SEXUAL ASSAULT CARE PATHWAY IN INTEGRATED SEXUAL HEALTH SERVICES

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Author:	Dr Lucy Jones Specialist in Sexual Health and HIV, Department of Integrated Sexual Health
Executive Sponsor:	Chief Executive
Approved By:	**Health Board**
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Version:	

Target Audience:

People who need to know about this document in detail	For all nursing and medical staff involved in the care and management of patients who have experienced sexual assault
People who need to have a broad understanding of this document	Executive Directors *Chief Operating Officer*
People who need to know that this document exists	*All staff involved in the care of patients who have experienced sexual assault*

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard	Choose an item.

Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint:

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BACKGROUND

Guideline Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Roles and Responsibilities

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff.

The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

Training Requirements

There is no mandatory training associated with this guideline.

Monitoring of Compliance

- By audit and review of complaints relating to miscarriage diagnosis and management.
- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.
- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

Complaints

All complaints should try to be resolved with the patient during any contact to avoid escalation. There concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

1.GUIDELINE DEVELOPMENT GROUP MEMBERSHIP

Sexual Violence Special Interest Group, Cwm Taf Morgannwg University health board

Dr Lucy Jones – Specialist in Sexual Health and HIV, Department of Integrated Sexual Health

Rachel Gilmore – Senior Nurse Manager, Department of Integrated Sexual Health

Dr Alexander Thomas – Chief Biomedical Scientist, Pathology, Royal Glamorgan Hospital.

Lay representatives – Caitlin Farley, Jawaria Aziz and Garry Dolton.

2.SOURCES FOR GUIDELINE DEVELOPMENT

British Association for Sexual Health and HIV National guidelines for the management of individuals disclosing sexual violence in sexual health services (2022).

The Royal College of Emergency Medicine, Best Practice Guideline Management of Adult Patients who attend Emergency Departments after Sexual Assault and / or Rape (2017).

Faculty of Sexual and Reproductive Health Position Statement on Domestic and Sexual Violence (2017).

Welsh government, Guideline for service provision for National enhanced service/specialised sexual health services. Violence against women

Violence against women domestic abuse and sexual violence: Cwm Taf Morgannwg Safeguarding Adult Group (2017).

3.SCOPE AND PURPOSE

This guidance forms Cwm Taf Morgannwg University health board Guideline on the Management of Adult and Adolescent Complainants of Sexual Assault. It is aimed at health care workers in level 3 sexual health settings. It may also be helpful for other professionals who manage sexual violence disclosures, for example, Emergency Medicine, Women's health, Mental health and wellbeing service and the Pathology. Many individuals do not disclose sexual violence and this guidance aims to provide guidance to support appropriate management when they do.

4.EDITORIAL INDEPENDENCE AND CONFLICT OF INTEREST

This guideline was developed and edited by the persons in section 1. No funding was obtained for development of the guideline. All authors have declared no conflict of interest.

5.RIGOUR OF DEVELOPMENT

This guideline was produced according to specifications set out in the BASHH CEG's 2015 document 'Framework for guideline development and assessment' https://www.bashh.org/bashhgroups/clinical-effectiveness-group/. A search of websites including the Welsh government, Public Health Wales, UK Department of Health, Crown Office, New Pathways and Rape Crisis was conducted using keywords ; sexual violence, sexual assault, rape, sexual violence, sexual abuse, sexually transmitted Infections, post exposure prophylaxis, Hepatitis B infection, HIV infection, adult, adolescent, male, female, transgender, HPV (human papilloma virus) Vaccination, self-harm, PTSD (post-traumatic stress disorder), domestic abuse, sexual dysfunction, self-harm or pregnancy. A database search of publications in the English language for the years 1990 -2023 was also undertaken. Databases included were Ovid Medline, Medline daily update, Embase, Pubmed NeLH Guidelines Database, Cochrane library. Conference abstracts from IUSTI, BASHH, BHIVA, ICAAC, ASHM, ECCMID, between 2019 and 2023 were reviewed as were guidelines from the Centre for Disease Control and Prevention (CDC).

6.FURTHER GUIDANCE DEVELOPMENT

To ensure the contents remain up to date, a review and updating of the document is recommended five years after publication.

7. PATIENT AND PUBLIC INVOLVEMENT

Public representation was sought from lay members. Feedback from members of the public was requested and actively sought during the development of the guideline.

8. INTRODUCTION

8.1 Types of sexual violence

Sexual violence can take on many different forms; it is not limited to acts of non-consensual intercourse but involves a wide range of behaviours, including attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation, female genital mutilation, and online facilitated abuse. It does not require the use of physical force. It affects all ages and genders. In most cases of sexual assault, the perpetrator is someone the victim knows, such as a current or former intimate partner, or a relative. Sexual assault is an act motivated by power and control.

