Sexual Assault Referral Service Needs Assessment Report

Sexual Assault Referral Service Stakeholder Group

June 2017
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Executive Summary

The Sexual Health Executive Steering Group was developed to refresh the sexual health strategy. The group agreed priority areas to undertake needs assessments that will inform the strategy, including the sexual assault referral service (SARS) where there are known gaps and issues around forensic services, and a lack of integrated partnerships and shared commissioning of the local SARS. To monitor progress and prepare for the SARS needs assessment a SARS Project Steering Group and a wider SARS Stakeholder Group were created respectively. The majority of the needs assessment was then undertaken by three further sub-groups of the Stakeholder group who gathered the necessary data and information.

Across the UK, sexual assault referral centres (SARCs) have been developed for claimants of sexual assault. These are specialised services which cover large catchment populations and are generally located in urban areas. Public Health England co-commission SARCs with police, local authorities and clinical commissioning groups as one of the public health functions under s7A of the Health and Social Care Act. On the island there is no SARC, and the SARS that is available is commissioned solely by the Isle of Man Constabulary, Department of Home Affairs, which would not be regarded as the best model for claimants of sexual assault.

The Public Health Outcomes Framework indicators show a lower rate of violence offences as well as sexual offences when compared to England. However, despite the proportion of recorded violent crimes reducing on-island, the proportion of recorded sexual offences has increased. The majority of rapes and sexual assaults reported to the police are from the under 25’s at time they reported to police, when compared to the time of incident this same age group is still in the majority but at increased numbers. For those under 13 at the time of the incident, almost all rapes are recorded as historic as are a high number of the sexual assault reports highlighting that during this data collection period the majority of under 13s did not report until later. Similarly, the majority of sexual assault claimants accessing the Genito-Urinary Medicine (GUM) or Victim Support service are under 25. It is important to note the upward trend of those presenting to GUM and Victim Support who have not been referred by the police.

The services offered on-island are not widely known or publicised to the public or across universal services, so when a disclosure is made, the claimant may not be fully informed of what is available. Instead, the support they receive may depend on where/who they disclose to, and that person’s knowledge of the services available. If the disclosure is made to the police, the claimant is more likely to receive information on the process and the support available, as the current SARS is run through the police. Raising awareness and promoting sexual assault provision and ease of access to services are priorities on-island. Not only for those who are claimants so they know there is support available, but also to raise public awareness of sexual assault to help boost public confidence in both the health and criminal justice systems.

If the sexual assault was recent and a formal complaint has been made to the police, the claimant will be offered to undertake a sexual assault forensic medical examination (SAFME). The current facility in which a SAFME is undertaken is within Thie Yn Lheihys, which is only available for those who have reached puberty. It is important to note that if no police investigation occurs, there is no way for the SAFME to be carried out and forensics stored to enable the claimant to make a
complaint at a later date if they wish to do so. Statistics show that only approximately 11% of sexual assault is reported to the police resulting in a high number of potential claimants who do not receive appropriate care. Further, there are concerns with the SAFMEs only being available during the evenings and weekends due to the current sexual offence forensic medical examiners (SOFMEs) working fulltime during the week. There are also concerns for accountability as there is no contract in place for the SOFMEs.

All pre-pubescent children and young people who require a SAFME are required to go off-island. This is usually to either the preferred SARC option, St Mary’s in Manchester or the Safe Centre SARC in Preston, with their best evidence interview undertaken upon their return to the island. Following this, a social worker will continue to support the claimant and family. Whether or not the pre-pubescent claimant requires a SAFME, there would be a joint investigation between social care and the police under Section 46 of the Children and Young Persons Act 2001. If the claimant was an adult who lacks capacity, safeguarding concerns will be referred to Adult Social Care by the police. However, there is no framework in place for this, nor is there any formally agreed pathway or process comparable to the position of children and young people.

Following a sexual assault, claimants will be signposted to attend the GUM service for sexually transmitted infection and HIV screening. If the claimant is female and has become pregnant as a result of rape, the Safeguarding and Vulnerable Women’s midwife will arrange a one to one meeting with the claimant. Additional support will be offered, and whether or not the women wishes to terminate the pregnancy discussed. Data gathered from the focus groups highlights that the system is not client-led with various concerns raised, including the lack of understanding for the 1995 Termination of Pregnancy (Medical Defences) Act. At present, termination of pregnancy can be carried out in certain circumstances including cases of certain sexual crimes. However, there are requirements that need to be complied with which may not be affordable or appropriate for the claimants’ wellbeing, whereby they have to disclose to so many people and different services.

There is a lack of third sector services supporting claimants of sexual assault, which reflects the limited commissioning from the Isle of Man Government. There is emotional and practical support for claimants of sexual assault via Victim Support, but there is no specific psychological support on-island. For best practice, the key roles that are usually provided by the third sector not currently available on-island include crisis workers and independent sexual violence advisors. The crisis workers can deliver immediate confidential, emotional and practical support to claimants throughout the initial stages of the claimants’ disclosure. The main role of an independent sexual violence advisor includes making sure that claimants of sexual assault have the best advice on which counselling and other services are available to them, the process involved in reporting a crime to the police and journeying through the criminal justice process, should they choose to do so. NHS England (2016) recommends that claimants of sexual assault should have a choice of care provision for on-going support and counselling. Improving access to psychological therapies, level three support, should be available either via the SARS, or be commissioned out to relevant services to offer support in a timely manner. Only if the claimants’ needs exceed this level of support, will the claimant need to be referred to the community Mental Health Service or an acute service.
Due to there being no formal contract for the SOFMEs, the on call budget is split between the two available SOFMEs with call outs being paid in addition to the on call fee. Ensuring a formal contract is in place will enable a fair system whereby an agreed retainer is paid. Victim Support have a service level agreement with the Department of Home Affairs where they receive a grant to support victims of crime, but this includes all crime and not just for claimants of sexual assault. For the police force and relevant social care teams, there are no staff employed solely for sexual assault, any cases will be covered under the general operations. If a pre-pubescent claimant travels off-island for a SAFME, a police officer and social worker will also attend, which is an additional cost for their time.

All local areas, whether or not they have a SARC, should ensure they meet the bare minimum points, including the opportunity for claimants to access SARC services as self-referrals, and the choice of whether or not to involve the police. These are NOT offered locally, which will need to be addressed for the new pathway and service specification on-island, for any of the options chosen. Through assessing the current SARS against the quality assurance standards and key minimum elements it has been established that the island doesn't meet any of the standards; it is only partially working towards a few, with the majority of standards not being met at all. This is for adults and pubescent young people, as well as the pre-pubescent children and young people.

To gather a clear understanding of the current SARS and gaps in provision, perceptions were sought from a number of professionals working in the field. Due to ethical reasons, those who have previously made a claim of sexual assault, as well as the general public were not approached. Instead, professionals working in the field were invited to attend one of the focus groups and/or provide anecdotal feedback. All of this data has been combined, resulting in four overarching themes: service integration; communication and efficiency; support services; and service access. The majority of the sub-themes that have emerged from these are areas that have been identified as gaps when benchmarking the current service against best practice.

Numerous gaps in the SARS service have emerged throughout this needs assessment. The more substantial gaps are focused around the lack of a formalised pathway between services; accessibility of the SARS; forensic evidence and decontamination protocols; availability of, support for and contract for the SOFMEs; support during and following the disclosure for claimants; and service awareness for the general public. To minimise these gaps, four potential pathways have been generated for a SARS we can offer on-island. As the current service is not meeting any of the quality standards, there is no option to avoid change. The unacceptability of the current situation and need for change has been recognised as a priority by the joint Safeguarding Children Board and the Safeguarding Adults Partnership and by the acting Designated Doctor for Safeguarding Children. The four pathway options include: SAFME on-island; SAFME commissioned from a SARC off-island; Hybrid model – SAFME for adults on-island, SAFME for pre-pubescent children off-island; or SAFME on-island by an off-island examiner. All pathway options meet the bare minimum standards and have strengths and weaknesses highlighted as well as an example overview pathway; the required changes; resources; and costs to consider.
Introduction

The sexual health strategy is out of date and previous attempts to renew this have been limited in scope and driven by the need to react to specific issues. This earlier work identified a wide range of issues and emerging concerns which led to the development of the Sexual Health Executive Steering Group. Initially the Steering Groups aim was to undertake a joint strategic needs assessment (JSNA) to develop key objectives for an updated sexual health strategy covering a comprehensive range of sexual health priorities. However, due to lack of funding this approach was put on hold and instead two areas were identified for fast tracking as needs assessments. These included Sexual Assault Referral Services (SARS) where there are known gaps and issues around forensic services, as well as the Integrated Sexual Health Services (ISHS) where staffing and sustainability issues were highlighted. This report is in regards to the SARS needs assessment, the ISHS needs assessment report is available on request.

One of the main gaps driving this needs assessment is the lack of integrated partnerships and shared commissioning of the local SARS. During the last decade, various reports have highlighted the need for access to high quality services to secure the best possible outcome for claimants’ of sexual assault within available resources. This includes the report ‘responding to violence against women and children – the role of the NHS’ which highlights the importance of meeting the needs of claimants’. When Public Health England (PHE) was established in 2013, it had delegated authority to commission Sexual Assault Referral Centres (SARCs) as one of the public health functions under s7A of the Health and Social Care Act. Supporting best practice, they proceeded via co-commissioning with police, local authorities and clinical commissioning groups. On the island there is no SARC and the SARS that is available is commissioned solely by the Department of Home Affairs (DHA) which would not be regarded as the best model for claimants’ of sexual assault.

1 Terms of reference for the Sexual Health Executive Steering Group are available on request. For membership details of this group refer to acknowledgements.
2 The term ‘claimant’ refers to a victim/survivor of sexual assault who has made a disclosure. This may also include those who make false disclosures of a sexual assault.
3 ‘Sexual assault’ is the blanket term that will be used predominately to refer to rape or any form of sexual violence, sexual offence or sexual abuse. Throughout this document the terms may be used interchangeably and not necessarily always according to their technical or legal definitions. For a ‘sexual assault’ definition refer to the glossary.
6 For a SARC definition refer to the glossary.
To monitor the progress of this needs assessment, the Sexual Health Executive Steering Group created a SARS Project Steering Group consisting of the relevant departments – Department of Health and Social Care (DHSC) and DHA. The Project Steering Group agreed to establish a wider SARS Stakeholder Group including members from different services within the departments; as well as services from other departments, such as the Department of Education and Children (DEC); and the third sector. Engagement from the Stakeholder group has ensured terms of reference were created and followed, along with a project charter where the project was scoped out thoroughly (see Appendix 1). Some of the stakeholders also supported one or more of the three sub-groups that were created to undertake the majority of the data gathering for the needs assessment; the results of which are included within this report identifying the gaps and providing pathway options to enable the creation of a clear service specification.

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7 For membership details of the SARS Project Steering Group refer to acknowledgements.
8 Terms of reference for the SARS Stakeholder Group are available on request. For membership details of this group refer to acknowledgements.
9 The three sub-groups include:

- **Quantitative statistics** - To gather quantitative statistics to cover population demographics and epidemiology/rates of specific STIs; HIV; contraception; and teenage pregnancy, with trends and future projections where possible.
- **Current Services** - To map current services and pathways; benchmark against best practice/quality standards, current activity and cost; and identify the gaps.
- **Qualitative data** - To gather qualitative data to cover service user and provider needs/views on sexual health services on the Isle of Man.
1. **Epidemiology**

1.1 **Public Health Outcomes Framework Indicators**

The relevant Public Health Outcomes Framework (PHOF) indicators are highlighted below and are based on police recorded crime data, per 1,000 population.

- Crude rate of violence against the person offences
- Crude rate of sexual offences

For 2014-15, the rate for the island was 6.8% of violence offences compared to England’s rate of 13.5%, and the island rate for sexual offences was 0.7%, compared to 1.4% for England, see Figure 1.

![Violence and Sexual Offences](image)

**Figure 1. The Isle of Man rate of violence and sexual offences per 1,000 population**

*Source: Data used in the calculation of this indicator is from the DHA, Chief Constables Report (2016)*

Violence offences include assault; domestic assault; public order offences; and sexual offences. In total there were 574 recorded violent crimes in 2014/15 reducing to 564 in 2015/16. However the proportion of recorded sexual offences has increased from 60 to 77 – which is an increase from 10.5% to 13.7% of recorded violent crimes. Please note, these figures are likely to be an under-representation due to a low number of crimes being reported, particularly in cases of domestic abuse.
Quantitative data has been gathered from the Police, GUM and Victim Support (VS) for the six year period 2010 to 2015, with some data for 2016. This has then been split into the following age ranges: 0-12; 13-17; 18-24, and then in five year increments. Due to small numbers for some age groups, it is not possible to show the full breakdown of this data, in order to preserve confidentiality. Consequently, most figures reported will be using aggregate totals.

1.2 Police

Police data has been split into two crimes: rape and sexual assault (which includes indecent assault and gross indecency).

The majority of rapes reported to police were from the 13-24 year age group at the time of reporting, with 65% of all reports being from the under 25s. When we compare this to the age at time of the incident, it is still the 13-24 year age group that are the majority (71% are under 25). However, the proportion of under 13s increased, with 92% of rapes in the under 13s being recorded as historic. This highlights that previously, the majority of under 13s did not report until later, however it is not possible to state that this is still the current situation.

The majority of sexual assaults were reported by those under 25 years old (69%). When comparing this to age at time of incident, it rises to 79% with a third being under 13 years old. Of the sexual assault reports that were classed as historical, 78% were under 13 years old at the time of the incident.

1.3 Sexual Assault Forensic Medical Examination

Data was requested for the number of SAFMEs undertaken both on-island and for the pre-pubescent children who travel to a SARC off-island. Unfortunately this data was not provided during the timeframe for this needs assessment. Anecdotally, one of the SOFMEs suggested approximately 12-20 SAFMEs are undertaken on-island annually.

1.4 Genito-Urinary Medicine

Genito-Urinary Medicine (GUM) is a key service for claimants of sexual assault, as they are at an increased risk of obtaining a sexually transmitted infection and/or HIV. Data for the islands GUM clinic is recorded for any form of sexual assault including rape, and cannot be separated. No one under the age of 13 accessed GUM services for sexual assault. The majority of sexual assault claimants accessing the GUM service are among the 13-24 year age group (56%), with 70% of all those accessing GUM services being under 30. Over the last six years, on average, 60% of sexual assault attendances had not been referred by the police. It is unknown how many of these (if any) went on to involve the police.

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10 Historical reports are those where the incident occurred more than a year before the report was made.
1.5 Victim Support

VS were able to separate their data into age at time of accessing the service and age at time of incident, as well as by rape and indecent assault. 88% of those supported by VS knew their perpetrators well as a friend or family member. The majority of claimants of rape who accessed VS were in the 18-24 year age group at the time of access. This same group is also the majority for those who accessed the service at the time of the incident. 51% of those accessing services were aged under 25 at the time of access.11 60% of those accessing services were aged under 25 at the time of the incident.12 For indecent assault, the majority of claimants were again in the 18-24 year age group at the time of access. However, the majority were in the 0-12 year age group at the time of the incident, which again highlights that children generally haven’t reported until later. 54% of those accessing services were aged under 25 at the time of access. 80% of those accessing services were aged under 25 at the time of the incident. Over the last six years, on average, 64% of rapes and half of all indecent assaults had not been referred by police.

1.6 Trends

Over the recent years, there has been a gradual increase of the number of reports and referrals to the police regarding sexual assaults, as shown in Figure 2 overleaf. The Police Public Protection Unit (PPU, which is responsible for investigating sexual and physical abuse towards children and vulnerable adults and all rape cases) has reported a 110% increase over the past year in referrals to their unit (not all referrals have resulted in investigations).

The Chief Constable supports this and suggests that:

"...victims feel sufficiently confident to come forward and place their trust in us. Reporting of high-profile cases in the UK has helped in this regard, but so has the excellent local media coverage of Isle of Man cases. This includes those where lengthy prison sentences were handed out to offenders who damaged the lives of vulnerable young people, sometimes as long as 40 years ago."13

11 65% were aged under 30
12 79% were aged under 30
When we look at three-year rolling averages, it is evident that the trend for reports of rape is steadily increasing, and the trend for reports of sexual assault is overall increasing, but not at such a rate as that for rape reports, see Figure 3.

Looking at the trends across the age groups in Figure 4, the most significant increase has been with the over 25s, with the 18-24 year group also showing an increase. This is important when considering the age of those presenting to the police.
However, the picture is slightly different when we look at trends across the age groups for the age at when the incident occurred, see Figure 5. The over 25 age group have remained almost constant, with all other age groups increasing, most significantly in the under 18s, which supports an increasing number of adults reporting childhood incidents.
GUM numbers remain fairly similar over the years as shown in Figure 6, but there is only limited capacity within the service (we have no way to measure the unmet need for this service).

