	Senior Medical Adviser Paediatrics, Scottish Government
Dr George Fernie	Clinical Advisor to the Police Care Network Board
Rod Finan	Professional Social Work Adviser, Office of the Chief Social Work Adviser/Getting It Right For Every Child Team, Scottish Government
Dr Stephanie Govenden	Joint Clinical Lead, North of Scotland Managed Clinical Network for Child Protection
Dr Rachel Hewitt	Programme Manager , NHS Healthcare Improvement Scotland
Dr Sarah Hill	Clinical Lead West of Scotland Managed Clinical Network for Child Protection
Dr Kranti Hiremath	Forensic Physician, South East Scotland
Dr Niove Jordanides	Project Manager, NHS National Services Scotland
Dr Charlotte Kirk	Lead Paediatrician for Child Protection, NHS Lothian
George Laird	West of Scotland Sexual Health Network and Child Protection Network

Jamie Lipton	Principal Procurator Fiscal Depute, Crown Office and Procurator Fiscal Service
Dr Jane MacDonell	Clinical Lead East of Scotland Managed Clinical Network for Child Protection
Detective Superintendent Martin MacLean	Lead for Child Protection, Police Scotland
Dr Pauline McGough	Consultant in Sexual and Reproductive Health, NHS Greater Glasgow and Clyde
Dr Katherine McKay	Lead Paediatrician for Child Protection NHS Greater Glasgow and Clyde
Wendy Mitchell	Professional Advisor Early Years and Children Services, Scottish Government
Jack Murray-Dickson	Child Protection Policy Team, Scottish Government
Anna O'Reilly	Assistant Director Bairnshoose, Children 1st
Jennie O'Reilly	Project Support, Scottish Government
Gill Short	Scottish Children's Reporter Association
Lesley Swanson	Child Protection, Care, Protection and Justice, Scottish Government
Sarah Tait	Network Manager, East of Scotland Child Protection Managed Clinical Network
Dr Fiona Wardell	Team Lead, Standards and Indicators, NHS Healthcare Improvement Scotland
Dr Deborah Wardle	Lead Clinician, Archway, NHS Greater Glasgow and Clyde. Associate Post Graduate Dean, NHS Education for Scotland Forensics
Detective Sergeant Deborah Wicksted	Child Protection, Care Protection and Justice, Scottish Government

11 Appendix D – Prevalence of Child Sexual Abuse

It is difficult to estimate the prevalence of child sexual abuse in Scotland for a number of reasons. Children may not disclose abuse until many years after it took place. Patterns of recording and responding to abuse have changed over time. Studies undertaken have used varying definitions and methods, making comparisons difficult between countries and over time.

The prevalence of reported abuse is higher in self-reported surveys than in reports by health, police or social work services.

The Crime Survey for England and Wales (2019)[72] estimated that 7.5% of adults aged 18 to 74 years experienced sexual abuse before the age of 16 years; this includes both adult and child perpetrators. It also reported that around 4 in 10 adults (44%) who were abused before the age of 16 years experienced more than one of emotional abuse, physical abuse, sexual abuse, or witnessing domestic violence or abuse. This proportion is higher for women than men (46% compared with 41%)[73]. The Scottish Crime and Justice Survey[74] asks people about experiences they have had since the age of 16 so there are not comparable figures available for Scotland.

The scoping report published in 2019 by the CSA Centre of Expertise[75] summarises the variations in prevalence data for England and Wales and suggests that some 15% of girls / young women and 5% of boys / young men experience some form of sexual abuse before the age of 16, including abuse by adults and peers.

Recorded crime statistics in Scotland 2017-2018 indicate that at least 40% of the 12,487 sexual crimes recorded in 2017-18 by the police related to a victim under the age of 18. They also show an increase in online child sexual abuse, which includes grooming and exploitation[76].

[72] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childsexualabuseinenglandandwales/yearendingmarch2019
[73] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/childabuseextentandnatureenglandandwales/yearendingmarch2019
[74] https://www2.gov.scot/Topics/Statistics/Browse/Crime-Justice/crime-and-justice-survey
[75] https://www.csacentre.org.uk/csa-centre-prod/assets/File/CSA%20Scale%20and%20Nature%20full%20report%202018.pdf
[76] https://www.gov.scot/publications/recorded-crime-scotland-2017-18/

12 Appendix E – Roles and responsibilities

All professionals working with children and young people who have experienced sexual abuse should have completed the relevant trauma-informed training modules[77]. All staff should be trauma informed however further details on the level of trauma training for each role are noted below.

Police

The police are the lead agency with responsibility for criminal investigations relating to children who have suffered or are likely to suffer significant harm (physical, sexual or neglect).