8.2 Statistics

773,000 adults in England and Wales aged between 16 and 74 experienced sexual assault (including attempt) in the previous year ending March 2020.2 Females experienced sexual assault four times more often than males and only 16% of females and 19% of men reported to the police in the previous year. March 2017 crime survey for England and Wales (CSEW) estimated that 12.1% of adolescents and adults aged 16 to 59 have experienced sexual assault (including attempts) since the age of 16 (20% women and 4% of men), equivalent to an estimated 4 million victims.3 Sexual crimes account for 5% of all crimes recorded in Scotland in 2018-19. There has generally been an upward trend in these crimes since 2010-11 with rape and attempted rape more than doubling (increasing by 115% overall) between 2010-11 and 2018-19.4 In Northern Ireland the public prosecution service reported 1594 cases involving sexual offences in the financial year 2018-19. There was a 9.7% increase in reported rapes from the previous year to 610 and 984 reports of other sexual offences representing a 6.3% increase.5 11 A report called “If only someone listened” published in 2013 by the Children’s Commissioner of England reported that a total of 2,409 children and young people were known to be victims of CSE by gangs and groups.6 In 2018, 638 children (533 female and 105 male) were reported as trafficked for sexual exploitation; an increase from 561 in 2017. These figures are likely to be an underestimate due to the difficulty in recognising and understanding that individuals have been victims of trafficking. In the same year, 1289 adults were reported as trafficked for sexual exploitation (1192 female, 94 male and 3 transgender); an increase of 1180 in 2017.

8.3 Legislation and consent

Statutory frameworks for sexual offences in the UK are provided by the Sexual Offences Act. Legislation is gender neutral making rape an equivalent offence if carried out against a man or woman. In addition, post-surgical transgender changes are acknowledged. Rape is legally defined as penetration of mouth, vagina or anus with a penis without consent. This includes changes following transgender surgery.

Sexual activity of any kind between adults and children under 16 years is unlawful. A child under the age of 13 years cannot legally consent to any form of sexual contact.

It is an offence for a person in a position of trust to engage in sexual activity with a child or young person under 18 years, or a person with learning difficulties or a psychiatric illness.

Sexual activity between two young teenage people under 16 years and of similar age is unlawful too, although is unlikely to result in prosecution if mutually agreed unless it involves abuse or exploitation. 1

In England & Wales the definition of consent is ‘agreement by choice with freedom and capacity to make that choice’.

8.4 Minimum requirements for sexual health services to support those reporting sexual violence

Sexual violence has both physical and psychological effects on health and well-being; these can be short- and/or long-term and can vary markedly between individuals.

SARCs (sexual assault referral centres) are established to manage patients following disclosure. However, initial disclosures are sometimes made in other health service settings. Sexual health services and Emergency departments are key areas where a disclosure may be made. Disclosures can be complex in nature. There are also strong links between sexual violence and domestic abuse including forced marriage.

Recommendations – Good practice points:

● Clinicians working within sexual health services should be able to identify concerns about sexual violence, have an understanding of the relevant medico-legal aspects and be familiar with local support services in order to respond to disclosures of sexual assault appropriately.

● Disclosure of sexual violence is difficult and patients should be assisted as much as possible with this process. This should include privacy and appropriate time allocated to an appointment where possible (e.g., a double-slot booked for a consultation). The structure of the service both in terms of clinic environment, appointment length and administrative processes should be considerate to the needs of patients disclosing sexual violence.

● All sexual health services should routinely ask all users about sexual assault.

● STI screening, HIV PEP, Hepatitis B PEP and emergency contraception should be provided in a timely fashion. This should be provided by appropriately trained staff to ensure prompt and supportive care is provided.

9. TRAUMA INFORMED PRINCIPLES

Trauma informed practice supports the recovery of those affected by trauma by providing them with a different experience of relationships with healthcare professionals, one in which they are offered safety rather than threat, choice rather than control, collaboration rather than coercion, and trust rather than betrayal. Each interaction with a healthcare professional provides an important part of recovery from sexual violence. Professionals should also be mindful that a consultation carries the risk of re-traumatisation if emotional or relational triggers go unrecognised and consider how to avoid triggers that will vary between individuals. Offering alternative choices when triggers are recognised may minimise the risk of re-traumatisation and the impact of trauma.

Summary of recommendations: Safety, Trust, Empowerment, Collaboration and Choice.

● Maintain the trust that has been established when someone has felt safe enough to make a disclosure by explaining confidentiality limitations early to avoid any perceptions of false promises.

● Establish and maintain rapport including awareness of the patient's gender identity and use of preferred pronouns.

● Provide an environment that allows adequate time and avoids interruptions during the consultation to promote feelings of safety.

● Enquire about pre-existing harmful coping strategies and domestic abuse to ensure onward safety when leaving the clinic.

● Identify and acknowledge the patient's priorities.

● Explain the options available in response to the recognition of their priorities and your clinical assessment.

● Involve the patient in the management plan, empowering them to make informed choices about what they do and do not want, including any proposed multi-agency involvement.

10. MANAGEMENT PLAN OPTIONS

10.1 Varying needs of the patient

Patient needs following a sexual assault vary between individuals and alter from the time of presentation. This pathway has been written for local use. Patients should be offered a gender choice of clinician if possible and always offered a chaperone for examinations.

10.2 Clinical enquiry

Elicit a brief history of the incident, gathering only information about events that is required and relevant. Offer and provide appropriate management and make appropriate immediate risk assessments on the individual's sexual and psychosocial wellbeing.