![Number of Sexual Assault claimants attending GUM](image)

**Figure 6. Number of sexual assault claimants attending Genito-Urinary Medicine**

*Source: Calculated using data supplied by GUM*

There is however an upward trend of those presenting to GUM who have not been referred by police, see Figure 7. For 2015 this was 88% of referrals, based on 17 claimants in total.

![% of Sexual Assault claimants who disclosed to GUM](image)

**Figure 7. Percentage of sexual assault claimants who disclosed direct to Genito-Urinary Medicine**

*Source: Calculated using data supplied by GUM*
VS trends show an increase in claimants of rape accessing services, and a significant increase in the number of claimants of indecent assault. Please note, the numbers of claimants accessing VS services during 2015 cannot be disclosed due to small numbers and therefore potential for identification of individuals, see Figure 8.

![Numbers accessing Victim Support services](image)

**Figure 8. Number of claimants accessing the Victim Support service for rape or indecent assault**  
*Source: Calculated using data supplied by VS*

Similarly to GUM, there are a large proportion of claimants who have not been referred to the VS service via the Police, see Figure 9. Although this doesn’t show the same upward trend as for GUM, it is still worthy of note.

![% of Sexual Assault claimants who disclosed to VS](image)

**Figure 9. Percentage of claimants who disclosed direct to Victim Support**  
*Source: Calculated using data supplied by VS*

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14 The 2016 data is only for January to June of that year.
2. Current Services and Pathways

Currently, there is no agreed pathway for SARS that can be shared with the public and followed by all services on-island. If an individual is sexually assaulted, it is difficult for them to find out the local support available to make informed choices about disclosing the assault. The claimant may not know where to disclose to or seek help, and the support they receive may depend on where/who they disclose to, and that person’s knowledge of the services available. Whilst there is no formal published pathway available, current practice (once a claimant makes a disclosure) is reflected in the pathway in Figure 10, based on discussions during the focus group sessions.

![Figure 10. Disclosure process](source)

Figure 10 shows the process that the highlighted services may take when a disclosure is made. This does not include the full police process shown in Figure 13 in the following section. Without including the police process, it is clear that there is only minimal support available for a claimant. As mentioned previously, the services offered are not widely known or publicised to the public or across universal services, so when a disclosure is made, the claimant may not be fully informed of what is available.

The disclosure process highlighted is just an overview of the current process, and the following section looks more in detail at the approach for different services. However, it is important to note that in regards to children and young people, there is a pathway in place with safeguarding playing a key role. Whether or not this pathway is implemented or consistently followed is unknown as there is no evidence to show it is. Figure 11 highlights the pathway. In regards to children and young people, there is a pathway in place in accordance with the Safeguarding Children Board safeguarding procedures. The police and social care are confident this pathway is followed for all cases known jointly to both services.
Although this formal pathway exists, there is no evidence to show it has been signed off by any of the appropriate partner organisations. It is also very brief and requires updating to a clear process, avoiding statements such as 'whenever possible'. Some of the issues with this pathway include: where the examination will take place – this should be based on pubescence and not age, and the Safe Centre SARC in Preston is mentioned as the first choice, however St Mary’s in Manchester is supposedly used more frequently. Also, it mentions the social worker must attend the examination with the child, but this does not occur. However, it does indicate the intention that the police and social care should work together to support the child/young person as discussed in detail in the following section. The pathway is supported by procedures for child protection medicals signed off by the Safeguarding Children Board.
2.2 Services in detail

Across the Isle of Man (IOM), the services which currently have sexual assault as part of their remit are shown in Figure 12 followed by an explanation for the service offered.

Figure 12. Isle of Man current sexual assault related services
2.2.1 Police

There are police stations in Peel, Ramsey and Castletown which are open office hours Monday to Friday and officers use them as a base outside these hours. The police headquarters in Douglas is open 24/7 and although the local stations have set times, the police operate 24/7 and will travel to the claimant. The police workforce is shown in Appendix 2 which highlights who is available to respond to claims of sexual assault.

The 24/7 workforce highlights that there is a need for a high number of staff to have relevant sexual assault training. In general, all officers will receive initial training which includes safeguarding and sexual offences (legislation mainly), followed by ten weeks on duty with a tutor to learn the procedural aspects. If there are no sexual assaults during this period then no operational experience will be gained during training. However, more specialised training is undertaken by the PPU including: specialist witness interview; suspect interview; serious child abuse investigation development programme; and dealing with adult’s subject of child abuse. All training is accredited through the National College for Policing (NCP), and is at the highest standard following home office best practice. Comparing to UK practice, the only aspect not included is the Sexual Offences Liaison Officers (SOLO), who respond to sexual offences and link in with a SARC. As the island does not have a local SARC, this approach is being adapted where an NCP approved initial response to victims booklet, including how to respond to a claimant of sexual assault, is being adapted for local use. Further, the police follow all NCP national standards.

Currently, the local SARS is all run through the police and therefore if a disclosure is made to the police, the claimant is more likely to receive information on the process and support available. There are operational procedures to follow for adults and a separate procedure for children and young people under 18 (see Appendix 3). These operational procedures are fairly detailed documents, and therefore a simplified pathway has been created in Figure 13 overleaf to show a visual of the police process for a co-operative adult. Additional steps run alongside this process for safeguarding children and adults who lack capacity, as mentioned following Figure 13.

Please note, this is not a formal pathway, and is based on the data gathered in the focus groups which highlights the process step by step for an adult who is cooperative and wants to pursue prosecution. However, it is also important to note that a claimant may initially involve the police and decide they don’t want to prosecute. In this situation, no further investigation for the claimant will take place and the claimant will be advised to attend the GUM clinic and VS details will be provided. If there are any concerns for the safety of the public or any safeguarding issues, the investigation into these will continue without the claimant’s involvement.

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Attendance or Call Out

Claimant visited by uniformed officer or if known sexual offence, a plain clothed PPU officer in an unmarked vehicle will attend if available.

Immediate medical attention required?

IF YES - AMBULANCE

Was assault carried out by a stranger?

IF YES – Immediate involvement of CID

Timeline is ascertained

RECENT 10 days or fewer between offence and reporting to police

SAFEME ASAP Taken to TNL

YES

NO

Are there any genital injuries?

General Medical examination – including any external injuries

REST PERIOD Support and services offered

Claimants are offered showers, clothes, third sector support, places to stay. Alongside this the police do an immediate risk assessment and make any referrals.

Continued overleaf...
If the claimant were a child or young person (under 18 years of age) the police process in Figure 13 would apply however there is a child protection procedure which must be followed. There would be a strategy meeting to plan a Section 46 inquiry. This refers to Section 46 of the Children and Young Persons Act and is the statutory duty of the DHSC to make inquiries to determine what action to take to protect a child at risk, or suspected to be at risk, of significant harm or abuse.
A report of sexual assault will almost always be a joint investigation in which the Police are responsible for the criminal element and social care work alongside, to ensure all safeguarding measures are in place. In cases that are likely going to result in an investigation into a sexual assault and where time is of the essence for the police, this meeting may take place over the telephone.

If the claimant were an adult who lacks capacity, again the police process in Figure 13 would apply. Alongside this, the police response officers are trained to identify any safeguarding concerns including those who may lack capacity. Any safeguarding concerns will be referred to Adult Social Care by the police. However there is no framework in place for this, nor any formally agreed pathway or process, comparable to the position of children.

### 2.2.2 Thie Yn Lheihys – Sexual Assault Forensic Medical Examination

In regards to evidence collection, Figure 13 highlights the timeline to ascertain the best method. If the sexual assault was recent, the claimant will be offered to a sexual assault forensic medical examination (SAFME). The current facility to undertake this SAFME is within Thie Yn Lheihys (TNL), based at the old Nobles Hospital site. This building is owned by DHSC who use part of it during the day, but there is a separate door to access the sexual assault facilities which only the police and social care have keys for. The facility includes an interview suite, medical examination room, waiting area, kitchen and shower room. This is the only facility currently available for claimants to have a SAFME, however the police have another interview suite available at police headquarters. On-island, the SAFME is only available for those who have reached puberty. All children and young people who are not pubescent are required to go off-island if they require a SAFME. This is usually either the preferred SARC option St Mary’s in Manchester or the Safe Centre SARC in Preston. The child will undertake their best evidence interview when they return to the island and ongoing support is put in place.

The process in Figure 10 is clear that the only way the SAFME can currently take place is when a formal complaint is made to the police. If no police investigation occurs, there is no way for the SAFME to be carried out and forensics stored so the claimant can make a complaint at a later date if they wish to do so. Statistics show that only about 11% of sexual assault is reported to the police, resulting in a high number of potential claimants who don't receive appropriate care. A pathway is needed whereby police involvement is only required upon a claimant’s decision to take forward prosecution. This will enable claimants to easily gain access to the pathway where the process can be discussed to allow them a more informed decision, with the option for a SAFME and storage of evidence. Therefore, this process requires updating so that the police investigation is just an option on the pathway, and does not prevent other processes from taking place.

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16 The SOFMEs are currently working by pubescence based on updated guidance. Previously this was based on age whereby only those aged over 13 would be examined on-island.
At present there are two female sexual offence forensic medical examiners (SOFMEs), and one male who is undertaking training, all of whom work fulltime in other roles during the week. Currently, the on-call rota is split between the female SOFMEs who can undertake the examinations during the evenings or weekends. There has previously been a service level agreement in place between the police with the formal contract being with custody, held with the Chief Inspector of Operations. Although the SOFMEs have continued to be paid and follow this contract, it is important to note that this contract expired roughly five years ago which raises concerns for accountability and professional governance.

2.2.3 Social Care

Social care has a statutory responsibility under Section 46 of the Children and Young Persons Act 2001 to make inquiries to determine what action to take, to safeguard a young person or child at risk or suspected to be at risk – this includes sexual assault. A social worker will support the child through the investigation and assess the risk, particularly where the suspect may be a family member. The social worker’s role is to ensure the child is protected from any further abuse or assault; advise the family on services available and act as an appropriate adult where appropriate. Where a child is subject to video interview the social worker conducts the inquiry along with the police officer for evidential purposes relating to the level of risk. The police officer conducts the inquiry relating to evidence for any possible charge and prosecution.

2.2.4 Emergency Department

Similar to Figure 13 showing a police pathway, there is no formally agreed SARS pathway for the Emergency Department (ED). The following pathway in Figure 14 appears to reflect current practice from discussions in the focus groups. This highlights the out of date language used, for example, ‘Social Services’. Going forwards, a formal pathway needs to be in place to ensure all staff provide the same service.

The ED pathway highlights how safeguarding and medical treatment are priorities. The sexual assault pathway may be engaged if there is a safeguarding concern in which social care become involved, and the claimant discloses to social care. However, the sexual assault pathway will be engaged by social care and not the ED. If however, the claimant makes a disclosure of sexual assault whilst in ED care, the claimant will be offered the involvement of the police. This will engage the sexual assault pathway if the claimant wishes to involve the police. If no police involvement, medical treatment will commence and relevant referrals will be made to support the claimant.
Figure 14. Emergency Department Pathway

Source: created based on data gathered during the SARS needs assessment focus group sessions
2.2.5 Genito-Urinary Medicine Service

The GUM clinic staff follow the British Association for Sexual Health and HIV (BASHH) Guidelines for Sexual Assault, whilst operating an appointment based clinic.

![Figure 15. Genito-Urinary Medicine Service Pathway for Adults](source)

*Referral – this may include: self; friend; carer; family or it could be via an official Pathway including: ED; third sector; MHS; DEC; Prison
*Unscheduled arrival – this may be either a pre-arranged appointment with no pre-appointment disclosure or a drop in
*The BASHH guidance timeline for a GUM examination following sexual assault is shown in Appendix 5.

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17 BASHH (2011) UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault. [https://www.bashhguidelines.org/media/1079/4450.pdf](https://www.bashhguidelines.org/media/1079/4450.pdf)
GUM is mainly a self-referral service with some formal and informal referrals from other service providers. If it is known that a person is a claimant of a sexual assault, either through a Police/SOFME referral, or a disclosure from the client themselves when booking an appointment over the telephone, every effort will be made to ensure they are offered a private room in the clinic if available. If a disclosure of sexual assault is made during a consultation, a discussion will take place regarding involvement of the police. If the client declines police involvement, or the assault is not recent, GUM staff will continue with tests/treatment as per recommended guidelines. However, if the assault was recent and the client wishes to involve the police, the police pathway will be engaged so that the SAFME can be completed first to avoid contaminating any evidence.

Following the BASHH guidance timeline, for a GUM examination following sexual assault (see Appendix 5), post-exposure prophylaxis after sexual exposure to HIV (PEPSE) is only available if there is a doctor available in the clinic, otherwise the claimant would need to attend the ED for this. Shows the adult pathway; the difference for children includes additional safeguarding measures. For adults who lack capacity to consent, the adult protection policy and procedures18 would be followed. It is important to note that a claimant can exit the GUM services at any time. If there is ongoing treatment, the GUM clinic will try and contact the claimant three times before closing the file. Further, the focus group discussion has highlighted that GUM still follow previous guidance based on forensic evidence being captured seven days since sexual assault, rather than the updated guidance of ten days.

2.2.6 Pregnancy Service

There is a risk of pregnancy in five per cent of rapes cases4. If a female claimant does not take emergency contraception, or they do and it is unsuccessful, they may become pregnant. They may not have made a disclosure before this point and may potentially then do so to their doctor or a midwife, for example. Once the maternity service are aware the pregnancy has been caused through rape, the Safeguarding and Vulnerable Women’s midwife will arrange a one to one meeting with the claimant. Additional support will be offered, and whether or not the women wishes to terminate the pregnancy will be discussed. Again, for the pregnancy service, there is no formally agreed SARS pathway. The pathway in Figure 16 appears to reflect current practice from discussions in the focus groups.

Although this is not a formal pathway, and therefore a different process may be followed by other midwives, a number of concerns arise. These mainly highlight how this pathway is not client led, where it should be focussed more on the claimant – all of the strategy meetings are about the child and not the mother (claimant). Letters are sent out, which may not be appropriate, especially in cases of domestic abuse. Some of the language used is also not appropriate, for example, ‘are they viable’. Similarly, some of the comments are too vague, for example, ‘sign post to third sector charities that may be able to help’. To enable claimants to be informed, all information and pathways should be clear and accessible with appropriate language used. Further, the pathway also highlights lack of understanding about termination of pregnancy legislation indicating that if a claimant wishes to have a termination they must be referred to the Mental Health Service (MHS). The following section highlights that this is not necessary under the current legislation.
2.2.7 Termination of Pregnancy

The 1995 Termination of Pregnancy (Medical Defences) Act allows termination of pregnancy to be carried out in certain circumstances. One such circumstance being in cases of certain sexual crimes if the pregnancy has lasted for less than 12 weeks. To enable the termination to proceed under the legislation on-island, all of the following requirements need to be complied with:

a) the pregnant woman has produced to the hospital surgeon and the medical practitioner an affidavit or other evidence taken under oath alleging that the pregnancy could be caused by rape, incest or indecent assault;

b) the pregnant woman has made a complaint to the police about the alleged rape, incest or indecent assault as soon as was reasonable in all the circumstances; and

c) the hospital surgeon and the medical practitioner are of the opinion, formed in good faith, that there are no medical indications which are inconsistent with the allegation that the pregnancy could be caused by rape, incest or indecent assault.

Although claimants who become pregnant as the result of rape are eligible for a termination free on-island, there is no support network or pathway in place. Based on the tight time frame, the absence of this clear pathway may result in the claimant becoming ineligible if more than 12 weeks of pregnancy have passed before seeing a hospital surgeon and medical practitioner. The lack of understanding of this Act from professionals may also cause delays as well as uncertainty for the claimants, potentially causing further distress. This Act also requires the pregnant claimant to involve the police and provide an affidavit or other evidence taken under oath, which could include a police witness statement. This may not be affordable or appropriate for the claimants’ wellbeing where they have to disclose to so many people and different services.

2.2.8 Mental Health Service

The Crisis Response and Home Treatment Team (CRHTT) provides an island-wide 24/7 accessible assessment and crisis response service for people who are experiencing significant deterioration in their mental health and/or an increase in their psychological distress requiring an urgent response to facilitate a resolution of crisis. Interventions are intensive and short term, and are designed to return the individual to a state of positive mental health. Once the crisis has been resolved and there is an improvement in the individual's mental health, the CRHTT practitioners may negotiate with the individual (and if applicable their carers) to transfer their care to another part of the MHS.19

The CRHTT accept direct referrals, as do the Drug and Alcohol Team who will support those who misuse drugs and/or alcohol. CAMHS accepts referrals for assessment and treatment, but only for children and young people (aged 0-18) via referral from a professional. All other MHS related referrals will go via the community MHS for adults, see MHS website for more information on what’s offered.

