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HEALTH AND SPORT COMMITTEE
12th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Chloe Riddell (Children 1st)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Wednesday 20 May 2020

[The Convener opened the meeting at 10:00]

Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill: Stage 1

The Convener (Lewis Macdonald): Good morning, and welcome to the Health and Sport Committee's 12th meeting in 2020, which is an online meeting. I ask all those who are taking part to ensure that their mobile phones are on silent.

The first item on our agenda is our third public evidence session on the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill at stage 1. Scrutiny of the bill began in February but was interrupted due to the pandemic. We are now taking evidence in May and June, with the intention that Parliament will be able to debate our stage 1 report in the autumn.

Today's session gives us the opportunity to discuss the implications of the bill for forensic medical services for children, including the provisions that make self-referral available only to those over the age of 16.

I welcome to the committee Chloe Riddell, who is the policy manager with Children 1st. Thank you for joining us today. Due to the challenging nature of managing a virtual meeting, we will be a little less spontaneous than usual, and will take questions in a pre-arranged order. I will ask the first questions, and will then ask each member to ask questions in turn, to which I will invite you to respond. Once each member has asked their questions, I will invite the next questioner, and so on, until the evidence session is concluded. I ask all concerned to keep questions and answers succinct in order that we can cover all the topics that we want to discuss today. When you are called, please give the broadcasting staff a few seconds to operate your microphones before beginning to ask your question or give your answer.

I will start by asking you about your approach to the general principles of the bill. Some evidence that we have received from you and other organisations including the NSPCC mentions missed opportunities or things that might have been done in addition to what is in the bill. First, what is your view of the general principles of the bill as they relate to children and young people?

Chloe Riddell (Children 1st): Good morning, committee. Children 1st welcomes the opportunity to give evidence today, and we appreciate the value that the committee is placing on progressing this important bill amid the pandemic. To begin with, it is important to be clear that Children 1st warmly welcomes the introduction of the legislation, which we consider to be an important step forward as part of the overall improvements to forensic medical examination for adult victims of sexual assault. The evidence that I will be providing on behalf of Children 1st today will focus on what we know from the experience of children and families in our services.

The most important thing to start with is to recognise the significant issue that the bill is trying to address, as was highlighted in the report from Her Majesty's Inspectorate of Constabulary in Scotland, which found major issues for those who have experienced rape or sexual assault. We strongly agree with Rape Crisis Scotland and other organisations that there is a need for continued leadership and significant on-going investment to bring services up to the standards that survivors need and deserve.

The written evidence that we have provided has been really clear that there are significant issues relating to children that are different from those that affect adult victims. The majority of children do not disclose abuse during childhood. Only a small number of children disclose abuse, and only a small number of them disclose within the seven-day timeframe that is specifically required for forensic medical examination.

For Children 1st, the key questions are why that is the case and what we can do to ensure that there are wholesale improvements not just to small areas but to the entire system. For us, that means that there needs to be a rights-based response to make sure that children's voices are heard and their physical and emotional needs are met, and that there is an interagency interdisciplinary response that takes into account exactly what a child who has experienced abuse needs to help them not just access justice, but recover from trauma.

I am sure that the committee has heard about the things that we have been speaking about, but Children 1st has called for a long time for a barnahus model in Scotland, which involves having everything in one place and a child-friendly approach to access to justice. In relation to the bill, we believe that there is real value in considering what forensic medical examinations look like for children and their families, but we want that to be wrapped up in an overall discussion about what is required for children in the context of a barnahus model.

Would you like me to comment a bit further on the specific things in the bill, or is that enough for the moment?

The Convener: That is certainly enough to get us started. I think that, broadly, you are saying that you support and welcome the general principles of the bill, but that there are areas where you would like to see a more holistic approach. Is that fair?

Chloe Riddell: Yes, I think so. For adult victims, it is a different conversation. In the consultation before the bill was introduced, Children 1st proposed that children should have a specific consideration, but we have not seen that in the bill. There are different areas that apply to children, and we need to ensure that we do not cut across the work that is going on in other areas around barnahus.

