Sexual assault: examination of the victim

Deb Wardle

Abstract

The majority of sexual assault disclosures are by females although most sexual abuse remains undisclosed. There are many factors feeding into this reluctance. Sensitive and appropriate management of disclosures is essential to re-empower victims in making choices on the course of events following disclosure. Not all victims opt to engage with the criminal justice system. However, the option of police engagement to some degree may be supported by the offering of third-party reporting, providing police with intelligence that would otherwise be inaccessible. The presence of genital injuries is more likely with non-consensual than consensual sexual activity, but genital injuries are still more likely to be absent following sexual assault. Physical examination following sexual assault seeks to identify any peripheral injuries associated with restraint or non-compliance. Screening to exclude the possibility of sexually transmitted infections should be informed by the incubation periods of common pathogens, and prophylactic treatment guided by local resistance patterns. Emergency contraception, ongoing contraception and safer sex advice should form part of the consultation. In addition, self-harm and suicide risk assessments should be undertaken to ensure onward safety. Finally, the potential impact of disclosures on clinicians should be acknowledged.

Keywords Forensic integrity; persistence data; rape; response to trauma; sexual assault; sexual offences; third-party reporting

What's new?

- Legislative changes: recent changes in sexual offences legislation within the UK reflects changing societal attitudes and values, incorporating gender equality within its definitions, and making it possible for both men and women to be victims of rape. This legislation also allows for transgendered persons to be victims of rape
- Additional UK legislation within the various jurisdictions supports the enhanced focus on the protection of those more vulnerable in our society
- Creating opportunities for disclosure: 'Routine enquiry' into gender-based violence is an important way of allowing women space to disclose previous or ongoing abuse. It was mandated in some care settings such as maternity and emergency departments in Scotland (but not the rest of the UK) in 2008
- Emergency contraception options: ulipristal acetate is licenced up to 120 hours post for use as emergency oral hormonal contraception in women not wanting a copper IUD
- Sexually transmitted infection (STI) treatment guidance: exclusion of STIs via testing with sensitive NAATs is preferable to the use of prophylactic antibiotics because of increasing resistance in *Neisseria gonorrhoeae*. Intramuscular ceftriaxone plus oral azithromycin is reasonable if prophylactic antibiotics are to be given

Disclosure of sexual violence

The majority of sexual violence to both female and male victims remains undisclosed.[1] Reasons for non-disclosure can be multifactorial and include fear of repercussions by the perpetrator, misplaced feelings of guilt and shame, protecting family members from knowledge of the trauma experienced, fear of re-traumatization when asked to recall events and a lack of faith in the criminal justice system.[2,3] In addition, the absence of an opportunity for supported disclosure may underlie this reluctance.

If medical concerns are a greater priority to the victim, general practitioners (GPs), staff in emergency departments or existing care providers, such as drugs workers, social workers or teaching staff, may be a source of information on, for example, accessing emergency contraception or STI screening. The inclusion of routine enquiry regarding non-consensual sexual activity in such presentations may support disclosure; it may also allow for implementation of ongoing support in the anticipation of reducing or preventing long term sequelae, such as anxiety, depression, substance misuse, re-victimization and suicide.[4]

It is important that the victim feels safe and believed when a first disclosure is made.

Following disclosure, the options available, including referral to sexual assault referral centre (SARC) where available, should be offered.[5] Disclosure to police should be discussed and reasons for declining this sensitively explored and documented.

Medical staff should document early disclosure of sexual assault in the words and phrases used by the client. For example, a comment such as; 'he raped me' should be sensitively clarified and documented; 'I confirmed with the client that by 'raped me' she was describing penile vaginal penetration without her consent.' In addition, the time, date, room used and any others present and their role should be legibly documented. There are varying responses to trauma and the demeanour of the victim may be included, highlighting any alterations from their usual state if this is already known.