There is no specific MHS pathway for claimants of sexual assault that can guide professionals towards the most appropriate psychological support for claimants. The focus group data mentions long waiting lists which may be partly due to inappropriate referrals, also that “victims don’t always want therapy – some have poor coping skills and little support so need a lot. Others are well supported and require minimal counselling support.” This quote is taken from the SARS focus groups (discussed later), and supports the guidance which suggests referrals to the MHS are only required if the level three support – improving access to psychological therapies (IAPT) is not sufficient (refer to post trauma/abuse counselling in the benchmarking section on page 47). The MHS website includes reference to self-help resources that can help us to look after our mental health and wellbeing. For some claimants this may be enough support initially, however there is no evidence to suggest this is currently being promoted through the SARS.

2.2.9 Third Sector

The lack of third sector services supporting claimants of sexual assault reflects the limited commissioning from the IOM Government. The third sector provides emotional and practical support to claimants of sexual assault and their friends and family. This includes guidance for the claimant to make an informed choice, whether or not they wish to involve the police. If the claimant wishes to prosecute, emotional support is available before, during and after the trial, with services being present throughout the court process. The DHA has a service level agreement with one third sector provider, VS, as detailed below.

Victim Support

The service level agreement VS have with the DHA is to provide services for victims of crime which includes sexual assault. As part of this agreement, VS offers a referral system from the police with no waiting list and court familiarisation (pre-trial visit to court to explain the process) for claimants who are prosecuting. Since 2016, funding for this service level agreement is reviewed on a yearly basis. At present VS are required to report the number of claimants supported each year to the DHA.

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Alternative outcome measurements are being reviewed similar to VS in other jurisdictions whereby the claimants’ confidence in the criminal justice system and their continuance of a case through to a prosecution are included.

Although they are not funded by VS UK, they follow the VS national training and standards\(^\text{23}\) and have clinical supervision monthly. There are four trained advisors for sexual violence, accredited by Victim Support UK. One member of staff is currently attending the IDVA (Independent Domestic Violence Advisor) SafeLives training course. For further information about VS visit: http://www.victimsupport.im/

\(^{23}\) https://www.victimsupport.org.uk/
3. **Current Costs and Activity**

Each adult rape is estimated to cost over £76,000 in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health service and costs incurred in the criminal justice system. The figure is likely to have increased since the data is from 2003/4 with no up to date figures being included in the recent UK service specification or commissioning framework. For child claimants, the UK Home Office has more recently estimated costs for rape and sexual assault as £88,467 and £35,278 respectively.

Costs for the IOM SAFME are detailed below. This includes specific additional costs associated with sexual assault, as many other costs are also involved in services day to day operations such as the police, ED, GUM clinic, pregnancy service and MHS.

### 3.1 Sexual Assault Forensic Medical Examinations

#### On call and turn out costs

On call fee for SOFMEs = £2,500 per month

There are currently only two SOFMEs who receive £1,250 each per month for being on call. Although this appears to be higher than the British Medical Association recommended retainer fees, the budget for SOFMEs on call has simply been split between the SOFMEs available. Ensuring a formal contract is in place will enable a fair system where an agreed retainer is paid.

#### Turn out costs

Table 1 shows the costs for SOFMEs to examine cases of sexual assault or child protection.

**Table 1. Turn out costs for the sexual offence forensic medical examiners**

<table>
<thead>
<tr>
<th>Time</th>
<th>Case</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>From 0800 to 1900</td>
<td>First Case</td>
<td>£87.94</td>
</tr>
<tr>
<td>From 0800 to 1900</td>
<td>Second Case</td>
<td>£70.30</td>
</tr>
<tr>
<td>From 1900 to 0800</td>
<td>First Case</td>
<td>£131.79</td>
</tr>
<tr>
<td>From 1900 to 0800</td>
<td>Second Case</td>
<td>£105.46</td>
</tr>
</tbody>
</table>

Source: DHA, PPU

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The turn out costs in Table 1 are for an initial half-hour period, any additional half-hour period or part thereof costs £33.27.

**Pre-pubescent children attending a SARC**

Table 2 shows the costs for pre-pubescent children attending a SARC off-island. The costs are per individual claimant visit, excluding travel and accommodation.

**Table 2. Costs for pre-pubescent children attending a SARC**

<table>
<thead>
<tr>
<th>Centre</th>
<th>Town</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Mary’s</td>
<td>Manchester</td>
<td>£1,300</td>
</tr>
<tr>
<td>The Safe Centre</td>
<td>Preston</td>
<td>£528</td>
</tr>
</tbody>
</table>

Source: DHA, PPU

Although there is a significant difference in the costs between these SARCs, it is important to highlight that the Safe Centre in Preston offers a more limited service and costs have not been increased over the period that the IOM has been accessing their service.

**Actual costs**

In addition to the on call costs, the SOFMEs undertaken on-island from April 2014 to (and including) January 2017 cost £7645.28. Table 3 shows the breakdown over these years, based on when the SAFME was carried out.

**Table 3. Costs for the sexual offence forensic medical examiners on-island**

<table>
<thead>
<tr>
<th>Year (Financial)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>£2,401.60 *</td>
</tr>
<tr>
<td>2015-16</td>
<td>£2,578.78</td>
</tr>
<tr>
<td>2016-17</td>
<td>£2,664.9</td>
</tr>
</tbody>
</table>

Source: DHA, PPU

* Please note, the costs for 2014-15 include total costs of £600.76 for the trainee SOFME shadowing. The trainee received the same amount as the qualified experienced SOFME which will also need to be addressed.

The additional costs for pre-pubescent children, attending a SARC off-island, for the same period could not be obtained during the timeframe for this needs assessment.
3.2 Police/Social Care

Any cases with regards to sexual assault will be covered under the general operations of the police force and relevant social care teams as no members of staff are employed solely for sexual assault. Therefore it is not possible to include a cost for their input. However, it is important to highlight that when a pre-pubescent claimant goes off-island for a SAFME, a police officer and a social worker will also attend. This will be an additional cost for their time, which is generally an overnight stay.

3.3 Victim Support

VS have a service level agreement with the DHA, which includes a general grant of £77,750 to support victims of all crime. This grant covers the sexual assault services mentioned previously with the approximate annual cost for sexual assault being calculated as £26,981. This figure is variable depending on the number of claimants attending VS each year, and is an approximate as there is no set cost per claimant, or type of support received. The approximate figure is based on the running costs for VS during 2016 divided by the total number of clients supported in 2016, multiplied by the number of sexual assault cases for 2016.
4. Benchmarking

The Survivors Trust is a national umbrella agency for over 135 specialist rape, sexual violence and childhood sexual abuse support organisations throughout the UK and Ireland. The Survivors Trust website includes details for just over 40 SARC s across England, Wales and Scotland. These are highly specialised services generally located in urban areas with large populations. The NHS England service specification acknowledges this, but highlights that all local areas, whether or not they have a SARC, should ensure they meet the following bare minimum points:

- An opportunity for claimants to access SARC services as self-referrals
- Choice of whether or not to involve the police
- Choice of gender of physician, where possible
- High levels of victim satisfaction
- An opportunity for the claimant to agree to evidence being stored in case they decide to report to the police at a later date, or to provide evidence anonymously

These are NOT offered locally, which will need to be addressed for the new pathway and service specification on-island, for any of the options chosen.

The resource for developing SARC s acknowledges that although it is ideal to have all services in one location, the term 'SARC' does not just refer to a building. SARC embraces a concept of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways. This approach allows co-ordination with wider healthcare, social care and criminal justice processes to improve health and well-being, as well as criminal justice outcomes for adult and child claimants of sexual assault. Thus highlighting how partnership working is key, and that SARC s may operate differently, but the services will still need to work towards attaining the elements set out. Table 4 includes the key minimum elements (KME) for a SARC which are also shown on a general SARC overview pathway in Figure 17. Key areas the current SARS does not have are highlighted in red text on this overview pathway.

This particular pathway is included as it shows an overview of the process. More specific pathways can be created based on this overview to include a pathway for children and young people; or more detail about post abuse services as shown in the appendix of the NHS England (2016) SARC service specification.

This pathway is also useful since the KME are highlighted, and can easily be linked to the quality assurance standards (QAS) in the self-assessment table (see Table 4). This is for SARCs to complete annually and has been adapted from the NHS England (2015) commissioning framework document which is based on the KME highlighted in the resource for developing SARCs document. The current QAS detailed in the service specification have updated and replaced the KME, and have therefore been included in the table to be self-assessed against with a reference to which KME they have updated. Usually this self-assessment is completed using the SARC Indicators of Performance (SARCIPs) shown in Appendix 6. However, since there are no official shared pathways on the island and only minimal data is collected, the SARCIPs have not been used for this self-assessment; instead the results are based on whether or not this is provided on-island.

The results of this assessment would be expected to highlight gaps as no specific SARC exists on the island. However, as these are the QAS of a SARC, and the island does operate a SARS, it may be expected that more of these are covered. Further details are provided following Table 4 for both the QAS and KME to highlight the gaps.
Figure 17. Sexual Assault Referral Centre Pathway and Minimum Elements

Source: A Resource for Developing Sexual Assault Referral Centres

*Please note, the red text in the diagram indicates the gaps on-island
### Table 4. Sexual Assault Referral Centre Quality Standards Self-Assessment

<table>
<thead>
<tr>
<th>Quality Assurance Standard</th>
<th>Link to KME number</th>
<th>Self-Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Twenty-four hours access to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure and age appropriate venue.</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Appropriately trained crisis workers to provide immediate support to the claimant and significant others, where relevant.</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Choice of gender of physician, where possible.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offence examinations for adults and children.</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Dedicated forensically approved premises (preferably for sole use).</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Decontamination protocols in place to ensure high quality forensic integrity and a robust chain of evidence in keeping with the Faculty of Forensic and Legal Medicine (FFLM) guidelines.</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The medical consultation includes an immediate health assessment including assessment of injuries and a risk assessment for self-harm, vulnerability and sexual health, and immediate access to emergency contraception, PEPSE, mental health and other health services and follow-up support, as required.</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Access or referral to support, advocacy and follow-up through a counselling service, including support through the criminal justice process (should the claimant choose that route). There should be an offer of counselling from specialists trained in pre-court age appropriate counselling, if necessary.</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Well-co-ordinated interagency arrangements will be in place, involving local Third Sector services supporting claimants: LSCBs, Safeguarding Boards for Vulnerable Adults, and Health and Wellbeing Boards.</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>The SARC has a core team to provide 24/7 cover for a service which meets NHS standards of clinical governance and the European Working Time Directive.</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*The following points are not included as Quality Assurance Standards, however they were included for the self-assessment in the Commissioning Framework (2015)*

| Minimum dataset and appropriate data collection procedures in each SARC.                   | 10                 | 1               | 1 |
| Extent to which your SARC is integrated with local support services for claimants.        | n/a                | 1               | 1 |
| Strengthening the sustainability of your SARC through joint commissioning and local strategic partnerships, including the Third Sector. | n/a                | 1               | 1 |

*Self-Assessment: 1 = does not meet QAS/KME  2 = partially meets QAS/KME  3 = meets the QAS/KME*
### 4.1 Self-Assessment Justification

Table 4 highlights whether the QAS and KME have been met, partially met, or not met. For the current SARS, none of the QAS/KME have been met, a few have been partially met, but the majority un-met.

Key points are highlighted for each QAS/KME below to justify the self-assessment scores. Each QAS/KME is highlighted separately, with additional key points only relevant for either pubescent or pre-pubescent claimants also mentioned.

<table>
<thead>
<tr>
<th>Quality Assurance Standard</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Twenty-four hours access to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure and age appropriate venue.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>KME: 1</strong></td>
<td></td>
</tr>
<tr>
<td>✓ TNL is secure and can be used 24/7</td>
<td></td>
</tr>
<tr>
<td>× Claimants cannot access TNL or the SOFME via self-referral</td>
<td></td>
</tr>
<tr>
<td>✓ There is no formal crisis support for claimants of sexual assault 24/7. However claimants can access the CRHTT 24/7, or VS during office hours.</td>
<td></td>
</tr>
<tr>
<td>× The SOFME can be accessed on the telephone for advice within an hour, but there is only access to the SAFME during evenings and weekends. Hence, it may be more than one hour until the SAFME is undertaken for those that can be undertaken on-island.</td>
<td></td>
</tr>
<tr>
<td>✓ The Emergency Department can offer emergency clinical care 24/7.</td>
<td></td>
</tr>
<tr>
<td>✓ Safeguarding pathways are in place 24/7 with a Duty Social Worker on call out of office hours.</td>
<td></td>
</tr>
<tr>
<td>✓ The security and safety protocols that are in place to protect claimants and staff include the needle stick policy; encouraging staff to remain up to date with infection control training; and no longer stocking diazepam at TNL due to high risk.</td>
<td></td>
</tr>
<tr>
<td>✓ Security and safety protocols to protect claimants and staff are followed, including risk assessment of claimants and co-ordination with other relevant safeguarding agencies.</td>
<td></td>
</tr>
<tr>
<td>✓ First aid can be provided for minor injuries.</td>
<td></td>
</tr>
<tr>
<td><strong>Pre-pubescent:</strong></td>
<td></td>
</tr>
<tr>
<td>× TNL is not an age appropriate venue. Pre-pubescent children cannot undertake a SAFME on-island. Due to travelling off-island for their SAFME, it is less likely for this to take place within the recommended 24 hours</td>
<td></td>
</tr>
<tr>
<td>Quality Assurance Standard</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>Appropriately trained crisis workers to provide immediate support to the claimant and significant others, where relevant.</td>
<td></td>
</tr>
<tr>
<td>KME: 2</td>
<td></td>
</tr>
<tr>
<td>×</td>
<td>No Crisis workers or similar are currently available.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Quality Assurance Standard</th>
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<tbody>
<tr>
<td>Choice of gender of physician, where possible.</td>
</tr>
<tr>
<td>KME: 3</td>
</tr>
<tr>
<td>×</td>
</tr>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Assurance Standard</th>
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</thead>
<tbody>
<tr>
<td>Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offence examinations for adults and children.</td>
</tr>
<tr>
<td>KME: 4</td>
</tr>
<tr>
<td>✓</td>
</tr>
<tr>
<td>×</td>
</tr>
<tr>
<td>✓</td>
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<tr>
<td>×</td>
</tr>
<tr>
<td>×</td>
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<tr>
<td>×</td>
</tr>
<tr>
<td>Pubescent:</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>✓</td>
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<tr>
<th>Pre-pubescent:</th>
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<td>×</td>
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</table>

### Quality Assurance Standard

**Dedicated forensically approved premises (preferably for sole use).**

**KME: 5**

| ✓ | There are dedicated premises at TNL with a separate entrance which can only be accessed by social care or the police. |
| × | TNL is not a sole use building as it is shared with social care who utilise other parts of the building frequently during the day. The walls are not soundproofed, which is inadequate for the interview suite, and disturbing for the doctor and claimant during the medical examination. |
| × | TNL is not forensically approved and was shown to be inadequate in the recent review. |

### Quality Assurance Standard

**Decontamination protocols in place to ensure high quality forensic integrity and a robust chain of evidence in keeping with FFLM guidelines.**

**KME: 5**

| × | There is no protocol, procedure or audit in place for decontaminating examination facilities. TNL is cleaned after an examination by a general cleaner, which does not meet the FFLM guidelines. Critical incidents have been flagged in which this facility had not been cleaned, and the examination was delayed until cleaning had taken place. |
| ✓ | The SOFMEs follow FFLM guidance for sample collections and labelling. |
| × | There are no multidisciplinary meetings for staff to discuss queries and practical issues with key experts and receive updates on developments in forensic practice. |
| ✓ | The SOFMEs attend forensic courses each year; meet to discuss updates and anonymised case reviews; and receive FFLM updates via email and checking the website as well as St Mary’s SARC website which has courses available. |
## Quality Assurance Standard

The medical consultation includes an immediate health assessment including assessment of injuries and a risk assessment for self-harm, vulnerability and sexual health, and immediate access to emergency contraception, PEPSE, mental health and other health services and follow-up support, as required.