The Convener: Thank you. Your mention of barnahus model prompts me to ask Emma Harper to ask her questions.

Emma Harper (South Scotland) (SNP): Good morning, everybody. I will ask a couple of questions about the barnahus model. Paragraph 34 of the policy memorandum on the bill says:

"The Scottish Government is committed to exploring how the Barnahus concept could operate in Scotland, which includes consideration of cases where the child may have suffered other forms of abuse than, for example, child sexual abuse. Barnahus provides Scotland with an opportunity to design a genuinely child-centred approach to delivering justice, care and recovery".

Barnahus is therefore in the policy memorandum. I like the fact that it is "bairn's hoose" in Scots, which shows how connected we are to our Nordic neighbours. Will you tell us a wee bit more about whether you believe that the bill supports the barnahus model?

Chloe Riddell: That is the central thing that I want to talk to the committee about today. I am not sure whether the committee is aware of this, but the barnahus model is recognised as a

"child-friendly, multidisciplinary and interagency model responding to child victims and witnesses of violence."

According to the European standards, it is not specifically about child victims of sexual abuse. The model that we should be looking at in Scotland, which Children 1st is really clear that we would like to see, would adhere very closely to the European standards. Healthcare Improvement Scotland is working to develop Scotland-specific standards, but we hope that they will adhere to the European standards as far as possible.

The central point about the barnahus is that everything happens in one space. In other countries, in relation to forensic medical examinations, it is not always possible for children to attend a barnahus when there are acute needs, particularly when there is an issue about ensuring that evidence is taken within the seven-day timeframe. As far as possible, however, we would hope that children's physical and medical needs would be met in the barnahus when the medical needs are not acute.

As is mentioned in the policy memorandum, the Government has been clear that the barnahus is the preferred destination for child victims and witnesses across Scotland and we are now considering carefully how that will work in practice. Children 1st has just received a £1.5 million award from the People's Postcode Lottery to begin to pilot a child's house in one of the localities in Scotland. We are at the early stages of planning what that would look like, but it is important for the committee to be aware that this is not a vision or a pipe dream—work on barnahus is happening.

We have some concerns about parallel processes going on. We do not want to be making small improvements in silos when what is needed is a wholesale change for children and their families.

The programme for Government commits the Government to exploring how the barnahus concept can operate in Scotland. As the Vulnerable Witnesses (Criminal Evidence) (Scotland) Bill was going through Parliament, the Minister for Community Safety was really clear about the Government's support for barnahus.

We are concerned that this bill may inadvertently cut across some of that work and have unintended consequences and impact on the progress of the barnahus approach in Scotland. The child rights and welfare impact assessment for the bill states:

"The Bill supports multi-agency working and is therefore 'Barnahus ready'".

However, we are not clear how that will happen in practice. How will the bill align to the barnahus provision, particularly if a pathway is being developed that would go through the rape and sexual assault task force clinical pathways subgroup? Is there guidance around how that will apply to children in relation to the bill? We are looking for a holistic interagency model of support, whereas the bill looks at a specific area.

Emma Harper: When we took evidence at the round-table session on 17 March 2020, we spoke about the processes for supporting children who have experienced abuse, and Sandy Brindley suggested that we would need a separate approach or a separate bill. I might need to go back and check the *Official Report* to see what was specifically said.

On the issue of unintended consequences, is one of your main concerns that there will be some

silo working or some working at cross purposes, which might not take into account the best model or the best processes for children?

Chloe Riddell: We recognise that this is a vital bill and it is particularly important for adult victims. For children, we have been talking about a different kind of approach. We do not want to create separate, parallel processes for children and we do not want to inadvertently invest in lots of state-of-the-art suites that are child friendly but sit outwith a barnahus process.

Our intention is to begin to pilot barnahus; it is not something that we are looking at doing in 10 years, although I hope that in 10 years, we will have something that works across the whole of Scotland. Our caution around some of the measures in the bill is about ensuring that the bill sits within a wider framework of what works for children.

