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

Consultation Feedback Report

November 2020

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Contents

Consultation on the Clinical Pathway for healthcare professionals working to support children and young people who may have experienced child sexual abuse

Following publication of the draft clinical pathway in May 2019, we held a 12-week consultation using a wide range of methods to capture comments and feedback.

During our consultation, we received 57 responses from a variety of stakeholders, including:

- Aberdeen City Council
- Angus Child Protection Committee
- Angus Council
- Angus Violence Against Women Partnership
- Barnardo's Scotland
- British Dental Association
- Care Inspectorate
- CELCIS
- Child Protection Committees Scotland
- Children 1st
- Children and Young People's Commissioner Scotland
- Children's Hospices Across Scotland (CHAS)
- Clackmannanshire and Stirling Child Protection Committee
- East Region Managed Clinical Network for Child Protection
- East Renfrewshire Child Protection Committee
- Dumfries and Galloway Child Protection Committee
- Falkirk Child Protection Committee
- Infant, Children and Young People's Transformational Change Programme Board, NHS Ayrshire and Arran
- Moira Anderson Foundation
- National Day Nurseries Association
- NHS Ayrshire and Arran
- NHS Borders
- NHS Greater Glasgow and Clyde
- NHS Highland
- NHS Lothian
- NHS Tayside
- NSPCC
- Perth and Kinross Council
- Police Scotland
- Rape Crisis Scotland
- Royal College of Paediatrics and Child Health Child Protection Committee
- Scottish Commission for Learning Disability
- Scottish Government Chief Social Worker Advisers
- Scottish Independent Advocacy Alliance
- Shetland Public Protection Committee
- Stirling Council
- Stop it Now! Scotland
- The Independent Care Review
- The Scottish Children's Reporter Administration (SCRA)
- Wellbeing Scotland

All comments on the draft clinical pathway were presented to representatives of the Chief Medical Officer's Taskforce for victims of rape and sexual assault (clinical pathways subgroup) in August 2019. Each comment was considered and responded to by the clinical pathways subgroup. Duplicate comments and all comments unrelated to the clinical pathway have been removed. All comments have been anonymised.

According to the Scottish Government's Citizen Space policy, comments which identify ongoing legal cases, personal identifying names or information, or inflammatory material have been redacted.

This consultation feedback report includes the comments received, together with the clinical pathways subgroup's response and any subsequent amendments to the clinical pathway.

During the consultation period, we held 5 focus groups with interested stakeholders and staff groups. The comments from these focus groups have been given an ID number and added as individual comments in the consultation report. This is to ensure that each comment given during a focus group is responded to individually.

Summary of responses

Throughout the consultation, respondents welcomed the opportunity to engage with the CMO Taskforce on this piece of work. Overall, respondents highlighted the need for the clinical pathway to reflect the principles of the changing Scottish legislative and policy landscape. The Barnahus model was highlighted as an example of best practice in this area by providing trauma-informed support, putting the child's rights first, without undue delay. Respondents further noted the principles of holistic, multi-agency and child-centred approaches as taken in the review of the National Child Protection Guidance and the findings of the Independent Care Review. In particular, respondents noted the need for people's experiences to shape the pathway. Further clarity was sought on the age of the 'child', with respondents expressing a preference for the pathway to cover children and young people up to the age of 18 in line with the UN Convention on the Rights of the Child and the changing policy landscape.

Some areas for further review were suggested, namely that the document should be amended to reflect the multi-agency nature of child protection, and in particular that the process a child or young person goes through is often a journey rather than a series of isolated events. Respondents highlighted the need for the pathway to issues inequalities of provision of recovery and support services, including the role of the third sector and community Child and Adolescent Mental Health Services (CAMHS). Additionally, respondents highlighted that the figures contained for the prevalence of child sexual abuse represented reported rates, and expressed a desire for the figures to reflect the healthcare-specific focus of the clinical pathway. There was a further recommendation from respondents that specific provision should be made for disabled children in order to ensure equity of provision.

In both the aims and the context provided in the pathway, respondents welcomed the focus on the provision of trauma-informed support and national consistency. In some areas, concern was expressed about the mechanisms of locally implementing the pathway.

Additionally, further information was requested on the relationship between the clinical pathway and a multi-agency child protection response, specifically the role of the Interagency Referral Discussion (IRD).

Respondents noted that the behaviour the perpetrators and the response of agencies to that behaviour could be highlighted. In particular respondents recommended highlighting several key areas of child sexual abuse, namely child sexual exploitation of children over the age of 16; online child sexual abuse; and sexual abuse within the context of wider domestic abuse. Respondents highlighted that situating children's experiences within this context, and the context of recovery, may help fulfil the aims of the pathway.

Acknowledgements

The CMO Taskforce would like to take this opportunity to thank everyone who responded and provided feedback during the consultation period.

Section 1: Introduction

ID.	Consultation comment	Clinical pathways subgroup group response
Do you believe the pathway would improve and standardise services for children who have disclosed sexual abuse and their families?		

Yes	**35**	**61.40%**
No	**12**	**20.05%**
Not Answered	**10**	**17.54%**

Comments

ID.	Consultation comment	Clinical pathways subgroup group response
641E-8	This pathway is aligned to our current procedures in [our area]. However, a standardised pathway will ensure procedures are consistent nationwide.	Noted
64ME-4	The Pathway will not improve the system because the system itself is not fit for purpose – and this is so for a number of reasons. If you have experienced a Joint Interview, and the lead up to it, you will know that it is not in any way child friendly. It is intimidating and does not in any way take into account the needs of a younger child in particular, the primary need being to first establish a relationship of TRUST. Basically what the JII asks of children is for them to immediately trust a total stranger with information they feel scared and confused about – information that they are barely able to process or understand themselves – in an alien environment into which they are thrust with very little warning or preparation. It is fundamentally inept and borders on being barbaric. It is essential to bear in mind that many sexual abusers embed threats in the mind of the child victims in order to silence them. How then can a child disclose to complete strangers in the context of a Joint Investigative Interview any concrete information while believing that it would result in a terrible fate befalling them or someone they truly trust.	The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and

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	The Barnahus model offers a far more child sensitive approach where time and care is taken to build a rapport of trust with the child in a safe and comfortable environment, which happens over a period of time and is not a rushed, stressed, invasive experience – as are some JI's in Scotland. The Barnahus model was referred to in a positive way in the Evidence and Procedure Reviews that took place in recent years, and yet I see no sign that this has been taken forward into the Scottish System of child protection.	receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64ME- 4	My daughter experienced a JI when she was 4 years old. We had to go to [a] Police Station and sit in the entrance where two large intimidating men stood behind the desk. It was an entirely unfamiliar setting for my daughter, and I felt it was unpleasant and potentially alienating. Then the social worker and police officer arrived and said we had to go somewhere else, which was the […] Hospital. We had to drive there and provide a lift to the Social worker who	Thank you for sharing your family's experience with us. Ensuring that children and young people's voices are heard, listened to and acted on are very important points.

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	was evidently very stressed and came across as being agitated. When we got there, it looked like an abandoned hospital. The context felt unfriendly and was bordering on eerie. My daughter tried to make conversation with the police officer and had obviously taken a liking to her, but still had to cope with the JI with the stressed Social worker who gave off no sense of calm or an appropriate level of warmth. Then my daughter had to go in to a white room, with nothing in it but two chairs, a table and a fake flower in a vase on the table. I felt that it was much more akin to a prison cell. There was nothing about the environment that was conducive to confiding, neither was the manner in which the whole run up had been handled. This kind of situation and treatment is not going to make a child feel safe or trusting	The Pathway promotes consistent, child centred and trauma informed care. Hearing the views and experiences of children and young people, and their families is key to this work and to driving improvements in all aspects of care and support. The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young

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		People who have experienced child sexual abuse and non-abusing parent/carer(s).
64ME- 4	All the material on CSA repeatedly states how difficult it is for children to disclose sexual abuse. It is incredible to think that in this day and age this kind of approach of JI is still used for children under 12. It might be suitable for children over 12, but I doubt even that. It is also well known that it can take children years to disclose. A recent NSPCC study states that it takes on average 7 years for a child to disclose – longer if they are younger. And of course, this cannot take into account the numbers of children who never disclose. None of this is taken in to account when the Joint services look at a case with younger children. It appears that no account is taken of behavioural and verbal clues from a child that could aid an assessment of risk. My daughter had a second JI – which came after a sudden disclosure to a boy on a play date, {…]". The second JI was conducted in a better way. It took place at her school, but there was no warning and it came as a shock to her. She was so frightened she was not able to say anything much. […]. I would have thought that given the context in which my daughter had confided this would have led to it being taken very seriously. After the second JI my daughter told me she had been too frightened to say anything because she "didn't know what would happen next". Then six years old, she was a couple of years older than at the first JI. Given how difficult it is for children to disclose it was remarkable she was able to say anything at all…The social worker's discounting of her statement I believe contributed to the Sheriff's final judgement which found in favour of her father. This means unsupervised access has already begun, and that unsupervised residential access is likely to begin quite soon. She is showing considerable distress before and after these events	Thank you for sharing your family's experience with us. Ensuring that children and young people's voices are heard, listened to and acted on are very important points. The Pathway promotes consistent, child centred and trauma informed care. Hearing the views and experiences of children and young people, and their families is key to this work and to driving improvements in all aspects of care and support. The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and

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		receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
641N-H	We think it is essential that the pathway is underpinned by both GIRFEC and the UNCRC, that the service design is adequately shaped by lived experience and that the language and terminology used are clear, concise and really explicit. It is vital that children are supported throughout the process and that expectations around disclosure and subsequent actions are accurate. We believe that equality impact assessments need to be conducted as soon as possible.	The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. Impact assessments on the Pathway have been carried out and informed revision of the initial draft.
641Z-W	My only concern is the timescale for forensic examination as we have had circumstances where a delay has been an issue both for the child and in	The Pathway indicates appropriate timescales for examinations to be performed in line with the relevant standards. These are contained in the

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	gathering evidence. Facilities like the Meadows in Larbert, Stirlingshire provide a non threatening holistic environment	NHS Healthcare Improvement Scotland Standards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards). Boards will work to deliver examination in line with these standards and, where appropriate, collaborate on a regional basis to meet them.
641T-Q	Yes - promotes consistent, child centred, trauma informed care.	Noted.
6418-U	Firstly, it is not clear what, if any, pathways this replaces. We are unclear as to whether there is a need for this or why this is required. There are no core/minimum standards contained within the pathway. Core/minimum standards would allow for reporting and measuring of services in a consistent manner.	The pathway is underpinned by the HIS standards for healthcare and forensic medical services and corresponding quality indicators (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards). A consistent reporting mechanism of service performance is being developed by the QI subgroup.
6418-U	There are no clear timescales set out for any stages of the process, however under the section for IRD, the pathway refers to 'within 24 hours'. The pathway should be aligned with the Police Scotland SOP and National Child Protection Guidance in relation to timescales for IRDs. It should also acknowledge local multi-agency IRD procedures.	The pathway refers to the timescales set out in the HIS quality indicators, which reflects the MCN Quality Standards and the need to reduce undue delay, in line with the principles of putting the child's best interest first.
6418-U	Consideration should be given to highlighting the importance of Education being consulted or be part of IRDs.	Guidance on the specific operation of IRDs has been developed nationally and has been included in the new National Child Protection Guidance which is currently out for public consultation.

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641K-E	The pathway should, if well-resourced throughout Scotland, provide a standardised, consistent approach to how clinical services respond to children who have disclosed sexual abuse.	Noted
6412-N	It will so long as the pathway is clear for all healthcare practitioners to use. For dentists, this needs to be a user-friendly resource where disclosure of sexual abuse is not a regular occurrence. When it is disclosed, this pathway must be in a format that is easily accessible by all members of the dental team who may receive the disclosure. Primary care dentistry is busy during clinical hours and referring to a long document is not practical, particularly when staff will not be using this pathway regularly. A dental specific version or supplementary dental guide would be useful. "It is not intended for this resource to be read cover to cover, rather, this resource is split into a number of chapters for easy access". In the current form this will be of little use to dental teams (except for the flow chart) as it is too much like a report than a toolkit or pathway. Alongside this should be an easy to use tool for practitioners who need to apply some of this pathway in their practices. Some of it can be read as a background document but as a useful tool it needs an accompanying streamlined document.	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it is not necessary and may be unhelpful to duplicate material already available in this area.
6414-Q	Shetland NHS use Paediatricians in Aberdeen for forensic medicals in sexual abuse cases and this paper does not acknowledge differing pattern of service provision nor does it emphasise that despite rurality and distance all children in Scotland have a right to a good service.	The clinical pathway aims to provide an outline of national consistency across Scotland, recognising necessary variation in local implementation.
64S9-X	I feel that the document is not specific enough in clarifying the roles and responsibilities of each organisation and could be widely interpreted across organisations rather than its purpose to standardise and improve the approach. It is too generic in its detail.	We have attempted to address the balance of describing best practice in line with current relevant legislation and guidance while allowing flexibility to take account of local multi-agency procedures.

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		The revised Pathway now includes a section on the roles and responsibilities of the professionals involved.
63SV-U	[Our] believes that consideration needs to be given to children with disability/complex needs as they have an increased risk of harm; I. May access respite - Separated from family II. Dependent on others III. Non-verbal communication IV. Exposed to a wider range of carers V. Rely on others for communication VI. Not aware of personal safety	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc. in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the Pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or

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		Getting It Right For Every Child (GIRFEC) must be considered.
64SE-A	[Our] welcome the introduction of the pathway to standardise services for children or young people who have disclosed sexual abuse. Current inconsistencies across the country may adversely affect child protection procedures, partnership working and service provisions. Ultimately, it is hoped the pathway will provide positive outcomes for children and young people and promote effective partnership working. We believe the role of [our] in child protection is already well defined; the introduction of the pathway for children and young people outlines the responsibilities of all professional bodies and should determine the bespoke care, information and support package a child or young person should receive.	Noted
64SN-K	Inclusion of recovery response and service commissioning - patchy at best across the country.	Noted. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64SB-7	The introduction of the Clinical Pathway has the potential to improve and standardise the services and supports children and their families receive where medical examinations are required due to experience of sexual abuse. In order for the potential of these improvements to be fully realised, further development of some areas of the Clinical Pathway is required. In particular, improvements could be made by: • Clearly integrating and embedding the Barnahus concepts throughout the Clinical Pathway, in particular, the three core principles of placing the best interests of the child at the centre of practice and decision-making; ensuring	The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context.

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	children's right to be heard and to receive adequate information at all times; and avoiding delay in protection, assistance and justice processes. (6) Currently, beyond the initial mention of Barnahus on page 7, there is little evidence of how the approach and concepts are reflected in the Clinical Pathway, and what this means for the way practitioners should operate. • Reflecting clear recognition of the vulnerability of all children, and their rights and entitlements to sensitive, trauma informed and holistic responses when receiving services as part of the Clinical Pathway. Regardless of the inconsistency in some areas of the Scottish legal system concerning the definition of a child, the UNCRC (which the Scottish Government is committed to incorporating into domestic law) is clear that anyone under the age of 18 is a child, and is entitled to have their rights upheld as such. This is also reflected in Girfec, which is in place for all children up to the age of 18. Furthermore, in recognition of the additional needs and vulnerabilities faced by children and young people with care experience, and the responsibility of the state to safeguard their rights and promote their wellbeing, Part 9: Corporate Parenting of the Children and Young People (Scotland) Act 2014, requires Scottish Ministers, NHS health boards, and a range of other public sector bodies to pay particular attention to meeting the needs and listening to the views of these children and young people in all areas of their services. Young people to whom the state is a corporate parent are entitled to additional support up to the age of 26. Their needs, and how these are taken into account in the Clinical Pathway, requires explicit clarification. • Providing greater clarity about how the Clinical Pathway is integrated within the wider multi-agency child protection system, in line with the Girfec approach. This is largely missing from the Clinical Pathway currently, and the shared responsibilities of all practitioners in responding to child sexual abuse, and the mechanisms through which partners work together, requires significant attention.	The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child

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		protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64SZ-Y	Whilst we are very supportive of the intention, and have been part of both the Task Force and the Clinical Pathways group what is missing from this pathway in its current format is the clear outline of the importance of support & advocacy which should be made available to the child &/or family throughout their engagement to enable them to make informed choices, to be able to access the support they need following disclosure and to enable recovery. Whilst the Barnahus model is referenced, what is missing from the body of the text is the importance of and need for young person centred support. This is clearly articulated in the adult pathway but missing from here. What was clearly demonstrated in the NSPCC research 'Right to Recover' into the experiences of children and young people who disclose https://learning.nspcc.org.uk/media/1128/right-to-recover-sexual-abuse-west-scotland.pdf was that for many there was little support provided once any immediate child protection concerns were addressed. This document will do little to clarify that this needs to change. On page 17 paragraph 2 for example it references having a child's plan and says 'The Child's Plan (GIRFEC) may include access to ongoing therapeutic support for the child and their family members / carers post examination, but also in the months and years following disclosure of Child Sexual Abuse (CSA). In many parts of Scotland	Noted. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	this is just not available and this needs to change. This should be stressed as something which is fundamental. Earlier in the document there are references to ACES and the impact of trauma on children, and on their parents, but without looking at the support needs as something which is not optional this will not change.	
64SH-D	The pathway as drafted would, if fully implemented, improve standards and services for children who have disclosed sexual abuse and their families. However, we believe that the focus on children who have disclosed sexual abuse is too narrow, and restricts the impact that this pathway could have. We believe that the document should cover clinical pathways for all children and young people who have or may have experienced sexual abuse. In focussing on children who have disclosed child sexual abuse, this document potentially misses an important opportunity to engage medical professionals in wider discussions about child sexual abuse; increasing their understanding of this type of abuse, their ability to identify signs and indicators, and therefore their ability to engage child protection processes at an earlier stage. This will impact on the support and protection the child or young person will receive. In our experience, very few children and young people will independently make a verbal disclosure of sexual abuse. Some are unable to do so due to age, developmental stage or disability; others do not feel able to disclose due to fear, shame or not recognising what they are experiencing as abuse. Recent research from the University of Bedfordshire (https://www.beds.ac.uk/ic/recently-completed-projects/making-noise) also identifies a number of situations where children and young people think they have made a disclosure, but this is not picked up as such by those around them. By limiting the focus to young people who disclose, many victims will be missed. At present, the pathway puts the onus onto the child by focussing on disclosure. The Scottish Government's wider child protection work encourages us to see child protection as everyone's business, while the current focus of this pathway relies on children to protect themselves by	The Pathway has been updated to refer to a disclosure or an initial concern. The Pathway has been updated to clarify that the scope is for children and young people who may have experienced sexual abuse There is now a section on child sexual abuse earlier in the Pathway. Revised National Child Protection Guidance will be published in 2021 and we have not replicated material from the draft of that guidance.

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	focussing on disclosure. The document does detail (in Section 5.1) a range of ways in which sexual abuse in children may present. We believe that this should be highlighted much earlier in the document, with medical professionals encouraged to look out for and identify these signs in all the children and young people they work with. This approach is particularly important as this pathway is for use by a broad spectrum of medical professionals. While those conducting a forensic examination, for example, may not be in a position to spot indicators of potential sexual abuse, others who have more regular or ongoing contact with children and young people such as GPs, health visitors, school nurses and LAC nurses, would be well placed to identify patterns and possible indicators. These might include recurrent STIs/UTIs, multiple pregnancies, terminations and use of emergency contraception, missed medical appointments or children regularly being under the influence of alcohol. They are also well placed to support the child before, during and after any eventual disclosure or child protection response. This document could be used to increase their understanding of the background risks and indicators for child sexual abuse.	
64SH-D	To best support medical practitioners through situations where they have reason to believe that a child or young person they work with may have experienced or be experiencing sexual abuse, we recommend that three pathways should be developed alongside one another to support medical practitioners: • One for children/young people who are experiencing abuse currently (and therefore require an immediate response); • another for children who have reported abuse that is not current or non-recent; • and a final pathway where there is suspicion or concern of abuse. We do not believe that one pathway for those who have experienced child sexual abuse is sufficient, as this does not take sufficient cognisance of different experiences and the different situations children and young people	The Pathway has been written to take account of various scenarios and explicitly addresses degrees of urgency required in child protection responses. We feel a single comprehensive pathway is preferable and easier for practitioners than multiple pathways addressing different scenarios.

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	may be in. In some circumstances, the pathway could and should be used as a basis for discussion between the medical practitioner and the child about what will happen next, and what the child should expect at different points in the process. It is therefore important that the pathway accurately reflects the different processes in different situations, to avoid children being given inaccurate information. It is also important that the response is based on the need of the child/young person and their individual circumstances; one response will not fit for all children and young people. Within the pathways for children currently experiencing abuse, or where there are concerns this is the case, distinctions in the pathway should be drawn where a child is at immediate risk and where there is ongoing but less immediate risk. For example, while a child who is being abused when visiting relatives every other weekend may require a Child Protection response, a child returning home from the medical appointment with the perpetrator of their abuse may also require a response from emergency services. We do not believe that all sections of the pathway as drafted would be required or appropriate for a child/young person who has disclosed non-recent or non-current sexual abuse, and therefore recommend that a parallel pathway is developed for this situation. Coordinating pathways should therefore be developed for children and young people who have disclosed ongoing abuse; children and young people who have disclosed non-current abuse; and children and young people where sexual abuse is suspected.	
64ST-S	The document is too high level - there is not enough practical information within it - how is to be implemented, what resource is there is provide the trauma informed care that is discussed.	The Pathway is aligned with current National Child Protection Guidance and has flexibility to take account of local multi-agency IRD procedures. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have

ID.	Consultation comment	Clinical pathways subgroup group response
		experienced child sexual abuse and non-abusing parent/carer(s). Training and education was offered to all health professionals at roadshow events prior to implementation of the resource.
64SU-T	I can not in all good faith support this in its current form because it is self defeating in its aims to save the life's of Scotland's children by promoting the murdering of unborn children itself via recommending the use of abortion in cases were minors have been raped. A babe should not be burnt at the stake for the crimes of a rapist ! Secondly, I can not support this because the laws in regards the age of sexual consent, age of marriage and age of majority are not in communion with one set standardised age and therefore there is a blatant inconsistent statement being made hear by the Scottish state to its society regarding when a child is a child and when an adult is an adult and therefore when free consent can be counted as valid or not counted as valid and therefore when rape actually occurs or does not occur until these issues are resolved as to make the lines in Scots law more consistent the pathway will fail both victims and those accused falsely in terms of actual objective reality as apposed to just Scottish Government legal dictate. Since this nations age of consent is 16 this pathway and its consultation should have focused exclusively on alleged victims who are 15 and below. This response will therefore be concerned with those alleged to have been raped 15 below and no higher. Thirdly, the pathway is limited in scope and in power even if one accepts all propositions including yes, even the abortion it actually does not have all the top qualities that should be present within it that are found in other systems in other nations, of which there children live in an even more protected child friendly environment than in Scotland. However, I do note that those nations have a higher human rights index score than Scotland. The system will not therefore make as big a contribution to ending the abuse of	There is a legal right in Scotland to clinically safe and legal abortion services. People should be supported and free to reach their own decision on whether or not to have an abortion. A child within the content of this clinical pathway has been defined as a person up to the age of 16. This is in line with clinical practice and reflects similar arrangements in paediatric services nationally. The CYPEG recognise that a 'child' is defined differently in various pieces of legislation, and have taken cognisance of the reasons for this differential. An additional appendix on the age of a child has been included.

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	children in this country as it could have done - abuse that I am not surprised has increased dramatically and that will only continue to climb at an alarming rate in Scotland regardless of previous the two points made. Outlawing the proscription of abortion should be the first and foremost move in stopping the abuse of minors in Scotland I believe followed by standardising the age of consent in which a person can exercise all there liberties to one national standardised age then redesigning this pathway to include more advanced measures to combat the sexual abuse of minors. This will leave no more blurred lines anymore to be had in regards maturity, learning difficulty or arguments around positions of trust for example or other claims such as inequality under the law due to characteristics that may lead to legal challenges by an alleged victim themselves of when the pathway is entitled to regard them as an alleged victim or allegedly not a victim by way of there given consent being or not being counted as valid by another as apposed to the person who actually gave there consent maintaining or not maintain they freely gave it and this will mean the Scottish state can regard any infraction of one set national age limit as child rape despite the under age persons opinion or not with full public support immediately allowing more robust credible prosecutions of any adult for breaching that national statutory standard of which will be then applicable to all regardless of who they are. Currently for all intents and purposes for most liberties the age is 18 but actually having sex and even voting to decide the destiny of the entire nation is 16 still horrifying is the ability of 12 year olds to consent to or refuse medical treatment until death occurs or life chances increase - a child under the national age of consent should have there health always attended to regardless of there consent therefore there life's saved the question of them giving or not giving there consent to treatment should not come into it - this state of affairs is absolutely ridicules. This needs to be changed to 18 for all rights and freedoms that would mean the right to: Refuse medical treatment. Marry. Have Sex. Vote. And all other freedoms. Be made18. Today's Scottish youth are far to immature to be granted any rights at any age younger than	

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	this whatsoever. Whatever position the Scottish Government takes on age though it must at least not be ambivalent. An adult is a consenting adult for all actions in all circumstances in a democracy no matter what those are or are not unless of course that adult is not an adult but a child that is under the one consistent national age limit, or an adult that says no, does not give consent, is unconscious, deemed severely incapacitated in mind, misinformed as to the nature of the act, coerced, blackmailed, significantly intoxicated or otherwise drugged as to be stupified. Once the national age limit for all rights and freedoms is consistent at 18 then this pathway may deal with incidences and only incidences were children have been alleged to have been raped with force, presumption of there consent, or by so called 'freely giving there consent'' to a person who has reached the national age limit or above. Until then, this pathway should focused on those 15 and below as to maintain credibility.	
64SD-9	[Our organisation] believes that the pathway supports the delivery of a consistent healthcare response to disclosure by children and young people of sexual abuse.	Noted
64SP-N	Those children and young persons who are the victims of sexual abuse need to have confidence in the way that they are handled following such allegations. The pathway seeks to improve and standardise services. The standard of service should be child-centric and not affected by where they live or to whom they disclose. The pathway may do much to support provision of confidence, transparency and support for the child. Paragraph 1.2 of the document notes that the pathway and guidance are to be used by healthcare professionals in Scotland. We suggest that others, including those working with children and young people such as teachers and social workers, also need to be aware of and understand the pathway. Publicity and awareness raising may be required to fully achieve the aims of the pathway.	The remit of the Pathway now covers local authority staff including teachers, Police and third sector. There will also in 2021 be revised National Child Protection Guidance to support these groups of staff.

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64SQ-P	It is helpful to have a pathway that provides clarity and consistency. However, the pathway would be strengthened if it reflected more explicitly, the engagement with relevant partners at all stages. This includes effective engagement with children, young people and their families	The Pathway now includes the organisations and individuals involved in its development. Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging and we have benefitted from the experience of Children 1st's involvement in developing the Pathway.
64SK-G	It has the potential to improve services but standardisation relies on a consideration of the wider supports that are available... eg page 10 talks about emotional and mental health support which varies greatly across Scotland	The clinical pathway aims to provide an outline of national consistency across Scotland, recognising necessary variation in local implementation.
64S6-U	Geography, has challenges (Dumfries). Police have to transfer consumables to Wishaw or Glasgow, challenges for us. Argyll – major issues children and adult, 4 hours to drive to Glasgow. Inverness, 4 local authorities, child need joint medical from Shetland or Orkney – Aberdeen or Glasgow. Occasions where there is an overnight stay. Should be doctor to patient not patient to doctor. Impact on the child. Fife – surrounded by 3 NHS authorities 4 in total. Tayport have to drive to Edinburgh, Kincardine again go to Edinburgh. Due to medical networks. 3 hour journey potentially. Aberdeen – Grampian. Elgin – we are now through NHS Boards to Inverness 35 miles, which use to be Aberdeen 70 miles do likewise for children as we now do for adults. Doctors would need to agree to that. Police and social work can normally stay local for interview, and we have the kit (laptop with camera and microphone). Wherever is closer to them. Child will still have to travel for the examination. Implement pathways and services aren't ready that's when we meet bumps. Don't meet expectations of victims. We are not doing what we will say we are going to do. If we implement a pathway we need to be ready, speak to others and that could dissuade others of reporting. Implementation of pathways	The Pathway is aligned with current National Child Protection Guidance and has flexibility to take account of local multi-agency procedures. The Pathway is not intended to address the variances between local provision of services and the need to travel to access small volume specialist services. It does make clear that the best interests of the child or young person should be the main consideration in all decision making.

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	would encourage reporting, cant services pathway have gaps initial positivity will become negative. Not doing the right thing. How are we going to promote the pathway in some way, schools, TV etc. pamphlets in GPs. Not going to have knowledge unless involved.	
64S4-S	GIRFEC should unpin this and be the starting point, especially if moving towards Barnahus. All the additional parts about the pace, the ways of working, and the team around the child. Without that, the pathway doesn't take into account current ways of thinking and working, and can't change anything. The values and language are trying to be there, but they are not exposed enough.	The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context.
64S4-S	Question the added value of this, other than as a useful reference document. It reads as though the Taskforce has decided there should be a clinical pathway, and therefore there is a clinical pathway. But what is the added value?	The Pathway is intended to describe best practice in line with current relevant legislation and guidance to assist practitioners in providing care and support to children and young people who have or may have experienced sexual abuse.
64S4-S	What is the document intending to change and what is it responding to? It's not driving to change anything, as it doesn't reflect the new practice.	The Pathway is intended to describe best practice in line with current relevant legislation and guidance to assist practitioners in providing care

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		and support to children and young people who have or may have experienced sexual abuse.
64S4-S	We are putting the onus and the responsibility on the child to actively disclose, and to have that responsibility. We should be keeping them safe, not expecting them to have to disclose, and people can be affected with a wider experience of sexual abuse within a familial setting (where an older sibling is disclose to protect a younger sibling who is at risk).	The Pathway notes the healthcare response that should be provided for a child or young person following disclosure of sexual abuse or for a child or young person where, through other interactions, there are indications that sexual abuse has occurred.
64S4-S	There is a loss of control--everyone knows what has happened, and once it is over young people can get dumped or left. With all of the feeling of the process, having the loss of control, fall-out between family, without support, and feeling like they are not believed. This is where wellbeing is not at the centre, and the wellbeing indicators are not discussed	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64MC-2	The inequalities experienced by those with care experience is well documented and understood, thus the need for a root and branch review of care which will conclude 2020. In Scotland there has been progress but there remain significant gaps between the legislation, policy and the implementation in practice. There are many, but one example which highlights this gap is continuing care – the evidence from those with care experience, the paid and unpaid workforce alongside data analysis has highlighted that this progressive legislation is not being implemented. The lack of continued support has a devastating impact on the lives of young people: homelessness, lack of emotional and financial support, resultant placement moves all highlight the fundamental lack of Corporate Parenting duties being implemented. As well as immediate day-to-day improvements to the lives of infants, children, young people and families experiencing the 'care system', [our] team is building a detailed understanding of the bridges and barriers to change (e.g. resources, culture, geography, provision etc.) in	Noted These findings in the reports of the Independent Care Review 2020 have been taken into account in the Pathway.

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	every context. [Our organisation] aims to identify and deliver lasting change in the care system and leave a legacy that will transform the wellbeing of children and young people […] There are some extremely successful stories of people who have experienced care as an infant, child and or young person and we don't want to continue painting the picture of stigma of those who have experienced care. However, what we do need is to change the picture, so that it is no longer relevant. Our response to this consultation is another step towards that. [Our organisation] fully backs the purpose and implementation of the clinical pathway, agreeing that it would improve and standardise services, though recognises that this opportunity for improvement has not realised its potential as it currently stands.	
64MC-2	[Our organisation] strongly urges that care experienced people play an integral part in the final content, taking the journey of care into account in each of the key areas; covering a range of ages and input within this, and in general are fully considered when looking at the content and outcomes.	Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging and we have benefitted from the experience of Children 1st's involvement in developing the Pathway. The reports of the Independent Care Review 2020 and the needs of care experience children and young people are referenced in the Pathway.
64MC-2	[Our organisation] welcomes the recognition of the importance of having a workforce across agencies all working to an approach of trauma informed care as a part of the pathway and recommends that this extends beyond the workforce, incorporating carers and families (including corporate parents).	Noted
64MC-2	[Our organisation] has a number of key areas being worked on just now, that will provide a very useful resource that will tie into this work; with findings not produced anywhere else to date. We would therefore request that the production of the final pathway document either takes into account [our]	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection

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	timings to allow for these key findings to play a part in the final document or alternatively, for there to be a planned review of the pathway in 12 months, that will allow for the findings to feed into this.	context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64MC-2	[Our organisation] urges that the age parameters reflect other areas of Scottish legislation: young people to whom the state is a corporate parent are entitled to additional support up to the age of 26; this must be reflected in the pathway. Scotland should act to protect our infants, children and young people at risk, working to help those at the heart of the trauma, bringing all relevant people and organisations together to act in the best interest of the victim, gaining the best outcome	The duties of corporate parents are discussed in the Pathway. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64MV-N	We welcome the Chief Medical Officer's commitment to developing consistent, person centred, trauma informed healthcare and forensic medical services and access to recovery for anyone who has experienced rape or sexual assault in Scotland. The 2017 HMCIS report found major issues in the support available for those who have experienced rape or sexual assault in Scotland, and it was right that swift action was taken to address this. However, in the introduction to the document it is stated that this guidance is intended to support the implementation of the outcomes of the Options Appraisal of the Taskforce (Honouring the Lived Experience). This recommended the option of Multi-Agency Centre with co-ordinated services for adults, children and young people who have experienced sexual assault and rape (acute and historic). It is also stated that these recommendations "are intended to be in line with the Barnahus concept". However, the Barnahus concept, as set out in the International Barnahus Quality Standards (see https://www.childrenatrisk.eu/promise/standards/) is	The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and

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	for multi agency and holistic services for "all children who are victims and/or witnesses of violence regardless the form of violence have equal access to the service and are offered a multi-disciplinary response" (standard 3). It is not clear how the option identified by the Options Appraisal process for all-age service for people who have experienced sexual assault and rape (acute and historic) can be reconciled with the Barnahus approach of multi-agency services for children who have experienced or witnessed violence, whether sexual violence or physical or emotional violence. Given that the Scottish Government has repeatedly stated said that Barnahus is its preferred direction of travel for supporting child victims and witness of crime, ensuring that they get the best support and can give the best evidence, we are uncertain as to how these two very different approaches can be reconciled. We recognize the work that has been done on the pathway, but there is a danger that if services are designed to address the needs of only some of the children who require Barnahus– those who have experienced sexual abuse – these services will not in practice be aligned with the requirements of the International Barnahus Quality Standards . The Scottish Government has now launched a process to develop Barnahus Standards for Scotland, which we hope and expect will set out how a Barnahus response will meet the needs of all children and young people who have experienced or witnessed, sexual, physical or emotional abuse and violence. These Barnahu standards must be cross cutting; covering justice, child protection, health and recovery. This should ensure forensic pathways for children and young people are aligned with the holistic, child-centred model of an accepted barnahus model, with the appropriate infrastructure to house it. Therefore the process of standards development will need to be completed before the pathway is finalised and rolled out. We acknowledge that the desire to bring about positive change has led to action on the issues raised in the 2017 HMCIS report across various departments, but this action has had the unintended consequence of creating different and increasingly conflicting timescales of work. We recognize that there is urgency in	receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	addressing the complex challenge of seeking to achieve an improved response to adult victims of rape and sexual assult. However we would stress that their needs are many ways significantly different to those of children and young people. Work to secure a child-centred, consistent, trauma sensitive and recovery focussed response for children and young people, including the clinical pathway. must therefore be undertaken within the Barnahus standards development process.	
Are there any key areas of research missing, or any general amendments you would suggest?		
64HR-C	There should be recognition that in some areas the reference to IRDs is taken to mean Initial Referral Discussion, which is specific to the initial tripartite discussion which takes place between the Police, Social Work and Health. This becomes an important distinction at para 5.3 as the Police use their Interagency Referral Discussion(s) in plural whereas other partners see the Initial Referral Discussion as a singular one off discussion about making decisions about how to proceed with the case.	The definition and role of interagency referral discussions has been expanded in line with the draft revised National Child Protection Guidance which seeks to encourage greater consistency across Scotland and is currently out for public consultation.
64H6-G	More clarity on the statement (used twice) that "the dynamics of child sexual abuse differ from those of adult sexual abuse." - seems to suggest that adults don't experience sexual abuse/violence from people known to them, which they overwhelmingly do.	Noted
64ME- 4	– younger children may not know the names of body parts and therefore use infantile language to describe acts or body parts. The lack of awareness of this – especially in the court system means that from a Sheriff's point of view a communication from a child may be vague or "non-sensical". In one case a child described how her daddy had put a needle up her bottom. This was not a description of what actually happened, but rather a description of the sensation. Younger children do not understand what abuse is and it may be that they have had it described as or are able to understand it as a game they	The remit of the Pathway does not include the training of police officers, social workers, court staff and officials including lawyers, sheriffs and judges, or any other agencies involved in the court system.