**KME: 6**

<table>
<thead>
<tr>
<th>✓</th>
<th>Practitioners are skilled in discussing with victims the implications for confidentiality to inform choice and consent for screening.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>The SOFMEs undertake a comprehensive assessment of the claimant. For example, if there are mental health concerns, the SOFME will contact Psychiatry prior to the claimant leaving. The sexual health assessment uses a flow chart to assess whether any infection prophylaxis is needed. HIV PEP has been obtained previously from the ED, or the other option is via the emergency pharmacist. All clients are informed about their individual risk of infection, and receive advice to attend the GUM clinic. If emergency contraception is indicated, it is issued immediately at the unit. If there are safeguarding concerns, the safeguarding team is informed, and if a multi-agency referral form has not been sent by the police it is filled and sent by the SOFME.</td>
</tr>
<tr>
<td>✗</td>
<td>For all of the assessments of the claimant mentioned above, there needs to be formalised pathways in place to ensure they are receiving the required follow-up support.</td>
</tr>
<tr>
<td>✓</td>
<td>Emergency contraception can be provided by the SOFME.</td>
</tr>
<tr>
<td>✗</td>
<td>Other forms of contraception are discussed, but not available on-site and therefore need to be sought from the family planning clinic or GP/Practice Nurse.</td>
</tr>
<tr>
<td>✓</td>
<td>Pregnancy tests can be done if indicated, and if the claimant consents. This would then be bagged for evidence.</td>
</tr>
<tr>
<td>✓</td>
<td>Screening for sexually transmitted infections is through the GUM service. All claimants are signposted to GUM as no formal referral is in place. STI testing will not be completed during the SAFME, as if an infection was detected at this point it would not benefit the claimant. This is because the detected STI would not be related to the latest intercourse, and therefore has the risk of being unfairly used against the claimants character in court.</td>
</tr>
<tr>
<td>✗</td>
<td>Referral between services does not reflect claimants needs and choices fully based on the limited options.</td>
</tr>
</tbody>
</table>

### Pubescent:

| ✗ | Information sharing protocols for safeguarding vulnerable adults are not in place. |

### Pre-pubescent:

| ✓ | Information sharing protocols for safeguarding children are in place. |
## Quality Assurance Standard

**Access or referral to support, advocacy and follow-up through a counselling service, including support through the criminal justice process (should the claimant choose that route). There should be an offer of counselling from specialists trained in pre-court age appropriate counselling, if necessary.**

### KME: 7

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>×</td>
<td>There is no independent sexual violence advisor (ISVA) provision on the island to support the claimant thoroughly through the criminal justice process.</td>
</tr>
<tr>
<td>✓</td>
<td>Victim Support currently has a service level agreement with the DHA to offer support to claimants with court familiarisation.</td>
</tr>
<tr>
<td>✓</td>
<td>Claimants’ can be referred to VS or the island’s MHS.</td>
</tr>
<tr>
<td>×</td>
<td>Service specification/s for claimant support needs to be formalised.</td>
</tr>
<tr>
<td>×</td>
<td>Need to ensure the appropriate counselling services are available for claimants, including pre-court counselling if required. This should be integrated with the ISVA provision and other multi-agency support such as independent domestic violence advisers (IDVA).</td>
</tr>
<tr>
<td>×</td>
<td>Need to promote access to self-help guidance.</td>
</tr>
<tr>
<td>×</td>
<td>There is limited access to clear and appropriate information throughout the process for claimants.</td>
</tr>
<tr>
<td>✓</td>
<td>All medical interventions are victim centred and claimants right to choice is emphasised immediately at the start of the consultation when the consent is taken. It includes the right of the claimant to refuse to see the doctor or to halt the examination at any time. The claimant chooses who they wish to have in the examination room with the SOFME, and when the history is taken.</td>
</tr>
</tbody>
</table>
Quality Assurance Standard

Well-co-ordinated interagency arrangements will be in place, involving local Third Sector services supporting claimants: LSCBs, Safeguarding Boards for Vulnerable Adults, and Health and Wellbeing Boards.

KME: 8

× Interagency arrangements need to be formalised to ensure they are well co-ordinated and based on local needs to support claimants on the island.

× There are no audit, quality management or evaluation processes in place.

Pubescent:

× Stronger links are required with the safeguarding board for adults where there are no current links.

Quality Assurance Standard

The SARC has a core team to provide 24/7 cover for a service which meets standards of clinical governance.

KME: 9

Please note, this QAS has been adapted slightly as the island does not work towards the European Working Time Directive or NHS standards.

× Currently the SARS core team only comprises of the SOFMEs and police PPU.

× The SOFME can be accessed on the phone for advice within an hour but there is only access to the SAFME during evenings and weekends. Hence, it may be more than one hour until the SAFME is undertaken for those which can be undertaken on-island.

× There are no dedicated counsellors, crisis workers or ISVAs for claimants of sexual assault on the island.

× There is no appointed clinical director for the SARS who has a clearly defined role and accountability for the service, including clinical governance and clinical quality.

× There is no SARS manager accountable for the strategic management of the service. This may include, but is not limited to operational matters; developing and implementing local policies and operational procedures; safeguarding; and information procedures.

As highlighted in Table 4, the following points are not included as QAS, however they were included for the self-assessment in the Commissioning Framework (2015), which Table 4 is adapted from. Therefore, these points have been included and self-assessed against with the self-assessment explanations highlighted below.
### Quality Assurance Standard

#### Minimum dataset and appropriate data collection procedures in each SARC.

**KME: 10**

| ✓ | The SOFMEs are registered with the data protection officer and comply with the data protection act. |
| ✓ | The data that is collected can be anonymised. |
| ✗ | There is no confidentiality policy that is displayed prominently for claimants in the service, or for those who may wish to access the service. However, confidentiality is discussed with the claimant during the consultation. |
| ✗ | The claimants’ files are transferred from TNL in person by the SOFME. They are then stored securely in a locked building as per the data protection act. |
| ✗ | There is no routine data collected (this should include for example: age, gender, sexual orientation, disability, ethnicity, religion or belief). |
| ✗ | There is no promotion plan in place to use the information collected to support service development (for example, using positive information about the service to encourage other victims to seek help). |

#### Extent to which the SARC is integrated with local support services for claimants.

| ✗ | There are no clear pathways between the islands SARS and local support services, which make it more difficult for claimants to access support. |
| ✗ | There are limited support services available for claimants of sexual assault |

#### Strengthening the sustainability of your SARC through joint commissioning and local strategic partnerships, including the Third Sector.

| ✗ | Commissioning for the current SARS is through DHA. To ensure an adequate service is offered without involving the police, this should be joint commissioned with DHSC, for example. |
| ✓ | Multi-agency stakeholder involvement in the needs assessment process which will inform the service specification and pathway development and monitoring. |
| ✗ | Governance arrangements for the current SARS is lacking with no audit, quality management or evaluation process in place. |
4.2 The Faculty of Forensic and Legal Medicine Standards

In addition to the above standards, SARC providers must deliver a service that meets the relevant quality standards set out by the FFLM. These standards are relevant to SARS, for both adults and children in relation to clinical practice for doctors, nurses and paramedics who are working in forensic medicine. In sexual offences medicine, doctors and nurses undertake SAFMEs. The service specification for paediatric services and the guidance from the RCPCH and FFLM is that in children, examinations should be conducted by doctors. All of the relevant standards are highlighted in Appendix 7.

4.3 Other Recommendations

The Dame Elish Angionlini review of how the Metropolitan Police Service and Crown Prosecution Service investigate and prosecute rape cases was published in 2015. The review contains 46 recommendations on how partners can improve the reporting, care, support and conviction rate in relation to sexual abuse.5

4.4 Post Trauma/Abuse Counselling

NHS England (2016)4 recommends that claimants of sexual assault should have a choice of care provision for on-going support and counselling. IAPT level three support should be available either via the SARS, or be commissioned out to relevant services to offer support in a timely manner. Only if the claimants needs exceed this level of support, will the claimant need to be referred to the community MHS or an acute service.

4.5 Third Sector

There are limited third sector services on the island which offer specific support related to sexual assault, as mentioned previously. For best practice, the key roles that are usually provided by the third sector which are not currently available on-island include:

- Crisis workers who can deliver immediate confidential, emotional and practical support to claimants throughout the initial stages of the claimants’ disclosure.5 This is usually during the claimants’ visit to the SARC and is one of the QAS to have crisis workers available at any time4 (refer to the benchmarking self-assessment from page 39 for further information ). The crisis worker can work in close co-ordination with the police and other healthcare professionals to enable the process to be more streamlined for the claimant.

- ISVA services support claimants through the criminal justice journey to achieve improved criminal justice outcomes. The ISVA may be based within the SARC or externally within another service.29 The support provided by an ISVA will vary from case to case, depending on the needs of the claimant and their particular circumstances. The main role of an ISVA includes making sure that claimants of sexual assault have the best advice on what counselling and other services are available to them, the process involved in reporting a crime to the police and journeying through the criminal justice process, should they choose to do so.4
4.6 Promotion

If someone is sexually assaulted, it would appear to be extremely difficult for them to know where to go to for support. There is no marketing or promotion of the current SARS on the island so the support they do receive, if any, will largely depend on how much who they have disclosed to knows about the current service. Before disclosing, the claimant may wish to try and find out what services are available locally and search online – if you search google in different ways for support in the IOM for rape or sexual assault, the main results are various news articles. The only form of known support highlighted is VS. The Manx Telecom directory lists ‘rape support Isle of Man’ which only provides a phone number and no further information. A claimant may build up motivation to call this number, only to find that this is not a valid phone number, with the operator saying the call has been denied.

Having no information available for this sensitive topic may impact further on the wellbeing of claimants likely to need access to this information. Access to the information would provide claimants knowledge of their options for support, enabling informed decisions about how they wish to proceed. NHS England (2016) would support this, highlighting how SARC services and what they provide are not generally well known, hence raising awareness and promoting sexual assault provision and ease of access to services are priorities. This is especially important for paediatric SARCs which have an important educational role, promoting awareness of the signs and symptoms of sexual assault and of the services available. If all of this is achieved, it is expected that numbers of individuals reporting sexual assault will increase over time.

The St Mary’s SARC provides a useful website which highlights the support available for claimants and the process they will follow based on their chosen option. There are a number of other good websites for different SARCs, all of which can be accessed via the Survivors Trust website. Various other methods of promotion such as social media should also be used to raise awareness of the fact that the island does have a SARS, not only for those who are claimants so they know there is support available, but also to raise public awareness of sexual assault to help boost public confidence in both the health and criminal justice systems.

29 St Mary’s SARC: http://www.stmaryscentre.org/
4.7 Other Jurisdictions

Jersey, Guernsey and Gibraltar were all contacted to gather further information in regards to how they manage any sexual assaults for their jurisdiction. Information was not provided by Guernsey or Gibraltar. Jersey has been very supportive of this needs assessment and has shared experience, see below.

4.7.1. Jersey

Jersey is in the process of launching a SARC for residents. This is a three year pilot and will cater for all in Jersey including adults, children and young people. To ensure competency of the SOFME they currently have a locum Paediatric Doctor who oversees child protection for Jersey who is experienced in sexual assault. This allows the SOFMEs to discuss client cases through peer reviews on a frequent basis and has improved the standard of care for claimants of sexual assault in Jersey. To ensure the smooth running of the SARC, a service manager will be employed to oversee the project and report on the progress and make improvements if necessary.

Previously, they have commissioned Mountain Healthcare SOFMEs to travel to Jersey to conduct the examinations so the claimants did not need to travel. To enable this, they built up the foundations of the SARC including the facility and interagency support pathways, so a number of the costs for setting up a SARC had already been covered. The main change that enabled the establishment of a SARC in Jersey, was having everything they felt necessary available on-island, after having tried the approach of commissioning off-island Mountain Healthcare SOFMEs to travel to the island to conduct the SAFME. One of the main concerns was based on the standard of the SOFMEs undertaking these examinations. This identified a need to have better governance and management arrangements, for the four on-island SOFMEs. To promote the SARC they are using the Police Scotland Rape Campaign resources, which Scotland was happy to share, adapted for local use. Jersey has provided copies of the SARC business case and rape action plan. Further information is available on request.

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5. Perceptions from people working in the field

To gather a clear understanding of the current SARS and gaps in provision, perceptions were sought from a number of professionals working in the field. Due to ethical reasons, neither those who have previously made a claim of sexual assault nor the general public were approached. Instead professionals working in the field were invited to attend one of the focus groups and/or provide anecdotal feedback.

5.1 Focus Groups

The focus groups were facilitated by members of the Change and Reform Team from within the IOM Government, Cabinet Office. The objectives for the focus groups were planned by the qualitative sub-group, and adapted with the facilitators based on their suggestions from experience running focus group sessions. Two different focus groups were arranged:

- **Ideal service** — Feedback on service currently provided and thoughts on what an ideal service would look like and what barriers might be in the way.

- **Customer journey mapping** — What is the experience currently for claimants (pathway through services) and what can we learn from this?

The number of attendees for the ideal service focus group was smaller than the customer journey mapping sessions and only required one session for those professionals currently working in the current SARS. The customer journey mapping focus groups required a wider pool of attendees, including various universal services, with three sessions plus an additional session taking place. Refer to acknowledgements for those who were invited and those who attended the focus groups.

5.2 Anecdotal Data

Anecdotal feedback was collected for the last five year period to support the quantitative statistics which covers this period of time. All stakeholders, relevant service providers and support workers were approached and given the opportunity to provide this (refer to acknowledgements).

All of this data has been combined in this report. Figure 18 highlights the four key themes in the black arrow boxes and all of the sub themes inside the speech bubble.
The majority of the themes that have emerged from the qualitative data are areas that have been identified as gaps when benchmarking the current service against best practice. All four overarching themes support the quality standards and focus on more specific points through the sub-themes, some of which are mentioned below under the relevant key theme.
5.3 **Service Integration**

“Continuity – no named individuals as point of contact for whole process”

“Single point of contact from beginning to end”

**Pathway**

“Information should be available to claimants as to where they can go for support, as well as what they should expect from the services”

“An agreed flow chart showing correct processes and checklist for all – this should include a process in-between the child and adult pathways for those who lack the capacity to consent”

“Sharing process to front line staff where disclosures might happen”

“Same outcome no matter who the disclosure is made to”

“Provide claimants with a more joined up service”

**Multi-agency**

“Multi-agency work is good on-island”

**Competent and consistent**

“Inconsistency in competencies”

**One stop shop**

“We need a central hub of support”

“One service, one environment fits all – interviews and exam”

**Not involving police**

“Being able to report, seek help and long term support, not involving police”

“Facility of forensic capture without complaint”

**Shared records**

“Rely on each other more when it comes to having a “history” with the client and expertise in that area”

“How does one agency know if another is already involved with a client if the client does not or cannot communicate that? Put information sharing protocols and procedures in place”
Legal system

“There needs to be recognition for a witness who lacks capacity to give evidence”

“Non-discriminatory practice throughout the sexual assault legal process is needed”

“Employees of the criminal justice system – should use appropriate language when addressing victims of sexual assault”

“Children are not considered credible witnesses and therefore families are often let down by the criminal justice system when cases collapse due to lack of evidence”

“Prosecution are getting better on-island”

“The Attorney General Chambers (AGC) have a sexual violence protocol which started earlier this year. This is a joint protocol with the police and AGC which allows for fast tracking crimes and prosecutors meeting with victims.”

Facility and equipment

“Don’t have necessary equipment to deal with children (eg. video colposcope)”

“Current facility not suitable or forensically up to standard – the physician can only be as competent as the venue allows!”

TOP funding and support

“Abortion law is demeaning”

“Offer abortion *FREE* on IoM per se but specific to sexual assault victims”

5.4 Communication & Efficiency

“Make sure the voice of the victim is heard more regularly and consistently recognised and acted upon – we might not have a problem with something but that does not mean that it would not negatively impact an abuse victim”

“Language/jargon used can be difficult for claimants to understand”

“Lack of full explanations leading to panic and distress”

“Listening to victims is important. Being believed is crucial”

“Communication between services vital when perpetrator and victim use the same services”
Service Awareness

“Lack of understanding of SARS and what services can be accessed – lack of availability of information”

“Lack of access to information to help decision making when considering disclosing”

“More public awareness of where people can go for help, what support is available and what the process is”

Safeguarding

“When promoting independent living and choice – what safeguarding needs are implemented when service user is not deemed to have capacity to consent to sexual activity and is placed at risk repeatedly?”

“All allegations of abuse or related physical or psychological actions should be taken seriously and concerns reported and followed up to safeguard the claimant”

Small community: confidentiality, anonymity, stigma

“Consideration of place of abode of both the victim and perpetrator (particularly when being released from prison) and how this may impact the movement/life of the victim”

“Concerns re: GUM clinic stigma when attending after an assault”

“Stigma is still a barrier. Do our services provide confidence? For all? We do have good services?”