David Stewart (Highlands and Islands) (Lab): One of the key elements of the bill is self-referral for forensic medical examinations. Are you comfortable with 16 being the minimum age for self-referral for young people? If so, why?

Chloe Riddell: That is a good question. As we state in our submission, our understanding is that child protection processes would apply for the majority of children and young people under the age of 16. We agree with the evidence from Rape Crisis Scotland—we would not want to add in what Sandy Brindley referred to as "a meaningless right", given the statutory duties and processes, and the option to involve child protection and the police where necessary. Of course, children and young people's safety must be of paramount concern.

10:15

We note the evidence that the committee heard last week from Dr McLellan, who said that we do not want to miss opportunities to ask young people to come forward and that there are some cases that are not quite as clear cut. We have experience of that in our own services, particularly relating to children who have been victims of child sexual exploitation but who might not necessarily recognise that they are victims. On balance, Children 1st believes that a rights-based approach to this is needed, taking into account a child's evolving capacity, in line with the United Nations Convention on the Rights of the Child. We acknowledge that there might need to be room for professional judgment and risk assessment. We also note that Social Work Scotland has submitted evidence about the complexities of the different pieces of legislation with regard to 16 and 17-year-olds and issues around legal capacity.

Children 1st's central point goes back to what we were talking about earlier, when we spoke about understanding why we are having these discussions about self-referral. The vast majority of children who experience sexual abuse do not receive a forensic medical examination and do not report that they have been abused. Again, we agree with Rape Crisis Scotland that we need to be much more realistic about what else needs to happen to reduce underreporting. For Children 1st, the answer is not necessarily to have broader discussions about self-referral. We would go to a much higher level than that and look at the entire system and at what needs to change so that children and families are comfortable and are able to receive a multiagency response that allows them to access support as well as justice. Children have a right to recovery, but at the moment that recovery need is not being met. Our sense is that, if there was a much more holistic response and a system that allowed children and young people to speak out in a safe way, we would not need to discuss why people are not referring and what we can do to address that.

David Stewart: I generally agree with your answer, but there have been calls from organisations such as Victim Support Scotland for the age limit to be lowered to 13. Would lowering the age not help detection and prosecution of child sexual abuse, particularly within families, where it has been historically low?

Chloe Riddell: When we add in the complexities that I set out relating to child protection, issues to do with lowering the age limit are quite complex. I do not think that it would be possible for us to have a blanket statement on 13-year-olds, because of the interaction, duties and professional responsibilities to engage with child protection and the police. Further consideration needs to be given to what evolving capacity looks like and what would be necessary to make a lower age limit a realistic option. We would probably need to do a bit more thinking and have discussions with, for example, the police, Social Work Scotland and the child protection organisations, which would be able to talk about what happens in practice.

David Stewart: My concern, as someone who worked on the front line in social work and child sexual abuse for many years, is the low detection rate. If we are talking about rights, lowering the age to 13, with the proviso that any self-referral would require to go to the police, would seem to give more rights to 13 to 16-year-olds and would, hopefully, improve the detection rate of child sexual abuse.

Chloe Riddell: As I mentioned, Children 1st's position on that is that a barnahus process or system in Scotland, which ensured that the needs

of children and families—their physical needs as well as their emotional needs—were met in one place, would provide more of a wraparound service. We would be able to meet the needs of children who have experienced abuse in one place, which, hopefully, would mean that children would feel much more comfortable talking about what has happened and disclosing abuse. That would be one way of dealing with the very low rates of referral and the underreporting of abuse, and it would ensure that abuse became much more visible.

Alex Cole-Hamilton (Edinburgh Western) (LD): I have a follow-up question to ask before I move on to my substantive question. It is also about the age of referral.

Without the barnahus model that you have described, young people who have suffered a sexual offence have to go through a traumatic process that the committee has heard about at first hand from those who have been through it. Can you explain the trauma that might be associated with the experience of presenting at somewhere such as the Archway and of having a forensic medical examination without the wraparound support of the barnahus model?

