

Sexual Assault Treatment Services

A National Review



National Steering Committee on Violence Against Women

*Researched and written by Angela O'Shea
on behalf of the Sexual Assault Review Committee*

Foreword



I welcome this comprehensive review of the sexual assault treatment services. This is a complex and sensitive area which provides vital services and support to people in crisis. It is essential, therefore, that these services are accessible and responsive to the needs of people who are subjected to such a traumatic experience.

The response to sexual assault involves close collaboration between the Gardaí, health services and the wider criminal justice system. The report sets out clearly their respective roles and the co-operation required between them which will ensure that in the collection of the necessary evidence, victims are treated in a sensitive and caring way and are provided with the necessary emotional and psychological support and counselling services.

The report identifies the key areas for the development of sexual assault treatment services. I am confident that the Health Service Executive together with my Department and the Department of Justice, Equality and Law Reform will work to ensure the speedy implementation of the recommendations in the report.

I commend the National Steering Committee on Violence Against Women, chaired by my colleague, Frank Fahey, Minister of State at the Department of Justice, Equality and Law Reform which commissioned this report and the staff of the Women's Health Policy Unit in my Department who provided the chair and secretariat for the review committee.

Mary Harney, TD
Tánaiste and Minister for Health and Children

Table of Contents

Foreword	3
Abbreviations	9
List of Tables	10
Acknowledgements	11
Executive Summary	13
SECTION 1: Sexual Assault Services in Ireland: Context for Review	
1.1 Introduction	19
1.2 Methodology	20
1.3 Significant Developments in the Past Decade	21
1.4 Summary	22
SECTION 2: Criminal Justice Process	
2.1 Introduction	23
2.2 An Garda Síochána	24
2.3 Forensic Medical Examination	24
2.4 Forensic Science Laboratory	25
2.5 Domestic Violence and Sexual Assault Investigation Unit	26
2.6 Director of Public Prosecutions	27
2.7 Summary	27
2.8 Conclusion	28
SECTION 3: Prevalence of Rape and Sexual Assault	
3.1 Introduction	29
3.2 Sources of Statistical Data	29
3.3 Comparing Data Sources	29
3.4 Reporting Rape and Sexual Assault	31
3.5 Attrition	31
3.6 Summary	33
3.7 Conclusion	33
SECTION 4: Emotional and Psychological Needs of Victims of Rape/Sexual Assault	
4.1 Introduction	35
4.2 Support Workers	35
4.3 Psychological Consequences of Rape and Sexual Assault	36
4.4 Forensic Examiners	36
4.5 Summary	36
4.6 Conclusion	37

SECTION 5: Review of Existing SATU services in Ireland

5.1	Introduction	39
5.2	HSE-Eastern Region: Rotunda Hospital	39
5.3	HSE-Southern Region:South Infirmary / Victoria Hospital, Cork	40
5.4	HSE-South Eastern Region: Waterford Regional Hospital	41
5.5	North West: Letterkenny General Hospital	41
5.6	Emerging Themes in Existing SATUs:	43
5.6.1	Introduction	43
5.6.2	Management	43
5.6.3	Forensic Medical Examiners	43
5.6.4	Nursing Services	44
5.6.5	Rape Crisis Services	44
5.6.6	An Garda Síochána	45
5.6.7	Scope of Service Provision	45
5.6.8	Young People Accessing Adult Services	45
5.6.9	National resource	45
5.6.10	Funding	45
5.7	Summary	45
5.8	Conclusion	46

SECTION 6: Gaps in Adult SATU Services

6.1	Introduction	47
6.2	HSE-Mid Western Region	47
6.3	HSE-Western Region	48
6.4	HSE-Midland Region	48
6.5	HSE – North Eastern Region	49
6.6	SATU, Tralee General Hospital	49
6.7	Summary	50
6.8	Conclusions	50

SECTION 7: Acute Child Sexual Assault Services

7.1	Introduction	51
7.2	Key Legislative Provisions	51
7.3	Presentation of a Child following Alleged Sexual Assault	51
7.4	Current Situation	52
7.5	Prevalence of Acute Rape/Sexual Assault in Children	52
7.6	Summary	52
7.7	Conclusions	53

SECTION 8: International Review of Models of Good Practice

8.1	Introduction	55
8.2	Child Abuse and Rape Enquiry Units: Northern Ireland	55
8.3	Sexual Assault Centres/ Sexual Assault Referral Centres	56
8.4	Centres of Excellence	57
8.5	Forensic Nursing	57
8.6	Summary	58
8.7	Conclusions	58

SECTION 9: Rationale to Determine Appropriate Locations for Future Developments

9.1	Introduction	61
9.2	Criteria	61
9.2.1	Sustainability of Services	61
9.2.2	Travel Time to Nearest SATU	63
9.2.3	Previous Reporting Rates	63
9.2.4	Discussion	64
9.3	Forensic Nursing: A Way Forward?	64
9.4	Summary	65

SECTION 10: Recommendations

10.1	Introduction	67
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REFERENCES	73
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APPENDICES

1.	Legislation	75
2.	Membership of Review Committee	77
3.	Number of reported rape cases by Garda division	79
4.	Overview of UK Sexual Assault Treatment Services	81
5.	Recommended minimum elements of service (Haven, London)	83
6.	Myths versus Facts about Rape and Sexual Abuse	85
7.	Recommendations forwarded to more appropriate fora	87

Abbreviations

ACSAS	Acute Child Sexual Abuse Services
CARE	Child Abuse and Rape Enquiry Unit
CSA	Child Sexual Abuse
DOHC	Department of Health and Children
DJELR	Department of Justice, Equality and Law Reform
DRCC	Dublin Rape Crisis Centre
DVSAIU	Domestic Violence and Sexual Assault Investigation Unit
FME	Forensic Medical Examiner
HSE	Health Service Executive
INO	Irish Nurses Organization
IMO	Irish Medical Organization
NCC	National Crime Council study
NCPDNM	National Council for the Professional Development of Nursing and Midwifery
NSC	National Steering Committee on Violence Against Women
NUI	National University of Ireland
PSNI	Police Service Northern Ireland
PTSD	Post Traumatic Stress Disorder
PULSE	Police Using Leading Systems Effectively
SAC	Sexual Assault Centre
SANE	Sexual Assault Nurse Examiner
SARC	Sexual Assault Referral Centre
SAVI	Sexual Abuse and Violence in Ireland study
SATU	Sexual Assault Treatment Unit
STI	Sexually transmitted infection
SVCC	Sexual Violence Centre Cork
RCNI	Rape Crisis Network Ireland
RPC	Regional Planning Committee on Violence Against Women

List of Tables

Table 1. Overview of victims' options	23
Table 2. Sexual offences reported to the Gardaí 2003	24
Table 3. Statistical overview	30
Table 4. Outcomes of criminal proceedings 2003	32
Table 5. Age profile of female victims attending the Rotunda	40
Table 6. Summary of existing SATU services	42
Table 7. Rotunda SATU attendance from outside of Dublin 2003	62
Table 8. Cork SATU attendance 2003	62
Table 9. Reported cases by HSE region per 100,000 population	63

Acknowledgements

We would like to express our thanks to the many people whose cooperation and assistance was essential to conducting this review. Our thanks in particular go to the members of the Regional Planning Committees on Violence Against Women, Rape Crisis Centre Coordinators and Sexual Assault Treatment Unit service providers whose willingness to sharing information has informed the approach of the Review.

The Review Committees work was also greatly assisted by the presentations made by the Police Service Northern Ireland, Forensic Nursing Working Group, Director of Public Prosecutions, Domestic Violence and Sexual Assault Investigations Unit, Dublin Rape Crisis Centre, Sexual Violence Centre Cork and Dr. Emma Curtis, Community Paediatrician, Tallaght Hospital, Dublin.

And finally, the Review Committee wish to acknowledge Mr Chris Fitzgerald for his commitment to this review and his excellent facilitation as chairperson to the Committee.

Executive Summary

Introduction

The seriousness and extent of rape/sexual assault is generally not acknowledged and it remains one of the most under-reported and under-recorded of violent crimes. There is a stigma attached to disclosing rape/sexual assault¹ which makes it difficult for victims to report it to the Gardaí or support services, therefore the prevalence of sexual violence in Ireland is unknown. Incomplete evidence from crime statistics, previous research reports and service uptake figures is insufficient to fully understand the nature and extent of the problem (McGee, et al, 2002).²

The aim of this review is to examine the provision of Sexual Assault Treatment Services in Ireland and in doing so:

- identify the most appropriate service for adult and teenage (both male and female) victims³ of sexual crime that would adopt a holistic approach to care, and in doing so incorporate all the relevant aspects such as health, justice and psychological needs;
- produce a report on the findings containing recommendations to present to the Tánaiste Mary Harney, Minister for Health and Children and Frank Fahy, Minister of State at the Department of Justice, Equality and Law Reform and the National Steering Committee on Violence Against Women.

Violence Against Women emerged as a major issue in the consultation process in the Department of Health's Policy Document on Women's Health in 1996. This led to the establishment of the National Steering Committee on Violence Against Women (NSC) and the publication of the Task Force Report on Violence Against Women (1997) which contained recommendations to address the needs of women who had been raped/sexually assaulted. In February 2005 a sub-committee of the NSC was convened to review the provision of Sexual Assault Treatment Services and address the issues that have to date hindered the development of appropriate, timely and professional Forensic Medical Examination services across the country to victims of recent sexual crime that incorporate the health, justice and psychological needs of the victim.⁴ The development of these services are seen to be the joint responsibility of the Department of Health and Children (DOHC) and the Department of Justice, Equality and Law Reform (DJELR).⁵

¹ See legal definitions Appendix I.

² The Sexual Abuse and Violence in Ireland study (SAVI) (McGee et al, 2002), an internationally recognized piece of research, was carried out by the Health Services Research Centre, at the Royal College of Surgeons (RCSI) in association with Dublin Rape Crisis Centre (DRCC). The main aim of this study was to estimate the prevalence of various forms of sexual violence among Irish women and men across the life span from childhood through to adulthood.

³ The terms 'victim', 'alleged victim', 'complainant' and 'survivor' are commonly used terms when referring to individuals who have been raped or sexually assaulted, the term used being dependant on the service being provided. It has however been agreed by the multidisciplinary review committee that in order to maintain uniformity throughout the document the term 'victim' will be used when referring to an individual who has been raped or sexually assaulted.

⁴ See membership of Review Sub-Committee Appendix II.

⁵ The Department of Justice, Equality and Law Reform is responsible for legal initiatives that can be put in place, including intervention programmes for perpetrators of domestic violence and awareness raising measures aimed at changing society's attitudes to domestic abuse. The Department also co-ordinates the work of the National Steering Committee on Violence Against Women.

The Criminal Justice Process

The care of victims of recent sexual crime relies on the expertise of many disciplines including An Garda Síochána, medical, counselling, scientific and legal professionals. Forensic medical examinations⁶ are an essential part of the process for victims who wish to proceed with criminal prosecution. In a criminal trial the only time evidence from a forensic medical examination is not required is when the perpetrator pleads guilty to the crime.

The forensic medical examination has unique features with the medical practitioner required to perform a dual role in addressing the immediate needs and concerns of the victim and in acting as an agent of law enforcement in the collecting of forensic evidence. While the forensic medical examination can be taken up to seven days following the alleged assault, positive results are more likely if the procedure is undertaken within the shortest timeframe possible. A forensic medical examination is time consuming, often lasting up to two hours and involves taking intimate external and internal samples from the victim for the collection of forensic evidence in order to identify the DNA of the perpetrator. Attendance for a forensic medical examination also offers an opportunity to treat minor injuries, undertake medical tests, provide preventative treatment and address the immediate psychological needs of the victim.

Prevalence of Rape/Sexual Assault

The SAVI study found that more than four in ten women (42%) and over a quarter of men (28%) experienced some form of sexual assault in their lifetime. Despite these figures only 1% of the males and 7.8% of the females reported to the Gardaí. Although statistical information is available in the annual reports of An Garda Síochána, SATUs, Rape Crisis Centres (RCCs) and the Rape Crisis Network Ireland (RCNI), comparing different sets of data is rarely comparing like with like as different agencies adopt various definitions to the term 'sexual crime' and agencies collect data for specific purposes rather than comparative purposes. This lack of comparable data highlights the need for relevant service providers to agree and develop mechanisms to coordinate the collection of data in order to create a baseline of information which can inform service delivery and future developments.

Emotional and Psychological Needs of Victims of Rape/Sexual Assault

The SAVI study found that of those who had experienced sexual violence as adults or children, 25% of women and 16.5% of men reported symptoms that met the full or sub-syndromal criteria for post-traumatic stress disorder (PTSD) in the past and 17% of women and 9.5% of men reported current symptoms that meet this criteria. It also found that victims of sexual violence were eight times more likely to have been a psychiatric inpatient than those without such experiences. While medical and nursing staff provide crucial psychological support, the role of the forensic medical examiner (FME) as an agent of law enforcement requires the forensic medical examination to be undertaken in as objective a fashion as possible. The RCCs emphasise the benefits to the victim of having an independent support person present to assist them in regaining personal power and control and propose that RCC support workers are called to the SATU automatically as in the Rotunda and Waterford, in the same way that the doctor, nurse and Garda are called on to support the victim.

⁶ This is an intimate internal and external examination carried out by a doctor on a victim of alleged rape/sexual assault for the collection of forensic evidence in order to identify the DNA of the perpetrator. For more detail see section 2.3.

Review of Existing SATU Services in Ireland

To date, Sexual Assault Treatment Units (SATUs) have developed in a relatively fragmented way rather than as a coordinated strategy. For this reason there is considerable disparity in the availability of such services across the country. Currently there are four SATUs in Ireland, existing in four HSE Regions, namely the Eastern, the South Eastern, the Southern and the North Western regions. Recruiting and retaining FMEs has been an on-going difficulty in all SATUs with the over-reliance on the limited number of available doctors increasing the risk of fallout. Management and implementation structures vary greatly between all SATU services particularly in relation to multi-agency management, personnel issues, scope of service provision and sources of funding. The SATU in the Southern region is the only service that has secured funding from the DOHC and as such is the only SATU that can be confident regarding its sustainability.

Gaps in Adult Services

Currently there are no dedicated SATU services in the Mid Western, Western, Midland or North Eastern HSE regions. Victims from these regions are therefore dependant on ad-hoc arrangements, where there are often long delays between the time the crime is reported to the Gardaí and the carrying out of a forensic medical examination. In failing to identify a local GP who is available to carry out the examination, the Gardaí are frequently required to transport victims to a designated SATU elsewhere, often taking 12 hours or more to make the round trip.

When reviewing reporting rates to the Gardaí for 2003 it was noted that the HSE Western and Midland Regions had particularly low rates of 3.6 and 4.4 cases per 100,000 population respectively in comparison to the national average for that year of 9 cases per 100,000. This finding would suggest that the lack of dedicated services in these regions acts as a deterrent to victims reporting to the Gardaí.

Gaps in Paediatric Services

A diagnosis of child sexual assault should rarely, if ever, be made on physical signs alone and a substantial proportion of sexually assaulted children have no abnormal physical signs. The decision on whether an immediate examination is necessary should be based on the advice of an experienced, skilled practitioner. A multi-disciplinary investigation with full interagency cooperation between social workers, psychologists, therapists and doctors is necessary when there is concern that child sexual assault has occurred.

Currently however there are no dedicated medical services for children who experience acute sexual assault in Ireland. Many cases present to A&E departments out of hours to staff with little or limited experience in the management of acute child sexual abuse. Over the years ad-hoc arrangements have developed in the three children's hospitals in Dublin to try to meet the needs of these victims. Developing appropriate services to meet the needs of children is extremely complex and requires extensive research which is beyond the scope of this review.

International Review of Models of Good Practice

Various models of service provision exist around the world ranging in scope from the medico-legal model which is limited to victims who wish to proceed with criminal prosecution, to the more holistic model incorporating the physical, forensic and psychological aspects of the victims needs which are available to all victims regardless of their decision to proceed with criminal prosecution or not.

Forensic nursing has been introduced in Europe, the US and Canada as a means of addressing problems encountered with the recruitment and retention of female doctors and providing the best possible service for victims. In the US forensic nurses now conduct the majority of forensic medical examinations on both adults and children, and includes provision of services to the police and criminal justice system. In the UK however the scope of the forensic nurse's practice is limited where they are accepted by the courts as an ordinary witness⁷ only, as opposed to the doctor who is seen as an expert witness. The evaluation of the UK forensic nursing pilot programme suggested that "the obvious next step for the long term lies in the development of the forensic nurse's role from documenter to interpreter of her own evidence, as is common practice in North America" (Regan et al, 2004).

Rationale to Determine Appropriate Locations for Future Developments

The findings of this review show that the responses experienced by victims of rape/sexual assault in Ireland, depends on where they live. The rationale to determine location of future developments is based on sustainability of services, travel time to the nearest SATU and previous reporting rates.

Recommendations

The development of SATU services are seen to be the joint responsibility of the DOHC and the DJELR. Both of these government bodies acknowledge the need to develop a more comprehensive rape and sexual assault treatment service, which is relatively local, easily accessible, provides appropriate privacy and is compassionate and empathetic to the victim while maintaining expertise and standards in service delivery. The implementation of the recommendations in this report requires the commitment from these two departments and their relevant agencies, to ensure sustainability through the ongoing provision of appropriate resources. The recommendations put forward by the review Committee are listed below.

1. Standardization of Existing Services

Aspects of current services which require standardization include:

- management procedures
- personnel issues in relation to medical, nursing and administrative staff
- involvement of support workers
- scope of services offered
- monitoring and evaluation of services
- national guidelines
- inter-referral pathways
- non-pay costs

2. Expansion of SATU Services

- Two additional services to be initiated in Galway city in the HSE Western Region and an appropriate location in the HSE Midland region.

⁷ An 'ordinary witness' is one who testifies on their personal opinion versus an 'expert witness' who can interpret, extrapolate and provide comment on facts, possibility and probability (Director of Public Prosecution, presentation to SATU Review Committee, 2005).

- The uptake of these services to be reviewed by the NSC in 2007 to ensure that the gaps in services have been addressed adequately and if not, that measures are taken to address these needs.

3. Forensic Nursing

- The introduction of a pilot programme in forensic nursing in Ireland where nurses undergo a higher diploma in order to qualify as a clinical nurse specialist in forensic nursing.
- Employ a co-ordinator to oversee, manage and evaluate the pilot programme and ensure availability of appropriate administrative support.
- Employ a part-time clinical supervisor and assessor.
- Obtain An Bord Altranais Level 2 approval for the Higher Diploma in Forensic Nursing.
- Conduct an external evaluation of the pilot programme to inform future practice and examine the future potential to advance to Advanced Nurse Practitioner in forensic nursing.