“School children – if a victim of sexual assault no anonymity. Victims and perpetrators in same school”

5.5 Support Services

“ISVAs and Crisis Workers are needed on-island”

Vulnerable

“If someone lacks capacity an additional known appropriate adult should be able to support them”

“If not a child, disabled, have learning difficulties, pregnant or elderly then you have to seek your own support when very vulnerable. Assume all complainants of sexual violence are vulnerable”
Counselling

“Full crisis intervention and support throughout the process, even if it is years later”

“Poor access to Mental Health Services and Psychology Services”

“If we are looking at the ideal service for the future, ongoing and effective counselling/psychological support should be made available”

“Consider IAPT (Improving Access to Psychological Therapies) under the existing Mental Health structure”

“Support/therapy provision should be considered for family and child, even when cases have collapsed due to lack of evidence”

“Victims, who require medication to support mental health, also require adequate emotional support. This is not always provided from psychiatrists.”

Self-help guidance

“More support services for victims – psychological services and advice offered”

“Professional Mental Health support services have long waiting lists (8-10 months). Signposting to appropriate services to support in the interim is needed”

“Victims don’t always want therapy – some have poor coping skills and little support so need a lot. Others are well supported require minimal counselling support.”

“Need for long-term support services for sexually assaulted children moving into adulthood. In particular, coping mechanisms for coming into contact/seeing perpetrator when going about personal business.”

Family and friends support

“Consideration for the support needs of families linked to the sexual assault. Personal coping mechanisms and advice on how to approach assaulted family member (particularly if they are of a vulnerable group – child, learning disabilities, etc.)”

“The information and follow up support for victims and their families could be better and we should be seeking to improve this”

“Support and appropriate signposting for parents of children who have been sexually abused”

Waiting list

“Mental Health Access - Huge waiting list. Especially if low intensity therapy level”
Perpetrator

“What support services are available for individuals who have been sexually assaulted and later convicted of a crime”

“Lack of understanding when a victim of sexual assault commits a sexual offence”

5.6 Service Access

“Services not available for those with an unorganised life – No fixed abode, sofa surfer, chaotic family”

“Follow up sessions difficult for those with a chaotic life i.e. – no fixed abode, sofa surfer, chaotic family, health needs – mental health, homeless, no family on IOM, isolated, physically disabled, - e.g. GUM”

Multiple access routes

“Only entry to [SA]FME through police – needs to be another route”

Service on island

“Families are vulnerable and will go through anything as don’t know any different. However they find it traumatic going off-Island and ask why they couldn’t do it at Nobles”

“Children being sent off-island is traumatic”

“The pathway currently states that any child under 13 years must be seen off-island at an appropriate centre. My concern if we sought to change this would be one of competencies of local forensic medical examiners. We would need to be sure we do not set up a system that depends on one or two doctors being competent to do the examinations this would result in a service which may prove unsustainable if one of them was off sick, on leave etc. Overall my position on this is that we need to be sure we have the resources, equipment and required competencies of enough Doctors before we could set up an on-Island system for children under the age of 13 years.”

Inequalities

“Need to consider diverse groups more”
6. **Gaps Identified**

i. SARS is only commissioned by the police, DHA. Thus no choice of whether or not to involve the police - claimants unable to undertake a SAFME without involving the police

ii. Choice of gender of SOFME

iii. Opportunity for claimants to access the SARS as a self-referral where the claimant can agree to evidence being stored if they decide to report to the police at a later date

iv. Crisis workers or similar

v. ISVAs

vi. Formalised referrals and pathways between services which are client led – including for adults, children and young people as well as for those who lack capacity

vii. Formal link to adult safeguarding board

viii. Service awareness for the general public – website, social media presence, posters

ix. 24/7 access to SOFME

x. Forensically approved facility which is age appropriate

xi. SOFMEs who are experienced in SAFMEs for children

xii. Video colposcope to examine children during the SAFME

xiii. SOFME contract and service specification

xiv. Evaluation and audit of the SARS, particularly the SAFME against the QAS

xv. Support and peer reviews for SOFMEs

xvi. Data collection following SARCIP – including the number of SAFMEs undertaken on-island and children travelling off-island to a SARC; and police/GUM data for time of incident

xvii. Up to standard decontamination protocols

xviii. Post trauma/abuse counselling (including pre-court) for all claimants

xix. Support for family members/carers and friends of claimants

xx. Promotion of self-help guidance

xxi. IAPT

xxii. Availability of police officers experienced in responding to disclosures of sexual assault
xxiii. Availability of services for those with an unorganised/chaotic life – for example, those with no fixed abode

xxiv. Support for those aged 16 to 18 who may have left home

xxv. Child claimants who still attend school potentially having to attend the same school as their perpetrator

xxvi. Difficulty for claimants who become pregnant to have a termination

xxvii. Difficulties for children and those who lack capacity to be seen as credible witnesses
7. **Pathway Options**

This work has generated four potential pathways for SARS we could offer for the island. All pathways meet the bare minimum standards and have both strengths and weaknesses. As the current service is not meeting any of the quality standards, there is no option to avoid change. The differences for the pathway options are highlighted later in this section. These need to be considered in combination with the points below, which highlight areas that need to be implemented for ALL of the pathway options to support an improved SARS.

i. Implement one of the pathway options.
   - Create a clear service specification to deliver the chosen pathway.
   - Refine the pathway to ensure it is robust with clear reporting mechanisms in place. There may need to be more than one pathway for adults, children and those who lack capacity. Some services may need alternative pathways too.
   - Implement the chosen pathway across all universal services offering support and training if necessary.
   - Ensure the information is accessible to promote the island’s SARS and pathway to raise public awareness of the support available.
   - Ensure the pathway is supported by formal contract arrangements, performance management and evaluation.

ii. The SARS needs to be jointly commissioned between DHA and DHSC to allow:
   - choice of whether or not to involve the police and still be able to undertake the SAFME; and
   - the opportunity for the claimant to agree to evidence being stored anonymously as the claimant may decide to report to the police at a later date.

iii. Provide the opportunity for claimants to access SARC services as self-referrals.

iv. Allow choice of gender of physician, where possible.

v. Ensure evidence collection and storage is forensically up to standard.

vi. Provide ongoing support for the claimant based on their age and individual needs.
   - Starting with a crisis worker or similar to ensure the claimant has one point of contact during the initial stages of their disclosure.
   - Followed up with an ISVA to be the one point of contact for the claimant, who can support with arrangements for post trauma/abuse counselling, as well as through the criminal justice journey if the claimant wishes to prosecute.
   - Age appropriate post trauma/abuse counselling, including pre-court if required.
   - Access to self-help materials relevant to the claimants needs.

vii. All services to record data using the same methods.
In summary, each of the pathway options will all have a similar:

- disclosure route into the SARS;
- police investigation;
- offer of post trauma/abuse support; and
- marketing to promote the SARS

The difference between the pathway options is where the SAFME will take place – on or off-island.

For each of the pathway options an example overview pathway has been created to show a visual of how this may work in practice as well as the following considerations being included:

- Required changes from the current SARS
- Strengths of this pathway option
- Weaknesses of this pathway option
- Required resources if this pathway option is chosen
- Consideration of costs involved for this pathway option

**The four pathway options include:**

Option A  SAFME on-island

Option B  SAFME commissioned from a SARC off-island

Option C  Hybrid Model – SAFME for adults on-island, SAFME for pre-pubescent children off-island

Option C  SAFME on-island by an off-island examiner
7.1 Option A, SAFME on-island

7.1.1 Example Overview Pathway

Figure 19 includes an example overview pathway for this option whereby all SAFMEs take place on the island.

Figure 19. Option A, SAFME on-island

Source: Adapted, based on the SARC’s Pathway and Minimum Elements diagram, see Figure 17
7.1.2 Required changes

Required changes to the current service are highlighted below.

**SAFME:**

a) Male SOFME trainee to complete training enabling him to work independently, or recruitment of a male SOFME
b) More than one SOFME needs to be competent in examining children
c) Formal governance, accountability and professional support arrangements
d) All FFLM standards to be followed
e) SOFMEs to be accessible 24/7
f) SOFME to be accessible by all services and not just police
g) Robust reporting lines for SOFMEs to follow
h) SOFMEs will need to gain experience in pre-pubescent SAFMEs
i) Availability of early evidence kits

**Venue:**

TNL to be refurbished or to relocate to a forensically approved and age appropriate venue

**Support:**

a) Availability of crisis workers or similar – need to consider current resources in regards to who would be most suitable and can be available 24/7 to guide a claimant through the process (potential overlap with domestic violence)
b) Availability of ISVAs
c) Availability of post trauma/abuse counselling
d) Access to self-help materials

**Awareness:**

SARS promoted using various methods to suit the needs of claimants – although the majority of claimants over the last five years have been under 25 years of age, there are still older adults suffering as victims of sexual assault.
7.1.3 Strengths

The strengths of adopting this pathway approach include:

a) Having a SARS on-island will raise awareness to encourage victims to disclose, as well as highlighting sexual assault as being unacceptable

b) Provide a more client-led service, offering support in the form of a crisis worker and ISVA who will be able to answer any queries to ensure the claimant understands the process

c) Self-referrals are likely to encourage more victims to disclose, as only 11% report to the police

d) Provide a 24/7 crisis worker response service

e) Availability of SOFME within an hour

f) There is currently a paediatric SOFME as well as a GP – both of whom are eligible to undertake SOFMEs for pre-pubescent children following the FFLM guidelines

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g) Best evidence can be gathered efficiently with less risk of contamination and lost time

h) The island has control over the content of the SOFME reports produced

7.1.4 Weaknesses

The weaknesses with this pathway approach include:

a) Based on the current figures, the SOFMEs may only examine a small number of pre-pubescent children each year. The recommendation is that SOFMEs undertake at least 20 examinations per year, although this is flexible to accommodate operational requirements in smaller communities. This highlights the need to consider how the SOFMEs can gain and maintain competency, which may include: cross site working, joint working, clinical attachments for training, peer review and the use of simulation training.

b) Continuity of service with low number of SOFMEs and potentially crisis workers

c) Designated Doctor for Child Protection post is currently vacant (at present, a locum is in place who has experience of child sexual assault)

d) Some individuals may not use the service on-island for confidentiality purposes. Need to consider how they can access a SARC on mainland (potentially advertise St Mary’s SARC)


32 The RCPCH and the FFLM are working with NHSE in order to develop 'a framework' which will better enable services to manage their workload and ensure the doctors undertaking such work maintain the breadth and depth of their knowledge, skills and experience. FFLM, RCPCH (2017) Child sexual abuse forensic medical examinations: Interim Guidance regarding numbers of examinations and the maintenance of competence. https://fflm.ac.uk/wp-content/uploads/2017/01/CSA-Examinations-Interim-Guidance-Dr-B.Butler-January-2017.pdf
7.1.5 **Required Resources**

The resources required if this pathway approach is adopted include:

a) Forensically appropriate and child friendly venue (forensic standard medical examination room, interview suite, waiting room, toilet and shower facilities)

b) Eligible and willing SOFMEs who can undertake examinations for pre-pubescent children

c) The SOFMEs undertaking pre-pubescent examinations will require sufficient protected time for the preparation of statements and reports for child protection requirements, criminal and family courts and for attendance at Court reflected in their job plans


d) Crisis workers

e) ISVAs

f) Post trauma/abuse support

g) Video colposcope

h) Training for front line staff where disclosures may occur

i) Website, social media presence, posters, etc.

j) Secure storage facilities for claimants’ notes

7.1.6 **Costs**

Considerations for costing for this option are highlighted below.

**Facility**

a) Forensic standard medical examination room, interview suite, waiting room, toilet and shower facilities (child friendly)

b) Secure forensic storage facility

**Equipment**

a) Video colposcope: approximately £10,000 – to be replaced every ten years, plus an annual service

b) General medical equipment

c) Forensic storage bags

d) Early evidence kits
**SOFME**

a) On call fee  
b) Call out fee  
c) CPD  
d) Management of the SOFMEs

**Support**

a) Crisis workers on call and call out costs  
b) ISVAs on call and call out costs  
c) Post trauma/abuse support

**Other**

a) Training front line staff  
b) Marketing
7.2. Option B, SAFME commissioned from a SARC off-island

7.2.1. Example Overview Pathway

Figure 20 includes an example overview pathway for this option whereby all SAFMEs take place off-island.

Source: Adapted, based on the SARCs Pathway and Minimum Elements diagram, see Figure 17.
7.2.2 Required changes

The changes required from the current services are highlighted below.

**SAFME:**

a) SOFMEs won’t be required – however need to consider eligibility criteria to determine which claimants can attend a SARC for a SAFME
b) Availability of early evidence kits
c) Formal governance and accountability to review the quality of SOFME reports from the SARC/s
d) Ensuring the commissioned SARC follows the FFLM standards
e) Compare SARCs, ensuring the journey to/from the SARC is as streamlined as possible to minimise decontamination
f) Thorough risk assessment in place for claimants travelling off-island for a SAFME to minimise and highlight decontamination concerns
g) SARC and SAFME to be available 24/7 to fit in with travel arrangements
h) The off-island SAFME to be accessible by all services and not just police

**Venue:**

a) TNL will no longer be required for SAFMEs, however the interview suite will be as the only other interview suite is in the police headquarters which is inappropriate for those not involving the police, and not suitable if the perpetrator has been interviewed in this interview suite. TNL interview suite will therefore need to be refurbished so it is sound proof or an alternative venue sought.
b) The interview suite needs to be appropriate for children

**Support:**

a) Availability of crisis workers or similar
b) Availability of ISVAs
c) Availability of post trauma/abuse counselling
d) Access to self-help materials

**Awareness:**

SARS promoted using various methods to suit the needs of claimants
7.2.3 **Strengths**

The strengths of adopting this pathway approach include:

a) Having a SARS on-island will raise awareness to encourage victims to disclose as well highlighting sexual violence as being unacceptable

b) Provide a more client-led service, offering support in a crisis worker and ISVA who will be able to answer any queries to ensure the claimant understands the process

c) Self-referrals are likely to encourage more victims to disclose

d) Provide a 24/7 crisis worker response service

e) SARC provision for all claimants of sexual assault will be dedicated to them and have a higher level of service than we can ever offer

f) Continuity of service improves. In the unlikely event the SARC provision closes, there will be alternative providers

7.2.4 **Weaknesses**

The weaknesses with this pathway approach include:

a) Traumatic for claimant having to travel off-island for the SAFME without showering

b) Increased difficulty for those who are domestically abused being able to attend without their partner being aware due to the length of time having to go off-island

c) Availability of SOFME within an hour is unachievable and difficult to achieve within 24 hours

d) Increased risk of evidence DNA contamination, loss and/or damage that will need to be transported back to the island

e) Increased risk of negative impact on the investigation process

f) Eligibility criteria to determine which claimants can attend a SARC for a SAFME

g) The island has no control over the content of the SOFME reports produced

h) Travel disruption to be considered as a risk

i) It may not be possible for the claimant to travel. For example, medical purposes, fear of flying/sailing, care of family members

j) There will need to be more than one crisis worker on call to ensure there is a back-up option in the event of more than one sexual assault case occurring and travelling to a SARC being required at the same time. This may also impact the police and/or social workers if they continue to attend the SARC as they currently do with pre-pubescent children

k) Increased cost for travel, accommodation and professional’s overtime

l) Increased cost for bringing UK professionals to the island for court procedures.

m) The off-island SOFME may struggle with the differences in legislation
7.2.5 **Required Resources**

The resources required if this pathway approach is adopted include:

a) Appropriate child friendly interview suite
b) Crisis workers on-island
c) ISVAs on-island
d) Post trauma/abuse support on-island
e) Training for front line staff where disclosures may occur
f) Training for off-island SOFMEs on the differences in legislation
g) Website, social media presence, posters, etc.
h) There will need to be formal contract arrangements in place for SAFMEs taking place off-island and there will need to be an island based contract manager.
i) Admin support for travel arrangements
j) Secure storage facilities for claimant evidence and notes

7.2.6 **Costs**

Considerations for costing for this option are highlighted below.

**Facility**

a) Interview suite (child friendly)
b) Secure forensic storage facility

**Equipment**

Early evidence kits

**SOFME/SARC**

a) Per claimant cost
b) Transporting evidence and claimant notes
c) Contract Manager fee

**Travel expenses**

a) Flights; taxis; hotel/s; food & drinks – this will include costs for claimant, crisis worker, as well as a family member/carer, social worker and police officer if a pre-pubescent claimant.
b) On call additional cost (crisis worker, social worker, police officer)
c) All of the above travel expenses will also apply to professionals attending court on-island
Support

a) Crisis workers on call and call out costs
b) ISVAs on call and call out costs
c) Post trauma/abuse support

Other

a) Training front line staff
b) Marketing
7.3. Option C, Hybrid Model
(SAFME for adults on-island, SAFME for pre-pubescent children off-island)

7.3.1 Example Overview Pathway

* same as on-island pathway for adults and pubescent young people, see Figure 19
* same as off-island pathway for pre-pubescent children, see Figure 20

* need to consider approach for those who lack capacity

7.3.2 Required changes

The changes required from the current services are highlighted below.

