Managing adult sexual assault

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BACKGROUND

It is estimated that only 15–20% of women who have been sexually assaulted report to police and therefore the real incidence of sexual assault in males and females is unknown.[1,2] Once reported, acute cases of sexual assault (within 72 hours of the allegation) may undergo a forensic medical examination to document injuries, collect forensic specimens and provide an opinion to be used by the criminal justice system.

OBJECTIVE

This article outlines the process of a forensic medical examination as well as providing a management flow chart for medical practitioners who are caring for a victim of sexual assault who does not wish to report to police.

DISCUSSION

Dealing with a sexual assault case is easier and more efficient when the treating doctor has a good understanding of the issues involved in adult sexual assault and how to obtain crisis care for the victim. Early management of a victim of sexual assault, regardless of whether they want to report to police, is important for minimising associated risks (sexually transmitted infections, pregnancy, psychological sequelae), and documenting injuries and obtaining forensic specimens.

A sexual assault occurs where someone performs a sexual act on another individual without that person's consent. In this discussion, an adult is defined as someone over the age of 16 years. Although sexual assault occurs regardless of gender, age or socioeconomic status, most sexual assaults occur on women aged 15–19 years by a male known to her in some capacity at the victim or the assailant's place of residence.[1,3,4] Vulnerable subgroups of people more likely to be at risk of sexual assault have been identified (*Table 1*) although the list is not exclusive. Sexual assault is underreported for a number of reasons (*Table 2*), not least of which may be a fear of the medical examination and the associated legal process.[1,2] Forensic medical examination of a victim of sexual assault requires accurate documentation and interpretation of injuries, collection of appropriate forensic specimens, and communication of findings and opinions to the criminal justice system.

Forensic medical officers have specialised training in sexual assault examinations and are skilled at these tasks. However, only a limited number of cases ever reach the forensic medical service and the majority of cases probably present to their general practitioner for follow up of associated problems – perhaps without disclosing the assault itself. Disclosure may be encouraged by asking about sexual assault directly.[5]

Table 1. Vulnerable subgroups

Physical factors
Young/adolescent
Elderly
Disabled
Drugs and alcohol
Pregnancy or postpartum
Mental or psychological factors
Drugs/alcohol
Intellectual impairment
Psychiatric illness
Social factors
Sex worker
Drugs/alcohol
Homeless
Men in prisons
Domestic violence
Language/cultural barriers
Communication/social interaction difficulties

History

A history from a victim of sexual assault must explore the details of the allegation in order to decide how the examination will proceed and what specimens should be collected (*Table 3*). For evidentiary purposes, the history is best obtained in the victim's own

words and without prompting where possible. With the increasing incidence of drug and alcohol facilitated sexual assault (DAFSA), the history is not always available or comprehendible, thereby making a guided examination more difficult. The history or account of events may also differ from that presented to the police or other agencies involved. This is not an indication that the history is false or misleading. A general medical and gynaecological history should also be obtained.

Examination

Where possible, the examination is best conducted by a forensically trained specialist[8] who is guided by the allegations made by the victim. It is a 'top-to-toe' examination, usually with the ano-genital examination performed last. Its primary purpose is the care and welfare of the patient, however, the examiner also documents injuries and obtains forensic specimens as the examination proceeds. Using a chaperone is advisable.

Injuries seen on examination are entered on a medical record, preferably a 'body chart', noting the size, type, colour and location of the injury. Photography is a useful adjunct to medical diagrams/notes, but should not be used in place of them. Genital photography is not routinely carried out and is only recommended in very specific circumstances. In the absence of any injury to the genitalia, it is impossible to ascertain by macroscopic examination alone whether sexual intercourse has occurred. It is never possible to determine whether sexual activity was consensual from the examination findings. A speculum examination is always indicated in cases of bleeding, pain, penetration with a foreign body, and/or to collect endocervical samples where the examination takes place over 24 hours after the assault. High vaginal swabs can be conducted blindly (*Figure 1*). Examinations after approximately 72 hours after the assault may be of little forensic value. Injuries may have changed or disappeared and sperm survival beyond this time is unlikely.

Examinations conducted solely upon a request to 'check if someone has had sex' or to 'check if someone has lost their virginity' are of no benefit (due to lack of 'answers') and the decision whether to perform them should be taken very carefully.

