RECOMMENDATIONS FOR REGIONAL SEXUAL ASSAULT REFERRAL CENTRES

Report of
A Department of Health
Working Group

August 2008

26 August 2008

Sir Liam Donaldson
Chief Medical Officer
Department of Health
Room 114, Richmond House
79 Whitehall
London SW1A 2NS

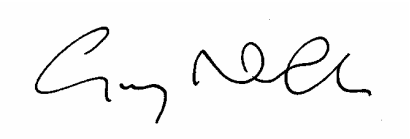
Dear Sir Liam,

Re: Recommendations for Regional Sexual Assault Referral Centres

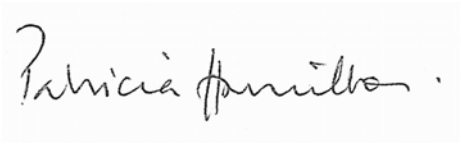
We have pleasure in submitting a copy of the above recommendations, which have the support of our respective organisations.

We request that the recommendations are given your fullest consideration.

Yours sincerely,

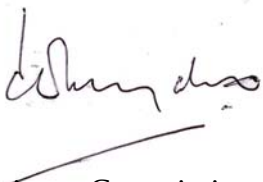


Dr Guy A Norfolk
President
Faculty of Forensic & Legal Medicine



Dr Patricia Hamilton
President
Royal College of Paediatrics and Child Health

Professor Sabaratnam Arulkumaran
President
Royal College of Obstetrics and Gynaecology



Assistant Commissioner John Yates
ACPO lead for Rape and Serious Sexual Offences involving adults

Professor Ian Gilmore
President
Royal College of Physicians

cc. Dr Harry Burns, Chief Medical Officer Scotland
Dr. Tony Jewell, Chief Medical Officer Wales
Dr Michael McBride, Chief Medical Officer Northern Ireland
Rt Hon Dawn Primarolo MP, Minister of State for Public Health

RECOMMENDATIONS FOR REGIONAL SEXUAL ASSAULT REFERRAL CENTRES

Contents

INTRODUCTION

1. In December 2006, guidelines were commissioned by the Department of Health and National Institute for Mental Health in England 'Complainants of Violence and Abuse Prevention Programme' (VVAPP) on behalf of the Department of Health as part of a cross government programme of research, policy and practice development working in partnership with the Home Office Sexual Crime Reduction Team and Complainants Unit.

2. The terms of reference of the Guideline Development Group (GDG) were:

   a) To draft guidelines for the forensic medical examination of adult complainants of rape and sexual assault.

   b) To ensure that there is a coherent and appropriate relationship between this and the existing guidance on forensic examinations in relation to possible child sexual abuse, one option being to combine them.

3. The President of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London was asked to chair the GDG, which comprised members of the other relevant Royal Colleges, Sexual Assault Referral Centre clinical directors, and representatives of the Association of Chief Police Officer, Home Office and the voluntary sector. A full list of the GDG members is attached at **Appendix A.**

4. These recommendations arose from the deliberations of the GDG.

5. Draft recommendations were prepared and presented to the full Guideline Development Group by a sub-group of practitioners working in the field. A list of sub-group members is attached at **Appendix B**.

CURRENT ARRANGEMENTS

Adult services

5. *The National Service Guidelines for Developing Sexual Assault Referral Centres*, published in October 2005, highlight the Sexual Assault Referral Centre (SARC) as a model of good practice in the provision of immediate aftercare to complainants of serious sexual violence. They were produced jointly by the Home Office and Department of Health because they are relevant to the police and health services in equal measure. Partnership working between these agencies, and with the voluntary sector, was recognised as being crucial in the provision of services to complainants of sexual violence, and in particular, to the success of SARCs.

6. Notwithstanding the drive towards collaborative working, services for the examination of adult complainants of sexual assault in England and Wales are predominantly provided and funded by the police.