4. Addressing Gaps in the Legal System.

- Establishment of a dedicated interview room in a Garda Station in each HSE region exclusively for victims of sexual crime.
- Introduce a policy in each SATU where medico-legal reports are automatically taped following each forensic medical examination.
- Consideration should be given to legislative change regarding the establishment of a national DNA database.

5. Promoting Networking and Sharing of Information.

- Develop networking links with National and Regional HSE care group/ Primary Care Units.
- Collation, analysis and publication of annual statistics.
- Bi-annual conference on the issue of Rape and Sexual Assault.

6. Further Research Requirements.

- The NSC to identify and commission research needs in the area of rape/sexual assault.
- Immediate priority should be given to informing the key players involved in child care services of the need to examine the provision of services to children and in doing so identify the most appropriate model/s of care.

7. Training

- Develop a professional accredited training programmes for doctors on the treatment of victims of rape/sexual assault; medico-legal documentation; court room appearance; and the psychological consequences of rape/sexual assault.
- Provide training for SATU Nurse Managers to facilitate STI follow-up on site.
- Development and facilitation of accredited multi-agency training programmes for all service providers.

Context for Review of Sexual Assault Services in Ireland

1.1 Introduction

The seriousness and extent of rape/sexual assault is generally not acknowledged and it remains one of the most under-reported and under-recorded of violent crimes. There is a stigma attached to disclosing rape/sexual assault which makes it difficult for victims to report it to the Gardaí or support services, therefore the prevalence of sexual violence in Ireland is unknown. Incomplete evidence from crime statistics, previous research reports and service uptake figures is insufficient to fully understand the nature and extent of the problem (McGee et al, 2002).

Aim of Review

The aim of this review is to examine the provision of Sexual Assault Treatment Services in Ireland and in doing so:

- identify the most appropriate service for adult and teenage (both male and female) victims of sexual crime that would adopt a holistic approach to care, and in doing so incorporate all the relevant aspects such as health, justice and psychological needs;
- produce a report on the findings containing recommendations to present to the Tánaiste Mary Harney, Minister for Health and Children and Frank Fahy, Minister of State at the Department of Justice, Equality and Law Reform and the National Steering Committee on Violence Against Women.

Rape undoubtedly remains one of the most heinous criminal acts that can be perpetrated against a person. Rape/sexual assault is an act of violence. It is a lust for power rather than a lust for sexual enjoyment. It is an invasion of the individual's physical and personal integrity (Kelly & Regan, 2002).

Violence Against Women emerged as a major issue in the consultation process in the Department of Health's Policy Document on Women's Health in 1996, which led to the establishment of a multi-agency Task Force on Violence Against Women. In 1997 the Task Force produced a report stating that:

“different players in the public and voluntary sectors could work more effectively if they could co-ordinate their efforts and welded their separate responses into a coherent and coordinated approach”

(Task Force Report 1997).

Following the publication of this report the Government established the NSC to provide a multi-agency approach to violence against women which included both sexual violence and domestic violence.⁸ In February 2005, a sub-committee of the NSC was convened to review the provision

⁸ The Task Force Report defines domestic violence as “the use of physical or emotional threat of physical force, including sexual violence in close adult relationships. In Ireland the Task Force Report uses “violence against women” as an umbrella term to describe both domestic violence and sexual violence, while recognising that domestic violence often includes sexual violence and sexual violence also occurs outside intimate relationships.

of sexual assault treatment services and address the complex issues that have to date hindered the development of appropriate, timely and professional forensic medical examination services across the country to victims of recent sexual crime, and identify models of optimum delivery of service. The development of these services are seen to be the joint responsibility of the DOHC and the DJELR. The membership of this review committee was drawn from the NSC with additional members co-opted in recognition of their expertise in this area. The membership includes representatives from DOHC, DJELR, An Garda Síochána, Health Service Executive (HSE), Irish Medical Organization (IMO), Nursing Professionals, Paediatricians, Adult Sexual Assault Treatment Unit (SATU) service providers, Rape Crisis Network Ireland (RCNI), Dublin Rape Crisis Centre (DRCC), Sexual Violence Centre Cork (SVCC), the Forensic Science Laboratory and the Irish Nurses Organization (INO)(See Appendix II). One of the members of the Committee, who had previous experience in setting up a SATU in Waterford, was appointed as Researcher and Project Coordinator to conduct the research and draft a report.

1.2 Methodology

The approach adopted for the review was both qualitative and quantitative. It allowed the experiences of service providers to inform the work, while also encouraging all involved to question and develop their understanding in relation to sexual assault treatment services. As sexual assault treatment services involve a multi-agency approach, different professionals were selected to review the different components of service delivery. In order to obtain a regional perspective, available representatives with a brief or interest in this subject from former health board regions were consulted with regard to their local situation.

These included:

- Members of the Regional Planning Committees
- Rape Crisis Centre Coordinators
- Existing SATU services
- An Garda Síochána
- Hospital Consultants
- Nursing Professionals
- General Practitioners

In addition the following national services were consulted: the Forensic Science Laboratory; the Domestic Violence and Sexual Assault Investigations Unit (DVSAIU); and the Director of Public Prosecutions (DPP).

Submissions were received from key stakeholders and informal conversations with a number of service providers also informed the consultation. A review of research, legislation and reports relevant to the issue was also undertaken with extensive references made to the research works of the UK based Child and Women Abuse Studies Unit.⁹ Quantitative data was compiled from

⁹ The 'Child Abuse Studies Unit', of London Metropolitan University was established in 1987 following a conference on child sexual abuse that brought together survivors, women's groups, services and professionals. Professor Liz Kelly was appointed the first full-time member of staff in September 1987 with a brief to develop research, information and networking. From the second year of the Unit's existence they have also focused on abuse of adult women in the home and other forms of gender violence and in 1994 became the 'Child and Woman Abuse Studies Unit' to more accurately reflect their work.

reviewing relevant data sets including the data sets from An Garda Síochána, Dublin RCC, RCNI¹⁰ and SATU annual reports.

1.3 Significant Developments in the Past Decade

The Beijing Declaration and Platform for Action, 1996

The Beijing Platform for Action was set up in September 1995 in Beijing China as part of the UN World Conference on Women. The Beijing Declaration stated:

“Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment of women of their human rights and fundamental freedoms. The long-standing failure to protect and promote these rights and freedoms in the case of violence against women is a matter of concern to all States and should be addressed.”

This conference was supported by 189 countries including the Irish Government which made a commitment to work toward the elimination of violence against women.

Garda Síochána Policy on Domestic Violence (1997)

The Garda Síochána Policy on Domestic Violence Intervention was developed in 1994 and revised in 1997. The Garda Síochána advocate a pro-arrest policy for incidents of domestic violence and state that where a power of arrest exists it should be used. The policy states very clearly that the primary role of the Gardaí when responding to domestic violence is protection through the enforcement of the law, not reconciliation which should be left to those who are skilled in the area. Under the policy the Gardaí must ensure that the victim is fully informed of the legal redress available to her/him through the civil courts and made aware of relevant services in the area.

Task Force Report on Violence Against Women (1997)

The key Irish policy development in the area of violence against women was the formation of the Task Force on Violence Against Women and its subsequent report (1997) which provides both policy and institutional frameworks for addressing violence against women. The Task Force Report includes a comprehensive examination of issues surrounding violence against women in Ireland. This report led to the establishment of planning committees on violence against women at national, regional and local level which aimed to “develop a coordinated partnership approach between the voluntary, community and public sectors” (Task Force Report, 1997). The report also recommended that “Forensic Medical Examinations be provided for victims in an appropriate, timely and professional manner”.

The Sexual Abuse and Violence in Ireland study

The SAVI study (McGee et al, 2002) is an internationally recognized piece of research, which was carried out in 2002 by the Health Services Research Centre, at the Royal College of Surgeons (RCSI) in association with DRCC. The main aim of this study was to estimate the prevalence of various forms of sexual violence among Irish women and men across the life span from childhood through to adulthood. This groundbreaking study which consulted over 3,000 randomly selected Irish adults found that 42% of women and 28% of men experienced some form of sexual abuse

¹⁰ Rape Crisis Network Ireland (RCNI) is a multi-member political and campaigning organisation committed to the elimination of all forms of sexual violence through effecting political, cultural and social change. Their agenda to effect change is directly provided by the experience and expertise of their member Rape Crisis Centres (RCCs) (RCNI, 2004)

or assault in their lifetime. (The prevalence of rape/sexual assault will be discussed in greater detail in Section 3 of this report).

Health Service Executive 2005

More recently we have witnessed the beginning of the health service reform process which, as described in November 2004 by Mr. Kevin Kelly the HSE Interim Chief Executive Officer at that time, was carried out to ensure that “service users receive the same high quality service, wherever they live”. In addition one of the actions in the Primary Care division of the 2005 HSE National Service Plan is to “provide services for women experiencing violence, abuse or sexual assault” (Quality & Fairness, 2001).

Health Board Initiatives

While the SATU at the Rotunda Hospital has been operating since 1985, the past decade has witnessed the development of three additional SATUs in Letterkenny in 1998, Cork in 2001 and Waterford in 2004. The Cork SATU received core funding from the DOHC while funding for the other two SATUs was sourced locally. (A review of these services will be discussed later in Section 5 of this report).

National Guidelines on Referral and Forensic Examination in Ireland (Forthcoming)

A National multi-agency working group has recently produced national guidelines which are due for publication shortly. These guidelines have been developed to enable the caregivers to deliver a service of the highest quality, in line with best international practice in this field, and to guide the HSE in the local, regional and national development of the infrastructure required for the delivery of appropriate care.

1.4 Summary

- Sexual violence in Ireland still remains one of the most under-reported and under-recorded of violent crimes.
- Violence Against Women emerged as a major issue in the consultation process in the Department of Health’s Policy Document on Women’s Health in 1996.
- This led to the establishment of the National Steering Committee on Violence Against Women and the publication of the Task Force Report on Violence Against Women (1997) which contained recommendations to address the needs of women who had been raped/sexually assaulted.
- In February 2005 a sub-committee of the NSC was convened to review the provision of sexual assault treatment services and address the issues that have to date hindered the development of appropriate services for adult and teenage victims of sexual crime that incorporate the health, justice and psychological needs of the victim.
- The approach adopted for the review was both qualitative and quantitative consulting with representatives from relevant agencies, and reviewing research, legislation and reports relevant to the issue.

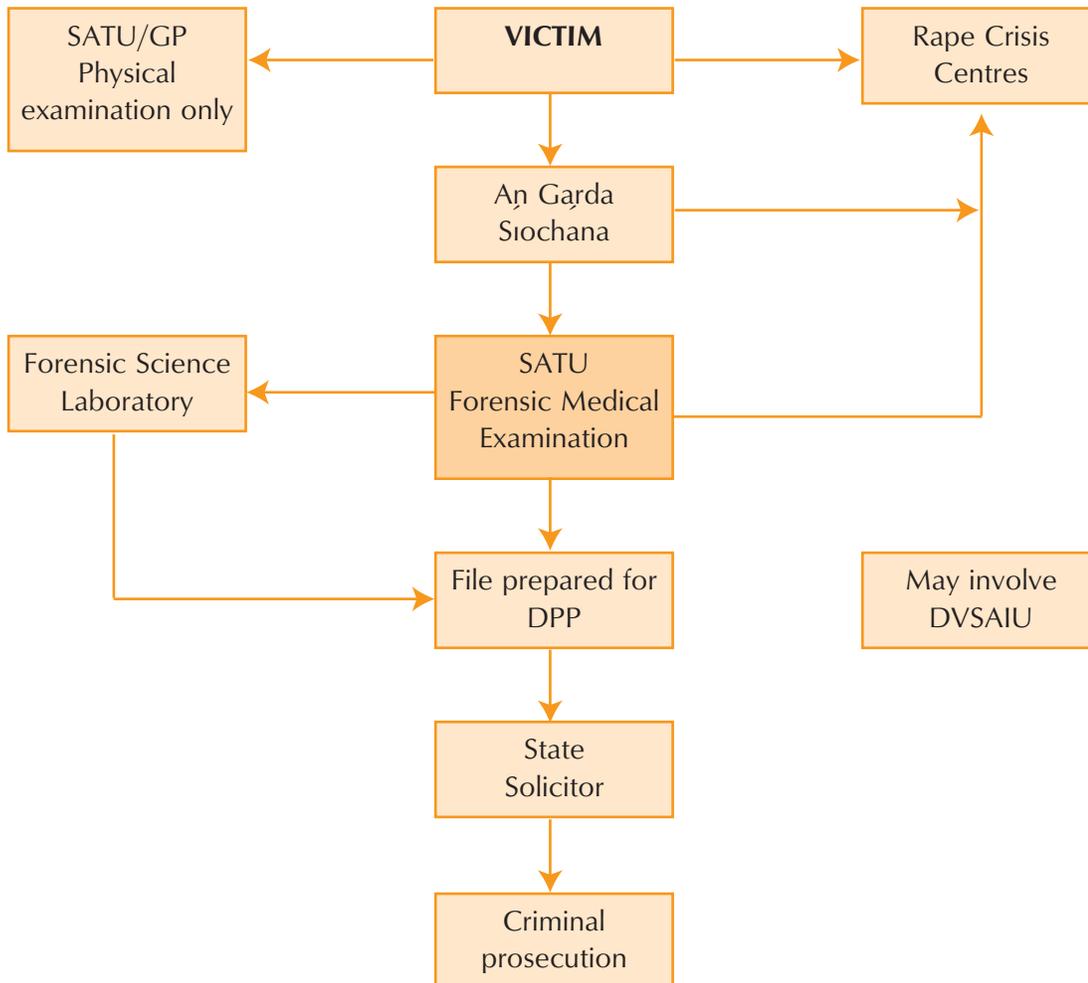
The Criminal Justice Process

2.1 Introduction

The care of victims of recent sexual crime relies on the expertise of many disciplines including An Garda Síochána, medical, counselling, scientific and legal professionals. A forensic medical examination is an essential part of the process for victims who wish to proceed with criminal prosecution. In a criminal trial the only time evidence from a forensic medical examination is not required is when the perpetrator pleads guilty to the crime.

Table 1 presents an overview of the possible options available to victims of rape/sexual assault and the interaction between various disciplines.

Table 1



2.2 An Garda Síochána

Victims of rape/sexual assault who wish to proceed with criminal prosecution report the crime to the Gardaí. In some cases, having attended a hospital or having gone for counselling to a RCC they may then in the course of or following treatment, decide to report the rape/sexual assault to the Garda which will institute a Garda investigation. The Gardaí will require a statement from the victim and may request them to submit to a physical examination for the collection of forensic evidence. The initial report or victim's statement is commonly taken in a Garda station interview room which can portray a clinical, stark or hostile environment. Depending on the availability of a SATU or local GP a victim may be required to wait in the Garda station for lengthy periods. Most Garda stations do not have adequate facilities to accommodate these vulnerable victims who are often required to wait in a room that is used for other purposes. Depending on the nature of the complaint a victim may be advised not to drink, eat, use the toilet or shower before the examination; as such activities may remove or affect evidential findings. When the victim is transferred to a SATU for the forensic medical examination they are accompanied by the investigating Garda.

During a forensic medical examination, samples are taken from the victim using a sexual offences examination kit.¹¹ The completed kit is collected with the victims clothing if deemed necessary, and transferred by the Gardaí for analysis to the Forensic Science Laboratory. An investigation file is compiled by the Gardaí containing statements and evidence and is submitted to the Director of Public Prosecutions. An Garda Síochána have a policy of keeping all victims of crime apprised of developments in their cases. Legal representation is only available to the victim in certain rape/sexual assault cases at a point when the prior sexual history of the victim is being raised by the defence barrister.

Table 2 shows the number of sexual offences reported to the Gardaí in 2003.

Table 2

Sexual Assault	1,449
Aggravated Sexual Assault	11
Sexual Offence involving a mentally Impaired Person	23
Gross Indecency	38
Buggery	78
Unlawful Carnal Knowledge	95
Rape Section 4	55
Rape of a Female	315
Incest	6

Source: An Garda Síochána 2003 Annual Report

2.3 Forensic Medical Examination

Hazelwood and Burgess (1995) identify five key elements in health responses to recent rape/sexual assault: treatment and documentation of injuries; collection of medico-legal evidence

¹¹ The sexual offences kit is designed for use in the examination of either the complainant or the suspect. It includes a form to be completed by the examiner which elicits information necessary for the scientific interpretation of results. It also itemises the samples taken. These may depend on the crime and the subject being examined but include swabs used to collect samples from the vagina, anus, mouth, blood samples, hair samples, nail scrapings and other samples considered relevant by the examiner.

and maintaining chain of evidence; treatment and evaluation of sexually-transmitted infections (STIs); pregnancy risk evaluation/prevention; crisis intervention and arrangement of follow-up counselling/support. A forensic medical examination is time consuming, often lasting more than two hours and involves taking intimate internal and external samples from the victim. While it can be seen as a positive step in regaining personal power, research demonstrates that it can be experienced as 'another assault' at worst, uncomfortable and invasive at best (Kelly and Regan, 2003a). At the same time a forensic medical examination may provide vital evidence that identifies the assailant, and/or supports the victim's account should the case come to court.

There are four purposes for collecting forensic evidence:

- to identify the assailant's DNA from blood, saliva, semen, hair, skin cells,
- to confirm recent sexual contact (injuries or soreness around the genital area, seminal fluid, saliva and internal injuries),
- to establish force (documentation of internal and external injuries, torn/soiled clothing, positive toxicology tests),
- to corroborate the victim's account (establish if findings are consistent).
(Kelly and Regan, 2003a)

Attendance for this forensic medical examination also offers an opportunity to treat minor injuries, undertake medical tests, provide preventative treatment and information, and address the immediate psychological needs of the victim. Research shows that those who report rape/sexual assault are much more likely to access healthcare and support in the aftermath, thereby improving the prospect of addressing concerns and minimising trauma (Kelly, forthcoming).

The forensic medical examination has unique features with the medical practitioner required to perform a dual role in addressing the immediate needs and concerns of the victim and in acting as an agent of law enforcement in the collecting of forensic evidence. Good practice involves understanding this dual function, and recognising that whilst they can often be combined relatively seamlessly, there may be conflicts for the victim and/or the medical examiner (Du Mont & Parnis, forthcoming). The professional undertaking this examination must have appropriate training in order to maximize the information that can be gathered, safeguard the evidence and have the ability to interpret the findings.

