Safeguarding and sexual assault

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Abstract

As clinicians, it is our duty to safeguard vulnerable adults and children, and recognize and act on previous, current and potential abuse. Sexual assault and abuse are common in both children and adults. It is therefore vital that we are alert to signs of this, and that we understand how best to manage this sensitive situation, working with the multidisciplinary team to provide holistic support that meets both the physical and psychological needs of the individual. It is important to understand the law relating to sexual activity in young people, and to be able to assess whether they have the capacity to consent to this. We should be vigilant for signs of potential sexual exploitation in vulnerable individuals and ensure safeguarding procedures are put in place when this is suspected.

Keywords Childhood sexual abuse; child sexual exploitation; Fraser guidelines; Gillick competence; MRCP; rape; safeguarding; sexual assault

Key points

- Sexual assault is common in both adults and children. In the vast majority of cases, the perpetrator is known to the victim
- When managing someone who has been sexually assaulted, the primary action is to ensure their physical safety and respect their wishes regarding the course of action. It is important to consider both their physical and psychological needs.
- The age of consent for sexual activity in the UK is 16 years. However, children under 16 may have the capacity to make decisions regarding this and, if they are found to be 'Gillick-competent', should be supported with safe sex advice and contraception

Safeguarding

Safeguarding is defined as 'Protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect'.[1] It incorporates protecting individuals from physical and psychological maltreatment, alongside promoting their well-being, and respecting their beliefs and wishes. As healthcare professionals, it is our duty to safeguard both our patients and individuals with whom we have indirect contact (e.g. patients' family members). General Medical Council (GMC) guidance regarding the duties of a doctor to safeguard states, 'You must take prompt action if you think that patient safety, dignity or comfort is, or may be seriously compromised'.[2]

Certain individuals are particularly at risk of abuse and exploitation, including children and young people, as well as vulnerable adults – those with a physical or learning disability, victims of trafficking, and individuals with mental health or substance misuse issues.

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Safeguarding is particularly pertinent when it comes to sexual health. All adults have a right to a consensual and safe sex life. It is our duty to support individuals, providing advice and contraception, whilst ensuring that they are not being abused or exploited – something individuals themselves may not recognize.

Sexual assault

Legislation regarding sexual assault is outlined in the Sexual Offences Act (2003) (see Further reading). Rape specifically refers to penetration by a penis of the vagina, anus or mouth of another person without their consent. Assault by penetration involves non-consensual penetration with a body part or object. Sexual assault is defined as the intentional sexual touching of another individual without consent.

Sexual assault is common, one study indicating that 85,000 women and 12,000 men are raped, and half a million adults sexually assaulted, in England and Wales every year. Around 90% of victims know the perpetrator.[3] It is likely that all clinicians will come into contact with someone who has been sexually assaulted; therefore it is vital that we are aware of appropriate management.

Management of someone who has been sexually assaulted

If a patient informs you of sexual assault, a number of factors should influence your management, including the time frame of events and the individual's wishes. Additional vulnerabilities, for example whether the patient has a learning disability, should be identified as further support can be required.

It is vital to act in a non-judgemental and empathetic manner, ensuring that the patient feels safe and their wishes are respected. Record any information given to you clearly in the patient's notes, using their own words, in case this is required later in legal proceedings.

Discussion should include referral to a sexual assault referral centre (SARC) for forensic examination, and whether the individual would like police involvement. Some SARCs offer forensic medical examination without police input, in case the patient wishes to pursue this option legally at a later date.

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If a patient requests a forensic examination, it is important to advise them how best to preserve DNA evidence, by avoiding drinking, brushing their teeth, bathing or washing their clothes. They should keep any sanitary towels/tampons and clothing, especially underwear. DNA persists for different times in various body cavities. Knowledge of this can guide whether patients should be referred for forensic examination (Table 1).

If the patient believes they were assaulted following the administration of drugs by the assailant, blood and urine should be collected within 3–4 days.

If an assault is recent and a patient does not wish to inform police or attend a SARC, it is appropriate to refer them to a sexual health clinic, where staff are experienced in managing sexual assault.

