Sexual assault and rape

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Abstract

Sexual assault is common and may present in all areas of obstetrics and gynaecology. All staff need to be aware of the key issues in assessment and treatment of such women and the local arrangements for forensic examination, where appropriate, in addition to the legal framework. These women deserve informed, sensitive physical and psychological care. They may require onward referral to specialist care. This chapter aims to increase understanding of the issues involved in the management of sexual assault in the UK.

Keywords domestic violence; gender-based violence; intimate partner violence; partner violence; rape; sexual abuse; sexual assault; sexual offense/offence(s); sexual violence

Introduction

Patients who have been victims of sexual assault can present in all areas of obstetrics and gynaecology and do not always present overtly and acutely. All doctors working in the speciality need to have an awareness of the possibility of sexual assault and how to manage the situation if they uncover it.

The definitions in British law from the Sexual Offences Act 2003 are detailed in Box 1.

Acute assault

Victims of acute sexual assault may report to the police directly, or to accident and emergency (A+E), Genitourinary Medicine clinics (GUM), Gynaecology, Antenatal, or Psychiatric services with covert or overt symptoms. It is crucial to any criminal case that evidence is gathered appropriately and the chain of evidence maintained. 16–58% have genital injuries but a higher proportion (38–80%), have non-genital injuries. Many have no injuries at all.

Assessment

When a patient first discloses an assault, it is important to assess the points in Box 2.

When disclosure is made the woman may be very distressed or may be very calm. Immediate medical need must take priority over everything else, if there are injuries these should be addressed, and there may need to be involvement of other medical teams. In some cases of extreme distress there may need to be involvement of the psychiatric team, but this is rare.

An "Early Evidence kit" should be used as soon as possible. This is a kit where a mouthwash, mouth swab and urine sample can be taken as soon as the patient presents so evidence is not lost. These kits are available in all A+Es and from the police. After these samples are taken the woman can be allowed to eat and drink.

The initial doctor should then seek advice from the local Sexual Assault Referral Centre (SARC) as to whether forensic examination is appropriate and make a judgement as to whether the patient can give consent for forensic examination. Forensic examination includes careful documentation and recording of any injuries and the taking of appropriate swabs to look for the identifying Deoxyribonucleic acid (DNA) of the perpetrator. Examination is external ("top to toe") and Internal (Mouth, Vagina, Anus) as appropriate and swabs can be taken from any skin or mucous membrane surface. Forensic examination is usually carried out in a specialist forensic suite, to decrease the likelihood of DNA contamination, but can occur in other situations such as in A+E or in the operating theatre in conjunction with the assessment and repair of injuries by the admitting medical team ± forensic examiners.

Important details to note at the time of this initial assessment are the age of the woman, signs of current intoxication, the

Sexual offences act 2003 (UK)

- ìRapeî is defined as non-consensual penetration of mouth, vagina, or anus by a penis
- ìSexual assaultî is defined as acts of sexual touching without consent
- ìSexual assault by penetrationî involves the insertion of object or body parts other than the penis into the vagina or anus (previously indecent assault)
- Circumstances will be considered by the court and mistaken belief of consent is not a defence
- Children under 13 cannot legally consent to sexual activity. Mistaken belief of age is not a valid defence

Box 1

Initial assessment

- When the event occurred
- What sexual act or acts occurred
- Whether she gave consent
- Whether she was competent to give consent at that time
- Whether she has reported to police or is wanting to report to police at this time
- What are her immediate medical needs

Box 2

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presence of learning difficulties, the need for an interpreter or advocate, pre-existing psychiatric or medical conditions and drug history (NB missing regular medications can complicate matters).

The woman's social situation must be reviewed as it is vitally important that if and when she leaves the team's care, she will be safe from further assault and violence. If she has children, their current location and safety should be assessed and addressed where necessary with the involvement of social services.

Each police authority has officers trained in sexual assault, who should be available on every shift. These are SOLO (sexual offences liaison officers) or SOIT (sexual offences investigation team). Not all women wish to go to the police. There is no obligation on the medical team to do so, unless there is significant risk of harm to others; always discuss cases of acute sexual assault with the SARC team prior to any intimate examination, so steps are taken to preserve evidence.

Case A: acute assault of an elderly woman: a 78 year old female was brought into A+E at 2 am. She had called 999 after having been assaulted in her own home. She had been beaten and vaginally and anally raped. She had a significant head injury, with possible fractured orbit, but was alert and orientated. The A+E staff had assessed her, given her some pain medication and called the O+G team to assess whether she had any internal injury.

On arrival the female registrar with no experience in sexual assault, could see that the patient was alert and orientated with stable vital signs and was not bleeding vaginally or rectally. In view of the head injury, the patient was being closely monitored by the A+E staff and was in the most appropriate place in the short term. The O+G doctor could therefore leave the patient to discuss the case on the telephone with the local SARC team and her consultant. She obtained a brief history from the A+E staff and the patient to share with the teams.

The woman lived alone and was usually fully self caring with no significant medical problems. She took a regular antihypertensive medication. She had family in the area who had not yet been alerted and she had decided not to involve them at this time. She had reported to police when she made her 999 call and there was a police officer trained in the management of sexual assault (SOIT/SOLO Officer) in A+E waiting to interview her when the A+E medical team felt it was appropriate. He had already requested that the A+E staff use an "Early Evidence Kit". Her home was not secure but the police were there, examining the crime scene.

The assault had occurred at 11pm that evening. A man had broken into her home, she thought to rob her. There had been vaginal and anal rape and violence in the form of repeated blows to the head and back. At the time of assault she was competent and had not given consent. She had no learning difficulties, mental illness, language needs and had not consumed any intoxicants of any sort. She was fit to consent to and wanted forensic examination.

After discussion, the SARC team came to the A+E and examined the woman together with the consultant gynaecologist on call. The decision was made not to move her in the light of her head injury. There were no serious internal injuries seen, and the external injuries and grazing of the perineum were documented by both teams. Forensic swabs for DNA were taken from the woman's skin, vagina and anus (see Box 4). These were labelled and bagged and handed straight to the SOIT Officer to ensure continuity of the "Chain of evidence".

Once this had occurred she could be transferred to the observation ward. She was washed and minor injuries treated. Immediate aftercare: PEP and Hepatitis B vaccination were discussed and given with regular analgesia. Specialist Maxillofacial advice was sought and received, initially by phone. Police statement and an Achieving Best Evidence (ABE) interview was undertaken later.

Good practice points

When a disclosure of acute assault is made:

- The most appropriate member of the O+G team on duty should attend and deal with the case. This would be the most senior or most experienced in this field. Consideration should be given as to whether a female doctor is available and is the most appropriate
- The case should always be discussed with the consultant on call, who will make the decision as to who should attend
- Continuity of care should then be practised as far as possible

Recent assault

The best evidence is obtained the sooner the forensic examination takes place after the assault. When the assault is recent (<14 days) the case should always be discussed with the SARC. The woman may not want to report to the police, but any available evidence should be taken and stored by the SARC and injuries documented in case this is needed later.

Key points to record

- Details of alleged assault, description of assailant, meeting place, place of assault
- Since assault — when ate, drank, showered/bathed/douched, passed urine, opened bowels, changed clothes. Ingestion of any kind of drugs or alcohol
- Gynaecological, obstetric, and sexual history. Last menstrual period, menstrual cycle, contraception
- Basic medical, surgical, and psychiatric history
- Medication—prescribed, over-the-counter, social, drugs of abuse
- Social history — family circumstances, children

Box 3

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