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	don't like. This is why, especially in the case of younger children, time and trust are two absolutely vital components for helping a child to disclose – not half an hour in a room like a cell with total strangers. The JI process informs what happens in a court room when an abusive parent is seeking a judgement that allows unsupervised access with a child he or she has abused. It is therefore absolutely vital to enable and comprehend every element of the disclosure of children. Fundamentally this takes time. It should only be conducted in the knowledge that it is a process. The failure to acknowledge and work with this is a systematic flaw in the inadequate system that exists. It fundamentally gives no time at all in the relative scale of the length of time children need in order to disclose enough of what has happened to them. To quote from Dr Sarah Nelson's book "Tackling Child Sexual Abuse", " Interviewing problems with ABE The formalisation of, and regulation around, interviewing of children, in prescribed official settings through Memorandum of Good Practice interviews, can be very valuable in court if carried out sensitively after building children's confidence and trust. The ABE (Achieving Best Evidence) phased interview approach centrally includes building rapport with the child, creating a child-centred environment and providing a free narrative phase, for the child to give a non-chronological account in his or her own words. But researchers have found that in practice many such interviews have been conducted in a flawed and unhelpful way for children. That includes the interview environment not being conducive for establishing rapport, not taking into account the child's age or trauma levels, inappropriate questioning, failure to account for confusion and memory problems, and frequent failure to build initial rapport (Westcott and Kynan, 2006; Robinson, 2008).There is also an inherent problem about the importance given to a child's free narrative in these interviews. This is a well-intentioned response to repeated claims that interviewers had been influencing children with suggestive questions. But sexual abuse is precisely a subject which most children feel constrained, ashamed or humiliated to talk about freely in the first place, most of all about the nature of degrading sexual	

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	acts committed on them. If they cannot be prompted by gentle yes-no questions, for example 'I wonder if perhaps this happened to you?'(without, of course, suggesting who the perpetrator was), many will not reveal much through free narrative. This problem is a classic example of defensive responses and reactions to the backlash, which do not actually fit well with children's own feelings, difficulties and reactions. Many interviews also still place stressed children in unnatural settings, with unfamiliar people. It has left the considerable and the greatest problem, that of aggressive defence cross-examination in court, untouched. It has responded to older social assumptions about the unreliability and untruthfulness of children, and to attempts to protect staff from accusations of poor practice. While gaining disclosures of child sexual abuse from children can be considerably improved, there needs to be far more emphasis on gaining other sources of evidence"	
64ME-4	There is little or no understanding about the sophistication of abusers. There is little or no understanding of the fact that they can look and sound like ordinary people and can come across plausibly and very personably. In contacting MOSAC (Mother of Sexually Abused Children) what they have said is "9 times out of 10 the abuser will get access" and "the system is stacked against you". From my own and others' experience I believe that what I was told is true. Events of the past four years have taught me that the functioning of the systems that are supposed to protect children are inadequate and that there are many areas of malfunction. On the subject of gathering material from a child who has been showing signs that he or she has been exposed to sexualised behaviour from an adult, I feel very strongly that the formal systems within the police and social work department do not have the time and expertise to engage with a child in the ways that lead to adequate assessment of the child's situation. My own daughter was referred by the GP to CALMS, but contact with that agency was prevented by her father, so she never got any professional help.	Thank you for sharing your family's experience with us. Ensuring that children and young people's voices are heard, listened to and acted on are very important points. The Pathway promotes consistent, child centred and trauma informed care. Hearing the views and experiences of children and young people, and their families is key to this work and to driving improvements in all aspects of care and support. The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse. The revised

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		National Child Protection provides guidance on wider child protection issues and ultimately some issues are for a court to decide.
64ME-4	It is well known that a child is more likely to disclose to the primary carer than anyone else. This is confirmed by the NSPCC study. A child's instinct is, correctly, to turn to a trusted parent or care giver. Why then does the child protection system expect a young child to be able to disclose to a complete stranger in an unfamiliar environment, without any time to build up a sense of trust?	The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse. The revised National Child Protection provides guidance on wider child protection issues.
64ME-4	A major subject that is not understood or recognised about perpetrators is what the abuse can consist of. The abuse can begin with fun games eg. A puppet game/ a dragon game/ dog game and later be led into something else, which can confuse the child so that he or she might well perceive this as still being part of the game. Deliberately confusing explanations and stories are told to the child so that they will struggle to be able to understand or describe what has happened to them. For example, common descriptions of semen refer to "milk", and many cases contain this signature description which is either misunderstood or ignored by the authorities. There is a kind of grooming that 'normalises' a certain kind of touch that involves private body parts. A perpetrator might even urinate on the child as preparation for subsequent ejaculation. There was a case thrown out of court because the court could not understand why a perpetrator would urinate on a child – or how it would be cleaned up. Urinating on a child can be considered to be a signature or hallmark of certain cases and is found in a significant number of cases and yet courts do not take it into account as being credible, or as being related to sexual abuse. Courts appear to lack the understanding of how perpetrators function. Psychologists may grasp the factors in cases where gross physical violence has been proved. However, the activities of other sexual abusers and damage to children created by a significant percentage of them is often outside their perception and understanding	The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse. The revised National Child Protection provides guidance on wider child protection issues and ultimately some issues are for a court to decide.

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64ME-4	Dr Richard Whitecross's study on Domestic Violence has led to further instruction and training on Domestic Violence in the court system. With regard to sexual abuse of children, highly advanced training is required for police, social workers, the courts and all other agencies that are involved. (NB: Sadly recent cases have demonstrated that despite this courts still cannot recognise Domestic Abuse and will give either equal parental rights or access to a demonstrably abusive parent.)	The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse. The revised National Child Protection provides guidance on wider child protection issues. The remit of the Pathway does not include the training of police officers, social workers, court staff and officials including lawyers, sheriffs and judges, or any other agencies involved in the court system. However, the Child Protection Committees (CPCs), which were established in each local authority in Scotland in 1991, are the key local bodies for developing, implementing and improving child protection strategy across and between agencies, bodies and the local community. Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities (Scottish Government 2019). CPCs should have an overview of the training needs of all practitioners involved in child protection activity. This includes practitioners with a particular responsibility for protecting children, such as Lead Professionals, named persons or other designated health and education practitioners, Police, Social Workers and other practitioners undertaking child protection investigations or working with complex cases.

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64ME-4	A film was made about a study of the links between CSA and postnatal depression: http://safetosay.co.uk/resources/ (Please watch the whole film – available on request). A specially trained social worker worked with a group of women who had postnatal depression. In the work they did it emerged that all the women had suffered CSA. None had disclosed it before. At a screening of this same film a social worker asked if every social worker should have the specialist training that the key worker in the film had. The answer should be glaringly obvious	The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse. The revised National Child Protection provides guidance on wider child protection issues. The remit of the Pathway does not include the training of police officers, social workers, court staff, or any other agencies involved in the court system. The Child Protection Committees (CPCs), which were established in each local authority in Scotland in 1991, are the key local bodies for developing, implementing and improving child protection strategy across and between agencies, bodies and the local community. Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities (Scottish Government 2019). CPCs should have an overview of the training needs of all practitioners involved in child protection activity. This includes practitioners with a particular responsibility for protecting children, such as Lead Professionals, named persons or other designated health and education practitioners, Police, Social Workers and other practitioners undertaking child protection investigations or working with complex cases.

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64ME-4	We can only guess at the number of undisclosed cases of child sex abuse in our society. Everything we know points to the likelihood that the number is significantly greater than current statistics show	Noted
64ME-4	Dr Sarah Nelson is a former Scottish Government Advisor. It is very worrying to note that her book "Tackling Child Sexual Abuse" had neither been read or heard of by the police I dealt with, the social workers, the court or any of the lawyers I dealt with. Even the senior QC I consulted who was known to be the top Family Law QC in Scotland had not heard of or read the book. This is a very damning fact. The only people that were aware of her work were certain Senior police that I spoke to. There is much absolutely essential detail in Dr Nelson's book, which has been available since 2016, and yet none of it appears to have been adopted or acted on	The remit of the Pathway does not include the training of police officers, social workers, court staff, or any other agencies involved in the court system. The Child Protection Committees (CPCs), which were established in each local authority in Scotland in 1991, are the key local bodies for developing, implementing and improving child protection strategy across and between agencies, bodies and the local community. Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities (Scottish Government 2019). CPCs should have an overview of the training needs of all practitioners involved in child protection activity. This includes practitioners with a particular responsibility for protecting children, such as Lead Professionals, named persons or other designated health and education practitioners, Police, Social Workers and other practitioners undertaking child protection investigations or working with complex cases.
64ME- 4	Scottish head of the NSPCC in a BBC article of 2018 made a call for a "Children's house" – I believe a reference to the Barnehus model. Again, this call has not been acted on by the Scottish government	There is a Scottish Government commitment to develop Scottish standards for the Barnahus concept, forming a framework for a child-centred approach to delivering justice, care and recovery for children who have experienced

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		trauma.
64ME-4	CSA is still not well enough understood by the key people who make judgements about the lives of affected children and their carers. There are a number of threats that seem to be in common use in cases of CSA: eg, that children will be dangled from a great height to instil the fear of death in them, they are told that mummy will be killed/ run over, they are told they will be killed/ thrown in a fire (see the book Strong Mothers by Anne Peake and Marion Fletcher). The fear and terror instilled in children is so severe that it can take years to unlock – which is why a JI in a stark room with a total stranger is highly likely to be completely useless. My belief is that JI's as they exist now should be scrapped altogether and replaced with a system which understands the true plight of the child, and the work force in the area needs to be educated with properly detailed understanding of the significance of each developmental stage of children. Appropriate responses in interaction with children, taking into account the developmental stage involved, is essential. It is crucial to have a detailed understanding of characteristics of perpetrators and the way they are likely to behave in order to ensure that a child behaves in the ways that they want them to. At present what knowledge is employed is severely deficient. A stark example of the deficit was shown by the social worker who asked the question about training at the film screening. The ability of courts and workers in the field to understand and protect children who have been sexually abused is very compromised by their lack of knowledge and understanding.	The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse and therefore this is out with the scope of the pathway.
64ME-4	The Scottish Government should follow the example of the Center for Judicial Excellence in America and do research and provide a fact sheet such as the one I will attach in my covering email. Here is an example of the content: 23. Can mental health professional investigators determine if a child has been sexually abused? Fact: No. Investigation of child sexual abuse allegations is a specialty field, and very few evaluators, mediators or social workers are	The Pathway is intended to support the clinical care of Children and Young People who have experienced child sexual abuse and therefore this is out with the scope of the pathway.

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	experts in this field. Alleged perpetrators can find that the process of psychological evaluation sometimes works to their advantage. "Psychological evaluators cannot distinguish reliably between incest offenders and non-offenders..." Clinical evaluation is especially poor at predicting future sexual offenses against children, scoring only slightly better than chance in assessing which men would re-offend and which would not." Psychological testing fared no better than clinical evaluation in predicting future sexual offenses against children. 51 "...[N]or is there a valid psychological test or profile that can conclusively determine whether an accuser, an accused, or a child is telling the truth about an allegation."5 At the same time, psychological testing of the mother who brings the allegation of child sexual abuse to the attention of the court is often used to discredit her reports. She may be described by the evaluator as angry or bitter about the divorce, hyper-vigilant, or paranoid. Such evaluations rarely take into account the normative psychological responses of mothers whose children have been sexually abused. This particular section highlights the problematic nature of the evaluation of the so-called experts in the field and their ability to make effective evaluations. This should be considered, researched and highlighted in relation to how to process information from "experts". In addition to this it should be recognised by the Scottish government that CSA is a specialised field and should not be dealt with by ordinary Sheriffs who have no training or detailed knowledge of the matters, as they will easily miss and misunderstand the common hall marks and signposts in such cases. CSA cases should be dealt with by specially trained Sheriffs who have in depth knowledge of child development and the psychology and common behaviours of perpetrators. What we have now is the equivalent of a GP performing brain surgery. I would not want that and I don't know anyone that would. As well as the need for specifically trained Sheriffs we should ensure that judgements about protecting children are not made by one person alone. There needs to be a system where one person's personal bias cannot affect the outcome of a	

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	child's life. This happens all too often and there is no adequate system of checks and balances to prevent this.	
641N-H	We believe that more work needs to be in done in terms of supporting children and young people with additional needs and learning disabilities, care experienced children and others who may be at risk – managing risk and promoting healthy relationships should be a priority. Supporting mental and emotional well being needs to be a priority throughout and there needs to be a clear definition and framework around trauma informed practice. Thought also needs to be given to supporting (non-abusive) family members or carers as they will be key to supporting the child or young person throughout the process and in recovery.	The Pathway now contains more material on these areas.
641Z-W	More information about support when reporting and following a report as this will be vital. There should be more about involvement of the third sector	The Pathway now contains a section on ongoing care and support for Children and Young People who have experienced Child sexual abuse and non-abusing parent/carer(s).
641H-B	Making and distributing of incident images - it is a form of sexual abuse - and would be useful to include this e.g. sending naked pictures/sexting. Would be useful to have guidance on what to do when this is reported	This issue is covered in the revised National Guidance on Child Protection which is currently the subject of consultation, but the Pathway does now make mention of the use of electronic media in child abuse.
641T-Q	The pathway structures how to immediately respond to a disclosure of sexual abuse however following this fails to address follow up or recovery from the event to ensure consistent and standardised care for all children.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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641K-E	Our consultation group were unable to identify any missing research that would further inform the pathway	Noted.
6412-N	The clinical pathway assumes that all healthcare practitioners know exactly what to do when they receive a disclosure. Whilst some healthcare professionals may receive training in receiving a disclosure, dentists are unlikely to have received the same training. Whilst they have their professional training, this is an area across the UK that is not covered in depth. It would be helpful in ensuring that in order to follow the pathway, that healthcare professionals including dentists and their teams are equipped to receive the disclosure in the first place.	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it is not necessary and may be unhelpful to duplicate material already available in this area.
6416-S	Albeit the document is targeted at Health professionals it would be appropriate to include more reference to the multi-agency nature of child protection at all stages from prevention through to intervention and support thereafter.	The Pathway now has more emphasis on the multiagency nature of child protection procedures.
6414-Q	Document well linked to research and guidance.	Noted
64SM-J	Age pathway applies to: Education colleagues raised an issue about the definition of the age of the child and wondered if it should be 18 if in full time education. However the caveat of additional support needs or vulnerabilities may be more appropriate. 16 is the legal age limit for consensual sexual intercourse and itmakes sense that this is the cut off . Vulnerable 16-18 year olds may not be in full time education. From a service perspective, current paediatric resources maybe significantly stretched if age over 16 included. Is there any information about numbers of 16-18 year olds seen annually currently by adult services?	The Pathway is applicable to the care of children and young people up to 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) who have disclosed sexual abuse of any kind. The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area.

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64SM-J	There is a large discrepancy between the number of sexual offences against children and the number of people proceeded against for sexual crimes every year although two tables in section 2 not directly comparable. Is there any new research or analysis which should be aware as to the reasons behind this and what can we do from a health prospective to improve these numbers (better forensic collection, documentation, etc.)How many convictions are recorded as a result of the prosecutions? Recent media coverage of rapes in England and Wales note only about 1.5 % end in prosecution. An overview of this type of data would also be useful if patients request this as part of informed consent. In section 6.1 3 iii – it is mentioned that the likelihood of obtaining positive forensic results decrease exponentially with time. It would be helpful if we had some actual Scottish figures regarding how often there is a positive result and the actual rate of positive results correlated with time the sample was taken after the assault. I am not aware how often a positive result is obtained and could not inform families accurately if they ask. Regarding acute abuse in Medical Section 6 "Examination should occur as soon as possible to obtain forensic evidence. Guidelines indicate that likelihood of obtaining positive forensics decreases exponentially with time. This is also true for documentation of injuries as the genital area heals extremely quickly". It would be useful to have clearer information about research about how quickly forensic evidence such as semen and DNA disappears and how quickly genital injuries disappear in order to plan medical timing and service provision of paediatric examination services out of hours including weekends. Agree that medicals out of hours outside 8-8 may not be in the best interest of the young person.	It is acknowledged that accurate information on the incidence of child sexual abuse is not available and the table has now been removed from the Pathway. The Pathway is aligned to the NHS Healthcare Improvement Scotland Standards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards).
64SM-J	In section 5.2 (IRD) – they mention consent for medical examination is part of that process. However, consent is taken at the time of the medical examination, not before. It is appropriate to consider who will give consent at	Now explicit in the Pathway

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	that stage in case in the rare instance that a warrant or CPO is needed but it needs to be clear that the consent will be taken by the doctors at the medical.	
64SV-U	[Our organisation] recommends adding information relating specifically to children with disabilities/complex needs and should be highlighted clearly. We specifically recommend adding/highlighting a link to the national guidance found in Child Protection Scotland: Protecting Disabled Children from Abuse and Neglect, May 2014	Now included in the Pathway
64SE-A	From the figures provided from Police Scotland it is evident that the number of sexual offences recorded against children has increased year on year and notably between 2013 and 2018 there has been an approximate 29% increase. It would be helpful if a comparison could be made between these and statistics with the number of children and young people who have benefited from support service or a support/care plan when a disclosure of sexual abuse has been made.	This information can be obtained from NHS Healthcare Improvement Scotland Standards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards), which include statistical figures on: 4.1 Percentage of people who received a psychosocial risk assessment at the time of the examination. 4.2 Percentage of people who were referred to all required services identified during a psychosocial risk assessment. 4.3 Percentage of people who were referred to: a) sexual health services b) a relevant third sector support organisation c) mental health services, or d) their GP. 4.4 Percentage of cases where initial follow-up contact was made by the forensic medical service within 72 hours of the end of the examination.
64SY-X	There is a large discrepancy between the number of sexual offences against children and the number of people proceeded against for sexual crimes every	The table has now been removed from the Pathway.

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	year, although the tables in section 2 are not directly comparable. Is there any new research or analysis of which we should be aware as to the reasons behind this and what we can do from a health perspective to improve these numbers (better forensic collection, documentation, etc.)How many convictions are recorded as a result of the prosecutions?.	
64SY-X	Section 5.2 (IRD) Consent for medical examination as part of that process. However, consent is taken at the time of the medical examination, not before. Where a Child Protection Order or Warrant is required, it is appropriate to consider who will give consent to a medical examination. However, consent will be taken by the doctors at the time of the medical. The paediatrician involved in the planning discussion (IRD) should take responsibility for taking the medical assessment forward – this is not always realistic since certain areas do not have capacity for paediatricians to take part in IRD's, given the numbers and short timescales (held within 24h). A medical representative should attend all IRD's and then information shared in order that a medical examination can be arranged	The Pathway is aligned with current National Child Protection Guidance and has flexibility to take account of local multi-agency IRD procedures. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SY-X	Section 6.1 3 iii "the likelihood of obtaining positive forensics decrease exponentially with time". It would be helpful if we had actual figures regarding how often there is a positive result and the actual rate of positive results correlated with time the sample was taken after the assault. This information would be helpful in order to inform families accurately if they ask.	Information on the correlation between the results of forensic samples and time of examination is not currently available.
64SY-X	Although ideally the victim should be able to request the gender of the examiner, at present this may not always be an option, and families may want to know how much decreased likelihood of positive sample collection is there if they wait a further 24 hours in order to have a preferred gender. "Examination should occur as soon as possible to obtain forensic evidence. Guidelines indicate that likelihood of obtaining positive forensics decreases exponentially with time. This is also true for documentation of injuries as the	Information on the correlation between the results of forensic samples and time of examination is not currently available.

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	genital area heals extremely quickly". It would be useful to have clearer information from research as to how quickly forensic evidence such as semen and DNA disappears and how quickly genital injuries disappear in order to plan medical timing and service provision of paediatric examination services out of hours including weekends. We agree that medicals out of hours outside 8-8 may not be in the best interest of the young person	
64SY-X	Section 6.7 "Reports should be produced within four weeks, as per MCN Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland and should include a clear summary of findings, interpretation of these findings in light of current evidence and a clear final opinion. Good practice is that the joint forensic report should be written and agreed by the paediatrician and Forensic Medical Examiner". Four weeks is a long time to wait for the outcome of the medical report – it would be good for decision making for the child if a summary of the findings could be available sooner, for example one week, with full report in 4 weeks. Locally, the paediatrician will send a letter to the GP, social work, and police which is usually available a week after the examination.	Flexibility to support this practice is now included in the Pathway.
64SN-K	Research into other legal systems and their experience of supporting families/victims without the need for corroboration.	The Pathway is written in the expectation that the requirement for corroboration will continue.
64SW-V	No, the pathway gives a broad overview of research/policy context whilst remaining a straightforward and accessible document.	Noted.
64SB-7	To strengthen the Clinical Pathway, the following additions are recommended: • To reflect the commitment to taking a rights-based approach, include reference to the UNCRC in Section 1.5	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child

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	• The inclusion of the Additional Notes for Practitioners: Protecting Disabled Children from Abuse and Neglect supplementary document to the National Guidance for Child Protection in Scotland is a necessary addition to Section 1.5. Research suggests that children affected by disability are 3 to 4 times more likely to be abused than non-disabled children, and that children with communication impairments, learning disabilities and sensory impairments are particularly vulnerable. (7) • In terms of Section 2, the difficulty in estimating the prevalence of child sexual abuse is recognised. Useful additions to the data referenced include: o The NSPCC estimate that 7 of every 8 children who experience sexual abuse do not come to the attention of statutory services. (8) o Reference to increased prevalence for children affected by disabilities, as noted above. o Findings from the 2015 survey by FRA, the European Union Agency for Fundamental Rights, reports that 18% of women in the UK said that they experienced sexual violence before the age of 15, by adult perpetrators. (9) (7) Scottish Government (2014) National Guidance for Child Protection in Scotland. Additional Notes for Practitioners: Protecting Disabled Children from Abuse and Neglect. Edinburgh: Scottish Government (8) Galloway, S., Love, R. & Wales, A (2017) The Right to Recover: Therapeutic services for children & young people following sexual abuse - An overview of provision in the West of Scotland. NSPCC (9) FRA (2015) Violence against women: and EU-wide survey. Main results. Luxembourg: European Union	Protection Guidance for Scotland, which is currently out for public consultation. The guidance on abuse of disabled children is now included in the Pathway. It is acknowledged that accurate information on the incidence of child sexual abuse is not available and has been removed from the Pathway.
64SJ-F	The pathway is very clear and comprehensive. Practitioners are referred to the document 'Delivering a Healthy Future - An Action Framework for Children and Young People's Health in Scotland' (Scottish Executive, 2007) regarding age appropriate environments of care. This publication is 12 years old and it may be beneficial to cite a more recent reference relating to this item. Pages 5 and 21- Amendment of date: CHILD PROTECTION GUIDANCE for Health Professionals. The Scottish Government, Edinburgh 2013 (not 2012). This is correctly documented in page 17 and elsewhere in	We consider the 2007 document to be relevant and clear on this point. Corrections now made. Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging

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	the pathway document. Page 6- 1.7 heading should read: who has developed the Guidance? Additionally, were young people consulted and involved? It's not clear from reading this if their voices have been heard	and we have benefitted from the experience of Children 1st's involvement in developing the Pathway.
64SZ-Y	The term child sexual abuse is used throughout this document. Generally this term is used where abuse has been over a period of time and is by an adult/older person. This term would not generally be used for example if we were talking about the rape of a 14 year old by her boyfriend. We would reconsider whether the sexual assault of a child or young person is a better fit if we are looking to improve the responses across the board, and to acknowledge within the text the differing nature of how children and young people might experience sexual violence and the differences in service responses and design. What was really clear in earlier workshops RCS have been at re responses was that children are not a homogenous group and that the needs of young children and teenagers are quite different in service delivery. This we believe needs acknowledged here. It may be referenced in some of the linked documents but it requires a more central focus. Non contact sexual abuse such as Image based sexual abuse is not mentioned. Whilst the driver for this work has been forensic provision if the aim is to look holistically at best practice in responding to sexual violence disclosures, including non contact abuse, then the law and context around image based and cyber enabled crime should be included. See recent research on the impact with recommendations https://www.dur.ac.uk/resources/law/ShatteringLivesandMythsFINALJuly2019.pdf	The language in the Pathway is aligned with the draft revised National Child Protection Guidance which is currently the subject of consultation. It now includes cyber enabled abuse.
64SF-B	Views of child, young person	Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging and we have benefitted from the experience of

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		Children 1st's involvement in developing the Pathway.
64SA-6	I would suggest there be more proactive information rather than reactive. From previous research there is a higher rate of adults than children disclose sexual abuse and I feel there should be more education and support for children to encourage disclosures when young in order for early intervention rather than victims having to live with this into adulthood.	The Pathway is intended to support practitioners caring for a child once a disclosure / concern has been raised that CSA has taken place.
64SH-D	We believe that this pathway should apply to all children and young people under 18. We believe this for the following reasons: • At present, the guidance includes 16 and 17 year olds who have a particular vulnerability. We would argue that having experienced child sexual abuse is in itself a vulnerability and it is therefore logical that all under-18s are responded to via this pathway. • All victims deserve access to a compassionate, trauma-informed, person-centred pathway; in our experience, young people aged 16 and 17 struggle to receive this through adult services and often feel unable to engage with adult processes. • The UNCRC, which will shortly be incorporated in Scotland, defines a child as under 18 years old. • Legislation and guidance that has recently been developed in this area, of which we are aware, is moving to a definition of a child as under 18. This includes: the Scottish Government definition of Child Sexual Exploitation and the Human Trafficking and Exploitation (Scotland) Act 2015. • We understand that the current review of the National Guidance on Child Protection (2014) is likely to recommend amending the definition of a child to all those under 18. Bringing the pathway into line with this would help to future-proof it, and prevent guidance having to be changed in future to keep pace with these developments. • We cannot identify any unintended consequences of including all 16/17 year olds in the pathway, but can think of many 16/17 year olds we have worked	The Pathway is applicable to the care of children and young people up to 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) who have disclosed sexual abuse of any kind. The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.

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	with who would have benefited enormously from a more child/young person-friendly process. In order to incorporate a range of learning styles, alongside the existing reports referenced in the document, links could be included to the following videos: • Tyler's Story, a short film by Seen and Heard documenting a young man's journey to and through disclosure within a health care setting (https://www.seenandheard.org.uk/) • Making Noise, a short animation sharing the voices of children and young people who have experienced sexual abuse and their experience of disclosure and service provision (https://www.beds.ac.uk/ic/recently-completed-projects/making-noise)	
64ST-S	How you do support young people that don't want the police/ SW involved. The document makes an assumption that all sexual abuse cases go to IRD which is not the case - how do we support the young people who disclose and want support but the disclosure does not need to go to IRD?	The Pathway is intended for cases which do involve police and social work. If a child presents to the health service reporting sexual abuse or assault, in most cases this would be reported to other agencies and an IRD held. It is difficult to imagine circumstances where this would not happen but in that case then the health needs of the child or young person would be addressed.
64SU-T	Children who have been alleged to have been raped should not be given abortifacients to end any human life in anyway whatsoever however they should be given the morning after pill to prevent life from occurring in the first place within certain circumstances, this can actually be done and I would highly recommend this. To summarise a new Catholic Law as of 25/2/2019 does permit the morning after pill as an act of mercy to child rape victims within three full days since the sexual assault against them took place and under the following nine conditions: 1 - The morning after pill is used by the girl between the time of assault say 3:00am in the Monday morning to 3:00am Tuesday the next morning. 2 -Or The Morning after pill is used rom	Noted

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	3:00am the Tuesday morning to 3:00am the Wednesday morning by the girl. 3 - Or finally the morning after pill is used from 3:00am the Wednesday morning to 3:00am the Thursday Morning. That means the girl can use the pill within a full 72 hours and providing the other conditions below are met its use can not be regarded as an abortion. Those otherf conditions are as follows: I - The girl is not suspected of being prior pregnant since the day of the assault. II - The girl has been indeed been sexually assaulted. III - The girl has not yet ovulated She must pass three tests also: A) The girls leutinizing hormone (LH) level must not be spiked. B) The girl must not be within her fertile period in regards her menstrual cycle. C) The intent of the girl must be to use the morning after pill as an emergency contraceptive and not as an abortifacient. If the morning after pill is used by her in any other way outside of this ritual then it is not a life defensive procedure of a child but murder of the other child or an attempt therefore in her womb. Thus should not be entertained physicians. I would support the pathway then if under the condition that it was to employ the procedure detailed above	
64SU-T	When an alleged rape of a minor has been reported all social work and police activity with regards to the associated child protection processes should be recorded by an active video device within a secularly locked compartment within a Barhanus such as CCTV in terms of the child and within a Police Station as concerns the adult - no other person but members of the court service should be able to open that compartment when interviewing the accuser or accused. In terms of the CCTV recording it should store all recording of the victim or accused within the Barnhanus or Police Station for three days forcing the Crown to either prosecute or let the detained go upon evidence if no prosecution is commenced then the recorded interviews should be allowed to automatically rewrite themselves if there is reason to prosecute or if accused or accuser has a complaint against the Crown, Police or Defence of unfair treatment then the Scottish Court Service should allow the interview to be saved by which ever side needs it to be saved for there	These areas relating to the investigation are out with the remit of the Pathway.

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	interests. The only other persons that should be able to access it are the prosecutor fiscal and defence solicitor once given clearance by the Scottish Court Service to do so and only if the child, child's guardian or crown decide to take the matter to a criminal court. Over the three days that the CCTV is retained the Crown Police and Defence must be able to view the recordings to examine them. Ideally a prosecutor fiscal and a defence solicitor should be able to examine and cross examine the child within a Barahus in the sight of a judge and jury this protects an alleged victim from being cheated of the justice due to them by deliberate malpractice or otherwise incompetent practice & any adult who is allegedly falsely accused by being deliberately set up by the child being coached or the adult themselves being coerced into giving a false confession. If any engagement or questioning of the accused or accuser by the prosecution or defence should occur out with those areas then the accuser and accused should continue to be able to record the approach of any such civil servant of the crown or agent of the defence and keep the recording for evidential purposes. If it is ceased and destroyed without a warrant then it should be a crime. All civil service personnel and agents of the defence should as well be able to use cameras and I would say the civil service or the crown should be obliged to carry recording devices unless within a private citizens property without a warrant. However if the authorities are investigating a claim of child sexual abuse recording should occur without need of a warrant in respect of private property between 2019 - 2021.	

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64SU-T	The decision to prosecute or not to prosecute should always remain with the crown first the child's guardian(s) second as the child is far too young to make any such decision on this matter themselves whatsoever unless it is a historic case and the child is then an adult. Keeping the Crown in primacy in this decision making process will enable the crown to act if they believe the child is being abused by the parent	As per 29(2)(e) and 48(5) of the Scotland Act 1998 detailed below, the statutory provisions confirm that the Lord Advocate is the independent head of the system of criminal prosecution. There are no plans to change these.' 48 (5): Any decision of the Lord Advocate in his capacity as head of the systems of criminal prosecution and investigation of deaths in Scotland shall continue to be taken by him independently of any other person. 29(1): An Act of the Scottish Parliament is not law so far as any provision of the Act is outside the legislative competence of the Parliament. (2) A provision is outside that competence so far as any of the following paragraphs apply— (e) it would remove the Lord Advocate from his position as head of the systems of criminal prosecution and investigation of deaths in Scotland
64SU-T	All medical support and health care management should not be recorded in any audio video format unless the alleged victim or alleged victims guardian requests or otherwise consents in writing to an offer to. The defence and prosecution should have access to material & forensic evidence collected by the medical services if the child who has been allegedly raped agrees in writing or there guardian agrees in writing. If the alleged victim or alleged victims guardian does not agree to any both of these sides accessing the material for cross examination purposes then the accusation should not proceed to a court of law at all. If evidence to prove guilt is damaged or lost	Consent for examination is addressed in the Pathway. The other issues here are out with the remit of the Pathway.

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	by the defence the defence should be held in contempt of the court and/or perhaps be removed from the Law Society of Scotland if the prosecution damages or looses evidence of the defence that would suggest innocence then case must be dismissed.	
64SU-T	GIRFEC should be completely removed from the pathway all together and if it must be implemented it must be observant of the UK Supreme Court Judgement UKSC 2015/0216 known as 'The Christian Institute and others (Appellants) v The Lord Advocate (Respondent) (Scotland)' respectively.	Reference to GIRFEC in the Pathway remains appropriate.
64SU-T	Information sharing should always be mindful of s22 of the Gender Recognition Act 2004 and be done with the transgender child's written consent only if children are able to ever transition in the future. This should be the case in regards transgender children who have not applied, are applying or have got a GRC - a transgender child even today should never be outed by having there gender designated at birth shared with other so called "colleagues" against there written consent if this does happen then the individual within the pathway who has outed them should be prosecuted for breach of that section. If outing happens by a person within the pathway in regards the accused without the accused persons written consent then the public servant themselves should be prosecuted under the same section of the gender recognition act as well with a mandatory three years imprisonment if found guilty by a jury of 15 in each scenario.	Noted.