Table 2. Reasons for not reporting sexual assault

Fear of the medical/legal process
Fear of retribution
Breakdown of relationships
Feelings of guilt/self blame and shame
Worried they won't be believed
Concern about being identified
Uncertain about what constitutes 'rape'
Wanting to 'put it behind them'
Lack of injuries to support allegation
Disbelief of the situation they find themselves in
Previous poor experience with reporting
Personal matter and will deal with it themselves
Known assailant
Concern of past sexual history being exposed
Cultural issues

Forensic specimens

Forensic specimens are collected during the examination and are based on the history of the allegation. The purpose of forensic specimens is to link the offender, the crime scene, and the victim. They may include biological specimens such as fingernail scrapings, skin swabs for blood, saliva or semen, external and internal vaginal/anal swabs, or trace specimens such as foreign bodies, debris and clothing. Urine and blood specimens may be taken for toxicological analysis if the victim is seen within 24–48 hours. Plain swabs (without transport medium) are used when collecting skin and mucous membrane (oral, genital) samples. They are placed into a swab container and then a paper bag to allow the specimen to dry. If the swab was taken specifically to look for semen, a dab in the middle of a correctly labelled slide is made to aid laboratory analysis.

Table 3. Taking a sexual assault history

Orifice(s) penetrated
Object(s) used
Possible sites of saliva/semen deposition
Elements of physical assault
General medical history
Gynaecological history
Sexual activity since the assault
Bathing/washing since the assault

Injury interpretation

Occasionally, a patient will attend a general practice or emergency department requesting medical attention for injuries sustained in a sexual assault. Certain injury patterns to the body might alert the medical practitioner to consider that sexual assault has taken place such as signs of strangulation, bite marks, and fingerprint bruising.[7] If the examination findings alert the practitioner to the possibility of sexual assault, they should ask the patient directly.

The majority of women (more than 60%) do not sustain genital injuries as a result of a sexual assault and severe genital injury is found in less than 1% of cases.[8–10] Genital injuries may also occur in consensual sexual intercourse and are therefore not indicative of sexual assault. Their presence (beyond the labia majora) does however, confirm that penetration of the female genital tract has

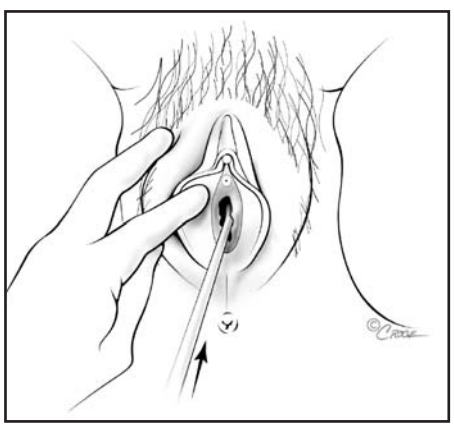

Figure 1. Diagram of a blind high vaginal swab. A plain swab is inserted into the high vagina after gently parting the labia; a technique used to sample possible fluids for foreign DNA/sperm

occurred (*Figure 2*).

Management of medical issues

Following the forensic medical examination consideration is given to weighing the 'risks' of contracting HIV following the sexual assault.

If the risk of contracting HIV is significant, immediate attention is given to postexposure prophylaxis regimens. Checking the patient's hepatitis B and tetanus status is also essential with appropriate immunisations given at the time of the examination. The likelihood of a sexually transmitted infection (STI) should be considered and an STI check conducted approximately 2 weeks after the assault. Baseline testing at the time of the assault may be considered in some cases (*Figure 3*).

Risk of HIV transmission = risk carried by the exposure x risk that source is HIV positive[11]

Emergency contraception should be given at the time of the examination (within 72 hours where indicated). A pregnancy check should be considered approximately 2 weeks after the assault.

Follow up counselling is offered by sexual assault or other such services (see *Resources*). Work illness certificates, alternate accommodation and child welfare or domestic violence intervention should also be addressed at the conclusion of the forensic medical examination.

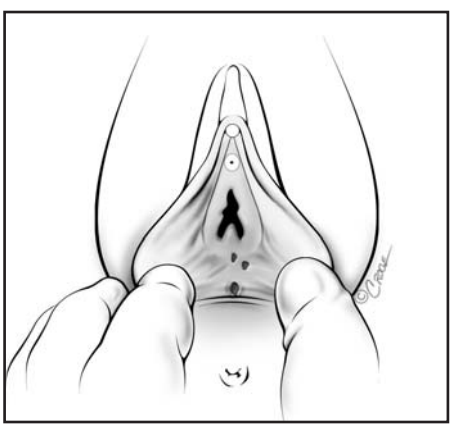

Figure 2. Lacerations (indicated by the arrows) seen in the posterior fourchette after separation of the labia minora. This is a common site of genital injury