**SAFME (on-island – pubescent children/young people and adults):**

a) Male SOFME trainee to complete training enabling him to work independently, or recruitment of a male SOFME

b) Formal governance, accountability and professional support arrangements for on-island SOFMEs

c) Ensuring all FFLM standards are followed by the SOFMEs on-island

d) SOFMEs to be accessible 24/7

e) SOFME to be accessible by all services, not just police

f) Robust reporting lines for SOFMEs to follow

g) Availability of early evidence kits

**SAFME (off-island – pre-pubescent children):**

a) If SOFMEs are not required to examine pre-pubescent children, need to consider eligibility criteria to determine which claimants can attend a SARC for a SAFME.

b) Formal governance and accountability to review the quality of SOFME reports from SARC.

c) Ensuring the commissioned SARC follows the FFLM standards.

d) Compare SARCs, ensuring the journey to/from the SARC is as streamlined as possible to minimise decontamination

e) SARC and SAFME to be available 24/7 to fit in with travel arrangements for pre-pubescent children

f) Thorough risk assessment in place for claimants travelling off-island for a SAFME to minimise and highlight decontamination concerns

g) Availability of early evidence kits
Venue:

a) TNL to be refurbished or to relocate to a forensically approved venue
b) The interview suite needs to be appropriate for children

Support:

a) Availability of crisis workers or similar
b) Availability of ISVAs
c) Availability of post trauma/abuse counselling
d) Access to self-help materials

Awareness:

SARS promoted using various methods to suit the needs of claimants

7.3.3 Strengths

The strengths of adopting this pathway approach include:

a) Provide a more client-led service, offering support in the form of a crisis worker and ISVA, who will be able to answer any queries to ensure the claimant understands the process
b) Self-referrals are likely to encourage more victims to disclose
c) Provide a 24/7 crisis worker response service

SAFME (on-island – pubescent children/young people and adults):

a) Having a SARS on-island (with the exception of pre-pubescent claimants travelling off-island) will raise awareness to encourage victims to disclose, as well highlighting sexual assault as being unacceptable
b) Availability of SOFME within an hour for any adults or pubescent young people
c) Best evidence can be gathered efficiently with less risk of contamination and lost time for any claimants who are adults or pubescent young people
d) The island has more control over the structure and content of the SOFME reports produced for adults or pubescent young people
SAFME (off-island – pre-pubescent children):

a) SARC provision for pre-pubescent children will be dedicated to them and have a higher level of service than we can ever offer.

b) Continuity of service improves for pre-pubescent children. In the unlikely event the SARC provision closes, there will be alternative providers.

7.3.4 Weaknesses

The weaknesses with this pathway approach include:

a) Continuity of service with low number of SOFMEs, and potentially crisis workers for the SAFMEs undertaken on-island

b) There will need to be more than one crisis worker on call to ensure there is a back-up option in the event of more than one sexual assault case occurring, and travelling to a SARC being required at the same time. This may also impact the police and/or social workers if they continue to attend the SARC with pre-pubescent children

SAFME (on-island – pubescent children/young people and adults):

Some adults and pubescent young people may not use the service on-island for confidentiality purposes. Need to consider how they can access a SARC on mainland

SAFME (off-island – pre-pubescent children):

a) Traumatic for claimant who is a pre-pubescent child as well as their family/carer who have to travel off-island for the SAFME, and waiting so long before they can shower

b) Availability of SOFME within an hour is unachievable for claimants who are pre-pubescent children, may be difficult to achieve this within 24 hours

c) Increased risk of evidence DNA contamination and damage that will need to be transported back to the island for pre-pubescent children

d) Increased risk of loss of evidence for pre-pubescent children

e) Increased risk of negative impact on the investigation process for pre-pubescent children

f) Eligibility criteria to determine which pre-pubescent claimants can attend a SARC for a SAFME

g) The island has no control over the structure or content of the SOFME reports produced for pre-pubescent child claimants

h) Travel disruption for the pre-pubescent children needs to be considered as a risk

i) It may not be possible for the pre-pubescent claimant to travel. For example, medical purposes, fear of flying/sailing, parents/carer need to care for other family members

j) There is a high cost involved for travel, accommodation and professionals working overtime in relation to pre-pubescent children
7.3.5 Required Resources

The resources required if this pathway approach is adopted include:

a) Crisis workers on-island who can travel off-island to a SARC with pre-pubescent children

b) ISVAs on-island

c) Post trauma/abuse support

d) Training for front line staff where disclosures may occur

e) Website, social media presence, posters, etc.

f) Secure storage facilities for claimants evidence and notes

SAFME (on-island – pubescent children/young people and adults):

Forensically appropriate venue (Forensic standard medical examination room, interview suite, waiting room, toilet and shower facilities)

SAFME (off-island – pre-pubescent children):

a) Appropriate interview suite which is child friendly

b) Training on the differences in legislation for off-island SOFMEs who examine the pre-pubescent claimants

c) For the pre-pubescent children travelling off-island to a SARC, there will need to be formal contract arrangements in place and there will need to be an island based contract manager.

7.3.6 Costs

Considerations for costing for this option are highlighted below.

Facility

a) Forensic standard medical examination room, interview suite, waiting room, toilet and shower facilities

b) Interview suite (child friendly)

c) Secure forensic storage facility

Equipment

a) General medical equipment

b) Forensic storage bags

c) Early evidence kits
**SOFME (adults and pubescent young people)**

a) On call fee  
b) Call out fee  
c) CPD  
d) Management of the SOFMEs

**SOFME/SARC (pre-pubescent children)**

a) Per claimant cost  
b) Transporting evidence and claimant notes  
c) Contract Manager fee for SARC provision off-island

**Travel (pre-pubescent children)**

a) Flights; taxis; hotel/s; food & drinks – this will include costs for claimant, crisis worker, a family member/carer, social worker and police officer.  
b) On call additional cost (crisis worker, social worker, police officer)  
c) All of the above travel expenses will also apply for professionals attending court on-island

**Support**

a) Crisis workers on call and call out costs  
b) ISVAs on call and call out costs  
c) Post trauma/abuse support

**Other**

a) Training front line staff  
b) Marketing
7.4 **Option D, SAFME on-island by an off-island examiner**
(The SAFME will take place on-island by a SOFME working in a SARC who is commissioned to travel to the island to undertake a SAFME when necessary)

7.4.1. **Example Overview Pathway**

* same pathway as SAFME on-island with a note highlighting delay in SAFME due to contacting and travel arrangements for SARC SOFME to attend the island

![Diagram](Image)

*Figure 21. Option D, SAFME on-island by an off-island examiner*

*Source: Adapted, based on the SARCs Pathway and Minimum Elements diagram, see Figure 17*
7.4.2 Required changes

The changes required from the current services are highlighted below.

**SAFME:**

a) Off-island male and female SOFMEs who are competent in examining children will be required for commissioning

b) Records of SOFME training and continued CPD/peer reviews will be required, ensuring they follow all FFLM standards

c) SOFMEs to be contactable 24/7

d) SOFME to be accessible by all services and not just police

e) Robust reporting lines for SOFMEs to follow

f) Availability of early evidence kits

g) Formal governance and accountability to review the quality of the off-island

h) SOFMEs reports

**Venue:**

TNL to be refurbished or relocate to a forensically approved venue that is age appropriate

**Support:**

Availability of crisis workers or similar

Availability of ISVAs

Availability of post trauma/abuse counselling

Access to self-help materials

**Awareness:**

SARS promoted using various methods to suit the needs of claimants

7.4.3 Strengths

a) The strengths of adopting this pathway approach include:

b) Having a SARS on-island will raise awareness to encourage claimants to disclose as well as highlighting sexual assault as being unacceptable

c) Provide a more client-led service, offering support in the form of a crisis worker and ISVA, who will be able to answer any queries to ensure the claimant understands the process

d) Self-referrals are likely to encourage more claimants to disclose

e) Provide a 24/7 crisis worker response service

f) Best evidence can be gathered on-island with less risk of contamination
g) The island will have some control over the structure and content of the SOFME reports produced

h) Continuity of service improves. In the unlikely event the SOFME resigns, there will be alternative examiners.

7.4.4 Weaknesses

a) The weaknesses with this pathway approach include:
b) SAFME within an hour is unachievable, may be difficult to achieve this within 24 hours
c) Need to establish who the SOFMEs will report to
d) Increased cost for SOFME having to travel to the island for court procedures in relation to the SAFMEs they’ve carried out
e) The off-island SOFME may struggle with the differences in legislation
f) Continuity of service with a potential low number of crisis workers
g) Some individuals may not use the service on-island for confidentiality purposes. Need to consider how they can access a SARC on mainland
h) Traumatic for claimant having to wait so long for the SOFME to arrive on the island before they can shower
i) Increased difficulty for those who have been or are being domestically abused being able to attend without their partner being aware due to the length of time they would need to wait for the SOFME to arrive on the island to undertake the SAFME
j) Increased risk of negative impact on the investigation process
k) Eligibility criteria to determine which claimants can have a SAFME by an off-island SOFME
l) The island has little control over the structure and content of the SOFME reports produced
m) Travel disruption for the SOFME trying to get to the island
n) Increased cost for off-island SOFME to be on call as well as their travel, accommodation and call out fees.
o) Increased cost for bringing off-island SOFMEs to the island for court procedures.

7.4.5 Required Resources

a) The resources required if this pathway approach is adopted include:
b) Forensically appropriate venue which is child friendly (Forensic standard medical examination room, interview suite, waiting room, toilet and shower facilities)
c) SOFMEs willing to travel to the island
d) Crisis workers on-island
e) ISVAs on-island
f) Post trauma/abuse support on-island
g) Video colposcope
h) Training for front line staff where disclosures may occur
i) Training for off-island SOFMEs on the differences in legislation
j) Website, social media presence, posters, etc.
k) There will need to be formal contract arrangements in place for the off-island SOFMEs and there will need to be an island based contract manager
l) Secure storage facilities for claimants evidence and notes

7.4.6 Costs

Considerations for costing for this option are highlighted below.

Facility

a) Forensic standard medical examination room, interview suite, waiting room, toilet and shower facilities (child friendly)
b) Secure forensic storage facility

Equipment

a) General medical equipment
b) Forensic storage bags
c) Early evidence kits
d) Video colposcope: approximately £10,000 – to be replaced every ten years, plus an annual service

SOFME from SARC

On call fee
Call out fee

CPD

Contract Manager fee for off-island SOFME attending the island

Travel expenses

Flights; taxis; hotel/s; food & drinks – off-island SOFME travelling to the island
Court procedures – off-island SOFME travelling to the island

Support

Crisis workers on call and call out costs
ISVAs on call and call out costs
Post trauma/abuse support
Other

Training front line staff
Marketing
7.5 Comments from Dr Liz Adamson, Designated Doctor for Safeguarding Children

Current situation is clearly not acceptable!

Would go for **Option C (Hybrid) for Children:**

1. Very unlikely that sufficient expertise could be robustly developed on the island because of the small number of cases and/or the small number of paediatrically trained FME’s.

2. Cover between the small number of FME’s would also be difficult and peer review would need to be organised off island if this were to counter the small number of on-island cases.

3. Child examinations require an appropriate colposcope and a skilled “second pair of hands” is needed in order to carry out the examination as well as obtaining a good colposcopic video. This is particularly important in children as it is common to only have a relatively short window of opportunity for direct visual examination and a video that can be studied at leisure can be vital. These facilities would also need to be provided if option C were to be implemented.

4. These considerations outweigh the disadvantage of the longer wait for medical examination in my view.

5. Many cases of child disclosure do not fall within a timeframe for forensic specimens so the delay would often not be too much of a problem.

6. Because of different genital anatomy and physiology in children, external swabs can be as informative as internal ones – the island’s FME’s or a well trained nurse could therefore take early evidence for the few children who do present acutely (depending on how the child reacts to this).

7. It is also unacceptable for children to have to attend separately for STD screening so this needs to be available at the time of the examination as is the case in a paediatric service.

In respect of age of puberty as the determining factor for a paediatric or adult service – in my view all children below 11 years of age should be seen in a paediatric service whatever their stage of puberty. From 11 to 16 years the decision can be based on puberty and from the 16th birthday onwards they can be viewed as adults. Having said which, it would probably be good practice to allow for flexibility around learning disability and/or obvious emotional immaturity. (Personally I have always advocated for all under 16 year olds to have a paediatric service as so many of them have complex problems that a paediatrician is likely to have more experience of. However, I accept that this is unrealistic for many services and probably unattainable on the Isle of Man!).
I feel that there probably needs to be clearer differentiation of the under 16 pathways from the adult pathways as there will always be child protection issues and a crime has always been committed (even if not pursued through the courts) so there are fundamental differences even if the venue/personnel for the SAFME are the same for the older children.

[Note from Deborah Brayshaw, Director, Families and Children: ‘if the adult “medical” pathway is followed for over 16’s from a safeguarding perspective they are legally still children under the law.’]
8. Acknowledgements

8.1 Sexual Health Executive Steering Group

Please note, this group identified the priorities for the needs assessments and then stood down to allow the needs assessments to be carried out. Whilst the needs assessment has been undertaken, numerous changes have occurred and the report is now being submitted to the Social Policy and Children’s Committee, so this group has not been re-engaged.

Chair Mr R Peake MHK
Dr H Ewart Director of Public Health
Dr M Couch CEO Health and Social Care
Mr M Kelly CEO Home Affairs
Prof Ronald Barr CEO Education and Children
Mr G Roberts Chief Constable (or representative of Isle of Man Constabulary)
Mr T Mansfield Director of Commissioning Health and Social Care
Ms A Howland Public Health Strategic Lead

SARS Project Steering Group
Dr H Ewart Director of Public Health
Mr T Mansfield Director of Commissioning Health and Social Care
Mr G Roberts Chief Constable
Mr J Bibby Detective Chief Inspector, Police
Ms M McKillop Detective Inspector, Police
Ms D Bell Senior Health Improvement Officer, Public Health

8.2 SARS Stakeholder Group

Please note a number of the members highlighted in the stakeholder group below are corresponding members whereby they would be involved in the circulations and send through comments but not attend the meetings. Further professionals were also invited to be a stakeholder but did not feel it was appropriate for their role.

