Response Sheet

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Please answer the consultation questions in the boxes below.

1. Do you agree with the new approach of the CPS to cases involving child sexual abuse?

The CMF welcomes these new guidelines and fully supports this new approach.

The Christian Medical Fellowship is a registered charity which unites and equips Christian doctors. We have over 4,000 UK doctors and around 1,000 UK medical students as members and are affiliated through the International Christian Medical and Dental Association (ICMDA) with similar organisations in over 70 countries.

As Christian doctors seeking to live and speak for Jesus Christ we aim to: practise whole-person medicine which addresses our patients' physical, emotional and spiritual needs; to maintain the deepest respect for human life from its beginning to its end; to serve our patients according to their healthcare need without partiality or discrimination on any basis and to care sacrificially for the poor, vulnerable and marginalised.

Our interest in this consultation is based upon our concern for the vulnerable within society. As Christians, we want to help to ensure that the laws on our

statute books are fair and just and protect vulnerable groups and individuals within society from exploitation and abuse and ensure that they are properly and equitably provided for.

2. Is it right that we should focus on the overall credibility of the allegation rather than the victim?

Yes, we agree that this is the right focus.

It is important that victims are not pre-judged and are treated fairly and equally. The allegation is the key issue, not the victim.

3. While the list of criteria for the suspects is non-exhaustive, have we got the factors right? (See paragraph 63)

We agree with the factors detailed.

In particular, it is important to be aware that doctors and other healthcare professionals should be included within groups who might have come into contact with the victim, through their positions of trust and responsibility for the health of their patients.

4. Would it be helpful to have an Annex setting out 'myths and stereotypes' surrounding this type of offending? If so, please provide details of 'myths and stereotypes' that would be useful in the circumstances.

Yes, we believe that having an Annex setting out 'myths and stereotypes' would be very helpful. In particular, we believe it is important that the Annex should include myths and stereotypes that have a medical component to them.

An example of a myth is that many members of the public (including the parents/carers of allegedly abused children) but also professionals (including some police officers & lawyers and even some doctors) may believe erroneously that a child who has been vaginally or anally raped will always have injuries to their vagina or anus respectively; therefore, the absence of such injuries may cast doubt in their minds on the allegation of child sexual abuse.

An example of a stereotype is that a child who has been chronically sexually abused is typically withdrawn and depressed. Whilst it is appropriate for doctors and other healthcare professionals to consider sexual abuse as one of the multiple possible causes when they are managing a child who does present as withdrawn and depressed, it is wrong for them to assume the converse (that is, that a child who doesn't appear withdrawn and depressed has not been sexually abused).

Furthermore, we suggest that the CPS consults with relevant specialist bodies – for example, the Forensic Medicine Committee (FMC) of the British Medical Assocation (BMA), the Faculty of Forensic and Legal Medicine (FFLM), the

Royal College of General Practitioners (RCGP) and the Royal College of Paediatrics and Child Health (RCPCH) – for further examples of such medical myths and stereotypes; in addition, these bodies could be asked to review the medical myths submitted during this consultation.

5. What more can the CPS do to support the victim and witnesses through the court process?

We recognise the vital support that the CPS already provides and value the work that the CPS does.

One issue that we consider important to highlight is the need to reassure and protect victims and witnesses who have been trafficked from abroad or who are from illegal immigrant families. Such victims may be particularly fearful of drawing attention to themselves by coming forward to the police. They may fear being placed in immigration centres and/or deported and therefore they may be less likely to report offences and/or provide evidence. Whilst we of course do not support illegal immigration, nevertheless it is important to ensure that all victims from either abroad or the UK are treated with equity and are given appropriate reassurance and protection.

For trafficked and illegal immigrant victims, it is necessary to consider whether their country of origin has the necessary infrastructure (that is, adequate and reliable on-going medical care and other aspects of victim support such as counselling) as part of the decision making process as to whether it is at all appropriate to send them back to that country. This will require more specialist awareness, input and resourcing by the CPS and a high level of liaison with and cooperation from the UK Border Agency.