• Focus on what happened, when (date and time if a recent assault), where and by whom.

• Ask about injuries which may need treatment. Reassure the patient that an absence of injury does not negate their account.

• Ask about symptoms to offer appropriate examination.

• Ask about types of sexual contact, including oral, vaginal, and anal penetration, in order to be able to offer appropriate (correct site) STI testing.

• The time frame for being able to collect DNA evidence depends on the type of sexual contact.

• In those at risk of pregnancy from the assault or recent consensual sex, ask about menstrual and contraceptive history to assess the level of risk and need for emergency contraception.

• Gather any information known about the suspect, which may help in assessing risk of HIV or Hepatitis B transmission and may inform the offer of HIV post-exposure prophylaxis (PEP) or Hepatitis B vaccination e.g., country of birth, intravenous drug use, bisexual person.

• Ask about current mood including any thoughts of self-harm, positive and negative coping strategies, support from friends/family and other professionals, mental health history, domestic abuse and alcohol and drug use, to assess the need for emotional support.

• Ask about any sex since the assault.

• Ask about current personal safety e.g., living arrangements, ongoing harassment by the assailant.

• Ask about any other help provided to date e.g., police, SARC referral, counselling referral, GP aware of the assault.

• There is no time limit between the sexual assault and appropriate management of the patient reporting sexual assault. Historical sexual assault should be treated in accordance with this guideline.

10.3 Documentation

Careful documentation is essential. It is best practice to use standardised documentation and to record sentences verbatim (in the patient's own words) where appropriate. Always remember to complete notes contemporaneously, date and time all entries and make them legible and in black ink if hand-written.

The names of any other people present during the consultation should be documented in the notes, as well as their relationship to the client, or their professional role. Traumatic events can affect memory recall and there may be discrepancies between clinical records and accounts taken as part of a police investigation.

10.4 Forensic enquiry

The first consultation should ascertain and address the individual's priorities in addition to explaining the options for information sharing with police.

Awareness of current guidance regarding timeframes for the opportunity of forensic capture is helpful to inform an individual when making their decisions. Healthcare professionals should liaise with the local SARC if further advice is needed.

Good practice point - If the recommended time frame for capture of forensic material has passed but the patient thinks they may have injuries relating to the assault, forensic medical examination, either as a self-referral or with police engagement, can still be used to document any genital or non-genital injuries. In the health board area this will be at a SARC (please see Appendix for details of local SARC and contact numbers). It is important to note that not all SARC's are able to provide care for patients aged under 16 years and this is provided by specific SARC's.

● If the individual opts to have forensic sampling, refer to local forensic medical services or SARC, for forensic medical examination (FME) and preservation of potential evidence.

● If the patient wants to attend a SARC for forensic examination it is recommended not to perform genital examination or testing before this has taken place.

11. POLICE INVOLVEMENT

Information sharing

If an individual discloses sexual violence, the options available to them on information sharing with other organisations, including police should be discussed.

Once the health care professional has excluded any immediate or ongoing adult or child protection concerns, the patient's decision should be respected. The options are below and option 1-3 may require engagement with SARC.

11.1 Intelligence reporting

Health professionals may provide information to the police with the patient's details anonymised. This can include perpetrator details. The information sharing is with the explicit, written consent of the individual and only for intelligence purposes. This consent form can be viewed in the Appendix. Local police guidance for partner intelligence sharing should be followed to ensure only appropriate information is disclosed. There will be no police contact or investigation based on an intelligence report. The intelligence may, however, support existing or subsequent police intelligence that may determine a police response and during that subsequent investigation the patient may inadvertently become identifiable.

11.2 Third party reporting

Third party reporting involves an agency or organisation reporting an incident on behalf of the patient with the knowledge that there will be a policing response and an investigation initiated. The reporting agency can be the conduit for police contact with the victim of the crime with the knowledge that police will require to speak to the patient. Whilst in most cases the police will not proceed with an investigation without the support of the patient it is 20 possible that the police may choose to act on third party reporting information for the protection of the wider public.

11.3. Police engagement

An individual may report to police directly to initiate a full investigation. There is no time limit between the incident and the opportunity to report sexual crime to the police. It is recognised that victims of sexual crime are often unwilling to reveal or talk about their experiences for some time.

11.4 No information sharing

The individual may decline any option of information sharing.

12. LIMITS OF CONFIDENTIALITY

When an individual is deemed to have capacity, information may be shared in the absence of consent only if there is concern for the safety or wellbeing of a child, other vulnerable individuals or is in the public interest, or required by law.

● Good practice point - The limits of confidentiality should be made clear early in the consultation.

12.1 Patients less than 18 years old

Any sexual abuse disclosure would normally constitute "significant harm" and warrant a referral to local authority children's care. However, from the age of 16 it is assumed that individuals have capacity to make their own decisions about medical care, including information sharing, and their decisions should be respected. This means that decisions about confidentiality and information sharing in 16- and 17-year-olds can be legally complex.

If there is any concern regarding the potential ongoing risk to siblings or other children, information sharing should be in line with local child safeguarding procedures.