Chloe Riddell: The children and families that we work with have often experienced lengthy delays. Some children even say that their experience of the current justice system almost retraumatises them. It adds to the trauma that they have already experienced.

In our evidence, we say that there is a shortage of paediatricians who are able to carry out forensic medical examinations and that they have difficulty in gaining and maintaining experience due to the low number of examinations. We have heard of children waiting for hours in a medical examination room, and, when the examination does take place, it happens with a number of professionals in the room. There is a lot of work to do on what the experience looks like for children.

We are not looking at the improvement only of medical needs; we want to ensure a whole-system response and to look at what a child needs in addition to having their acute medical needs addressed. We might want to look at improvements to joint investigative interviews or to how the court system works. It is about providing wraparound support so that, from the moment a child discloses abuse, they feel safe and that there is support for them and their non-abusing parent or carer. That support should continue throughout the process, so that the process itself does not become even more traumatising than what they have already experienced.

Alex Cole-Hamilton: If we start promoting self-referral for those aged over 16, is there a possibility that that might unintentionally act as a barrier for younger victims? There is a corollary to that: are we anxious about driving younger people into a system that might cause them additional trauma when there are other routes by which they could receive justice and receive attention for the offence that they have suffered?

Chloe Riddell: Those are very good points. There are lots of unintended consequences for us to think through. Something that we raise in our evidence, and which might come up later, is that the bill is deliberately very narrow in scope: it deals with children who have experienced sexual abuse. However, we know that medical examinations are required for children who have not experienced sexual abuse but who have experienced other types of abuse. We have some concerns about the accidental creation of a two-tier system whereby there is statutory provision in one area and non-statutory provision in another.

Mr Cole-Hamilton raised the issue of what might happen if we raised awareness of reporting. What would that look like for someone who has experienced a non-sexual offence? Would we not want to encourage children to come forward and talk about all types of offences? We must make sure that, when children come forward and are brave enough to talk about their experiences, they are met with a trauma-informed, compassionate and rights-based response. That response should not be fixed in one area; it should be provided across the entire system.

Alex Cole-Hamilton: There could be a situation in which a young person does not necessarily want to involve the police right away but wishes to self-refer so that evidence could be collected and used in the future. Would there ever be a situation in which self-referral for people under the age of 16 would be appropriate, given the current system?

Chloe Riddell: In my initial response on self-referral, I said that Dr McLellan talked about the need for professional judgment in some cases. We absolutely do not want to put up barriers that mean that children do not talk about what they have experienced because they do not want to involve the police at a certain time. As I mentioned, that is particularly relevant to child sexual exploitation, because it might take a while for a child to realise that what they experienced was abuse, so there are some issues to think through.

The primary way of looking at the issue involves ensuring that we take a rights-based approach and consider what evolving capacity looks like. We need to look at it in the context of the current child protection system, because we do not want to accidentally put in place measures that cannot be implemented or to suggest to children that they will

be able to undergo forensic medical examinations without the involvement of the police, given that there could be statutory processes or professional duties to refer cases to child protection services in order to keep children safe.

Brian Whittle (South Scotland) (Con): As you have already mentioned, Social Work Scotland has suggested that, if self-referrals always remain confidential unless the individual subsequently contacts the police, that could be at odds with child protection. If we are going to legislate, it is important that the bill provides the flexibility to allow the kind of treatments that you have suggested. Are the provisions in the bill in line with child protection guidance? If not, should they be?

Chloe Riddell: That goes back to what we talked about previously. Children are not referred to in the bill at all. There are no specific provisions for children and there is no reference to child protection processes, so there is probably some work to be done to think that through. If the decision is that additional guidance will be provided or if we are looking at a particular pathway, we have some concerns about how that might cut across what we are trying to achieve through the barnahus approach.