6. Do you have any further comments on the Interim Guidelines on Prosecuting Cases of Child Sexual Abuse?

Current variations in the standard of Clinical Forensic Medicine

As a representative body of health professionals we are concerned that there is no guarantee or statutory requirement that both victims and suspects be examined by healthcare professionals who have a standard level of specialist training and expertise. This has obvious implications for the medical welfare of both victim and suspect, for the psychological wellbeing of the victim, for the standard of evidence-gathering from both victim and suspect, and for the likelihood that a high standard of professional witness evidence (that is, a statement and subsequent testimony in court).

Currently the practise of clinical forensic medicine (CFM), which is comprised of general forensic medicine (GFM, the examination and care of detainees in police custody) and sexual offence medicine (SOM, the examination and care of complainants and victims of sexual assault), is sub-optimal due to both non-NHS commissioning and to a lack of specialist status.

Non-NHS commissioning

Traditionally, CFM has been commissioned by individual Police Forces on behalf of the Home Office; however, over the next few years, responsibility for this is transferring to the Department of Health. This is a welcome move that should, to a degree, drive up clinical standards.

Lack of specialist status

There is wide variation in the clinical backgrounds, training and expertise of doctors and nurses working in the field of CFM around the UK. CFM is not yet considered a medical speciality by the General Medial Council (GMC) and so *any* doctor who is registered with and licenced by the GMC may be eligible to work in either general forensic medicine (that is, forensic physicians (FPs) caring for suspects in police custody suites including gathering evidence from suspects of child sexual abuse) and/or sexual offence medicine (that is, sexual offence examiners (SOEs) examining and gathering evidence from complainants and victims of sexual assault).

Although consultant paediatricians are often involved in the examination of acute cases of child sexual abuse, the examination team usually includes an SOE. These SOEs are not subject to a mandatory level of training or qualification. A further problem is that there is inconsistency across the UK as to the age when an under-age complainant or victim ceases to be treated (for the purposes of medical examination) as a child and is instead examined by a SOE in an adult examination facility without the involvement of a paediatrician. For example, in some areas of the country 14 year old girls are examined by a sole SOE who may not be female and may not have sufficient experience of adolescent hymen examination; and yet in other areas of the country all girls under 16 are examined by a specialist paediatric SOE or a specialist consultant paediatrician together with an SOE who is trained to FFLM-approved standards (see below).

The FFLM has just, in August 2013, re-issued guidance on the appropriate clinical backgrounds and minimal training and supervision standards (both for doctors working in both GFM and SOM, for nurses and other healthcare professionals working in GFM and for nurses working in SOM). However, these guidelines are merely gold-standard aspirations. They have not been endorsed by the Department of Health as it starts its incorporation of CFM into the NHS commissioning fold. And they are non-binding for both individual healthcare professionals and CFM providers, who are currently mainly commercial companies commissioned by the individual Police Forces.

Summary & Conclusion

Although the gradual move to NHS commissioning of CFM services is most welcome, we are concerned that such a move will not in itself ensure optimum clinical and forensic standards. The ongoing lack of specialist status for CFM will continue to be a problem. We are aware that the GMC has been asked by the FFLM to consider designating CFM as a medical sub-speciality with its own training pathway and specialist examination. We would be in favour of

such a move as we believe it would bring CFM into line with other medical specialities, so ensuring the uniform provision of gold-standard evidence-gathering from both suspect and victim. This has obvious benefits for the prosecution of cases of child sexual abuse.

Therefore, we suggest that the Interim Guidelines should make some mention of the above current variables and should encourage local agencies to ensure that their CFM services are commissioned to those standards recommended by the FFLM. Furthermore, we would encourage the CPS to support moves to grant specialist status to the field of CFM.