● Disclosure of sexual violence by a child should follow Cwm Taf Morgannwg University health board safeguarding procedures.

12.2 Adults at risk

Adults may be unable to protect themselves from harm because of a learning disability, mental ill-health, substance use or a physical disability. If an adult discloses sexual violence and there are any concerns about their capacity to protect themselves from harm, then information may need to be shared with social care or the police. Recommendations:

● Professionals should be aware of the possibility of coercive control influencing the level of duress which may impede the individual's ability to decide freely.

● Gender based violence disclosures that include complex issues around capacity assessment and appropriate information sharing, should be discussed within the multidisciplinary team (MDT) and may also include consideration of advice from a medical defence organisation. Clearly document the subsequent decision-making processes.

13. FORENCSIC MEDICAL CARE

Recommendations:

● SARC referrals may be with or without police involvement.

● Clinicians should be aware of local referral pathways into SARC services. If the patient agrees to a FME they should be advised to avoid washing or cleaning teeth, and to retain any items of sanitary wear or clothing worn at the time of the incident or immediately afterwards, even if laundered. (GPP)

● Physical examination that includes the collection of swabs for potential DNA or semen analysis, should only take place in facilities that are forensically secure, the SARC. Forensic physical examination should only be carried out by a forensic medical examiner.

● Assess immediate safety, including ongoing domestic abuse and arrange treatment of injuries.

● Patients under the age of 18 years should be referred to a SARC that can provide care for patients of this age group.

14. GENITAL EXAMINATION

If the patient has chosen to be referred for a FME, to preserve DNA evidence, a physical examination should not be performed in the sexual health clinic unless there is an urgent indication for examination e.g. serious injury/ bleeding etc.

Collaborate with patients on balancing their priorities and medical emergencies against forensic capture.

If the patient prioritises reduction of pregnancy risk via insertion of a copper IUD as emergency contraception over forensic capture, then their informed decision should be respected.

During the examination the examiner and chaperone should carefully observe the patient looking for any signs of distress or dissociation. If there are any signs of distress or re-traumatisation, address any identified triggers and re-affirm consent to continue with the examination, asking for permission to continue and terminating the examination if requested.

If a patient has disclosed vaginal penetration, having not been sexually active before, then interpretation of hymenal findings may be useful evidentially and knowledge of how to examine, describe and interpret hymenal findings is beneficial.

Recommendations:

● Referral to the local SARC or a community paediatrician for examination and consideration of photo-documentation of genital findings using a colposcope should be considered (referral forms for self-referral, health professional referral are available in the appendix).

● Patients not referred for a FME who present with injuries or genital symptoms should be offered a carefully conducted genital examination. Those without injuries or symptoms, with consideration of incubation periods, can be offered an examination or self-taken sampling for STI's

● If Female genital mutilation (FGM) is identified, follow local process.

14.1 Observation of injuries

Although genital injury is not common after sexual assault, careful assessment for, and documentation of injuries is required. Non- genital or genital injuries needing treatment should be referred to a minor injuries or emergency department for further assessment and management. Recommendation: ● In those not attending or declining SARC involvement, examination of all sites of assault should be offered and inspected for injuries and signs of STIs.

15. SEXUALLY TRANSMITTED INFECTION (STI) TESTING

15.1 Good practice point: use BASHH UK guidelines for specific infections.

Tests for STIs should be offered after sexual assault as described in the current BASHH guidance on testing for STIs (to include NAAT's for Chlamydia and Gonorrhoea, Syphilis, HIV, Hepatitis B and C) etc., link - https://www.bashhguidelines.org/current-guidelines/sexual-history-taking-sti-testing-and-specific-groups/guidance-on-sti-testing-2021-and-2023/

Offer screening in all cases where there is a risk of infection, including assault by penetration by an object or a digit if there is any possible STI transmission or pregnancy risk.

● Consider appropriate incubation periods and offer appropriate testing. Chlamydia and Gonorrhoea (at least 14 days after the sexual assault). Syphilis, HIV 4th generation test, Hepatitis B and C (on first point of contact, 45 days after sexual assault). Offer blood borne virus testing up to 12 weeks after the sexual assault if patient requests; HIV POCT tests are recommended from 90 days after sexual contact as per BASHH/BHIVA guidelines).

● A laboratory chain of evidence form should accompany each sample taken, even if the sexual assault is reported many months or years after it occurred.

All Wales SOP's for sample requirements for alleged victims of sexual assault in not finalised and local (CTMUHB) laboratory SOP for processing samples are not finalised after consultation with the laboratory manager. However, in the interim time the microbiology laboratory manager at Royal Glamorgan Hospital has requested that practitioners taking samples for STI's should perform a Chlamydia/Gonorrhoea NAAT AND a red-topped, dry swab for confirmatory testing is requested by the Criminal Prosection Service. These should be performed for each relevant anatomical site sampled e.g., pharynx, vaginal, cervical, rectal.

Practice point – two sample types (NAAT and a dry, red-topped swab) should be taken for each site. This is so confirmatory testing can take place if requested by the CPS. Local procedures may change from the time of writing, so always check with the microbiology laboratory if there is any uncertainty.