The needs of a victim of sexual crime and the criminal justice system can be divided into two distinct categories:

- *Victim needs*: Treatment of injuries, prompt examination, crisis intervention and psychological support, prevention of STIs, assessment and prevention of pregnancy
- *Criminal justice system needs*: Accurate history of assault, documentation of physical findings, collection and preservation of evidence, interpretation of findings, presentation of findings, providing expert opinion in criminal proceedings (Kelly and Regan, 2003a).

2.4 Forensic Science Laboratory

The Forensic Science Laboratory was established in 1975 to provide impartial scientific evidence following the examination of items from crime scenes and complainants. Each year the laboratory receives more than four hundred and fifty cases of alleged sexual assault.

While the forensic medical examination can be taken up to seven days following the alleged assault, the examination is more likely to yield positive results when it is undertaken within the shortest time-frame possible. Throughout the period of analysis of samples received in the Forensic Science Laboratory, scientists maintain communication with the investigating Garda, clarifying details of the case if necessary. Results of the findings are submitted to the DPP on completion of the case to form part of the Book of Evidence.

In most sexual assault cases the laboratory receives a sexual offences examination kit taken from the victim and also from the suspect. They also receive clothes worn by the person at the time of the assault and where appropriate the clothes worn by the suspect. In some cases samples taken from the scene are also analysed.

The sexual assault kit is analysed for the presence of semen. The clothes of the complainant will also be analysed for the presence of semen depending on the circumstances of the case. The clothing will be checked for damage and blood staining. In some cases the forensic scientist will look for hairs and fibres, which may have transferred between the two parties. If necessary samples of urine and blood will be sent for toxicology. Depending on the circumstances of the case items from the scene will also be analysed for the presence of blood, semen or fibres.

If semen, blood or other body fluids are detected DNA profiling may be carried out. DNA profiling is the technique used to identify areas of high variability in the DNA of individuals. DNA is present in all body tissue. The DNA from crime stains, such as semen on vaginal swabs is compared with the control DNA from suspects and victims. This control DNA is extracted from blood samples, or in the absence of blood hair roots or buccal (mouth) swabs. In the case of stranger rape where the victim does not know the assailant DNA profiling will always be carried out on any seminal staining recovered and the profile is kept on file for future reference.

A milestone in forensic genetics is the ability to build DNA databases of profiles from criminals for intelligence work. In theory DNA profiles from semen found on a rape victim or blood found at a scene could be checked against a database to determine if there is a matching individual.

In the UK where their National DNA database was established in 1995 the impact has been extensive. In 2004 there were more than 2.7 million Criminal Justice samples on the UK National DNA Database and 243,627 crime stain records. Since April 1995 there have been 584,539 suspect to scene matches and 38,417 scene to scene matches. The database has been most successful in volume crime but has helped solve a significant number of sexual assaults and murders. It has also helped to speed up investigations as it can eliminate the innocent as well as identify the guilty.

Although the introduction of a National DNA Database in the UK has proven successful as yet we have no legislation for such a database in Ireland. In March 2004 the Law Reform Commission published a consultation paper "The establishment of a DNA database. To date the situation is that there is still no database in Ireland. It is envisaged that the availability of a national DNA database would have a significant impact on the investigation of Sexual assault cases in Ireland.

2.5 Domestic Violence and Sexual Assault Investigation Unit

The Domestic Violence and Sexual Assault Investigation Unit (DVSAIU) was established within An Garda Síochána in 1993 and placed under the National Bureau of Criminal Investigations with

a country wide brief. This followed from a recommendation of the investigation into the Kilkenny Incest Case that such a unit should be established to deal exclusively with all aspects of rape, sexual assault and domestic violence. Advice, guidance and assistance in the investigation of child sexual abuse, other sexual crimes and domestic violence, is given to the Gardaí by personnel from the DVSAIU. The DVSAIU also liaises with relevant Government Departments, State bodies and voluntary groups, embracing a multi-agency approach to tackling these crimes and their causes.

The DVSAIU may lead the investigation in more complex cases.

2.6 Director of Public Prosecution (DPP)

The Office of the Director of Public Prosecutions was established by the Prosecution of Offences Act, 1974. The Act provided for the transfer to the Director of all functions previously performed by the Attorney General in relation to criminal matters. The mission of the Director of Public Prosecutions and his/her Office is “to provide on behalf of the People of Ireland a prosecution service which is independent, fair and effective”.

The DPP enforces the criminal law in the courts; directs and supervises public prosecutions on indictment in the courts; and gives general direction and advice to An Garda Síochána in relation to summary cases and specific direction in such cases where requested. The Chief Prosecution Solicitor provides a solicitor service within the Office of the Director of Public Prosecutions to act on behalf of the Director.

When the investigation file, including the victim’s statement to the Garda and findings from the Forensic Laboratory is submitted to the DPP, he/she will make an assesment as to whether there is sufficient evidence to proceed. Based on the findings, it will either be forwarded to the Chief Prosecution Solicitor within the office of the DPP to proceed or returned to investigating Garda.

2.7 Summary

- Victims of recent sexual crime may require various services to address their needs. Some may wish to attend a RCC only to address their psychological needs; some may seek medical attention from their GP/SATU; others may choose to proceed with a criminal prosecution thereby engaging with various service providers in the criminal justice system which will involve An Garda Síochána, Sexual Assault Treatment Services, the Forensic Science Laboratory and the DPP.
- When a victim reports a recent rape/sexual assault to the Gardaí they will generally be requested to submit to a forensic medical examination for the collection of evidence.
- While the forensic medical examination can be taken up to seven days following the alleged assault, positive results are more likely if the procedure is undertaken within the shortest timeframe possible.
- Attendance for a forensic medical examination also offers an opportunity to treat minor injuries, undertake medical tests, provide preventative treatment and address the immediate psychological needs of the victim.
- When the investigation file, including the victim’s statement to the Garda and findings from the Forensic Laboratory, is submitted to the DPP, he/she will make an assesment as to whether there is sufficient evidence to proceed. Based on the findings, it will either be

forwarded to the Chief Prosecution Solicitor within the office of the DPP to proceed or returned to the investigating Garda.

2.8 Conclusion

While many disciplines are in place to facilitate victims of rape/sexual crime who wish to proceed with criminal prosecution, services should be enhanced to support victims in staying with the process and securing a conviction. This refers in particular to the environment in which the victim is interviewed by the Garda Síochána when they make the decision to report the crime. At this stage victims are particularly vulnerable and the lack of dedicated facilities in Garda Stations may deter them from proceeding with the case. It is recommended that comfortable, private facilities are allocated in a Garda Station in each HSE region where victims of rape/sexual crime can feel safe and supported while giving their statement in advance of the forensic medical examination.

In addition, consideration should be given to reviewing the legislation in Ireland with regard to introducing a National DNA database in light of the success that has been achieved in the UK.

Prevalence of Rape and Sexual Assault

3.1 Introduction

This section examines the data collected by different agencies, the factors that influence the reporting of rape/sexual assault and the reasons why many of these cases are lost from the legal process. It also presents a summary of relevant statistics from various data sources including An Garda Síochána, the Rotunda SATU, DRCC and RCNI.

3.2 Sources of Statistical Data

In Ireland there is limited research on the prevalence of rape/sexual assault which is echoed across Europe according to a study by Liz Kelly and Linda Regan for the Rape Crisis Network Europe, "Rape: Still a Forgotten Issue" (2003b). It is notoriously difficult to evaluate levels of sexual crime and available figures are said to only represent the tip of the iceberg (SAVI 2002). Many factors militate against the disclosure of these offences to the Gardaí or support organizations. Until very recently the main source of quantitative data has been the official crime statistics. These consist of data gathered by the Gardaí in relation to the number of offences "reported or known" to An Garda Síochána in any one calendar year, and are published in the Garda Síochána Annual Report.

Statistical information is also contained within the annual reports of SATUs, RCCs and the RCNI. These data sets provide information on the experiences of those who have made a conscious decision to disclose to, or otherwise seek help from the organization concerned and therefore does not reflect the quantity of cases who do not attend SATU or RCC services.

Crime or victim surveys such as the recent National Crime Council study (NCC) 'Domestic Abuse of Women and Men in Ireland' (2005)¹² and the SAVI study (McGee et al, 2002) have been used to assess incidents of sexual violence amongst the general population.

3.3 Comparing Data Sources

Comparing different sets of data on rape/sexual assault is rarely comparing like with like as different agencies adopt various definitions to the term 'sexual crime' and agencies collect data for specific rather than comparative purposes. For example, while all victims undergoing a forensic medical examination in SATUs will be recorded in the Unit statistics as an attendance, the category under which this crime is recorded on the Garda Síochána database (PULSE) depends on the presenting evidence and could be recorded under a less serious crime than rape or sexual assault (Leon, 2003).

¹² Domestic Abuse of Women and Men in Ireland (2005) was a study conducted by the National Crime Council (NCC), in association with the Economic and Social Research Institute (ESRI) to identify the extent and impact of domestic abuse against women and men in intimate partner relationships in Ireland. The study was based on a survey of a nationally representative statistical sample of over 3,000 adult women and men, as well as focus group interviews with Traveller and immigrant women.

Hence, reviewing available statistics depends on the definition being applied:

- *National studies*: These studies such as the SAVI and NCC studies present the largest data sets where the experiences of the general population are randomly sought representing victims who may or may not have disclosed.
- *SATUs and RCCs*: These data sets represent victims who have made the decision to disclose and are therefore less than those presented in national studies.
- *An Garda Síochána*: Data sets from An Garda Síochána are smaller again, where sexual crimes are often not recorded until the investigation process is well under way and the findings determine the category under which the crime is recorded (Leon, 2003).

Table 3: Overview of Statistics for 2003 from An Garda Síochána (reported rapes), Forensic Science Laboratory (rape/sexual assault cases) and SATU Attendances. (Waterford omitted as it did not commence operating until 2004)

	Garda statistics	Forensic Lab.	Discrepancies	Rotunda	Cork	Letterkenny
Longford/Westmeath	3	12	A	1		
Mayo	5	5		0		
*Galway/Roscommon	13	9	B	5		
Sligo/Leitrim	4	8	A	2		
Wexford/Wicklow	13	**12	B	13		
Laois/Offaly	7	9	A	7		
Tipperary	9	10	A	1	10	
Cork	30	40	A&E	0	72	
Limerick	12	11	B	0	15	
Dublin Met. Region	98	152	A/C/D	187	1	
Waterford/Kilkenny	17	16	B	5	1	
Kerry	14	12	B	0	4	
Louth/Meath	28	34	A	20		
Carlow/Kildare	27	27		22		
Clare	15	6	B	1	8	
Cavan/Monaghan	17	16	B	15		
Donegal	58	15	B&F	0		25
Total	370	417	See note below	285	***114	25

*West & East Galway merged with Roscommon **Wexford only ***3 cases occurred overseas

Statistical Discrepancies: The following are possible explanations for the discrepancies presented above:

- A. More kits received by the Forensic Science Laboratory than the number of rape cases reported:** This suggests that victims underwent Forensic Medical Examinations but withdrew their statement or the case was recorded as a crime lesser than rape.
- B. More cases are reported to the Gardaí than the number of kits received in the Forensic Science Laboratory:** This suggests that some cases are reported too late to have forensic value (clothes washed and no semen expected after a week)
- C. Large number of cases reported in Dublin:** In some cases a victim is brought to the Rotunda from outside of Dublin and will be attended to by a female Garda from Dublin. This case may therefore be recorded as a Dublin case,
- D. Registration of cases:** There can be a difference between the location of the alleged rape and where it is reported.
- E. Cork SATU:** 40 kits were received in the Forensic Science Laboratory whereas only 30 cases were reported to the Garda. Unknown explanation for this discrepancy. The attendance of 72 victims at the Cork SATU would suggest that 32 (44%) of the those who attended did not have a forensic medical examination.
- F. 34 of the 58 incidents refer to the same injured party and the same offender.**

Sources: An Garda Síochána, Forensic Science Laboratory, SATUs in Dublin, Cork and Letterkenny.

3.4 Reporting Rape and Sexual Assault

Given the nature of rape/sexual assault cases, it is inherently difficult to encourage victims to come forward and the decision to report rape/sexual assault can be extremely complex. Kelly and Regan in 'Rape: Still a forgotten issue', (2003b) outline the reasons as to why women do not report including the following:

- not naming the event as rape
- not thinking the police/others will define the event as rape
- fear of disbelief
- fear of blame/judgement
- distrust of the police/courts/legal process
- fear of family and friends knowing/public disclosure/stigma
- fear of further attack/intimidation
- divided loyalty in cases involving current/ex-intimates
- Language/communication issues for women with disabilities and/or whose first language is not that of the country where they were assaulted (ibid).

The State's duty to exercise due diligence¹³ in the investigation and punishment of sexual crime requires the state to take all reasonable measures to ensure that victims are encouraged and supported to make complaints. The SAVI study found that more than four in ten (42%) of women and over a quarter of men (28%) experienced some form of sexual abuse or assault in their lifetime. Despite these figures disclosure rates to Gardaí are strikingly low. Of those who disclosed adult sexual assault, only 7.8% of the females and 1% of the males reported to the Gardaí. For those who did not report, 20% thought it was too trivial, 15% felt ashamed or embarrassed, 6% blamed themselves while 7% thought that others would blame them. (McGee et al, 2002)

3.5 Attrition¹⁴

Reporting sexual crime does not automatically instigate commencement of proceedings as cases can be lost at a number of points and for a variety of reasons: the police may not be able to identify the attacker; the victim may decide to withdraw their statement; the DPP may decide there is not enough evidence; and the case may be lost in court. The decision not to proceed is being taken more and more frequently with six cases out of every ten falling out at this stage (Leon, 2003). Of the limited number of cases that do reach the courts, the trial process, viewed from the perspective of the victim, poses very significant challenges. The entire judicial process has been described as humiliating and fundamentally lacking in justice. The delay in waiting for a trial date, having to sit in over-crowded public waiting areas with the perpetrator, dealing with 'robust' cross-examination regarding previous sexual history or corroboration warnings, leave many of the minority who reach this stage appalled and disempowered. Figures from the court service reveal that the number of rape/sexual assault cases brought to trial at the Central Criminal

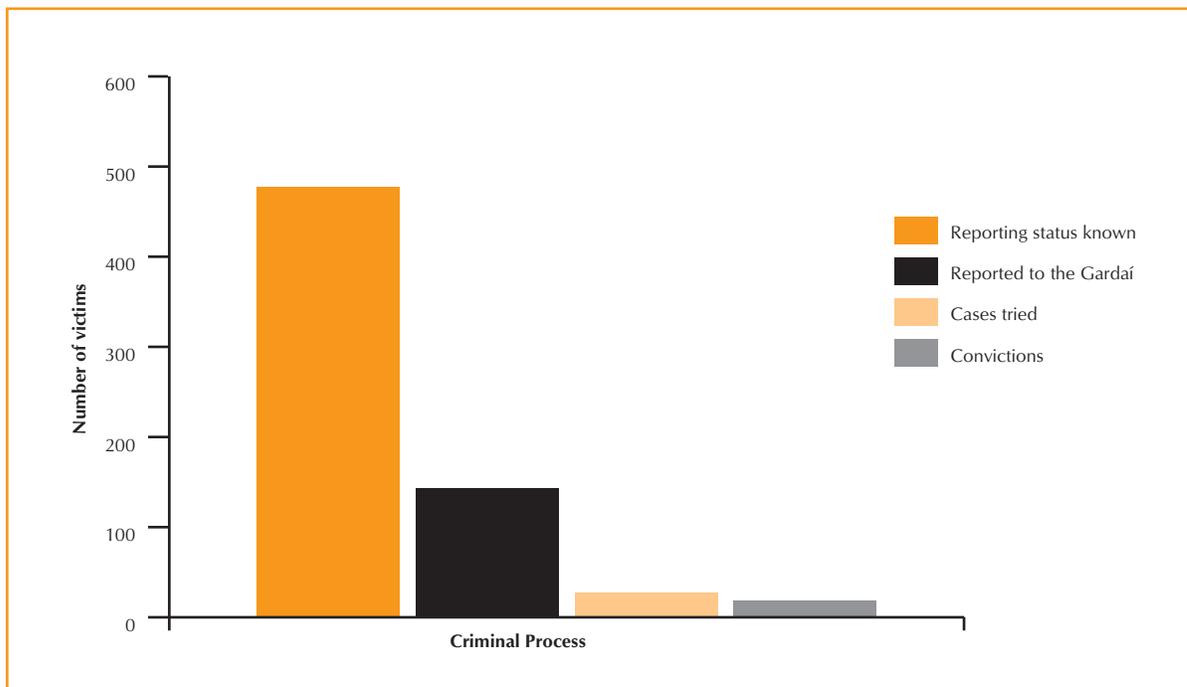
¹³ Due diligence is the level of judgement, care, prudence, determination, and activity that a person or organisation would reasonably be expected to do under particular circumstances.

¹⁴ Of crimes committed, a smaller proportion are reported; of those reported, a smaller proportion are prosecuted; of those prosecuted a smaller proportion end in conviction. This progressive reduction between crimes committed and those which end in conviction is known as the process of attrition. (Living Without Fear, Home Office, 1999:31); The process by which reported rape cases are lost from the legal process, and thus do not result in a criminal conviction (Child and Women Abuse Studies Unit).

Court has fallen from 130 cases in 1999 to only 37 cases in 2004. Along with the 40% acquittal rate in contested rape trials, it is understandable why so few engage in and stay with the process (RCNI, 2005). To develop a deeper understanding of factors which influence Ireland’s high attrition rate, the Law Faculty of the National University of Ireland Galway (NUIG), has recently commenced a three-year study which was commissioned by the RCNI.

Table 4 presents statistics drawn from the DRCC 2003 Annual Report. Of the 477 cases where the reporting status of victims was known, 143 (30%) cases were reported to the Gardaí, of these 27 cases (19%) were tried resulting in 18 (13%) convictions. It is worth noting that reporting and convictions in this context refers to clients seen in DRCC in 2003, although the reporting and convictions may have occurred in previous years.

