

**Best Practice Guideline**

**Management of Adult  
Patients who attend  
Emergency Departments  
after Sexual Assault and /  
or Rape.**



**Revised Oct 2015**

## Summary of recommendations

- Where possible and practical, victims of sexual assault and rape should be assessed in a Sexual Assault Referral Centre. (Level 5 evidence: Strong recommendation.)
- Any forensic examination should only be performed by a clinician with suitable specialist training in an appropriate environment. (Level 5 evidence: Strong recommendation.)
- Person identifiable information about sexual assaults and rapes should not normally be shared without consent, except in exceptional circumstances. (Level 5 evidence: Strong recommendation.)
- Emergency contraception should be available to victims attending the emergency department. (Level 5 evidence: Strong recommendation.)
- There is no requirement for emergency physicians to take pre-transfusion blood samples for the police. (Level 5 evidence: Strong recommendation. )
- Post exposure prophylaxis for sexually transmitted infections should be available to victims attending the emergency department. (Level 2 evidence: Strong recommendation.)

## **Scope**

This guideline has been developed to assist Fellows and Members of the Royal College of Emergency Medicine caring for adult patients who have suffered rape and sexual assault.

## **Reason for development**

To improve patient care.

## **Introduction**

### **Definitions**

In England and Wales, under the Sexual Offences Act 2003 the definition of rape is the non-consensual penetration of vagina, mouth or anus by a penis.<sup>i</sup> Sexual assault by penetration is the non-consensual, intentional insertion of an object or part of the body other than the penis into the vagina or anus. The Act also treats any sexual intercourse with a child under the age of 13 as rape and defines the age of consent as 16.

### **Epidemiology**

Only a minority of sexual assaults are reported to the police. Sexual offences are common, but infrequently present to Emergency Departments, though accurate data is lacking. While the majority of assaults are against women of child bearing age, children, the elderly and men can be victims too. The majority of assailants are known to the victims and a large numbers of cases are associated with drinking alcohol.<sup>ii iii</sup> Sexual assault may not be disclosed initially and the treating clinician should be suspicious when there is domestic violence and in patients requesting for emergency contraception.

### **Consequences of sexual assault**

Rape may result in physical injuries, sexually transmitted infections including HIV and Hepatitis B, unwanted pregnancy and psychological symptoms, which may culminate in post-traumatic stress disorder and affect immediate family or partners. These can range from sleeping difficulties, poor appetite, flashbacks, feelings of numbness, anger, shame and denial, avoidance behaviour, depression, suicidality, self-harm, relationship and sexual difficulties.

## **Assessment**

### **The Sexual Assault Referral Centre (SARC)**

Patients who have been sexually assaulted may present to the ED after the assault. Whilst the ED can manage some aspects of their care, it is best practise to encourage patients to go to a Sexual Assault Referral Centre (SARC.) A SARC is a one-stop location where victims of sexual assault can receive a forensic examination, emergency contraception and post exposure prophylaxis, psychological counselling, legal advice and other support, all in one place from professionally trained staff. They bring together all of the different legal and medical agencies and departments, which helps both the victims and those investigating the crimes.<sup>iv</sup> Victims can choose to be dealt with anonymously if they do not wish any involvement from the police.

A SARC cannot deal with acute injuries.

For the nearest SARC please look at the link. (This does not have locations for Scotland or Northern Ireland.)<sup>v</sup>

<http://maps.google.com/maps/ms?ie=UTF8&hl=en&msa=0&msid=110494870022180976736.000493bef414397b01210&z=6>

### **What should occur in an ED**

Patients who present to the Emergency Department should be assessed for physical injuries that may require treatment. Treatment of associated immediate life threatening injuries takes priority over forensic examination.

If a victim is unwilling to attend a SARC, Emergency Department staff should respect that decision and be able to manage emergency contraception and sexually transmitted infection risks. Assessment should be conducted in a non-judgemental, confidential and supportive manner.

Do not attempt any form of pelvic examination unless there is significant bleeding, as this may disrupt any forensic evidence that may be taken at a later date.

There are very few occasions when the collection of evidence should be considered in the Emergency Department e.g. if the victim has physical injuries requiring ongoing management. In such cases the forensic samples should be taken by an appropriately trained forensic physician. Many SARCS will have the provision for the forensic medical examiner (FME) to attend the hospital if this is deemed necessary in the victim's best interests. In such cases the forensic physician will examine and take clothing from the patient, so ED staff should wear gloves and take care not to cut through blood stains or stab holes etc.

