Chapter 1

Initial contact

Bernadette Butler

Listen to the patient, he is telling you the diagnosis.
William Osler

Introduction

This chapter has one chance to make a first impression on the reader. Similarly, the clinician has only one chance to make a first impression on the patient who has experienced domestic and/or sexual abuse, such that the patient has the confidence to disclose what has happened to her.

She (or he) may have taken months or years before feeling able to speak about what has happened, so it is essential that she experiences a sympathetic, non-judgemental response from the clinician. Descriptions of the positive effects of an empathetic and non-judgemental responses have been given by two female doctors who themselves sought help following sexual violence and domestic abuse, respectively [1, 2]. This positive response also has the effect of validating the patient's experience of abuse.

This chapter aims to describe the magnitude of the problem of domestic and sexual violence and abuse, and cover the important aspects of the initial contact between the clinician and the patient.

A note about terminology

The police often use the term 'victim' to describe the person affected by a crime. In healthcare, a variety of terms may be used: patient, complainant, complainer, client, service-user and customer. However a recent article suggests that those for whom we provide care prefer to be called a 'patient', so this is the term used here [3].

The magnitude of the problem

The World Health Organization (WHO) Report on violence and health showed that violence and abuse are common and an everyday experience for many [4]. When abuse is experienced by women, children and the elderly, the perpetrator is often someone close to them: a partner, parent or carer [4].

Intimate partner (domestic) abuse and sexual violence are common, occur in all societies and affect all age groups and genders; it occurs in same-sex relationships, but it is predominantly women who experience the abuse by men [4, 5]. Such violence and abuse reflect gender inequality, and data from the World Health Organization multi-country study showed the lifetime prevalence of physical or sexual partner violence (or both) for women in the countries studied varied between 15% and 71% [5].

In England and Wales, the Home Office provides statistics on reported crime – figures covering the most recent 11 years are shown in Table 1.1 [6, 7].

The British Crime Survey (BCS – since April 2012, called the Crime Survey for England and Wales) describes individuals' experiences of crime: annually, about 22 000 people aged 16–59 years are interviewed. The BCS recognizes that some crime, particularly inter-personal and sexual violence, is under-reported [8, 9]. In the BCS for 2008/9 it was noted that about 40% of those who had experienced a serious sexual assault told no one about it [8]. Of those who had told someone, women were more likely to tell a friend or relative and men more likely to speak to a work colleague; only 11% told the police [8].

In the 2010/11 BCS, 30% of women and 17% of men had ever experienced domestic abuse; this gave rise to estimates of 4.8 million women and 2.8 million men who had ever experienced domestic abuse. In terms of sexual violence, the BCS 2010/11 reported 19% of women and 2% of men had experienced some sort of sexual assault between the ages of 16 and 59 years [9].

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Table 1.1 Reported crimes in England and Wales

	Total sexual offences	Rape of a female	Rape of a male	Domestic violence
2002/3	58 890	11 445	850	506 000
2003/4	62 452	12 378	894	447 000
2004/5	62 862	12 869	1144	402 000
2005/6	62 080	13 327	1394	358 000
2006/7	57 522	12 624	1150	407 000
2007/8	53 566	11 664	1009	580 238
2008/9	51 429	12 133	963	741 643
2009/10	54 344	13 902	1172	721 344
2010/11	54 919	14 589	1303	739 099
2011/12	53 664	14 767	1276	796 935

All these figures serve to highlight that many of our patients will have experienced such abuse.

Lastly, recent research in children (self-reported) suggests that whilst child maltreatment may be less prevalent in 2009 than it was in 1998, there is still a significant minority of children experiencing severe maltreatment [10]. In turn, this is associated with adverse consequences for those children, such as poor emotional well-being, self-harm, suicidal ideation and delinquent behaviour [10].

Disclosure

The impact of violence and abuse on adults and children is well recognized, such that knowledge and skills in dealing with such presentations are required in the curricula for specialist medical training, as well as the foundation training programme [11]. A specific training resource pack has been developed to assist foundation trainees and their trainers [12].