15.2 Forensic Significance of STIs

The possibility of a sexually transmitted infection pre-dating the incident would need to be excluded before an STI assumed evidential importance. If the patient is otherwise previously sexually inexperienced before the assault (e.g. a child), or last had many years (such as over 5 years) ago, then identification of an STI may be important in terms of evidence of assault. A "chain of evidence" documentation can be used. The presence of an STI may also assume evidential value when diagnosed in someone who has been penetrated in a sexually naïve site (for example anal penetration by a penis in a patient who has not previously had anal penetration). Female genital anatomy and movement of discharge from the vagina may result in transfer of infection and therefore, rectal STIs may be seen in those not reporting previous anal penetration. As a result, a rectal STI in someone who has had vaginal penetration cannot be assumed to be a result of anal penetration. In a sexual health setting, contact the SARC or local forensic service if you need additional advice on sending samples with a chain of evidence form.

Good practice point - The appropriate STI tests will depend on the time elapsed since the assault, and the risk of STIs from sex before and after the assault. It is good practice to explain to the patient that for each STI, tests are only reliable after a certain time has elapsed. Testing at first presentation in addition to 2 weeks post assault may help to determine whether a bacterial infection pre-dates the incident or may be a result of it.

15.3 Home STI testing

Patients should be offered opportunities to test at the end of the incubation period for each STI. These should be performed in clinic by a health care professional. Home testing kits may be provided if patients decline.

All tests may potentially give false-positive results, and the positive predictive value of a positive result is lower in low prevalence populations. It may be helpful to discuss this with patients at the time that the test is taken.

15.4 HIV, Syphilis, Hepatitis B and Hepatitis C and pre-PEP monitoring

As for all STIs, testing for syphilis and blood-borne viruses at the time of presentation may detect infection acquired during the sexual assault (depending on time frames), or prior to the assault. Testing at the time of presentation can be helpful to allow prompt management of any infection.

● HIV testing should be performed using a fourth-generation HIV serology test (which detects both HIV antibody and p24 antigen) at least 45 days after the assault.

● BASHH/BHIVA PEP guidance should be followed when considering use of PEP.

● If PEP is given, the HIV follow-up testing should be conducted as recommended in the current BASHH/BHIVA PEP guidance.

● Syphilis serology and Hepatitis B and C testing are offered on the point of contact, 45 days after the assault and 12 weeks after the assault.

16. PROPHYLAXIS FOR STIs

16.1 Prophylaxis against Bacterial STIs

Routine use of antibiotics for prophylaxis against STIs after sexual assault are not recommended. Evidence shows that the disadvantages of giving prophylactic antibiotics include the promotion of antibiotic resistance where antibiotics are not needed, and the reinforcement of the incorrect belief that there was a high risk of infection. Provision of antibiotic prophylaxis without appropriate testing and follow up may result in missed opportunities for partner notification, and possible re-infection of the patient if the source of infection was someone other than the assailant.

Prophylaxis for bacterial STIs should not be routinely recommended but could be considered in certain cases.

Good Practice Point ● If the patient requires an intrauterine device (IUD) for emergency contraception, then refer to the FSRH guidelines and if considered indicated, for example if the assailant is known to have an infection, treatment can be started. Discuss the pros and cons of this with the patient.

16.2 Post Exposure Prophylaxis Following Sexual exposure for HIV (HIV PEPSE)

BASHH/BHIVA UK Guidelines for the use of HIV post-exposure Prophylaxis (PEPSE) should be followed.

If the patient presents within 72 hours of sexual assault, then a risk assessment for acquisition of HIV should be performed.

Using the latest BASHH/BHIVA PEPSE guidelines carry out a risk assessment for HIV.

Good practice point: Use of PEPSE is recommended where there is a risk of HIV transmission of over 1 in 1000, and PEPSE should be started as soon as possible.

Clinicians should bear in mind that transmission of HIV is likely to be increased by physical genital injury, presence of bleeding or by multiple assailants.

Sexual health clinics should work closely with their local SARCs in immediate provision of PEPSE and/or follow up.

The current BASHH/BHIVA PEPSE regimen should be provided.

If hormonal contraceptive methods are being used, or other medications, use the Liverpool University drug Interactions website to ensure there are no interactions (https://www.hiv-druginteractions.org/checker). Ensure all drug-drug interactions are checked.

Patients on PEPSE should consider using condoms until they have had negative follow up tests for HIV, to reduce the very small residual risk of onward HIV transmission to partners.

Baseline assessments must be completed and follow up arranged as per BASHH/BHIVA guidelines (HIV serology test and eGFR in particular).

If the patient is already taking daily Pre-exposure Prophylaxis (PrEP) with tenofovir/emtricitabine, then PEPSE is not required, provided they are taking this correctly, have not missed any doses and continue to take for at least 48 hours following a rectal assault and 7 days following a vaginal assault.

For those on event based PrEP regimes the risk differs depending on the pattern of use pre-incident, time since last dose and the site of exposure switching to PEP may be appropriate.

16.3 Prophylaxis against Hepatitis A

Post exposure vaccination for Hepatitis A following sexual assault would only be recommend if within two weeks of a contact of a confirmed case or one week after onset of jaundice in the index case.