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64SU-T	Police should lead and decide in any criminal investigation independent of the IRD and not on the dependency of the agreement of just the social work or medical services however in regards the alleged victims treatment including forensic evidence collection by doctors and preservation of evidence given by the alleged victim to the medical services voluntary the medical services should take the lead in accordance to the Hippocratic oath. Any forensic medical evidence not of the accused but of the accuser such as there blood or other material collected by police-doctors should be only handled in accordance to the wishes of the accuser or accusers guardian. In short a police-doctors duty in respect of issues pertaining to the accuser should be to the Hippocratic oath over Scots law. The only incidence a police doctor should have any duty in regards the accused under the Hippocratic oath is in matters separate from securing material for there conviction but only pertaining to saving there life, for exsample, if the accused suddenly takes a seizure.	These matters are out with the remit of the Pathway.
64SU-T	The IRD should be adaptable to work with the RMP or other law enforcement agencies including HMRC and The UK Border Force if it must be implemented. It should also be able to work against any person from the inside under direction of those or other agencies of CAAPD or other superior division of law enforcement. It must always and only be used in accordance to Scots law. If there a jurisdictional issues then the law of Scotland should prevail if the alleged incident is said to have occurred in Scotland unless it has been alleged to have occurred by a member of the UK Armed Forces in which case UK military law should take precedence however the court marital must be held within Scotland. If in the event a member of CAAPD is accused then the L-rd advocate should take the lead if in the event a L-rd advocate is accused then the alleged victims guardian should be granted a bill of criminal letters.	Issues of jurisdiction for various police forces are out with the remit of the Pathway.

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64SU-T	There should be no actions based on unsubstantiated concerns of another but only upon an allegation by a child, the child's guardian or were a doctor believes physical injury to the infants body would suggest sexual violence has occurred once there is collaborative evidence also. The apparatus should not degrade parents as "Supposedly trustworthy adults' either, as most parents in Scotland are good and trustworthy the anti-parental disdain and hatred behind that statement in fact is the kind of tactic once employed […] in order to eliminate the family unit and encourage full state control of the infants view of the world and there own personal world in order to aligned them with the view of the state as warned about when judgement was delivered against the Named Person Scheme by the UKSC when it decreed: " There is an inextricable link between the protection of the family and the protection of fundamental freedoms in liberal democracies... Different upbringing produce different people. The first thing that a totalitarian regime tries to do is to get at the children, to distance them from the subversive, varied influences of their families, and indoctrinate them in their rulers' view of the world. Within limits, families must be left to bring up their children in their own way. " (UK Supreme Court judgement on the Named Person, para. 73) Unless of course a parent has sexually abused there child then I would be the first to recommend the child pit themselves against them and certainly not to trust them if they value there own survival. However there is a great presumption of guilty being placed upon parents by the state stating that they are 'supposedly" trustworthy. That's actually creepy. Who is automatically ore trustworthy than the parents then ? […] That statement is outrageous - the parents of Scotland are awed an apology ! I fear that more likely actually that the Scottish State could launch an unsubstantiated concern of sexual, emotional or negligent abuse or coach a child to the same simply to effect the attempt at state control of a child as warned about in the Supreme Court Judgement previously cited above. Especially if there is a monitory, political or other incentive for the state to do so such as trafficking children mostly from working class, immigrant or religious backgrounds to middle to upper	The comments are out with the remit of the Pathway.

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	class families or so called more 'providing politically correct families' to ensure the so called future wellbeing of that child. If a religious family brings there child up in there faith to regard gay marriage as "incorrect" or if a gay family brings there child up to regard gay marriage as 'correct" will those cases be seen as child abuse by the state and grounds for intervention ? In a democracy both cases should never be used as grounds for removal ! Also the inherent unjustified and prejudicial suspicion towards young working class single mothers with large families in the consideration of environments so called more likely than not to be conducive to child rape being punted by some feminist academics who look down at such women that stay in the home instead of competing in business is an outrageous slander as well. This apparatus if it go's forward should not therefore be solely focused on households either as there is no one "type of person" from one "type of place" that can be said to be or not to be a child rapist, child rape can be committed by anyone, anywhere. To believe or put anything else forward as infallible is totally naive.	
64SU-T	The current seems data to suggests that rape of minors is indeed mostly done by a genetic man in a position of power & trust or otherwise known to them which yes includes in a lot of cases the father of a household - such statements do not always make a rule though and I think such sweeping interpretations held as infallible fact have more to do with an irrational ideological hatred of a perceived so called patriarchy from the far left feminist bridge than actual scientifically verified data especially when that data is limited in scope in so far as it has not been derived and can not be derived from all worldwide child abuse incidents as to detect or otherwise investigate every incidence in Scotland let alone internationally is an impossible task to do so in the first place. The current limited data from the United Nations and Vatican City State gathered independent of each other does seem to actually collaborate the assertion of the Scottish Government made upon its own limited data on this point as well in that it is genetic men who seem to be the	The Pathway aims to respond to victims of CSA, regardless of who the alleged perpetrator may be.

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	main perpetrators and genetic girls &transgirls that seem to be the main victims however what the data does not state is who the "Father" or "Other male figure" in each case involving a family home studied actually was. Was the attacker the genetic man who co -conceived his genetic daughter or trans daughter ? Or the genetic mother or trans mothers new genetic male partner […] for example ? Was it a gay father ? Or gay fathers lover ? A transman or trasnmans genetic male or transmalelover ? And if men are more likely than woman to commit these acts especially to little girls and trans girls does that mean there more safer in a lesbian family or a trans lesbian family than in a family with two male partners or one with a mum and with a dad or trans dad and trans mother or even one trans parent and none trans? Who knows Scottish Government ? We can only speculate and speculation is not good enough. The data from domestic cases seems to show that the most likely candidate is actually step brothers and step fathers. It maybe that such conclusions based on such data will be replaced actually as cases are always occurring plus more and more cases are now starting to show that child abuse may actually be being committed more commonly and has been more commonly carried out by genetic men not in family homes but in secular state institutions such as care homes, the third sector, and religious organisations - case in point the ongoing Scottish Child Abuse Inquiry of which I have provided intelligence too. So the temptation hear is to label all genetic fathers more likely than others to rape there little girls or trans girls or indeed the little girls or trans girls of others when that may not actually be the case. However, I do give way to the Scottish Governments point that regardless of who the male actually is it does seem to be males that carry out the abuse ore so than women or transwomen this has been independently verified and the authors own project, […] into this issue has also found the same those who harmed me when I was younger were all males - it seems to be committed more so by men from a middle class to upper class background that are in power, holding authority and positions of trust such as the police, army, and political institutions as well as churches, synagogues and mosques. I am there for	

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	worried at this systems configuration being classist and primary focused on families of the poor or working class. Some of the biggest child molesters in the U.K. also had a string of letters after there name Scottish Government. Therefore it is little girls and little trans girls from poor, immigrant and working class backgrounds under the so called trust of professional genetic men outside of there families that need empowered, emancipated and embraced. There also could be the added fact though that the reason most of the data suggests genetic males is because no serious worldwide study of the sexual abuse of children by genetic women has ever been conducted. In fact while the author is neither a defence solicitor or procurator fiscal it is my current understanding that there is little to no recognition in Scots law that a genetic female can be a child sexual predator or that one even exists as most of the laws governing this area only recognise penetrative acts by the sex organ of heterosexual men, trans men with a penis or transwomen without a vagina. If say a genetic women was to sexually abuse her child by penetration using an instrument the genetic female could be prosecuted for common law assault yes but the genetic male, transmale with a penis or a transwomen without a vagina can be prosecuted for child rape right off the bat - if that is true then that is not right. There is actually an inherent prejudice against men, transwomen without vaginas transmen with penis due to an assumption by the public at least that genetic women are not capable of such acts as well and that little boys or little transboys with a penis or little transgirls without vaginas may not by implication be real victims of a real rape if a genetic woman should rape them. That is clearly an injustice and is akin to the case of when homosexual persons if raped by another man had to have there attacker prosecuted under assault laws while heterosexual woman who were raped were given the chance to prosecute there rapists under rape laws. What's interesting is that the data tends to show that genetic women are more predisposed to being traffickers and suppliers of children to genetic male rapists especially for monitory gain or to impress a potential mate. The current data seems to show that genetic male pedophiles and genetic female	

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	traffickers maybe more likely than not not to be gay or straight but bisexual. However making such data an infallible guide maybe erroneous as well because clearly not all bisexual people male or female are pedophiles or rapists. Its very important then to remember that rapists and child sex abusers no matter what gender or sexuality they are - are very few in number compared to the entire population in Scotland and while they may be gay or straight male or female they do not represent all members of the gender or sexuality they are a member of. Arguments around what gender or sexuality is least likely or not least likely are essentially futile to be honest.	
64SU-T	Children who have been allegedly raped or are allegedly at sever threat of it can not afford to have those responsible for there safety be partisan, pick and choose whom they protect or prosecute for any reason. Equality in the law in this area must always be paramount or the result could be a dead child. I don't believe Scotland's authorities are capable of such none partisan operating right now. For example while the system pledges to believe all children in there accusation I think we would quickly find it turns cynical if a child was to accuse any prominent member of the government example. In fact a response was given to the adult pathway by the author and free speech was heavily redacted in a partisan way under fears of "liability" being placed upon the Government if it was fully published due to it mentioning high profile organisations, vulnerable minority groups and what should happen IF certain actions ever took place. I must be making an impact after all. The inability to be impartial and be prepared to talk about let alone hold to account the governments own persons in positions of power and trust as well as the public is as self evident as it is hypocritical. While adults may accept that, it can not be allowed to be accepted in the case of children unless of course the Governments stability is placed more important than believing a child may have been possibly raped. If the system really is credible and willing to dispense justice based solely on establish fact or to not pursue if no evidence is established then It does not matter if it's an accusation against a head of	These comments are out with the remit of the Pathway.

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	one of the four governments of the UK, the author or a poor person on the street it must be investigated and either prosecuted or the falsely accused exonerated without fear or favour. The state must also be ready to jail an adult or place in a child's detention centre a child false accuser, if they are a member of the government or public and the false allegation is against a member of the public or government but there allegation should first be established by a court as false and as even a false accuser deserves to be regarded as innocent until proven guilty first the only person that should deem an allegation false in regards an accuser without needing to prove its first false is the accuseds defence solicitor. Such as the prerogative of defence solicitors. Anything else is just a mockery of the justice due to victims and the falsely accused.	
64SU-T	Above all, the primary objective of the system even more so than prosecuting the alleged rapist of the child must be to save the life of the child. You can not save a child from harm or have them testify against there alleged attacker if they have already been buried Scottish Government. Therefore I am in favour of this system being medically centred. PEPs should be issued to children who have been alleged to have been raped.	The Pathway is focussed on the delivery of consistent care and support to Children and Young People who have experienced child sexual abuse.
64SD-9	[Our organisation] notes that the Pathway is intended to supplement existing national guidance and standards. [Our organisation] welcome the high level summary of the clinical pathway which retains the Interagency Referral Discussion as the core response expected by statutory agencies of disclosure of sexual abuse by a child or young person.	Noted.
64SP-N	We note that the document refers to children and young people making 'disclosures' of sexual abuse. From a legal perspective, it would be more appropriate to use the term 'allegations', reflecting the fact that these	We note the point about the most appropriate terminology from a legal perspective. In the pathway we now refer to a disclosure or an initial

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	procedures will be taking place at an early stage of investigations, and it will not yet have been established whether a sexual assault has occurred. There is no specific reference to how this resource should be introduced to those healthcare professionals who will be working in relation to the pathway. We would be interested to know how this will be incorporated into the training and education of healthcare professionals and those working in other relevant fields	concern. The terminology in the Pathway is aligned with the National Guidance for Child Protection in Scotland 2014. Training and education was offered to all health professionals at roadshow events prior to implementation of the resource.
64SQ-P	The aim of the pathway as set out in para 1.1 is "a resource to outline the process for the healthcare response to disclosures by children and young people of sexual abuse of any kind". We found very limited mention of child sexual exploitation as a form of sexual abuse and suggest including reference and links to research on this.	More information on CSE has been added.
64SK-G	Page 6 1.7--were young people consulted and involved? I'm not clear from reading this if their voices have been heard	Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging and we have benefitted from the experience of Children 1st's involvement in developing the Pathway.
64S6-U	Consent – parents being suspects. Children over 13 can give own consent. Under 13 – parent in the room when the parent is in the room. Cases where the child is over 13 and the consultant still wants to contact parents. Agency cannot override parent's decision. In our area, consent lies with paediatrician not the police and we use warrants.	Guidance on obtaining consent for an examination under various circumstances is included in the Pathway with references for further information if required by health staff.
64S3-R	The pathway needs to be anchored more in wider child protection guidance and winder discussions on supporting child and young people in Scotland	The Pathway now contains more information and background on the wider child protection context in Scotland.

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64S3-R	Need to ensure that the pathway is tied into the revised integrated national guidance for child protection and be aligned with the UN Convention on the Rights of the Child. All children under the age of 18 should be considered as part of the pathway, rather than 16, in line with new guidance. It should be explicitly stated that child protection may be considered for young people up to age 18, and this is legally linked to ongoing work in relation to CSE	The pathway is applicable to the care of children and young people up to 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) who have disclosed sexual abuse of any kind. The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64S3-R	For young people aged 16-18, referenced in section 5.1, it should be recommended that adult support and protection may need equally need to be considered. It would also be good to see a reference to onward involvement in adult services for this age group. For 16-18 year old young people with learning disabilities, for example, adult support and protection may be working as part of the pathway (as the disclosure will likely be made in this context). The use of 'vulnerability' should be aligned to wider discussion on supported decision-making and a rights-based approach.	The Pathway now includes reference to adult support and protection measures.
64S3-R	The section on legislation needs to be expanded in relation to corporate parenting duties, in particularly given that health boards are statutory corporate parents	The Pathway has been revised to include information on corporate parenting.

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64S3-R	Additional information on how the pathway relates to regional and local models would be helpful, especially if the child protection procedures cross different localities, where regional centres are used. Need to be clear about the interface that the pathway will be implemented through and wider governance arrangements	The Pathway is aligned with current National Child Protection Guidance and has flexibility to take account of local multi-agency IRD procedures. It is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation when the revised National Child Protection Guidance is implemented. The reports of the Independent Care Review 2020 and the needs of care experienced children and young people are referenced in the Pathway.
64S4-S	The pathway does not reflect current practice and where practice is moving towards, both in principles and practice	The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area. The Pathway is aligned with current National Child Protection Guidance and has flexibility to take account of local multi-agency IRD procedures. It is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation when the revised National Child Protection Guidance is implemented. The reports of the Independent Care Review 2020 and the needs of care experienced children and young people are referenced in the Pathway.
64S4-S	Who is going to use this, and pick it up? Is it organised as a document that will be picked up and used by many agencies, or will a clinical pathway only be used by one agency?	The Pathway is primarily intended for the health service but may, on occasion, be relevant to police, social work, Crown Office and Procurator Fiscal Service and third sector.

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64S4-S	Is the updated guidance on health professionals referenced, and if so what is the purpose of an additional clinical pathway?	The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area.
64MC-2	Input from Care experienced people In person Care experienced people have often been subjected to many different forms of abusive behaviour, before entering care (and sometimes during care) creating a lasting impact on their lives. Where this is the experience of the young people our systems need to enable options and not hurdles. To expand upon our point 1: There is much evidence to back the high percentages of people who have experienced care having been subjected to sexual abuse, with an understanding that we do not have figures that reflect reality, due to the nature of the matter, but we are aware of the issue at large . You need look no further than The Scottish Child Abuse Inquiry and the current work it is undertaking to gauge the size of the problem [Our organisation] therefore asks that the final pathway has significant and meaningful input from people who have experienced care as the experts, alongside people from the field of working with people who are in care or have been so; allowing there to be the opportunity for us to get this right, increasing the likelihood in the future of people to come forward where they are subject to sexual abuse. We have the opportunity to gain insight and understanding how to best ensure the pathway works for and with people who are in our 'care system'. To expand upon our point 3, the [our organisation] urges that our findings, due to be published summer 2020 play an integral part to the final shape of the clinical pathway (timeline detailed in our 'Journey' report).	The points about care experience people is important. Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging and we have benefitted from the experience of Children 1st's involvement in developing the Pathway.
64MC-2	[Or organisation] is having the opportunity to find out and collate lived experience and wisdom of people from across Scotland. That means actively listening to the voices of children and young people in care, care leavers –	Engagement in this area with Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s) is challenging

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	young and old – and families and carers. It is their experiences and voices that is giving clarity and focus on what matters in this complex and challenging task. These findings are generating a picture we have never had the opportunity to explore to this level until now. [Our organisation] does not want to hold up the launch of the pathway but is of the belief that the findings of the work being undertaken since early 2017 should play a fundamental part to the final shape of the document. Were this not to be possible, we would ask for a 12 month review on the document, allowing for these to be added at a later date.	and we have benefitted from the experience of Children 1st's involvement in developing the Pathway. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64MC-2	[Our organisation] recognises that it may not be beneficial to have a full listing stating who the pathway is for. However, [our organisation] believes that there needs to be a broader listing than is currently provided and that Corporate Parents are part of this: In 2015, 24 groups of bodies and public bodies were named as Corporate Parents with legal duties to deliver on to people who have experienced care as an infant, child and or young person. With the implementation of these changes, [our organisation] urges that there is communication with The Corporate Parenting Board so that the changes can play an important part in their knowledge and understanding of what options are available. Corporate parenting responsibilities are set out as: (1) It is the duty of every corporate parent, in so far as consistent with the proper exercise of its other functions — (a) to be alert to matters which, or which might, adversely affect the wellbeing of children and young people to whom this Part applies, (b) to assess the needs of those children and young people for services and support it provides, (c) to promote the interests of those children and young people, (d) to seek to provide those children and young people with opportunities to participate in activities designed to promote their wellbeing, (e) to take such action as it considers appropriate to help those children and young people— (i) to access opportunities it provides in pursuance of paragraph (d), (ii) to make use of services, and access support,	Communication with Corporate Parents was part of the communications strategy when the Pathway and various other Taskforce documents were launched.

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	which it provides, and (f) to take such other action as it considers appropriate for the purposes of improving the way in which it exercises its functions in relation to those children and young people. [Our organisation] recommends that this become part of pathway and considered throughout the document and any role out for the changes, for example. Without this there is a risk / chance of good practice not being shared where needed	
64MM-C	5.2 Interagency referral discussion - consideration should also be given to any other child who may have been affected or who may still be at risk, rather than only children living within the same household.	An important point but out with the scope of this pathway.
64M5-M	The title of the document is 'Clinical Pathway for Children and Young People who have disclosed sexual abuse'. However, within the text the document is variously referred to as 'clinical pathway' 'clinical pathway and guidance' and 'guidance'. Whilst we acknowledge that this is not our area of expertise, our understanding is that clinical pathways are multi-disciplinary plans of care to support the implementation of guidelines and protocols. We wonder if it might be confusing, in a health context, to be referred to as a 'clinical pathway' and as 'guidance'? In a more general sense, we note that the pathway is to be used by NHS Boards, LAs and IJBs (pg. 5; Section 1.2). We would respectfully suggest that the title 'Clinical Pathway' may make the document feel less relevant to core partner agencies. Whilst 'Clinical Pathway' is a familiar concept in health settings, we note that this term most commonly relates to hospital based interventions and plans. It may be helpful to consider re-naming the document 'Collaborative Care Pathway' in order to increase its relevance to core partner agencies, as well as the wider multi-disciplinary health team. A 'Collaborative Care' pathway perhaps better describes the necessity of health working in collaboration with other core services, to ensure the child's emotional health needs are central to the response at every stage of their journey, to ensure improved health and wellbeing outcomes, as well as justice outcomes. We note the longstanding,	The Pathway now has more information on the wider child protection context in Scotland and multiagency procedures as well as emotional wellbeing and recovery needs. On reflection we will keep the title of Clinical Pathway but take the point on this and have detailed the purpose of the document in section 1. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.

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	expert consensus about the need for multi-agency services working in close collaboration around the child and family, if not co-located, to ensure that the child's emotional wellbeing and recovery needs are at the very heart of a caring response to child victims of sexual assault and abuse (including National Co-ordinating Networking Board; HMICS Strategic overview; 'SARC plus' model under consideration in CMO Taskforce). We would wish to see this fundamental principle more clearly articulated in the introduction and throughout the pathway. We would query the age group of children and young people that the pathway is applicable to. We are aware that a child is defined differently in different legal contexts in Scotland, and that the HIS Standards define a child as under the age of 16, except in cases where the child is deemed vulnerable. Given the moves towards implementation of UNCRC in Scotland, it would seem wise to future-proof the pathway, in line with the UNCRC definition of a child. It is also our understanding that the revised National Child Protection Guidance, which is currently being drafted by the Scottish Government, will define a child as a person up to the age of 18. We would strongly support close collaboration in the drafting of and consultation around these two essential documents.	
64MW-P	The consultation document makes reference to The Children and Young People Expert Group which provided advice on tailoring recommendations to children and young people and states that the recommendations are intended to be in line with the Barnahus concept. As this is not the case we would suggest that the Barnahus is explained as follows: The Barnahus model was adopted in order to create a specific legal system that responds to the special needs of children about whom there is a suspicion that they have been subjected to violence or abuse. The Barnahus (which literally means Children's House) is a child-friendly, interdisciplinary and multi-agency centre for child victims and witnesses where children could be interviewed and medically examined for forensic purposes, comprehensively assessed and receive all relevant therapeutic services from appropriate professionals.	The Pathway is not intended to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and

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	These are: criminal investigation, collaboration/protection, physical health and mental health. Moreover, the Barnahus is a place at which the social services, the police, the public prosecutor's office, forensic medicine, paediatrics and child and adolescent psychology can confer and collaborate, particularly in the initial stages of the preliminary investigation and the social investigation. In addition to this, we would highlight that the work of the CYP expert group is wide and encompasses more topics than the Barnahus model of care alone	receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64MW-P	In discussing the prevalence of child sexual abuse, the pathway presents figures on the numbers of these offences recorded by Police and the number of people prosecuted for sexual crimes against children. [Our organisation] believes this reads to the suggestion that the new pathway is being implemented to increase prosecution in these crimes. Instead the pathway should aim to standardize care and develop minimum standards to ensure that all victims of abuse are provided with better care and offset at least some of the trauma associated with abuse. In response to this we would suggest the inclusion of the numbers of examinations that are undertaken by health boards for child victims of sexual abuse however, robust national data is not currently collected (We do understand that a pilot for an ISD national dataset is forthcoming)	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s).
64MV-N	As stated above, further work should be done to reconcile this document with the Scottish Government commitment to Barnahus, making sure that the pathway work becomes part of the wider Barnahus standards development process. This should include the process of gathering evidence that will need to underpin Barnahus development work.	The Pathway is not intended to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes

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		consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
Do you have any further general comments on the pathway document?		
64HR-C	Does the health service not have any responsibility for providing victims of sexual abuse with details of what supports may be available to them either, via CAMHS - regarding any thoughts of suicidal ideation as a result of their trauma, or third sector supports which may assist the child or young person in dealing with the aftermath of their abuse? The Aims of the Clinical Pathway as outlined at paragraph 3 specifies that, 'services...are able to promote health, wellbeing and recovery' but there is little by way of content around how the pathway links to wellbeing and recovery.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
6417-T	The NHS England Strategic Direction appendix describes 'Lifelong care for victims', recognition of the long term effects of CSA is crucial.	The Pathway describes in broad terms what ongoing support to aid recovery should be

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		available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64ME-4	The pathway is only a repetition of known facts that have been generally accepted for quite some time. It does not take in to account, or implement, changes that will actually make a difference to the children in most need. In fact, the pathway is grossly inadequate. I know that one of the main criticisms of the Barnehus model is that it can interfere with the quality of evidence collected, but through rigorous research and analysis there is no reason why proper systems could not be put in place to ensure that questions or conversations are of the necessary quality. Most importantly there is the need for a system which gives the child time, a sense of safety and an opportunity to trust another adult in whom they can confide. I believe that use of the Barnehus system provides a more accurate indicator if sexual abuse has taken place and as I understand it, the statistics back that up	The Pathway is not intended to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64ME- 4	From Dr Sarah Nelson's blog: Most children and young people do not disclose of their own accord; or not in ways that adults can understand; or only anonymously; or only in very sympathetic and protective circumstances. (Crisma et al 2004; McElvaney 2013). Most adults, including teachers, do not	The pathway has been updated to not only cover disclosures by children, but to also be applicable when a concern has been raised that a child may have experienced sexual abuse.

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	know, or are nervous of asking, or believe they should not ask. Perpetrators do not tell. Social work and children's hearing statistics show identification of CSA has been consistently falling- the figures are tiny- even though at the same time reports to police of sexual crimes against children, including online crimes, keep rising (Nelson 2016b). A recent Scottish study (Marryat & Frank 2019), using Growing up in Scotland study statistics to draw conclusions about Scottish children affected by ACES, did not even consider CSA, since there were 'too few cases to include' (sic). Yet the questions used, the environment of the GUS surveys and the respondents chosen would have meant that GUS surveys have been very unlikely to reveal sexual abuse. In addition to all these difficulties we have the phenomenon of children being taken away from their mothers when, after a court case which the father has won, the children continue to disclose what has happened to them ie. Instead of anyone actually making an effort to listen to the children, they are taken away from their mothers by the court and may be put into the care of their fathers. One of the number of mothers to whom this happened said she felt the court wanted to "punish" her as the court concluded that she and the other mothers were prompting their children to speak about abuse. This is utterly horrifying when potentially valid disclosures are being made by the children and are not investigated by the authorities. This constitutes further abuse of the child by the state. It is essential that the child is not written off at this stage, particularly given the deficit in the current system. I am personally referring to Scottish cases – the link below is American but the same applies: https://centerforjudicialexcellence.org/2019/07/31/a-gendered-trap-when-mothers-allege-child-abuse-by-fathers-the-mothers-often-lose-custody-study-shows/ This happens in Scotland and I have been warned by my solicitor that if I do not comply with the wishes of the court, or if my daughter continues to disclose of her own accord there is a risk she will be taken away from me.	
64ME- 4	What I know is what my daughter disclosed to me. What I know is that she feels scared to be with her father on her own. If she decides to say anything	Thank you for sharing your family's experience with us.

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	more to anyone besides myself I risk having her taken away from me – and there is no mechanism for her to have her feelings or opinions heard. Even though the website for the Children's Commissioner for Scotland says Article 12 of the UNCRC says that every child "has the right to be listened to and taken seriously". It says, "children and young people have the human right to have opinions and for these opinions to matter. It says that the opinions of children and young people should be considered when people make decisions about things that involve them, and they shouldn't be dismissed out of hand on the ground of age". Article 12 is not upheld in Scotland. No one has listened to my daughter's opinion. No one has taken her views. There is no mechanism through which she can have her voice heard. […]my daughter HAS an opinion and that opinion HAS NOT been heard and has effectively been prohibited. If she does speak now she risks being taken away. Some mechanism needs to be installed IMMEDIATELY to ensure that the voice of the child is heard and so that Article 12 is properly implemented and active in Scotland.	Ensuring that children and young people's voices are heard, listened to and acted on are very important points. The Pathway promotes consistent, child centred and trauma informed care. Hearing the views and experiences of children and young people, and their families is key to this work and to driving improvements in all aspects of care and support. The Scottish Government have indicated their intention to incorporate the UNCRC in to Scots law and have introduced the Bill to Parliament.
641N-H	It is vital that we approach the disclosure process with believing the child from the outset.	This point is emphasised in the Pathway.
641Z-W	The places to refer to are Stop it Now or Rape Crisis on your main page. Stop it Now work with offenders so that is giving the wrong message to children and young people about who to call. Survivors of childhood abuse do not feel rape crisis is relevant in many cases. To ensure safety and appropriate safeguarding this page should highlight the specialist sexual abuse organisations funded by the survivor policy team.	Noted
64MW-P	The philosophy of this clinical pathway should be underpinned by the principles set out in the United Nations Convention on the Rights of the Child (UNCRC) and the European Convention on Human Rights (ECHR). This emphasises the child as an individual, as part of a family, and part of a	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection

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	community who has rights which should be recognised and upheld. • Article 4 (protection of rights): governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled. • Article 12 (respect for the views of the child): when adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account. • Article 16 (right to privacy): children have the right to privacy. • Article 19 (protection from all forms of violence) states that all children have a right to be protected from 'all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.' • Article 24 (health and health services): every child has the right to the best possible health and to medical care and information. • Article 39 (rehabilitation): children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society • Article 34 (sexual exploitation): governments should protect children from all forms of sexual exploitation and abuse	context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
6412-N	As per question 1. the pathway needs to be a useful tool for practitioners and there needs to be a short separate document that is easy to use particularly for dental practices. It is likely that dental practices will be undertaking only the first two stages on the flowchart and also the management of healthcare need if appropriate and relevant to the patient's oral health. It is unlikely that dentists will perform a medical examination in the context of this pathway so something that is profession specific would be helpful.	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it is not necessary and may be unhelpful to duplicate material already available in this area.
6416-S	The document is straightforward, clearly written and informative. The outcome that children and young people get appropriate and timely access to	The Pathway covers the journey of care and support for the child or young person, from initial

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	health care and to emotional, mental health and social support is welcome although it does not set out standards or details and, as above, fails to include sufficient reference to partner agencies including social work, education and police appropriately. The document balances the child and young person's needs and the requirements for criminal prosecution. Information sharing between agencies has been impacted following GDPR with a rise in actual and perceived difficulties so it would be helpful if the document linked to any new Scottish Government guidance in relation to information sharing. The inclusion of trauma informed services and ACEs is appropriate but would benefit from more contextual information. The diagram on page 14 is helpful but not entirely accurate as it fails to include Education or Third Sector partners.	concern through to their onward recovery. It describes the requirement for close working between the NHS, social work services, police and the third sector to ensure the provision of a holistic healthcare response.
6414-Q	The principles are sound, but the introduction is not strong enough on emphasising the need for a clear pathway to be adopted in the best interest of children and young people.	The introduction has been enhanced to make clear the aims of the Pathway.
64S9-X	It does not seem to place the child or young person at the heart of the process and is systems focused without recourse to consideration of the wellbeing and mental health of the child or young person and their family.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64SX-W	The document is for health practitioners and focuses - rightly - on the role and function of forensic medical examinations. These will be necessary when there is evidence of contact sexual abuse. However the document has a wider role in relation to how health care professionals should respond to sexual abuse disclosures more generally. There are gaps in how the document conceptualises sexual abuse that would be relevant to identification of - and responses to - sexual abuse in health settings (particularly sexual health settings for instance). Lack of reference to abuse online or more nuanced discussion of sexual abuse perpetrated by peers /	The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The language in the Pathway is now aligned with the draft revised National Child Protection Guidance and it now refers to cyber enabled abuse. However, as the Pathway is intended to support the delivery of care and support to

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	harmful sexual behaviour are particular weaknesses. These are addressed in particular sections later in our response	Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s) it does not attempt to cover these wider issues.
64SM-J	The format is user friendly and the links to other documents are helpful and makes this a good resource for further training / CPD for clinicians. Use of diagrams was helpful in IRD section. It might have been better if the consultation questions mirrored the sections of the document exactly.	Noted.
64SV-U	[Our organisation] believes that the section 4.3 Trauma-Informed Services – would benefit from a section on children with disabilities including impact of non-verbal disclosure, relying on others to recognise / identify potential signs of sexual abuse etc. It is worth noting at this point that there is a lack of research, information and statistics on abuse of children with disabilities. Across the whole pathway [our organisation] recognises the complexity of recognising the signs that a child / young person has been abused. That is why we feel that this is a specific opportunity for the pathway, clinical process and medical examination to advise, support and inform professionals and heighten awareness of the signs of abuse to children and young people with disabilities.	The Pathway refers to the draft revised National Child Protection Guidance which covers this area in more depth. However, as the Pathway is intended to support the delivery of care and support to children and young people who have experienced sexual abuse and non-abusing parent/carer(s)following disclosure it does not attempt to cover wider issues of recognising abuse that are covered in the revised guidance. More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations / information sharing etc. in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the

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		person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64SE-A	The pathway to be a success will require multi-agency tiers of national and local support. Police Scotland acknowledge effective sharing of information and engagement between professional bodies is essential for the identification of risk; assessments; investigations and service provision to children and young people who have disclosed sexual abuse. It would be helpful to establish if there will be a formal approach built in the pathway process to obtain feedback and identify good practice or areas of improvement.	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SW-V	Well presented, straightforward and accessible as notes above.	Noted.

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64SB-7	In order to be as useful as possible to practitioners, the Clinical Pathway document may benefit from clarifying the purpose of document, and that the stated purpose fully aligns with the contents of the document. The statement of purpose in Section 1.1 is noted as 'a resource to outline the process for the healthcare response to disclosures by children and young people of sexual abuse of any kind'. However, this is not clearly reflected in the document. Rather than guidance about responding to disclosures, the document provides a detailed account of the process for undertaking medical examinations of children, where such examination is required under child protection procedures. Throughout the document, introductory or summary information is provided on a range of areas related to the purpose of the document (such as disclosures, indicators of sexual abuse, adverse childhood experiences, as well as legislation, policy and procedures), however this information appears cursory, and its place and purpose in the document is unclear. If the document is partly intended as a signposting document to more detailed information, this should be clear, and the expected practice implications of such signposting for those using the Clinical Pathway must be identified	The Pathway now has more information on the role of health and the medical examination of children and young people. This is included within a description of the wider child protection context in Scotland and the processes of IRD, JII and, in broad terms, what ongoing support to aid recovery should be available to victims and families.
64SJ-F	The pathway appears robust and comprehensive. It's a timely, useful resource; which is clear and focused on raising standards to promote a consistency of approach. Additionally the focus on 'trauma informed' service provision is important. The gap for the 16-18 year olds and the arrangements to support staff who work in health care practices to be aware of the signs of sexual abuse/cultural issues arranged marriages that are abusive. The LAAC are highlighted it is the hidden that seek help in clinic settings. Staff need ongoing education and support from a strategic level to identify. Clear guidance would be beneficial when considering which legislation or policy applies to a young person aged 16-18 years as this can be dependent on a young person's individual circumstances and could therefore be managed differently nationally	The Pathway is intended to describe best practice in line with current relevant legislation and guidance and so covers up to age 16 (18 years for those with vulnerabilities or additional needs). The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child

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		Protection Guidance for Scotland, which is currently out for public consultation.
64SF-B	I am surprised that there were no public health school nurses or health visitors involved in the consultative group. While initial forensic examination and clinical assessment does not directly involve these professional groups, their clear remit within the child protection process and development of child centred practice and often continued support of these children and young people would make their contribution notably worthwhile.	Noted
64SA-6	This is a useful document as a health professional using trauma informed care on a daily basis.	Noted.
64SH-D	Throughout our response we have noted specific suggestions on improving the structure and clarity of the document, but overall we have a concern that the pathway document is not easy to follow, and at times the information presented seems so complex that we are concerned this may cause readers to disengage. In particular, we note that while the document is not intended to be read from cover to cover, separate sections can be difficult to understand without reference to other content. The structural device of hyperlinking to different documents within the text also gives the impression that further reading is necessary to fully understand the issues. Medical professionals working with children and young people are likely to come into contact with those who have experienced or are experiencing sexual abuse. It is therefore vital that the information in the pathway is presented in an accessible way, which empowers professionals to take a proactive, supporting and responsive role. We believe that the document would be improved by child sexual abuse being presented as an issue with which medical professionals will routinely engage, rather than as a complex legal issue. We believe that this could be achieved by ensuring that throughout the document the focus is on the child, and what the medical practitioner can/should do alongside the child to	We have restructured the document to make it easier to read and changed the format of references and suggestions for further reading.