The clinical setting

A patient may disclose in a variety of settings and the disclosure may or may not be anticipated by the clinician.

Clinicians working in a Sexual Assault Referral Centre (SARC) may expect contact from patients, the police and other agencies, where information about sexual violence and abuse will be disclosed; in these situations initial contact will most often be by telephone. At present, in the UK, there are no equivalent services for those experiencing domestic violence or abuse.

Table 1.2 Clinical settings and presentations

Clinical setting	Possible complaints
General practice	Recurrent presentations; chronic pain; physical injuries; depression; emergency contraception; injury to a child or their symptoms/signs
Antenatal clinic/labour ward	Recurrent presentations; ante-partum haemorrhage; pre-term labour; physical injuries, perhaps with an implausible explanation
Gynaecology clinic	Chronic pelvic pain; sexual problems
Termination of pregnancy clinic	Unplanned pregnancy; failure of contraception
Sexual health clinic	Emergency contraception; failure of contraception; concerns regarding sexually transmitted infections
Emergency department	Physical injuries; emergency contraception; injury to child or their symptoms/signs
Sexual assault referral centre	Referral for care (forensic or therapeutic) by the patient, their family/carer or other agency, e.g. social services, police
Medical services for prisoners, detainees, refugees and asylum seekers	Chronic pain, disclosure of abuse or violence as a reason for seeking asylum

However, initial contact and disclosure of domestic and/or sexual abuse or a concern about it may take place in almost any situation where the clinician may be dealing with physical, psychological, general or pregnancy-related symptoms, signs or indicators [13].

Table 1.2 shows examples of clinical settings and presentations where a disclosure may be made or a concern regarding abuse may arise.

However, over the time she has practised, the author has had unexpected disclosures made to her in a variety of settings (clinical and non-clinical), many of which were unrelated to her work in an SARC (Box 1.1).

It is important to appreciate that a patient may find herself unexpectedly in a situation where she suddenly decides 'I can tell this doctor what's happened to me' – and that doctor may be you.

Confidentiality

This is often a significant concern for patients, and should be discussed as part of any consultation. Whilst

Box 1.1 Settings where unexpected disclosures were made to the author

- By a female clinician at a conference
- By a female clinician on a hospital ward after I had seen a patient on the ward
- By a female clinician at a training day
- By the husband of a friend (abuse took place when he was in a previous relationship)
- By a male patient in the casualty department
- By a female patient on the phone when discussing unrelated care
- By a female patient in a colposcopy clinic
- By a female patient in a family planning clinic
- By a female patient in a sexual health clinic who had attended for a routine smear

the General Medical Council (GMC) requires clinicians to preserve their patient's confidentiality, there will be occasions where it will be necessary to share information with police, e.g. in relation to a crime or in the public interest [14] and to Children's Social Care where child safeguarding concerns have been identified [15, 16]. Other healthcare professionals will have similar responsibilities.

The disclosure

A patient's disclosure may be spontaneous, so the diagnosis is clear:

Patient: *I was sexually assaulted last night.*
Patient: *My partner hit me again; he's caused all these bruises.*

On the other hand, the initial history may cause the clinician to ask more questions to help elicit the history and these should be asked without a partner or carer present .

Clinician: *Of course I'll be able to give you the morning-after pill, or what we call emergency contraception. You said you'd had unprotected intercourse, two nights ago; may I just ask if what happened was with your agreement or consent?*
Clinician: *I saw you last month here in casualty, with similar injuries to your face and arms. I was worried about you: the injuries are more than I would expect from just a trip and tumble at home. It's important I check everything is OK, so may I ask you, do you feel safe at home?*

Box 1.2 The HARK questions [20]

In the last year…
H = humiliation
… have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
A = afraid
… have you been afraid of your partner or ex-partner?
R = rape
… have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
K = kick
… have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

Clinician: *This problem* (indicate what) *has been associated with being in or coping with an abusive relationship. Is something like this happening to you?*

Clinicians should also be aware of circumstances where asking about domestic and/or sexual abuse may be appropriate. It may arise as part of the provision of routine antenatal care [17]. However, concerns regarding abuse may occur from other aspects of the history or presentation, e.g. chronic pelvic pain [18].