There are definitely complexities relating to confidentiality and child protection, but they do not apply only to forensic medical examinations and certainly not only to sexual abuse. The complexities are much broader than that. To some extent, we need a much wider discussion to ensure that there is clarity for professionals about what the expectations are and how we keep children safe. We should not prevent children from coming forward to talk about what they have experienced, and we should gather that important evidence within the seven-day window so that, if they want to, children can access justice at a later date as part of their recovery journey.

Brian Whittle: Is the child protection element relating to abuse missing from the bill? Does that need to be considered?

Chloe Riddell: Yes. Children and young people have distinct needs, particularly when they experience abuse. As it stands, the bill does not differentiate between a child and an adult, and the provisions apply only to examinations that are carried out in relation to sexual offences. We have already talked a little about our concerns about narrowing the scope to that specific area and the possibility of creating a two-tier system.

10:30

The issue is much wider than only forensic medical examinations; it is a question of creating a whole-system response to any type of abuse that includes the justice, health, social work and education systems. Children do not separate each part of the process. They do not work in silos—we do—so we have to think about the whole framework. Children are not going to think, "This is my forensic medical examination, and that bit went really well. Now, I am going to move across to my interview". We need a whole-system response.

We have always been really clear that any proposals to strengthen and improve forensic medical examinations must align effectively with wider child protection processes. Forensic medical examinations should form part of a holistic multi-agency approach to protection needs.

There are complexities that do not apply to adults. There are certain complexities around vulnerable adults, but for children there might be interactions with hearings, for example, and also wider health and safety assessments. There is potential for children to be looked after or removed from a home if there is a risk to their safety.

In our written evidence to the committee, we said that forensic medical examinations

"must ... be seen as fully supporting the child protection as well justice processes".

As it stands, there is nothing in the bill on that. There is potential for some guidance. However, our concern is that guidance or a children's pathway that is specifically focused on forensic medical examinations would not be part of the whole-system approach that the barnahus model would offer.

Brian Whittle: I will go back to David Stewart's point. If the expectation is that a self-referral by a 16 or 17-year-old could initiate a child protection process, the question is why the self-referral provision is not extended to children under the age of 16.

Chloe Riddell: As I said, there are a number of complexities and—at the risk of sounding like a broken record—for us it is a question of taking a rights-based approach and considering what is in the best interests of the child involved.

There is some further thinking to do about the child protection processes, both on the other legislation that Social Work Scotland mentioned in its evidence to the committee, and on the other guidance and processes. An update of the child protection guidance is also coming. There is a lot more to think through, which means that I cannot give a cut-and-dried answer.

The priority has to be keeping children safe, which is why child protection processes might kick in. However, there needs to be an allowance for professional judgment and flexibility, because there is such a narrow window in which to collect the evidence. It is important to a child's recovery needs that—where possible, and where they want

to—they are able to access justice, and the forensic examination is an important part of that.

David Torrance (Kirkcaldy) (SNP): My questions are on specific issues that relate to the ability of looked-after children who are over the age of 16 to access self-referral services. Should those children be able to access self-referral services without triggering police involvement?

Chloe Riddell: I do not have much more to add than what I have said already about all children.

There are really important considerations for looked-after children, and lots of considerations about existing child protection processes that they might already be involved in. However, it is key that we do not separate children into groups by saying that there would be a certain response if the children were looked after or if they came from a particular socioeconomic background, for example.

We are talking about children—often children who have experienced horrific abuse. Children 1st takes the view that we need to consider a multi-agency response that takes into account those children's physical and emotional needs, and that ticks the boxes on access to justice while supporting recovery. In those circumstances, there does not need to be a significant difference between how we respond to a child who is looked after, and how we respond to a child who is still living at home.

The Convener: On that last point, a person who has been a looked-after child is covered by the bill, as you said, as self-referral covers everyone over 16. I take your general point about not distinguishing between one group and another, but are there specific questions around self-referral that might be more pertinent for young people who have been looked-after children?

Chloe Riddell: It is probably worth exploring that a little further. I am not able to comment in a lot of detail. The Scottish Children's Reporter Administration and organisations such as Who Cares? Scotland might have a view on the particular needs of looked-after children and their interaction with services.