Paediatric services

7. The provision of services for child or adolescent complainants of sexual abuse/assault varies considerably across the UK. Children and adolescents are seen in a variety of settings including non-dedicated inpatient or outpatient units in NHS Trusts, dedicated children's facilities in NHS Trusts, forensic suites or SARCs. Local services will depend on historical arrangements, local procedures and protocols, newly developed managed clinical networks, new commissioning arrangements between Primary Care Trusts, Practice Based Commissioning Groups and the Police, and the presence or absence of appropriately trained paediatricians or forensic physicians (FPs). Single or joint examinations (between paediatricians and FPs or other practitioners, such as genitourinary physicians) vary depending on the skills and competencies of individual examiners and local arrangements. The use of the colposcope is patchy; photodocumentation is of variable quality; and the availability of peer review and support is not uniform.

8. However, significant progress has been made to improve services and the required standards for practice are now embodied in the following texts:

- The joint Royal College of Paediatrics and Child Health (RCPCH) & Faculty of Forensic and Legal Medicine (FFLM) guidance (2007), which details the competencies and skills of practitioners undertaking paediatric assessments;
- The 'Child Protection Companion' (RCPCH 2006);
- 'Physical Signs in Sexual Abuse: an evidence-based review and guidance for best practice' (RCPCH March 2008);

9. Notwithstanding the above, there remains confusion in many parts of the country about who is responsible for arranging the first contact examination of adolescents who allege acute sexual assault. This confusion needs to be resolved.

RATIONALE FOR THE GUIDELINE

10. Services to complainants of sexual assault have become increasingly disparate across the UK, and there are problems ensuring minimum standards for forensic and medical examinations; clinical governance & quality assurance; and adequate training of staff.

11. Research published in 2006 identified the wide disparities in levels of service offered to complainants of sexual abuse (Pillai & Paul 2006). In particular, they highlighted both the inadequate number of FPs in some areas to provide coverage for examinations of children and issues around cross-contamination. In the non-SARC services studied, lack of co-operative working with local health services, lack of equipment, and lack of 'in house' medical follow up arrangements was the norm.

12. Many police forces now outsource the provision of forensic medical services. *Without Consent*, published jointly in 2007 by HM Crown Prosecution Service

Inspectorate and HM Inspectorate of Constabulary, examined five sites where services had been outsourced (two with SARCs and three without). Issues with the service provided included:

a) delays in examining the complainant because of an insufficient number of FPs being available;
b) inappropriate samples being taken;
c) poor facilities for examinations;
d) lack of understanding of the needs of the complainant;
e) lack of expertise to deal with sexual offences, in particular examinations of children, and thus no ability to supply the police with an expert opinion on their findings;
f) no evidence of succession planning for FPs who were close to retirement age; and
g) FPs recruited from abroad and employed on short-term contracts returning to their homes at the expiry of the contract, with inevitable consequences if their attendance is required at conference or at court.

13. Police prosecutors and members of the Bar expressed particular concern about the level of expertise of some of the FPs employed by the outsourced companies.

14. These guidelines have been developed to ensure that these practices are not allowed to continue, and that for complainants of rape and sexual assault, whatever their age, examinations are conducted in a sensitive, understanding and professional manner, by suitably trained physicians and paediatricians.

THE NEED FOR SERVICE IMPROVEMENT

15. In areas where SARCs have been established there is evidence of improved access to forensic and medical examinations and to psychological support for complainants of rape together with higher levels of user satisfaction with the services provided (Lovett, Regan & Kelly 2004).

16. However, in many police areas, sexual assault examination facilities are only used a few times each week which means that it may not be cost effective to develop the key service elements, namely:

a) Minimum standards for forensic and medical examination in all relevant healthcare settings;

b) Clinical governance & quality assurance;

c) Training and qualifications;

d) Follow through and on care with mainstream health services (GPs, community paediatricians, mental health care) and specialist voluntary sector services providing counselling and other therapeutic interventions;

e) Provision for meeting the needs of children experiencing chronic sexual abuse and the effects of historical abuse on adults;

f) Funding arrangements for forensic services.