Opportunistic hepatitis A vaccination may however be appropriately offered if falling within a risk group e.g. MSM, PWID or those with hepatitis B/C.

16.4 Prophylaxis against Hepatitis B

Use of Hepatitis B vaccine alone has demonstrated to be highly effective in preventing transmission after exposure to HBV, through the production of specific antibodies to HBsAg.

Hepatitis B vaccinations are now part of routine UK immunisations for children born on or after 1st August 2017. Patients should be offered vaccination in line with current national recommendations.

Ideally, immunisation should commence within 24 hours of exposure, although it should still be considered up to a week after exposure.

Delivery of later vaccine beyond the seven days is unlikely to be effective as post exposure prophylaxis however is not likely to cause harm. There may be other indications for offering the vaccine to patients in line with current public health guidance to consider.

As vaccine alone is highly effective, the use of HBIG in addition to vaccine is only recommended in high-risk situations or in a known non-responder to vaccine. Vaccine should be simultaneously offered.

Recommendations

● The vaccine should be offered early, preferably within 24 hours. As post-exposure prophylaxis there is little evidence to support its effectiveness beyond 7 days.

● All three schedules are likely to have similar effectiveness as PEP but the accelerated (four doses at 0, 1, 2, and 12 months); or ultra-rapid (four doses at 0, 7– 10 days, 21 days, and 12 months) are preferred because of higher completion rates in addition to rapid development of immunity in those at ongoing risk and where compliance is an issue.

● The adult dose (20mcg /1ml) is licensed for use in those 16 years or over.

16.4 Human Papilloma Virus (HPV) vaccination Human papillomavirus (HPV).

There are more than 100 types of HPV that infect squamous epithelia including the skin and about 40 types that affect the mucosae of the anogenital and upper respiratory tracts.

Sexual contact with an infected person is the method of transmission for genital HPVs, primarily through sexual intercourse. Therefore, risk is related to the sexual history of partners, having a new partner and also number of sexual partners.

There is no published evidence to support the effectiveness of HPV vaccination in a post exposure setting with respect to any HPV related pathology (this includes cervical intraepithelial neoplasia, anal intraepithelial neoplasia and external warts).

Recommendations is based on current BASHH guideline:

● HPV vaccination is not routinely given post sexual assault to all adult survivors of sexual violence in the acute setting.

● We recommend that all survivors are questioned with respect to their HPV vaccination history and all those who are currently eligible for the HPV vaccination as per current UK guidelines are advised and signposted to commence (or complete any incomplete) HPV vaccination courses.

17. PREGNANCY RISK ASSESSMENT & EVIDENCE POTENTIAL

17.1 Pregnancy assessment recommendations

● Assess all those reporting sexual assault for risk of pregnancy and provide appropriate testing for pregnancy and assessment for emergency contraception (EC), if required

•Provide EC following the FSRH guidelines on emergency contraception.

If time has elapsed from the assault so that EC cannot be provided, then advise that a Pregnancy test (PT) will be positive at 3 weeks post assault.

If a pregnancy test is positive, discuss options which include:

• Continuing with the pregnancy

• Termination of pregnancy

• Paternity testing.

If the patient wishes to terminate the pregnancy, POC may be used as DNA evidence. If there is uncertainty about whether the biological Father is the suspect or a partner, paternity testing using chorionic villous.

If the patient continues with a pregnancy, make a referral to a GP or an antenatal clinic and share relevant information about the assault, with the patient's consent. This may include discussion on the option of obtaining a DNA profile from the baby at some time point after delivery.

18. ONWARD REFERRAL AND PSYCHOLOGICAL SUPPORT

A detailed assessment and management of the psychological consequences of sexual assault **i**s not expected in the sexual health setting, however awareness of symptoms and knowledge of referral and treatment options is beneficial. Communication with the patient's GP, with consent, should be encouraged as they are best placed to actively monitor person who is at **r**isk of developing Post Traumatic Stress Disorder (PTSD).

Recommendations:

● Check signposting and referrals for psychological assessment and intervention have been made as appropriate.

Those involved in the prosecution of an alleged offender should not prevent a witness from receiving therapy and the therapeutic service should be allowed to deal with any trial related issues.

Good practice point:

● Signpost to support, and with consent communicate with the patient's GP.

19. DISCLOSURE OF MEDICAL NOTES

19.1 Clinical notes can be requested and may form a part of the evidence in a criminal trial. This should be with the necessary authorization from the patient or from the courts. The requests should explain the issues in the case, so far as they are known, and be precise. The purpose should be to elicit a genuine and focused search for relevant documents or information. The clinician may later be requested to provide a statement and be cited as a professional witness, particularly if one of the first people the individual disclosed to.

As healthcare professionals it is important to challenge the stigma surrounding sexual ill health and any presumption held by some that all STI transmission is associated with risky sexual behaviours. Good communication may allay any unnecessary requests. This may include an STI diagnosis that is unrelated to the incident being investigated. Speculative inquiries are inappropriate. Recommendations:

● Ensure that local procedures for disclosure of medical records in line with governance requirements and Caldicott principles are followed.