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	support them through this pathway. The document could be strengthened throughout by increasing the focus on the child/young person's own agency and rights within this process. The list of other documents in Section 1.5 could usefully include information on children's rights, and in Section 1.7 it would be helpful to mention what work, if any, has been done with children and young people as part of the process of developing the pathway.	
64ST-S	The key issue that is missing is resource - currently there are huge waiting lists for all services that provide support for sexual abuse victims (children and adults). The idea of providing trauma informed care and support for children in this position is great but is not sustainable with current resource.	Resources are out with the scope of the Pathway.
64SU-T	Another aspect of concern is the MAPPA program that any system like this would most likely take input from including list 99 or s142 of the Education Act 195. Now MAPPA and list 99 are great tools to protect children and fight crime if the persons being monitored have been found guilty by a jury of 15 in Scotland of a crime against children but they are potential infringements on UK, EU and UN human rights legislation when they list people in secret, potentially without notification, and without due process and trial - despite there review policy. The people being monitored in secret could be innocent in fact are so presumed such until trial and conviction. I believe also in regards list 99 or the barred list there is scope to exclude people fro working with children simply for being disabled with a mental health issue. Are there a majority of LGBT persons on MAPPA or s142 lists ? None-White people ? Or political or religious suspects for example ? We only have the government & law enforcement word that they maybe not and unless one adores the idea of abandoning democracy by having there authorities unquestioned that word is not good enough unless it is able to be verified by the electorate objectively. There is also potentially a risk of disability discrimination with this planned system hear as well while the author firmly believes the age of consent should be 18 for all genders and all	These comments are out with the remit of the Pathway.

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	sexualities in line with the recommendation of both Vatican City State and the United Nations if Scotland is going to maintain its historic 16 year old age of consent law (Which the author used to support as well as 17) then it must be equal to all.	
64SU-T	The author being learning disabled is aware that disabled people are sexual persons as much as anybody else and unless we are severely lacking in our capacity, coerced, forced, drugged, misinformed, duped, have our consent assumed or are otherwise unconscious simply having a learning disability or mental health disability in and of itself for that matter does not automatically invalidate our consent if it has been freely given at 16. One must be careful then that we the disabled are not unduly denied our human right to seek, give or receive mutually consented to sex and found a family nor that those at 18+ that are not disabled who have consented to sex with people like us at 16 are prosecuted. The disabled are entitled to a states legal age of consent to marry and found a family as well. Having a learning difficulty or mental health issues does not automatically mean us giving our consent is any less valid than that of a person from the enabled community without such issues. If a carer or parent or civil servant must decide if the giving of consent by a disabled person at 16 or any age above is valid or not or if flirtation between a 16 year old disabled or mentally ill person and a 18+ year old enabled person is appropriate or not then that person should have a very good firm basis too ever intrude in that persons private sex life and declare the free giving by that person as being not free or invalid. I am also rather insulted by the assertion that 16 year old disabled persons who have been allegedly raped should be treated as alleged child rape victims compared to enabled alleged victims of rape of the same age who would be seen as adults - they maybe victims and may require assistance from the state certainly but they should still be treated as adults as much as there enabled counter parts even if they have indeed been raped by their consent being regarded as invalid due to sever incapacity.	The Pathway emphasises the need for individualised care and support if concerns are raised about potential abuse.

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64SU-T	Having a learning, maturity or mental health issue and being raped in any way does not make one a child that has been raped if they are 16 it makes them a disabled, mentally ill or immature adult that has been raped and they should be treated as an adult victim like all other adult victims all be it with there disability taken into consideration if this nation is maintaining a 16 year old age of consent. As stated there are also issues regarding the lack of capacity issue and prejudice in regards justice that I am concerned about. For example a person charged with looking after the disabled persons interests could decide that the disabled person is capable of heterosexual sex but not homosexual sex, can comprehend being there genetic gender but not transitioning into another gender under the context of stating the disabled person can understand certain things but not others. Not only would that be a discriminatory act towards that disabled person but if a charge of rape against there gay partner was to be raised by there carer then there partner could be accused of such not for raping the person but simply for having the wrong type of consented to sex. Or for another, if a disabled person is incapable of giving consent at all and therefore sex with them even if they verbalise a yes is rape on part of the enabled person does that also mean the disabled person if they commit a sex crime are incapable of being held responsible or punished for there actions because clearly if they can't comprehend as to there rights they can't comprehend as to there responsibilities either. Now the states way of getting round this is to state that the person can comprehend to one thing but not the other therefore they can't comprehend when there having sex but can when there raping somebody and true yes a rapists could attempt to argue they can't comprehend raping somebody but they can sex but that can not be the case they either both in both cases can not comprehend to the reception or commission of an action good or bad or they can. Finally again, if a disabled persons, mentally ill persons or immature persons consent or withholding of it can be disregarded as either invalid or valid by the state and not the person in regards sex at 16 compared to there	The Pathway emphasises the need for individualised care and support when concerns are raised about potential abuse. Some of these comments are out with the remit of the Pathway

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	enabled counter parts what is stopping the state from disregarding the wishes of the disabled 16 year old alleged victim in regards there decision to keep a resulting possibly disabled child compared to the enabled alleged victims whom would have there consent to keep there healthy child respected ? The state itself ? Yes, humanity did that one and it lead to the eugenics program.	
64SU-T	I am worried that if a child or disabled person is allegedly raped that the state will override any girls choice to keep her child on the mere basis of her age or incapacity thus activate an abortion. This would be and should be unacceptable to all Scottish Catholics especially those who support no sex until marriage.	There is a legal right in Scotland to clinically safe and legal abortion services, within the limits that are currently set down in law, should this be required. People should be supported and free to reach their own decision on whether or not to have an abortion.
64SU-T	In short while no civilised person including the author would ever condone raping a disabled person and certainly if that disabled person is under 16 or 16+ and says no or does not give consent or has there consent presumed that should be enough to protect and prosecute, a concern to protect a disabled person at 16 when that 16 year old gives there consent could be used to discriminate and deprive that person of there liberties upon prejudicial grounds liberties that don't belong to the state but to them. A capable adults consent must never be assumed and if it is withheld or given it should be respected even if they are disabled. Some religions may take objection to welfare concerns around intended spouses at 16 being prevented from marrying due to concerns around disability as well as the disabled spouses themselves. There are a lot of enabled persons out there whom may wish to regard the disabled persons giving of consent as not given or invalid simply because there interest is not in the presence or absence of capacity but because they do not believe people with disabilities should be marrying or procreating at all simply because they are disabled. That is why the author strongly recommends the age of consent be raised to 18 for every gender and every sexuality for every person for everything including marriage as to	The Pathway emphasises the need for individualised care and support when concerns are raised about potential abuse. Some of these comments are out with the remit of the Pathway.

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	avoid issues such as the described which require more complex considerations both on a moral and legal level in order to be just.	
64SQ-P	We found the document referred to as both a resource and guidance. It will be important to clarify the status of the document and for this to be used consistently throughout to avoid confusion.	The Pathway has been revised to describe the document as guidance. The purpose of the pathway is to ensure a consistent approach to the provision of healthcare and forensic medical examination services for children and young people who may have experienced sexual abuse. It is intended to complement existing guidance, standards and legislation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SQ-P	We welcome the emphasis on trauma informed practice and alignment to the National Trauma Training Framework.	Noted.
64SQ-P	We suggest that Child Protection Committees be added to those who should use this resource	The comment has been noted and Child Protection Committees have been included as professionals who should use the guidance.

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64SQ-P	We suggest the document strengthen links to the national guidance for child protection in Scotland and the work being developed in respect of the Barnahus model	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. It is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64S1-P	[Our organisation] outlines the need for the pathway: • To include children and young people with learning disabilities in the context of the pathway • To	More on the vulnerability of disabled children and young people to all forms of abuse is now

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	reframe the aims of the pathway • To support the disclosure of children and young people with learning disabilities • To ensure children and young people with learning disabilities understand their options through the provision of accessible information and advocacy • To ensure a whole person approach to medical examinations.	included. There is more on taking consent for examinations / information sharing etc in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64S6-U	Feedback from people using the pathway. Lived experience. Ongoing for adult pathway, implement a way forward we need to get the feedback via support services. Appropriate services for children. Half a year from CAMHS for children. Information sharing is important. Consent	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have

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		experienced child sexual abuse and non-abusing parent/carer(s).
64S3-R	The document is accessible and easy to read, although we understand this is a clinical pathway and the language is not necessarily a shared language. The heading are clear, the intentions of the pathway are made explicit, and the links are useful	Noted.
64S3-R	The document should be a 'live' document and be continuously updated to keep pace with national development, especially given the development of new integrated guidance documents and national integrated child protection models, with GIRFEC at the centre. Additional guidance on self-referral for over 16s should also be added when it is available	The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64S4-S	The child should be at the centre of the document and they're not. No mention of the team around the child.	The purpose of the Pathway is to ensure a consistent approach to the provision of healthcare and forensic medical examination services for children and young people who may have experienced sexual abuse. It is intended to complement existing guidance, standards and legislation. The Taskforce vision is for consistent, person-centred, trauma-informed healthcare and forensic medical services and access to recovery for anyone who has experienced rape, sexual assault, or child sexual abuse in Scotland.

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		The Pathway now has further information on how the GIRFEC approach can be used to support victims. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64S4-S	Not much in relation to health, wellbeing and recovery. Not much of a focus on recovery given that it needs to be trauma-informed, and the onward referral and support system is not gone into detail--not just about referring, but everyone's responsibility.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64S4-S	There are already pathways to deal with disclosure for a multi-agency response, and these are linked in the pathway document. Do you really need another document just because you're a consultant? Also guidance references documents for forensic and legal aspects, as these procedures are already there. GMC has guidance for the involvement of health and the role of paediatrics. Why do we need a clinical pathway in the first place?	The Pathway is intended to assist practitioners by describing best practice in line with current relevant legislation and guidance with all the relevant information in one document.
64S4-S	The pathway is not doing everything it could be, but is more than just a clinical document. Need something equally concise and detailed, but set within GIRFEC.	The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for

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		Scotland, which is currently out for public consultation.
64MC-2	[Our organisation] is supportive of the pathway and welcomes work taking place. However it must reflect the needs of children and young people who are in 'the care system', have experienced care, and the people and organisations who work in the area; without this, the pathway will not reflect the needs of the country. o To take into account Part 9: Corporate Parenting of the Children and Young People (Scotland) Act 2014 , we would ask the age to be reviewed. Young people to whom the state is a corporate parent are entitled to additional support up to the age of 26. [Our organisation] would expect the pathway to sit in line with this legislation. o[Our organisation] recommends that the pathway is looked at from a well-being approach, rather than a rights-based approach; this ties into the trauma informed care model to be used. o[Our organisation] highlights that there are no specific arrangements listed for written consent where a child is looked after away from home. [Our organisation] would ask this to be considered and improved for the final documentation. o[Our organisation] notes that the approach takes into account an agency approach. [Our organisation] would, however, ask that there is more clarity to the wider agency approach, and that this is reflected in the process and any final flow charts, etc. Currently this does not reach the potential it offers, and does not reflect the expectations and responsibilities that should be within the document. o In addition to the above point, the [our organisation] would ask that there is training and guidance made available for a broad range of agencies who will feed into the pathway. o Aftercare should always be designed around the needs of the person leaving care, supporting them to lead a fulfilling life, for as long as they need it. Therefore there should be no barriers to this and as much support in place to enable this. o The key message comes from someone who shared their story with [our organisation] in the hope of delivering change: "Listen to us. Stop making decisions about us without asking us."	The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.

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64MM-C	From a stance of Violence Against Women and Girls: Page 10 - the statement made regarding the difference between adult sexual abuse and child sexual abuse, needs to be looked at again as it implies that adults may not experience sexual abuse at the hands of someone they trust (www.rapecrisisscotland/help-facts/)	The Pathway has been revised to provide more clarity.
64MY-R	Overall in agreement with the document. 1. Purpose is clear and supports consistency in practice and access to support. 2. It should provide a useful reference and resource for all agencies.	Noted.

Section 2: Context

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Do you agree with the context given in the pathway document?		

Yes	**36**	**63.16%**
No	**8**	**14.04%**
Not Answered	**13**	**22.81%**

Comments

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641E-8	For children who are deemed to be at risk of Child Sexual Exploitation (CSE) they may not be adequately covered by the phrase "up to 18 years of age with vulnerabilities" so can you include the category of CSE here.	The comment has been noted and the Pathway has been revised to include Child Sexual Exploitation.
641E-8	Potentially, inclusion of the need for translators should be included in this pathway in light of the increased number of trafficked children from overseas	We would regard provision of a translator when required to be part of routine service delivery.
641N-H	It would be useful for the guidance to include some case study examples so that practitioners can identify what it may look like in practice.	This should be covered in training and education for practitioners.
64ME-4	It is a good attempt to clarify information about CSA – but the approach to interviewing and supporting children needs to be reviewed as a matter of urgency and a real commitment to helping children who are the most vulnerable should be made.	These matters are out with the scope of the clinical pathway and are for the training of professionals involved in the interviews.
641T-Q	Good context and background provided with a highlighted emphasis on the difficulties of estimating prevalence of sexual abuse in children.	Noted.

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6412-N	The context and prevalence section raise awareness but as a toolkit it is unlikely to be revisited more than once. In its current format – how often are practitioners expected to use this? Is it every time they receive a disclosure of abuse or is this information embedded in regular safeguarding training? As it stands it is not very clear and as a result, we suggest it will probably not be looked at very often. To embed this, it will need to be very easy to use and not time onerous.	The Pathway is intended to assist practitioners by describing best practice in line with current relevant legislation and guidance with all the relevant information in one document.
6414-Q	4.5 Page 13 "where young people age 13 to 15 are involved in consensual sexual activity" is a comment that would benefit from some further clarity. If the "consensual" activity is with someone over 16 then it may require a CP response. Additionally interpreting what is "consensual" is complex e.g. many young people involved in Child Sexual Exploitation would believe they were consenting. The legal context section needs expanded in any future guidance. We are aware this is about developing a clinical pathway but clinicians should understand that evidence sufficient to satisfy the criminal standard of proof (beyond a reasonable doubt) does not mean there will be legal proceeding or that such proceedings will result in a conviction. Indeed, the chances are that there will be no conviction at the end of a trial and the impact of that in terms of the young person's recovery and their continuing entitlement to criminal injuries compensation needs explained as clinicians have a role in this. CICA claims are awarded on a scale £1000 for loss of a thumb for example. Where harm is lingering or carries a lifelong risk (images on the internet of abuse) then the award may be higher but it will usually require input from a clinician to make the argument that the impact of abuse is likely to persist and will require therapeutic input.	Reference to the legal framework has been reviewed. Comments on CICA etc are out with the scope of the Pathway.
64SX-W	Section 2 on Prevalence give a good overview of the subject. This issue with the section is about methodology used in surveys. For instance the Crime Survey for England and Wales is referred to, but the definition of sexual	Noted

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	abuse excluded abuse by adolescents (sexual abuse was defined as something perpetrated by an adult). Most studies (such as the widely cited NSPCC 2011 Maltreatment study) have some kind of methodological flaw that leads to prevalence figures being presented as artificially low. You refer to the 2019 CSA Centre for Expertise report which is the best and most recent overview to draw on. The 15% of girls and 5% of boys figure is referred to in page 16 of this report. The next sentence of the report states 'The methods used and number of questions asked affect estimates; at the higher end, international estimates reach 30% for girls and 23% for boys.' This is a useful corrective and we would suggest this would be a helpful last sentence if added to the paragraph discussing the Centre for Expertise report on page 8 of the Clinical Pathway document.	
64SX-W	Section 4.1 'Who is a child'. In cases involving abuse of a position of trust, the victim may be 16 or 17? Does this need to be referred to here? Similarly, if a vulnerable individual at age 17 was coerced into providing a sexual image of themselves, this would not be deemed to be child sexual abuse in the definition provided in the Clinical Pathway document. However, the viewing of a sexual image of a 17 year old would be a crime. Clearly the document should not needlessly complicate the issue of who is a child, but do these situations need to be referenced? These could be referred to in Appendix A. 3.) Section 4.2 describes sexual abuse are always caused by those in a position of responsibility, trust, or power of the victim. This is almost always true, but is there something more that could be usefully said about power? If a 15 year old girl breaks up with her boyfriend and he shares sexual images of her (obtained in a consensual context) with peers - is this sexual abuse? It would fall under the Abusive Behaviour and Sexual Harm (Scotland) Act 2016 and would be dealt with as a child protection matter. This section would be improved with a statement noting that sexual abuse can occur both online and offline and involve contact, non contact forms of abuse or both. Is peer on peer sexual abuse something that needs	We anticipate that these complexities will be addressed during an IRD discussion as part of the Pathway. The Pathway has been updated to include further information on CSA with additional clarification for younger and older children.

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	to be considered here more generally in the document? The power relationship may not be so obvious in such cases but it will often be present .A recent UNICEF report looking at international data on sexual violence stated that adolescent girls are at greatest risk of forced sex within the private sphere, in the context of intimate partner relationships (https://www.unicef.org/publications/files/Violence_in_the_lives_of_children_and_adolescents.pdf). It may be that we want to label these situations as sexual violence in childhood rather than abuse, but these situations can also be considered to be - and should be responded to as - sexual abuse. Such cases may be identified in sexual health settings and the utility of this document needs to be considered there. Further information about how health professionals can best respond to harmful sexual behaviour in adolescence (including peer on peer sexual violence and intimate partner sexual violence in adolescence) can be found at https://learning.nspcc.org.uk/health-safeguarding-child-protection/harmful-sexual-behaviour-guidance-health/	
6413-P	We believe that in the context of trauma informed services there should be recognition that some children and young people have a legal right to access independent advocacy. The Mental Health (Care & Treatment) (Scotland) Act 2003 gives anyone with a mental disorder a legal right to access independent advocacy. This means that any young person who has disclosed sexual abuse and has a mental health disorder which includes mental illness, autism, learning disability or related condition should be able to access independent advocacy. In situations where a child or young person is disclosing sexual abuse and they have support from independent advocacy then the independent advocate will ensure; - they know and understand their rights - they are able to understand what is happening - they are able to communicate their needs and wishes - they are able to participate effectively - they are understood by others - they can think through their choices - they can make informed decisions	The Pathway emphasises the need for individualised care and support if concerns are raised about potential abuse.

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64SM-J	There is a large discrepancy between the number of sexual offenses against children and the number of people proceeded against for sexual crimes every year although two tables in section 2 not directly comparable. Is there any new research or analysis which we should be aware as to the reasons behind this and what can we do from a health prospective to improve these numbers (better forensic collection, documentation, etc.) How many convictions are recorded as a result of the prosecutions.	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64SR-Q	Not sure this is needed and if it stays will need to be updated annually in a 'live' version of the pathway	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SE-A	The definition of a child is currently an issue due to a number of factors including current legislation. This can make procedures and decisions in child protection inconsistent and also confusing to practitioners. The clinical pathway is applicable to the care of children less than 16 years of age or up to 18 years of age for young people with vulnerabilities or additional support needs. A young person making a disclosure may present to the pathway having only reached 16 years of age and due to identifying factors may be categorised as an adult and would automatically fall would full under the remit of the adult pathway. It is however, important for practitioners who first engage with the young person to establish if they have previously been a victim of sexual abuse and the extent of the abuse. This will help determine	The Pathway is applicable to the care of children and young people up to 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) who have disclosed sexual abuse of any kind. The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area. The Pathway is intended to describe best practice in line with current relevant legislation and

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	the most suitable form of support. In addition, the practitioner must be alive to the emotional and physical development of the young person which may be more akin to that of a child rather than an adult, thus, consideration should be given to measures being put in place under the pathway for children rather than the pathway for adults. Police Scotland welcome the development of trauma-informed practice, which requires consistency to be delivered effectively. Therefore, we would appeal where possible, the same practitioners/professionals should be allocated to a child or young person in order to provide support and familiarity; promoting a safe comfortable environment for the child or young person. Giving consideration to the legal context core agencies must have a mutual understanding of legal obligations if a child or young person makes a disclosure of child abuse. Collectively, we have shared responsibilities under child protection procedures to assess and minimise risk to children and young people. The views of the child or young person should be taken into consideration, but should not detract or prevent us from following child protection procedures. In addition, there should be no conflict in relation to a duty to report to other agencies and patient confidentiality	guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SN-K	CSA in the context of the whole systems around the child needs to be addressed within the pathway, not just from a medical perspective. Assessment and recovery pathway needs to address attachment, resilience and familial context.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64SB-7	The issues in the context section are all important and relevant, however the concern identified in our answer to Section 1.3 applies. Much of the information in sections 4.1-4.5 is brief, introductory, and disconnected from the stated aims and purpose of the document. If the issues cannot be covered comprehensively within the document, it may be more beneficial to signpost to the National Guidance for Child Protection in Scotland (2014).	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection

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	This guidance is currently being reviewed, and utmost care should be taken to ensure the content of the Clinical Pathway document is aligned with the reviewed guidance to avoid the document quickly becoming out-of-date. Suggested specific amendments include: • 4.1 'Who is a Child' – o Whilst we recognise the complex legal landscape in relation to defining the age of a age, to align with the Scottish Government's commitment to the UNCRC, the Clinical Pathway should apply to all those under 18. This recognises the right of these individuals' to a child-centred responsive approach, which takes into account their additional vulnerabilities as children and young people. Furthermore, extending the application of the Clinical Pathways to care experienced people up to the age of 26 should be considered, in line with corporate parenting duties and responsibilities. • 4.2 'Sexual Abuse' – o Consistency with the definition of sexual abuse generally used in Scotland, taken from the National Guidance for Child Protection in Scotland (2014), is recommended. o Relocate references to the legal context to section 4.5. • 4.3 'Trauma-Informed Services' – o We strongly support a focus on trauma-informed services for children who have experienced sexual abuse. However, this section itself is brief, and a trauma-informed approach is not integrated into the document. The Clinical Pathway would be significantly strengthened by explicitly detailing the role of health practitioners in ensuring trauma-informed responses, in the multi-agency context, at every stage of the child's journey, including future planning and recovery. o Replace 'sexual violence' with 'sexual abuse' in the opening sentence of this section. All experiences of sexual abuse require a trauma-informed response, not only experiences of sexual violence. • 4.4 'Adverse Childhood Experiences' – o This section could be strengthened, it currently contains very limited detail. o The language used in this section is highly clinical, emphasising the diagnosable disorders which can result when child sexual abuse is not 'treated'. This could be improved by taking a more holistic view of the child, the need to be trauma-informed, and attend to their overall wellbeing in responses to child sexual abuse. • 4.5 'Legal Context' – o The focus of this	context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. There is now more information and context on trauma informed care and adverse childhood experiences.

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	section, particularly on responding to disclosures of sexual abuse by children, is potentially confusing. Firstly, there is not enough information to constitute comprehensive guidance. Secondly, the Clinical Pathway appears aimed at practitioners undertaking medical examinations, which will occur after disclosures have been made. o The lack of clear references to relevant law in this section is confusing. The statement that additional context is provided in Appendix B is noted, however this appendix is simply a list of Acts (plus a paragraph outlining some aspects of the Children and Young People's (Scotland) Act 2014 which have not yet commenced) and as such the legal context is largely unexplained.	
64SZ-Y	Page 11 the paper states: " The dynamics of child sexual abuse differ from those of adult sexual abuse." We are not clear what is meant by this? The paper goes on to say "It is more likely for a child to experience sexual abuse at the hands of a family member or another supposedly trustworthy adult." This is the same for adults. For both it is about power and control, it is about silencing and blaming and putting barriers in the way of disclosure, whether internal within the person e.g. by making them feel responsible and to blame, or externally by threatening and isolating. With both, workers need to be aware of their own power, and work to build trust, utilising the trauma informed principles. Also the term 'adult sexual abuse' is referenced, what does this mean? We consider that people would read that as sexual abuse of a vulnerable adult. We consider this to be vague and unhelpful. If what the paper is trying to convey is it is important to consider the context of how children are abused and assaulted then this needs to be spelled out explicitly with practical considerations for practice. This phrase is used again later in the document on page 12, with the same feedback. On Page 11 the paper states: With childhood sexual abuse children are often too young to know how to express what is happening and seek out help. Again the use of CSA limits what kind of sexual assault this might be seen to apply to. This might not be the key barrier with older children, but with both there are	The term children and young people is now used throughout the document. The Pathway has been revised to provide more clarity.

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	significant barriers such as fear of not being believed, fear of being blamed, judged or of getting themselves or others into trouble. Also in this section the paper describes child sexual abuse of a child. We feel it is important to also highlight sexual assault of older children by peers/older children and to recognise coercion and the peer pressure at play which might be not about age but gender and status. In terms of health care responses it is important that this is given consideration and weight re training and staff responses. It would be useful to use the terms children and young people throughout the document and not just in the title to emphasise this.	
64SH-D	In relation to the Crime Survey for England and Wales (2016), we assume that the wording should be clarified to explain that the percentages relate to any form of sexual abuse, not any form of abuse as currently drafted. It is important that the context given in this section reflects both contact and non-contact offences. The definitions of child sexual abuse explored later show that not all abuse involves physical contact with the child or young person (for example, online grooming), and it is vital that medical professionals both identify and respond to situations where any form of sexual abuse is taking place. The language in relation to the CSA Centre for Expertise paper could be simplified and clarified by referring to abuse by "adults and other children/young people" rather than adults and peers. The word 'peer' suggests someone of a similar age, when in reality abuse by another child or young person can encompass this, but can also include children/young people of different ages, and relationships between children/young people of the same age where a power imbalance creates an abusive context.	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s).
64SU-T	The context itself is what is failing the proposed system. A great part of the system despite its recommendation of abortion and my objection to it is in fact, very well intended and if other advanced qualities were added could be very effective indeed but I will tell you now its no were near the other systems I have examined from other nations. Even if such advancements	The Pathway is applicable to the care of children and young people up to 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) who have disclosed sexual abuse of any kind.

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	were to be made in the Scottish system the legal context of Scotland will lead to the system ultimately not achieving its objective to be just in regards victims and the falsely accused in terms of objective reality. It is incapable in that respect because as stated by the UKSC in regards some child protection measures in Scotland, the measures and the laws the system will be governed by in terms of protecting children are themselves incompetent and thus actually potentially dangerous to the wellbeing of children. Now that irrespective of the abortion issue may have been completely avoided if it was designed only to tackle issues of rape regarding children 0-15 regardless of any gender or sexuality without mixing in those who are 16-17 in the same "young persons" bracket. This is not England. The 16-17 year old age bracket should have been dealt with in the adult pathway or the age raised for all rights and freedoms to 18 by a referendum. Before a system like this is ever put in place there needs to be three things already present in Scotland: A) A fundamental change in the attitude of Scottish adults towards Scottish children and Scottish children towards Scottish adults. B) A fundamental change in the laws in Scotland that define when a child is a child and when they are not, when rape is rape and when it is not. C) Proper selection, training and allocation in regards the people on the ground operating such a system like this. There should also be: I) A clear understanding of what police can and can not do. II) A clear understanding of what social work can and can not do. III) A clear understanding of what medical personnel can and can not do. And ultimately there should be a management for the modus operandi that the system will work by that is: 1. Responsible to the public. 2. Accountable to the public. 3. Transparent to the public All within an atmosphere that yes constantly offers the alleged victim collaboration and control, power and support, trust and safety as proposed by the Scottish Government. I want to say something on collaboration - the government should only collaborate on matters of fact and fact only in these cases facts as to those established or facts as to those witnessed by the civil service. I find the legal context that will be the backdrop to this rather bizarre	

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	as evidenced in such statements as: "A child and an older child" Now there is either a child or an adult, there is no such thing as an older child or younger adult in regards child protection. The line between an adult and child needs to be stark and evident. Or that a child of the age of 13-15 needs to have there statement of consent to sex interrogated by the state to verify there consent is "truly genuine" well no - they don't because a child under 16 can not give there consent. Period. End of argument. If a child therefore at 13-15 purports to give consent then they have not given anything of the sort there's no need for an interrogation to verify any genuineness about it because there is none it's not consent in anyway shape or form a child can not consent to sex to any person older, the same age or younger. Full stop. If the child has given it to somebody of the same age at 13-15 then the parents of both partners should be given social work support as a mandatory requirement. If it is true that a person at 13-15 can give valid consent in some incidences if the state deem it "true consent" then who decides that ? Them, criminal law enforcement or the assessor of such genuineness and why ? Perhaps this system should be more interested in its creators and proponents than innocent families - a case of deflection perhaps ? Furthermore, if the state deems a person at 13-15 can in some incidences give true consent then whom can they give it too other persons of 13-15 or a 60 year old ? Finally, if the state can justify incidences were a 13-15 year old can give "True consent" then what are we doing maintaining a statutory age of consent at 16 ! It should be lowered to 13 then should it not ? Perhaps that's the ultimate aim of those making such bad statements - No ! Clearly, clearly Scotland that is not the correct answer, the correct answer is to not interrogate a 13-15 year old to verify if there consent is genuine the correct answer hear is to regard all and any giving of consent by any person at 13-15 in regards sex to anyone regardless of sexuality or gender as automatically invalid in every case no matter who they give it to without exception whatsoever. As stated there needs to be a change in law and in	

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	context as well as adults attitudes to children before the pathway can bring any change to Scottish society in this area.	
64SD-9	The context provided would benefit from additional resources to support practitioners in understanding the impact of adverse childhood experiences. A link to the NHS Health Scotland Gender Based Violence resource is suggested http://www.healthscotland.scot/health-topics/gender-based-violence	The section on adverse childhood experiences in the Pathway has been reviewed and enhanced.
64SP-N	We have concerns over the definition of a child, primarily in the differentiation of 16 and 17 year olds with "vulnerabilities and additional support needs". Introducing the concept of 'vulnerability' as a qualifier risks a lack of clarity and certainty in the application of the pathway, and may not result in the best outcomes for the individual concerned. In addition, it is unclear how the assessment of vulnerability will be made, who will make that assessment, and what criteria will be applied. Being defined as a child attracts specific protections in law. For instance, the Vulnerable Witness (Criminal Evidence) (Scotland) Act 2019 (2019 Act) provides for safeguards as to how the child should give evidence in serious cases which include those of sexual abuse. This provides for all those under the age of 18 to be treated as vulnerable witnesses. In addition, the United Nations Convention on the Rights of the Child, which the Scottish Government has stated its intention to incorporate into Scots law, applies to all those up to the age of 18, which is also reflected in the Children and Young People (Scotland) Act 2014. However, we also note that the definition of child varies across different pieces of legislation, for example the Sexual Offences (Scotland) Act 2009 uses the ages of 13 and 16 when framing sexual offences against children. It would be helpful to maintain consistency of approach across the range of relevant legislation regarding children that have been affected by sexual abuse. Clarity and certainty in how the application of the clinical pathway is to operate should be the objective taking into account what	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.

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	provides the best outcomes for the individual concerned. We would recommend that the pathway applies to all up to the age of 18, with regard to the different needs of different age groups.	
64SP-N	The description of the law in this area could be more nuanced. Paragraph 4.2 of the consultation briefly highlights the Sexual Offences (Scotland) Act 2009 Act and the distinctions made in that Act between different age groups. More could be done to set out the legal context clearly and more comprehensively. It may also be worth noting that in limited circumstances, consensual sexual activity involving older children is not illegal (e.g. where both parties are aged 13-15 and the behaviour does not involve penile penetration or genital contact; or where a party is over 16 but the difference between A's age and B's age does not exceed 2 years and the behaviour does not involve penile penetration or oro-genital contact). However, while such conduct is not covered by an age-based offence, it would of course be covered by the general sexual offences, for example sexual assault if consent is not present	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SQ-P	While we agree with the overall context of the pathway document, we suggest the following amendments: We question whether the definition of "children and young people with vulnerabilities and additional support needs" is clear enough and suggest that this is likely to be too open to interpretation. We suggest that, in line with UNCRC that all children and young people under 18 years of age would be entitled to this clinical pathway. Para 4.1: The term 'accommodated' should be removed from 'looked after and accommodated' so as not to exclude those children and young people looked after at home, in kinship care or on a permanence order. Para 4.2: We suggest it may be helpful to include in section 4.2 a definition of child sexual exploitation as a form of sexual abuse Para 4.3: Trauma informed care should also underpin work with the child's family and professionals already working with the child e.g. teachers, bearing in mind	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. The Pathway describes in broad terms what ongoing support to aid recovery should be

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	recovery is most likely to take place through the enduring relationships within the child's network. Para 4.5: the phrase "passed on" implies a shifting of responsibility for child protection and such language should be avoided in line with the principles of GIRFEC – it may be more appropriate to say "should be considered as part of local child protection procedures"	available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). A definition of CSE is now included in the pathway.
64S1-P	[Our organisation] believes further development is required within the context section of the pathway document. In particular, [our organisation] welcomes attention being given to the increased risk of sexual exploitation to children and young people with learning disabilities (please refer to Recommendation 1). This was discussed in detail in [our organisation] submission to 'Equally Safe: A consultation on legislation to improve forensic medical services for victims of rape and sexual assault' (2019, p.3-5) . This outlined the risk present to adults as well as children and young people with learning disabilities and the barriers they experience in accessing justice. In addressing the context regarding the risks to children and young people with learning disabilities to sexual assault and rape, [our organisation] points to a range of relevant literature spanning across the twentieth century, including but not limited to Wescott (1991) and Hershkowitz et al (2010) . In particular, [our organisation] welcomes the pathway drawing from 'Underprotected, Overprotected' (2015) which highlighted an increased risk to children and young people with learning disabilities due to a number of complex factors including: • The challenges for children and young people with learning disabilities in identifying risk • The overprotection and isolation of children and young people with learning disabilities • The limited awareness of the sexual exploitation of children and young people with learning disabilities among professionals. A full list of contributing elements to increased risk found in this study is discussed in more detail in 'Overprotected, Underprotected' (2015,p.41). In addressing the risks to children and young people with learning disabilities, the pathway should also highlight the rights	In anticipation of the revised National Guidance for Child Protection in Scotland which addresses these issues in depth, the Pathway stresses general principles that underpin the consideration and conduct of investigative activities in relation to children and young people who may be harmed and those who may cause harm to others.