Senior Investigating Officer (SIO)

An officer of Detective Inspector rank who has overall responsibility for the investigation of a serious crime. This will usually be the Detective Inspector of the Child Protection Team. In terms of trauma training, the SIO should be trained to a *trauma-skilled level.*

Inter-agency Referral Discussion (IRD) Sergeant

Usually of Detective Sergeant (DS) rank who undertakes the day-to-day police representation during IRDs:

- Will be responsible for assessing and deciding what information it is necessary, proportionate and justified to share with other agencies
- Conduct risk assessments in respect of all relevant children in child protection cases
- Makes decisions in conjunction with other IRD participants with regards to tasks and actions required in child protection cases
- Will provide a point of contact to professionals who require an understanding of what is happening in a criminal investigation

In terms of trauma training, IRD Sergeants should be trained to a *trauma-skilled level*

Investigating Officer

Usually a Detective Constable (DC) who will undertake joint investigations with social work (and other relevant agencies) conducting enquiries including (but not limited to):

- Joint Investigative Interviews (JII) of children*
- Attending joint paediatric forensic examinations and provide briefing to the paediatrician and forensic physician prior to the examination and obtain a debrief and initial opinion at the end of the examination
- Use of Emergency Child Protection powers (where required) to ensure safety of a child

[77] https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/national-trauma-training-framework.aspx

- Will take statements from witnesses (civilian and professional)
- Seize relevant productions and documents pertinent to the case
- Arrest suspected persons
- Report circumstances to COPFS and / or SCRA
- Attend multi-agency meetings relevant to the case

*Some areas of Scotland have dedicated officers whose only involvement in the child protection investigation is to undertake the JII of the child. At conclusion of the interview, they will pass the details over to the Investigating Officer and take no further part in the enquiry.

In terms of trauma training, Investigating Officers should be trained to a *trauma-skilled level* and *trauma-enhanced level* if also involved in the JII.

Children's Reporter

Children's Reporters are employed by the Scottish Children's Reporter Association. The reporter's primary function is to decide whether to refer a child (generally up to age 16 but up to age 18 in some circumstances) to a children's hearing. Any person may refer a child to the reporter if they consider a compulsory supervision order might be necessary for the child; local authorities and the police have a duty to do so. The reporter will investigate a referral as appropriate to determine whether there is sufficient evidence of any of the statutory grounds for referring a child to a children's hearing and, if so, whether there is a need for a compulsory supervision order. Investigation may include seeking information and reports from a range of persons such as social workers, teachers, health visitors and doctors. The Reporter will refer a child to a children's hearing only if satisfied as to the evidence of a statutory ground and the need for a compulsory supervision order. If the Reporter refers a child to a hearing, the Reporter prepares the 'statement of grounds' setting out the statutory ground and the supporting facts that the reporter believes apply.

If arranging a children's hearing for any purpose, the reporter gives notification and papers to those entitled to receive them. Within a children's hearing the reporter keeps the record pf proceedings and supports fair process, but decision-making lies with the panel members. If the child and relevant persons do not accept or understand the statement of grounds, the children's hearing may refer the statement of grounds to the sheriff for proof. The reporter conducts any proof proceedings, and also conducts any appeal to the sheriff against a decision of a children's hearing.

Social Worker

The social worker has joint lead responsibility along with an officer from Police Scotland for conducting a child protection inquiry agreed on and planned at the IRD. This will include interviewing a child who has been the victim of child abuse and / or neglect. This will happen under JII arrangements.

They have responsibility for child protection inquiries relating to children who have suffered or are likely to suffer significant harm, assessments of children's immediate safety and their wellbeing in the longer term. As the Lead Professional, they ensure coordination of the assessment, the identification of desired outcomes and actions to be taken by whom and by when within a single assessment and planning process. They are the key point of contact for family / carers / advocates / guardians and other professionals who as partners to the Child's Plan provide support and services to ensure the safety and wellbeing of the child.

The social worker will also assess the immediate safety and longer-term wellbeing needs of the child and assume the Lead Professional role for the coordination and delivery of the agreed desired outcomes in the Child's Protection Plan.

The longer-term coordination of the Child's Plan / Child's Protection Plan may be undertaken by a different social worker than the one who took part in the child protection inquiry. Local practice will vary in relation to this according to local child protection procedures.

As lead professional, social workers should be trained to a *trauma enhanced* level.

Paediatrician

With appropriate training and expertise in child protection, a paediatrician will:

- Contribute to IRD discussions, advise on the need for an examination along with the type of examination and timing. If an examination is not required record the reasons for that decision
- Gather relevant background information on the child and family along with a comprehensive medical history of the child
- Carry out the examination, if required, in line with relevant standards and guidance
- Provide or arrange for any immediate health needs to be met
- Make a detailed contemporaneous record of the examination and findings (if any)
- Arrange appropriate follow up and ongoing care
- Communicate with the General Practitioner and other health services as required
- Produce a report (jointly with forensic physician if a joint paediatric forensic examination has been performed) within an appropriate period
- Liaise with police and social work as required as part of ongoing child protection procedures e.g. in relation to a Child Protection Order
- Give expert evidence to a hearing or trial if required

In terms of trauma training, paediatricians should be trained to a *trauma-skilled* level.