As I said, the bill is not specific on the interaction with child protection processes. I imagine that such issues might be dealt with in a pathway or guidance, and when an assessment is made, consideration will certainly need to be given to how to keep a child safe. That will involve consideration of where the child is living and how they can access appropriate support and justice while remaining safe in their current situation.

George Adam (Paisley) (SNP): There is a debate about children and young people who are alleged to have perpetrated sexual assault and abuse, and different organisations have different opinions. The NSPCC commented:

> "NSPCC would support the provisions in the bill being extended in order that the duty on health clearly covers the forensic examination of all children. We would equally welcome a statutory basis for the provision of therapeutic interventions to address children's harmful sexual behaviour."

However, Rape Crisis Scotland thinks that the bill should not be extended to cover child perpetrators. What is the opinion of Children 1st on that?

Chloe Riddell: There are practical considerations that would need to be taken into account. We and I think other organisations, including Rape Crisis Scotland, mentioned in our written submissions the importance of training and resources to ensure that there are secure, safe and appropriate spaces for children and young people.

There are practical considerations around ensuring that a child under 18 who requires an examination and is alleged to have perpetrated an offence does not come into contact with someone who is accusing them of a crime, by meeting them in a corridor, for example. Those practical issues need to be thought through.

Children 1st takes a rights-based approach and would consider the rights of the child in either situation, but further thinking is needed before I can give a definitive answer to your question. We must uphold the rights of the child in both situations. We must meet the recovery needs of a child who has or is alleged to have perpetrated a crime, as well as those of a child who has experienced a crime.

George Adam: Thank you.

Brian Whittle: At last week's meeting, we discussed the length of time for which evidence and records should be retained. From your experience, and given the potential for a person to decide to act on the evidence much later in life, how long should evidence be retained in a multi-agency context?

Chloe Riddell: We have put some detail in our written submission. There are a number of issues around the safe storage of the information that pertains to children—and this goes back to our point about there being no specific recognition of children in the bill.

Specific issues for children need to be considered. We have experience of children who have decided much later in life to revisit a disclosure. I have mentioned children who have experience of child sexual exploitation. As the Parliament will have heard during the passage of previous legislation, and as we know through our

work, children often do not initially recognise themselves as victims; that understanding may take a while.

A number of young people and adults have returned to us, years after previous contact, and shared that they recognised, at that point, and in a way that they were not able to understand or communicate when they were younger, that what they experienced was grooming or abuse.

It is not cut and dried. A lot of children and young adults do not subsequently want to make a further disclosure. However, it is important that the option should be there, as much as possible. For some children and young people, having the option—to think through whether it might be appropriate for them, or might help in their recovery journey—is really important.

The question goes back to what we talked about earlier: what would prevent someone, whose forensic medical evidence was stored, from wanting to access justice? We need to take a hard look at the justice system, and why it would prevent children and families from wanting to seek justice. There is a multitude of different reasons.

If we had a multi-agency response that was child centred and trauma informed, and that allowed children and young people to share their story in a way that was not traumatising, we might be able to increase reporting, or the number of convictions, because children and families would be much more willing to share their stories.

Miles Briggs (Lothian) (Con): Good morning, Chloe, and thank you for joining us.

I want to pick up on some of your answers to David Torrance and to George Adam, with regard to supporting children. What does the bill need to include in order to support children who have additional needs or who are disabled?

Chloe Riddell: I am trying to find my notes on that.

As I mentioned, the bill does not specifically mention children. The policy memorandum says that the Government's view is that

"the healthcare response must be sensitive to the specific needs and circumstance of children and young people";

however, that is completely absent from the bill.

Our view is that children have the right to recovery. In Scotland, we are about to incorporate the UNCRC, so we must make sure that we are meeting children's recovery needs in a way that is currently not happening. There is an absence of high-quality recovery support services for children.