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	of this group to romantic relationships as well as friendships. [Our organisation] believes that in addressing this the Scottish Government can work towards the achievement of the recommendation made in 'Overprotected, Underprotected' (2015) which said: "The Scottish Government must ensure the development, revision, and implementation of legislation, policy, and guidance to meet the needs of young people who experience, or are at risk of, CSE." (Franklin et al; 2015, p.144)	
64SK-G	Page 11--the document mentions children up until 16-18 depending on vulnerabilities then on page 11 mentioned care experienced young people... we have a corporate parenting responsibility until age 26 in the CYP act to this needs explained and context added to clarify. Pg 12 would be helpful to include align with the definition of trauma-informed care as explained in the NES psychological trauma framework... trauma informed is much wider and would support all those involved with this pathway to use a trauma informed lens on the child's journey p 12 the 4 rs are good but be helpful to use the trauma informed organisations diagram by NES which frames it in the context of trust, safety, empowerment, choice, collaboration and relationships 0 12 4.4 would change the title to childhood adversity as opposed to ACEs	The vulnerability of care experienced young people up to age 25 has been emphasised in the Pathway. There is an enhanced section on trauma informed care.
64S7-V	4 and 4.3.1.3 Trauma Informed Services and 4.3.1 Trauma Informed Child and Family Centred Care Could "Sowing Seeds: Trauma Informed Practice for Anyone Working with Children and Young People" https://vimeo.com/334642616 be included as a resource instead of or as well as Opening Doors in Useful resources. To also highlight that in trauma informed practice with children it also important to consider the age and stage of the child, to understand the potential impact of trauma and also how they might present and communicate.	There is now more information and context on trauma informed care and adverse childhood experiences. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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64S7-V	Section 4.4 Understanding the Impact of Adverse Childhood Experiences Should be clearer in stating, adverse, stressful and traumatic experiences. Currently does not state traumatic. Also inaccurate and overstated impact. "When not properly treated, child sexual abuse can result in a lifetime of Post Traumatic Stress Disorder (PTSD), depression and anxiety." Would advise rewording to something more general such as "When childhood sexual abuse is not responded to with trauma informed principles and specific interventions where required, it could result in poorer outcomes in terms of mental health, physical health and social outcomes"	There is now more information and context on trauma informed care and adverse childhood experiences. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64S7-V	Other resources to refer to in terms of Trauma Informed Practice are the Forensic Medical Examination Guidance. NES Forensics updated and developed resources following the CMO request in 2018 that all doctors working in sexual offences have accessed training in trauma informed principles of practice. Collaboration with NES Trauma ensured that the resulting emanual, video walk through of a forensic examination and two days of face to face training had trauma informed principles embedded throughout. These resources remain accessible to those who have attended training. Also the Joint Investigative Interview Training which is currently being revised by Social Work and Police staff, in line with a new protocol. Again NES Trauma have provided input in developing this training and highlight the importance of child development and impact of trauma. Both of these areas would be relevant to this pathway	There is now more information and context on trauma informed care in the Pathway.
64S3-R	Further context in relation to the new child protection guidance should be given, in addition to information on corporate parenting duty and the additional context of adult support and protection. GIRFEC is initially referenced, but not weaved throughout the document to emphasise the child rights and wellbeing context, especially in relation to new work around child protection. Further information on the legal context of the children's hearing	The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a

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	system needs to be added. Additional legal context in relation to vulnerable witnesses is also needed.	wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. Further information on the Children's Hearing system is now included in the Pathway.
64S3-R	The figures outlined in the introduction do not highlight the experience of children and young people as it refers solely to police date. SRCA have data on concerns raised and child protection concerns within the children's hearing system	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s).
64S4-S	Have to get to paragraph 4 before the discussion of child sexual abuse.	This has been brought forward after the introduction and wider child protection context.
64MX-Q	Information sharing across agencies. Someone to link in and share. Need a co-ordinator. Each health board has different opinions on what they want to receive (information). Under 16years there shouldn't be difficulty as they should be in child protection. Whose responsibility is it is to share information written into the pathway. Nothing explicit about after care, inclusion team would do that. All within young person service. Support worker who would follow up within 48hours and refer to Sandyford. SLA is for forensic examination, can also include follow up. The choice should be the child's. We cannot force that on the child. Number 12 missed out – something about after care, co-ordinator. Make sure we are all working to same specification – consistency. Small numbers for children – high quality for small number of children Lack of consistent nursing support. Peripatetic nursing? Co-ordinator role? Help to drive the standards. Implementation of	The Pathway is a clinical pathway intended to support the delivery of consistent high quality clinical care across Scotland and it is set within current legislation, guidance and clinical practice in this area. The revised Pathway now includes a section on the roles and responsibilities of the professionals involved. Hyperlinks are provided throughout the pathways for all resources referenced or referred to in the document.

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	the pathway – resource, model and governance. Custody care nurses all work under standard setting/training/data/competencies for custody care we could apply those. Pre and post exam. Clinical pathways as a rule – depends on implementation, governance and monitored. Need processes around that. Something not in the control of the servicers – i.e. test results. Also admin support for reports etc. – need resources. Monitoring – sense of improvement. We have numbers from the police, clinical numbers? Not sexual offences, number of examinations should be noted. Number of children seen by SARC. Maintaining skills. Other guidance exists in non-health setting. Adapting this pathway (another version) for other agencies to use.	
64M5-M	It is helpful for the draft pathway to contain a section on the prevalence of CSA. The lack of robust prevalence data at both national and local level may at least in part contribute towards the low priority given to the planning and delivery of therapeutic services for children who have experienced sexual abuse, particularly younger children. The section would be very helpfully strengthened by containing clear evidence on the proportion of children experiencing sexual abuse who are likely to come to the attention of statutory services. For example, a report by the Children's Commissioner for England found that as few as 1 in 8 children are estimated to come to the attention of statutory agencies.2 Children whose abuse does come to light during childhood must be understood as the 'tip of the iceberg' of a much larger number who are sexually abused whilst growing up and this should be clearly articulated in the Pathway. We would also strongly welcome the section being fleshed out to further clarify the difference between the data on the population prevalence of child sexual abuse and the administrative data recorded by agencies, for example police and social work. Recent UK and Scotland specific reports in this area are referenced and linked below . Lastly, it might flow better if the prevalence section was contained at section 4, immediately following the definition of CSA (for example; what is CSA;	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s).

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	how prevalent is it?) It is helpful for the draft pathway to contain a section on the prevalence of CSA. The lack of robust prevalence data at both national and local level may at least in part contribute towards the low priority given to the planning and delivery of therapeutic services for children who have experienced sexual abuse, particularly younger children.	
64M5-M	We welcome the inclusion of a definition of child sexual abuse. In order to increase ownership of the Pathway across the services/ agencies to which it pertains, it might be helpful to use the Scottish Government definitions of CSA and CSE, contained in National Guidance Child Protection. As mentioned, the guidance is currently under review; liaison with the review team will be important to ensure consistency. More information about the context of CSA/ CSE would also be extremely helpful to clarify the dynamics of child sexual abuse. For example, from The Right to Recover: This broad (Scottish Government) definition encompasses the many different contexts and situations in which sexual abuse occurs. This includes within the child's family, circle or community; peer to peer abuse perpetrated by other children, including within teenage intimate relationships. It includes sexual abuse and exploitation conducted online, a new platform for abuse both by peers and adults which includes, for example, causing or coercing a child to watch a sexual act, and grooming a child online. Child sexual exploitation (CSE) is a type of abuse which is recognised as taking a variety of different forms and takes place in a variety of contexts including organised crime. The Scottish Government definition of CSE is a form of child sexual abuse in which a person(s), of any age takes advantage of a power imbalance to force or entice a child into engaging in sexual activity in return for something received by the child and/or those perpetrating or facilitating the abuse. As with other forms of child sexual abuse, the presence of perceived consent does not undermine the abusive nature of the act. Explicit in these definitions is the misuse of power. The social position of children involves not only their reliance upon adults for all their basic material and emotional	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation.

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	needs, but subordination to adult authority, a relationship often reproduced in dynamics between older and younger children. Additionally, inequality between the sexes and therefore the social position of women, and not only children, shapes the context for sexual abuse. Globally CSA is recognised as a form of gendered violence rooted in sexual inequality.12,13 Evidence overwhelmingly points to child sexual abuse as a problem affecting a significant minority of the population, both female and male, but with a higher prevalence (2-3 times higher) amongst females. Over 90% of all sexual abuse is perpetrated by males, with around one third involving physical force. Approximately two thirds of CSA is extra-familial, with young people's intimate partner relationships, and therefore socialised gender relationships, forming a key context	
64M5-M	Missing Section - Impacts of child sexual abuse on children and families […] regards it as imperative that the care pathway outlining the stages in the joined-up health response to children following sexual abuse raises practitioner's awareness of the potential impacts of sexual abuse on the health and wellbeing of children and young people, and families, during childhood and at later stages in life. This information underlines the critical importance of the pathway in supporting practitioners/ services to meet the holistic health needs of all children and young people experiencing sexual abuse, minimising preventable harm to health and wellbeing in the short and long term. There is extensive research literature on impact to draw on. A recent rapid evidence assessment of the impacts of CSA, published by the Independent Inquiry into Child Sexual Abuse, provides a very helpful summary. It also includes vital information about identified risks and protective factors which may impact on a child's experience of recovery, including the response of health services and other agencies. https://www.cypnow.co.uk/digital_assets/7fc18fa4-5745-48e6-bb02-b0e3157061f6/IICSA-Impacts-of-CSA-REA-English-summary-report-FINAL.pdf It is critical that health practitioners, and all practitioners,	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	understand the potential impact of their response to a child, on the child's journey to recovery. It is also of fundamental importance that the pathway outlines the potential impacts of child sexual abuse on families/ non-abusing carer. Health practitioners in West of Scotland described sexual abuse – in particular familial – as 'like a bomb going off on the family' . Impacts experienced by non-abusing parents as a result of their child's abuse can mirror the outcomes experienced by victims107 and can affect all aspects of parents' lives, including their physical health, personal relationships, employment and financial stability. 108 Crucially, parents can find it very difficult to support a child who has experienced abuse, at a time when they are trying to cope with acute emotional upheaval, which can have a critical impact on the child's chances of recovery. Understanding the potential impact on carers helps underline the necessity of a supportive carer response. Support for non-abusing carers, on a case by case basis, will range from providing information and support at each stage, to facilitating access to therapeutic support, where required. The document references current work being undertaken by the CMO Taskforce to explore enhanced provision of family support services (5.1, pg. 14). Further information on the nature of enhanced provision would be extremely helpful in order that we can comment.	
64M5-M	4.3 Trauma informed Services 'The core experience of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based on the empowerment of the survivors and the creations of new connections' Herman (1992) Trauma and Recovery pg. 133 This section could very helpfully be expanded to include some brief text around the fundamental characteristics of child sexual abuse in order to make information about trauma informed practice really meaningful to practitioners. For example, understanding the nature of the 'relationship' between child and abuser – where all power and control resides entirely with the abuser, helps underline why it is critical for services to help children and	There is now more information and context on trauma informed care and adverse childhood experiences. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	young people feel in control of the processes they are going through, with trusted support, information and choice being given at every stage of the journey. We would also stress the need for a paragraph which indicates that a central reason for the pathway – and indeed a trauma informed response - is to ensure that the child, young person and non-abusing carer/ family are supported towards recovery, including support to access therapeutic services, where indicated. It might also be helpful to include some brief information to de-bunk what may be a common assumption: that if children are not displaying overt symptoms of what adults consider distress, there may be no need to intervene. The evidence around ACES provides clinical evidence to support the moral imperative that a) children have a fundamental right to recover from sexual abuse and access therapeutic services and b) a trauma informed response to a child is based on the principle of addressing preventable harm and minismising negative outcomes in the short and long term. Useful resources describing a trauma informed approach to working with people who have experienced CSA include 'Yes You Can: Working with Survivors of Child Sexual Abuse'. (Scottish Executive, 2005).	
64MV-N	The context gives a useful overview of the issues that need to be considered before discussing the pathway, but need to be revised to ensure the link with child protection approaches	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.

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64MV-N	The WHO definition quoted on page 11 defines child sexual abuse in very general terms, and does not give clarity on issues of consent. A more helpful definition of child sexual abuse can be found in Para 36 of the National Child Protection Guidance. 36. Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of indecent images or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways (see also section on child sexual exploitation). The NCPG definition makes that sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64MV-N	The final paragraph on page 11 also needs to be clarified. While it is true that the 2009 Act does create a separate "offence of engaging an older child in sexual conduct with or towards another older child", and in these circumstances child protection risk assessment is appropriate, even if a child "engages by consent in the conduct in question" an offence has still been committed and, according to the National Child Protection Guidance, child sexual abuse has taken place. However, the final paragraph on page 11 could be read as implying that situations where older children are involved, 'consent' is apparently given and no immediate child protection concerns raised do not come within the ambit of child sexual abuse and therefore the pathway does not need to deal with children in these situations. [Our organisation] believes the pathway must be flexible enough to meet the needs of any child who has disclosed child sexual abuse under the terms of the NCPG	References to legislation in the Pathway have been updated in line with additional comments from COPFS.

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64MV-N	It would also be worth citing the description of child sexual exploitation set out in paras 572 -575 of the National Child Protection Guidance. As with all sexual abuse the sexual exploitation of children and young people is a hidden form of child abuse, with distinctive and insidious elements of exploitation and exchange. In some cases consent may appear to have been given, and the sexual activity may be may just take place between one young person and a peer, but nonetheless sexual exploitation is abuse and should be treated accordingly.	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64MV-N	These issues around consent and definition of abuse highlight the necessity of the pathway being designed to work within wider child protection process. Whilst we recognise that all age services and parallel pathways for adults and children might have been identified by the options appraisal process as the best approach, any response to disclosures of child sexual abuse needs to take account of the very different needs, rights and issues for children and young people. This journey, from disclosure to recovery, should also be the core remit of the Barnahus standards development group. We recognise and welcome the speed of movement on the development of Barnahus by Scottish Government in recent months. It is very likely that had that development started sooner, the pathway for adults and children and young people would have been addressed separately from the outset. [We] believe that the Barnahus development work so far can help develop clarity about what a good response for children and young people looks like in relation to this pathway. Alongside that links to the pathway can be included in the discussion and planning for Barnahus standards for Scotland	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.

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64MV-N	We would also like to see a stronger and more complete section on adverse childhood experiences. The current section is very limited, and some of the language used – such as "When not properly treated, child sexual abuse can result in a lifetime of Post Traumatic Stress Disorder (PTSD), depression and anxiety" does not fully reflect the current Scottish government approach to ACEs. We have therefore, as a suggestion, drafted a longer and more detailed section 4.4, which we hope is a useful starter for a longer and more detailed coverage of ACEs. It is largely drawn from the Scottish Public Health Network (ScotPHN) publication 'Polishing the Diamonds, Addressing Adverse Childhood Experiences in Scotland' by Sarah Couper and Phil Mackie and published in May 2016: 4.4 Understanding the Impact of Adverse Childhood Experiences It is recognised that sexual abuse is one of the Adverse Childhood Experiences that can impact the health and wellbeing of individuals throughout their life. In particular the dynamics of child sexual abuse and the associated grooming process and/or coercive aspect of the abuse can affect all aspects of a child's life and therefore addressing these is also a necessary part of the recovery process. Young people who are victims of sexual abuse can experience issues like difficulty in concentrating in school, challenges in their interpersonal relationships and places themselves at repeated risk as a result of the complex feelings and response to abuse. For some they find that the consequence of disclosing abuse is that they are taken from their family in order to remain safe, or some find themselves in a conflicted situation where family, friends and peers can choose to believe either their story or that of the accused. The importance of being listened to and heard in a non-judgemental environment cannot be underestimated, as it is through the process of sharing their thoughts and feelings that young people can be supported to make sense of their experiences and begin to understand why they may feel and act in certain ways. Children and young people can be helped to cope with the impact that being sexually abused has had on their sense of sense and the way in which they relate to the	There is now more information and context on trauma informed care and adverse childhood experiences. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	world around them, through being offered respectful, relationship based therapeutic support. Conversely if young people are not offered the support they need to recover from the impact of sexual abuse, we know from adult survivors that some will go on to develop symptoms of mental ill health such as depression and anxiety or may be given diagnosis of Post Traumatic Stress Disorder (PTSD or other mental health diagnosis. Many will also have an increased likelihood of developing a chronic physical illness	

Section 3: Clinical Pathway

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Do you agree with the aims of the pathway?

Yes	**40**	**70.18%**
No	**5**	**8.77%**
Not Answered	**12**	**21.05%**

Comments

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64HR-C	Yes, but please see response provided in section 1 about the lack of detail provided about how the Clinical Pathway covers the aspects of wellbeing and recovery.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64ME-4	The aims of the pathway are to help children – but as before the method, scale and scope is inadequate.	Noted

641N-H	It is crucial that all approaches are clearly defined and consulted upon and that the pathway is designed to accommodate the needs and wellbeing of children and young people. It is essential that expectations are set appropriately and that each individual knows and understands what is expected of them, and what the process will be. It is vital that every child is treated with respect and dignity and that they are believed from the outset.	Noted The Pathway now includes an Annex with roles and responsibilities. The importance of taking concerns seriously is emphasised.
641K-E	Our consultation group agreed that the aims of the pathway encompasses the crucial areas from disclosure through potential medical to the essential therapeutic support. However the aims state that health services "should" and there was an opinion from the group that this should be "will" be provided. If this pathway is to be successfully applied there will be significant resource implications. Currently there is a significant shortfall regarding therapeutic services for children and young people but in particular for those children under the age of 12. Our consultation group considered the children and young people we currently work with, or have previously worked with. The therapeutic supports are being provided by social work teams within our own organisation and voluntary organisations – in particular RASAC with young people over the age of 12 and their families. In some instances private providers are being approached to provide this therapeutic service. However there needs to be further discussion about who the most appropriate private providers would be if the health service is unable to provide this from their current resources. The main question being asked was in relation to who would provide the immediate and longer term support within health. The aims state "timely access" and "holistic and trauma-informed approach" but the routes into this support and how they are going to be delivered are not clear We are in agreement with the aims being nationwide and that regardless of where you live in Scotland you should expect a consistent, quality response and service.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). However, the Pathway is not intended to direct the allocations of resources which are for local services to determine to support local implementation.

6412-N	Dentists are likely to be involved in bullet points 1-4 to a greater or lesser extent. They cannot however participate in bullets 5 and 6 around providing trauma support or around medical examinations. There is minimal support out there for dentists to help them provide patients who have previously experienced sexual abuse or trauma with a bespoke level of care	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it not necessary and may be unhelpful to duplicate material already available in this area.
64SE-A	The aims of the pathway are clear and place emphasis on the requirement for a multi-agency response to children or young people who have disclosed sexual abuse.	Noted.
64SB-7	We agree with the aims stated in Section 3. We strongly support the attention in the opening paragraph to the importance of partnership working, and ensuring children (and those who care for them) are supported in a manner which promotes health, wellbeing and recovery. The references to holistic support and trauma-informed practice are also particularly positive. To improve the aims still further, consideration should be given to explicitly stating the aim of being rights-based in responses to disclosures of child sexual abuse. Additionally, explicit recognition should be given to the aim that services will be responsive, and practitioners will enable children (however they communicate) to communicate their views and needs, rather than any onus or pressure being on the child to make themselves understood. Whilst the 'aims' section of the document is strong, we are concerned that the stated aims and approaches are not coherently integrated into the Clinical Pathway, and therefore into practice. It is thus difficult to see how these aims will be realised.	The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards: • focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration

		• age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SH-D	We would add safeguarding to the aims of the clinical pathway. This could be achieved using the following wording: "services for the child or young person and those who care for them are able to promote health, wellbeing and recovery, and maintain a focus on safeguarding." The wording of the fourth bullet point in Section 3 ("Balance confidentiality with the need to share information to safeguard the child or young person, or other children and young people at risk of harm") suggests an inherent conflict between confidentiality and information sharing, and may unconsciously act as a barrier to clinicians sharing information and intelligence. In our experience of working with a range of statutory partners, while confidentiality must of course be balanced with the sharing of information relating to a particular individual, agencies also hold a range of 'softer' intelligence, which can more readily be shared, and can be invaluable in working together to tackle	The Pathway is intended to describe best clinical practice in line with current relevant legislation and guidance. The Pathway is not intended to change the IRD or Joint Investigative Interview process or to introduce a Barnahus model or facility to Scotland. However, it is 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context. The Pathway promotes consistency in Scotland across a number of areas covered by the European Barnahus Quality Standards:

	child sexual abuse. For example, information on individuals of concern and places of concern can be shared. This document should leave practitioners feeling empowered to share information, rather than discouraged from or fearful of doing so. It should also be noted that where there is a child protection concern, information should be shared in order to help safeguard the child/young person, and pathways should detail whom this information should be shared with. The final bullet point in this section ("Ensure that the examination meets the forensic standards required to support any future criminal justice process including the requirement that facilities used for forensic medical examination are appropriately maintained and comply with the agreed forensic decontamination processes and procedures") is extremely clinical/legal, and clearly places the focus on collection of evidence. There is very welcome reference in Section 6 to the fact that the primary purpose of medical examinations is to support the health and wellbeing of the child, and that the collection of forensic evidence is a secondary purpose, but that important nuance does not come across in this final bullet point.	• focussing on the best-interests of the child or young person, the right to be heard and receive information and avoiding undue delay • multidisciplinary and interagency collaboration • age appropriate facilities • interagency case management • medical examination • the provision of ongoing support and therapeutic services for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SU-T	Not entirely- because it's aims are not clear enough. Every civilised human being in Scotland including the author never wants there to be any incidence were a child is ever raped. However, this is not well thought out. Any incidences of those 16-17 who have been raped should have not been brought into this but should have been addressed only in the adult pathway as continuously stated. It's aim should only have been with dealing with persons 15 and below. Furthermore, in regards the actual stated aims the	The Pathway is relevant when providing care and support up to the age of 16 years unless there are vulnerabilities or additional needs which make it appropriate for young people aged 16 and 17.

	aims state this: Aim One: " Work in partnership across agencies with a shared commitment to the best interests of the child. This includes listening to and believing the child. " What do we mean by work with ? And what agencies ? What do we mean by the best interests of the child ? And who ultimately decides what they are ? The state ? The child ? Or the parent ? And why one over the other ? I wonder would the state believe the child if they accused a leader of one of the four constituent nations of the U.K. or would that not be believable all of a sudden ?	
64SU-T	The biological mother, biological father or other guardian(s) other than the state are the best people to decided there child's interests. A child should always be aloud to speak and be listened to as well as having there accusation meticulously investigated but there is automatic no reason to believe the child or disbelieve them for that matter either. The accusation could be false or it could be true and believing or disbelieving them is not going to change that. The only belief that will count for that raped child is the faith in them given to them by a jury. The objective therefore should not be on motive notions such as belief or disbelief but on establishing forensic evidence. Nothing says the child has been raped by her dad more than a parental DNA match between her father and her unborn baby for example. And nothing says a child has not been raped by her father other than a parental DNA negative result between that father & the hypothetical baby in his daughters womb either. The accused in any accusation not just rape of a child or adult is always innocent until proven guilty and should always remain anonymous until such guilt is found by a jury - the burden of proof always lays upon the accuser (in the UKs case the Crown) in any democracy and the accused has a right to know what the accusation actually is, what evidence there is to support it as well as who has made the allegation against them. Anything else can lead to injustice. I know it, you should know it and anybody purporting to have an ounce of intelligence or respect for democracy should know it.	Noted

64SU-T	Aim 2: " Be focused on the reduction of further harm and promotion of the recovery of the child and family, whether or not there is an ongoing criminal justice process. " Yes - but only with the parents consent and certainly in terms of medical recovery but if any harm reduction measures mean limiting or interfering in the life's of those accused then that should happen only in proportion to substantiated reasonable suspicion based on objective evidence and in totality only after a verdict of guilt has been found by a jury. After due process, not before. Its something you often find in western democratic nations Scotland.	This is out of scope of the clinical pathway.
64SU-T	" Provide appropriate and timely access to health care, emotional, mental health and social support. " Yes but only with the families consent or the alleged victims. " Balance confidentiality with the need to share information to safeguard the child or young person, or other children and young people at risk of harm. " That balance should be done in accordance to observing UKSC Judgement as given in the case of the Christian Institute and others (Appellants) v The Lord Advocate (Respondent) (Scotland) in regards all children and in accordance to s22 of the Gender Recognition Act 2004 in regards transgender people. GIRFEC should be totally dropped.	Noted
64SU-T	In regards risk of harm who defines what that is ? What do we mean by it ? And why ? The proposition not only states just risk of harm but possible risk of harm or in laymans terms none verified suspicion of risk of harm - there actually does not need to be a real risk of harm or harm at all. That's just a blank check to remove children from there families on a so called professionals ego trip. Unacceptable. This system equates emotional harm, psychological harm or negligence with sexual harm as if it is the one and the same issue or of the same criminal magnitude. I am sorry but there is a massive difference in a male shouting an insult at his daughter each day not attending to her needs or traumatizing her by beating up the child's mother in front of her then actually penetrating his own flesh and blood with is penis and if those proposing this can not see that then they are incapable	Noted

	of proportionate judgement and I dread to think what will happen to people if this is put out as some sort of magical mythical 'The SNP will fix it in every child's case" - ridiculous. Its that kind of misequation of action that makes real victims of rape look very silly indeed and by stating the former does not in anyway mean domestic abusers should not face justice for there despicable crimes they have committed either.	
64SU-T	" Offer a holistic and trauma-informed approach to therapeutic support " I have no problem with this as long as its offered and not enforced.	Noted.
64SU-T	" Ensure that the examination meets the forensic standards required to support any future criminal justice process including the requirement that facilities used for forensic medical examination are appropriately maintained and comply with agreed forensic decontamination processes and procedures. " Yes ! Absolutely Yes ! Because that, that alone will bring justice to an incident of rape of a child for a child or of false allegation for a falsely accused adult more so than belief or none belief. Solid science not speculation, not suspicions, not politically motivated parties […] but good old fashioned scientific provable observable fact. The best tact for the prosecution in these cases is to "get all scientific" on the accused.	Noted.
64SU-T	A suspicion of child abuse about a man is no guilt of child abuse. - In a democracy he is still innocent because he most likely is. An allegation of child abuse against a man is no guilt of child abuse. - In a democracy he is still innocent because he most likely is. An arrest of a man for child abuse is no guilt of child abuse. - In a democracy he is still innocent because he most likely is. A no comment, no defence raised or non compliance in police or judicial proceedings from a man is no guilt of child abuse - In a democracy he is still innocent because he most likely is. A charge of child abuse of a man is no guilt of child abuse. - In a democracy he is still innocent because he most likely is. A prosecution for child abuse of a man is no guilt of child abuse. - In a democracy he is still innocent because he	Noted.

	most likely is. A trial of a man of child abuse by court, media or public opinion is no guilt of child abuse- In a democracy he is still innocent because he most likely is. But An actual verdict of guilt of child abuse upon the accused man by a jury of 15 of his country persons IS guilt of child abuse in a democracy therefore when it comes him being innocence most likely he is NOT. What the state needs to guard against then is a failure in duty of a public official to investigate a complaint when requested to do so by the alleged victim or an attempt at suppression of a victims complaint or taking any side in regards the accused or accuser without evidence but merely on corruption, prejudice or assumption if this should happen the public official should both loose there job and be imprisoned for a mandatory 30 years imprisonment because there actions could either lead to an alleged victim loosing justice an a child rapist able to harm again or an innocent person being locked up for 75 years. Procurator Fiscals of yesteryear were made of much sterner stuff Scottish Government and did not have the luxury of inferring guilty into a no comment reading more so into circumstantial evidence or even take recourse to double jeopardy either back in the day a procurator fiscal had to actually think and do there job upon objective evidence and were a respected civil servant for it. The answer is not to make the standard of proof lower or less watertight in order to just satisfy a conviction quote but to equip and train Prosecutor Fiscals to be better and more skilled. Justice should be the objective hear not enforcing government policy. Inferring guilt upon a "No comment" should be abolished. Protections against double jeopardy reinstated and while an accused may have thereCadder rights the prosecution should be given more government funding to invest in more forensic services to gather more objective evidence, to concentrate on securing collaborative evidence and mounting intelligence for the prosecution of there cases.	
64SD-9	[Our organisation] welcome the high level summary of the clinical pathway which retains the Interagency Referral Discussion as the core response expected by statutory agencies of disclosure of sexual abuse by a child or young person.	Noted.

64SP-N	We support the aims of the pathway in that it sets out how the health service is to respond to allegations of sexual abuse. This transparency helps everyone to understand the process. The requirement that the "examination meets the forensic standards required to support any future criminal justice process" is paramount. This needs to consider the issue of future proofing – preserving such evidence for future and not currently envisaged purposes, while respecting the principles of data protection and privacy. We note that the Scottish Biometrics Commissioner Bill was introduced on 31 May 2019. Account may need to be taken of its provisions in preparing the pathway	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation
64S1-P	[Our organisation] welcomes a reframing of the aims to ensure they reflect a truly child-centred approach. [Our organisation] welcomes aims which focus on rights, wishes, and needs of the child or young person. To achieve this [our organisation] asks for a reframing of the aims which includes a reference to listening to the child or young person, taking into account their wishes and ensuring their understanding. This reflects both the UNCRC Articles 12 and 13. As Scotland approaches the incorporation of the UNCRC into Scottish legislation, it will be critical that these pathways are reflective of this legislative and cultural change. In achieving this, [we] welcome particular consideration being given to ensuring children and young people with learning disabilities who may experience challenges in communication, are given the opportunity to have their views heard (please refer to UNCRC;1989, Article 23). [Our organisation] therefore asks that the following statements are included in the aims of the clinical pathway: • Listen to and take account of the wishes of the child and young person (unless these wishes place a child at risk of harm) • Ensure children and young people who face challenges in communication are given space, time and opportunity to make their views known • Ensure, where appropriate, children and young people understand the process of disclosure and forensic medical examination as well as the results and implications of their	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. The Pathway now has more information and context on trauma informed care and adverse childhood experiences.

	decisions. [Our organisation] also welcomes consideration being given to ensuring children and young people experience an age-appropriate service and a clear reference to a trauma-informed approach to therapeutic support. [Our organisation] welcomes clearer guidance on what this approach means in practice. This should be expanded on in sections 4.3 in relation to trauma-informed services	
64S4-S	What is the purpose and the audience? For a clinical pathway, is this about a clinical process. Is this for people who already have experience in this area of work? Consider the level this should be pitched at, and this will depend on what you include. Needs an additional paragraph: who is this for (e.g. consultants), and who is this applicable to	The Pathway is intended to assist practitioners by describing best practice in line with current relevant legislation and guidance with all the relevant information in one document.
64S3-R	The intention is good, and the pathway is intended to underpin wider processes. Child-centred as a whole, but depends on implementation. Ensure that the pathway highlights the pace, place and persons involved. Consider mirroring the new integrated child protection guidance, and highlight the shared principles and headline interagency principles. The aims overall fit with the new guidance.	The Pathway now includes an Annex with roles and responsibilities. The Pathway is aligned with current National Child Protection Guidance and has flexibility to take account of local multi-agency IRD procedures. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation
64M5-M	Section 3 is very helpful in clearly articulating the wider remit of health when caring for children who have experienced sexual abuse and their families, including the collaborative nature of the response, the promotion of therapeutic recovery and timely access to emotional, mental and social support. We would greatly welcome a clearer statement around the aim of the pathway as strengthening and improving the holistic health response to all children and young people following sexual abuse, to support the delivery of the HIS standards in Scotland. We also consider it imperative for	The introductory paragraph on the aims of the Pathway has been revised along these lines. The Pathway now has more information and context on trauma informed care and adverse childhood experiences.

	the pathway to articulate more clearly how it relates to the HIS Standards. Our understanding is that the pathway is a tool to support services and practitioner's to better realise the HIS standards in relation to all children and young people. In this vein, it may be helpful to reference the HIS standards in relation to specific aims. For example, HIS Standard 2 requires each NHS board to ensure that people who have experienced rape, sexual assault or child sexual abuse receive person-centred and trauma-informed care and recognises that such care is dependent on people and services working collaboratively and in genuine partnership. 2.8 of the Standard requires that support is provided to enable people to access immediate and follow-up healthcare; trauma care, including evidence-based psychological therapies; mental health services, including safety planning; sexual health services, support services, and independent advocacy. (HIS Standards, pg. 15). The pathway should illustrate the steps needed to achieve this. Bullet point 3 on the provision of appropriate and timely access to care and support should specifically reference support for both the victimised child and the family/ non-abusing carer. The response of the non-abusing carer following disclosure of child abuse and their ability to cope and respond supportively to their child, is a critical factor in the child's recovery; the importance of supporting non-abusing carers in the treatment of children who have experienced sexual abuse has long since been recognised . Facilitating access to recovery support for both child and non-abusing carer/ family, must be a central aim of the health response to CSA.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). Reference to the HIS Standards is made throughout the pathway (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards).
64MV-N	Yes, in particular the recognition that the pathway needs to be focussed on the reduction of further harm, and the promotion of recovery of the child and family. This includes recognition of the need for a wide variety of support, including trauma-informed therapeutic support.	Noted.

Do you agree with the layout and content of the pathway process?