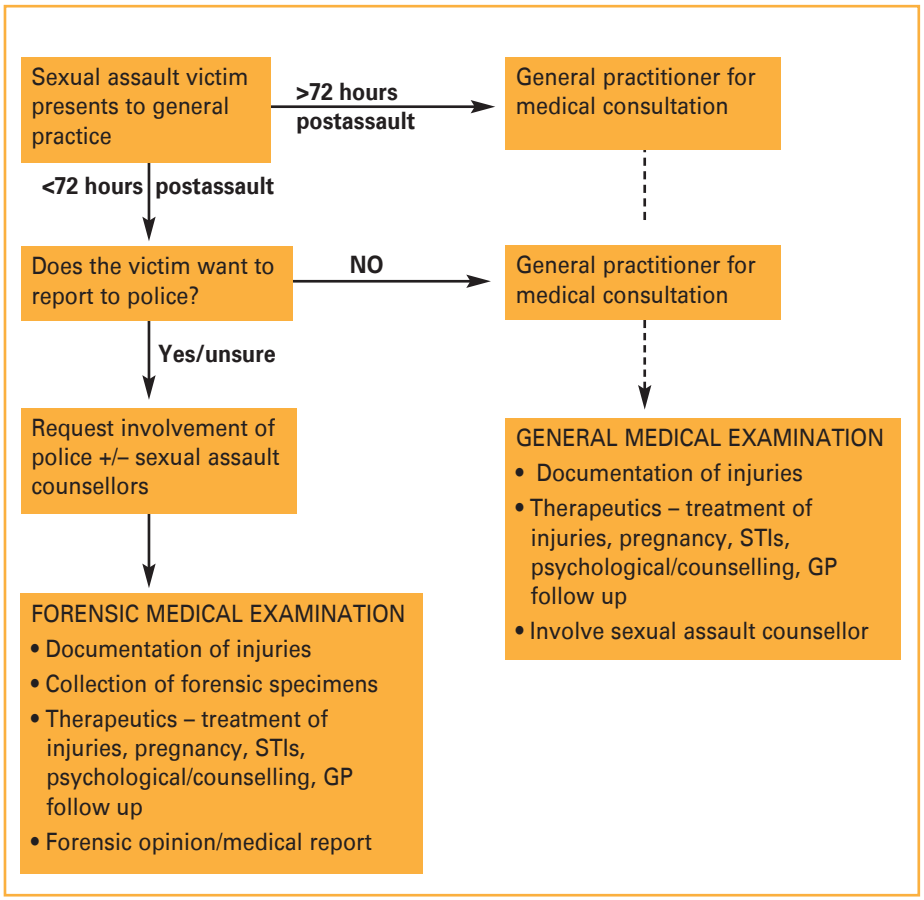

Figure 3. Management of a sexual assault victim

Summary of important points

- A doctor providing care for a victim of sexual assault must consider documentation and treatment of injuries, specimen collection, treatment and follow up for STI, pregnancy and psychological issues.
- Early referral to forensic services assists the documentation/interpretation of injuries and collection of forensic evidence.
- Asking about sexual assault may encourage disclosure.
- The absence of a genital injury does not exclude a sexual assault.
- The presence of a genital injury is indicative of penetration – it does not conclude whether consent was present or not.

Resources

Australian Capital Territory
Canberra Rape Crisis Line
PO Box 916, Dickson 2602
Phone 02 6247 2525

New South Wales
Rape Crisis Centre
Phone 02 9819 6565
Country NSW 1800 424 017
TTY 02 9181 4349

Northern Territory
Sexual Assault Referral Centre
Casuarina Plaza, Casuarina 0810
Phone 08 8922 7156

Queensland
Statewide Sexual Assault Helpline
Free Call 1800 010 12

South Australia
Yarrow Place
55 King William Road, North Adelaide 5006
Phone 08 8226 8777
After hours 08 8226 8787
Toll free 1800 817 421

Tasmania

Sexual Assault Support Service
Southern region: Phone 03 6231 1811
Northern region: Phone 03 6334 2740
Northwest region: Phone 03 6431 9711

Victoria
CASA House – Centre Against Sexual Assault
270 Cardigan Street, Carlton 3053
Phone 03 9344 2210
After hours 03 9349 1766
Country Victoria 1800 806 392
TTY 03 9349 2466

Western Australia
SARC – Sexual Assault Resource Centre
Phone 08 9340 1828
Free call 1800 199 888

Conflict of interest: none declared.

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