● Any third parties named in the notes, apart from the suspect, should be redacted along with any other unnecessary information.

● Consider consulting with the legal department of the organisation where you work, the Caldicott Guardian and medical defence or regulatory organisations if concerned and document their advice.

20. AUDITABLE OUTCOMES

Among those attending Sexual Health Services reporting sexual assault or rape:

1. The proportion of patients under the age of 18 for whom there is documentation of a safeguarding assessment. Target 97%

2. The proportion of patients for whom there is a documented assessment and (where appropriate) the offer of hepatitis B vaccination. Target 97%

3. The proportion of patients having a documented assessment and (where appropriate) the offer of post exposure prophylaxis against HIV infection. Target 97%.

4. The proportion of patients having a documented offer of baseline testing for STIs, syphilis, HIV, Hepatitis B and C- target 97%

5. The proportion of patients completing baseline testing for STIs, syphilis, HIV, Hepatitis B and C - target 80%.

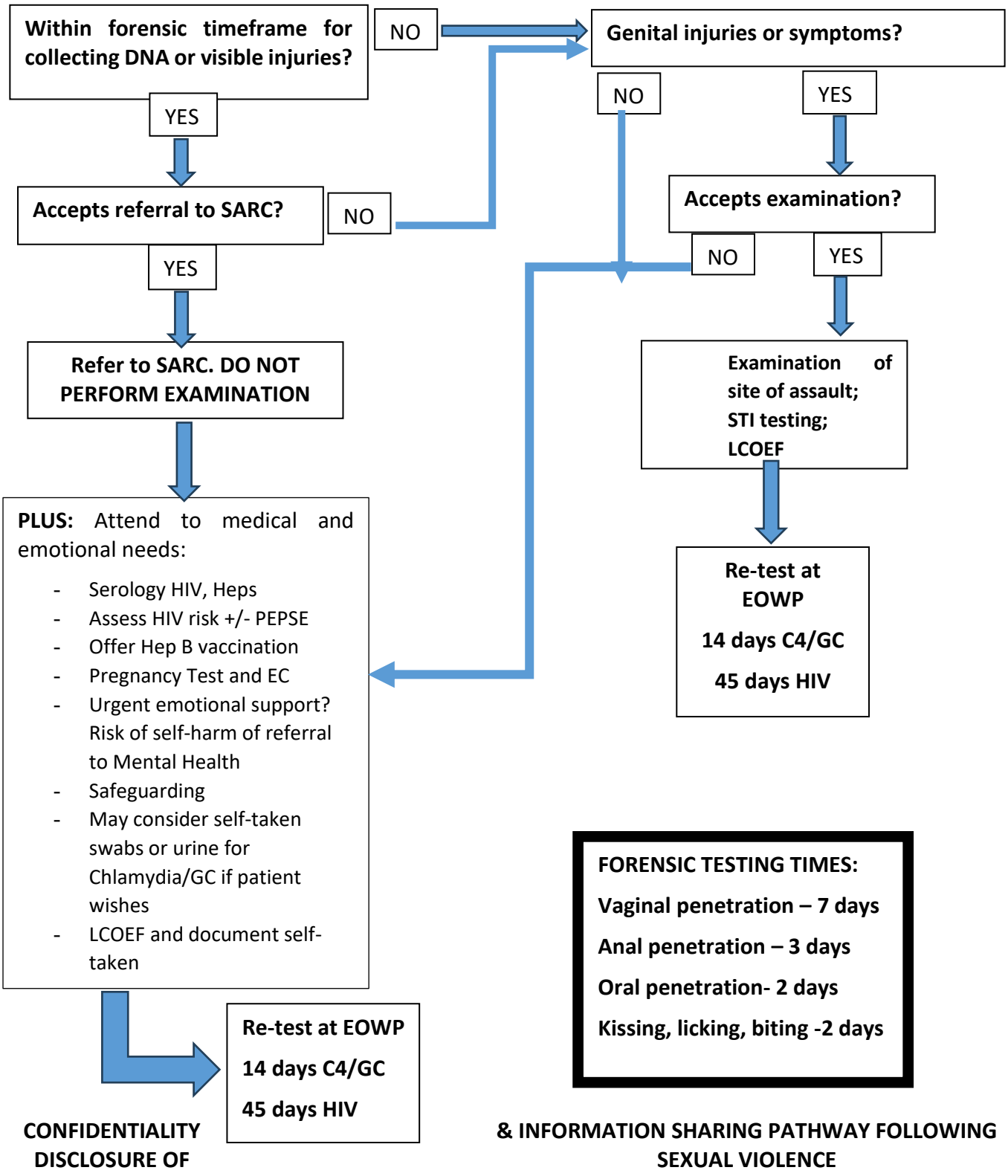
6. The proportion of patients for whom there is documentation of enquiry regarding previous, current or ongoing domestic abuse – target 97%.

7. The proportion of patients for whom there is documentation of assessment of need for and (where appropriate) offer of emergency contraception – target 97%.