Yes	**25**	**43.86%**
No	**18**	**31.58%**
Not Answered	**14**	**24.56%**

Comments

64HR-C	More useful details could be included to strengthen how the Clinical Pathway covers the aspects of wellbeing and recovery	More information is now included in the Pathway.
64ME-4	As per above, the content needs to be more in line with what current research points to: the urgent need to establish a system that truly addresses the needs of the child and more comprehensive detailed training in all areas of Child Protection	Noted. The Pathway supports practitioners while training is the responsibility of employers.
64MW-P	The committee agrees with all the described aims but would recommend an additional aim of: Ensure that all victims of abuse are provided with the minimum standard of care outlined in this pathway.	The comment has been noted and Pathway has been revised to include the aim.
6417-T	The pathway process could perhaps be extended to show medical and on-going support/therapeutic interventions. This would align with the 'holistic manner' described at 6 - Medical Examination. At 5.3 - JII - would be helpful to see the importance of the physical surroundings of formal interviews and the need for consistent, sensitive interview approaches whilst gathering evidence being covered.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). Further information on JII's is available in the revised National Child Protection Guidance which is currently out for public consultation
641N-H	While the pathway processes are clear, there seems to be an absence of support for a child (and non-abusing family) as they go through each stage. It is essential that the relevant bodies effectively collaborate with third	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have

	sector organisations who may provide specialist support for children and families. In terms of aiding recovery, this additional support is crucial.	experienced child sexual abuse and non-abusing parent/carer(s).
641Z-W	It should include support that can be offered by the third sector throughout the process	The third sector is now specifically included in the opening paragraph of the Pathway. We have not included detail in the Pathway of services offered as these vary by region and over time.
641K-E	The Inter-agency referral discussion (IRD) notes advise that this is a discussion between police, social work and health but there is no reference to the inclusion of education colleagues. Although we understand that in relation to criminality and the gathering of forensic information is not the responsibility of education acknowledgement of their role is necessary. The notes also indicates that the paediatrician who is involved in the planning discussion should take the medical assessment forward. However the consultation group's experience was that paediatricians are rarely involved at the initial planning stage. The health representatives are usually a school health nurse, health visitor or nurse advisor for child protection. The discussion with a paediatrician usually occurs following the IRD and is a separate discussion between them and usually (but not exclusively) a police officer. Therefore clarity is required about the expectations of health regarding who is best placed to attend such IRD's and should this be an individual who is able to make a decision regarding the need for a forensic medical?	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance in discussing IRDs, which is currently out for public consultation.
6412-N	The flowchart is a useful tool but having to refer to other sections makes it less useful as an immediate clinical tool.	Noted.
6416-S	As above more reference to the multi-agency nature of child protection intervention would be appropriate with specific reference to social work, education and third sector services included.	This point is now emphasised in the opening paragraph of the Pathway.

64SX-W	ss 5.2 - an IRD should include consideration of 'immediate safety of child and any other children living in the house' Are the last 3 words in this sentence necessary. From a contextual safeguarding perspective, shouldn't the IRD consider immediate safety of children at school and in community as well as living in the house? This is particularly relevant with respect to safeguarding concerns about adolescents.	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance in discussing IRDs, which is currently out for public consultation.
64SM-J	Yes: Useful resources for further training / CPD for clinicians given	Noted.
64SV-U	Although we believe it could be more "user friendly".	Noted.
64SR-Q	Page 14 - Just a small point that the diagram is probably slightly misleading. The decisions from IRD fall into three categories, 1. Joint Investigation; 2. Single Agency Response 3. Feedback to the Named Person (for consideration of progression of wellbeing/child's plan etc) Under Joint Investigation it should be clear that the Joint Investigative interview, Child protection processes and criminal investigation (as opposed to Police Investigation) falls to BOTH police and SW as opposed to how the diagram tends to show responsibility for individual agencies (Police and SW). Whilst within a Joint Investigation Police and SW will take responsibility for different parts of it, this is absolutely a joint process. Health's requirement to conduct a JPFE or Therapeutic/Specialist Medical (various names across the country) also falls under a Joint Investigation Under Single Agency Response - this would separate out a Police Investigation from those actions that SW, Health, Education (and any other relevant agency) may be tasked with conducting from the IRD. Page 15 - 5.1 - use of the word "historic" and "historical" - these are not words that we tend use within sexual abuse investigations and probably would prefer "non-recent". 5.2 "The IRD is an interagency discussion including police, social work and health that occurs within the 24 hours after initial disclosure being received by any agency…" Suggested re-wording… "The IRD is an interagency discussion including (but not limited to) Police, Social Work and	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance in discussing IRDs, which is currently out for public consultation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.

	Health when it has been suspected that a child or young person has suffered, is suffering or maybe at risk of harm or abuse" Think these just highlights that an IRD is not dependent upon a disclosure from a child - it can be raised where a third party identifies significant risk of harm (whether actual or probable). Under all three headline decisions from IRD then a request for Health to undertake an examination of the child could be an option and maybe it would be helpful to make this clear? Section 5.4 The guidance is being updated but may not be ready for publication of the pathway so again a 'live' version will need updating as and when. Page 16 - There is a sentence in the first paragraph that reads… "The IRD aims to share information and identify the risks to the child (and other children in the household) so that immediate safeguarding measures can be taken" this should probably read… "The IRD aims to share information and identify the risks to the child/young person (and any other child/young person deemed to be relevant and connected to the concern) so that immediate safeguarding measures can be taken" I'm just conscious that if we are as prescriptive as children in the household, it might confuse professionals about information sharing??	
64SE-A	The pathway process detailed in the flow chart, is in the main accurate, however, it does not include Social Work as being part of the Joint Investigative Interview (JII) process. A JII is conducted by Police and Social Work and should not be conducted as a single agency response, albeit one agency may be the lead. It would be helpful if this could be reflected on the flow chart. Inter-agency Referral Discussions are pivotal to the full process of the pathway. It is essential that the core agencies of Police, Social Work and Health consider the importance of also including education, if appropriate during IRD process as information from each agencies supports long-term and short-term decisions made in respect of a child or young person. It is vital that the IRD process is the platform to avoid single agency decision-making as this does not promote a collective response and does not always result in the best outcomes for a child or young person. Police Scotland's approach to the IRD process has been	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance in discussing IRDs, which is currently out for public consultation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.

	standardised to achieve consistency in our policing roles and responsibilities to child protection. By committing to a national protocol to IRDs we hope to enhance local partnership working.	
64SY-X	Yes: Useful resources for further training / CPD for clinicians given	Noted.
64SB-7	Whilst it is sometimes useful to use diagrams/flowcharts to represent complex systems and processes, in this case the process diagram fails to capture important aspects of the multiagency response to child sexual abuse. For instance, rather than a disclosure simply triggering an interagency referral discussion, importantly it should trigger support to the child and their family, in line with the Barnahus approach. Additionally, the sense of multiagency working is limited, where what is required is an emphasis on the way in which practitioners will work together to ensure children's needs are planned for and met. Similar to other sections, the purpose of this section of the Clinical Pathway document is somewhat confusing, again giving some limited introductory information on topics such as Joint Investigative Interviewing and Interagency Referral Discussions, without constituting usable guidance. If the purpose is to place the medical examination in context, this could be better achieved with greater emphasis on matters such as interagency collaboration and support to children and their families. Therapeutic support helps rebuild children's lives by helping them to understand and move on from difficult experiences. The response of non-abusing parents and carers is critical to children's recovery, and this must be reflected in the planning and provision of support from multiagency partners. (10) In relation to the detail of the stages outlined in the diagram, it is concerning that the 'Management of Healthcare Needs' stage receives limited attention. This is an important and complex stage of the process, where multiagency plans to meet assessed need should be made and implemented, in line with the Girfec approach. The reader is referred to Section 6 for more information on 'follow up' from the medical examination, however the content of section 6 which relates to 'follow up' is very limited,	The sections on IRD, JII and support for Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s) has been updated. The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance in discussing IRDs, which is currently out for public consultation. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.

	focuses on processes, and fails to reflect any sense of the trauma-informed, child-centred approach the Clinical Pathway sets out to aim for. Section 5.2 refers to Interagency Referral Discussions (IRD). Whilst the document sets out an overview of the IRD process, it is important to note that there is significant variance in IRD practice across Scotland. The current National Guidance for Child Protection in Scotland (2014) does not contain guidance on IRDs, however this will be encompassed in the reviewed guidance, to be published in 2020. (10) Galloway, S., Love, R. & Wales, A (2017) The Right to Recover: Therapeutic services for children & young people following sexual abuse - An overview of provision in the West of Scotland. NSPCC Section 4: Medical Examination 1 Do you agree with the medical exami	
64SZ-Y	The layout is accessible, albeit much of the key information needed is in the attached links. Re content see below for specific comments: Page 2. Paragraph 8. Throughout the document the term child sexual abuse is used. This should be changed. p.8 you reference stats from England around prevalence and say "The Crime Survey for England & Wales (2016) reported that 10.5% of women and 2.6% of men had experienced any form of abuse; 3.4% of women and 0.6% of men had experience of penetrative offences." When you reference 'abuse' do you mean all kinds of abuse eg emotional and physical abuse or is this shorthand for sexual abuse? Important to be clear. On page 8 the paper also references the increase in reports of sexual crime reporting by young people and state "There is an increasing trend of police recordings over the past 5 years, but the reasons for that trend cannot be identified with certainty." Whilst this is true I think 2 issues are important to include here. Firstly (which is mentioned elsewhere) that the vast majority of reports are historic and outside the forensic window, and that even where forensics or child protection are not concerns that there should still be an onus to consider the wider and longer term mental and physical health needs of the person disclosing. It is also important to include the number of young people where cyber enabled sexual crime is an issue – the threatening and/or sharing of intimate	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People who have experienced child sexual abuse and their non-abusing parent/carer(s). The language in the Pathway is aligned with the draft revised National Child Protection Guidance. It now includes cyber enabled abuse. The Pathway now has further information on how the GIRFEC approach can be used to support Children and Young People who have experienced child sexual abuse. The Pathway is to be considered an interim pathway and will be subject to review to take

	images. This is often minimised and young people blamed but image based abuse can have significant impacts on the wellbeing of the young person as evidenced in this new research https://www.dur.ac.uk/resources/law/ShatteringLivesandMythsFINALJuly2019.pdf For this reason the legislation for this should be included in the document about legal content. On page 9 you use the term 'allegedly' here: " Cases are counted in the year that the case was concluded rather than when the crime was (allegedly) committed. " I would suggest this term should not be used anywhere as it implies dubiety of the veracity of the disclosures, which is not the role of health. Not being believed is one of the biggest barriers to disclosure and modelling the best practice in language we can for all health professionals is what this document should aspire to. Police Scotland have moved away from this terminology and instead talk of the far more neutral 'reports. You could say something else like: Cases are counted in the year that the case was concluded rather than when the crime was reported to have taken place. On page 12 you reference the NHE Education Opening Doors trauma informed practice resource. It would be worth including the Sowing the Seeds one which is about trauma informed practice with children & young people https://vimeo.com/334642616 On page 13 you talk about checking whether under age sexual activity is truly consensual and " to ascertain if this activity is truly consensual and ensure the child is not a victim of exploitation or grooming." It would be helpful if coercion could be added in there. Again I think that the adolescent experience might be missed as grooming and exploitation implies more of an age/power dynamic than some of the more subtle coercive behaviour which could be missed in a more peer to peer abusive situation. On page 14 Do all disclosures need an IRD? What about a 15 year old who was raped on holiday, who has a supportive family, and who doesn't want to report to the Police. What role would social work and the Police have? It would be appropriate to consider support needs by the health care professional eg Look at sexual health and/or referral to rape crisis, but what actions would statutory services take? Whilst this is high level and would apply to many cases if this is too black and white it risks	account of any changes to relevant guidance or legislation. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

	services providing support to young people having no confidentiality and having to disregard the young person's choice, for the 13-15 age group, when specialist agencies will be risk assessing and reviewing child protection and risk constantly. Compared with the much more holistic and collaborative adult pathway this seems like a poor sister. The term "Management of health care needs" for example, unlike the assessment and referral protocols and pathways around psycho social physical and mental health care needs for adults. On Page 15 again the term allegation is used in paragraph 4 which is unhelpful and has a hint of disbelief, which would be picked up by survivors & family members if used by professionals. This would be better replaced with the neutral term disclosure in this context. On page 15 the list re presentingsymptoms, the last one is not the same format, eg a perpetrator of abuse. Page 15 When referring to child protection the paper highlights assessing: " Immediate safety of child and any other children living within the house." I would suggest removing 'in the house' and say 'who may be at risk'. The existing phrasing limits the risk and setting to the family home and the risks may be outwith that, eg in the wider family, care setting, a school etc. Page 16. Paragraph 2, also names the household : "The IRD aims to share information and identify the risks to the child (and other children in the household) so that immediate safeguarding measures can be taken." Again I would suggest that 'in the household' is removed so that this is considered beyond a single family setting. Page 17. As highlighted earlier re the Child's Plan you state "The Child's Plan (GIRFEC) may include access to ongoing therapeutic support for the child and their family members / carers post examination, but also in the months and years following disclosure of Child Sexual Abuse (CSA)." This is one of the key areas for improvement in the current system. This should be much more of a feature. There is reference to work in the taskforce considering this but the intention should be clear. I would suggest this should be changed to something along the lines of: "The Child's Plan (GIRFEC) SHOULD ALWAYS CONSIDER THE NEED FOR access to ongoing therapeutic support for the child and their family members / carers	

	post examination, but also in the months and years following disclosure of Child Sexual Abuse (CSA)." This cannot be overstated.	
64SH-D	As noted in Section 1, Question 1, we believe that coordinating pathways should be developed for children and young people who have disclosed ongoing abuse; children and young people who have disclosed non-recent or non-current abuse; and children and young people where sexual abuse is suspected. We also believe that the pathway should apply to all children and young people under 18. If it is the case that the guidance remains for those under 16 (or up to 18 for young people with vulnerabilities and additional support needs), it is essential that the guidance signposts to support for 16/17 year olds. Simply treating young people who have been through this experience as adult abuse victims is not sufficient. The pathway would be strengthened by focussing more on support for the child/young person. At present, support for the child is not included until the very end of the pathway at Section 5.5, but we believe that it should be a consideration from the outset. One important element of this is that the pathway must include a step between disclosure and IRD where the medical practitioner considers whether or not the child/young person is currently safe (for example whether they are leaving the appointment with the perpetrator), and if not, supports the practitioner to know how to take steps to help to secure the child/young person's welfare. In order to ensure that medical staff are equipped to provide support, additional guidance on how to respond to a disclosure (expanding on the useful 'listen and believe' message) could be included in this document. It should also further detail (prior to IRD) who professionals should contact in the first instance, how arrangements for an IRD are made, and any relevant timescales for doing so. It would also be useful for the pathway to include consideration of what role the medical practitioner is able to play in providing ongoing support to the child or young person. If the child or young person has chosen to disclose to a medical professional, this could be because they feel they can trust them, or feel a connection with them, so in some cases an ongoing supportive relationship could be extremely beneficial. While this is more	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

	likely to be appropriate/possible in some contexts than others (for example, school nurses), all medical professional should be encouraged to consider a follow-up appointment. As noted in Section 1 above, we believe that the pathway could be strengthened by considering how children and young people can be more involved in the process. The language and processes in Section 5.2 could be revised to assist with this. For example, seeking the child/young person's views on, and consent to, a medical examination should come before decisions about the type or location of the examination. We welcome mention in the pathway of support for those around the child, and would be pleased to see this section expanded and strengthened with the outcomes of the work being taken forward by the Taskforce. Making support available to non-abusive carers and family members to better respond to their child's needs was found to be a key component of a child's recovery by the NSPCC's 'Right to Recover' work in 2017 (https://learning.nspcc.org.uk/research-resources/2017/right-to-recover-sexual-abuse-west-scotland/) Barnardo's colleagues in England recently conducted research into the needs of young victims and witnesses involved in criminal justice processes relating to CSA and the practical and operational considerations of undertaking this kind of work within a multi-agency environment. Five elements were identified as being central to helping children and young people to cope with the emotional stress and turmoil they can experience, and help set them on a pathway to recovery. These were: sense of self and control; relationships and support networks; emotional and physical health; practical support; and safety and safeguarding. This may be a useful framework from which to promote a holistic, child-centred response from medical practitioners. (https://www.barnardos.org.uk/journey_to_justice_summary_paper.pdf)	
64ST-S	Too simplistic and does not reflect the nature of sexual abuse - most cases will not fit into a nice simple flowchart and this should be acknowledged.	Noted.

64SU-T	For many reasons the primary being proscription of abortifacients that would be used to abuse another child in the womb by killing them. Two wrongs don't make a right. One can not stop abuse towards a child by killing another child in that case you are only left with one dead baby and a dead mothers soul. There are also other inherent dangers hear for both a real victim and a real falsely accused person concerning the planned system to be perfectly honest and I don't think the Government in those cases would honestly care as long as there safe and there public policy looks as if its working.	Noted.
64SD-9	[Our organisation] welcome the high level summary of the clinical pathway which retains the Interagency Referral Discussion as the core response expected by statutory agencies of disclosure of sexual abuse by a child or young person. [Our organisation] notes the on going work of the Chief Medical Officer Taskforce and the intention to legislate for self referral. Although it is expected that any legislation will take account of the need to manage any disclosure by a child or young person as a potential child protection concern, for the avoidance of doubt the pathway should include guidance for practitioners is circumstances where a child or young person attempt to self referral.	Members of the CYPEG worked collaboratively with the child protection Managed Clinical Networks and third sector parties to develop a short, accessible leaflet specifically aimed at young people who may undergo an examination. It sets out what young people can expect both during and following the process as well as providing sources of support. In addition to the leaflet for young people we are producing an Easy Read version of the forensic medical examination process. We will review the use of this product and the leaflet for young people when undertaking any future revisions and will consider further accessibility requirements at that point.
65SQ-P	There are significant inaccuracies in section 5, both in the illustrated flowchart and subsequent text. The diagram: • The flowchart diagram is both inaccurate and confusing. • Joint investigative interviews are a joint social work and police activity and the diagram should reflect this. • Child protection processes involve all agencies and not solely social work as	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation.

	indicated in the diagram • We suggest that placing the box 'Inter-agency child protection procedures' at bottom of the diagram is misleading as these procedures govern the whole process and not just the end point. It may be more helpful to say 'multi-agency support to protect the child and promote their wellbeing' as this would capture the GIRFEC approach whatever the outcome of the child protection enquiry	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64SQ-P	Para 5.1: • There is no mention of young people aged 16 and 17 years and the response required for those in this age group • There is no mention in the bullet points or text of child sexual exploitation, how this may present, and the multi-agency response required • Bullet point 3 – it may be helpful to include episodes of running away or going missing as a key behaviour likely to raise concerns about a child or young person Para 5.2: • While the guidance sets out the areas for consideration by those taking part in an initial referral discussion (IRD), the purpose of the IRD i.e. to ensure co-ordinated inter-agency child protection processes up until the point of child protection case conference (CPCC) is held or until a decision is made that a CPCC is not required, is not clear. The areas for consideration refer up to the point of investigation/examination rather than beyond this, such as the health contribution to the initial risk plan. • It may be more helpful to state that an IRD should take place as soon as possible after disclosure and in accordance with local child protection procedures than to specify a timescale. Para 5.3: • The description given of the joint investigative interview does not sufficiently reflect this activity. It may be more helpful to use the definition set out in national guidance ie "the purpose of joint investigations is to establish the facts regarding a potential crime or offence against a child, and to gather and share information to inform the assessment of risk and need for that child" (National Guidance for Child Protection in Scotland, 2014, p.89). • We suggest removing the heading	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation. CSE is now mentioned within the Pathway. The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, which is currently out for public consultation.

	'Police investigation' as the feedback to the IRD is a joint activity and not police only	
64S1-P	In Franklin et al's research regarding sexual exploitation children and young people with learning disabilities, the authors were able to identify significant barriers which stopped children and young people disclosing sexual exploitation. The children the authors spoke to recounted: • Not feeling able to tell their social worker because of a lack of trust • Having difficulties understanding the questions being asked of them • Not understanding they are or were being abused • Not having reports of abuse believed. The authors stated that when disclosure did occur it usually only happened after a long time when a positive and trusting relationship was built with a professional. The same research raised concerns regarding a lack of professionals enquiring about the sexual exploitation of the children and young people they support. The authors stated, "The evidence gathered in this study also indicates that adults, including professionals, are not proactively identifying potential signs of exploitation, thus placing an incredible burden on young people with learning disabilities to disclose they have been sexually exploited, and therefore to have an understanding of and recognise, their own sexual exploitation". (Franklin et al; 2015, p.132) In considering this, [our organisation] welcomes part 5.1 'Disclosure by a child/ young person', giving in-depth attention to some of the barriers children and young people may face in disclosing sexual exploitation and abuse. The guidance should then make reference to a number of approaches and tools which may help a person to disclose. This could include the routine inquiry form produced by CKUK and Central Sexual Health. You can view this resource here. This form provides a tool to help professionals to ask people with learning disabilities about things like relationships, sex and also abuse. This form is being used as part of NHS Health Scotland's Guidance about learning disabilities and gender-based violence. In addition, visual tools to prompt conversations on different types of abuse may be helpful. For example, the 'blob image on abuse' which can be accessed here. To support this type of discussion with individuals who	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.

	may communicate non-verbally, [our organisation] requests the use of Talking Mats Keeping Safe Resource. Information about this can be found here. In terms of helping practitioners to understand if they may need to have a conversation with a child or young person regarding sexual abuse or child sexual exploitation, the following 'Child Sexual Exploitation – Potential Indicators' Tool used in South Ayrshire may be a helpful resource. This can be accessed here. [Our organisation] welcomes the use of all aforementioned tools as part of the pathway and should be provided to professionals and practitioners alongside the document (please refer to Recommendation 5). [Our organisation] would welcome the opportunity to develop this training if required. While [our organisation] welcomes the role of the types of aforementioned tools to support children and young people with learning disabilities to disclose sexual abuse, [we] believes there is also a wider issue regarding the appropriate provision of Relationship, Sexual Health and Parenting Education for children and young people with learning disabilities, which requires further attention outside the remit of this response. Following a disclosure of abuse, [we] believes that it is critical that the pathway ensures professionals recognise the importance of children and young people understanding all there options regarding medical examinations and prosecution of offenders. To achieve this all information will need to be developed in a variety of formats including easy-read	
64S1-P	Ensuring children and young people understand their choices and options For all children and young people with learning disabilities, there is a potential power imbalance in dealing with adult professionals. In 'UnderprotectedOverprotected' (2015) the author's stated that, "The evidence highlights that protecting children and young people must start with the basics of listening to them and providing early support to prevent exploitation." (Franklin et al; 2015, p.135) However, potential power imbalances between professionals and children and young people with learning disabilities may lead to children and young people's voices being lost. There is also a risk that the way information is framed when given to	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when

	people with learning disabilities, may limit their choice and control in decision making. In [our] earlier response to the Scottish Government [we] stated that due to perceptions of vulnerability of people with learning disabilities, well-meaning professional's shielded critical information from people with learning disabilities. This response stated: "Shielding people with learning disabilities from information deemed 'unsuitable' denies them the opportunity to make informed decisions. Without the provision of accessible information which is articulated and understood, it is difficult to ensure a person has come to their decision based on an understanding of the outcome. Even when a professional is not actively withholding information individual challenges can occur as a result of unclear and non-explicit communication." To counter this, [our organisation] asks that the guidance provides suggestions for the provision of accessible information in a range of formats. Moreover, the guidance should outline the role of advocacy for children and young people with learning disabilities	appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64S1-P	[Our organisation] believes there is a need for the clinical pathway to ensure that accessible information about what happens when you disclose abuse, as well as your choices following disclosure, is provided in appropriate health care settings. [Our organisation] recommends that, as a starting point, easy read documents outlining both the disclosure process and options following disclosure should be created. An additional easy read document about what happens during a forensic medical examination should also be provided. As an example, [our organisation] points to a four-part easy read guide published by Learning Disability Wales for parents with learning disabilities. See below: • Your rights when you are pregnant • Your rights when your baby is born • Your rights with social services • Your rights when your child is taken away [our organisation] recommends that as part of the development of the clinical pathway the Scottish Government works with NHS Health Scotland and third sector	The Taskforce is working with the child protection Managed Clinical Networks to develop guidance specifically aimed at young people who may undergo an examination.

	partners (for example Values into Action Scotland) to produce similar documents. These documents should outline children and young people's rights when they disclose and their rights in regard to forensic medical examinations. These guides can be used with all children and young people and should be widely available. For children and young people who face challenges in literacy, supporting videos should be made. These videos should include BSL and Makaton. Brail versions of the easy read should also be widely available	
64S1-P	[Our organisation] believes there is an important role for advocacy services in supporting children and young people with learning disabilities who have experienced rape and sexual assault. Following disclosure, [our organisation] believes the first stage should be an offer of timely advocacy provision. The role of the advocate should be to ensure the child or young person fully understands their circumstances and the outcomes of any of their decisions. This could counter the potential amenability of children and young people with learning disabilities, who at times are taught compliance as good behaviour (Wescott; 1991) [Our organisation], therefore, requests the provision of independent child and young people's advocacy to ensure children and young people are supported to make their voices heard. In line with [our] earlier response to the Scottish Government, [our organisation] believes this will support commitments to the UNCRPD and The Mental Health (Care and Treatment) (Scotland) Act (2003) . As [we] stated, "Ensuring advocacy provision as part of this process for people with learning disabilities will meet a commitment to Article 12 of the UNCRPD as well as The Mental Health (Care and Treatment) Act (2003) which provides a legal right to advocacy for people with learning disabilities and places a responsibility on local authorities and health boards to take 'reasonable steps' to ensure individuals are informed about advocacy services, their remit and how to access these services" (SCLD; 2019, p.13) Moreover, [our organisation] believes that a commitment to provide advocacy to children and young people will also support the realisation of Article 12 of the UNCRC which says that, "States Parties shall assure to the child who is	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that

	capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" (UNCRC; 1992, p.5) In understanding The Scottish Government's commitment to embed the UNCRC principles into Scottish legislation and policy and the ongoing work in this area, SCLD would ask that provision of advocacy for children and young people who have experienced rape and sexual assault be included in this guidance. This can be supported with links to advocacy organisations who could provide this service.	although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64SK-G	P14 The pathway in green box states 'management of healthcare needs' but the rest of the document and supporting information talks about health and wellbeing needs--needs to be consistent as there are subtle differences..page 18 states the purpose of the medical examination is about health and wellbeing needs so green box should mirror this	Now revised.
64S3-R	The diagram reflects the IRD process. Interviews between police and social work are always joint, and need to check this is reflected in the diagram. The diagram implies that the child protection procedures don't apply until further down the pathway, after the IRD. Child protection procedures usually apply from the moment a concern is raised.	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, in discussing IRDs. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64S4-S	Need a brief summary about why each document that is hyperlinked is relevant for each section. Although it is a short document, people may feel they'd missed out if they don't read all associated documents, and get caught up in clicking through additional documents.	The Pathway is intended to supplement existing national guidance and standards, highlighted in section 1. Hyperlinks are provided throughout the

		pathways for all resources referenced or referred to in the document.
64S4-S	Illustrations are very useful. Need to make the support and onward forward support section clear within the trauma-informed model. Narrow focus, as there is not enough focus on family support	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64S4-S	No real involvement of CAMHS in the flow-chart, when they are an important agency.	Noted. Mental health is now mentioned rather than CAMHS which may not be the necessary service in every case.
64S4-S	In our research, consultants rarely attended case conferences. May get a health visitor or a school nurse, once or twice a GP, but the initial decision-making is not usually benefiting from the discussion involving health.	Noted.
64S4-S	At the moment, it looks so siloed---police have one role, social work another, health another etc. This does not reflect where we are going and how this shared responsibility works in practice. A web of support around the child should be reflected, rather than a linear process.	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, in discussing IRDs. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64S4-S	IRD process as it is detailed is not often how it happens and doesn't give an accurate representation. Lothian has a flow-chat which puts the IRD in the centre in a way this is more accurate	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, in discussing IRDs.

		The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64MW-P	One minor point, would be to lengthen the line to the Health box to visually show that this involvement will come both at the IRD and then after an initial Police and Social Work investigation	The diagram has now been revised and has a different layout.
64MV-N	The diagram on page 14 of the document, despite the aim of the pathway being (as stated on page 10) promotion of recovery of the child and family, makes no mention of recovery or therapeutic support for the child or family. The end point of the pathway is child protection, not the ongoing recovery of child and family. If the aim of the pathway is reduction of further harm, and the promotion of recovery of the child and family (as stated earlier in the document) this need to be central to the diagram on page 14. [We] believe that recovery should start at the point of disclosure, so this should be a central feature of the diagram. The third paragraph of section 4.5 draws a distinction between consensual and non-consensual sexual activity. However, it would be important to clarify in this paragraph that, as previously highlighted, the National Child Protection Guidance states that "Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented", so even where a child claims to have consented to sexual activity an offense has taken place and child sexual abuse has occurred	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance.

64MV-N	As previously stated [we] ultimately believe that ensuring children and young people who disclose any form or abuse or harm get a holistic, multi-agency and trauma informed approach is best achieved through the development of the Barnahus standards for Scotland, and this pathway needs to be considered within Barnahus processes and context.	The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context.

Section 4: Medical Examination

ID.	Consultation comment	Clinical pathways subgroup response

Do you agree with the medical examination section of the pathway?

Yes	**30**	**52.63%**
No	**11**	**19.30%**
Not Answered	**16**	**28.07%**

Comments

ID.	Consultation comment	Clinical pathways subgroup response
641V-S	The delivery of planned medical examinations (>7 days since reported event) form the bulk of assessments in pre-pubertal children. These can be undertaken inlocal facilities close to the child's home by appropriately trained paediatricians and forensic medical examiners Acute medical assessment (<7days since reported event) are fewer in number and more commonly affect older CYP, most typically over the age of 12 years. Forseveral years we have had a well functioning system for these individuals to travel to GGC facilities in Archway or the Children's Hospital. This provides theappropriate balance of clinical expertise and access to services in line with other highly specialist services for CYP that are centrally delivered. Young childrenoccasionally have acute anogenital injuries that require surgical intervention and treatment at the Royal Hospital for Children. Paediatriciansexaminining children following acute sexual assualt require to assess a number of children to maintain competence in the field and to be able todeliver medical opinion in court. This expertise necessarily can only be provided by a small number of individuals with sufficient expertise. It is not possible to	These are important points more appropriate for Boards and the Regional Planning Groups when planning services and the associated staffing and training needs.

ID.	Consultation comment	Clinical pathways subgroup response
	deliver this level of expertise when larger numbers of individuals require to maintain competence e.g. where a service is provided from a number of DGHs ratherthan 1 regional location.	
641N-H	It is essential that mental and emotional support are adequately built in to this section of the pathway and that steps are taken to ensure that all individuals fully understand the process.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
6418-U	This section does not define a comprehensive medical assessment or indicate in what circumstances this may required or undertaken instead of a forensic medical assessment. This section should also include if/when a comprehensive medical should take place for non-acute cases, particularly since many disclosures of sexual abuse are of an historical nature.	The comment has been noted and the pathway has been revised to include information on comprehensive medical examination.
641K-E	Children and young people who reside in the Perth & Kinross area are expected to travel to Dundee for any forensic medical procedure even where deemed non-acute. The pathway states that "Service locations for the medical examination should be flexible" however the experiences of the consultation group were that children are all expected to travel to Dundee. It could be argued that in Perth we have a suitable medical facility at PRI and that this could be used flexibly and the appropriate medical staff could travel to that location. This has been an area of tension at times where it would be in a child's best interests to be seen at a more familiar environment within easy commuting distance for them. The medical is a time of considerable anxiety for the victim and their family and a more localised environment would assist in removing some of this anxiety. The medical examination information also states that the clinicians should have "relevant experience for children and young people with complex conditions	These points are more appropriate for NHS Tayside when planning services and the associated staffing and training needs.

ID.	Consultation comment	Clinical pathways subgroup response
	or additional needs" Our consultation group enquired how much access the clinicians have to for example to interpreters and specially trained staff where communication is an additional need for that child or young person. Although this requirement will be in the minority of situations consideration needs to be explicit.	
6412-N	Please could you clarify what you mean by medical examination under forensic standards? Most dental practitioners do not have the paediatric/ forensic dentistry skills to take part in medical examination. If a dental assessment is deemed necessary as part of this, then this will be done by specialist colleagues. Dentists will be involved in this process mostly at the 'Management of Healthcare Needs' stage. Clinicians should be kept fully appraised of the patient's status and background, so that this can be used to tailor their dental care package.	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it is not necessary and may be unhelpful to duplicate material already available in this area.
6414-Q	Agree broadly but have the following comments: P6.1 Page 18 "written consent from an individual with parental rights". This does not reflect the fact that children and young people can give their own consent; (Age of Capacity (Scotland) Act plus recent case law) or may live with adults who do not have parental responsibilities. It is not appropriate to ask a parent who is an alleged perpetrator for consent or not to a medical examination of their children.	Noted. The approach to consent in the pathway has been expanded and clarified.
64SM-J	Regarding timing of medical examinations in historic cases; paragraph 2, section 6 medical examinations is in direct contradiction to paragraph 3b1 of the same section. The first says the examination must be done within 2 weeks, the second that timing must be done in the best interest of the child. Timing of the medical examination for historic abuse needs to be appropriate for the child, the two week standard in the HIS standards seems to be arbitrary and may result in a tick box culture of undertaking	The Pathway is intended to support implementation of the HIS standards by Boards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards). The two-week indicator was arrived at by clinical consensus. In rare cases where this is not clinically appropriate we

ID.	Consultation comment	Clinical pathways subgroup response
	examinations when the child is not ready. Why is this time period chosen? I agree there needs to be a responsive service which does not have long waiting times but interest of child paramount. In section 6.1 #10. Consider giving a brief written summary of findings and outcome as well as a clear list of contacts for follow up at the end of the examination". Does this mean to police and social work or to young person/family? This is not clear	anticipate that clinicians will act in the best interests of the child.
64SR-Q	The timing of the examination in section 6.1 - there is no reference to the agreed HIS Standards QIs for acute and non-acute examinations - just the following: Timing of the JPFE should be agreed as part of IRD process and would not usually place between 20:00 and 08:00 unless there are medical needs of the child which require immediate attention. For specific guidance on timings of examinations, please refer to the FFLM Guidance for the examination of children and the RCPCH "Purple book" (physical signs of child sexual abuse) (the website address is provided in the resources). Section 6.1 There should be reference to the updated version of the MCN Guidance on Consent	The Pathway is intended to support implementation of the HIS standards by Boards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards). The two-week indicator was arrived at by clinical consensus. In rare cases where this is not clinically appropriate we anticipate that clinicians will act in the best interests of the child. The approach to consent in the pathway has been expanded and clarified.
64SE-A	Police Scotland recognise during any disclosure of sexual abuse the medical examination to address the health and wellbeing of a child or young person is paramount and secondary to this is collation of forensic evidence. From a policing perspective, at this early stage it is important to establish if there are serious concerns in relation to the child or young person being examined or indeed any other children or young person who at that point may still be at risk from an abuser.	Noted.
64SY-X	Section 6, paragraph 2- timing of medical examinations in historic cases is in direct contradiction to paragraph 3b1 of the same section. The first says theexamination must be done within 2 weeks, the second that timing must be in the best interest of the child.	The Pathway is intended to support implementation of the HIS standards by Boards (Healthcare and forensic medical services for people who have experienced rape or sexual

ID.	Consultation comment	Clinical pathways subgroup response
	Timing of the medical examination for historic abuse needs to be appropriate for the child, the two week standard in the HIS standards seems to be arbitrary andmay result in a tick box culture of undertaking examinations when the child is not ready. Why is this time period chosen? There needs to be a responsive service which does not have long waiting times but the interests of the child is paramount. Section 6.1 #10. Consider giving a brief written summary of findings and outcome as well as a clear list of contacts for follow up at the end of the examination. Does this mean to police and social work or to young person/family? This is not clear	assault standards). The two-week indicator was arrived at by clinical consensus. In rare cases where this is not clinically appropriate we anticipate that clinicians will act in the best interests of the child.
64SN-K	Agree with well-being of the child being primary concern but forensic examination for evidence collection is something we need to continually challenge. Submissions have continually been made to Scottish Government to abolish corroboration in Scots law, a unique feature which requires two different and independent sources of evidence before conviction can occur. This is likely reflected in the tables indicating the rate of incidence vs rate of conviction/criminal proceedings. The process of examination itself can never be trauma negative.	Noted.
63SB-7	To some extent. Whilst this section comprehensively details the medical examination process, it does so in an entirely procedural manner, which fails to reflect the child-centred intentions expressed elsewhere in the document. Despite the opening paragraph of this section reflecting the primary purpose of the medical examination as identifying needs and planning to address the child's needs in a holistic manner, the stated secondary purpose of collecting forensic evidence for formal police and court proceedings appears to be the main focus. Clearer reflection of the Barnahus principles and approach could redress this imbalance.	Noted. The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context.

