Sexual assault: examination of the victim

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Abstract

While rape and sexual assault are common, most offences remain unreported. These crimes are associated with acute and chronic physical and psychological morbidity and may be linked to substance misuse, healthcare neglect, 'risky' sexual behaviour and eating disorders. Early interventions may reduce serious psychological morbidity in some individuals. Most research focuses on the impact of sexual violence on women, but the principles of management apply to both male and female complainants.

Keywords HIV; prophylaxis; psychosocial support; rape; risk assessment; sexual assault; sexually transmitted infections

What's new?

- Risk assessment
- Forensic timeframes and sampling
- Prophylaxis against pregnancy and STIs/HIV
- Aftercare including screening for STIs

Rape may be defined as non-consenting sexual relations with another person obtained through physical force, threat or intimidation. The Sexual Offences Act 2003 (England and Wales), the Sexual Offences (Northern Ireland) Order 2008 and the Sexual Offences (Scotland) Act 2009 provide a statutory framework for Sexual Offences within the United Kingdom where rape is the intentional penetration by the penis of the vagina, anus or mouth. Other offences include assault by penetration, sexual assault and causing sexual activity without consent. Additional measures are in place to protect the vulnerable, particularly children and those with mental disorders.

- Rape is intentional penetration by the penis of the vagina, anus or mouth.
- Assault by penetration is intentional penetration of the vagina or the anus by part of the body or any other object.
- Sexual assault is intentional sexual touching.
- Causing sexual activity without consent is intentionally engaging another in sexual activity.
- Consent is agreement by choice, and with the freedom and capacity to make that choice.

Incidence and prevalence

Worldwide it has been estimated that one in five women will become a victim of rape or attempted rape in her lifetime. Women are more at risk of experiencing violence in intimate relationships as part of domestic abuse. Sexual violence by non-partners (for example, a relative, acquaintance or work colleague) is also common in many settings. Significant under-reporting of sexual offences to the police is well recognized worldwide making such statistics unreliable.[1]

In 2008/09, the police in England and Wales recorded 12,165 rapes against women, an increase of 5% over the preceding year. Sexual assaults on a female fell by 4% to 19,740 offences. Rapes of a male decreased by 4% to 968 offences and sexual assaults on a male fell by 12% to 2323 offences. Overall, only 6% of rapes reported to the police result in a conviction. However, 37% of all cases prosecuted as sexual assault result in a conviction for sexual assault.[2]

Presentation

The victim may present to various agencies within hours to years after the offence. Early presentations may be made to the police, an Accident and Emergency department, a walk-in centre, a dedicated Sexual Assault Referral Centre or a Sexual Health Clinic. At the first contact with any service, it is crucial that all aspects of care are addressed in a non-judgemental and caring environment. The manner in which this is undertaken may alleviate or exacerbate the victim's distress.[3]

When an individual does not wish to report the assault, a comprehensive history and examination should be undertaken. Clear and careful records of this consultation are essential, because they may be used in evidence if the victim decides to report the crime later.

The priorities for care, in chronological order, are:

- treatment of severe injuries
- assessment of safety
- prophylaxis against HIV infection
- prophylaxis against pregnancy
- forensic medical examination
- risk identification including self-harm and safeguarding
- screening for sexually transmitted infections (STIs), including HIV
- counselling and psychological support
- support for the victim's partner and family, if appropriate.

Physical injuries

Physical violence occurs in about one-half of reported rapes. Few cases require hospital admission. Tetanus prophylaxis should be considered in all such cases. Antibiotic prophylaxis (co-amoxiclav, 625 mg 8-hourly) should be prescribed for bite wounds less than 24 hours old that affect soft tissue only and exhibit no clinical signs of infection. Genital injuries are found in 24–53% of cases; most require no treatment. About 20% of women have no injuries following rape.

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Early presentation (0–7 days)

Once physical injuries requiring emergency management have been excluded, a forensic medical examination (FME) should be offered to all adult female complainants of sexual assault who present within 7 days of the offence with or without police involvement. Early evidence kits containing a mouth swab, a mouth rinse and a container for a urine sample should be used as soon as possible after presentation, to preserve evidence. A physician trained in forensic medicine/sexual offences examination should perform the assessment.