Clinicians may not feel they have the knowledge and skills to ask the appropriate questions, so training is important. An understanding of inter-personal violence can be gained from the 'Power and Control Wheels' developed for use in a domestic violence programme in Duluth, USA [19]. In turn, four relatively simple 'HARK' questions can be used to obtain the relevant information (Box 1.2) [20].

There is a significant impact on the patient in respect of the response by the clinician to a disclosure, so that she feels believed and her experience is validated or affirmed [21].

In a wider context, the Stern Review highlighted the importance of the response of other agencies, e.g. police, in 'honouring the experience' of the individual and her feeling of 'being believed' [22].

Details of the allegation(s) or incidents

Whatever the circumstances of the disclosure, it is important to establish some basic information:

- name
- date of birth (age)
- contact details

– if the contact is made by phone, then where relevant, the person calling on their behalf, e.g. the police, the GP, a friend.

One must establish whether the patient has told anyone else: if not, then the information disclosed is that of 'first complaint' and is evidentially significant. The information obtained and documented is evidence, in itself, and so the clinician must try to avoid asking leading questions and must date, time and sign the record. The clinician may later be asked to provide a statement on what was said and/or a copy of the record may be required for criminal justice purposes. Indeed, the author has been required to produce the written record of telephone contact with a patient, for use in a trial. This telephone proforma had been completed some years beforehand, where the woman who had alleged a rape did not attend for a forensic medical examination.

It can assist to use a proforma, to obtain the necessary information; noting what is said verbatim ensures that information is documented accurately and nothing is assumed, missed or altered.

In particular, care must be taken with children or those with a learning disability, such that words or ideas are not introduced to them, with which they may not be familiar, and so alter or potentially 'contaminate' evidence. Nevertheless, it is important to have sufficient information to enable the provision of the necessary clinical care.

The other relevant information might be summarized in a number of interrogative words, as used in a poem by Kipling:

> *I keep six honest serving-men*
> *(They taught me all I knew);*
> *Their names are What and Why and When*
> *And How and Where and Who …*
>
> Rudyard Kipling, 'The Elephant's Child', *Just So Stories* (1902)

In relation to the incident(s), the following should be established:

– What happened
– When it happened
– To whom it happened
– By whom it happened (who is thought to have done it)
– Where it happened
– How it happened (physical violence, restraint, facilitated by drugs or alcohol).

Identification of clinical needs

The clinical care of the patient is always the first priority, but often this can be combined with evidence collection, where the latter is appropriate.

Information must be obtained to assist in the decision-making process regarding the patient's needs in relation to the assessment of and provision of care for:

– Acute injury
– Other acute medical care, e.g. emergency contraception, vaccination, assessment for post-exposure prophylaxis for HIV and hepatitis B
– Mental capacity or consent issues, which might arise through acute intoxication, injury, mental health problems or learning disability; or the need for someone with parental responsibility for a child
– Adult and/or child safeguarding issues
– Risk assessment of ongoing abuse: is the patient physically safe, now and in the immediate future. Can she go home?
– Risk assessment of mental health, in particular that of self-harm, whether new or an exacerbation of a pre-existing condition
– Psycho-social support, e.g. management of post-traumatic stress disorder (PTSD), referral for counselling or to other agencies.

Other considerations

As well as the clinician's assessment of the patient's needs, it is important to ask the patient what she wants or feels she needs. A disclosure by the patient may be only the first step along a journey or process to stop the abuse and extricate herself from the situation. The patient may disclose an historical incident, about which she wishes to do nothing more.

One should ask if the patient has thought of speaking to the police about what has happened and if she does, whether she would like your assistance to do so. Similarly, she may want need help with finding and referral to other support services and organizations. Many patients, if asked, may prefer that the clinician, or individual to whom they have disclosed, contacts an organization, on their behalf, rather than simply 'signposting'. This helps because it avoids the patient having to tell her story again and again.