Dependent on the time elapsed since the incident, delay in engaging with police following sexual violence may adversely affect forensic evidence (Table 1). SARCs offer the opportunity for collection and retention of clothing items and swabs that may be relevant in the investigation of sexual crimes; this allows for sample storage with forensic integrity whilst considering the option of police engagement without significant evidence being lessened or lost through subsequent bathing or laundering of clothing. Documentation of associated peripheral or genital injuries before they heal is also a consideration, although it is more common for genital injuries to be absent following non-consensual penile vaginal penetration.[6–8]

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Persistence data of biological material and drug and alcohol metabolites following various types of sexual assault

Type of assault	Persistence time frame
Digital-vaginal penetration	12 hours
Penile-oral penetration	2 days
Penile-anal penetration	3 days
Penile vaginal penetration	7 days
Seminal fluid/soil/fibres on skin	2 days, possibly 7 days if unwashed
Drug-facilitated sexual assault	**Alcohol:** Blood and urine: up to 3 days after incident **Drugs other than alcohol:** Blood: up to 3 days, Urine: maximum 14 days. Head hair: 6 months

Table 1

If an individual declines police engagement, there remains the option of third-party reporting of the incident to the police[9,10] (Table 2). This is available irrespective of time elapsed since the incident. It involves the complainer consenting to the healthcare professional forwarding details of the incident including assailant's names and contact details where known, but with-holding the victim's details.

It is more common for the victim to know the perpetrator of sexual violence.[11] In cases of partner assault, preserving anonymity is compromised if the victim shares the last name, although this may not deter some victims from using this information-sharing process.

Be mindful of the association between domestic abuse and sexual violence.[12] The sexual element of intimate partner abuse is often not the first to be disclosed, if at all. Many police forces have a 'domestic abuse team' web site that facilitates anonymous information sharing.

Third-party reporting forms are forwarded to the police intelligence unit. Victims should be reassured that third-party reporting will not result in the perpetrator being questioned by police about the incident until the victim makes a formal complaint. This is important when the victim is fearful of repercussions.

Clinical management

Manage each client as an individual whilst ensuring the safeguarding of children and vulnerable adults. (Table 3). Whilst documenting details of the incident in clinical notes, reassure the client that their concerns will be dealt with. If they have concerns about confidentiality, advise them accordingly.

Definitions of legal terminology

Third-party reporting	A method of encouraging crime reporting to someone other than police in a non-police setting. Information is then shared with police without revealing the victim's personal details. The nature of the incident and the information provided determines the level of action and ensures victim safety is paramount. Where there is insufficient information to follow up the report, the information is retained as police intelligence providing a picture of events within a geographical area.
Police intelligence	Information provided to police by different methods is shared with other agencies and used to predict future crime patterns and inform prevention and intervention strategies.
Forensic evidence	Evidence (such as an object, substance or test result) that is usable (admissible) in a court of law.
Forensic capture	The collection of samples relevant to investigation of a crime with appropriate labelling, packaging and chain of custody to allow use as evidence in court. Packaging includes the use of tamper-evident bags that, once sealed and signed, must be accompanied by a chain of evidence.
Chain of custody	Chain of custody/chain of evidence is the documentation from the moment forensic evidence is packaged until it arrives in a court of law to ensure evidence is not tampered with. Who transferred items to whom, when, where and for what purpose?
Forensic integrity	The collection of evidence in an appropriately cleaned, isolated area to limit the amount of cross-contamination and the subsequent transfer of packaged evidence with chain of custody.
DNA cross-contamination	A forensic sample is contaminated when any trace materials are added after the crime has been committed. This could occur before, during or after samples are taken. Evidence could be deemed unusable (inadmissible) for use in court if found to be contaminated as potential for miscarriage of justice and prosecution of wrong person.
Persistence data	The maximum time that, for example, spermatozoa will remain in a particular site (e.g. the mouth) following a crime. Physiological processes such as salivation may lessen quantities present in the mouth. External factors such as drinking or brushing teeth may also affect persistence, hence the timely examination of victims.
Consent	In the Sexual Offences Act (England & Wales), consent is defined as agreement by choice, having freedom and capacity to make choice. To understand, consider, decide and communicate a decision without coercion or influence, similarly in Northern Ireland. In Scotland, the Sexual offences (Scotland) Act defines consent as 'with free agreement' and emphasizes consent as a dynamic process with the ability to withdraw consent at any time. The capacity of those with mental disorder to consent is also included.

Table 2

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