REGIONAL SEXUAL ASSAULT REFERRAL CENTRES

17. This document sets out proposals for the development of regional centres of excellence, to be known as Regional Sexual Assault Referral Centres (RSARCs), which will address the key service elements listed above by organising and supporting:

a) initial training;

b) professional development;

c) quality assurance & clinical governance;

d) management of complex cases;

e) professional support;

f) court work;

g) research

18. The RSARC will be the epicentre for the management and training services, and the majority of examinations will be undertaken at this facility. However, a few Local

Sexual Assault Referral Centres (LSARCs) will be provided for those complainants unable to travel to the RSARC.

19. The staff of the RSARC will support and manage the infrastructure of a designated number of LSARCs. These arrangements will ensure that the maximum travelling time for a complainant is 120 minutes.

20. The GDG is currently unable to recommend an 'all age' model of service delivery through RSARCS as it is mindful of the fact that any proposed service model for children and adolescents should reflect the RCPCH discussion document 'Modelling the future' (Dec 2007). Although this discussion document recommends that services should be delivered through a Managed Clinical Network, which closely mirrors the adult model of Regional and Local SARCS presented in this paper, the detail of the RCPCH model requires further discussion and development.

21. However, in general terms, given that most pre-pubertal children present with concerns of historic abuse, which may be part of a complex picture of long standing significant harm, their needs will be best served if they are seen by doctors with appropriate knowledge and skills in dedicated paediatric centres. Conversely, adolescents alleging an acute sexual assault are likely to be seen, and to receive the most appropriate service, in a dedicated SARC.

22. Clearly, to meet the needs of all children there will need to be close collaboration between RSARCS and the regional paediatric services. In addition there need to be clear local protocols for the management of acutely assaulted children who need to be examined out of hours.

MEDICAL CARE OF THE COMPLAINANT

23. Both regional and local sexual assault referral centres must be able to provide the following medical aftercare: -

1) First aid for minor injuries;
2) Emergency contraception with an appropriate care pathway;
3) Pregnancy testing with an appropriate care pathway;
4) Prophylaxis for sexually transmitted infections with appropriate follow-up and care pathway;
5) Provision of, or referral for, Hepatitis B immunoglobulin and/or vaccination with appropriate follow-up and care pathway;
6) Provision of, or referral for, post-exposure HIV prophylaxis with appropriate follow-up and care pathway;
7) Screening for sexually transmitted infections when appropriate, for example when examining suspected historic assault/ sexual abuse.

24. The RSARC will ensure that counselling is available for all complainants of sexual assault. The counselling will be age appropriate for the individual and mindful that there may be a court case pending.

25. Service level agreements may need to be in place to allow for follow up at the complainant's local genito-urinary clinic where this is appropriate.

26. With the consent of the adult patient, details of the aftercare provided should be communicated to the complainant's General Practitioner. With adolescents under 18 years, local child protection guidelines, including information sharing protocols, will be followed.

27. For further information on the medical needs of complainants of rape and sexual assault please see guidance entitled Medical Care Following Sexual Assault: Guidelines for Sexual Assault Referral Centres (SARCs).

CLINICAL DIRECTOR

28. Each Regional Sexual Assault Centre will have a Clinical Director. The Clinical Director will hold responsibility for ensuring the provision and maintenance of a high quality, appropriate medical service to Centre clients. The post holder will form part of a team consisting of a manager, administrator, forensic physicians, forensic nurses, crisis workers, independent sexual violence advisors and counsellors working alongside other medical personnel, police officers and statutory and voluntary agencies. The Clinical Director will play a key role in the development of the Centre, and make a significant contribution to the Centre's strategic planning, policy formulation and to achievement of the Centre's objectives.

29. A draft job description for the Clinical Director is given as Appendix C.

FORENSIC PHYSICIANS

30. Forensic physicians who undertake sexual assault examinations will be recruited from doctors who have acquired appropriate sexual health and/or paediatric competencies during at least three years speciality training in one or more of the following disciplines: -

    a) Genito-urinary medicine;
    b) Obstetrics and Gynaecology;
    c) Paediatrics;
    d) Sexual and Reproductive Health;
    e) Accident and Emergency;
    f) General Practice;
    g) Clinical Forensic Medicine.

