Responding to Victims of Sexual Violence Who Present to the Adult Emergency Department - Full Clinical Guideline

Reference no.: CG-EMD/2021/018

1. Introduction

Patients who have been victims of sexual violence may present to the Emergency Department rather than the police, or they may attend the ED with the police. Sexual violence is a general term that encompasses rape, sexual assault, sexual abuse or any other kind of unwanted sexual act or activity. This guidance is designed to ensure that all aspects of patient care are considered when treating these patients. The main focus of this guideline is on the care of patients who have recently been assaulted but there is a section on how to care for those who may disclose historic sexual abuse.

The guideline is divided into sections:

1. General approach
2. History
3. Managing injuries
4. Infections
5. Pregnancy
6. Safeguarding considerations
7. Onward referrals
8. Disclosure of historic sexual abuse

2. Aim and Purpose

This guideline aims to provide clinicians with a standardised approach to the assessment and treatment of patients who present to the adult emergency department as victims of sexual violence. The guidance covers clinical and safeguarding aspects of care and highlights when patients require onward referrals, and where these referrals should be made.

3. Definitions, Keywords

BBV – blood borne viruses

DV – domestic violence

EC – emergency contraception

ED – emergency department

PEPSE – post-exposure prophylaxis for HIV

SARC – sexual assault referral centre

Sexual violence – rape, sexual assault, sexual abuse

4. Guidance

1. General approach

It is likely that these patients will be scared and distressed when they attend the ED. They will need to be given adequate time to feel comfortable talking about what has happened and to have discussions about the care we want to provide for them. How you approach talking about their assault may impact on what they choose to do next.

If the patient has been assaulted within the last 7-10 days offer them a referral to the Sexual Assault Referral Centre (SARC). This should only be done after treating any injuries and considering how to manage the risk of infections and possible pregnancy. The SARC can provide a safe space for a forensic medical examination and ongoing support but does not provide acute medical care.

DNA may remain for up to 72 hours, so advise the patient to avoid bathing, washing clothes, brushing teeth or drinking liquids prior to a forensic medical examination if this is what the patient wants. Keep clothes, particularly underwear, that the patient was wearing at the time of the assault.

Remember that victims of sexual violence can be of any gender, and may have been assaulted by those of any gender. Do not make any assumptions and always ask the patient.

Give the patient the choice of male or female clinician, and accept that they may not want to see a clinician of a particular ethnicity if this triggers memories of their assault. This may not always be possible, and there should be a balance between patient wishes, the need to provide treatment and the availability of staff in the ED.

2. History

It is important to take a careful history of the assault. You may find it difficult to ask some of the questions, but the details will help you to plan the care your patient needs. Document what your patient tells you carefully as your notes may be used in any future prosecution.

The history should include:

- Time, date and location of assault
- Number of perpetrators
- Details of perpetrators – are they known to the patient, ethnicity, any knowledge of the perpetrator's health e.g. blood borne viruses
- Any physical violence and injuries sustained. Consider high risk features such as attempted strangulation
- Any weapons used
- Sexual acts – oral, vaginal, anal, digital or penile penetration
- Ejaculation or condom use

You will also need to take a standard medical history including past medical history, medications including contraception, and a social history. It is important to identify whether there are any safeguarding needs either for the patient, or for any children in their household.

3. Managing Injuries

Treatment of any immediately life threatening injuries takes precedence over any forensic medical examination.

No pelvic examination should be performed unless there is bleeding requiring immediate treatment. Always ask about bleeding as patients may not volunteer this information.

It is unlikely that any forensic examination will be required in the Emergency Department but should it be needed then this should be carried out by an appropriately trained person. Should a forensic medical examination be required in ED the police should be contacted so that this can be arranged. If clothing is removed in the ED then this should be done carefully and should be kept in case required by the police.

The patient should be examined from head to toe looking for injuries. This includes looking in the mouth. Ideally document the injuries on a body map. If the police are already involved with the patient they may take photographs for their records. If the patient has wounds that require closure and wants police involvement, then contact the police before the wounds are cleaned and closed as the police may be able to arrange for these to be swabbed for DNA.

Provide treatment for all injuries and arrange appropriate follow up before the patient is discharged even if they will be attending the SARC.

4. Infections

There is a risk that the patient may contract blood borne viruses or sexually transmitted infections as a result of the sexual violence, and patients should be assessed for these.

Patients should have blood samples taken for HIV, Hepatitis B and Hepatitis C screening if they consent to these tests. The results do not need to be reviewed before the patient is discharged from the Emergency Department. Prior to discharge the patient should be informed that they need to be reviewed at a sexual health clinic for these results (details are at the end of this guideline), or their GP.

Hepatitis B: The initial screening blood test should be HBsAg. If positive the lab will automatically look for other markers of hepatitis B infection to look for chronicity.

All patients who have not previously completed a full course of Hepatitis B vaccination should be offered immunisation for Hepatitis B.

They should receive an accelerated course with doses at Day 0, 1 month, 2 months and 12 months post-exposure. They should receive a 20mcg dose of an appropriate vaccine. When patients are discharged they need to be aware that they will require further doses of

vaccination and their GP should also be informed. Hepatitis B vaccination course can also be completed at the sexual health clinics.