Department of Health and Social Care, Public Health Directorate
Chair Dr H Ewart Director of Public Health
Ms D Bell Senior Health Improvement Officer, Sexual Health Lead
Ms J Dunn Senior Nurse Health Protection
Ms M Sayle Senior Public Health Intelligence Analyst

Department of Health and Social Care, Corporate Services Division
Mr T Mansfield Director of Commissioning

Department of Health and Social Care, Primary Care Directorate
*Dr I Kewley Director of Primary Care
Ms A Philips Lead Nurse Prison
Department of Health and Social Care, Acute Healthcare Division
Ms M Morris Executive Director of Health
*Mr M Quinn Medical Divisional Manager
Dr D Mandal Genitourinary Medicine Consultant
Ms A Dawson Genitourinary Medicine Clinical Nurse
Dr A Hamm Clinical Director, Sexual Assaults Service
Ms J Sloane Head of Midwifery

Department of Health and Social Care, Emergency Department
Dr D Hedley Nobles Hospital, A&E Doctor

Department of Health and Social Care, Mental Health Directorate
Ms E McClean Child and Adolescent Mental Health Service Manager
*Mr R Bailey Professional Leadership Team
Mr D McClean Safeguarding Lead, Mental Health

Department of Health and Social Care, Social Services, Adults Social Care
Ms J Bradford Social Work Assistant

Department of Health and Social Care, Children and Families Social Care Directorate
Ms N Couling Principle Social Worker Children and Families
*Ms J Frank Service Manager, Initial Response Team

Department of Home Affairs
Deputy Ms M McKillop Detective Inspector, Police
Ms J Welch Probation Service Officer

Department of Education and Children
*Ms M Keary Physical and Emotional Health Education Officer
Ms G Burns Child Protection and Safeguarding Officer
Ms G Phillips Student Welfare Officer, University College Isle of Man

Third Sector
Ms J Sloane Crossroads Care Adults Representative
Ms H Murphy Crossroads Care Children’s Representative
Mr M Manning Graih Representative
Mr T Watterson IOM HIV Support Group Representative
Ms M Brabbs Safe Strong Secure (3S) Representative
Ms A Seed St Christopher’s Representative
*Ms L King The Children’s Centre Representative
Ms C Brand The Manx Rainbow Association Representative
Ms P Gelling Victim Support Representative

* Dr I Kewley, Director of Primary Care has now retired
* Mr M Quinn is no longer the Medical Divisional Manager and has been replaced on the Stakeholder Group by Mr M Smith.
* Mr R Bailey, Professional Leadership Team for Mental Health, no longer attends. The MHS is covered by Ms E McClean and Mr D McClean.
* Ms J Frank, Service Manager, Initial Response Team, has retired and been replaced on the Stakeholder Group by Ms J McEwan.
* Ms M Keary, Physical and Emotional Health Education Officer, stepped down from the Stakeholder Group and Ms G Burns attended to represent DEC.
* Ms L King, The Children’s Centre Representative, nominated Mr M Meaghan to represent The Children’s Centre.
### 8.3 SARS Stakeholder Sub-Groups

**Quantitative Statistics**
- **Lead Ms M Sayle** Senior Public Health Intelligence Analyst
- **Ms A Dawson** Genitourinary Medicine Clinical Nurse
- **Ms M McKillop** Detective Inspector, Police
- **Ms M Brabbs** Safe Strong Secure (3S) Representative
- **Ms P Gelling** Victim Support Representative

**Current services cost and activity**
- *Lead Mr T Mansfield* Director of Commissioning
- *Lead Dr A Hamm* Clinical Director, Sexual Assaults Service
- **Ms D Bell** Senior Health Improvement Officer, Sexual Health Lead
- **Ms M Sayle** Senior Public Health Intelligence Analyst
- **Ms M McKillop** Detective Inspector, Police
- *Dr H Greig* General Practitioner & SOFME
- **Dr D Hedley** Nobles Hospital, A&E Doctor
- **Ms A Dawson** Genitourinary Medicine Clinical Nurse
- **Mr R Bailey** Professional Leadership Team
- **Ms M Brabbs** Safe Strong Secure (3S) Representative
- **Ms P Gelling** Victim Support Representative

*Mr T Mansfield was the commissioning lead and Dr A Hamm was the clinical lead
*Dr H Greig was nominated for this sub-group but was unable to attend

**Qualitative Data**
- **Lead Ms D Bell** Senior Health Improvement Officer, Sexual Health Lead
- **Ms J Frank** Service Manager, Initial Response Team
- **Ms E McClean** Child and Adolescent Mental Health Service Manager
- **Ms G Phillips** Student Welfare Officer, University College Isle of Man
- **Ms J Sloane** Crossroads Care Adults Representative
- **Ms H Murphy** Crossroads Care Children’s Representative
- **Ms M Brabbs** Safe Strong Secure (3S) Representative
- **Ms P Gelling** Victim Support Representative

### 8.4 Further Support

- **Ms J Wheeler** Change and Reform Programme Lead, Cabinet Office
- **Ms AM Goldsmith** Change and Reform Programme Lead, Cabinet Office
- **Ms P Smith** Change and Reform Officer, Cabinet Office
- **Ms C Collister** Public Health Intelligence Assistant
- **Mc E Bennett** Health Improvement Officer, Public Health

### 8.5 Anecdotal Feedback & Focus Group Attendees

This includes Service Providers and Support Workers who provided qualitative data. This was either via anecdotal feedback or through attending one of the SARS focus groups.
Anecdotal Feedback from SARS Stakeholders:
Ms M McKillop  Detective Inspector, Police
Dr A Hamm  Clinical Director, Sexual Assaults Service
Ms A Dawson  Genitourinary Medicine Clinical Nurse
Ms J Frank  Service Manager, Initial Response Team
Ms E McClean  Child and Adolescent Mental Health Service Manager
Mr D McClean  Safeguarding Lead, Mental Health
Ms J Sloane  Crossroads Care Adults Representative
Ms H Murphy  Crossroads Care Children’s Representative
Ms M Brabbs  Safe Strong Secure (3S) Representative
Ms P Gelling  Victim Support Representative

Anecdotal Feedback from other professionals:
Dr W Van Der Merwe Consultant Paediatrician
Ms H Crossey  Designated Nurse for Safeguarding Children
Ms M Swindlehurst  Service Lead for Adult Community Nursing
Mr G Daly  Learning Disabilities Liaison Nurse
Ms M Davies  Specialist Health Visitor for Vulnerable Adults
Ms J Dalton  Minor Injuries Unit, Nurse Practitioner
Mr J Hawkins  Minor Injuries Unit, Lead Nurse Practitioner
Mr D Griffiths  Team Manager, Adult Social Care Directorate
Mr P Jackson  Dementia Strategy Lead, Mental Health Directorate

Ideal Service Focus Group
(one session held)
• Police
• SOFMEs
• Emergency Department
• Mental Health
• Public Health
• Safe Strong Secure

Customer Journey Mapping Focus Group
(three sessions held + an additional session)
• Emergency Department
• Adult Social Care
• Police
• Children and Families
• DEC Safeguarding
• Graih
• DEC PSHE Lead
• Health Visitor
• GUM
• The Children’s Centre
• School Nurse
• Midwifery
• St Christopher’s
• Mental Health
• Crossroads
• Safe Strong Secure
• Victim Support
• GP
• Youth Service & School
• Listening Service
**Invited but could not attend / did not respond**

Those who were invited to these focus groups but could not attend or did not respond include:

- SOFMEs
- Manx Rainbow Association
- HIV Support Group
- Samaritans
- Relate
- Age Isle of Man
- Prison
- Family Planning

- Pharmacy
- Probation
- Youth Justice
- Older Person’s Mental Health
- Adult Social Care, Disabilities Team
- Pathology lab
- University College IOM
9. Glossary

**Sexual Assault:** A sexual assault is any sexual act that a person did not consent to, or is forced into against their will. It is a form of sexual violence and includes rape (an assault involving penetration of the vagina, anus or mouth), or other sexual offences, such as groping, forced kissing, child sexual abuse or the torture of a person in a sexual manner.  

**SARC:** A SARC provides services to victims of rape or sexual assault regardless of age and gender, and whether the victim reports the offence to the police or not, and can provide onward referrals to other health and social care services according to need.

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Appendices
# Sexual Assault Referral Services Project Charter

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Sexual Assault Referral Service (SARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Description</td>
<td>To undertake a full needs assessment including epidemiology, current pathway and services, activity and cost, benchmarking against best practice and views of providers and support workers. To produce a specification and pathway to support victims/survivors (regardless of gender) of rape or sexual assault. This should include whether or not the victim/survivor chooses to report the offence to the police. As well as supporting the victims/survivors to make informed decisions about what they want to do next.</td>
</tr>
<tr>
<td>Project Justification</td>
<td>There is currently no fully operational SARS locally. The service the IOM operates is not meeting best practice and the forensic equipment is due for renewal. To produce a needs based specification for sexual assault referral services, by either replacing current arrangements or linking with the UK. This should include a pathway for children and adults; men and women; as well as for those with a learning disability. The remit will cover victims/survivors of sexual assault on the Isle of Man including those who have been sexually assaulted off-island who report the assault to services on the island, irrespective of whether they are an Isle of Man resident.</td>
</tr>
<tr>
<td>Project Sponsors</td>
<td>Henrietta Ewart and Michelle McKillop</td>
</tr>
<tr>
<td>Project Lead</td>
<td>Danielle Bell</td>
</tr>
<tr>
<td>Project Manager</td>
<td>To be confirmed once appointed</td>
</tr>
<tr>
<td>Project Start Date</td>
<td>July 2016</td>
</tr>
<tr>
<td>Project Finish Date</td>
<td>March 2017</td>
</tr>
<tr>
<td>Outcomes</td>
<td>To produce a needs based specification and pathway for sexual assault referral, by either revising current arrangements or links with the UK.</td>
</tr>
</tbody>
</table>
| Key Relationships  | - Integrated Sexual Health Service Stakeholder Group  
                     - Safeguarding boards |
Key Deliverables

A needs assessment including:

- Analysis of data on sexual assault
- Completion of mapping against current services spend and activity
- Benchmark against best practice/quality standards spend and activity
- Qualitative input from service providers and support workers
- Gap analysis completed
- Identification of priority areas
- Consider and make recommendations for the involvement of other services and professionals such as community pharmacists
- Service specification for the sexual assault referral service based on the needs assessment
- A clear pathway for sexual assault referral

Key Milestones

- Completion of focused needs assessment
- Completion of mapping against current services
- Benchmark against best practice/quality standards
- Gap analysis completed
- Identification of priority areas
- Service specification and pathways agreed
- Passed to the Sexual Health Strategy Steering Group for decision and funding

Project Scope

- Needs assessment for SARS
- Service specification for SARS

Out of scope

Other sexual health services (although links as appropriate will need to be included in the pathway)

Stakeholders

SARS Stakeholder Group

Support Required

IT support, admin and secretarial support
Appendix 2

Police Workforce

Minimum 24/7
10 Response Officers
1-2 Sergeants
Duty Inspector

Mon-Fri
7 Detectives
9am-5pm
1 Detective Sergeant
1 Detective Inspector

Mon-Thurs
No Detectives on call but Duty Inspector may call Detectives
Evenings
to see if anyone is available, if required.

Weekends
2 CID Detectives
on call 5pm Fri
To 8am Mon
1 PPU Officer
1 Detective Superintendent
8. Prioritise the protection of life and urgent medical attention, if an ambulance is dispatched please advise the crew of forensic awareness and provide guidance.

9. Establish location of the victim in relation to the suspect – Is the victim still at risk, categorise the level of response.

10. It is essential that the victim is told prior to the arrival of the Police:

11. Not to wash or bathe

12. Not to change, wash or dispose of any clothing

13. Not to go to the toilet (If they insist, request that the urine be retained in a clean container)

14. Not to have anything to drink or clean their teeth

15. Where possible ascertain location of the suspect if known to caller and location of incident taking place.

16. Except in emergency the officer attending the location of the victim shall not attend in a livered vehicle and the victim will be made aware of this fact.

17. The Duty Sergeant shall be made aware of the call. If available the duty DS shall be notified followed by the Duty Inspector, where there is no DS available the Duty Inspector shall be made aware.
18. In the event the suspect is a stranger this will be classed as a major incident and the Duty Inspector shall be notified immediately.

19. When possible the victim should be taken to the Thie-Ny-Lheiys facility in order to be examined by the on call sexual offences FME.

20. Officers should remain mindful of cross contamination at all times.

21. Where possible the first account should be recorded / obtained / secured and this should include a description of the offender where possible.

22. Subsequent full victim interviews will be conducted by CID or PPU officers.

23. **Non recent or Historic incident;**

24. No requirement to inform duty Inspector.

25. CID or PPU shall be notified at the earliest opportunity and will expect a crime report, initial account details in the most appropriate format and a full hand over including officer statements and any exhibits to be provided or completed.

26. **Which department shall take over the investigation?**

27. CID will deal with Rape in the main UNLESS;

   * The rape is interfamilial
   * Victim or offender is under 18 years of age
   * Victim or offender is vulnerable through mental health or learning difficulties
   * Historic or complex nature or significant child safeguarding issues

In the event any of the four above categories apply the PPU will deal.
Police Standard Operational Procedures for Rape, Sexual Assault or Abuse through Violence or Neglect on a Child (under 18yrs)

Isle of Man Constabulary

EMERGENCY SERVICES JOINT CONTROL ROOM
POLICE STANDARD OPERATIONAL PROCEDURES

SUBJECT: RAPE, SEXUAL ASSAULT OR ABUSE THROUGH VIOLENCE OR NEGLECT ON A CHILD (UNDER 18yrs)

UPDATED: 28/11/2015

Incident has recently occurred (Past 24 hours)

1. Prioritise the protection of life and urgent medical attention, if an ambulance is dispatched please advise the crew of forensic awareness and provide guidance.

2. Establish location of the victim in relation to the suspect – Is the victim still at risk, categorise the level of response.

3. Safeguarding the child and any other children identified as being at risk shall be the priority.

4. For sexual offences - It is essential that the victim OR caller on behalf of the victim is told prior to the arrival of the Police:

5. Not to wash or bathe the victim

6. Not to change, wash or dispose of any clothing

7. Victim not to go to the toilet (If they insist, request that the urine be retained in a clean container)

8. Victim not to have anything to drink or clean their teeth

9. Where possible ascertain location of the suspect if known to caller and location of incident taking place.

10. Except in emergency the officer attending the location of the victim shall not attend in a livered vehicle and the victim or caller will be made aware of this fact.

11. The duty Sergeant shall be made aware of the call. The Duty Inspector shall be made aware immediately and may deem the matter a serious or major incident dependant on the circumstances. If available the duty DS shall be notified immediately.
12. Secondary to notifying the Duty Inspector, the DS and DI of PPU shall also be made aware at the earliest opportunity.

13. The duty child social worker MUST also be made aware however if the police are dealing with a dynamic situation he / she shall liaise with the senior officer.

14. For sexual offences - When possible the victim should be taken to the Thie-Ny-Lheiys facility in order to be examined by the on call sexual offences FME (Advice will be required from the FME regarding their capability to examine certain children in certain situations) Policy decision will be required on this point from Duty Inspector.

15. Officers should remain mindful of cross contamination at all times

16. Where possible the first account from the person to whom the victim disclosed should be recorded / obtained / secured and this should include a description of the offender where possible if the offender is unknown to the victim.

17. MARF must be submitted to PPU regardless of DCSW being made aware

18. Subsequent investigation and full victim interviews will be conducted by PPU officers.

19. Non recent or Historic incident;

20. Inform duty Inspector

21. Consider safeguarding as a priority

22. PPU shall be notified at the earliest opportunity and will expect a crime report, initial account details in the most appropriate format and a full hand over including officer statements and any exhibits to be provided or completed.

23. MARF must be submitted to PPU

24. Which department shall take over the investigation?

25. PPU
Appendix 4

Local pathways previously created

a) Isle of Man Sexual Assault Pathway

Read Me (all)
- People who have been sexually assaulted may feel vulnerable, alone, confused, distressed, tearful or angry.
- They can appear calm or withdrawn but may also be emotional, uncooperative or aggressive.
- Make them feel safe, valued and supported.

Read Me (prescriber notes)
- Post coital contraception
  - Either Levonelle 1.5mg stat if less than 3 days
  - Ella One stat up to 5 days
- Intrauterine device via Family Planning or Gynaecology Services up to day 19 of a 28 day cycle

STI Management
- Offer post exposure prophylaxis as per local guidelines.
- STI screening 10-14 days post assault.
- Offer Hep B vaccine as per BNF.
- Screening for HBV after 3 months.

Yes

Any injury requiring treatment

Deal with any injuries
- Encourage patient to involve police
- Insist for forensic examination

Any injury requiring treatment

Yes

Assess HIV risk ASAP (see PEP Guidance)
- Aims to start PEP within 1 hour

Patient accompanied by Police?

Advise urgent police involvement for referral to the Forensic Medical Examiner (FME).
- See advice re early evidence samples.

Patient agrees to forensic examination

Complete injury care
- Consult police advice regarding early

Discuss post coital contraception, STI management and Hepatitis B vaccination.
- Advise patient to visit CUM clinic as soon as possible.
- Inform about available sources of support.
- Consider PEP 3-7 days STI screening 10-14 days HBV screening 3 months after assault if decline CUM.

Forensic examination to take place?

Yes

Discharge home
- Provide information for supporting victim support.
- Give contact telephone numbers.

Patient feels unsafe at home?

Seek guidance from police/duty social worker

No

Care of the victim is paramount. The need for care overrides the need for evidence. Consider collection of evidence if possible.

Patient accompanied by Police?

Advise urgent police involvement for referral to the Forensic Medical Examiner (FME).
- See advice re early evidence samples.

Patient agrees to forensic examination

Complete injury care
- Consult police advice regarding early

Discuss post coital contraception, STI management and Hepatitis B vaccination.
- Advise patient to visit CUM clinic as soon as possible.
- Inform about available sources of support.
- Consider PEP 3-7 days STI screening 10-14 days HBV screening 3 months after assault if decline CUM.

Forensic examination to take place?

Yes

Discharge home
- Provide information for supporting victim support.
- Give contact telephone numbers.

Patient feels unsafe at home?