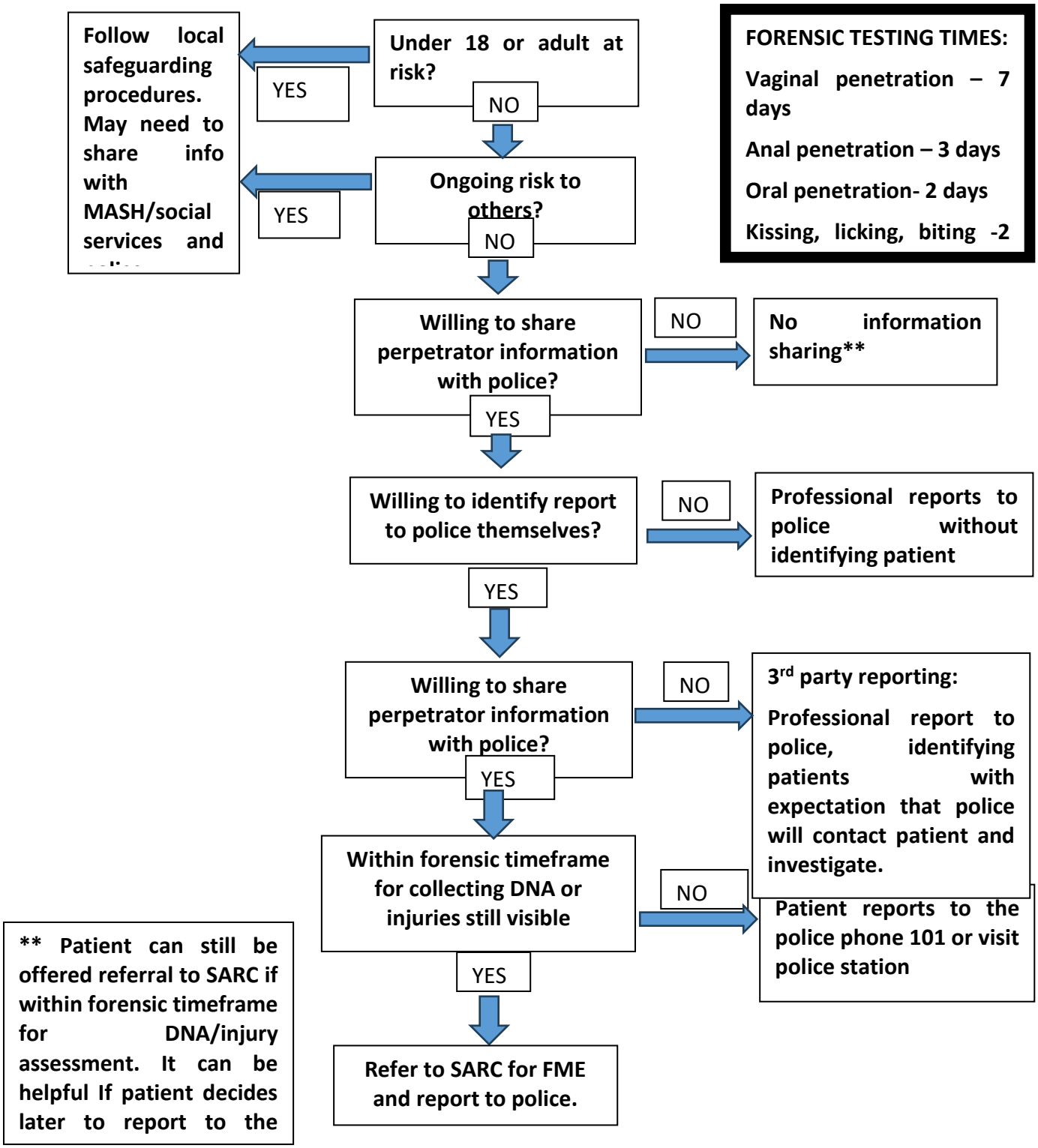
8. The proportion of patients for whom there is documented advice about or evidence of pregnancy testing after the appropriate interval – target 97%.

9. Documentation of the offer of baseline testing for STIs and syphilis and blood borne viruses including HIV, hepatitis B and C infections -target 95%.

Summary of SA care pathway in accordance with guidance:



CONFIDENTIALITY DISCLOSURE OF & INFORMATION SHARING PATHWAY FOLLOWING SEXUAL VIOLENCE


Under 18 or adult at risk?
YES
Follow local safeguarding procedures. May need to share info with MASH/social services and
NO
Ongoing risk to others?
YES
NO
FORENSIC TESTING TIMES:
Vaginal penetration – 7 days
Anal penetration – 3 days
Oral penetration- 2 days
Kissing, licking, biting -2
Willing to share perpetrator information with police?
NO
No information sharing**
YES
Willing to identify report to police themselves?
NO
Professional reports to police without identifying patient
YES
Willing to share perpetrator information with police?
NO
3rd party reporting:
Professional report to police, identifying patients with expectation that police will contact patient and investigate.
YES
Within forensic timeframe for collecting DNA or injuries still visible
NO
Patient reports to the police phone 101 or visit police station
YES
Refer to SARC for FME and report to police.
** Patient can still be offered referral to SARC if within forensic timeframe for DNA/injury assessment. It can be helpful If patient decides later to report to the