As we have, the NSPCC has highlighted that the bill includes a statutory duty of forensic medical examination, but not of other aspects of justice and recovery for children. The bill deals only with sexual offences. There are wider issues about the recovery needs of children beyond those who have experienced sexual offences. We do not want a system that has in place statutory obligations around children's recovery needs for sexual offences, but no similar statutory obligations for other areas. Section 4 of the bill includes the information that is to be provided to children before examination. Section 5 is about healthcare needs. Those are the obvious places where something could be added.

However, we need to give the matter further thought before we make amendments. Children 1st's view is that there needs to be a whole-system look at the matter, and a complete redesign of the system for children. It is not simply about additional support for children's recovery in relation to sexual offences or forensic medical examinations; it is about the system that is in place when a child discloses abuse and it is about their recovery needs in the round.

10:45

I know that some evidence suggests that there is a need for a second bill or a part 2 bill, as was mentioned earlier. The issue for us is that wraparound holistic support must accompany forensic medical examination, whether it is in relation to sexual offences or other offences, but the bill does not achieve that, at the moment.

Miles Briggs: Thank you. That is helpful.

On including support for children in the bill, what support would you like to be put in place—for example, involving youth work organisations to provide peer support—and what would best practice look like?

Chloe Riddell: I would use some caution. I know that I sound like a broken record, but I repeat that our concern is that legislating for specific support services for children who have experienced sexual offences will leave children who have experienced other types of offences without the support that they require.

There is a huge gap in therapeutic support—the type of support that Children 1st provides, for example, where we look at the recovery needs of the child and the non-offending parent, as well as the support that other third sector organisations can offer.

You are right to mention advocacy and peer support, but that support is not specific to forensic medical examinations; it is required to meet children's recovery needs when they have experienced abuse. It is not limited to the support that they require around a forensic medical

examination; it includes support to recover from their experiences.

Our issue is that putting something on children's recovery needs in the bill and having guidance on how that would be implemented in a pathway document would mean that we have a process that is parallel to the barnahus process. It is absolutely vital that we make sure that children can access the support that they require, but I have concerns about inadvertently putting in place things that either contradict or that unintentionally run parallel to something that is happening in the wider context for children.

Miles Briggs: You touched earlier on reporting of cases. I believe that the Barnardo's evidence suggests that the number of cases of sexual offences that have been committed by children against other children has doubled in the past four years. What other models around the world are you aware of? I know that work has been going on in this field in the indigenous populations in Australia and North America. Is there already a model in other legal systems?

Chloe Riddell: I am not sure whether I have mentioned the barnahus approach before. [*Laughter*.] That approach would be the starting point for us. There are a number of examples of how it can be used; in different countries, barnahus works in different ways.

As I have mentioned, Children 1st would like to ensure that we in Scotland adhere as closely as possible to the European standards. There is some room within that to consider what has worked in other countries and what has not. We have done a number of fact-finding missions to Iceland and other countries that use barnahus. We are part of the PROMISE exchange, which is a network of countries that have implemented a barnahus model, and we are able to draw on best practice there. You are right that there is a lot that we can learn from internationally.

Of course, because we are about to incorporate the UNCRC, we can do a lot of thinking about what that looks like for children who have experienced or are victims of crime or abuse, or for children whose recovery needs must be met elsewhere.

Emma Harper: I will continue on what you said about barnahus. The policy memorandum says that the Care Inspectorate and Healthcare Improvement Scotland have been

"commissioned by the Scottish Government to develop Scotland-specific standards for Barnahus based on the European PROMISE Quality Standards".

I am concerned that if we take a piecemeal approach with regard to barnahus, the expectations or needs of children will not be met by the bill. What do we need to do? Do we need to create a whole barnahus approach in a separate bill? Are we at risk of dealing with the matter piecemeal if we do not include our barnahus approach completely in the bill?

Chloe Riddell: You have very neatly summarised our concerns and worries about the bill. Our view is that we need to make improvements to various parts of the system, but we need to do a whole-system redesign, rather than try to make improvements separately in silos. The discussion about what should happen next is challenging, and should probably involve a broader conversation among the Government, the committee and other organisations, including the police, healthcare and social work, about what that would look like.