It may be helpful to have available the names and contact details of relevant organizations and

Box 1.3 List of local individuals and organizations

Hospital/clinic: Local named Doctor/Nurse/Midwife for Safeguarding
Police: Local numbers for units dealing with domestic and sexual violence, e.g. Community Safety Unit (CSU), Child Abuse Investigation Team (CAIT)
Sexual Assault Referral Centre(s)
National Domestic Violence Helpline (Refuge and Women's Aid)
Social care: Local borough's Children's Services and those for adults, e.g. Learning Disability Team
Local borough's Multi-Agency Risk Assessment Conference (MARAC)
Independent domestic violence and independent sexual violence advocates (IDVAs and ISVAs)
Voluntary (third) sector organizations, e.g. Victim Support, Refuge, Rape Crisis, Co-Ordinated Action against Domestic Abuse

individuals with whom you may need to make contact (Box 1.3).

Forensic medical evidence

Forensic medical evidence comes in many forms: the history given, and if undertaken, the examination findings and the forensic samples taken. All these can, with other evidence, contribute to the jigsaw which helps build a criminal case, when a complaint has been made to the police.

However, many complaints are never made to the police at all, or if they are, not at the time of the incident. A forensic medical examination (FME) service can be offered by many SARCs, whether or not a complaint has been made by the police, i.e. to police and non-police (self) referrals.

An FME may be appropriate, which, in turn, may assist in the process of a criminal investigation either because the police are already involved, or because the individual wants to have that option. An FME can be conducted to:

- Document injury (following physical and/or sexual violence)
- Obtain forensic medical samples, e.g. swabs for body fluids and/or DNA or other trace evidence, urine and blood for toxicology, etc.

It is usually time-limited in so far as the persistence of DNA decreases with time and injuries heal. However, clinicians should be aware they can support the preservation and collection of evidence.

Recent incident

In dealing with a recent incident, the clinician must:

- Ensure that any disclosure is documented accurately
- Advise on avoiding washing, eating or drinking if an FME is likely or planned
- Advise on keeping and not laundering bedding and clothing, or discarding sanitary wear or nappies
- Retain any gloves or instruments used for necessary examination
- Record injuries by describing their site, size, shape, colour and any signs of healing (possibly using medical photography)
- Use early evidence kits (EEKs) if available.

Historical incident

For a historical incident, the clinician must:

- Ensure that any disclosure is documented accurately
- Advise on keeping and not laundering bedding/clothing.

Most medical evidence collection is conducted by specialists in a forensically appropriate unit (e.g. by staff at SARCs), and more detailed information about this is provided in later chapters.

Whilst some may argue that an FME does not have any therapeutic benefit, the explanation of the presence or absence of injury, and the reassurance that someone has examined her is important to the patient, as well as informing the clinical decision process, regarding the provision of medical care.

Medical care should be provided at the first point of contact, where possible, notwithstanding that different clinical settings will influence what can be provided.

Consideration may need to be given to the provision of:

- Emergency contraception and which type is the most appropriate
- Vaccination against tetanus
- Prevention of blood-borne viruses including post-exposure prophylaxis against hepatitis B and HIV.

There is abundant guidance in the UK to assist clinicians, provided by a number of different organizations. These resources are all subject to regular review, so it behoves the clinician to check to ensure they are using the most up-to-date guidance (Box 1.4).

Box 1.4 Clinical resources

(1) **The British Association of Sexual Health and HIV (BASHH)**
www.bashh.org/guidelines
- *Management of Adult and Adolescent Complainants of Sexual Assault*. 2011; amended in June 2012.
- *UK National Guideline for the Use of Post-Exposure Prophylaxis Following Sexual Exposure*. 2011.

(2) **Care and Evidence** www.careandevidence.org/

(3) **Department of Health** (**DOH**)
- *Immunization against infectious disease* (The Green Book) www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book
  Chapter 18. Hepatitis B. Last update in December 2013.
  Chapter 30. Tetanus. Last update in April 2013.

(4) **Faculty of Forensic and Legal Medicine (FFLM)** http://fflm.ac.uk/library/
- *Guidelines on Paediatric Forensic Medical Examinations in Relation to Possible Child Sexual Abuse* (with the RCPCH). Update October 2012.
- *Recommendations for the Collection of Forensic Specimens from Complainants and Suspects*. Last update July 2014; updated twice yearly, in January and July.