ID.	Consultation comment	Clinical pathways subgroup response
64SZ-Y	We agree with much of the content with the following comments: Page 18. Re medical examinations the paper states: "In cases of non-acute sexual abuse that is outside the forensic capture window, a medical examination will still be required for the child. How quickly a non-acute case needs to be seen may vary according to clinical need. It is envisaged that such cases would be seen for paediatric assessment within two weeks of a decision being made that such an assessment is required." The language here is a concern re the choice and control of the patient (the use of will rather than may). It assumes we are talking about a much younger child, and again links to the earlier point about the differences in children and adolescents who can make some decisions about their own healthcare needs and wishes. Trauma informed practice emphasises safety, trust, collaboration, choice and empowerment. If a 15 year old discloses to her GP that she was coerced into sex by her previous boyfriend this guidance reads like a medical examination will be required of her and she will have no choice. This is not what would happen in practice so we consider this needs some qualification in the main text. In this scenario the young woman does not need to engage with the Police if she chooses not to. Support & advocacy should be offered, as it would be for adults, to enable her to make an informed choice, but she and the pathway should be clear that this is her choice. Page 21, paragraph 9. The pathway states: "Follow up for other needs, for example referral to Children's Reporter or other agencies, should be arranged and documented." No mention is made of who these might be. Rape Crisis services across Scotland support young people aged 13+ with support and advocacy navigating the justice system, enabling them to make informed choices and supporting them and their families through what can be traumatic and confusing. Clinicians need clear information about 1) the need for support & advocacy and 2) where to access this locally. As the Right to Recovery Research highlights, in many areas these services do not exist, especially for children of primary school age and	The Pathway has been updated to note that not all cases of non-recent sexual abuse require an examination. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced Child sexual abuse and non-abusing parent/carer(s).

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	below, and their families. This gap needs to be addressed if we are to mitigate the impact of trauma in the longer term.	
64ST-S	Need to add somewhere in this section that the medical examination is optional (the young person has a right to refuse a medical examination) - the thought of a medical examination can put many young people off from disclosing sexual abuse or sexual assault. If report of sexual abuse is historic then a medical examination might not be required.	Noted. The Pathway is clear that a young person with capacity should give or not give consent as they choose.
64SU-T	The use of abortifacients to abuse children by killing them in the womb is what is preventing me from supporting what in effect is actually the best most competent part of this proposition.	Noted.
64SD-9	[Our organisation] notes and supports the statement around the primary purpose of medical examination and the secondary criminal justice considerations.	Noted.
64SP-N	Paragraph 6 refers to the management of taking forensic evidence. It would be helpful to have more detail to explain the phrase "carefully managed", including reference to any existing protocols, guidelines, or similar measures and resources. We would suggest that the model of Joint Investigative Interviews should be applied to this pathway. This is an established and understood process, allowing for collaborative working and a tailored approach for each child or young person affected. There is published guidance on the Joint Investigative Interviewing of Child Witnesses in Scotland issued in December 2011.	The Pathway now uses the language of the draft revised National Child Protection Guidance in discussing JII and IRDs.
64S7-V	There should be more included on how to embed trauma informed practice into the medical examination	There is now more information in the Pathway on trauma-informed practice.

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64S4-S	It references comprehensive medicals, but doesn't go into detail about where one type of medical may be used over another, especially in non-acute cases. Very rare that forensic medicals within the window present to services. Realistic Medicine is not mention, especially in relation to the person-centeredness.	There is now more discussion about the different types of medical examination and when they are appropriate.
Do you have any further comments or suggested amendments to the medical examination section of the pathway document?		
64HN-8	At present in my area there are no female FMEs and unless some are trained urgently I cannot see this situation improving. It has been difficult to attract female doctors into this area and this may require some thought about the roles of FME and how it can be combined with other interests	Availability of female examiners is out with the scope of this pathway. The Workforce and Training Subgroup of the Taskforce is leading work to support the increase in the number of female examiners.
64HD-X	unable to access the 'purple book (physical signs of child sexual abuse) - so unable to comment	Noted.
64S1-P	[Our organisation] supports the statement at the start of the section on medical examinations which outlines that the primary purpose of the medical examination is to address the health and wellbeing needs of the child and the secondary purpose being the gathering of forensic evidence. However, [our organisation] notes that while the document makes this assertion, the medical examination section of the pathway is focused on procedures around the gathering of evidence. While [our organisation] recognises the importance of this, to ensure this section reflects the primary statement, there is a need for a reframing towards a more child-centered approach. This could be achieved by dividing the medical examination into two sections: • The first on addressing the health and wellbeing of the child • The second on the collection of forensic evidence. An expanded section on the health and wellbeing needs should address the wider needs of a	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	child and young person, including potential referrals to appropriate support. This should also highlight the importance of medical examiners and other staff having positive and supportive attitudes to children and young people, including those with learning disabilities. Where possible this should be supported by training on unconscious bias and learning disability awareness training. Within the primary purpose, it may also be helpful to outline who can be present to support a child or young person during a joint pediatric examination and in what circumstances this may not be appropriate. Overall, by separating the two sections the pathway document can allow for equal weight to be given to both the primary and secondary purpose of this process and more detailed considerations within the two sections. In addition to this, [our organisation] would welcome further expansion on point 6.2 (p.18) regarding written consent from an individual with parental rights. In [our] earlier response to the Scottish Government, [we] expressed concern about consent being given for under 16-year-olds by parents or guardians. [we] said that this statement required further attention as there may be instances in which: • "A parent or guardian may be abusing • A parent or guardian is protecting an individual, with a relationship to the family, who is abusing • A parent or guardian is protecting a trusted caregiver • A parent or guardian does not believe the child or young person." [we] went on to state that in such circumstances in which there are concerns about parents or guardians acting to conceal abuse, further legal processes should apply. Within this process the following UNCRC articles should be considered: • the views of the child or young person should be heard and taken into account (UNCRC, Article 12,1989) • Children and young people should have access to high quality health services (UNCRC, Article 24,1989) and • Children and young people are protected from sexual exploitation (UNCRC, Article 33, 1989). In understanding these rights, [our organisation] welcomes clear guidance being given within the pathway about appropriate measures when a professional suspects concealment. Further discussion with police, Health	

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	Scotland and third sector children's organisations will be required to develop these steps	
641Z-W	Timescales should be more explicit and examination should take place as soon as possible with support in place	The Pathway is intended to support implementation of the HIS standards by Boards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards). The indicators in the standards were arrived at by clinical consensus. In rare cases where these are not clinically appropriate we anticipate that clinicians will act in the best interests of the child.
641U-R	Is there evidence available about precisely how quickly forensic evidence is lost after an acute sexual assault? This would help inform timings of examinations including the need for weekend services or out of hours services	The HIS standards take account of this and the timescales for forensic examinations allow for capture of any relevant forensic evidence (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards).
641T-Q	Importantly, the pathway document discusses that written consent must be obtained from an individual with parental rights and responsibilities if cannot be obtained from the child themselves. I feel that further guidance should be written on this regarding when a parent is the alleged assailant and where legally alternative consent can be obtained.	This concern is now covered in the Pathway.
6418-U	There are too many hyperlinks to other procedures and documents, in this section in particular, but also throughout the document. If another policy/document is of	References in the Pathway have now been rationalised.

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	importance to the pathway, more explicit information and/or relevance to this pathway should be explained, supplemented by a hyperlink to the full document. There is also no reference to Section 4 in Section 6. For this pathway to be truly trauma-informed, this should be more explicit. Sections 4.3 and 4.4 arestatements regarding Trauma-informed practice and ACEs, but do not appear to be directly incorporated into the pathway, for example how and where medicals take place. If the document is to reflect the principles of the Barnahus model, this needs to be covered more comprehensively. Whilst we appreciate that there is ongoingwork/developments re the model, the basic principles could still be reflected in the pathway. Point no. 9 on page 21 refers to the follow up support following a medical, however this needs to be more robust/comprehensive. It should make therole/responsibilities of medical staff more explicit, especially if mental health/emotional needs are identified. Again the principles of the Barnahus model would offer some insight into how children and young people should be supported following medicals etc. The pathway should of course primarily focus on the process and immediate safety of children and young people, but to be truly trauma-informed, it should also consider how they could be supported in their recovery following abuse.	The Pathway now has more information and context on trauma informed care and adverse childhood experiences. The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context. The Pathway now includes an Annex with roles and responsibilities.
6412-N	As above, more clarification needs to be given particularly to dentists about the term 'medical examination'.	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it is not necessary

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		and may be unhelpful to duplicate material already available in this area.
6414-Q	Page 20 regarding the provision of report in 4 weeks. Reports on medicals will in many cases be required much more quickly in order to protect children, e.g. to apply for a Child Protection Order and this needs to be included.	The comment has been noted and the Pathway has been revised to address this point.
6413-P	There needs to be further consideration given to issues of consent, especially for disabled children and young people including those who may have a learningdisability, autism, capacity issues and/or communication needs.	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc. in the Pathway with hyperlinks to more detailed guidance if required.
64SM-J	In section 6.1 3 iii – it is mentioned that the likelihood of obtaining positive forensic results decrease exponentially with time. It would be helpful if we had some actual Scottish figures regarding how often there is a positive result and the actual rate of positive results correlated with time the sample was taken after the assault. I am not aware how often a positive result is obtained and could not inform families accurately if they ask. Regarding acute abuse in Medical Section 6 "Examination should occur as soon as possible to obtain forensic evidence. Guidelines indicate that likelihood of obtaining positive forensics decreases exponentially with time. This is also true for documentation of injuries as the genital area heals extremely quickly". It would be useful to have clearer information about research about how quickly forensic evidence such as semen and DNA disappears and how quickly genital injuries disappear in order to plan medical timing and service provision of paediatric examination services out of hours including weekends. Agree that medicals out of hours outside 8-8 may not be in the best interest of the young person.	The HIS standards take account of this concern and the timescales for forensic examinations allow for capture of any relevant forensic evidence (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards).

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64SV-U	[Our organisation] would like to highlight that children and young people with disabilities may not have the linguistic ability to communicate that they have been abused, what kind of abuse they have experienced or name their abuser, plus professionals may not be aware of resources to assist communication. If a child and young person does not have access to someone who is familiar with their unique adapted communication styles at time of disclosure then effectively this may stop/ prevent the child / young person having their voice heard – which is conflicting with UNCRC, article 12 and The Children (Scotland) Act 1995	Noted. These circumstances are not unique to CSA and apply to other forms of abuse. Relevant services have an obligation to facilitate communication with service users as best they can.
64SE-A	The medical examination section appears accurate and exemplifies best practice, however it does not reflect current practice and the varying standards that are being adhered to across the country. A reoccurring issue identified is that of children or young people being transported long distances to a specific medical establishment for the purpose of a Joint Paediatric Examination (JPFE), when there are obvious establishments nearer. Identifiably, issues and conflicts arise around where a JPFE will takes place impacted by availability of Paediatricians and Forensic Medical Examiners. It would be worthy of considering the option of appropriate medical staff travelling to the nearest and most suitable medical establishment to the child to reduce additional stress and anxiety placed on the child or young person due to unnecessary time or travel delays. Consent appears not to be consistent across the country with there being challenges relating to Paediatrician's refusing to examine children when a parent who is the suspect refuses to give consent for a medical examination of a child. Issues have also been identified relating to Paediatrician's refusing to conduct medical examinations even when a warrant has been granted by the court for the examination as it is deemed there is no parental consent.	Some of these issues are out with the remit of the Pathway. However, the Pathway is intended to promote consistency of provision across Scotland and to support Boards to deliver services as locally as possible.

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64SW-V	Consideration could be given to including some guidance regarding support for the child/young person within the medical. At times young people attend for medical and are not allowed to have social work staff (or other support) with them during the medical even when they are requesting it. Having a trusted person with them can help to make the experience less traumatic for a young person however whether this is permitted is not consistent and does not appear to be related to medical need.	The Pathway now states that the examination is carried out in child-friendly surroundings, with the right support for their age, stage and understanding.
64SB-7	A medical examination is likely to be an intrusive and frightening experience for any child, and particularly so for those who have experienced sexual abuse. This section could be significantly improved by acknowledging this, and integrating examples of the ways in which a trauma-informed approach to practice can be embedded. For example, setting out whose role it is to explain, in developmentally appropriate language, the process to the child; ensure the child has the opportunity to look at the room in which the examination will happen; talk the child through the process whilst it is going on; comfort the child; ask their permission; and support the parent or carer. This includes meeting the needs of the child and their family after the examination, in terms of any ongoing dialogue. Other specific amendments to this section include: • 6.1.2 – Complexities involving arrangements for written consent from an individual with parental rights should be made explicit. Such as, what arrangements are in place if the individual with such rights is potentially responsible for the abuse. Additionally, what arrangements are in place in the example of a child who is looked after away from home, whose parent cannot be contacted within the required timescales. • 6.1.3.b – Reference to neglect and emotional abuse is confusing in this heading. Additionally, rather than referrals being 'assessed according to clinical need and requirements of the child protection process', they should be assessed according to the child's needs and best interests.	The Pathway now states that the examination is carried out in child-friendly surroundings, with the right support for their age, stage and understanding. Consent for examination is addressed in the Pathway with hyperlinks to more detailed guidance if required.

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64SJ-F	Suggestion to change of lay out / flow of 6. Medical Examination as follows Paragraph 3 starting "the Joint Paediatric Forensic examination .." should become paragraph 2 i.e. after the first/ top paragraph Sentences at the beginning of paragraph 2: "It can be very hard for children and young people to reveal abuse. Often they fear there may be consequences. Some delay telling someone about abuse for a long time, while others never tell anyone, even if they want to." Fits in better under 5.1 Disclosure by a child / young person: suggest it is placed prior to the sentence ending (NSPCC). The rest of Paragraph 2 starting "In cases of non-acute sexual abuse that is outside the forensic capture window, …… such an assessment is required", should become final/ paragraph 3 in this section.	The section on disclosure has now been revised.
46SF-B	Paediatricians are given the responsibility of health assessment, in a medical / clinical sense forensic reports provide facts which is applicable and required however if holistic assessment is optimum for future care, GIRFEC assessment tools should be used and any further follow up by school nursing staff discussed.	The section on GIRFEC in the Pathway has now been expanded.
64SA-6	I feel this should be reinforced to all services that this is part of the pathway as this was not something that is known in my area	Noted.
64SH-D	We welcome the clarification in the pathway document that the primary purpose of a medical examination is to address the health and wellbeing of the child or young person in a holistic manner. With this in mind, it is particularly important for this document to recognise the potential for medical examination to contribute to the trauma experienced by the child or young person, and the importance of taking all possible steps to avoid this. The issue of consent should be expanded within this section, to ensure that children's rights are fully considered in each situation. If consent is not being sought from a child (for example, where parental consent is sought) or there is use of anaesthetic, then this should be made clear to the child	The discussion of consent and capacity in the Pathway has been revised and emphasises these points.

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	while supporting them through the process – both before and after the examination. Discussion of the interplay between consent from children/young people and parental consent would also be useful in this document. It should be highlighted that a child can withdraw their consent for the examination at any time, and this should be explored with a child/young person prior to undertaking any examination, as well as discussions with children/young people about what to expect. Areas for expansion should include how examiners check in with young people and obtain consent throughout the process. It should be explicitly stated that if consent is withdrawn during the examination it must be stopped immediately. The document should support medical practitioners to recognise the interplay between the child having power within this situation and their power having been removed in a sexual abuse situation, in an effort to avoid further traumatisation	
64ST-S	Again this presumes that all these cases go to medical examination - not all sexual abuse cases go to medical examination and this should be noted within the document	The pathway has been revised to provide clarity.
64SD-9	In comparison to the Adult pathway, there is little detail on evidence based management of pregnancy and sexual health needs	Noted. However, the Pathway has a hyperlink to the MCN Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland.
64SP-N	We would suggest that this section would benefit from a discussion of capacity, and how to assess the ability of a child or young person to consent to, or refuse, medical examination. Further detail on obtaining the views and wishes of a child or young person may also be helpful. In addition, we would suggest that there should be greater clarity in the role of parents in situations where the child or young person is capable of	The discussion of consent and capacity in the Pathway has been revised and emphasises these points.

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	consenting to treatment, including situations where they may not want parental involvement. In a situation where the child or young person has capacity, parental consent is not a relevant factor. Section 2(4) of the Age of Criminal Responsibility (Scotland) Act 1991 expressly provides that a child under the age of 16 has the legal capacity to consent to medical procedures and treatments where they are capable of understanding the nature and possible consequences of such procedure or treatment. This is applicable in the context of the pathway, and should be reflected in the pathway document. Children and young people should be fully supported to understand and make decisions on these issues, and this is likely to be an area to be included in training and guidance for those who work with children and are involved in obtaining their consent or support in relation to such procedures.	
64SQ-P	The separation of the primary and secondary purposes of the medical examination was helpful in maintaining an important focus on the needs of the child or young person	Noted.
65SQ-P	6.1.8: This section could be strengthened to emphasise the responsibility of health professionals such as GPs, community paediatricians, mental health staff and the child's health visitor/school nurse in ensuring that identified health needs, including emotional wellbeing needs, are being met.	Noted.
64SQ-P	6.1.10/11: These paragraphs should be strengthened to include the responsibility of health professionals and their ongoing contribution to joint working for example providing written reports and participating in decisions affecting the child at child protection case conference etc	The revised Pathway now includes a section on the roles and responsibilities of the professionals involved.
64S1-P	[Our organisation] welcomes this clinical pathway and asks that going forward there is a more active inclusion of children and young people with learning disabilities within this. For this to be addressed, [our organisation]	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for

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	asks that rates of sexual abuse and rape experienced by children and young people with learning disabilities are included within the context section. [Our organisation] stresses that this should be framed in terms of rights and potential risks and not presented as 'children and young people with learning disabilities are intrinsically vulnerable'. To support this [our organisation] welcomes a reframing of the pathways aims with a focus and weight being given to the rights, wishes, capabilities, and needs of the child or young person. Attention should also be given to guarantee that the pathway is age appropriate for each individual and that clearer definitions of trauma-informed practice are available	examinations/information sharing etc in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64S1-P	To reinforce the inclusion of children and young people with learning disabilities within this pathway, it is critical that the document highlights the barriers experienced by this particular group. To support this the pathway should provide resources to facilitate the disclosure process as well as resources to help professionals identify potential child sexual exploitation.	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc in the

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	This should be supported with accessible information for children and young people with learning disabilities on what happens to them following a disclosure and advocacy provision as part of the ongoing work around the incorporation of the UNCRC. Finally, [our organisation] supports the child-centred and holistic approach outlined by the document. However, [our organisation] believes the section on medical examinations needs further development to ensure practice matches policy intention.	Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced), that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64S1-P	[Our organisation] believes that by addressing the recommendations, we can ensure an equitable experience of service provision for children and young people with learning disabilities, to the rest of the population. Centrally, this work will help to ensure children and young people with learning disabilities are treated in a way that best preserves their dignity and allows for recovery from assault.	Noted.

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65SK-G	Pg 18 'How quickly a non-acute case needs to be seen may vary according to clinical need--this doesn't read well from a person centred/trauma informed perspective. The pathway is varying between clinical need and health and wellbeing needs... needs consistency throughout. P 18- sentence regarding 2 doctors present is 'good medical practice'--again, not trauma informed.. what about it language that is supporting the young person	The pathway has been revised to be consistent and promote child centred, trauma informed care.
64S6-U	Early information sharing. Other agency inputs. Is there a need to put the child through examination, trauma informed. Consistent approach to medicals. 4 local authorities, one of the key things to iron out is timescales. Appreciation forensic windows, evidence for police if required timeously using the Standards for adults. Balanced with it remaining victim centred. Some areas where paediatricians are not involved. Forensic window needs to be considered. IRD should have health, social and police involvement. Reflect the current practice – issues around volumes etc. Lanarkshire does NAI Glasgow paediatrician will come in or neuro surgeon, which helps. Paediatrician won't it's a health representatives. Benefit having paediatrician at the time and everyone is there. Updates from social work is different from paediatrician. In Ayrshire, health protection advisors – rota system. Always health, social work and police. Same in Inverness. Early IRD stage that all the information is there at the time. First action is contact with paediatrician for medical need. CPAs and rota system available all the time. Reviewing joint protocol IRD Tayside child protection nurses are always at those, not always paediatricians – no issues up here. Dumfries – multi agency. Health social work and police works well for IRD. Paediatrician comes in to inform discussions. Medical examinations are the problem, age of the child	The Pathway is aligned with current National Child Protection Guidance and aims to promote consistency with the flexibility to take account of local multi-agency IRD procedures. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.

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64S7-V	6.1 Considerations for the Medical Examination and Follow up Should be something included that recognises the age and stage of the child being examined and adapting communication style to engage the child/young person and engage them in a way that helps them to feels safe. Something about how the physical examination can be re-triggering and having an agreed way for the child/young person to alert the examiner if they become overwhelmed and need a break or to stop. Something about how to include the child/young persons current ways of coping to help them before, during and after the examination. To support putting trauma informed principles in practice, would advise practitioners to walk through your service in the shoes of the child/young person, from first contact to last contact. Consider the communications you receive, the buildings you visit, the people you meet and interactions you have, the physical spaces you encounter and the policies you are affected by. Then thinking about how to implement trauma informed practice of safety, choice, collaboration, trust and empowerment. Would again advise looking at the Forensic Medical Examination Guidance and the Joint Investigative Interview training	These considerations are part of the training of doctors and nurses undertaking examinations and therefore out with the scope of the Pathway.
64S4-S	Trauma-informed practices and ACEs are referenced but this is not explicit in the medical section, and is not cross-referenced throughout the document.	The Pathway now contains more information and context on trauma informed care and adverse childhood experiences.
64S4-S	Education are not referenced in relation to the IRD. This is an omission given the new relationships, sexual health and parenting work is pertinent to this, as it may be through this that a young person may disclose or partially disclose. For wellbeing, all children will benefit.	The comment has been noted and the Pathway now contains reference to education attending IRDs when appropriate.
64MX-Q	Support, trauma informed and care afterwards. Please to see about the examination, wishes of the child should be taken into account and consent can be withdrawn at any time. Parent or carer with parental consent and agree to child participating in examination. See more around that it pretty	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	much says that a parent can consent, the 2nd part take child's view and children are competent to consent from 8 years old.	
64MX-Q	Young people haven't been given a proper choice – that is my biggest concern they are coheres into examination by well-meaning clinicians, police and parents – not trauma informed and can be damaging to the young person children who are 13, 14, and 15. Should be led by the child always – stop at any point if they become uncomfortable. Laid out in pathway – might not be as clear as it could be. Children if young, can often make their own decision	The Pathway now contains more information and context on trauma informed care and adverse childhood experiences. The discussion of consent and capacity in the Pathway has been revised and emphasises these points.
64MX-Q	How would consent work if parents are suspects – parents would not be there. Phone consent is possible. Usually go for joint consent. Part of the concern we have is standardising, different places doing different examinations, wide geographical area – experience is not always the same. We should be giving same standard of examination. 22 paediatricians doing this work in west of Scotland, do we know if these staff are competence? Standardise the examination. Set up services in different areas – 3 centres doing everything for all age groups. Body of trained staff, hub of expertise – putting little bits of money into different areas does not work. Look at ways to transport these people timeously to Aberdeen or Edinburgh from Shetland for example. Roles and responsibilities (notes in pathway) – police and social work, joint forensic examinations. Not practice we don't currently have – no necessarily something we would comply with.	The discussion of consent and capacity in the Pathway has been revised with hyperlinks to further guidance if required. The Pathway aims to promote consistency with the flexibility to take account of local multi-agency IRD procedures. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64MX-Q	Acute – support and help is there as quick as possible. Forensic evidence. Equality issues, lack of translators, end up getting delays sometimes quite for some time. Nurses at Archway and translators and other people. Appropriate adults – disabilities. Other pathways fits in social, vulnerability – then there is constraints on resources, capacity and availability. Avoidable delays, interpreter that is an avoidable delay. Should not be delayed.	These issues are for local services to consider within the parameters of the Pathway.

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64MM-C	While the pathway makes reference to forensic medicals, there are no comments made to how children and young people should be supported to attend. This is more of an issue in the evenings, Public Holidays and at the weekends particularly when medicals do not take place in D&G, with limited transport options - would health or police be able to assist with transporting? Best practice for children would be to have key people there to support them if and when possible and it would be beneficial if this was emphasised in the pathway. 6.1.2 - Written consent from a parent; clarity needs to be provided when the abuse has been perpretrated by a person who holds parental rights - can the child themselves give consent without parental consent?	The discussion of consent and capacity in the Pathway has been revised with hyperlinks to further guidance if required. These issues of support for Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). are for local services to consider within the parameters of the Pathway.
65M5-M	Section 5 - Clinical Pathway Processes High level summary diagram The high-level summary of the pathway as currently drafted appears to represent parallel journeys through health processes and criminal justice/ child protection processes, which are almost entirely distinct. A trauma informed, child centred response to a child/ young person following abuse depends on close, collaborative working by the various services around the child and family at every stage and the pathway must endeavour to illustrate this. The health and social care needs of children and safe carers post abuse, for example, are often inextricably linked. Assessing a child's emotional recovery needs depends on in-depth assessment and understanding of a child's family context and wider social circumstances, and cannot progress without close collaboration with other agencies, most notably social work, where involved. Elsewhere in the pathway, evidence gathered directly from a child or young person during the Joint Investigative Interview process, may provide crucial information to inform emotional wellbeing assessment. The pathway should illustrate how this kind of collaborative working will enhance the health response to the child and family, minimising the risk of repeat trauma, for example by different	The Pathway now describes in broad terms what ongoing support to aid recovery should be available and emphasise the integrated response required for Children and Young People who have experienced child sexual abuse and non - abusing parent/carer(s).

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	assessment processes necessitating a child telling their story repeatedly. NSPCC is acutely aware that this kind of collaborative working is well underway in some areas in Scotland, and also that achieving it in practice depends on working out processes at a local level. However, the high-level pathway must illustrate the what of what needs to happen, in order to provide guidance for those working out the 'how' at local level.	
65M5-M	5.1 Disclosure by a child / young person. The pathway has elsewhere importantly established that remarkably few children themselves report abuse, whilst it is happening, or ever. Initial concerns about child sexual abuse are much more likely to be raised or reported by others. The pathway should clearly reflect this (for example, this section/ box could be duel titled 'Disclosure/ Concerns Raised about Abuse'). The pathway should underline the vital importance of the professional/ practitioner response to a child's disclosure, in a meaningful way. The reaction of adults to disclosure is a critical first stage of a child's journey to recovery and can have significant impact, either positive or negative. Unsupportive responses by caregivers or professionals to a disclosure of CSA may exacerbate victims and survivors' feelings of guilt and shame, and may deter them from seeking support in the future. Supportive responses to disclosure, and supportive relationships, have been found to be significant factors in promoting recovery . It would be extremely helpful if the pathway contained basic information/ guidance for practitioners about what a child centred response to a direct disclosure of abuse by a child/ young person looks like. For example, Let Children Know You're Listening (NSPCC, 2019) is a short animation providing simple, core messages on the most helpful ways for adults to respond to a child where they disclose/ try to disclose and would be a useful link. https://learning.nspcc.org.uk/research-resources/2019/let-children-know-you-re-listening/ Summary information on the nature of children and young people's disclosures would also be very useful to help practitioners understand more 'indirect' ways children and young people	The Pathway now emphasises the need for the professional to respond to disclosures sensitively in a child-centred manner.

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	may commonly try to communicate their experiences (ref). Section 5.1 briefly acknowledges the potential impact of disclosure on the child and the need to offer appropriate support as required. We would strongly support this section being strengthened, in line with previous comments, to include non-abusing carer support	
65M5-M	Information about IRD contained in the Pathway must dovetail with a) Police Scotland Standard Procedure Protocol and b) National Guidance Child Protection. This section should be produced in close collaboration with Police Scotland and the SG team who are currently reviewing the National Guidance. This is not to suggest that the care pathway should contain a level of detail appropriate to other services, but rather that it is couched in similar language and reflects the same stages, in order to be recognisable and credible. The last paragraph detailing the responsibility of the paediatrician involved in the IRD could be fleshed out considerably to describe the nature of inter-agency collaboration at this stage. For example, social work and police colleagues may know the child and family far better than the paediatrician, and will be able to provide valuable insight to their early emotional care needs, at medical stage and beyond.	The Pathway has been updated to reflect the language of the draft revised National Child Protection Guidance, in discussing IRDs. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
65M5-M	The Joint Investigative interview is carried out in order to facilitate the child's full disclosure. This has traditionally been understood as serving the evidential needs of the justice system. However, it is imperative that the JII and the child's disclosure should be widely accepted and understood as a critical stage in a child's journey to recovery. Enabling/ facilitating a child's direct disclosure of abuse is central to their therapeutic recovery, as expressed in the principles of a Barnahus approach (REF). It would be extremely helpful if the care pathway helped articulate and promote this understanding about JII, in conjunction with police and social work colleagues.	Additional information has been added on the role of JII within the child and young person journey of disclosure.

ID.	Consultation comment	Clinical pathways subgroup response
65M5-M	The high-level summary pathway appears to suggest that all children who experience sexual abuse will be involved in interagency child protection procedures and that during this process, 'multi-service and/ or multi-agency support is put in place' (pg. 13, draft pathway document). This is not true in all cases. The Right to Recover research identified 2 distinct groups of children: those who are assessed as at risk of on-going harm and in need of protection, and those who are assessed to be at no on-going risk of harm. According to health practitioners, those children most likely to be assessed as not at on-going risk of harm are children who have experienced rape/ sexual assault by a 'stranger' or someone outside their 'circle', and those children whose families are judged to be coping. It may be that in some cases the emotional support needs of these children and families are considered and planned for at the stage in the process (multi-agency case conference) where they are assessed as not needing CP procedures. However, there is absolutely no guarantee that this is the case and our understanding is that no one profession/ practitioner is responsible for ensuring that these children's and family's needs for information, support and potentially therapeutic intervention are assessed and met. The document could be helpfully adapted to outline the pathway for both groups of children and young people; those in need of protection and those assessed to be of no further risk, and identifying the health needs of both. It is critical that this is done in conjunction with the National Guidance Child Protection.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
65M5-M	[Our organisation] strongly welcomes the statement on the primary purpose of the medical examination, as being to address the health and wellbeing of the child in a holistic manner, including considering the immediate and long term emotional wellbeing needs of the child and arranging on-going care. However, the pathway does not provide guidance on the steps that need to be taken for this to be realised for children and families, nor whose role it will be to assess the emotional needs of the child and non-abusing carer.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).

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	We note that the pathway details the responsibilities of the paediatrician and forensic medical examiner in the JPFE, but contains no guidance at all on the issue of emotional health assessment. This must be urgently amended. A key recommendation of the Right to Recover research is that medical assessment should include emotional wellbeing as a core component and that some kind of standardised emotional wellbeing assessment should be carried out with all children experiencing abuse, at an appropriate stage. It may be helpful to consider models which already exist; for example, the mental/ emotional wellbeing assessment which forms part of the holistic health and social care response to all children accessing the Lighthouse service in London may be helpful. Paragraph 2 of section 6 makes it clear that the pathway is for all children who have experienced sexual abuse, including non-acute abuse outside the forensic capture window. In doing so the pathway recognises, in line with the United Nations Convention on the Rights of the Child and with the HIS standards, the right of all children to a health response and support to recover. We are concerned, however, that this fundamental principle is not at all clearly articulated throughout the pathway. For example, the high-level summary diagram appears to contain no information about the 'health response' to children who do not undergo a joint paediatric/ forensic medical examination. Or is it the case that a joint paediatric/ forensic medical examination is indicated for all children who experience abuse, in acute and non-acute cases? This needs urgently clarified in the summary diagram and in the document.	
65M5-M	Medical examination is a critical stage in the child's journey after abuse, and can be very daunting. The pathway must underline the imperative of information and emotional support for children and families at this stage, in order that they fully understand what is happening. We are concerned that the issue of consent for medical examination is dealt with in a perfunctory manner in the draft document. Whilst links are provided to GMC guidance	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s)

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	on consent, we consider it important for the pathway document to articulate the importance of a 'trauma focussed' approach to the issue of informed consent. Giving information about procedures, listening to and discussing concerns and ensuring the child/ family have choice and feel in control of what is happening, are all critical to obtaining informed consent. We are aware that there are good examples of child/ family friendly information about what happens at medical examination and of therapeutic play approaches being used to help children and young people relax prior to medical examination. The pathway should include examples and links to/ resources on best practise. Section 6 point 9 - Follow up of other needs, for example referral to the children's reporter or other agencies, should be arranged and documented. [Our organisation] is extremely concerned that this vital stage in the care pathway is dealt with in one, perfunctory sentence. We consider it imperative that this section is fleshed out substantially, in the text and in the summary diagram, if the 2017 HIS standards are to be made real for children and young people. At the very least, the pathway must provide guidance on following up a child's needs for on-going, longer term therapeutic recovery and the role of health in ensuring this happens. Critical information to support referral includes: • provision of therapeutic recovery services for children and families at a local level, including 3rd sector and 'holistic' provision. • information about the referral processes (often complex) and responsibilities • access to supportive interventions for non-abusing carers and family members as an intervention for the child's recovery The pathway should also consider who else needs access to this information, for example G.Ps, Education etc, in order to refer children and/ or carers to services, in cases of historic abuse, or support them to access supportive services.	There is now more information and context on trauma informed care and adverse childhood experiences. Guidance on obtaining consent for an examination under various circumstances is included in the Pathway with references for further information if required by health staff.
64MY-R	Remove the word 'within' which is in the final sentence of part 6 on page 20.	Noted.