We are not yet clear exactly what legislation would be required, because we do not yet have Scottish standards. As you mentioned, the first step is to work with Healthcare Improvement Scotland on Scottish standards. As I have mentioned a number of times, we want to ensure that the standards, guidance and pilot schemes involve a real multiagency response, and that they have buy-in from all the sectors that are involved. We have concerns about parallel processes that are really well intentioned, but might accidentally cut across work that needs to be considered as a part of a whole.

Sandra White (Glasgow Kelvin) (SNP): Good morning, and thank you for your evidence so far. It has been really interesting.

I am interested in data that has been collected. Your submission mentions subject access requests that are made by a parent who is seeking access to full medical records, even though, unfortunately, that parent committed the crime. Are there data protection issues that need to be addressed in relation to children and young people?

Chloe Riddell: Children 1st has raised the issue a number of times with regard to the criminal courts and the civil courts. We are currently discussing the Children (Scotland) Bill with the Justice Committee and have raised with it the issue of ensuring that children's best interests are at the heart of any decision to share information that Children 1st and others hold with potential perpetrators of abuse, in discussions around contact, for example. The same principles that we are discussing there would apply here. As we mention in our written evidence, some such parents who have made subject access requests to see their child's medical records have been successful.

It is the same discussion as the one in respect of the civil courts. We do not want to put in place barriers to accessing justice, or to stop the courts

from exploring what has happened to someone, but we need to ensure that children's best interests are taken into account. Clear safeguards need to be put in place because of the potential sharing, with alleged or convicted perpetrators, of personal, private and sensitive information.

Sandra White: That highlights the difficulties that have been raised previously. This is not just a health issue. You mentioned that the Justice Committee is looking at the issue, and that you have spoken to it, too. If we were to go further, and cover children in the bill, we would need to correspond with the Justice Committee.

Should information from forensic medical examinations be linked to, or be part of, an individual's healthcare record? What does that mean for confidentiality and the rights of children? Children should have ownership of their health records.

Chloe Riddell: The information that Children 1st holds is not necessarily about children's health needs. Questions on what information can be accessed are probably for health boards and legal professionals.

The discussion on civil courts is about the different information that we would hold, but the same principle applies: the child's best interests should be taken into account. That does not necessarily mean that information should not be provided to courts, or that information should not be shared. Rather, it means that it should be shared in an appropriate way and, crucially, that the child should be aware of what is happening to their information—they should have a sense of who is being told what—and feel that their voice and views are being taken into account. We are not saying that information that is pertinent to a case should be withheld from criminal or civil courts, but that information should be shared in a sensitive way that takes into account children's rights.

Sandra White: If we incorporate children's rights into the bill, should the child have ownership of their data, including their forensic medical records? If the child is too young for that to be appropriate, should ownership be with an advocate? Having read your submission, my greatest concern is that perpetrators, or alleged perpetrators, could access information that they could use against the child. Many others share that concern.

Chloe Riddell: Without seeing any proposals, it would be hard to comment on the specifics. In some cases, it is appropriate for information to be shared with the court in order to secure a conviction. That is the case in relation to forensic medical examinations—we need to have all the information and the evidence. However, it must be gathered in a trauma-informed way that must take into account children's rights, so that the process is not traumatising for them and they do not feel that they do not know what is happening.

That brings us back to the high-level broader discussion about a child's whole experience—not just their experience of forensic medical examinations, but of court processes and interviews and how they all knit together in a trauma-sensitive way that leaves the child feeling that their recovery needs have been met. We know that some systems and processes are traumatising, but rather than fix small parts of the system, we need to look at it as a whole.

The Convener: Thank you for your evidence, which is extremely helpful to the committee. I am certain that we will be following up with others some of the issues that have been raised.

That concludes the public part of our meeting. Our next meeting will be at 10 o'clock on Wednesday 27 May, when we will discuss Covid-19 testing. Additional details will be made public in the *Business Bulletin* and via the committee's social media, in the usual way.

11:00

Meeting continued in private until 11:19.

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