31. They will be expected to undergo the training described in the matrix in Appendix D.

32. The recruitment process will ensure that there is always a female doctor available.

33. The contracted hours will depend on the service needs and must take account of how court appearances impinge on a FP's time.

CAREER PROGRESSION

34. Forensic physicians will be actively encouraged to obtain a higher qualification in clinical forensic medicine and, in order to improve retention, such qualifications will lead to substantive appointments within the RSARC with an appropriate change in the pay scale.

Proposed Diploma in Sexual Assault ⇨ Staff Grade

Membership of the Faculty of Forensic and Legal Medicine ⇨ Associate Specialist

TRAINING POSTS

35. Regional Sexual Assault Referral Centres that wish to provide training opportunities for post-foundation doctors will have to seek accreditation from the FFLM. Such posts will normally only be approved if the RSARC is within a teaching hospital.

36. These posts will only be available to doctors with at least six months full-time post-foundation (or 12 months part-time) experience.

37. Although, after appropriate training and experience, trainee doctors may be deemed competent to undertake examinations independently they will have constant supervision and a defined route to a second opinion from the Clinical Director, a Trainer or a RSARC Associate Specialist or Staff Grade doctor.

TRAINERS

38. Trainers will have at least **five years experience** in sexual offence examinations (adults and children); membership of the Faculty of Forensic and Legal Medicine; evidence of attendance at a 'training the trainers' course; and experience in training.

OTHER KEY STAFF:

FORENSIC NURSES

39. Forensic nurses have an accepted role supporting the examinations.

40. Forensic Nurses with appropriate seniority, experience and training (including in bimanual examinations) will be able to undertake examinations of adult complainants independently. Nurses who will be working independently would be required to participate in the same training as the forensic physicians (see matrix).

CRISIS WORKERS

41. Crisis workers will be available for all examinations of complainants of sexual assault and will provide telephone support and information and crisis management to complainants attending for a forensic medical examination.

SARC MANAGER

42. The SARC manager will be directly responsible for the strategic and operational management of the regional and local sexual assault referral centre, delivering national and local targets and quality standards within a defined budget.

ADMINISTRATOR

43. The administrator will provide full administrative support relating to the full range of services provided by the RSARC and to the RSARC Manager, Clinical Director, counselling and forensic teams.

44. The administrator will deal directly with individual enquiries from clients, police officers, forensic physicians and other professionals, providing information within the terms of confidentiality policies. He/she will receive clients and visitors into the RSARC and ensure appropriate communication with team members.

FUNDING

45. It is recommended that funding for the proposed sexual assault examination services would be provided through Department of Health commissioning arrangements. This will ensure that the service becomes incorporated into NHS clinical governance arrangements thus facilitating closer integration with the paediatric services.

46. Police forces would enter into service level agreements with the commissioning authorities to fund police referrals to the service.

REFERENCE MATERIALS

HM Crown Prosecution Service Inspectorate and HM Inspectorate of Constabulary (2007). *Without Consent – a report on the joint review of the investigation and prosecution of rape offences.* HMIC: London.

Home Office (2005). *Medical Care Following Sexual Assault: Guidelines for Sexual Assault Referral Centres.* Home Office: London.

Home Office and Department of Health (2005). *The National Service Guidelines for Developing Sexual Assault Referral Centres.* Department of Health: London.

Lovett J, Regan L, Kelly L (2004) *Sexual Assault Referral Centres: developing good practice and maximising potentials*. Home Office Research Study 285. Home Office: London.

Pillai M, Paul S (2006) *Facilities for complainants of sexual assault throughout the United Kingdom*. Journal of Clinical Forensic Medicine 13: 164–171.

Royal College of Paediatrics and Child Health (2006). *Child Protection Companion.* RCPCH: London.

Royal College of Paediatrics and Child Health and The Faculty of Forensic and Legal Medicine (2007). *Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse*. FFLM: London.

Royal College of Paediatrics and Child Health (2008). *The Physical Signs of Child Sexual Abuse: an evidence-based review and guidance for good practice*. RCPCH: London.