Hepatitis B immunoglobulin 500units i.m. should be given to a non-immune patient who has been sexually assaulted by someone who is known to have Hepatitis B infection. See the Hepatitis B Post Exposure Prophylaxis Guideline on Koha for further details.

Hepatitis C: The initial screening blood test should be Hepatitis C antibody testing. Further confirmatory testing will be required if this initial sample is positive.

HIV: There is a window of opportunity to start anti-retroviral treatment in those at risk of HIV infection after sexual assault, so decisions regarding starting post-exposure prophylaxis (PEPSE) will need to be made in the ED. PEPSE must be started as soon as possible and within 72hours of the exposure.

Any trauma resulting in breeches of the mucosal barrier will increase the risk of HIV transmission.

Risks of HIV transmission from a known HIV positive source.

Type of Exposure	Estimated risk of transmission per exposure from a known HIV-positive individual not on ART
Receptive anal intercourse	1 in 90
Receptive anal intercourse without ejaculation	1 in 170
Receptive anal intercourse with ejaculation	1 in 65
Insertive anal intercourse	1 in 166
Insertive anal intercourse not circumcised	1 in 161
Insertive anal intercourse and circumcised	1 in 909
Receptive vaginal intercourse	1 in 1000
Insertive vaginal intercourse	1 in 1219
Semen splash to the eye	<1 in 10,000
Receptive oral sex	<1 in 10,000
Insertive oral sex (receiving)	<1 in 10,000
Blood transfusion (1 unit)	1 in 1
Sharing injecting equipment (includes chemsex)	1 in 149

Needlestick injury	1 in 333
Human bite	<1 in 10,000

HIV PEPSE is recommended when the risk is estimated to be greater than 1 in 1000, and should be considered when the risk is estimated between 1 in 1000 and 1 in 10,000. Post-exposure prophylaxis is not recommended when the risk is less than 1 in 10,000.

In the UK, high risk groups of people would be men who have sex with men, intravenous drug users from high risk countries and people who have immigrated from high risk countries. This may influence your decision on whether to recommend PEPSE.

Following sexual assault PEPSE may be more readily considered as there is an increased risk after damage to mucosal membranes following trauma.

If you decide to start PEPSE you must:

- check HIV status (this does not need to be known before giving medication)
- send blood for Hepatitis B and Hepatitis C screening and syphilis testing
- check U&Es, LFTs, bone profile
- if patient is female perform a pregnancy test (these drugs are unlicensed in pregnancy)

Give the patient a PEP starter pack. This may need ordering from pharmacy, and it will contain either 3 or 5 days of medication and drug information leaflets. In the starter pack is:

- Truvada one tablet once a day
- Raltegravir 400mg twice a day
- Drug information leaflets

Common side effects include nausea/vomiting and loose stools as well as headaches and fatigue. The patient can be prescribed loperamide and/or cyclizine to manage the side effects of diarrhoea and vomiting.

Three days of treatment is not the full course so patients will need to attend a sexual health clinic for further medication and discussion. It is important that the patient contacts the sexual health clinic as soon as possible if they have been started on PEP as they will need a further assessment and prescription. The patient should be encouraged to make the appointment before they run out of PEP.

Sexually Transmitted Infections: Patients do not need to be given empiric treatment for sexually transmitted infections such as chlamydia or gonorrhoea. They will be screened and treated for these as needed when they attend the sexual health clinic.

Tetanus: If there are any wounds then consider the need for tetanus prophylaxis or immunoglobulin.

5. Pregnancy/Emergency Contraception

Female patients should all be offered a urinary pregnancy test, unless they have heavy PV bleeding that may affect the result (then offer serum pregnancy test). If the pregnancy test is negative and there is a chance that the patient could get pregnant from their attack then offer emergency contraception. A useful flowchart on the options for emergency contraception can be found at https://www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017/

There are several options available to a woman who wishes to proceed with emergency contraception. Details are available in the Emergency Contraception guideline on Koha but below are key points:

- The copper IUD is the most effective form of emergency contraception but cannot be inserted in ED, and may not be wanted after sexual violence. Thus, women wanting emergency contraception should be offered hormonal methods.
- Ulipristal acetate (UPA-EC) is more effective than Levonorgestrel (LNG-EC)
- If a woman has already taken UPA-EC then LNG-EC cannot be used in the following 5 days
- If a woman has already taken LNG-EC then UPA-EC may be less effective if taken in the following 7 days

Levonorgestrel (LNG-EC)

- Dose is 1.5mg PO as a single dose
- Licensed as emergency contraception for up to 72hours after UPSI. Ineffective if used more than 96hours after sexual intercourse
- If the patient has a BMI >26 or body weight of >70kg will need to take two tablets (3mg)
- Pregnancy rate after using LNG-EC within 72hours of UPSI is 0.6%-2.6%
- If a woman vomits within 3 hours of taking Levonorgestrel she should return as soon as possible for repeat treatment
- Side effects – vomiting, nausea, headache, dysmehorrhoea
- Check BNF for any cautions in who should have Levonorgestrel prescribed.