Forensic Physician

A doctor responsible for the forensic aspects of a joint paediatric forensic examination, contributing to joint report with the paediatrician and, if required, giving evidence in legal proceedings. Doctors fulfilling this role for children or young people who may have experienced sexual abuse should have completed the NES *Essentials in Sexual Offences Forensic Examination and Clinical Management (Adults & Adolescents) - Best Practice for Scotland* training course and should be trained to a *trauma-skilled* level.

13 Appendix F – GIRFEC

All decisions relating to children's safety or wellbeing needs should be based on children's rights as articulated in the United Nations Convention on the Rights of the Child (UNCRC) and the principles of Getting It Right For Every Child (GIRFEC).

The GIRFEC approach supports planning for children and young people to promote, support and safeguard their wellbeing and to ensure that any action to meet needs is taken at the earliest appropriate time to prevent acute needs arising. GIRFEC provides a consistent and unified approach to identifying concerns, assessing needs, and agreeing actions and outcomes.

The GIRFEC approach is based on key principles which should continue to underpin any assessment and decision making in relation to a child or young person's wellbeing. This means always having the child or young person at the centre with meaningful input to discussions and decision making, along with their parents or carers where appropriate; considering the needs of the child or young person in the context of their family, unique world and circumstances, as well as their strengths and factors that affect their resilience. This ensures that support is accessible and responsive to the individual child or young person's needs and ensures that services work in partnership to provide a cohesive and coordinated network of support that is provided through a single planning process.

This support will also reflect the foundations of the Promise[78] to children and young people in Scotland contained in the seven reports of the Independent Care Review published in February 2020. Advocacy and therapeutic support will particularly relate to the following foundations:

- Voice: Advocacy and therapeutic support will actively listen to what a child or young person says they need and want and build that support package accordingly
- Family: Therapeutic support will also be provided to the non-abusing family members of a child or young person
- People: Advocacy and therapeutic support will actively support a child or young person to maintain relationships with people who are important to them from their family and wider community
- Scaffolding: Advocacy and therapeutic support will be available to a child or young person and their family from the right people at the right time as long as it is required

[78] https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

14 Resources

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[79] https://fflm.ac.uk/wp-content/uploads/documentstore/1352802061.pdf
[80] https://fflm.ac.uk/publications/guidance-for-best-practice-for-the-management-of-intimate-images-that-may-become-evidence-in-court-2/
[81] https://fflm.ac.uk/publications/guide-to-establishing-urgency-of-sexual-offence-examination/
[82] https://fflm.ac.uk/publications/guide-to-establishing-urgency-of-sexual-offence-examination/
[83] https://fflm.ac.uk/publications/fflm-quality-standards-for-doctors-undertaking-paediatric-sexual-offence-medicine-psom/
[84] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people
[85] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent
[86] https://www.ermcncp.scot.nhs.uk/wp-content/uploads/Standards-OIs_for_Child_Protection_Medical_Examinations_v1.pdf
[87] https://www.nes.scot.nhs.uk/our-work/trauma-national-trauma-training-programme/
[88] https://vimeo.com/274703693
[89] http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/sexual_assault_services.aspx

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NHS Health Scotland (2018) Gender Based Violence[91] [cited 27 October 2020]

NHS Health Scotland (2019) Adverse Childhood Experiences[92] [cited 27 October 2020]

NHS Lanarkshire (2015) Trauma and the Brain: Understanding Abuse Survivors Responses[93] [cited 27 October 2020]

Paediatric Care Online (2013) Child protection companion (2nd edition)[94] [cited 27 October 2020]

Royal College of Paediatrics and Child Health (2012) Peer Review in Safeguarding[95] [cited 27 October 2020]

Royal College of Paediatrics and Child Health (2015) The physical signs of child sexual abuse: an updated evidence-based review and guidance for best practice[96] (2nd edition) [cited 27 October 2020]

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[90] http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/sexual_assault_indicators.aspx
[91] http://www.healthscotland.scot/health-topics/gender-based-violence
[92] http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces
[93] https://vimeo.com/126501517
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[95] https://www.rcpch.ac.uk/resources/peer-review-safeguarding
[96] https://www.rcpch.ac.uk/shop-publications/physical-signs-child-sexual-abuse-evidence-based-review
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[98] https://www.rcpch.ac.uk/resources/service-specification-clinical-evaluation-children-young-people-who-may-have-been
[99] https://www.rcpch.ac.uk/resources/faculty-forensic-legal-medicine-fflm-guidance