(5) **Faculty of Sexual and Reproductive Healthcare** (**FSRH**) www.fsrh.org/pages/clinical_guidance.asp
- *Emergency Contraception Guidance*. Last update January 2012.
- *Drug Interactions with Hormonal Contraception*. Last update January 2012.

Box 1.5 Organizations and resources

World Health Organization (WHO)
www.who.int/violence_injury_prevention/en/
http://whqlibdoc.who.int/publications/2004/924154628X.pdf

The Home Office www.homeoffice.gov.uk/crime/violence-against-women-girls/

Association of Chief Police Officers www.acpo.police.uk/ProfessionalPractice/Crime.aspx

Women's Aid www.womensaid.org.uk/

Refuge http://refuge.org.uk/ and www.nationaldomesticviolencehelpline.org.uk/ 08082000247

Rape Crisis England and Wales www.rapecrisis.org.uk/

Co-ordinated Action against Domestic Abuse (CAADA) www.caada.org.uk/index.html

National Society for the Prevention of Cruelty to Children (NSPCC) www.nspcc.org.uk/

National Association for People Abused in Childhood (NAPAC) www.napac.org.uk/

Survivors UK (for those experiencing male rape and sexual abuse) www.survivorsuk.org/

Other potentially useful organizations and resources are listed in Box 1.5.

Conclusion

Domestic and sexual violence sometimes overlap with each other and are common, global issues, which are often suffered in silence. Providing an environment where patients feel able to disclose the abuse that they have suffered is essential. Once a disclosure has been made, the clinician must provide the patient with the most appropriate advice about the choices available to her and support in the decision-making process. This advice should aim to address any acute medical needs, prevent the risk of ongoing abuse and facilitate contact with other organizations which can assist the individual, including where appropriate, involvement of the criminal justice process.

Clinicians who provide care and support to those who have experienced sexual and domestic violence may be adversely affected by what they hear and see; this is vicarious trauma [23]. Therefore, it is crucial that they also have support available to maintain their own well-being.

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Chapter 2

Significant law: sexual offence medicine

Nigel J. Callaghan

The basics of law

The law in England, Wales, Northern Ireland and Scotland is broken down into two basic parts; *Statute law* and *Common law*. The law set out in Acts of Parliament (*Statutes*) is supreme and overrides any conflict with the common law. *Common law* ('judge-made law') is a set of principles applied equally across the country and covers those areas not covered by Acts of Parliament and can have an effect on how Statutes are interpreted. The system of courts in the United Kingdom is *hierarchical*, that is to say decisions made by higher courts must be followed by the lower courts. This is a system of *precedent*.

Criminal law

Criminal law is basically a set of rules to govern society which must be followed and is intended as a deterrent. The consequences of breaking them result in *punishment*. In England and Wales and Northern Ireland, criminal trials take place in *Magistrates'* or *Crown Courts* depending on the type of offence. Appeals from these courts are to the Criminal Division of the High Court, the Court of Appeal and finally the Supreme Court, for England, Wales and Northern Ireland.

Scottish criminal law governs the rules of criminal law in Scotland and relies far more heavily on common law than in England and Wales.

Part 1 of the Criminal Procedures (Scotland) Act 1995 illustrates how criminal cases in Scotland are dealt with. One of two procedures can be followed depending on the seriousness of the offence. They can be heard before a Justice of the Peace (JP) or Sheriff. The Sheriff Court can deal with some criminal cases. Cases can be heard before a Sheriff or a Sheriff and a jury. Serious cases, such as murder, are dealt with by the High Court, heard by a judge and jury. A decision of the Sheriff Court in criminal cases can be appealed in the High Court. This is the final court of appeal for all criminal cases in Scotland.

In *criminal proceedings*, a case is brought by *the Crown* against an individual or group and the *defendant* (the person in *trial* for the alleged offence) is *prosecuted*. All defendants are *presumed innocent* until proven guilty in a court of law.

The Crown Prosecution Service (CPS) is the prosecution service for England and Wales.