If the patient is going to be examined by a FME after their injuries have been dealt with, advise the patient to avoid showering, brushing teeth and preserve the clothes worn until they have been examined.

### **Pre-transfusion blood sample**

There is no requirement for pre-transfusion blood samples, unless this is performed as part of an assessment for exposure to blood borne viruses. If the police request a pre-transfusion blood sample, this service should be provided by a suitably trained doctor, usually a forensic medical examiner, who can quality assure the chain of evidence.<sup>vi</sup>

## **Role of the Emergency Physician**

- The emergency physician must appreciate that their response to disclosure may have an important impact on their patient. The emergency physician should be sensitive and sympathetic. The absence of injuries does not exclude sexual assault.
- Take a careful history of the assault including time and location of the assault, characteristics of the assailant(s), physical violence, sexual acts (vaginal, oral, anal; Penile/digital penetration).
- Particular effort should be made to take accurate and contemporaneous notes.
- Any forensic medical examination should only be performed by a clinician with suitable specialist training, ideally in a forensically secure environment to avoid DNA contamination.
- The medical assessment should ideally be performed by the most senior or appropriately trained doctor in the emergency department. Patients should be offered a choice of gender of the doctor where possible.
- Examine everywhere where including inside the mouth looking for bruising, abrasions, and lacerations and any patterns such as fingertip marks. Look and treat for any bite marks. Document examination findings clearly as you may be asked to produce a statement later or go to court if the victim decides to press charges at a later date.
- Consider the possibility of pregnancy. Emergency contraception should be offered to the victim.
- Consider the possibility of exposure to sexually transmitted infections, see below.
- Victims may need further referral to Social Services, Victim Support, a Community Safety Unit or other organizations which can offer them support after the assault.
- Any concerns about child welfare or vulnerable adults should lead to the activation of local safeguarding procedures.

## **Exposure to blood borne viruses**

Assessing exposure to infections is often difficult and the donor is rarely available or willing to provide samples for testing. Where there is a reasonable chance that the patient has been potentially exposed to sexually transmitted infections, prophylaxis should be offered. Expert advice should be sought from the relevant on-call service. This varies between organisations, but is usually from the Genito-urinary medicine or infectious diseases services. Baseline blood tests should be taken for Hepatitis B, Hepatitis C and HIV in the ED.

Hepatitis B: if the perpetrator is not known to be Hepatitis B negative, then accelerated Hepatitis B vaccination should be considered. This usually involves a dose of Hepatitis B vaccine at the time of presentation and two further doses from the patient's General Practitioner at one and two months after the exposure. Hepatitis B Immunoglobulin can be

provided in high risk situations at the time of presentation and provides passive immunisation for up to 7 days after an exposure. Follow up blood tests should be organised through the Genito-urinary medicine clinic or GP three months after exposure.

HIV: The decision to offer Post Exposure Prophylaxis after Sexual Exposure (PEPSE) is not always straightforward. PEPSE should be considered where: the assailant is known to be HIV positive, has risk factors, anal rape, multiple assailants or there is bleeding. PEPSE may be effective at reducing HIV transmission if it is administered within 72 hours, but is more effective when administered earlier. Emergency departments should have access to PEPSE. Patients who receive PEPSE should be followed up by an appropriate service, usually the Genito-urinary medicine service who will decide whether to continue PEPSE. Fourth generation HIV testing is now routine and can detect seroconversion at 4 weeks post exposure.

### **Exposure to bacterial infections**

- Transmission of sexually transmitted infections is more likely where there are multiple assailants, biting, defloration, wounds, or anal intercourse. Transmission is also likely when the assailant is a man who has sex with men, or injects illegal drugs.
- Prophylactic antibiotics should be offered. Local protocols vary but a common regime is Cefixime 400mg + Azithromycin 1g + Metronidazole 2g as single oral stat doses. This may reduce the need for follow up in some cases.
- For pregnant or breastfeeding women Cefixime 400mg + Azithromycin 1g is regarded as safe , but these cases can be discussed with the relevant on-call specialty, either infectious diseases or Genito-urinary medicine.
- Genito-urinary medicine follow-up should be offered as the initial assessment may be too early for most sexually transmitted infections to be evident.

Please refer to the British Association for Sexual Health and HIC guidelines for more detail.<sup>vii, viii</sup>

### **Psychosocial care**

The victim often knows the perpetrator which may lead to psychosocial problems. Emergency physicians should be able to identify and support patients who develop post-traumatic stress disorder and depression by referring them to SARCs or the patient's GP. Appropriate written information about relevant services should be available in the Emergency Department.