Table 4: Outcomes of criminal proceedings where reporting status of victims attending DRCC in 2003 was known to them



Percentage of all cases reported to the Gardaí	30
Dropped	20
Pending	24
Guilty plea	0
Convicted	13
Acquitted	6
No information	37

Source: DRCC 2003 Annual Report

3.6 Summary

- There is limited research on the prevalence of rape/sexual assault both in Ireland and throughout Europe.
- Although statistical information is available in the annual reports of An Garda Síochána, SATUs, RCCs and the RCNI comparing different sets of data is rarely comparing like with like as different agencies adopt various definitions to the term 'sexual crime' and agencies collect data for specific rather than comparative purposes.
- Data sets produced from surveys seeking out victims' experiences are the largest, followed by statistics from support services which represent victims who have made the decision to disclose, followed by the data sets from the Gardaí which are the lowest, where sexual crimes are recorded based on the presenting evidence.
- Significant discrepancies exist between the number of cases reported to the Gardaí, the number of Sexual Offence Examination Kits received by the Forensic Science Laboratory and the number of victims undergoing forensic medical examinations in existing SATUs across the country. Possible explanations for these discrepancies include: victims withdrawing their statements; cases are reported too late to have forensic value; cases may be reported from a different county or country where the assault occurred; possible reporting of historic cases; victims attending SATUs for non-forensic reasons and unknown causes.
- The SAVI study found that more than four in ten (42%) of women and over a quarter of men (28%) experienced some form of sexual assault in their lifetime. Despite these figures only 7.8% of the females and 1% of the males reported to the Gardaí.

3.7 Conclusion

While reviewing available statistics helps us begin to develop an understanding of the prevalence of rape/sexual assault in Ireland, the data sets can only be examined in isolation as they do not compare like with like. This lack of comparable data highlights the need for relevant service providers to agree and develop mechanisms to coordinate the collection of data in order to create a baseline of information which can inform service delivery and future developments.

Emotional and Psychological Needs of Victims of Rape/Sexual Assault

4.1 Introduction

The Review Committee was aware of the importance of consulting with victims of sexual crime during the process, in order to obtain their perspectives on current services and identify the appropriate service response from the victim's point of view. The restrictions of time however did not facilitate an in-depth study with victims, bearing in mind the sensitivity of the subject and the surrounding ethical issues. It was therefore agreed by the Committee that the views of the RCCs, who work solely with victims of sexual violence, would be sought with regard to the victim's emotional and psychological needs. Submissions were received from DRCC and the Sexual Violence Centre Cork (SVCC) who both have provided a counselling/support service to victims of rape/sexual assault for over twenty years and reflect the experiences of the other RCCs providing SATU support.

4.2 Support Workers

Both the DRCC and SVCC offer a 24 hour on-call support service to victims of rape/sexual assault who attend their locally-based SATUs in the Rotunda in Dublin and the South Infirmary in Cork respectively. In the Rotunda, the policy is to automatically call in the on-call support worker when a victim attends the SATU. The victim then has the choice to engage with the support worker if they wish to do so. In 2004, 205 of the 285 victims who attended the Rotunda were seen by support workers from DRCC. In the Cork SATU however, the policy has changed since the first year of the service where the victim is now given the option of calling in the support worker, unlike the original policy of calling them in automatically. In 2004, 15 of the 131 victims who attended the Cork SATU were seen by support workers from SVCC.

Based on their experiences, both Dublin and Cork RCCs have highlighted the importance of addressing the emotional and psychological needs of the victim in addition to their physical and forensic needs. Medical and nursing staff can provide crucial psychological support in terms of treating the victim with respect, providing information in a way that they can understand, and offering them an informed choice with regard to treatment. However, part of the FME's role is to act as an agent of law enforcement requiring the forensic medical examination to be undertaken in as objective a fashion as possible. Both An Garda Síochána and the FMEs are obliged by law to disclose all evidence coming to light, even that which may benefit the defence/accused. The RCCs emphasise the importance to the victim of having a supportive individual present to assist them in regaining personal power and control as they make decisions regarding medical care. There is strong evidence that advocacy rather than counselling is the primary need of victims in the immediate and short-term aftermath of rape/sexual assault, especially where there has been an official report to the Gardaí (Kelly and Regan, 2003b). It is therefore considered that these support workers are an essential part of the team and it is recommended that they are automatically called to the SATU in the same way that the doctor, nurse and Garda are called on to support the victim.

It has in the past been argued that the victim should be given the choice to call in the RCC support worker at the time. However, the experiences in the Cork RCC would demonstrate that more often than not they would decline this offer as they feel it inappropriate to disturb a person unknown to them, very often in the middle of the night. At this stage the victim will experience fear, shock, confusion, disbelief and self blame and are generally reluctant to make decisions with regard to their needs, which in itself is why the support worker is essential to the process. Victims may feel too much self blame or shame to request a special service and may not understand the nature of the support being offered. Hence it is not offering a victim a choice to ask if they want to have a support worker called in to meet with them. It is however offering the victim a choice if the support worker is present or on the way.

4.3 Psychological Consequences of Rape and Sexual Assault

The Task Force Report (1997) found that the emotional and psychological effects of rape/sexual assault can have long-term consequences in terms of women's mental health. This finding was also reflected in the SAVI study which found that victims of sexual violence were significantly more likely to have used medications for anxiety or depression and eight times more likely to have been a psychiatric inpatient than those without such experiences (McGee, 2002).

The findings of the SAVI study also inform us that approximately one in three women (30%) and one in four men (18%) reported that their experience of sexual violence (either in childhood, adulthood or both) had a moderate or extreme effect on their life overall. It found that a quarter (25%) of women and one in six (16.5%) men reported having experienced symptoms in the past and 17% of women and 9.5% of men reported currently experiencing symptoms consistent with a diagnosis of PTSD.¹⁵

4.4 Forensic Medical Examiners

Undergoing a forensic medical examination can be a daunting prospect for any victim of sexual crime. It can also be a challenging task for the FME who needs to be aware of the meaning of the examination to the victim in that they are likely to be feeling dirty, ashamed, vulnerable and extremely sensitive to any implication that they are not telling the truth (Lovett et al, 2004). The Attrition Study found that the attitude and approach of the individual examiner has an enormous influence on the victim's experience of the examination (Leane et al, 2001). This research also indicates that professionals can be influenced by assumptions and myths¹⁶ about rape/sexual assault victims which can result in professional practice that militates against victims being believed and their needs being met, and consequently contribute to attrition of rape cases when appearing as a professional witness during the trial of the case.

4.5 Summary

- Submissions were received from DRCC and SVCC with regard to victims' emotional and psychological needs. Both RCCs offer a 24 hour on-call support service to victims of rape/sexual assault who attend their locally-based SATUs.

¹⁵ The symptoms of PTSD involve re-experiencing the traumatic event (as thoughts, memories or dreams), persistently avoiding situations which are associated with the trauma, and a numbing of general responsiveness (impaired relationships with people, for instance, or loss of interest in activities), and persistent symptoms of increased arousal (easily startled, irritable, etc. (SAVI, 2002).

¹⁶ See appendix VI for common myths and facts on rape/sexual abuse.

- While medical staff provide crucial psychological support, their role as an agent of law enforcement requires the forensic medical examination to be undertaken in as objective a fashion as possible.
- The RCCs emphasise the benefits to the victim of having an independent support person present to assist them in regaining personal power and control and propose that RCC support workers are called to the SATU automatically in the same way that the doctor, nurse and Garda are called on to support the victim.
- The SAVI study found that a quarter (25%) of women and one in six (16 %) men reported having experienced symptoms consistent with a diagnosis of post-traumatic stress disorder (PTSD). It also found that victims of sexual violence were eight times more likely to have been a psychiatric inpatient than those without such experiences.

4.6 Conclusion

Historically the role of medical personnel has been to address the physical and psychological needs of the victim. However as FMEs they are required to remain as objective as possible which could in fact make the victim feel increasingly guilty and less believed. This is an extremely vulnerable time when the victim needs the support of a caring individual who is there solely for them, who completely supports their story, and is available to support them through the trauma of the examination as they relive the details of the rape/sexual assault. These are the services currently being provided by RCC support workers and as such the Review Committee supports the policy requested by RCCs where support workers are seen as a core part of the SATU team and are therefore automatically called to the SATU to support each victim.

Review of Existing SATU Services in Ireland

5.1 Introduction

To date, Sexual Assault Treatment Services in Ireland have developed in a relatively fragmented way rather than as a coordinated strategy. For this reason there is considerable disparity in the availability of such services across the country. Currently there are four SATUs in Ireland, existing in four HSE Regions, namely the Eastern, the South Eastern, the Southern and the North Western regions.

In order to obtain a regional perspective, available representatives from Health Service Executive (HSE) regions including health service providers, RCC counsellors and An Garda Síochána were consulted with regard to their local situation. This section presents a summary of how existing SATUs are currently operating and presents emerging themes regarding their future needs to ensure sustainability.

5.2 HSE-Eastern Region: Rotunda Hospital

The SATU in the Rotunda hospital Dublin was established in 1985 and was the first dedicated sexual assault treatment service in Europe. Although the Rotunda Unit serves the greater Dublin region, approximately 35% of the victims who access the service per annum are from outside of Dublin. The Unit conducts on average 300 forensic medical examinations per annum of which an average of 95% of the victims report to the Gardaí. While the Rotunda will see victims of rape/sexual assault who do not wish to report to the Gardaí, due to the lack of resources this service is limited to day-time hours by appointment only. The Rotunda provides a holistic service to post-pubescent clients offering forensic medical examinations, emergency contraception and STI follow-up services. Support workers from the Dublin RCC are generally called in to support each victim as they present to the Unit. A SATU liaison committee chaired by the Unit Director, Dr. Mary Holohan with membership including representatives from An Garda Síochána, Dublin Rape Crisis Centre, the Forensic Science Laboratory, medical and nursing personnel oversees and advises on the work of the Unit.

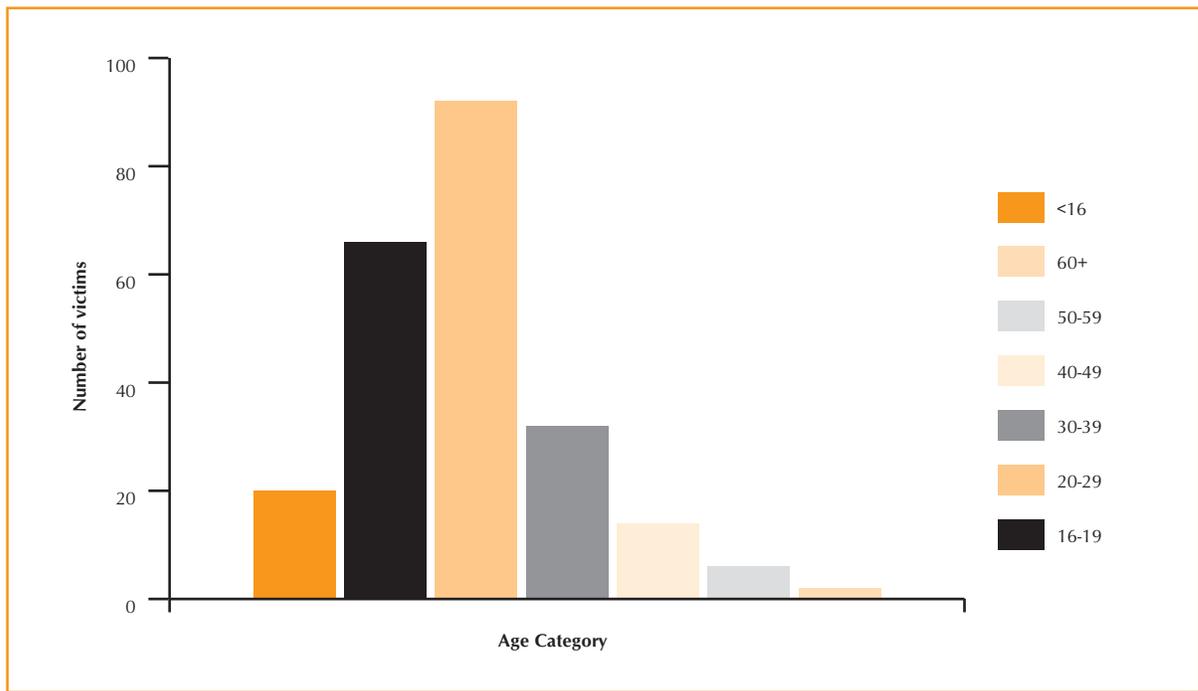
Currently operating for 20 years, the Rotunda SATU holds extensive expertise in the forensic/medical treatment of victims of rape/sexual assault. Dr Holohan facilitates regular training programmes for multidisciplinary service providers throughout the country. Despite having gaining international recognition as a 'centre of excellence' (Kelly and Regan, 2003a), repeated submissions to DOHC to secure funding have to date been unsuccessful, with the service currently surviving on monies made available from the main hospital budget.

Facilities at the Rotunda have recently improved with the refurbishment of three rooms on the ground floor of the administration building which is within the Rotunda complex. Prior to this the service operated from one room in the busy out-patients department. While this has marked an improvement in facilities at the Rotunda SATU, staffing issues pose a threat to the sustainability of the service. Difficulties in recruiting and retaining doctors have escalated over the years to the stage where it is now at crisis point. Over-reliance on the limited number of experienced,

competent doctors has increased the degree of fall-out with this 24/7 service currently depending on a core group of only 3 doctors. In addition the availability of nursing staff is limited to a half-time nurse manager, with nursing support to attend to victims out of hours reliant on the availability of nurses from the Gynaecology ward which causes a conflict of needs between the Gynaecology nursing services and those of the SATU.

The age profile of victims attending the Rotunda SATU over a seven year period (1997-2003) presented in the chart below demonstrates that the most common age category of victims accessing the service is between 20-29 years followed closely by the 16-19 year old category. One may consider these combined age groups to be high risk, however the Medical Director of the Rotunda SATU and the RCNI have both expressed concerns regarding the barriers to accessing services experienced by those under 16 years and over 29 years.

Table 5: Average female attendance at the Rotunda SATU by age category (1997-2003)



Source: Rotunda SATU

5.3 HSE-Southern Region: South Infirmary/Victoria Hospital, Cork

The SATU in the South Infirmary/Victoria Hospital Cork was established in 2001 to provide a service for the Munster Region after a multi-agency group of campaigners driven by the SVCC secured funding from Micheál Martin, the Minister for Health and Children at the time. The Unit sees on average 115 clients per annum of which an average of 33% are from outside of Cork County. The average reporting rate to the Gardaí is 70%. According to the SATU staff the facilities at the Unit are excellent providing a comfortable, homely, spacious, private environment which is non-threatening to the victim. A similar environment has also been allocated in the Anglesea St. Garda Station which is in close proximity to the SATU, where the victim’s statement can be taken by the Gardaí before the forensic medical examination is carried out at the SATU.

Unlike the Rotunda, the Cork Unit has a full time Nurse Manager and a team of nurses who provide an out of hours on-call service. This is in addition to a team of GPs who provide an on-call service from 1pm to 9am Mondays to Fridays and twenty-four hour cover on weekends. While the core services delivered are similar to those in the Rotunda, some aspects of the service differ particularly in relation to the engagement of the RCC support service. When clients present to the Cork SATU this is offered as an optional extra, rather than a core part of the service. Another significant variance is the Cork SATU will see clients who are aged 14 years and above whereas the Rotunda will see post-pubescent clients and do not define a specific age category.

As retaining a rota of doctors has been an ongoing problem for the Cork SATU, remuneration rates for the doctors who provide this on-call service have recently been increased in line with rates paid in the Rotunda SATU.

5.4 HSE-South Eastern Region: Waterford Regional Hospital

The SATU in Waterford is the most recently-established service which commenced operating in September 2004 to provide a service to victims in the HSE-South Eastern Region. The Unit was established by a multi-agency Task Force, creating a partnership approach and shared ownership of service developments. An ongoing multi-agency steering/evaluation committee meets every six weeks to review the provision of services and address any problems as they arise. De-briefing meetings are facilitated for service providers every two to three months providing them with the opportunity to promote and enhance teamwork, share information and ideas, and offer support and guidance where required.

In its first year of operation (September '04-August '05) the Unit has seen 52 victims of rape/sexual assault. It is envisaged however that attendance will increase to 60-80 per annum with increased awareness of the service. The range of services the SATU provides include: forensic medical examinations, emergency contraception; STI follow-up appointments; and counselling/advocacy from an RCC support worker. The service is however limited to victims aged 14 years and above who report the incident to the Gardaí. Victims who do not wish to report the incident can contact the Unit for advice and support but are advised to attend their own GP or are given the name of an alternative GP if they require medical attention/emergency contraception. The rationale for introducing this policy was due to concerns regarding the potential for increased demands on medical personnel who currently provide this on-call service on a voluntary basis. This limitation on service provision was deemed necessary until such time as doctors are appropriately remunerated. Although at the moment there are 14 GPs on the rota, in the absence of remuneration, retention of doctors is of major concern and poses a serious threat to the sustainability of the service. The limited budget available to the Unit is used for the half-time post of nurse manager, on-call nursing costs, recurring equipment costs and training.

5.5 HSE-North West: Letterkenny General Hospital

The SATU at Letterkenny General Hospital was established in 1998 to improve the service to victims in the Donegal region. It was set up by a group of concerned nursing staff, the Registrar from the A&E Department and supported by the goodwill of five local GPs. Funding to equip and furnish the Unit, which is comfortable and homely, was raised locally by concerned individuals. Unlike the other three SATUs, the services are offered to both adults and children.¹⁷ The Unit, which sees an average of 25 clients per year, has limited its catchment area to the Donegal region

¹⁷ Children are seen by a Consultant Paediatrician.

only, due to medical staffing issues and the difficulty of attracting GPs to the service. Unlike the other Units, the budget for the Letterkenny SATU is sufficient to cover on-call nursing costs only. Although there is a great deal of local support for this Unit, it is struggling to remain open with only two doctors providing the forensic medical examination service on an ad-hoc basis. Cessation of this much needed service seems inevitable unless immediate steps are taken to address this crisis.

With an increasing awareness of the difficulties encountered in attracting GPs to the service, the Nurse Education Centre at Letterkenny General Hospital investigated potential alternative options and in doing so they examined the possibility of the forensic medical examinations being carried out by Forensic Nurse Examiners. (For more see Section 9).