The Crown Office and Procurator Fiscal Service (COPFS) is Scotland's prosecution service.

The Public Prosecution Service (PPS) is Ulster's prosecution service.

Facts in issue are those facts that the prosecution are required to prove or disprove in order to establish the guilt of the accused and those facts that the defence are required to prove in order to establish a defence that they have raised.

In criminal proceedings, the basic rule ('Woolmington Principle' or 'Presumption of Innocence') is that the prosecution bear the legal burden of proving every fact in issue which includes that of proving the *actus reus* (the wrongful act or omission that comprises the physical components of a crime) and *mens rea* (*a guilty mind; a guilty or wrongful purpose; a criminal intent, guilty knowledge and wilfulness*) of the offence with which the accused is charged.

A defendant may simply say nothing in response to the accusations as generally it is for the prosecution to prove its case, not for the defendant to prove her/his innocence. However, if the defendant raises a fact in issue in her/his defence, that is something to disprove what the prosecution are saying, then the legal burden of proving what the accused has raised in his/her defence rests with the defence.

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The *standard of proof* in criminal proceedings, where the legal burden of proof relies on the prosecution, is proof beyond reasonable doubt. Proof beyond reasonable doubt does not require certainty but if there is more than a remote or fanciful possibility that the facts in issue are not as the prosecution allege, then the proof to the criminal standard has not been attained. 'Proof beyond reasonable doubt' and 'be satisfied that they feel sure' of the accused's guilt are key phrases to bear in mind.

Civil law

Civil law allows individuals *redress* against each other when legal rights have been or are likely to be affected. Successful outcome to civil litigation is an order requiring or preventing an action (the *injunction*) or an award of money (*damages*). Civil proceedings are dealt with in the *County Court* or the *High Court* depending on various factors including the value of the claim and the area of law involved. Appeals from these courts – 'Courts of First Instance' – are to the Court of Appeal and then, if necessary, to the Supreme Court.

In civil proceedings, the facts in issue are the facts that the *claimant* (the person claiming the wrongdoing) is required to prove in order to establish his claim and those that the *defendant* (the alleged wrongdoer) is required to prove in order to establish a defence she/he has raised. The basic principle of legal burden of proof in civil proceedings is that the party who asserts the existence of a fact bears the legal burden of proving it: 'he who asserts must prove'. The standard of proof required by law in civil proceedings is proof upon the *balance of probabilities*, that is a party discharges the legal burden of proof in relation to a fact in issue if it is satisfied that the fact is more probably true than false.

Evidence

Evidence is information that may be presented to a court or tribunal to help it weigh up the probability of some fact asserted before it that is information by which facts tend to be proved or disproved.

Oral evidence means the statements of a witness made orally in court and presented as evidence of the truth of which he or she states. Contemporaneous notes may be used to assist in the giving of oral evidence.

Real evidence usually takes the form of a material object produced for inspection by the court either to prove that the object in question exists or to enable the court to draw an inference from its own observation as to its physical condition or value, for example, CCTV footage, photographs or objects removed from the scene of a crime.

Circumstantial evidence, sometimes known as *indirect evidence*, is information and testimony presented by a party in a civil or criminal action that permit conclusions that indirectly establish the existence or non-existence of a fact or event that the party seeks to prove.

Hearsay evidence is evidence of those who relate, not what they know themselves, but what they have heard from others. As a general rule, hearsay evidence of a fact is not admissible. There are, however, exceptions to the rule.

Opinion evidence is evidence of what the witness thinks, believes or infers in regard to facts in dispute, as distinguished from personal knowledge of the facts themselves. The rules of evidence ordinarily do not permit witnesses to testify as to opinions or conclusions.

A witness of fact is someone who gives evidence of things within their personal knowledge such as things they have seen, heard or done.

A professional witness of fact is a practising member of a profession, e.g. a healthcare professional who takes part in legal proceedings and gives evidence to matters of fact. For example, a Sexual Offence Examiner may have seen a complainant 'A' with bruising and a laceration. As a professional witness, the Forensic Medical Examiner would offer in his/her witness statement and/or in court proceeding details as to the identity of the person, how she/he may have come to be seen by the examiner, what injuries were present, where they were present, were there any striking characteristics about the injuries complained of or discovered, e.g. patterning or foreign bodies in the wounds, what was the complainant's condition, where and when was the complainant treated (if at all).