APPENDIX A

MEMBERS OF THE WORKING GROUP

Omar Abu-Rish Staff Officer to ACC Hapgood

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Fay Maxted The Survivors Trust

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Rosalyn Proops Royal College of Paediatrics and Child Health

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APPENDIX B

MEMBERS OF GUIDELINE DEVELOPMENT SUB-GROUP

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Jan Welch

Clinical Director, The Haven, Camberwell

Cath White

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APPENDIX C

EXAMPLE OF JOB DESCRIPTION OF CLINICAL DIRECTOR

The Clinical Director will be funded for a minimum of two programmed activities per week to provide protected time for teaching and research in addition to their clinical and managerial duties (as described below).

- **Professional Responsibilities**

1. To provide a high quality medical service to SARC clients;

2. To guide the RSARC & LSARC teams and offer a clear strategic lead to the development of service plans that meet local and national targets relating to the field of sexual assault;

3. To lead and provide clinical supervision of the forensic team to ensure that the medical needs of the client are met;

4. In liaison with the RSARC Manager, manage the performance of the RSARC, both in terms of the efficient and effective use of all resources and the development and maintenance of the highest standards of client care and delivery;

5. To work in partnership with senior managers responsible for the provision of LSARCs to ensure the efficient and effective use of all resources and the development and maintenance of the highest standards of client care and delivery;

6. To involve all staff in the development of client services and harness their commitment to the achievement of agreed performance targets;

7. To oversee the delivery of the Clinical Governance agenda for the RSARC & LSARCs and ensure that Job Plan reviews and appraisals for all medical staff are undertaken and personal development plans formulated as appropriate;

8. To carry out forensic medical examinations at the request of police and self referral clients, GPs, Social Workers and others where appropriate;

9. To supervise the training of the forensic team;

10. To initiate and take part in research related to the work of the Centre;

11. To participate in national and international educational meetings.

Potential applicants will be able to demonstrate the following **qualifications and experience:**

- at least five years experience in examining adult and child complainants of sexual offences;
- Membership of the Faculty of Forensic and Legal Medicine;
- skills in management and managing change;
- experience of teaching;
- evidence of leadership;
- evidence of having acted as an educational supervisor
- experience of working in a multi-agency environment.

APPENDIX D

TRAINING FOR FORENSIC PHYSICIANS

Post	Training And Maintaining Competence	When?
All Doctors	• Adult forensic course* • Paediatric forensic course* * Approved by the FFLM (and others e.g. RCPCH, RCOG)	Before starting at RSARC or before starting independent work
All Doctors	• Structured induction to RSARC with documentation of completion • Structured induction to Trust • Shadowing until deemed competent to lead examination by Trainer or Clinical Director* • Supervision of examinations until deemed competent by Trainer or Clinical Supervisor* • Statement writing training (with ongoing support for writing statements until deemed competent by clinical director) • GU skills unless already competent * The doctor will have been supervised for a least two adult/young person cases and ten child cases (<12 years) plus attendance at peer review meetings for one year before working independently in the respective field	Commencement
All Doctors	• Witness skills training* • Criminal justice interface training * Approved by the FFLM	Within 6 months of starting on call
All Doctors	• Basic life support • Infection control • Other mandatory training	Yearly
All Doctors	• Conducting a minimum of 20 forensic examinations (unless on agreed leave, e.g. maternity leave, when initial examination on return should be supervised) • Attend 50 hours per year of continuous professional development with relevant content e.g. forensic awareness • To include a minimum of 4 peer review meetings • Annual appraisal with line manager	Yearly
All Doctors	• Attendance at 1 day 'best SARC practice' course	At least every 3 years
Experienced Hospital Practitioners	Meeting with supervising doctor	At least every 6 months
Doctors In Training (e.g. Junior Clinical Fellows, GP Trainees)	Attendance at relevant training sessions and courses as agreed in job description/with supervising doctor e.g. GP teaching, family planning course etc	As agreed
Staff Doctors And	Courses on:	As agreed in PDP with

Associate Specialists	• Management • Teaching • Appraisal • Research methods • Statistics • IT	supervising consultant

Each doctor will be allocated a training budget to be used for courses and training approved by the Clinical Director.