Table 6: Summary of Existing SATU Services

	Dublin	Cork	Letterkenny	Waterford
Background				
Commenced	1985	2001	1998	2004
Average no. cases/annum	280	120	25	60-80 envisaged
Services available to	Post-pubescent	Aged 14 years and above	All ages*	Aged 14 years and above
Management				
Directorship	Dr. M. Holohan	Dr. J. Coulter	Mr. King	Dr. J. Birmingham
Steering Committee	Yes. Meet quarterly	No/Informally	Yes. Every 6 weeks	
Monitoring	Internal database	Internal database	Internal database	Internal database
Audit/Client feed-back	Minimal via RCC	No formal arrangement	No formal arrangement	Under review
Staff debriefing	No formal arrangement	No formal arrangement	No formal arrangement	Bi-monthly
Doctors				
Number of doctors	3 GPs	7 GPs	2 Drs	13 GPs & 1 hospital Dr.
Medical report taped/written	Always	Always	Always	On request only
Coordination of rota	Dr. Holohan	Nurse manager	No rota	Nurse manager
Nurses				
Nurse management	4 half days/wk	Full time	No manager	Half time
No. nurses on rota	Currently recruiting	8	10	14
Rape Crisis Services				
Support workers	Called to each case	At request of victim	At request of victim**	Called to each case
Management Participation	On steering committee	Minimal	Minimal	On steering committee
An Garda Síochána				
% referrals to the Gardaí	97%	70%	100%	100%
Management Participation	On steering committee	Informal	Have a Liaison Officer	On steering committee
Funding				
	Hospital budget	HSE	Hospital budget	Community care budget

*In Letterkenny children are seen by a Consultant Paediatrician, the SATU environment is child friendly and supportive and is sometimes used.

**Letterkenny SATU is in the process of setting up a system where the RCC support worker is called in for each case.

5.6 Emerging Themes in Existing SATUs

5.6.1 Introduction

The summary of existing SATU services illustrated by Table 6 demonstrates the differences in local organizational and implementation approaches. For the purpose of this review the findings from the consultation with existing services have been categorized under the following emerging themes:

- Management
- Forensic Medical Examiner
- Nursing Services
- Rape Crisis Services
- An Garda Síochána
- Scope of Service Provision
- Young People Accessing Adult Services
- National Resource
- Funding

5.6.2 Management

As previously stated, all existing SATUs have been set up on an ad-hoc basis driven by concerned local service providers. As such, management and implementation structures vary greatly.

- *Steering committee:* While each of the four Units adopt a multi-agency approach, the Rotunda and Waterford SATUs are the only services with formal multi-agency steering committees. The lack of this structure elsewhere places responsibility for developing the service onto the SATU Directors, who have otherwise extremely busy work schedules. This can have a limiting impact on the scope of the service provided which can potentially focus on the forensic medical examination, losing the vision of a multi-agency, holistic transparent service.
- *Staff support:* Similarly the only existing service with formal structures in place to support staff is the SATU in Waterford. The Nurse Manager in Waterford coordinates meetings for nursing and medical staff every 2-3 months to reflect on and share their experiences to date and address any issues of concern. This allows service providers to feed into the development of the service and creates a more supportive, motivating work environment.
- *Monitoring:* Although all four SATUs currently collect data on the victims who access their services, the lack of standardization regarding the information collected prevents the comparison of different data sets which is essential in developing a profile of the national situation.
- *Service Audit:* While existing SATUs are supportive of victims accessing their services, there are currently no formal structures anywhere in the country where the victim can give feedback to the SATU on the service they have received, which is essential to ensure that the services being provided are meeting the client's needs.

5.6.3 Forensic Medical Examiners

- *Recruiting and retaining doctors:* According to current SATU personnel, many doctors are reluctant to become involved in providing this service. The rationale presented by doctors

for not wanting to provide forensic medical examinations is the lack of a structured coordinated approach to service provision and concerns regarding both the experience of and the significant time commitment required should the case go to court. Many are also acutely aware of their own lack of expertise and training in the area of forensic medicine and the subsequent legal procedures which ensue when a prosecution takes place. Over reliance on the limited number of available doctors increases the risk of fallout among existing service providers which is reflected in the limited number of doctors currently providing the service. In addition, due to the ad-hoc way in which existing services were established and the absence of a national framework, the current rates of pay that doctors receive varies considerably.

- *Medico-legal reports:* The policy in all SATUs except for Waterford is to either tape or write a medico-legal report on all victims who wish to proceed with criminal prosecution. These arrangements and the subsequent payment for the report were agreed locally between the Gardaí and developers of each service hence the lack of standardized practice. An Garda Síochána and the Irish Medical Organization have negotiated a schedule of payment to medical practitioners for the provision of examination and report writing services, which is reviewed every six months.¹⁸ This schedule however has been interpreted differently in different locations resulting in a marked variation in payment for both conducting the forensic medical examination and writing the medico-legal report.

5.6.4 Nursing Services

The availability of dedicated nursing personnel varies considerably in each SATU:

- *Nurse Management:* While the SATUs in Dublin, Cork and Waterford all employ Nurse Managers either on a full or part time basis, coordination of the SATU in Letterkenny is dependant on the availability of the Nurse Manager in the A&E Department. As such there are no dedicated personnel in Letterkenny responsible for the management and development of the service.
- *On-call Nurses:* Variances also exist in the availability of on-call nurses to provide an out of hours service with rotas existing in Cork, Waterford and Letterkenny; Dublin is still dependant on the availability of nursing staff being drawn from the Gynaecological ward to coordinate the service and attend to the victim.

5.6.5 Rape Crisis Services

- *Steering group membership:* RCCs are active members of the Rotunda and Waterford steering committees and are therefore able to play a significant role in how services are provided and developed. The general lack of involvement of RCCs in the provision and development of the Letterkenny and Cork SATUs increases their risk of becoming a forensic/medical service only, losing the vision of a holistic, client-centred, multi-agency approach.
- *Support Workers:* Evidence would suggest that the involvement of Support Workers at an early stage will reduce the risk of PTSD and will increase the uptake of ongoing support services such as those provided by RCCs. While the involvement of Support Workers from RCCs is seen as a core part of service provision in the Rotunda and Waterford SATUs, they are called to the Cork Unit on the request of the victim. The RCC and SATU in Letterkenny are in the process of setting up the structures for a support worker to be

¹⁸ See Appendix VII.

called when a victim attends the SATU. With appropriate resourcing Support Workers could be provided by RCCs to all SATUs.

5.6.6 An Garda Síochána

- *Steering committee membership:* While the Garda Síochána have excellent working relationships with all SATUs, formal arrangements for feeding into service provision and development only exist in the Rotunda and Waterford Units where Garda representatives are part of the SATU steering committees. These more formal arrangements ensure the provision of a more transparent, reflective service and facilitate channels of communication and the sharing of information.

5.6.7 Scope of Service Provision

- To date services in Waterford are only available to victims who wish to report the crime and proceed with the criminal justice system. This policy was introduced due to concerns regarding fallout of doctors who are currently not being paid to provide the on-call service unlike the arrangement in the Rotunda and Cork SATUs. In the Rotunda however, the service to victims who do not wish to involve the Garda is limited to day time hours by appointment only. Letterkenny has no formal rota but all victims will be seen if they present.

5.6.8 Young People Accessing Adult Services

While both the Cork and Waterford SATUs have a minimum age limit of 14 years for victims accessing their services, the Rotunda will see post-pubescent young girls and Letterkenny accept both children and adults. Children seen in Letterkenny SATU are seen by a Consultant Paediatrician with the physical environment of the SATU being used. Discussions have recently taken place with Paediatricians in Dublin and SATU service providers to determine an appropriate age from which young people should access adult services. It was agreed that age 14 years should be the minimum age for access to adult services. (Paediatric services are discussed in Section 7 of this report).

5.6.9 National Resource

Having gained over twenty years experience in the provision of SATU services the Rotunda SATU has acted as a national resource advising others in the setting up of services and in the provision of training for medical professionals. This role of national advisor/trainer has grown over the years requiring the Medical Director of the Rotunda SATU to provide many of these tasks outside of working time on a voluntary basis.

5.6.10 Funding

Cork is the only SATU with secured funding from the HSE to provide their services and as such is the only SATU that can be confident regarding its sustainability.

5.7 Summary

- To date, SATUs in Ireland have developed in a relatively fragmented way rather than as a coordinated strategy. For this reason there is considerable disparity in the availability of such services across the country. Currently there are four SATUs in Ireland existing in four HSE Regions, namely the Eastern, the South Eastern, the Southern and the North Western regions.

- Management and implementation structures vary greatly between all SATU services particularly in relation to multi-agency management, personnel issues, scope of service provision and sources of funding.
- Recruiting and retaining FMEs has been an on-going difficulty in all SATUs. Over-reliance on the limited number of available doctors increases the risk of fallout among existing service providers. In addition the Garda Síochána schedule of payment for conducting forensic medical examinations and writing medico-legal reports has been interpreted differently in different locations resulting in a marked variation in payment in different SATUs.
- Availability of dedicated nursing staff varies in each SATU.
- It is the policy in two SATUs only to automatically call in RCC support workers when a victim attends their Unit.
- To date services in Waterford are only available to victims who wish to report the crime and proceed with the criminal justice system.
- In the Rotunda availability of services to victims who do not wish to involve the Gardaí is limited to day-time hours by appointment only.
- Cork is the only SATU which has secured funding from the DOHC to provide their services and as such is the only SATU that can be confident regarding its sustainability.

5.8 Conclusion

This review has highlighted the variation in service provision across the existing four SATU services and demonstrates how each service currently operates in isolation, in the absence of a national strategic framework. In recent times however a considerable number of service providers from relevant agencies have begun to recognize the value of standardizing service provision across current services, a concept which is supported by the Review Committee. Provision of a standardized holistic, multi-disciplinary, multi-agency response to the treatment of victims of rape/sexual assault across the country would contribute towards the development of a client-centred, supportive service. In addition the Review Committee believes that standardization of services may help to attract more doctors to this area of work and help to dispel some of their reluctance to become involved in the area, insofar as they develop into supportive centres for excellence. Specific recommendations addressing these themes and the need for standardization of existing services are included in Section 10 of this report.

Gaps in Adult SATU Services

6.1 Introduction

Currently there are no dedicated SATU services in the Mid Western, Western, Midland or North Eastern HSE regions. On some occasions in the past forensic medical examinations in these regions were carried out by doctors who had no specific training or experience in this area of medical examination, or by non-consultant hospital doctors who were working on six-month contracts and might no longer be working in the country if and when a case came to court. Contrary to public perception, forensic medical examinations are generally not conducted in hospitals by Accident and Emergency (A&E) staff. This policy is understandable in light of the demands placed on A&E departments and the disruption to the service caused by subsequent court attendance. In addition due to the lack of services the main focus of service providers has been associated with the urgency in carrying out the forensic medical examination, resulting in limited attention to the psychological and on-going needs of the victim.

Victims of rape/sexual assault from these regions are therefore dependant on ad-hoc arrangements, where there are often long delays between the time the crime is reported to the Gardaí and the carrying out of a forensic medical examination, if it is done at all. In failing to identify a local GP who is available to carry out the examination, the Gardaí are frequently required to transport victims to a designated SATU elsewhere, often taking 12 hours or more to make the round trip, depending on the distance to the Unit. Research tells us that victims are more likely to make a report to the Gardaí when they know that there is a SATU in their community and where they know that they will be attended to in a professional, compassionate and consistent manner.

6.2 HSE-Mid Western Region

The HSE-Mid Western Region includes Clare, Limerick and North Tipperary with a population of 339,591 in 2002 (CSO, 2004). While the staff at the A&E Department of the Mid West Regional Hospital in Limerick will allocate a cubicle to a victim of rape/sexual assault for the duration of the forensic medical examination, it is hospital policy that their staff do not conduct the examination. If the Gardaí are unsuccessful in sourcing a GP to conduct the examination, arrangements are frequently made for the victim to be seen at the Cork SATU. In 2003, 37 cases were reported to the Garda with 28 (76%) of the victims having attended the Cork SATU and 2 (5%) were seen at the Rotunda SATU. While the reporting rate for the mid-western region in 2003 was equal to the national average of 9 cases per 100,000, the Limerick RCC have expressed concerns regarding the low uptake of their services from victims who attend the Cork SATU.

The Mid Western Regional Planning Committee (RPC) on Violence Against Women SATU Sub-Committee has campaigned for a dedicated SATU since 2001. Several submissions for funding were put forward to relevant government departments but have to date been unsuccessful. While measures were pursued to address the situation locally by training a group of interested GPs in the management of victims of rape/sexual assault, commencing a rota was not feasible at the time due to the lack of funding to establish and run the service.

6.3 HSE-Western Region

The HSE Western Region includes Roscommon, Mayo and Galway with a total population of 380,297 in 2002 (CSO, 2004). In 2003 3.6 cases of rape per 100,000 population were reported to the Gardaí in this region which is the lowest rate of reporting in the country in comparison to the national average for that year at 9 cases per 100,000. Victims of rape/sexual assault in the Western Region have to date depended on the goodwill of local GPs to carry out forensic medical examinations when they report the case to the Gardaí. Because the Gardaí however are dependant on a limited number of GPs who are willing to carry out these examinations there are often long delays between a victim reporting the incident and carrying out the forensic medical examinations. Alternatively the victim has the choice of travelling 4-6 hours to the nearest SATU, which is frequently far too traumatizing for them to endure, and subsequently many withdraw their statement. In 2003 only 14 sexual offence examination kits were received in the Forensic Science Laboratory although 18 cases were reported to the Gardaí. This discrepancy would suggest that some cases were reported too late to have forensic value (clothes washed and no semen expected in the body after a week). In total 5 (28%) of the victims who did report to the Gardaí attended the Rotunda SATU. Hence the alarmingly low reporting rate to the Gardaí could be evidence of attrition caused by the lack of a dedicated service in the region.

In recognition of a need for a dedicated SATU service in the region a sub-group of the Western RPC recently met to move the development of this initiative forward. Discussions with personnel in Community Care suggest that a HSE premises may be available in Shantalla, Galway city to accommodate a SATU. In addition a group of GPs have recently received introductory training on forensic medical examination and have expressed an interest in joining a rota for on-call doctors in the event that a coordinated service was established.

6.4 HSE-Midland Region

The HSE Midland region includes Longford, Westmeath, Offally and Laois and had a population of 225,363 in 2002 (CSO, 2004). The need for dedicated services in the region has been highlighted by the HSE Midland Sexual Health Strategy which stated that *“the current lack of appropriate services increases the trauma for the person involved and there is a need to standardize and develop protocols for victims presenting to the Midland area services”*.

In 2003 4.4 cases of rape were reported to the Gardaí per 100,000 population which is compared to the national average for that year of 9 cases per 100,000. This is the second lowest reporting rate in the country following the West, with only 10 cases reported to the Gardaí in 2003, of which 8 victims (80%) attended the Rotunda SATU. While 21 forensic kits were received in the Forensic Science Laboratory from this region for that same year, it would suggest that victims underwent the forensic medical examination but subsequently withdrew their statements. Where these additional forensic medical examinations were carried out is unknown. It was suggested by the coordinator for Services for Violence Against Women¹⁹ in the region that these examinations were conducted by doctors at the Midland Regional Hospital in Mullingar, although this has not been confirmed. Regardless however of where these additional forensic medical examinations were conducted, the attrition rate of 52% is extremely significant and would suggest that it was contributed to by the lack of a dedicated service in the region.

¹⁹ Coordinators of Services for Violence Against Women are currently employed in the Midwest, Midland and North East regions only.

6.5 HSE-North Eastern Region

The HSE North Eastern area including Monaghan, Louth, Cavan and Meath had a population of 344,965 in 2002 (CSO, 2004). In 2003 a total of 45 cases were reported to the Gardaí in the North East region which at 13 cases per 100,000 population, is significantly above the national average reporting rate for that year which was 9 cases per 100,000 population. A total of 50 kits were received in the Forensic Science Laboratory which would suggest that 5 of the victims (10%) underwent the examination and withdrew their statement. 35 examinations were conducted at the Rotunda SATU from victims residing in the North East which represents 78% of those reported to the Gardaí and 70% of the sexual offence examination kits received in the Forensic Science Laboratory.

Some of the service providers consulted in the North East with regard to their local situation confirmed that the extensive road network allows relatively easy access to the Rotunda SATU in Dublin in comparison to other parts of the country. A principal recommendation of the evaluation of services for women experiencing violence in the North East, *'Changing Direction'* (Timoney et al, 2003) was to extend RCC services for victims of rape/sexual assault. No reference was made to the need for a dedicate SATU at that time.

6.6 SATU, Tralee General Hospital (*ceased operating October 2004*)

The SATU at Tralee General Hospital commenced operating in 2002 and ceased in 2004. It was originally established by a group of concerned service providers including medical personnel, An Garda Síochána and staff from Tralee RCC.

The Unit was established to provide a holistic Sexual Assault Treatment service to victims of sexual crime in the Kerry region and saw an average of 25 victims per year. Even though a Unit had been in existence in Cork city since 2001, this group felt it was not appropriate for traumatized victims to travel to the service in Cork. In addition they were concerned about the psychological needs of the individual and felt it essential that a support worker from the client's local Rape Crisis Centre was available to meet with them when they presented at the SATU.

Until the Unit closed in October 2004 due to lack of funding, clients were seen by the Gynaecology registrar on call at the hospital. If they were unavailable, the medical director of the SATU would carry out the examination herself. Until its closure, despite much campaigning no funding had been secured to operate the service except for four nursing hours per week which was used for administration of the SATU. The service did not have a dedicated building but had access to the facilities of the Foetal Medicine Unit during the day and the Colposcopy Unit out of hours.

It was the policy of the SATU that every victim met with a support worker from the local RCC. Over the two-year period while the service was in operation, they found that the uptake of formal counselling services in the RCC was excellent, which they attribute to the initial contact that was made with their support worker in the SATU.

Until its closure the nursing cover was provided by transferring nurses from the Gynaecology ward, which subsequently left the ward short staffed for sometimes up to four hours. In the latter half of 2004 the nursing support from the Gynaecology ward was withdrawn due to workload demands, hence the SATU service was formally ceased.

6.7 Summary

- Currently there are no dedicated SATU services in the Mid-Western, Western, Midland or North Eastern HSE regions.
- Victims of rape/sexual assault from these regions are therefore dependant on ad-hoc arrangements where there are often long delays between the time the crime is reported to the Gardaí and the carrying out of a forensic medical examination .
- In failing to identify a local GP who is available to carry out the examination, the Gardaí are frequently required to transport victims to a designated SATU elsewhere, often taking 12 hours or more to make the round trip.
- When reviewing reporting rates to the Gardaí for 2003 it was noted that the HSE Western and Midland Regions had particularly low rates of 3.6 and 4.4 cases per 100,000 population respectively in comparison to the national average for that year of 9 cases per 100,000. Hence the alarmingly low reporting rate to the Gardaí could be evidence of attrition caused by the lack of a dedicated service in the region.
- A SATU was established at Tralee General Hospital in 2002 which ceased operating in 2004 due to lack of resources.