ID.	Consultation comment	Clinical pathways subgroup response
64MW-P	In the section on the timing of medical examinations reference should be made to the timing of acute forensic assessment outlined in Sexual offences: Pre Pubertal and Post pubertal Complainants3" To enable a similarly high quality service across Scotland the CP committee would suggest that reference is made to the quality standards expected of each service as laid out in the Service specification for the clinical evaluation of children and young people who may have been sexually abused (p8)5. Although a number of these standards are addressed in the pathway there are some issues that are not identified, including an appropriate chaperone for the examination and the maintenance of competencies for clinicians. Point 8 on the follow up of health needs makes no mention of mental health so the committee would recommend the addition of 'a risk assessment follow up for suicide, self■harm, child sexual exploitation or domestic violence' as stated in Service specification for the clinical evaluation of children and young people who may have been sexually abuse. Referral to the Children's Reporter, as mentioned in point 9, tends not to be carried out by the paediatrician – child protection medical information is used and added to other information and presented to the reporter by social care.	The Pathway is intended to support consistent adherence to the NHS Healthcare Improvement Scotland Standards (Healthcare and forensic medical services for people who have experienced rape or sexual assault standards) which allow reporting and performance management using an agreed dataset. A chaperone must be offered for all intimate examination according to GMC guidance. The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s).
64MV-N	More clarity is needed around consent issues for children and young people. The final paragraph of page 18 states "Written consent from an individual with parental rights (if child under 16) or child themselves must be obtained for the examination." It is not clear from this when consent would be required from the child, and when it would be required from the individual with parental rights. It is also not made clear what would happen if a parent does not consent to an examination but a child does, or when a parent or carer consents but a child does not	Guidance on obtaining consent for an examination under various circumstances is included in the Pathway with references for further information if required by health staff.

Section 5: Appendices

ID.	Consultation comment	Clinical pathways subgroup response
Do you have any comments on the appendices of the pathway document?		
64HR-C	Looks comprehensive	Noted.
64HN-8	Clearly laid out	Noted.
64HF-Z	They are helpful and informative	Noted.
64HD-X	Lots of information	Noted.
641R-N	The Children's Hearings (Scotland) Act 2011 should be added to Appendix B: Legal Context.	The comment has been noted and the reference added in the Pathway.
6417-T	'Honouring the Lived Experience' appendix, - 1. Executive Summary, para 3, refers to '....access to recovery for anyone who has experienced rape....' yet at 4. Case for Change, para 2 - reference is made to 'women's physical, mental, sexual and reproductive health'. Is this document referring to all genders or women only?	The Pathway has been revised to ensure the vision of the Taskforce for consistent, person-centred, trauma-informed healthcare and forensic medical services and access to recovery for anyone who has experienced rape, sexual assault, or child sexual abuse in Scotland is clear.
641Z-W	This refers to the named person where it is not clear who that is or indeed if it is operational in every Local Authority area	The revised Pathway now includes a section on the roles and responsibilities of the professionals involved.
641U-R	Useful resources	Noted.
641T-Q	Useful to have access to links providing further information on the legal context surrounding children who have disclosed sexual abuse.	Noted.

ID.	Consultation comment	Clinical pathways subgroup response
6418-U	The document is titled Clinical Pathway for Children and Young People who have disclosed sexual abuse: This pathway is relevant for children under 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs). However, in the appendix the definition of a child doesn't specify/distinguish children and young people with vulnerabilities or additional support needs. This can be confusing when applying the definitions to young people aged 16-18. Furthermore, it should reference the Children and Young People (Scotland) Act 2014 which considers the definition of a child. Consent and the age of a child/young person also needs to be considered within the context of this appendix. This should include how to deal with situations if consent is not given, especially if a parent is the suspected perpetrator of the abuse. This appendix also references Getting it Right for Every Child. The links here need to be clearer and clarified. The reference to Named Person Service needs to be considered in light of the on going national discussions and outcomes of the discussions.	Guidance on obtaining consent for an examination under various circumstances is included in the Pathway with references for further information if required by health staff.
6416-S	'Who is a child?' provides clear information for practitioners and the 'Legal Context' is helpful	Noted.
6414-Q	Helpful resources and links to research.	Noted.
64SR-Q	Page 22 On reading this again we wondered why we were not suggesting a child is a child until 18th birthday. Wonder if the reference to the Children's Hearings Act should be the first piece of legislation referred to - child is up to 16 years - and the others explain where there may be variation with children's procedures being used until 18 years? Page 24 Possibly redundant in light of Appendix A. ?combine Appendices A and B?	The Pathway is intended to describe best practice in line with current relevant legislation and guidance including age of child. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64SW-V	Useful given the multi-agency context to have these included for reference as needed.	Noted.

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64SH-D	In relation to Appendix B on the legal context, we believe there is value in extending this to children and young people who have been sexually abused, rather than only those who have disclosed, including legal context on grooming and prevention. The two documents below are suggested additions. • Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005 which, among other useful information, refers to Risk of Sexual Harm Orders • Human Trafficking and Exploitation (Scotland) Act 2015 which highlights the issue of children and young people being recruited for the purpose of sexual exploitation.	The language in the Pathway is aligned with the draft revised National Child Protection Guidance. It now includes reference to grooming and CSE.
64SU-T	It is destructive to the aims of natural justice.	Noted.
64SD-9	The legal context and definitions of who is a child are welcome appendices.	Noted.
64SP-N	In relation to Appendix B: Legal Context, we would refer to our comments on section 4, above. We also note that reference should be made in this appendix to the Adults with Incapacity (Scotland) Act 2000. This Act applies to individuals age 16 and over, and is likely to be of particular relevance to people with "vulnerabilities and additional support needs", who may have a guardian appointed to them. The pathway document should accordingly take account of the roles and functions of appointees and others under the 2000 Act. It may also be useful to refer in more detail to some of the obligations undertaken by the United Kingdom by ratification of United Nations Convention on the Rights of the Child and Convention on the Rights of People with Disabilities	The Adults with Incapacity Act is now referenced. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64SP-N	Table 2 of the consultation provides data for the number of persons proceeded against for sexual crimes relating to children but it is made clear that "convictions / proceedings data does not include any sexual crimes against children where the age of the victim was not specified in the	The figures in the Pathway are provided for context only. The primary aim of the Pathway is to promote the delivery of consistent high quality care and support to Children and Young People

ID.	Consultation comment	Clinical pathways subgroup response
	legislation used to prosecute the offender". It would be helpful to know which offences have been included here, and the possible impact that this method of calculating might have on the statistics. For example, the indication is that these figures would not include, for example, a prosecution of a person for the offence of rape in cases where the victim was an older child (age 13-15) because age of the victim is not specified in section 1 of the Sexual Offences (Scotland) Act 2009.	who have experienced Child sexual abuse and their non-abusing parent/carer(s).
64SQ-P	Appendix A is not particularly helpful in what is already recognised as being a complex landscape of legislation for young people age 16 and 17. The listing of the different definitions of a child highlights this complexity and may be confusing for practitioners. We suggest that the final sentence of Appendix A ('the priority is to ensure that a vulnerable young person who is, or may be, at risk of significant harm is offered support and protection) should be placed at the beginning of Appendix A as an overarching principle so that the services provided are young person centred whatever the legislative basis	The pathway has been revised to include more detail on young people aged 16 and 17 years old.
64SQ-P	We note that it is the Scottish Government's intention to bring forward legislation in this parliamentary session to incorporate the UN Convention on the Rights of the Child into domestic law. UN CRC defines a child as an individual who has not attained 18 years of age and current legislation may have to be amended in the light of this. We anticipate that the revised National Guidance for Child Protection will provide further clarity on the issue of protection for 16- and 17-year olds and the Appendix should perhaps refer to that, rather than list current legislation	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64SQ-P	It is not clear how Appendix B will assist practitioners understand the legal context for managing disclosures of sexual abuse. Only the 2014 has an explanatory paragraph. The appendix would be more helpful if a brief explanation is given as to how each of the relevant Acts frame how practitioners should respond to disclosures of sexual abuse or simply give	The Pathway is not intended to detail the legal context for managing disclosures but provides the links for further information.

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	links to the relevant Acts. The final paragraph which explains the 2014 Act sits under the link to the Vulnerable Witness Bill which is potentially confusing	
64SQ-P	The most important thing is that an Interagency Referral Discussion is undertaken to plan a child centred response to disclosures. It would be clearer and simpler to re-state this with reference to the relevant legislation and guidance	The definition and role of interagency referral discussions has been expanded in line with the draft revised National Child Protection Guidance, which is currently out for public consultation.
64S4-S	The age of the 'child' does not link into UNCRC or to the CYP Act. Many different definitions can cause confusion in relation to the title of the document and what is outlined in the appendix.	The Pathway is intended to describe best practice in line with current relevant legislation and guidance. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. It will fit in to a wider child protection context described by the revised National Child Protection Guidance for Scotland, which is currently out for public consultation.
64S4-S	More detail needed on consent, and what happens when a child or young person is controlled by a suspected perpetrator who must be the person to consent for the medical examination. Need to mention things like child assessment orders, explored in the additional context about what is best for the child. This should be discussed in relation to a child rights issue. All of this is deal with in different documents.	Guidance on obtaining consent for an examination under various circumstances is included in the Pathway with references for further information if required by health staff.
64MM-C	Consideration would need to be given to local arrangements re: IRD's given that IRD's fulfil different functions across all Local Authorties. Some serve	The definition and role of interagency referral discussions has been expanded in line with the

ID.	Consultation comment	Clinical pathways subgroup response
	as CP planning other's dont so all LA's will need to ensure their own local arrangements support this pathway.	draft revised National Child Protection Guidance being going for consultation in 2020.

Section 6: Final Comments

ID.	Consultation comment	Clinical pathways subgroup response
Do you have any comments or additions on topics which are not covered in previous sections? Please be specific in your reasons and include any resources or references we should consider.		
641R-N	[Our organisation] thinks that it would be helpful if an agile review of the pathway could be developed. We think this will be required as a result of the re-write of the Child Protection Guidance 2014 and the update of the GIRFEC National Practice Model. The development of a Scottish Barnahus will also impact on the clinical pathway for children in a very real and positive way.	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. The Pathway is considered 'Barnahus ready' in that it could align with future development of a Barnahus model in the Scottish legal and child protection context.
641N-H	It is essential that the pathway is informed by those who support children and young people with lived experience of sexual abuse and therefore we suggest that relevant organisations such as crisis centres, NSPCC, Barnados, SCLD, Zero Tolerance etc are adequately consulted. It would also be useful to know how this policy might link up with other protection policies such as the disclosure of female genital mutilation.	The Pathway has benefitted from third sector involvement. The Pathway now includes information on Female Genital Mutilation.
64ME-4	Tackling Child Sexual Abuse by Dr Sarah Nelson – is vital and essential reading for this arena. Most practitioners in the field have not read it and that should not be the case. Detailed study of this book is imperative. Dr Nelson is a former advisor to the Scottish Government. Center for Judicial Excellence – Fact Sheet	Noted.
641Z-W	Many children and young people feel they have consented to sexual activity and it is years later they realised what the grooming process was. There should always be a consideration of possible child protection for a child under 16 and under 18 with additional vulnerabilities	Noted.

ID.	Consultation comment	Clinical pathways subgroup response
641H-B	Important to cover sexting/sending and recivieing naked images as so common and is a criminal offence	The language in the Pathway is aligned with the draft revised National Child Protection Guidance, which is currently out for public consultation. It now includes cyber enabled abuse.
641U-R	There is a significant lack of resources within the NHS for children who have experienced trauma or sexual abuse/ assault. Currently in the area I work there are no resources for this purpose for under 12 year olds. There are resources from voluntary agencies for 12 years and over who have experienced sexual assault. These agencies also provide some support to family. They do not provide direct support to the child. There is limited resource from voluntary agencies to support other professionals working closely with a child on a consultation basis.	The Pathway describes in broad terms what ongoing support to aid recovery should be available to Children and Young People who have experienced child sexual abuse and non-abusing parent/carer(s). However, it is not prescriptive about how that should be done and cannot determine the allocation of resources.
6418-U	There are many other consultations and work streams (e.g. Joint Investigative Interview process, Barnahus Model, review of National Child Protection Guidance) recently or currently being undertaken. This can possibly cause some confusion and/or duplication of work. The documents/work streams should have clear links with each other, noting where pathways cross over or take precedence. It is unclear why this pathway is required – what led to it being developed? There is not a sense that the child is central to this process. To this end, the pathway needs to incorporate the UNCRC at least. It also doesn't reflect the current and real practice of multi-agency/partnership working that already happens in child protection processes.	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
6412-N	In order to ensure the main aim of the document is met i.e. a "resource to outline the process for the healthcare response to disclosures by children and young people of sexual abuse of any kind" then front line clinicians (in this case dentists and their teams) should receive training on what to do	Advice received from the Children and Young People Expert Group and the Steering Group for the revised National Child Protection Guidance is that education, guidance and support on child

ID.	Consultation comment	Clinical pathways subgroup response
	when they receive a disclosure and how to act and react. This will have a pivotal effect on the rest of the pathway, and it is vial that this step is identified and included.	protection is available from employers (or voluntary organisations/charities in the case of volunteers). The advice is that it is not necessary and may be unhelpful to duplicate material already available in this area. Training for wider health professionals is out with the scope of the pathway.
6416-S	Given the current focus on Female Genital Mutilation it may be helpful to make specific reference to this within the document as well.	The Pathway now includes information on Female Genital Mutilation.
6414-Q	Broadly, this is a helpful document. Nationally the resources should be available in every area to provide services to the highest standard and this pathway should be adopted so it is disappointing to note that the opening introduction states that it does not constrain NHS or Police Scotland – so it could just be ignored.	The Pathway is intended to describe best practice in line with current relevant legislation and guidance to assist practitioners in providing care and support to children and young people who have or may have experienced sexual abuse.
6413-P	We believe an EQIA should be carried out as we are concerned the clinical pathway does not adequately cover the needs of children and young people with disabilities. BAME, LGBTI, Disabled and looked after children will all have specific, intersectional and differing needs that are not covered in the pathway, e.g. the child should be able to choose the sex of the practitioner carrying out their examination and there may be particular reasons why this might be important to a victim of sexual abuse. Also for some disabled children or young people it may be necessary to have specialist equipment such as a hoist. We believe there needs to be overt reference to adopting a human rights based approach and to supported decision making as children and young people whohave been sexually abused need to know and understand their rights and be supported to make decisions about how they wish to	An EQIA has been carried out on the Pathway.

ID.	Consultation comment	Clinical pathways subgroup response
	proceed.The document also needs to make reference to some children and young people having a right to access independent advocacy and recognising how it cansupport them and make the process of disclosure and evidence gathering easier and smoother. Any information produced needs to be accessible and easy to read and age appropriate for children and young people.	
64SM-J	Clear sections and good use of resources and links	Noted.
64SV-U	[Our organisation] would like to point out that children with disabilities and augmented communication are less likely to have access to victim support services. We would finally like to highlight that in reality there is a danger that children and young people with disability who experience abuse can be hidden in plain sight. That is why it is so important to make sure that information about children with disabilities and abuse is clearly and obviously included in the pathway	More on the vulnerability of disabled children and young people to all forms of abuse is now included. There is more on taking consent for examinations/information sharing etc in the Pathway with hyperlinks to more detailed guidance if required. The Adults with Incapacity Act and the Adult Support and Protection Act are now included within the pathway for consideration when appropriate. The limits to confidentiality when the person or others are considered to be at risk of ongoing harm are now included. The Pathway makes provision for young people aged 16 and 17 with additional vulnerabilities to be included within its remit including the use of child protection procedures if appropriate. It also provides guidance on the appropriate approach to young people aged 16 and 17 where the provisions of the Adult Support and Protection (Scotland) Act 2007 may be appropriate. The Pathway advises practitioners that for particularly vulnerable young people aged 16 and 17 (and potentially up to 25 years if care experienced),

ID.	Consultation comment	Clinical pathways subgroup response
		that although the young person is on the adult pathway, the requirements of public bodies related to corporate parenting and/or Getting It Right For Every Child (GIRFEC) must be considered.
64SR-Q	Overall it reads very well and is a practical guide that people should find useful. Various sections of it are topical now but will become dated and need removed. Others will need to be updated as things change. Therefore important there is a 'live' version of the pathway owned by an organisation who update it regularly possibly annually.	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64SY-X	The definition of the age of the child has raised some queries, specifically if it should be 18 if in full time education or with additional support needs or vulnerabilities. However 16 is the legal age limit for consensual sexual intercourse. From a medical perspective, current paediatric resources may be significantly stretched if aged over 16 included. Is there any information about numbers of 16-18 year olds seen annually currently by adult services?	The Pathway is applicable to the care of children and young people up to 16 years of age (or up to 18 years of age for young people with vulnerabilities and additional support needs) who have disclosed sexual abuse of any kind. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64SN-K	• Re-traumatisation through medical examination – research required. • Corroboration (previous proposal by Lord Carloway) needs reviewing again, particularly for offences against children. • No mention of good trauma recovery practice and prevention of mental health deterioration.	There is now more information and context in the Pathway on trauma informed care and adverse childhood experiences.
64SW-V	Overall I found the pathway straightforward and accessible. It is largely representative of practice in Angus but it is useful to have the pathway laid out clearly as it is here.	Noted.

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64SB-7	Throughout the document, there are references to underage sexual activity and sexually harmful behaviour displayed by young people. As with other aspects of this guidance, neither of these issues receive sufficient attention for the reader to fully understand the context of these complex matters (which are not necessarily equivalent to child sexual abuse) and there is a danger that their inclusion serves to undermine the focus on child sexual abuse.	These issues are now addressed in more detail with reference to the relevant legislation.
64SJ-F	The pathway provides numerous sources of very important and critical information for practitioners. It may be useful to also provide information and weblinks to additional resources which would enable a self-assessment of services, particularly relating to whether the Getting it Right for Every Child practice model is being fully implemented and if the requirements of a 'trauma informed' service are being met. The Children and Young People (Scotland) Act 2014 define a child as someone who has not attained the age of 18. As included above re clarity of what legislation should be followed for 16-18 year olds, the Adult Support and Protection (Scotland) Act 2007 can be applied to over 16 year olds and if so these young people would not be considered under child protection processes. This needs to be clear for practitioners and suggest that the C&YP (Scotland) Act 2014 definition of a child be applied – up to 18 years old.	There is now more information and context in the Pathway on trauma informed care and adverse childhood experiences. The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation
64SH-D	We believe that section 4 of the document, on which no consultation questions are asked, is key to ensuring that medical practitioners have an up-to-date, relevant understanding of CSA, which enables them to identify CSA and act in the best interests of those who have or may have experienced it. We would suggest the following amendments: 4.1 As noted above, we believe that the clinical pathway should be applicable to all children and young people up to the age of 18. 4.2 We believe that a simple, accessible definition of child sexual abuse would be most useful here. The WHO definition used does not offer a great deal of clarity and is not widely	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation. The definition of CSA from the draft revised National Child Protection Guidance (which is currently out for public consultation) is now included in the Pathway.

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	used in policy and practice around CSA in Scotland. It is very important for the definition to extend to subtypes of child sexual abuse, including child sexual exploitation, online child sexual abuse, grooming, and contact/non-contact abuse. Alternative definitions include: • Guidance for Child Protection (2014) (currently under review: "Sexual abuse is any act that involves the child in any activity for the sexual gratification of another person, whether or not it is claimed that the child either consented or assented. Sexual abuse involves forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of indecent images or in watching sexual activities, using sexual language towards a child or encouraging children to behave in sexually inappropriate ways (see also section on child sexual exploitation)." • NSPCC definition (available in full at: https://learning.nspcc.org.uk/child-abuse-and-neglect/child-sexual-abuse/) which has been widely cited by other medical bodies (cf. https://www.rcoa.ac.uk/safeguarding/child-protection/child-sexual-abuse) It may be useful for this section to draw a distinction between children and young people, highlighting the differences in the most common forms of abuse within different age groups. The list of ways in which CSA may present (currently at Section 5.1) should be moved to 4.2, and retraction of a disclosure should be added. To avoid referring to children as perpetrators, the final bullet point should be rephrased to say "a child exhibiting unexpected, problematic or harmful sexual behaviour may have exhibit this behaviour due to their own experience of sexual abuse" We do not believe that the paragraph suggesting that the dynamics of child sexual abuse differ from adult sexual abuse is helpful or necessary. The information on the Sexual Offences Act should be included in Section 4.5 rather than 4.2. 4.3 and 4.4 Sections 4.3 and 4.4 should be amalgamated. The information in section 4.4, on the possible impact of ACES, should be rewritten to be clear	

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	that child sexual abuse is an established Adverse Childhood Experience, and that experiences of trauma can impact negatively on brain development, behaviours and mental health, whilst acknowledging that impact is very dependent on the individual circumstance of the child and crucially, the support they have around them. This should precede the information on trauma-informed services in 4.3, making explicit that the reason services must be trauma informed is to take cognisance of this possible effect, and to avoid anything which could be re-traumatising for the child/young person and create a space for recovery. 4.5 This section is titled 'legal context', but it may be more useful to frame this section explicitly in terms of what a medical practitioner is legally required to do in different situations, with the focus on practitioners' actions rather than the full complexity of the law (references could of course be provided for those who wish to have a fuller legal understanding). The language in this section could be simplified and clarified: the term non-consensual activity should be replaced with sexual abuse to avoid undue complication for medical practitioners around the complexity of consent. So, for example, the second paragraph should read that information must be passed to police about any child or young person under 13 who has been engaged in any sexual activity, any child or young person who has disclosed any form of sexual abuse (including sexual exploitation), or where there is suspicion or concern that this child/young person may be experiencing abuse. Where a child/young person discloses any sexual activity with an adult, Child Protection processes should be followed. It is important to note that due to the grooming process, children and young people can be made to believe they have consented or are to blame for their abuse, or have been deceived into believing that it is not abuse. Professionals are still required to respond to instances where there has been an adult involved as a child protection concern, regardless of whether the child/young person can currently understand the situation as abusive or not. In cases where there has been reported or suspected sexual activity with another child/young person over 12, practitioners should	

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	exercise professional curiosity in terms of gauging children/young people's understanding of consent and 'free agreement', and the circumstances surrounding the relationship between the young people. If it is disclosed or suspected that this relationship may be abusive, professionals should again use a child protection response. Where a child over 12 is disclosing consensual sexual activity with another child over 12, this should be closely monitored and appropriate supports offered.	
64SS-R	The UN Approach to Justice for Children outlines children's rights in relation to the justice system. These rights apply both to children in conflict with the law and those who are victims of crimes. They are grounded in the United Nations Convention on the Rights of the Child (UNCRC) and its principles of: • prioritising the best interests of the child; • ensuring no child is discriminated against; • recognising every child's right to life and to development; and • advancing the right of the child to express their views and have them given due weight. Article 34 of the UNCRC requires that states protect children from all forms of sexual exploitation and sexual abuse. Ensuring that perpetrators of sexual abuse are successfully prosecuted is an important part of fulfilling those obligations and ensuring that robust evidence is collected, including via forensic medical examinations is essential. However, article 39 of the UNCRC also places an obligation on states to "promote physical and psychological recover and social reintegration of a child victim of any form of neglect, exploitation or abuse…" . The current consultation does not address this and instead focusses solely on the process of forensic medical examination. Whilst we understand that legislation on this issue is complex, we would prefer this clinical pathway to be considered as part of a holistic clinical pathway which also addressed the recovery and support needs of children who are victims of sexual abuse. Holistic support for children who experience sexual abuse We believe that children's rights, particularly given the Scottish Government's commitment to incorporation of the UNCRC into Scots law,	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context.

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	would be better served by proposals which were grounded more firmly in children's rights and drew on international best practice as demonstrated by the Barnahus model. The Scottish Government has committed to exploring the introduction of the Barnahus model of children's centres, which provide a holistic and child-centred context for the investigation of sexual abuse and the continued recovery of child victims. We are disappointed that, despite reference to the Barnahus model in the introduction, this consultation places the proposals within current operational contexts and in particular, as outlined in the pathway illustration on page 14, continues to separate the health service from other agencies' involvement. Finally, we are deeply concerned that the proposals do not include all children under the age of 18. The protective rights outlined by the UNCRC apply to all children up to age 18 and article 2 requires that states parties "respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind" . On page 22 of the consultation document it is stated that article 1 allows the setting of a lower age of majority under law. Whilst this applies to empowerment rights, such as the right to vote or to instruct a solicitor, it is not the case that states may choose which children are entitled to protective rights, such as those in articles 34 and 36 of the UNCRC. The existence of the UNCRC is based on the premise that all children under the age of 18 have vulnerabilities, as a result of being a child, and therefore require additional protections to those provided by other human rights treaties. The protections proposed by this consultation should therefore be extended to all children under the age of 18 and we feel there would be a case for extending them beyond 18 for those with disabilities and other specific vulnerabilities. Recommendation We recommend that: • Scottish Government consider the clinical pathway for children who have disclosed sexual abuse within the wider discussion around the introduction of the Barnahus Model to Scotland • Any provisions be extended to all children under the age of 18, in line with the UNCRC.	

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64ST-S	Main comments are that this document is too high level and discusses what should be done but there is nothing about how it should be implemented - is there an assumption that each Health Board follow this up with a local policy on implementation? If so them this should be added. Also there is nothing about resource / funding for the trauma informed services discussed in the document.	Local implementation of the Pathway is the responsibility of the local health boards.
64SU-T	Yes. This could have been really something. It really could have been - even in the same league with some of the best child protection systems on this planet but this, this right hear, is yet another Scottish Government failure like the Scottish independence bid was a failure because most of the politicians in government are failures. Due to a combination of inept and inconsistent law, politics before persons and the propagation of unverified theory this is going to lead to more harm than good. I am dismayed I can not support this. I would have loved to absolutely loved to. Trust me because right now Scotland's children in particulate are perhaps one of thee most endangered groups in North Western Europe in ways this government could not even begin to mentally process and still remain sain let alone comprehend over a consultation response. This governments obsession with abortion and targeting religious persons and the family unit is what is stop it from receiving the dire support from the public and international community that it needs in order to progress ! I have been both falsely accused in an incident of claim by police they then subsequently admitted too was false and also a victim to such abuse when I was younger as well. I do have sadly, lived experience of this sort of thing and its very hard to prove but sacrificing democratic legal protections designed to defend those falsely accused is far too great. I am just sorry to the children of Scotland for there Government loosing there independence, EU membership and futures were we could have advanced this nation to a just society for them. I want to say another thing one thing that really sticks out hear is the statement that being a victim of abuse could actually be a sign of that person being a child abuser - talk	Noted.

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	about victim blaming and being problematic Scottish Government ! This is an assumption based on the pet criminological theory that victims themselves could become perpetrators due to the abuse cycle certainly in so much as some cases even known to the author this certainly can be true but its not true in the majority cases. This theory is being more and more debunked by academics upon research that seems to show this is actually not water-tight after all as most victims are good people who have been victimised living very hard life's and while they may due to there experience go on to commit crime very few actually go on to commit the same crime that was committed to them out of sheer loathing of there abuser and not wanting to be anything like them.	
64SD-9	[Our organisation] note that there is little guidance or detail in the management of forensic samples. Further guidance on forensic sampling and sequence, including reference to the Recommendations for the Collection of Forensic Specimens from Complainants and Suspects (FFLM 2019) should be included. https://fflm.ac.uk/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-3/ […] notes that there is a lack of supporting information or guidance on grooming and abuse perpetrated by children and young people - who may themselves be the victim of sexual abuse. This challenging presentation is often encountered in practice and there may be an opportunity for the Pathway to raise awareness of this, and provide guidance on management of disclosures of abuse by children and young people who are themselves victims.	The language in the Pathway is aligned with the draft revised National Child Protection Guidance. It now includes grooming and CSE.
64S7-V	General points Positive that it highlights the systemic aspects and different procedures and roles that people have. Positive that primary purpose is the health and wellbeing of the child in a holistic manner and secondary is collecting forensic evidence.	Noted.

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64S4-S	No mention of the third sector or CAHMS, or other areas of support. May be embedded in support documents, but you'd need to go through and read every link, which people obviously might not do.	The third sector and requirement for support with mental health are now included in the Pathway.
64S4-S	Talks about non-recent disclosures, but no reference to the adult part of it. E.g if this is an adult who is presenting. The challenge is when an adult presents with a disclosure of non-recent abuse, it takes you back to being a child again, and you lose your sense of 'adult' experience and assertiveness. Maybe reference to some adult policies and procedures	This is covered in the Adult Clinical Pathway.
64S4-S	Is it intended as a procedural pathway, or to help people to work with children who have disclosed sexual abuse, or adults disclosing what happened to them as a child. It's a very medical model (although it is a clinical pathway) but suggest there should be a wider reach, as the medical model is not always the correct model. It references historical abuse because we are not good enough at finding ways to encourage them to come forward. This document doesn't take us any further, and we're stuck with CSA at the moment particularly around familial CSA, and we don't deal with it well enough at all.	Noted.
64S4-S	The pathway is based on disclosure, but we are aware that many child and young people we work with may never make a formal disclosure, even though we may have significant concerns about them. It felt to me that there is a small number of children and young people who would actually benefit from this. Sexual health services often work with people who have experienced sexual abuse, even if they don't make a disclosure, and they get that support. It should be broadened out.	Noted. However, the Pathway is intended to describe care and support within child protection procedures following a disclosure.
64S4-S	There's a real shift nationally towards different models and language (e.g Barnahus model), but this is not reflected in the document. E.g using 'management of health needs' rather than 'health and wellbeing'. There is an	The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context.

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	emphasis on 'doing to', and the person-centredness can get lost. Interagency child protection produces is a narrow chart.	
64S4-S	The document might quickly be out of date, given ongoing work in relation to child protection guidance, joint investigative interviews, new health guidance etc.	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64S4-S	The UNCRC and child right, not 'doing to' is not addressed.	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.
64S4-S	It would be interesting to see the feedback from the CYP Expert Group, as it mentions in the document that feedback has been sought and changes made. What were their comments?	This has been incorporated into the updated Pathway.
64S4-S	Where does this sit alongside the principles and evidence base of the Barnahus? The children's rights, taking time, letting the child be at the centre, therapeutic way of working, trauma at the centre, relationship-building... all of this is missing in the pathway. This needs to be highlighted up front, and threaded throughout the document. Address the issue about whether the medical is being done for the child or for evidence-collection and court purposes. What are the priorities for health and the purpose of a medical intervention?	The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context.
64MX-Q	Other agencies, collaborative and effective not sure. Doesn't feel as collaborative. It is a clinical pathway, health focused. Quite process driven, more than just this bit – where is the bits about exploitation, needs to be identified, needs to be A&E, schools identifying those risk factors. There are several factors. Change it to pathways, multi-agency pathways as title? How children get to this point more quickly dependent on how we are identifying	The revised Pathway now makes clear that the care and support provided to Children and Young People who have experienced Child sexual abuse and non-abusing parent/carer(s) is multiagency and multi professional.

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	risk factors, sharing information – effective, people are sometimes reluctant to share information. Agencies can be defensive about sharing information. Feels multi-agency – doesn't have that full collaborative, concerns full comprehensive agency, sharing of information. 1.5 Other documentation – supporting the signs guidance – sexual exploitation. References missing around exploitation in particular – some feedback to develop that a bit more. How we can work collaboratively. How does that work in terms of point of disclosure? Need for ongoing support and difficulty accessing, delays in examinations, healthcare in IRD. Pathways covers up to 16years	
64M5-M	[Our organisation] greatly welcome the creation of a specific care pathway for children and young people following sexual abuse. This is a critical development in supporting CYP's highly distinct health and wellbeing needs, including their emotional health needs, to be met in the round following sexual abuse. • We particularly welcome that the pathway is for all children and young people who have experienced sexual abuse (acute and historic) and that it articulates the fundamental role of health in responding to children and young people's emotional health and recovery needs following abuse. We also welcome the acknowledged importance of partnership working around the child and family, and reference to trauma approach to children, young people and their families. • However, we are concerned that these and other essential features of a child's pathway are not illustrated in the high-level summary (Clinical Pathway Process diagram, pg.13), nor articulated comprehensively throughout the stages of the pathway. Perhaps most critically, there is little clarity in the document about who is responsible for what at each stage of the pathway process. As such, we would welcome significant revision, if the pathway to act as a tool to support health services, health care professionals and partner agencies in meeting the 2017 HIS standards and making these real for children. • Given the success of the care pathway depends on close collaboration with key partners, we would also respectfully suggest that an 'extra stage' in the consultation would be	The Pathway is to be considered an interim pathway and will be subject to review to take account of any changes to relevant guidance or legislation.

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	helpful. This will allow the pathway to be developed in collaboration with partner agencies and in-line with the core national standards and guidance, most importantly the National Guidance Child Protection, currently under revision, the Standards for a Scottish Barnahus, currently being drafted by the SG in collaboration with a multi-agency working group and the Standard Police Protocol on Child Protection and Guidance for JIIT.	
64MY-R	In section 5.2 – Clinical Pathway process/ IRD page 15 • Consideration should be given to Education being part of IRD for school age children • Governance for IRD should be considered.	The comment has been noted and the Pathway now contains reference to education attending IRDs when appropriate.
64MW-P	Child Sexual abuse should not be considered in isolation from all other forms of physical and emotional abuse and neglect. Therefore all services that provide a paediatric and forensic service must employ those who have a high level of skills in identification, assessment, and both multi-disciplinary and multiagency management of all forms of child maltreatment. 5 This should be clearly stated within the clinical pathway document.	Agree. The Pathway sits within the wider child protection context in Scotland which is now discussed in the document.
64MV-N	While welcoming the Scottish Government commitment to addressing the issues raised in the 2017 HMCIS report, we need to make sure that work to strengthen the clinical pathway for children and young people who have disclosed sexual abuse is considered within the developing work on the Barnahus approach, and takes full account of particular issues for children and young people around consent, the nature of child abuse and ACEs.	The Pathway is 'Barnahus ready' in that it will facilitate the introduction of a Barnahus model in the Scottish legal and child protection context. There is now more information and context in the Pathway on trauma informed care and adverse childhood experiences.

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