### **Information sharing with outside agencies**

Emergency physicians should assume that clinical information is confidential. Patients should be offered police involvement, but any decision not to involve the police should be respected. In exceptional circumstances, information can be shared with the police and statutory agencies such as social services. These circumstances include:

1. Where the victim is a child. Any sexual assault of a child should trigger local safeguarding procedures.
2. Where there are concerns about the welfare of children of the victim.
3. Where the victim lacks capacity and is unlikely to regain capacity.
4. Where guns or knives have been used by the perpetrator.

The decision to share information with outside agencies should be taken by the supervising Consultant and ideally discussed with another Consultant. Clear documentation of a decision to share information should be documented in the patient's case notes and this should be communicated to the patient, where practical.

### **Useful organisations and sources of support**

Rape Crisis: <http://rapecrisis.org.uk/>

Victim Support: <https://www.victimsupport.org.uk/>

Women's Aid:

[http://www.womensaid.org.uk/?gclid=CjwKEAjwzJexBRCA\\_pGo8IK0ilASJABfGlDb9848Lk\\_zj\\_a2fYnp2IlmzG0Ft6om2BLXymyW7d8EWnRoCX0zw\\_wcB](http://www.womensaid.org.uk/?gclid=CjwKEAjwzJexBRCA_pGo8IK0ilASJABfGlDb9848Lk_zj_a2fYnp2IlmzG0Ft6om2BLXymyW7d8EWnRoCX0zw_wcB)

The Havens, SARCs in London: <http://www.thehavens.org.uk/>

SARC in England and Wales: <http://www.nhs.uk/Service-Search/Rape-and-sexual-assault-referral-centres/LocationSearch/364>

Care and evidence, web site for professionals: <http://www.careandevidence.org/>

## **Contributing Authors**

Prepared for the Best Practice Sub Committee of the Clinical Effectiveness Committee by Dr Adrian Boyle, Dr Catherine Hayhurst, Dr Meng Aw-Yong, and Dr Martin Weise. 2011.

Revised by Dr Carole Gavin and Dr Catherine Hayhurst 2015.

## **Acknowledgements**

Mary Newton, Mrs Charnjit Dhillon, Mr Robert Greatorex, Polly Rossetti, Daniel Parkes, Dr Patrick Cadigan, Dr Neil Lazaro, Prof Matthew Cooke.

## **Review**

Within three years or sooner if important information becomes available.

## **Disclaimers**

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

## **Research Recommendations**

None identified.

## **Key Words for search**

Sexual assault, rape, crime, blood borne viruses, post exposure prophylaxis.

## **Publication date**

June 2011, revised Oct 2015.

## **Appendix 1**

### **Methodology**

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

### **Evidence Levels**

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.

## References

- <sup>i</sup> <http://www.legislation.gov.uk/ukpga/2003/42/contents>
- <sup>ii</sup> Kelly L, Lovett J, Regan L. A Gap or a Chasm? Attrition in Reported Rape Cases. Home Office Research Study 293. London: Home Office, 2005
- <sup>iii</sup> Operation Matisse. Investigating Drug Facilitated Sexual Assault. London: Association of Chief Police Officers, November 2006
- <sup>iv</sup> Abbey A, Zawacki T, Buck PO, Clinton A, McAuslan P. Alcohol and Sexual Assault. Alcohol Health and Research World 2001; 25:43 -51
- <sup>v</sup> Welch J. Medical Care following Sexual Assault: Guidance for Sexual Assault Referral Centres. London: Home Office, 2005.
- <sup>vi</sup> <http://www.nhs.uk/Service-Search/Rape-and-sexual-assault-referral-centres/LocationSearch/364>
- <sup>vii</sup> Emergency care for complainants of sexual assault. Wiese M, Armitage C, Delaforce, J WelchJ. J R Soc Med 2005;98:49–53. <http://jrs.sagepub.com/content/98/2/49.full.pdf>
- <sup>viii</sup> UK National Guidelines on The Management of Adult and Adolescent Complainants of Sexual Assault 2011.<http://www.bashh.org/documents/4248.pdf>
- <sup>ix</sup><http://www.bashh.org/BASHH/Guidelines/Guidelines/BASHH/Guidelines/Guidelines.aspx?hkey=072c83ed-0e9b-44b2-a989-7c84e4fbd9de>
-