Management of a sexual assault presenting within 7 days

If the assault occurred within the previous 7 days, the first action is to ensure that the patient and any children in their care are in a safe place, and manage any physical injuries (Table 2).

Baseline screening for sexually transmitted infections (STIs) should be offered, and prophylaxis against hepatitis B and HIV considered. Hepatitis B vaccination can be administered, as this can have a prophylactic effect against acquiring the virus for up to 6 weeks following exposure. If the perpetrator is known to be hepatitis-B-positive, consider administering hepatitis B immunoglobulin.[4] The potential risk of HIV transmission and need for HIV post-exposure prophylaxis, should be discussed if the assault occurred within the previous 72 hours (consult British Association of Sexual Health and HIV (BASHH) guidelines[4] regarding indications for HIV post-exposure prophylaxis).

The potential for pregnancy in female victims should be evaluated, and emergency contraception offered.

Prophylactic antibiotics can be considered to treat chlamydia, gonorrhoea and trichomoniasis, although risk of acquisition from sexual assault is low. It is preferable to offer a repeat STI screen 2 weeks after the assault if the patient is asymptomatic.[4]

It is important to consider the psychological impact of the assault, assessing any potential self-harm risk and arranging access to psychological support services.

You should ensure that follow-up is in place for future vaccination, STI and pregnancy screening, and to assess that the individual is coping.

Management of a sexual assault presenting after 7 days

If an individual attends >7 days after an assault, it is important to consider evaluation for hepatitis B vaccination, pregnancy testing and STI screening and treatment. The window period for bacterial STI testing including chlamydia and gonorrhoea is generally accepted as 2 weeks after exposure, for syphilis 6 weeks, and for hepatitis B/C and HIV up to 3 months. However, if fourth-generation HIV tests are used, most cases are detectable by 4–6 weeks. Hepatitis vaccination can prevent infection if given up to 6 weeks after assault.

In addition, assess how the individual is coping, and ensure appropriate psychological support is in place.

Forensic timescales[4]

Type of assault	Timeline of DNA persistence
Kissing, biting or licking	48 hours
Oral penetration	48 hours
Vaginal penetration	7 days
Anal penetration	72 hours
Digital penetration	12 hours

Table 1

Management of a sexual assault presenting after 1 year

If a patient discloses a historical incident of sexual assault, the most important initial action is to be empathetic and non-judgemental, acknowledge how difficult it must have been for the patient to make this disclosure and accurately document the information provided. STI screening may be relevant if the individual has not accessed testing since the event.

The patient should be asked whether they want to report the assault to the police, and, with their consent, their general practitioner should be involved in order to help provide psychological support.

Childhood sexual abuse (CSA)

CSA is common. A study by Radford et al.[5] found that 1 in 20 children are affected, with 1 in 3 of these children reportedly not disclosing this abuse. CSA particularly affects vulnerable children, disabled children being three times more likely to be victimized.

CSA can be divided into two main categories – contact abuse, wherein an abuser makes physical contact with a child, and non-contact abuse, which includes grooming, exploitation and making or viewing child pornography. Non-contact abuse also includes encouraging a child to watch or hear sexual acts, for example showing pornography to a child.

CSA may be reported much later in life. The 2015–2016 crime survey for England and Wales (see Office for National Statistics in Further reading) attempted to capture data on the extent of historic childhood abuse. It reported that 7% of all adults had experienced sexual abuse in childhood, with only 25% of individuals informing someone about this at the time.

Diagnosis

It can be difficult to establish whether a child has been sexually abused. Children can present with a variety of physical and mental health symptoms: they can undergo a change in behaviour, becoming withdrawn and anxious, suddenly behaving badly or sexually inappropriately, developing secondary enuresis or soiling themselves.

The prevalence of STIs in those who have been abused is low, with a prospective study of >500 children who were believed to have been sexually abused demonstrating that only 8.2% of the female children <14 years old had an STI (see Girardet et al. in Further reading). Abused children who have an STI can be asymptomatic. The presence of an STI does not automatically indicate sexual abuse, as there are other potential modes of transmission, but should always arouse suspicion and prompt further enquiry.

CSA can be perpetrated by men, women or other children. Those who are suffering sexual abuse can also be a victim of

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