Seek guidance from police/duty social worker

No

Police to arrange transport
b) Victim Process Chart

Options available:
- Specialist Support
- Risk Assessment
- Medical Care
- Forensic Examination
- Sexual Health Screening
- Emergency Contraception
- Organise follow-up care and counselling

If you choose not to proceed at any point options are still available for follow-up care and counselling.
Appendix 5

BASHH - Management of Adult and Adolescent Complainants of Sexual Assault

Suggested follow-up schedules after sexual assault  NB:

- Not all will be applicable - the client’s wishes must be taken into account
- PEPSE follow-up recommendations may change and the reader is advised to check the latest PEPSE guidelines from BASHH

At presentation

- Baseline HIV, hepatitis B, C and syphilis serology
- HIV PEPSE baseline bloods such as: FBC, U&E’s LFT’S, Glucose, Amylase
- 1st Hepatitis B vaccination or booster dose if previously vaccinated
- STI screening if symptomatic
- Consider prophylactic antibiotic treatment if that is what the client wishes
- Self-harm risk identification with referral to mental health if risk high, or GP if low to medium risk
- Assessment of safety, practical needs and child protection
- Counsellor makes contact to arrange follow up appointment

2 weeks post assault

- STI screening
- 2nd Hepatitis B vaccination (if accelerated schedule)
- HIV PEPSE Review
- Self-harm risk identification if risk medium to high (or not assessed at 1st follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, safety, practical needs and child protection issues
- Counsellor review if necessary or if client wishes

3 weeks post assault

- 3rd Hepatitis B vaccination
- HIV PEPSE review if necessary
- Pregnancy test if indicated
- Self-harm risk identification if risk medium to high (or not assessed at 2nd follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, safety, practical needs and child protection issues
- Counsellor review if necessary or if client wishes
4 weeks post assault

- HIV serology if high risk exposure, using 4th generation HIV test if HIV PEPSE was not given
- HIV PEPSE final follow up bloods such as FBC, LFTs, Lipids and glucose
- Syphilis serology
- Self-harm risk identification if risk medium to high (or not assessed at 3rd follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, practical needs, as well as safety and child protection issues
- Counsellor review if necessary or if client wishes

6 weeks post assault

- Syphilis serology
- Screening for chlamydia if bacterial prophylaxis given post assault
- Self-harm risk identification if risk medium to high (or not assessed at 4th follow up visit) with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, practical needs, as well as safety and child protection issues
- Counsellor review if necessary or if client wishes

3 months post assault

- HIV, hepatitis B, C, syphilis serology
- Self-harm risk identification with referral to mental health if risk high, or GP if low to medium risk
- Assessment of coping, practical needs as well as safety and child protection issues
- Counsellor review if necessary

4 months post assault

- HIV serology if HIV PEPSE was taken
- 6 months post assault
- HIV test if 4th generation HIV tests not available
- Hepatitis B, C and syphilis serology
Appendix 6

**Sexual Assault Referral Centre Indicators of Performance**

**Key:**
- ● NHSE performance schedule
- ◊ Annual audit

<table>
<thead>
<tr>
<th>Key Performance Indicator / Information Measure</th>
<th>KPI Description</th>
<th>Monitored via:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Complaints / Victim Voice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complaints Initial Response</td>
<td>100% of complaints receive an initial response within 3 working days</td>
<td>●</td>
</tr>
<tr>
<td>Complaints Full Response</td>
<td>100% of complaints receive a detailed response within 25 days. If further action is required beyond the timescale then a subsequent date will be agreed with the complainant</td>
<td>●</td>
</tr>
<tr>
<td>Quarterly Patient Survey</td>
<td>Quarterly patient survey conducted with an action plan drawn up and reviewed monthly</td>
<td>◊</td>
</tr>
<tr>
<td><strong>Clinical Suitability/Supervision</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice of SoE Examiner (Gender)</td>
<td>Clients offered choice of gender of forensic medical practitioner</td>
<td>◊</td>
</tr>
<tr>
<td>Completion of SOM</td>
<td>% of SOE's who have completed &gt;= 20 hours SOM within the past 6 months</td>
<td>◊</td>
</tr>
<tr>
<td>PDR Agreement</td>
<td>% of SARC Staff who have an agreed PDR for the preceding 12 months</td>
<td>◊</td>
</tr>
<tr>
<td>Peer Review</td>
<td>% of SoE's who have had &gt;= 4 peer review meetings in the previous 12 months</td>
<td>◊</td>
</tr>
<tr>
<td>Mentorship</td>
<td>% of Examiners who have a named mentor</td>
<td>◊</td>
</tr>
<tr>
<td><strong>STI / BBV Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Testing</td>
<td>% of victims tested for HIV</td>
<td>●</td>
</tr>
<tr>
<td>Sexual Infection Testing</td>
<td>% of victims tested for a sexual infection</td>
<td>●</td>
</tr>
<tr>
<td>Hepatitis B Testing</td>
<td>% of victims tested for Hepatitis B</td>
<td>●</td>
</tr>
<tr>
<td>Hepatitis C Testing</td>
<td>% of victims tested for Hepatitis C</td>
<td>●</td>
</tr>
<tr>
<td><strong>PEPSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of PEPSE</td>
<td>% of victims who were assessed for PEPSE</td>
<td>●</td>
</tr>
<tr>
<td>Uptake of PEPSE</td>
<td>% of victims who received PEPSE within 72 hours</td>
<td>●</td>
</tr>
<tr>
<td>Completion of PEPSE</td>
<td>% of victims who received PEPSE who completed the recommended course</td>
<td>●</td>
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<tr>
<td><strong>Sexual Health</strong></td>
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<tr>
<td>Emergency Contraception</td>
<td>% of victims who received Emergency Contraception</td>
<td>●</td>
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<tr>
<td>Referral to Sexual Health</td>
<td>% of victims who were referred to sexual health services</td>
<td>●</td>
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<tr>
<td><strong>Response Times</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact on First Call Out of Hours</td>
<td>% of SoE who respond to first call out of hours</td>
<td>●</td>
</tr>
<tr>
<td>Urban Area Response Times</td>
<td>% of victims seen by a SoE within agreed contract times in urban areas</td>
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</tr>
<tr>
<td>Rural Area Response Times</td>
<td>% of victims seen by a SoE within agreed contract times in Rural areas</td>
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<td><strong>Counselling</strong></td>
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</tr>
<tr>
<td>Counselling Waiting Times</td>
<td>% of patients who waited &lt;= 4 weeks for first counselling appointment</td>
<td>●</td>
</tr>
<tr>
<td>Counselling</td>
<td>% of victims provided counselling with14 days</td>
<td>●</td>
</tr>
<tr>
<td><strong>Criminal Justice</strong></td>
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<td></td>
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<tr>
<td>Statements</td>
<td>% of Statements received within 14 days of Sexual Offence Examination.</td>
<td>●</td>
</tr>
<tr>
<td>ISVA</td>
<td>% of victims engaging the services of a named ISVA</td>
<td>●</td>
</tr>
<tr>
<td>Assault Reported to Police</td>
<td>% of victims who report incident to the police</td>
<td>●</td>
</tr>
</tbody>
</table>
### Sexual Assault Service - Minimum Data Set

<table>
<thead>
<tr>
<th>Attendance</th>
<th>Male Victims</th>
<th>●</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Female Victims</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>Attendances in hours</td>
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<tr>
<td></td>
<td>Attendances out of hours</td>
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<tr>
<td>Assault Type</td>
<td>Rape</td>
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<tr>
<td></td>
<td>Sexual Assault (Non Rape)</td>
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<tr>
<td></td>
<td>Historic Abuse</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>Child Abuse</td>
<td>●</td>
</tr>
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<td></td>
<td>Grooming</td>
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<tr>
<td>Contact Type</td>
<td>Forensic Client</td>
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<tr>
<td></td>
<td>Non Forensic Client</td>
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</tr>
<tr>
<td></td>
<td>Forensic Client Follow Up</td>
<td>●</td>
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<tr>
<td></td>
<td>ISVA Follow Up</td>
<td>●</td>
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<tr>
<td></td>
<td>Counselling Follow Up</td>
<td>●</td>
</tr>
<tr>
<td>Source of Referral</td>
<td>Police – SOLO</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>Police – CID</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>Police – Control Room</td>
<td>●</td>
</tr>
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<td></td>
<td>Police – Other</td>
<td>●</td>
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<tr>
<td></td>
<td>Voluntary Sector</td>
<td>●</td>
</tr>
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<td></td>
<td>Social Services</td>
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<td></td>
<td>School</td>
<td>●</td>
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<tr>
<td></td>
<td>GUM/CASH Clinic</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>GP</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>Family/Friends</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>A&amp;E</td>
<td>●</td>
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<tr>
<td>BME Status</td>
<td>White-British</td>
<td>●</td>
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<tr>
<td></td>
<td>White-Irish</td>
<td>●</td>
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<tr>
<td></td>
<td>White-Other</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>White &amp; Black Caribbean</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>White &amp; Black African</td>
<td>●</td>
</tr>
<tr>
<td></td>
<td>White &amp; Asian</td>
<td>●</td>
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<tr>
<td></td>
<td>Indian</td>
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<tr>
<td></td>
<td>Pakistani</td>
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<tr>
<td></td>
<td>Bangladeshi</td>
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<td>Asian-Other</td>
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<tr>
<td></td>
<td>Black-Caribbean</td>
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<td></td>
<td>Black-African</td>
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<tr>
<td></td>
<td>Black-British</td>
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<tr>
<td></td>
<td>Black-Other</td>
<td>●</td>
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<tr>
<td></td>
<td>Chinese</td>
<td>●</td>
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<tr>
<td></td>
<td>Not Known / Given</td>
<td>●</td>
</tr>
<tr>
<td>Age</td>
<td>&lt;=12</td>
<td>●</td>
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<tr>
<td></td>
<td>13-15</td>
<td>●</td>
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<tr>
<td></td>
<td>16-17</td>
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<tr>
<td></td>
<td>18-24</td>
<td>●</td>
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<td></td>
<td>25-34</td>
<td>●</td>
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<tr>
<td></td>
<td>35-44</td>
<td>●</td>
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<tr>
<td></td>
<td>45-54</td>
<td>●</td>
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<tr>
<td></td>
<td>55-64</td>
<td>●</td>
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<tr>
<td></td>
<td>65 +</td>
<td>●</td>
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</table>
**Definitions for SARCIP:**

### Complaints / Victim Voice

<table>
<thead>
<tr>
<th><strong>Complaints Initial Response</strong></th>
<th>100% of complaints receive an initial response within 3 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>The number of complaints that receive an initial response with 3 working days</td>
</tr>
<tr>
<td>Denominator</td>
<td>The total number of complaints received within the reporting period</td>
</tr>
</tbody>
</table>

### Complaints Full Response

100% of complaints receive a detailed response within 25 days. If further action is required beyond the timescales then a subsequent date will be agreed with the complainant.

| Numerator                      | The number of complaints that receive a detailed response within 25 days |
| Denominator                    | The total number of complaints received within the reporting period |

### STI/BBV Testing

#### HIV Testing

The % of victims tested for HIV

| Numerator                      | The number of victims tested for HIV |
| Denominator                    | The number of referrals into the SARC during the reporting period |

#### Sexual Infection Testing

The % of victims tested for a Sexual Transmitted Infection

| Numerator                      | The number of victims tested for a Sexual Transmitted Infection |
| Denominator                    | The number of referrals into the SARC during the reporting period |

#### Hepatitis B Testing

The % of victims tested for Hepatitis B

| Numerator                      | The number of victims tested for Hepatitis B |
| Denominator                    | The number of referrals into the SARC during the reporting period |

#### Hepatitis C Testing

The % of victims tested for Hepatitis C

| Numerator                      | The number of victims tested for Hepatitis C |
| Denominator                    | The number of referrals into the SARC during the reporting period |

### PEPSE

#### Availability of PEPSE

The % of victims who were assessed for PEPSE

| Numerator                      | The number of victims who were assessed for PEPSE |
| Denominator                    | The number of referrals into the SARC during the reporting period |

#### Uptake of PEPSE

The % of victims who received PEPSE within 72 hours

| Numerator                      | The number of victims that received PEPSE within 72 hours |
| Denominator                    | The number of victims that were assessed for PEPSE within the reporting period |

#### Completion of PEPSE

The % of victims who received PEPSE who completed the recommended course

| Numerator                      | The number of victims that competed the recommended course |
| Denominator                    | The number of victims that received PEPSE |
### Sexual Health

#### Emergency Contraception
The % of victims who received Emergency Contraception

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of victims who received Emergency Contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of referrals into the SARC during the reporting period</td>
</tr>
</tbody>
</table>

#### Referral to Sexual Health
The % of victims who were referred to Sexual Health Services

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of victims who were referred to Sexual Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of referrals into the SARC during the reporting period</td>
</tr>
</tbody>
</table>

### Response Times

#### Contact on Frist Call Out of Hours
The % of SoE’s who respond to first call out of hours

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of SoE’s who responds to first call out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of out of hours calls</td>
</tr>
</tbody>
</table>

#### Urban Area Response Times
% of victims seen by a SoE within agreed contract times in urban areas

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of victims seen by a SoE within agreed contract times in Urban Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of victims from urban areas</td>
</tr>
</tbody>
</table>

#### Rural Area Response Times
The % of victims seen by a SoE within agreed contract times in Rural areas

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of victims seen by a SoE within agreed contract times in Rural areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of victims from Rural areas</td>
</tr>
</tbody>
</table>

### Counselling

#### Counselling Wait Times
The % of victims who waited <= 4 weeks for first counselling appointment

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of victims that waited &lt;= 4 weeks for first counselling appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of victims referred for counselling</td>
</tr>
</tbody>
</table>

#### Counselling
The % of victims provided counselling within 14 days

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of victims provided counselling within 14-days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of victims referred for counselling</td>
</tr>
</tbody>
</table>

### Criminal Justice

#### Statements
The % of Statements received within 14-days of Sexual Offence Examination

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of forensic examination statements received within 14 days of a Sexual Offence Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>The number of referrals into the SARC during the reporting period</td>
</tr>
<tr>
<td><strong>ISVA</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>The % of victims engaging the services of a names ISVA</td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of victims engaging with ISVAs services</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>The number of referrals into the SARC during the reporting period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assault Reported to Police</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The % of victims who report incident to the police</td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of victims who report incident to the police</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>The number of referrals into the SARC during the reporting period</td>
</tr>
</tbody>
</table>
Other Relevant Standards

The following list includes relevant FFLM and RCPCH standards for SARCs (at time of printing):


- The Service Specification Service specification for the clinical evaluation of children and young people who may have been sexually abused (September 2015): http://www.rcpch.ac.uk/system/files/protected/page/Service%20Specification%20for%20the%20clinical%20evaluation%20of%20CYP%20who%20may%20have%20been%20sexually%20abused_September_2015_FINAL.pdf


- Peer Review in Sexual Offences including Child Sexual Abuse cases and the implications for the disclosure of Unused Material in criminal investigations and prosecutions: https://fflm.ac.uk/wp-content/uploads/documentstore/1396515960.pdf
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASHH</td>
<td>British Association for Sexual Health and HIV</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>DEC</td>
<td>Department of Education and Children</td>
</tr>
<tr>
<td>DHA</td>
<td>Department of Home Affairs</td>
</tr>
<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FFLM</td>
<td>Faculty of Forensic and Legal Medicine</td>
</tr>
<tr>
<td>GUM</td>
<td>Genito-Urinary Medicine</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>IOM</td>
<td>Isle of Man</td>
</tr>
<tr>
<td>IRT</td>
<td>Initial Response Team</td>
</tr>
<tr>
<td>ISHS</td>
<td>Integrated Sexual Health Service</td>
</tr>
<tr>
<td>ISVA</td>
<td>Independent Sexual Violence Advisor</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>KME</td>
<td>Key Minimum Element</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Service</td>
</tr>
<tr>
<td>NCP</td>
<td>National College for Policing</td>
</tr>
<tr>
<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>PEPSE</td>
<td>Post-Exposure Prophylaxis after Sexual Exposure to HIV</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PHOF</td>
<td>Public Health Outcomes Framework</td>
</tr>
<tr>
<td>PPU</td>
<td>Public Protection Unit</td>
</tr>
<tr>
<td>QAS</td>
<td>Quality Assurance Standard</td>
</tr>
<tr>
<td>SAFME</td>
<td>Sexual Assault Forensic Medical Examination</td>
</tr>
<tr>
<td>SARC</td>
<td>Sexual Assault Referral Centre</td>
</tr>
<tr>
<td>SARCIP</td>
<td>SARC Indicators of Performance</td>
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<tr>
<td>SARS</td>
<td>Sexual Assault Referral Service</td>
</tr>
<tr>
<td>SOFME</td>
<td>Sexual Offence Forensic Medical Examiner</td>
</tr>
<tr>
<td>TNL</td>
<td>Thie Yn Lheihys</td>
</tr>
<tr>
<td>VS</td>
<td>Victim Support</td>
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