6.8 Conclusion

The lack of services for victims of rape/sexual assault further compounds the sense of guilt and self blame they express, which acts as a deterrent to them reporting the crime. Measures to decrease these gaps are addressed further in section 9 of this report.

Acute Child Sexual Assault Services

7.1 Introduction

The presentation of Child Sexual Abuse²⁰ (CSA), is a difficult and upsetting experience for all involved. Children may present in a variety of ways and to different agencies: A&E departments, GP surgeries, social services, schools etc. Many cases come out of hours and often present to staff with little or limited experience in their management (McKay, 2005). In order to develop a deeper understanding of the issues that surround the provision of Acute Child Sexual Abuse Services (ACSASs) a group of paediatricians and A&E consultants from the three Dublin-based children's hospitals were consulted for their views.

7.2 Key Legislative Provisions

Since the publication of the 1987 Child Abuse Guidelines by the DOHC the profile of child abuse as a social problem has risen considerably in Ireland. During this period significant reforms have taken place in terms of legislation, policies and services established to promote the protection and welfare of children. The Child Care Act, 1991 updated legislation for the welfare and protection of children in relation to the care of children who have been '*assaulted, ill-treated, neglected or sexually abused or who are at risk*'. In September 1992, the UN Convention on the Rights of the Child was ratified by Ireland and came into force on 21 October 1992.

Services within HSE Community Care regions; who hold statutory responsibility for child care and child protection have in recent years been re-organised and expanded to accommodate this service (DOHC, 1999).

7.3 Presentation of a Child Following Alleged Sexual Assault

While sexual assault of adults and child are of equal significance, the management of care is different for both. Adults are encouraged to report it to the Gardaí and undergo a forensic medical examination if it is within 7 days of the crime. With children however, the presentation of assault occurs in a number of ways, some clearly indicating the probability of assault while others lead only to the suspicion that assault is a possibility. A clear statement by the child is the single most important factor in making a diagnosis of sexual assault. A diagnosis of child sexual assault should rarely, if ever, be made on physical signs alone and a substantial proportion of sexually assaulted children have no abnormal physical signs. A multi-disciplinary investigation with full interagency cooperation between social workers, psychologists, therapists and doctors is necessary whenever there is concern that child sexual assault has occurred (McKay, 2005).

²⁰ Child sexual abuse is defined as; '*Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal or for that of others*', (Children First) or; '*The involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend and to which they are unable to give informed consent or that violate the social taboos of family role*', (Shecter and Roberge 1976) or; '*Sexual abuse is the exploitation of a child for the gratification of an adult*' (Fraser 1981).

7.4 Current Situation

Currently there are no dedicated medical services for children who experience acute sexual assault in Ireland. Over the years ad-hoc arrangements have developed in Dublin to try to meet the needs of these victims. Examinations, both acute forensic and elective, are performed in all three children's hospitals by doctors from various backgrounds and in a variety of settings which often causes confusion among agencies as to where to refer the child and when. While all three children's hospitals provide an overall child friendly environment, there is a general lack of privacy with examinations frequently taking place in the clinical environment of a resuscitation room. At present, few places meet the appropriate requirements for forensic examination, and equipment such as a colposcope, photo-recording equipment and facilities to record findings are not normally available. Nowhere at present can offer victims and families an out of hours service, providing adequate space and comfort where they can take some time to deal with their trauma.

Outside of Dublin children presenting to A&E departments may or may not be seen by an experienced doctor and are very often subject to repeated interviews/examinations due to the lack of appropriately skilled personnel. Frequently parents/guardians are advised to transport the child to an A&E department in one of the Dublin based children's hospitals, even though they do not provide a formal CSA service. Furthermore, a physical examination is only a small part of the overall assessment and investigation of such cases but one which often causes confusion. In fact it is not always appropriate to conduct an immediate physical or forensic examination on a child who presents with an allegation of assault. The decision as to how to proceed should be based on the judgement of an experienced skilled examiner.

7.5 Prevalence of Acute Rape/Sexual Assault in Children

In the absence of structured data collection procedures it is notoriously difficult to estimate the number of children who require forensic or medical examination every year. It is estimated that approximately 13-14% of sexual offence examination kits received in the Forensic Science Laboratory per annum are from young people under the age of 15 years which equates to approximately 65 cases.

7.6 Summary

- Currently there are no dedicated medical services for children who experience acute sexual assault in Ireland.
- Many cases present to A&E departments out of hours to staff with little or limited experience in their management.
- Over the years ad-hoc arrangements have developed in the three children's hospitals in Dublin to try to meet the needs of these victims.
- Since the publication of the 1987 Child Abuse Guidelines by the DOHC, the profile of child abuse as a social problem has risen considerably in Ireland.
- During this period, significant reforms have taken place in terms of legislation, policies and services established to promote the protection and welfare of children.
- Services within HSE Community Care regions who hold statutory responsibility for child care and child protection have in recent years been re-organised and expanded to accommodate this service.

- A diagnosis of child sexual assault should rarely, if ever, be made on physical signs alone and a substantial proportion of sexually assaulted children have no abnormal physical signs.
- The decision on whether an immediate examination is necessary should be based on the advice of an experienced, skilled practitioner.
- A multi-disciplinary investigation with full interagency cooperation between social workers, psychologists, therapists and doctors is necessary when there is concern that child sexual assault has occurred.
- In the absence of structured data collection procedures it is notoriously difficult to estimate the number of children who require forensic or medical examinations.

7.7 Conclusion

Developing appropriate services to meet the needs of children is extremely complex and requires extensive research which is beyond the scope of this review. Consultation is required with relevant service providers including Community Care Services who hold responsibility for child care and management within the HSE.

It is recommended that immediate priority should be given to informing the key players involved in child care services of the need to examine the provision of services to children and in doing so identify the most appropriate models of care that adopt a holistic approach to service delivery and maximize the potential of a successful conviction.

International Review of Models of Good Practice

8.1 Introduction

A recent international review of models of service provision revealed that whilst in some countries a single model of provision predominates, in the majority there are a range of models, as well as less organized forms of provision, operating simultaneously. Therefore for most victims of rape/sexual assault, the responses they encounter depend not only on which country they live in but also where they live within that country (Kelly & Regan, 2003a). This section outlines a number of models of good practice as identified throughout the consultation with service providers and in the extensive works of Professor Liz Kelly and Linda Regan from the Child Abuse Studies Unit, of London Metropolitan University.

8.2 Child Abuse and Rape Enquiry Units: Northern Ireland

Currently there are four Child Abuse and Rape Enquiry Units (CARE) in Northern Ireland based in Garnerville in Belfast, Enniskillen, Derry and Coleraine. Both adult and child victims of acute and chronic rape/sexual assault are interviewed and examined in these CARE Units. The Units are managed and funded by the Police Service Northern Ireland (PSNI) with all four Units located in a police environment. Any complaint or report of rape/sexual assault, child abuse or domestic violence is immediately referred to dedicated police teams, of which there are eleven. The CARE unit in Garnerville, Belfast was visited on a fact-finding mission as part of this review and senior PSNI representatives presented an overview of their services to the Review Committee.

When a victim reports the rape/sexual assault, a dedicated trained police officer makes all the arrangements to interview the victim within the CARE unit and arranges the forensic medical examination as necessary. The interview rooms at the Unit are equipped with adjoining observation rooms, video links and camera recording equipment. These facilities are used particularly in cases of child abuse where the child victims are being interviewed or also in interviewing vulnerable adults, such as those with learning difficulties. The medical examination rooms provide colposcopy, photography and video documentation facilities.

In the CARE Unit in Garnerville, many of the eight doctors who cover the 24-hour rota work elsewhere part-time either as GPs or at senior registrar level in hospitals in addition to rota cover at the CARE Unit. Examinations of children are usually carried out jointly by the senior doctor at the Garnerville unit and community or consultant paediatricians.

At their presentation to the Review Committee, the PSNI representatives outlined the advantages and disadvantages of their current system. The advantages include having dedicated, well-trained and experienced Police Officers dealing exclusively with cases of sexual assault and abuse in both adults and children. Funding is available from the PSNI to provide adequate facilities, staff training and remunerate the doctors for their time and expertise. Disadvantages include being entirely police-managed and having only limited links to health services. To date, there is no facility for a person who declines police involvement to avail of the services. A facility where a person could have a medical examination including taking forensic evidence samples, which could be securely stored, is being considered. Links to counselling services are also limited.

8.3 Sexual Assault Centres/Sexual Assault Referral Centres

There are a number of models of Sexual Assault Centres (SACs), many which have developed in response to criticisms by women's groups at the lack of dedicated services for victims of rape/sexual assault. Some countries such as Canada have extensive networks, while others such as Germany, Switzerland and the UK have a number of centres, often located in major cities or locations where women's groups or committed medical staff have campaigned to improve local provision. SACs aim to provide a high quality of comprehensive care to anyone who has experienced recent sexual assault (Kelly & Regan, 2003a). In Canada their mandate is "to attend to the medical, emotional, social and medico-legal needs of the victim in a prompt, professional and compassionate manner and to provide leadership in the prevention of sexual assault" (Du Mont & Parnis, 2002). Their broader framework (in contrast to a more limited medico-legal model) emphasises the importance of choice, respect, empowerment and honouring difference, alongside linking crisis intervention, long term support and prevention (Kelly, Regan 2003a).

SACs tend to be limited to recent sexual assaults, ie within two weeks, and are available to women, men and children. SACs are invariably a private suite of rooms, one of which is equipped for forensic examinations. Some SACs are limited to two rooms – one for examination and another for support/follow-up and a shower room; others have more extensive facilities.

In North America there is often a strong victim advocacy programme where advocates are expected to link in at the earliest point, ie when someone first attends a Centre. SACs place emphasis on choice and options, meaning that a staff member will be allocated to explain the procedures and the options; many SACs offer services regardless of whether a report will be made to the police, and offer the possibility of taking samples, and having them stored for a period of time, so that the decision about reporting can be taken at a later date. A number of SACs, especially in Canada, have integrated pro-active follow up within the week of attendance. Funding of SACs varies, with some in North America being supported through federal or state funding for victim services or health care budgets (Kelly & Regan, 2003a).

The Home Office of the United Kingdom announced the Crime Reduction Programme (CRP) in 1998, which aimed to develop and implement an integrated approach to reducing crime and making communities safer. As part of this programme the Violence Against Women Initiative (VAWI) was launched in July 2000, and specifically aimed to find out which approaches and practices were effective in supporting victims and tackling domestic violence and rape/sexual assault. Thirty-four multi-agency victim focused pilot projects were funded of which 10 are SACs, or more commonly known in the UK as Sexual Assault Referral Centres (SARCs). Prior to this however, St.Mary's SARC in Manchester, was established in 1986. The 1990s saw the growth of additional SARCs across Britain with two 'REACH Centres' (Rape, Examination, Advice, Counselling, Help) established in Sunderland and Newcastle, the 'STAR project' in West Yorkshire and the 'Juniper Lodge' project in Leicestershire. In the UK funding for staff and services has come from police budgets, with health covering the accommodation costs. More recently three SARCs have been established in London, known as Havens, based in Paddington, Camberwell and Whitechapel.

A recent UK study (Lovett et al, 2004) has recommended an inter-agency, integrated approach to service provision similar to services provided by the SARCs in the UK. The study found that SARC service users rated the environment and conduct of the forensic examiner as the highest, in comparison to users of other models with a higher proportion of cases resulted in forensic medical examinations. It was also found that the examiners in SARCs were more likely to conduct

the examination with care and sensitivity, including offering as much control as possible to the victim. (Detail on UK services see Appendix IV)

8.4 Centres of Excellence

A 'Centres of Excellence' model operates in Scandinavia with centres existing in Copenhagen, Oslo, Reykjavik and Uppsala. This model, which is described as the 'Nordic model of Rape Crisis Centres'; is always hospital based and often developed through the vision and leadership of a committed female doctor. They represent a national resource, usually based in the capital city. What distinguishes a Centre of Excellence is that they are usually well funded, recognised nationally (and often internationally) as holding extensive expertise, and invariably undertaking research and publish findings in medical and other journals. Such services specialise in the emergency response to recent rape/sexual assault and therefore encompass forensic medical examinations and treatment informed by research and crisis counselling. There tends to be very strong links with other agencies, especially the police and prosecutors. Their role is to be an example of best practice, continually updating knowledge and skills, in the light of their own and international knowledge base. While those who attend such centres will be seen by skilled and experienced staff, there are a number of disadvantages for those outside of the catchment area who cannot access the services. Resources tend to be drawn to the centre, with limited development and provision elsewhere (Kelly and Regan, 2003a).

8.5 Forensic Nursing²¹

Forensic nursing is the application of nursing sciences and skills to public and legal proceedings, combining forensic science with the treatment of trauma. A forensic nurse is expected to provide direct services to victims, professional consultation and services for the police and legal system (Kelly & Regan, 2003a).

In 2001 a forensic nursing pilot programme was commenced at St. Mary's SARC in Manchester. The potential of forensic nursing had been recognised as a means of addressing the issues of waiting times for victims particularly during daytime hours in addition to addressing problems encountered with the recruitment and retention of female doctors. Prior to commencing the pilot, the nurse involved completed a one-week training course in Seattle, USA. During the pilot, 1,072 forensic medical examinations were carried out at St. Mary's Centre. Of these 249 (23%) were conducted by the forensic nurse and the remaining 823 were conducted by the 13 forensic doctors who provided the service out of hours, averaging 63 (6%) cases each. The role of the nurse examiner was primarily to collect evidence and to write statements if requested to do so. During the pilot phase, 51 (20%) statements were prepared. Evidence given by the nurse in court was not challenged in any way, however she only attended court on two occasions during which she was asked to go through her statement. Hence, the forensic nurse examiner was seen as an ordinary witness²² as opposed to the doctor who was seen as an expert witness, even though their relevant clinical experience would have been significantly less than that of the nurse for the same period. The evaluation of the pilot suggested that "the obvious next step for the long term lies in the development of the forensic nurse's role from documenter to interpreter of her own evidence, as is common practice in North America"(Regan et al, 2004).

²¹ Reference to nurses includes both nurses and midwives.

²² An 'ordinary witness' is one who testifies on their personal opinion versus an 'expert witness' who can interpret, extrapolate and provide comment on facts, possibility and probability (Director of Public Prosecution, presentation to SATU Review Committee, 2005).

In the US a range of Forensic Nurse specialisations have developed including the Sexual Assault Nurse Examiner (SANE). These forensic nurses now conduct the majority of forensic examinations on victims of rape/sexual assault. Whilst their area of expertise began in adult rape, forensic nursing in the US has now expanded to encompass child sexual abuse. Most of the sexual assault nurse examiners are part of a larger multidisciplinary Sexual Assault Response team (SART). (The feasibility of introducing a pilot programme on forensic nursing in Ireland is discussed in more detail in Section 9).

8.6 Summary

- A recent international review of models of provision revealed that whilst in some countries a single model of provision predominates, in the majority there are a range of models, as well as less organized forms of provision, operating simultaneously (Kelly & Regan, 2003).
- Currently in Northern Ireland the PSNI manage and fund 4 Child Abuse and Rape Enquiry Units (CARE) which are all located in a police environment. Any report of sexual assault, child abuse or domestic violence is referred to dedicated police teams, of which there are eleven. As the CARE units are funded and managed by the PSNI they are primarily medico-legal models and lack the psychological support and on-going care that is an essential aspect of the victim's recovery.
- Sexual Assault Centres (SACs) / Sexual Assault Referral Centres (SARCs), operate across Canada, Australia, Germany, Switzerland and the UK. They are usually based in hospitals in major cities and provide a high quality of comprehensive care to anyone who has experienced recent sexual assault.
- A 'Centres of Excellence' model operates in Scandinavia with centres existing in Copenhagen, Oslo, Reykjavik and Uppsala. These Units are always hospital based, usually in the capital city and represent a national resource. While those who attend such centres will be seen by skilled and experienced staff, resources tend to be drawn to the centre, with limited development and provision elsewhere.
- In the US Forensic Nurse specialists now conduct the majority of forensic medical examinations on victims of rape/sexual assault. In the UK in 2001 a pilot Forensic Nursing programme commenced at the SARC in St Mary's Hospital Manchester. While the Forensic Nurse conducted over 200 forensic medical examinations over the pilot phase she was seen as an ordinary witness in court with only the doctor seen as an expert witness. One of the principal recommendations of the evaluation was that the forensic nurses role needs to progress from documenter to interpreter of the evidence, as is common practice in North America.

8.7 Conclusion

In our efforts to provide a holistic service to victims of rape/sexual assault we must address their physical, psychological and forensic needs as well as the requirements of the criminal justice system. A client-centred approach demands that services are relatively local, easily accessible, provide appropriate privacy and are compassionate and empathetic to their needs. While the Review Committee acknowledges that specific aspects of existing SATUs in Ireland require immediate attention, generally speaking the model adopted in Ireland to date is similar to the inter-agency, integrated approach in SARCs in the UK. This approach to future service development has been endorsed by the Review Committee as a recommended way forward.

Given that examinations have to be conducted by medically trained staff, the need for forensically clean conditions to ensure no contamination of evidence, the importance of access to medical care, and the need for a 24/7 service, hospital settings are the most suited. The realities of sexual assault, and its immediate impacts, make the environment in which examinations take place critical. A private, dedicated space, which combines clinical needs for cleanliness in the examination room with a separate calming and relaxing location to undertake interviews and support are recommended as minimum requirements in future service developments.

Rationale to Determine Appropriate Locations for Future Developments

9.1 Introduction

The findings of this review show that the responses experienced by victims of rape/sexual assault in Ireland depends on where they live. This geographical lottery means that while some victims have access to organized dedicated services, many are still dependant on local ad-hoc arrangements which can become a deterrent to the victim sourcing appropriate care to meet their needs and continuing with criminal prosecution.

Having reviewed the gaps in services we are now faced with the challenge of determining where services should be located to ensure that victims of rape/sexual assault nation wide have easy access to coordinated holistic care.