Sexual Assault Referral Centres (SARCs) enable victims of rape and attempted rape to undergo FMEs, with documentation of injuries and storage of forensic samples, without disclosure to the police at presentation. The complainant may choose to provide the police with personalized or depersonalized data, intelligence and/or forensic samples. These can be used to establish a picture of offending even if an investigation does not occur. Sperm survives in the rectum for up to 3 days and in the vagina for up to 7 days; in most cases, the opportunity to obtain evidence is then lost. Forensic samples can be taken from clothes, carpets or furniture over a longer period, however, so regardless of how much time has elapsed, the police should be informed if the victim wishes to make a complaint.

Some victims are reluctant to involve the police, because of adverse publicity about the criminal justice system. In many countries, however, police have made efforts to reduce the trauma of the forensic/police encounter. In England and Wales, for example, investigations are undertaken by senior police officers with trained officers who liaise with the complainant. Dedicated teams have been established by the Metropolitan Police Service to investigate sexual offences in London.

Forensic history and examination: the aim is to retrieve and preserve evidence that may corroborate the victim's story, eliminate a suspect, or identify an assailant and assist in the prosecution of the case. History-taking, examination and specimen collection (Table 1) are tailored to these aims, rather than being open-ended as in most other medical consultations. The police will have obtained an initial account of the alleged incident before the examination, and this is available to the forensic physician/sexual offences examiner. Consent should be obtained for the history and examination. The history should include:

- date and time of the assault
- location
- assailant details
- type of assault (physical, sexual)
- orifices involved, condom use and whether ejaculation occurred
- patient's action after the assault
- presenting symptoms
- medical history (including menstrual and contraceptive history in women)
- sexual intercourse in the previous 10 days
- drugs (prescribed, recreational and over-the-counter) taken in the previous 4 days
- alcohol consumed within 12 hours of the assault.

In England and Wales, a standard kit is provided for the collection of specimens, containing a paper gown and pants, self-labelled swabs, containers and bags for blood and urine, a needle and syringe (plus non-alcohol-containing skin wipes), plastic gloves and blank body maps. A form should be completed and returned to the forensic laboratory giving brief details of the assault and the specimens taken.

Collection of forensic specimens (see www.fflm.ac.uk)

Site/sample	Investigation	Time of test after incident
• Blood (preserved)	Analysis for alcohol, drugs and volatiles/solvents	<3 days
• Urine (preserved)	Analysis for alcohol and drugs	<4 days
• Buccal scrapes	Reference sampling for DNA profiling	No restriction
• Mouth swabs	Semen analysis	<2 days
• Mouth rinse	Semen analysis	<2 days
• Vulvo-perineal swabs	Body fluids	<7 days
	Digital contact	<12 h
• Low vaginal swabs	Body fluids	<7 days
	Digital contact	<12 h
• High vaginal swabs	Body fluids	<7 days
	Digital contact	<12 h
• Endocervical swabs	Body fluids	2–7 days
	Digital contact	<12 h
• Perianal swabs	Body fluids	<3 days
	Digital contact	<12 h
• Anal swabs	Body fluids	<3 days
	Digital contact	<12 h
• Rectal swabs	Body fluids	<3 days
	Digital contact	<12 h
• Skin swabs	Detection of body fluids, cellular material and lubricant	<2 days

Body fluids are blood, saliva, semen, seminal fluid, vaginal secretions, faeces and urine.

Table 1

The oral cavity should be sampled as soon as possible after the assault when there has been an allegation of penile penetration or the history is unclear (e.g. following drug-facilitated sexual assault). Spermatozoa are most likely to be identified within a few hours of the incident. These samples may be obtained before the formal assessment.

If possible, the victim should not wash, bathe or defecate before the examination. Complainants should first remove their clothing while standing on a paper sheet. All clothing (particularly if not changed since the assault) and the paper sheet are usually retained as evidence and investigated for fibre and debris. It is useful at this stage to check for any stains on the clothing (e.g. soil, blood, semen) and to note their position. A full examination should then be made, starting with the head and working down. Injuries such as bites, bruises, abrasions, lacerations and incised wounds are noted, measured and recorded carefully on the body maps provided.

Swabs, both dry and moistened with water, are taken from areas that have been licked or bitten, for saliva and possible DNA analysis. Additional control dry and wet skin swabs should be taken to eliminate the possibility of DNA contamination.

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