The Sexual Offence Examiner as a professional witness would not be asked to interpret the clinical findings of what the examiner saw, that is, there would be no expectation that the examiner as a *professional witness* would be obliged to interpret the facts to give their opinion as to the causation of the injuries so described or discovered.

An expert witness: occasionally a court may permit opinion evidence to be admitted in proceedings. That is, because of experience and qualification, a

healthcare professional may be permitted to state her/his opinion on, for example, the likely causation of the injuries so discovered on complainant 'A'. In the criminal court context, with respect to matters calling for special knowledge, an expert Sexual Offence Examiner *may* be allowed by the court to draw inferences and state their opinion to provide a judge and jury with a ready-made inference which the judge and jury, due to the technical nature of the facts, are unable to formulate. In essence, an expert's opinion is admissible to furnish the court with medical information which is likely to be outside the experience and knowledge of a judge and jury. However, if on the proven facts a judge and jury can form their own conclusions without help, then the opinion of the expert is unnecessary.

Corroboration is a unique feature of Scots criminal law. Corroborating evidence means at least two different and independent sources of evidence are required in support of each crucial fact before a defendant can be convicted of a crime. This means, for example, that an admission of guilt by the accused is insufficient evidence to convict in Scotland, because that evidence needs to be corroborated by another source. However, testimony from some experts, such as Forensic Medical Examiners or doctors, is accepted by courts on the basis of the expert's report alone, therefore requiring no corroboration

The Criminal Procedure Rules 2005 make provision concerning the duties of expert witnesses in criminal proceedings and the contents of their reports and guidance concerning the duties of expert witnesses in criminal proceedings. Also, the contents of expert witness reports and testimony have derivation both from case law and from guidance produced by the Crown Prosecution Service. Guidance is also offered by the British Medical Association, the Faculty of Forensic and Legal Medicine and by the Law Society of Scotland in the *Code of Practice: Expert Witnesses Engaged by Solicitors*.

Notes, records and statements

A note or a record (which may be written or recorded electronically, digitally or audial recorded) is a primary source of evidence. Notes/records should be taken contemporaneously with the date and time and a full accurate record of what has been heard, seen, done, touched or smelled, etc. should be included in the notes/records. Contemporaneous notes help establish continuity of evidence and provide evidence of facts that form the basis for opinions. They also provide the basis for showing how and why decisions/recommendations/opinions were reached or made. They also serve to refresh the memory when preparing a statement/report and also in any subsequent legal proceedings.

A statement or a report is a written form of evidence which will set out the primary sources of evidence including facts recorded in notes and documents and real evidence. Statements or reports are generally written at a later stage than notes or records. Statements may be required for tribunals, civil or criminal proceedings or for regulatory hearings.

Protecting clinical notes and statements

The *Caldicott Report* was published in 1997 and made recommendations relating to patient confidentiality and recommended ways in which patient-identifiable information is handled.

The Committee produced six key principles which govern the use of patient information. A key recommendation was the establishment of a network of organizational guardians to oversee access to patient-identifiable information. All NHS organizations are now required to have such a guardian, known as the *Caldicott Guardian*.

The principles and recommendations highlight all areas of information handling, including the obtaining, storing and sharing of data. There is also a requirement to appoint a Caldicott Guardian by each health organization.

Caldicott Guardian principles

Principle 1 *Justify the purpose(s)*. Every proposed use or transfer of patient-identifiable information within or from an organization should be clearly defined and scrutinized, with continuing uses regularly reviewed by an appropriate Guardian.

Principle 2 *Don't use patient-identifiable information unless it is absolutely necessary*. Patient-identifiable information items should not be used unless there is no alternative.

Principle 3 *Use the minimum necessary patient-identifiable information.* Where use of patient-identifiable information is considered to be essential, each individual item of information should be justified with the aim of reducing identifiability.