9.2 Criteria

In determining the most suitable locations for future service developments in Ireland the following factors were taken into consideration by the Review Committee:

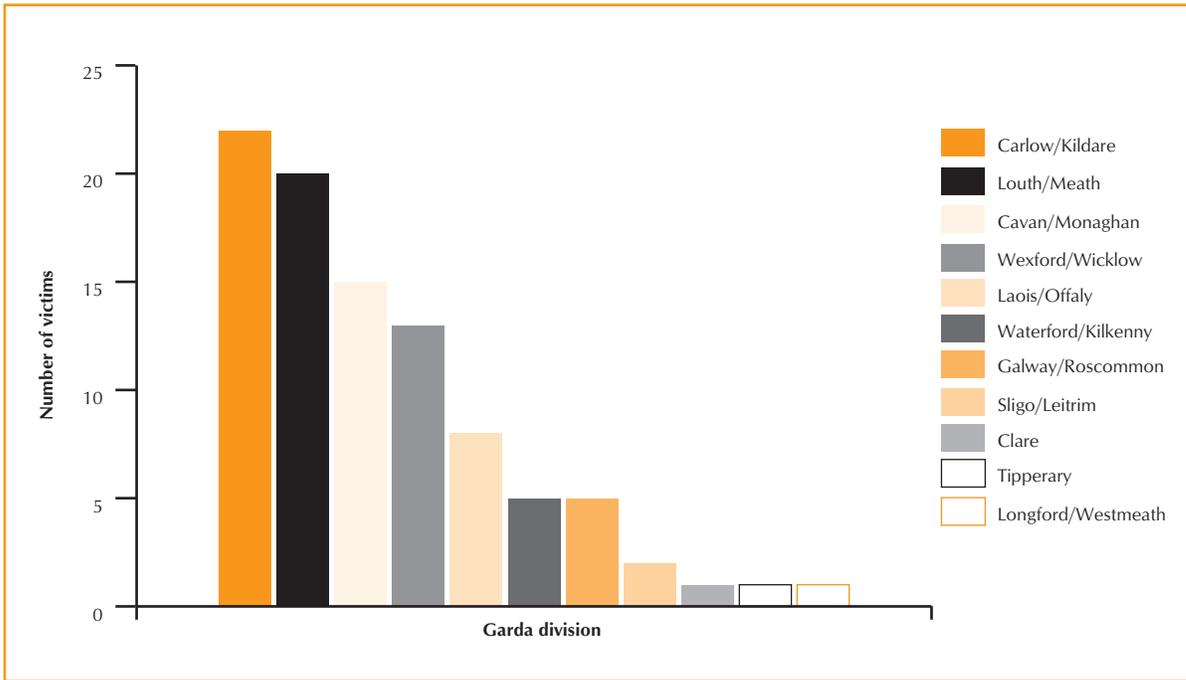
- Sustainability of services
- Geographical access and travel time to nearest SATU
- Previous reporting rates

9.2.1 Sustainability of Services

Services need to be accessible to and utilised by a large enough number of victims so that staff can retain and increase their professional competencies. A strategic approach must therefore be adopted in identifying the ideal geographical locations, and areas where victims currently have no access to services must be targeted, whilst protecting the sustainability of existing services. Bearing this in mind it is useful to examine the geographical origin of those attending the Rotunda and Cork SATUs for 2003 presented in Tables 7 and 8 below.

Of the 285 victims who attended the Rotunda in 2003, 93 (33%) travelled to the Unit from outside of Dublin. The chart below demonstrates that the vast majority travelled from the Eastern part of the country, with very few having come from the West or North West.

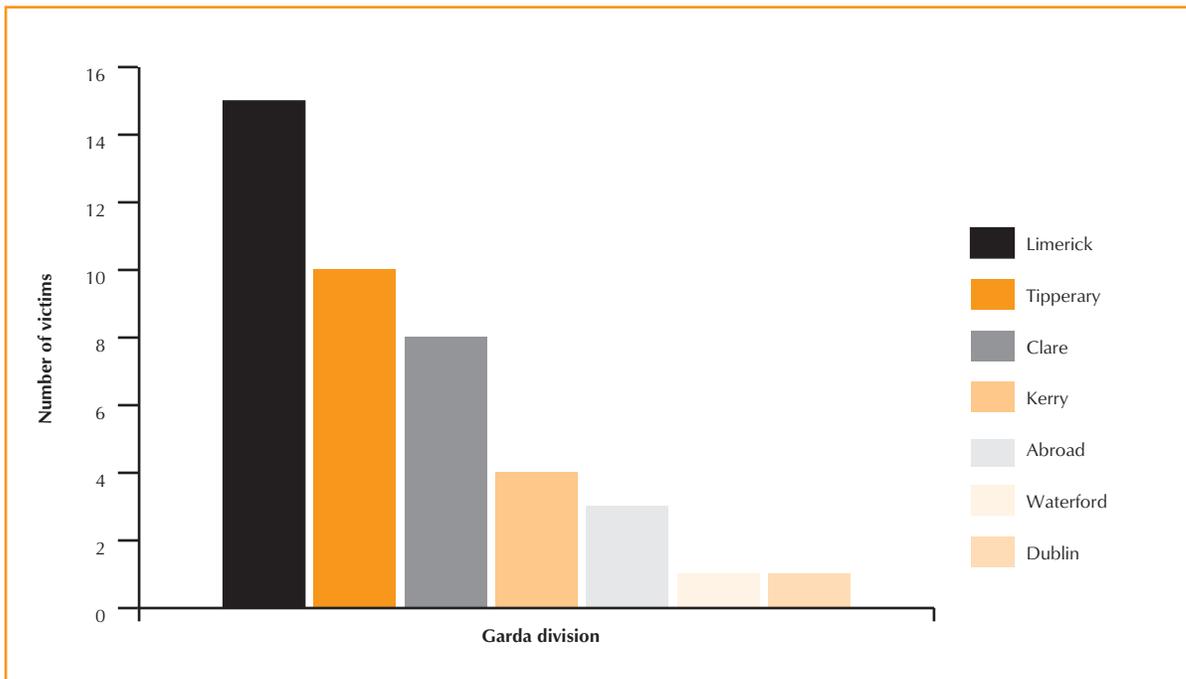
Table 7: Number of cases seen in the Rotunda from outside of Dublin in 2003 by Garda division



Source: Rotunda SATU

Of the 114 victims who attend the Cork SATU in 2003, 42 (37%) travelled to the Unit from outside of Cork. The chart below demonstrates that the majority of these victims travelled from the Mid-Western Region.

Table 8: Number of cases seen in Cork SATU from outside of Cork in 2003 by Garda Division



Source: Rotunda SATU

9.2.2 Travel Time to Nearest SATU

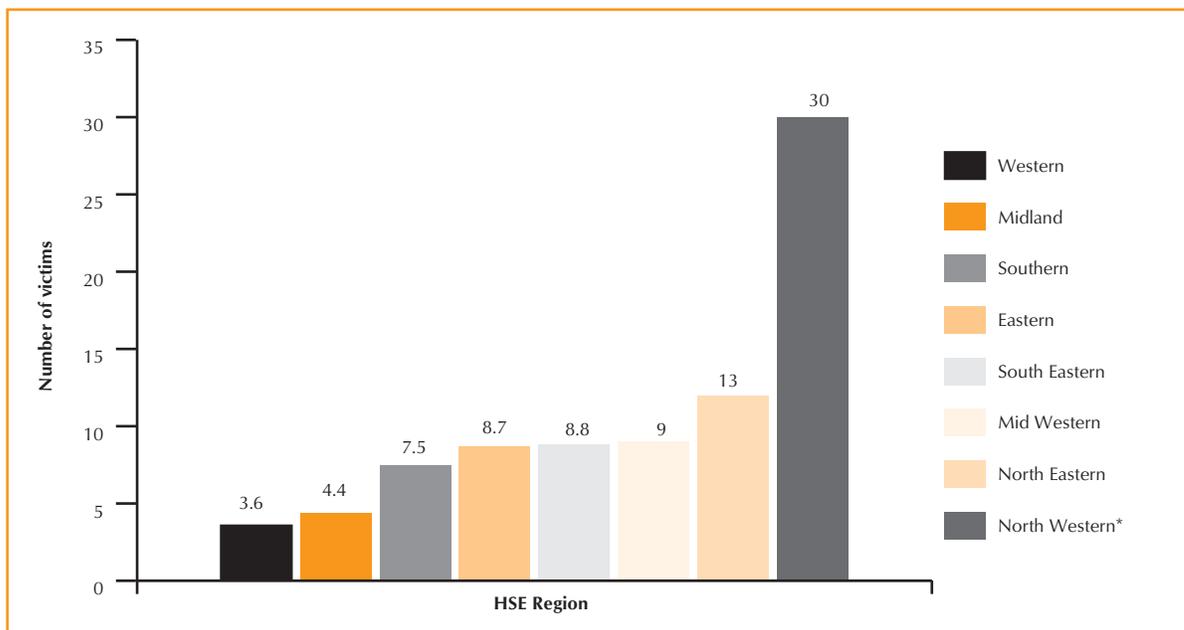
While it is recommended that services are relatively local, it must be ensured that the care that victims receive is provided by practitioners who conduct forensic medical examinations on a regular basis thereby maintaining their skills and level of expertise. It is impossible to estimate potential reporting rates but with improved access to coordinated, accessible services it is envisaged that reporting rates would increase significantly, particularly in the Western and Midland HSE Regions where the rates are currently extremely low. It is recommended that newly established services are located so that any victim of rape/sexual assault in Ireland is within a maximum of 3 hours drive of a SATU.²³

9.2.3 Previous Reporting Rates

Table 9 below displays the number of reported cases by HSE Region per 100,000 population in 2003. The national average reporting rate for that year was 9 cases per 100,000 population, however the Western and Midland HSE regions record dramatically lower reporting rates at 3.6 and 4.4 cases per 100,000 respectively. Although not conclusive, it would suggest that the absence of dedicated SATUs in these regions contributes to this low reporting rate and it is envisaged that by providing a coordinated SATU within these regions reporting rates to Gardaí would significantly increase.

The situation in the North East however is quite the opposite with an above average reporting rate of 13 cases per 100,000. This would indicate that access to services in the Rotunda is sufficient to meet the needs of victims in this area.

Table 9: Number of reported cases of rape by HSE region per 100,000 population in 2003



* 34 of the 58 incidents reported in the North Western Region refer to the same injured party and the same offender.

Source: An Garda Síochána 2003 annual report based on 2002 census

²³ See Appendix V for the criteria used in The Haven SARC in Paddington, London.

9.2.4 Discussion

Bearing in mind the criteria identified to inform service developments it is recommended by the Review Committee that SATUs are initially established in Galway city in the HSE Western region and an appropriate location in the HSE Midland region. It is also recommended that the uptake of these services is reviewed by the NSC in 2007 to ensure that the gaps in services have been addressed adequately and if not, that measures are taken to address these needs.

9.3 Forensic Nursing: A Way Forward?

With an increasing awareness of the difficulties encountered in attracting doctors to the service, the Centre of Nurse Education for Donegal and the Nursing Practice Development Unit at Letterkenny General Hospital investigated the possibility of the forensic medical examination being carried out by forensic nurse examiners which is a recognized nursing speciality in the US and in many countries across Europe. In 2002, two nurses from Letterkenny travelled to Tulsa in Oklahoma in the US to undertake the Sexual Assault Nurse Examiner Course. On return to Ireland a working group was established to examine the feasibility of introducing forensic nursing into Ireland and to develop a training model for forensic nurse examiners. Membership of this group included the two nurses from Letterkenny in addition to representatives from the INO, National Council for the Professional Development of Nursing and Midwifery (NCPDNM), DJELR, Royal College of Surgeons, Rotunda SATU, State Pathology Department, DPPs office, Legal Profession and the DVSAIU. It was considered by the group that forensic nurse role development in Ireland should be at Clinical Nurse Specialist level, with the minimum academic qualification being a Higher Diploma in forensic nursing.

Acknowledging the difficulties in recruiting and retaining doctors, the feasibility of nurses conducting forensic medical examinations in Ireland has been examined more recently by the Review Committee. The committee sought the advice of the office of the DPP regarding the acceptance of the nurse's testimony as an expert witness in court. Generally speaking the DPP felt it would be a positive move forward. While there was some concern raised about the uncertainty of nurses being accepted as expert witness which is at the discretion of the judge, it was felt that advanced training and qualifications, membership of a professional body and a number of years experience in the field would support the argument.

Kelly and Regan (2003) describe some of the advantages of forensic nursing as:

“Increasing the likelihood of being able to provide a female examiner; examiners are frequently highly skilled and specialised; well organised systems ensure prompt availability; systems can be designed so that the provision of a report and giving evidence in court are considered core elements, rather than extras; provision can be less expensive than that involving doctors; and organised forensic nurses have become strong advocates for not just ensuring minimal standards, but building concepts of respect, privacy and dignity into service provision”.

In developing a model of forensic nursing in Ireland attention should be given to the experience in other countries. Kelly in her evaluation of the forensic nursing pilot programme in Manchester suggests that:

“any forensic nursing training programme needs to encompass skills development in the areas of understanding sexual assault, internal examination, forensic practice, identification and documentation of findings, where relevant use of colposcopy and preparing statements

and giving evidence in court". She goes on to say, "for forensic nursing to develop, investment will be needed in a recognized and accredited training programme".

The forensic nurse pilot programme in Manchester is significantly different from that proposed in Ireland. While the nurse employed during the pilot had a significant amount of experience in conducting forensic medical examinations she had limited academic training in forensic medicine. In Ireland the criteria for the role of Clinical Nurse Specialist is clearly defined by the NCPDNM and the post holder requires a Higher Diploma relevant to the area of specialism, as well as a number of years clinical experience in the specialist area. On discussion with the DPP representative, he felt that this type of specialised training should be acceptable to the courts in Ireland.

It was also suggested by the Review Committee and numerous respondents throughout the consultation process that due consideration should be given to a change in legislation to ensure that the evidence of forensic nurse examiners is accorded equal status by the courts with that of FMEs.

The Review Committee therefore recommend the introduction of a pilot programme in forensic nursing in Ireland where nurses undergo a higher diploma in order to qualify as a Clinical Nurse Specialist in forensic nursing.

9.4 Summary

- The findings of this review show that the responses experienced by victims of rape/sexual assault in Ireland depends on where they live.
- The rationale to determine location of future developments is based on sustainability of existing services, travel time to the nearest SATU and previous reporting rates.
- It is recommended that newly-established services are located so that any victim of rape/sexual assault in Ireland is within a maximum of 3 hours drive to a service.
- Based on the rationale presented and to ensure a geographical spread of SATUs it is recommended that two additional services are initially developed in the HSE Western Region and the HSE Midland region.
- It is also recommended that the uptake of these services is reviewed by the NSC in 2007 to ensure that the gaps in services have lessened and review what further measures need to be taken.
- The Review Committee recommends the introduction of a pilot programme in forensic nursing in Ireland where nurses undergo a higher diploma in order to qualify as a Clinical Nurse Specialist in forensic nursing.

10.1 Introduction

Victim contact with medical personnel following sexual crime takes place in the context of the legal engagement of a doctor to conduct a forensic medical examination. This examination is part of the gathering of Garda evidence and as such the responsibility for providing the examiner must lie with the Garda Síochána through the auspices of the DJELR. Yet in addressing the care of victims of sexual crime we cannot look at the legal system in isolation. In our efforts to provide a 'holistic' service to victims of rape and sexual assault we must also address their physical, emotional and psychological needs.

The development of sexual assault treatment services are therefore seen to be the joint responsibility of the DOHC and the DJELR. Both of these government bodies acknowledge the need to develop a more comprehensive rape/sexual assault treatment service which is relatively local, easily accessible, provides appropriate privacy and is compassionate and empathetic to the victim while maintaining expertise and standards in service delivery.

The implementation of the recommendations in this report requires the commitment from these two departments and their relevant agencies to ensure sustainability through the ongoing provision of appropriate resources.

The recommendations are presented under the following categories:

1. Standardization of existing services.
2. Expansion of SATU services.
3. Pilot programme on forensic nursing.
4. Addressing gaps in the legal system.
5. Promoting networking and sharing of information.
6. Further research requirements.
7. Training

Recommendation 1: Standardization of existing services.

The overview of existing service delivery demonstrates the differences in local organizational and implementation approaches to addressing sexual assault posing difficulties for inter-agency cooperation. As previously stated, all existing SATUs have been set up on an ad-hoc basis been driven by concerned local service providers. As such, management and implementation structures vary greatly. The Review Committee recognize the lack of co-ordination between agencies and the value of drawing the expertise of these different services together to provide a standardized, multi-disciplinary, multi-agency response to the treatment of victims of alleged rape/sexual assault and therefore make the following recommendations:

R.1.1 Management Procedures	Responsibility
R.1.1.1 Establish a national standardization committee with representatives from existing SATUs and NSC to coordinate standardization by the end of 2006 and to oversee the implementation of the recommendations contained in this report under the guidance of the chairperson of the NSC.	HSE
R.1.1.2 Employment of a National Medical Director on a part-time basis to act as a resource to SATUs nationally, facilitate training programmes / conferences, drive and monitor the recommendations in this report.	NSC/HSE
R.1.1.3 Employment of a full or part-time Clinical Nurse Manager level 2 in each SATU to manage and coordinate the service	HSE
R.1.1.4 Establish a multi-agency steering committee in each SATU with defined terms of reference.	HSE
R.1.2 Medical Personnel	Responsibility
R.1.2.1 Standardize payment of doctors by the HSE to provide the on-call service in line with rates currently paid in the Rotunda SATU.	HSE
R.1.2.2 Standardize payment of doctors by An Garda Síochána to conduct forensic medical examinations and write medico-legal reports in line with An Garda Síochána schedule of payments.	DJELR
R.1.2.3 Develop standardized job descriptions for doctors.	Standardization Committee/NSC/HSE
R.1.2.4 Develop standardized terms of contract incorporating periodic appraisal to identify needs.	Standardization Committee/NSC/HSE
R.1.2.5 Conduct regional / national recruitment drive (road show/ advertising in medical press/ websites/ colleges) to attract more doctors to the services.	NSC/HSE
R.1.2.6 Standardize medical charts and medico-legal reports.	Standardization Committee/HSE
R.1.2.7 Introduce a policy in each SATU where it is standard practice to tape medico-legal reports automatically following each case.	Standardization Committee/ HSE
R.1.3 Nursing Personnel	Responsibility
R.1.3.1 Standardize pay structures for on-call nurses in line with national theatre nurse on-call rates.	HSE
R.1.3.2 Standardize terms and conditions in SATU nurses' contracts.	HSE

R.1.4 Administration	Responsibility
R.1.4.1 Provide administrative support for each SATU to meet the needs of each Unit.	HSE
R.1.5 Support Workers	Responsibility
R.1.5.1 Adopt the policy in each Unit where the coordinating nurse automatically calls an appropriate support worker to be available to meet with the victim as part of the core service.	HSE/SATU Steering Committee
R.1.5.2 Ensure access to a suitable room where the support worker can meet with the victim in private.	HSE
R.1.6 Scope of Services	Responsibility
R.1.6.1 Extend access to SATU services to victims of rape/sexual assault who have chosen not to make a report to the Gardaí.	HSE
R.1.6.2 Adopt the age of 14 years as the minimum age for access to adult SATU services.	Standardization Committee/HSE
R.1.7 Monitoring and Evaluation	Responsibility
R.1.7.1 Develop a national standardized database and monitoring tools for on-going evaluation of each SATU and cross-referencing statistics between services.	Standardization Committee
R.1.7.2 Conduct periodic external evaluations of each SATU.	HSE
R.1.7.3 Incorporate HSE clients' complaints procedure into standard practice for the investigation of complaints.	Standardization Committee HSE/SATUs
R.1.8 National Guidelines	Responsibility
R.1.8.1 All SATUs to adopt the already-developed national guidelines as standard practice.	Standardization Committee/HSE
R.1.9 Inter-referral Pathways	Responsibility
R.1.9.1 Standardize the design and dissemination of inter-referral pathways between all potential points of referral.	Standardization Committee
R.1.10 Non-pay costs	Responsibility
R.1.10.1 Provide standardized funding for non-pay costs in each SATU	HSE

Recommendation 2: Expansion of SATU Services

There is a strong argument for the expansion of SATU services which includes the low reporting of rape, delays in locating a forensic examiner, the environment in which forensic examinations take place, inconsistency of evidence gathering, absence of medical follow-up and support services for victims. The rationale to determine location of future developments is based on sustainability of existing services, geographical access and travel time to the nearest SATU and previous reporting rates. With the increase in service provision there is the likelihood of an increase in service demand.

	Responsibility
R.2.1 Based on the rationale presented and to ensure a geographical spread of SATUs it is recommended that initially two additional services are developed in Galway city in the Western region and an appropriate location in the Midland region.	HSE/DJELR
R.2.2 It is also recommended that the uptake of these services is reviewed by the NSC in 2007 to ensure that the gaps in services have been addressed adequately and if not, that measures are taken to address these needs.	NSC

Recommendation 3: Pilot Programme on Forensic Nursing²⁴

Acknowledging the difficulties in recruiting and retaining doctors, the feasibility of nurses conducting forensic medical examinations in Ireland as a Clinical Nurse Specialist has been examined by the Review Committee. While there was some concern raised about the uncertainty of nurses being accepted as expert witness, which is at the discretion of the judge, the Review Committee were advised by the Director of Public Prosecutions (DPP) that advanced training and qualifications, membership of a professional body and a number of years experience in the field would support the argument. In Ireland the criteria for qualification as a Clinical Nurse Specialist are clearly defined and require a Higher Diploma in the specific area as well as a number of years clinical experience.²⁵

	Responsibility
R.3.1 Introduction of a pilot programme in forensic nursing in Ireland where nurses undergo a higher diploma in order to qualify as a clinical nurse specialist in forensic nursing.	DOHC/HSE
R.3.2 Employ a co-ordinator to oversee, manage and evaluate the pilot programme and ensure availability of appropriate administrative support.	HSE
R.3.3 Employ a part-time clinical supervisor and assessor	HSE
R.3.4 Obtain An Bord Altranais Level 2 approval for the Higher Diploma in Forensic Nursing.	DOHC/HSE
R.3.5 Conduct an external evaluation of the pilot programme to inform future practice and examine the future potential to advance to Advanced Nurse Practitioner in forensic nursing.	HSE

²⁴ Reference to nurses includes both nurses and midwives.

²⁵ On discussion with the DPP representative, he felt that this type of specialised training and experience would be acceptable to the courts in Ireland.

Recommendation 4: Addressing Gaps in the Legal System

It is well established that a significant proportion of sexual assaults are not reported to the Gardaí and that the attrition rate in rape cases in particular, is high. The development of a national SATU service has the potential to improve this situation, especially if enhancements to the criminal justice response are fully integrated into the development of this new service. The Committee therefore recommends that the following initiatives are introduced, or where already in place are implemented effectively:²⁶

	Responsibility
R.4.1 Establishment of a dedicated interview room in a Garda Station in each HSE region exclusively for victims of sexual crime.	DJELR
R.4.2 Introduce a policy in each SATU where medico-legal reports are taped automatically following each forensic medical examination (See also R 1.2.7).	Standardization Committee/ HSE
R.4.3 Consideration should be given to legislative change regarding the establishment of a national DNA database.	DJELR

Recommendation 5: Promote Networking and Sharing of Information

	Responsibility
R.5.1 Develop networking links with national and regional Care Group/Primary Care Units.	NSC/SATUs
R.5.2 Collation, analysis and publication of annual statistics.	NSC
R.5.3 Conduct bi-annual conferences on the issue of Rape and Sexual Assault.	NSC

Recommendation 6: Further Research Requirements:

	Responsibility
R.6.1 The NSC to identify and commission research in the area of rape/sexual assault.	NSC
R.6.2 Immediate priority should be given to informing the key players involved in child care services of the need to examine the provision of services to children and in doing so identify the most appropriate models of care that adopt a holistic approach to service delivery.	DOHC

²⁶ See Appendix VII for recommendations which are forwarded to more appropriate fora.

Recommendation 7: Training:

	Responsibility
R.7.1 Development and facilitation of professional accredited training programmes for doctors on: <ul style="list-style-type: none">■ the medical/forensic treatment of victims of rape/ sexual assault, medico-legal documentation, and courtroom appearance.■ Psychological consequences of rape/sexual assault including attitudes and false beliefs.	HSE
R.7.2 Train Clinical Nurse Managers in each SATU to provide the STI follow-up services on site.	HSE
R.7.3 Development and facilitation of accredited multi-agency training programmes for all service providers.	HSE

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Rape is defined in the Criminal Law (Rape) (Amended) Act 1981, as amended by the Criminal Law (Rape) (Amendment) Act, 1990, as sexual intercourse with a woman who at the time of the intercourse does not consent to it and at that time the man knows the woman does not consent, or is subjectively reckless to whether she does or does not consent. In the event that a man believing that a woman was consenting to sexual intercourse, the jury must have regard to the “presence or absence of reasonable grounds for such belief”. The circumstances under which a jury may have regard to the reasonableness as to the defendants’ belief in consent is in determining whether he honestly held such a belief and not in relation to whether such a belief would be shared by a “reasonable man”.

The 1990 act introduced a new offence known as ‘**Rape under Section 4**’. This means a sexual assault that includes: (a) penetration (however slight) of the anus or mouth by the penis, or (b) penetration (however slight) of the vagina by any object held or manipulated by another person. The offence is gender neutral and it addresses forms of violation other than vaginal penetration by the penis. However it does not include penetration of the anus by an object.

Incest: Punishment of Incest Act 1908, as amended, provides that a man who has sexual intercourse with his granddaughter, daughter, sister, or mother shall be guilty of incest; consent is not relevant.

Underage Sexual offences: Unlawful Carnal Knowledge; The age of consent is 17 years for both heterosexual and homosexual intercourse. Sections 1 and 2 of the Criminal Law Act 1935 make it a criminal offence to have ‘unlawful carnal knowledge’ of girls under 15 and 17 respectively. Under the age of 15 years consent is never an issue, while under 17 years the age appropriateness of the other party may be an issue (ie. If both parties are under 16 years and consent is not being contested). The presence of consent is not a defence, nor is it a defence where the accused believed the girl to be over 17. Section 3 of the Criminal Law (Sexual Offences) Act, 1993 criminalizes buggery with a person under the age of 17 years.

The Criminal Law (Rape) (Amendment) Act, 1990 also provides:

Section 2 replacing the existing offence of indecent assault with the offence of sexual assault. **Section 3** creating the offence of aggravated sexual assault, which is a sexual assault that involves serious violence or threat of serious violence or is such as to cause injury, humiliation or degradation of a grave nature to the person assaulted. Both offences are gender neutral. It used to be known as indecent assault’, and is still generally understood to mean an assault in circumstances of indecency. This offence covers a range of conduct, from non-consensual sexual touching to a sexual attack just falling short of rape. It carries a maximum penalty of five years’ imprisonment. Both types of sexual assault are gender neutral.

- Section 5 (1) abolishing the marital exemption in relation to rape.

- Section 6 abolishing the common law rule that stated that a boy under the age of 14 years was incapable of rape.
- Section 9 stating that failure or omission by a person to offer resistance does not, in itself, constitute consent. Most people who are subjected to an attack will be strongly inclined to offer resistance but may find themselves so overcome with fear that they are unable to resist, or realise that it may be unwise to do so given the strength or aggressiveness of the attacker. In such circumstances, failure to offer resistance is clearly not to be equated with consent. (O' Malley 1996)

The issue of **consent** is central to proving the crime of rape (Task Force Report 1997), yet consent remains undefined statutorily in Irish Law. However the Law Reform Commission 1995 proposed the following definition: "Consent means freely and voluntarily given and without in any way affecting or limiting the meaning, otherwise attributable to these words, a consent is not freely given if it is obtained by force, threat, intimidation, deception or fraudulent means. A failure to offer resistance to a sexual assault does not constitute consent to a sexual assault".

For rape and sexual assault to constitute a crime, consent must be absent or the victim must lack the legal capacity to consent, for example:

- be below 17 years,
- be a person whose capacity to consent is presumed invalid due to their level of disability,
- be a blood relative of a person e.g. father / daughter.

A victim of rape/sexual assault does not have the right to separate legal representation in Irish law. Legal aid is only available to the victim in certain rape/sexual assault cases where the prior sexual history of the victim is being raised by the opposition.

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Number of Reported Rape Cases by Garda Division

Presents the number of rape cases reported to the Gardaí by Garda Division per 100,000 population in 2003. The national average for 2003 was 9 cases per 100,000.

	Population	2003	%
Longford/Westmeath	102,653	3	2.9
Mayo	117,446	5	3.4
Galway/Roscommon	380,297	13	3.4
Sligo/Leitrim	83,979	4	4.7
Wexford/Wicklow	231,272	13	5.6
Laois/Offally	122,437	7	5.7
Tipperary	140,131	9	6.4
Cork	447,829	30	6.7
Limerick	175,304	12	6.8
Dublin Met. Region	1,122,821	98	8.7
Waterford/Kilkenny	181,885	17	9.3
Kerry	132,527	14	10.5
Louth/Meath	235,826	28	11.8
Carlow/Kildare	209,958	27	12.8
Clare	103,277	15	14.5
Cavan/Monaghan	109,139	17	15.5
Donegal	137,575	58	42

Overview of UK Sexual Assault Treatment Services

St Mary's Manchester Sexual Assault Referral Centre (SARC) is located in St. Mary's Women's Hospital and provides an integrated response to adult victims of rape and sexual assault in Greater Manchester. Core services include: forensic and medical examinations; counselling; screening for STIs; post-coital contraception and pregnancy testing; and 24-hour telephone information and support. Examinations are conducted by a team of forensically trained female examiners and supported by Crisis workers who act as advocates on behalf of the victim. The CRP Violence Against Women Initiative enabled the piloting of a forensic nursing service at the SATU as it was becoming increasingly difficult to provide cover by medical personnel due to their commitments to their private practices. While the forensic medical examination is an important part of the service, the SARC service manager emphasized the main focus of their service is the availability of immediate and ongoing counselling to the victim. The St Mary's team has recently expanded to include a full-time member of staff to track the progress of each case through the criminal justice system.

REACH (Rape, Examination, Advice, Counselling and Help) was established in 1991, and has two sites: the Ellis Fraser Centre in Sunderland (in a hospital); and the Rhona Cross Centre in Newcastle (in a house in a residential area), providing services to adult victims/survivors who live in the Northumberland or Tyne and Wear areas. Services and structure are similar to St Mary's, with the exception that there are no Crisis or Support Workers.

STAR (Surviving Trauma After Rape) is not a centre and does not provide forensic examinations, which are provided by police surgeons in rape examination suites across West Yorkshire. The primary role of STAR is to provide consistent support for victims/survivors of sexual assault across West Yorkshire through its own Initial Support Workers and commissioning counselling close to where its service users live. STAR also employs a Case Tracker who records the progress of any reported rape, and keeps the victim/survivor informed about decisions.

The 'Haven' SARC in Camberwell, London was established in 2000 followed by two additional Havens in Paddington and Whitechapel. All three Havens are closely coordinated providing support, information, advocacy, medical attention and forensic examination and organizing follow up medical and support service appointments as necessary. The Havens are linked to Sapphire projects²⁷ which are based in police stations in the Metropolitan Police area, staffed by police officers with specialized training who provide a best practice police response to sexual crimes. The Haven in Paddington which was visited as part of the review provides state-of-the-art facilities with direct access from the street. The one-way flow of clients through the Unit minimizes the risk

²⁷ Sapphire was started in January 2001 following extensive consultation both within and outside the Metropolitan Police Service and in response to the objectives contained in the Metropolitan Policing Plan. The three-year Sapphire strategy addresses six core strands: intelligence, investigation, targeting, diversion, problem solving, and forensics.

of contamination from a previous client, as does the forensic examiner and the crisis worker taking showers between cases, which is standard practice.

In addition to the above, the 'Sanctuary' SARC serves Swindon, Wiltshire; the Milne Centre and Cabot Suite serve the Bristol area and the SAFE centre serves Preston.

Recommended minimum elements of service to be offered by a Sexual Assault Referral Centre (Haven, London 2005)

Definition:

- A dedicated, forensically-secure facility integrated with hospital services
- Accessible 24/7, with availability for victims within 4 hours by appointment when needed
- Provided by a partnership including linked specialist police officers, health services, and the voluntary sector

A SARC should provide:

- Availability of forensic examination for those raped within the last 7 days, within 4 hours in cases of immediate need
- Female doctors by default, or appropriately trained female Sexual Assault Nurse Examiners. All SANEs should be supervised by doctors trained and experienced in forensic examination, to ensure not only the highest standard of forensic examination but also in interpretation of injuries for criminal justice purposes
- Crisis workers to support the victim, the examination, the doctor and the police
- Immediate on-site access to emergency contraception and drugs to prevent sexually transmitted infections including HIV
- Integral follow-up services including psycho-social support / counselling, sexual health, and support throughout the criminal justice process
- Infrastructure to ensure ongoing client care, DNA decontamination, staffing, training and maintenance including stocking of medication
- A managed, quality-assured service

Myths versus Facts about Rape and Child Sexual Abuse

MYTH: People are usually sexually assaulted by strangers.

Fact: 75-85% of attackers are known to their victims, and are often in a position of trust or authority (DRCC, annual statistics, 2003). The impact of this stranger rape myth: 54% of clients of the Dublin Rape Crisis Centre raped by strangers reported to the Gardaí, while only 17% of those raped by relatives or boyfriends reported (2003 DRCC Statistics & Financial Summary).

MYTH: Rape is an act committed by someone who is mentally ill.

FACT: Most rapists are men of all ages and from all walks of life. Of 646 convicted rapists studied in a US study, they were no more psychologically disturbed than violence-prone offenders of other crimes such as robbery or assault (Prof. M. Amir of Chicago University).

Impact of the demonised rapist myth: victims are often confronted with disbelief because their perpetrators do not fit the stereotype – they seem such ‘normal’ or decent people.

MYTH: Only attractive girls are raped.

FACT: All women are subject to the possibility of rape. Interviews with rapists confirm that perceptions of the attractiveness of a woman in most cases is not an important factor of the attack.

Impact of this myth: the mistaken belief that rape is about sexual attraction and that somehow a women ‘asked for it/ wanted it’ by being attractive or getting dressed up.

MYTH: Rape doesn’t have to happen; resist and you won’t get raped.

FACT: Physical force and violence is always present or implied in rape. The rapist is in control of how they act, the victim is always reacting. Whether a victim reacts by resisting, freezing or submitting, the rapist will choose their action regardless.

The impact of this myth: Survivors blame themselves. Society and the justice system question the survivor’s actions.

MYTH: Women often make false accusations of rape.

FACT: Reporting sexual abuse involves complex, invasive and sometimes traumatic procedures. Women who have been subjected to sexual abuse are often treated with suspicion and disbelief. Taking these factors into consideration makes it seem highly unlikely that a woman would make a false accusation of rape.

Impact of the false allegations myth: Victims are disbelieved by family, friends and acquaintances, particularly if the rapist is known to them, because it is suspected she/he may harbour motives of revenge or spite. As a result victims do not report or proceed with prosecutions and those around her are reinforced in the belief that she lied in the first place.

MYTH: Rape is a well-reported crime.

FACT: Only between 10% and 20% of cases are reported to Gardaí. Fear of being disbelieved, of hurting their loved ones (if, for example, the perpetrator is a family member) and fear of the attacker can influence a survivor's decision not to report. Also many women try to forget it ever happened.

Impact of low reporting: denial of the scale of the problem in our society and perpetrators continue to get away with it in huge numbers.

MYTH: Sexual violence only happens to an unfortunate few.

FACT: Irish research found that one in five adult women and one in ten adult men experience contact sexual violence.

Impact: denial of the scale of the problem, the isolation of the victim and the empowerment of perpetrators.

MYTH: Child Sexual Abuse is a rare occurrence.

Fact: The SAVI Report* found 20.4% of Irish women and 16.2% of Irish men had experienced contact sexual abuse in childhood. A further 10% of women and 7.4% of men had experienced non-contact abuse.

MYTH: Most children are abused by strangers.

Fact: In 2003, only 5% of clients of the Dublin Rape Crisis Centre who were sexually abused as children did not know their abuser. In 68.5% of cases the abuser was a family member, and in 26.5% was another person known to the child (The SAVI report, McGee et al., Liffey press 2002).

MYTH: Boys are not sexually abused.

Fact: In 2003, 15% of callers to the DRCC telephone counselling line were male. The SAVI Report found that most young men (60%) who had experienced child sexual abuse had never told anyone prior to disclosing to the researcher.

Impact: men and boys find it particularly difficult to seek help. Perpetrators continue to get away with it.

(RCNI web site)

It has been agreed that the recommendations below are forwarded to the the appropriate fora

1. To the joint RCNI/Garda working group

- Nominate a designated senior Garda Siochana in each region to act as liaison officer with their regional SATU.
- Introduce debriefing / supervision procedures for all Garda Siochana dealing with victims of sexual violence
- Allocate every victim of sexual violence with a designated named Garda Siochana to liaise with them throughout the process of criminal prosecution.
- Develop formal arrangements for the provision of information to victims.

2. To the NSC Legal Issues sub-group

- Video evidence for vulnerable / intimidated witnesses.
- Cross examination by way of video link therefore the victim does not see the abuser.