Ulipristal Acetate (UPA-EC)

- Dose is 30mg PO as a single dose
- Effective for up to 120hours (5days) after UPSI
- Overall pregnancy rate is 1-2% if administered within 120hours
- If a woman vomits within 3 hours of taking Ulipristal she should return as soon as possible for repeat treatment
- Effectiveness of Ulipristal may be reduced if the woman takes progesterone in the 5 days after taking Ulipristal
- Do not use in women taking liver enzyme inducing drugs and for 28days after they have been stopped
- Do not use at the same time as drugs that increase gastric pH
- Check the BNF for any cautions in who should have Ulipristal prescribed

Breast Feeding and Emergency Contraception

- Women should express and discard breastmilk for 7 days after taking UPA-EC
- Women should be advised that there is limited evidence that LNG-EC has no adverse effects on their breastmilk or infant

6. Legal and safeguarding considerations

Sexual assault and rape are serious offences and it is important to consider the safeguarding and legal implications of this, and whether disclosures must be made against the patient's wishes. These decisions may be very complex. If the patient does not want the police to be informed, and you believe that these disclosures must be made, seek help and advice. In the first instance you should discuss with an Emergency Medicine consultant and if there is no consultant in the ED speak to the Emergency Medicine consultant on call. The Trust safeguarding team can be contacted within normal working hours. The Trust legal team are also available to provide advice at all times, but they should only be contacted after discussion with an EM consultant.

There should be thorough documentation about how the decision to disclose information to the police and/or social care was reached. This should include the reasons why this was done and what information was disclosed. If the patient does not consent to information being shared then you should inform them about the disclosure and make it clear that this does not depend upon their consent. The amount of information disclosed should be the minimum required to achieve the purpose of the disclosure, and the number of people who receive the information should be as small as possible.

If the patient is a child (under the age of 18 years) then you must protect them by sharing information about abuse or seriously harmful sexual activity with relevant services, such as the police and social care[1]. This includes if the young person is being supplied with drugs and alcohol in order to get them to comply with sexual activity, or if they have been coerced into taking part in sexual activity. The patient may not report this as abuse but their consent is unlikely to be valid making this an assault.

If the patient is under the age of 13, or is older but lacks capacity to consent to sexual activity then this information must be immediately passed to the police and children's social care.

If the patient is an adult the GMC states that confidentiality is an important legal and ethical duty but is not absolute. You may disclose personal information to the police and/or social care without breaching the duty of confidentiality when any of the following circumstances applies[2]:

- the patient consents
- the disclosure is of overall benefit to a patient who lacks capacity
- the disclosure is required by law
- the disclosure is in the public interest.

A patient will only be considered to have capacity in this situation if they have the capacity to consent to sexual activity and capacity to decide whether or not to involve the police. If an adult patient has capacity then disclosure to the police should be considered only if this is in the public interest. Informing the police without the patient's consent may be in the public interest if others remain at risk of serious harm or death, for example from a person prepared to use weapons, or in cases of domestic violence where others or children are at risk. The GMC state that there are circumstances in which disclosing personal information without consent is justified in the public interest other than to prevent death or serious harm, but these circumstances are uncertain. Due to the difficulties in identifying these circumstances the GMC suggests that advice is sought from a Caldicott or data guardian or legal adviser not directly connected with the use for which disclosure is being considered.

Issues that should be considered before informing the police include:

- potential harm or distress to the patient arising from the disclosure
- potential harm to trust in doctors generally
- potential harm to others (specific individuals or in general) if we do not disclose
- potential benefits to the individual or society from the disclosure
- the nature of the information that is to be disclosed
- whether harms can be avoided or benefits gained without the disclosure.

It is possible to make anonymous reports of rape to the police that contain details of the assault without naming the victim, and this will allow police to understand crime happening in their area. In Derby/Derbyshire anonymous reports can also be made to SV2 by the patient who can then inform the police.

The Royal College of Emergency Medicine considers that there are four occasions on which the police can be informed against the patient's wishes:

1. Where the victim is a child
2. Where there are concerns about the welfare of the 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

Even if the patient refuses to involve the police it may be appropriate to make referrals to social care. The most likely examples of this is if the victim has been assaulted by a partner or ex-partner, particularly if they have children with the assailant. If domestic violence is revealed then the Safer Lives (CAADA-DASH) checklist should be completed, and a referral to the Multi-Agency Risk Assessment Conference (MARAC) if necessary. If there are concerns about the ongoing safety of the victim's children then a referral to Children's Social Care should be made. Adult safeguarding referral criteria are that the patient is over 18, be in need of care and support, and be at risk of suffering abuse or neglect and because of their needs be unable to protect themselves. If your patient meets these criteria then a referral to Adult Social Care should be made. Follow the normal processes to make these referrals.

7. Onward referrals

Sexual assault referral centres – all patients who have been victims of sexual assault within the last 7-10 days should be offered a referral to the local SARC. The SARC can provide forensic medical services if wanted, but also ongoing support and advice. Patients can choose to have a forensic medical examination without involving the police, and the samples can be stored for up to two years in case they change their mind. The SARC can provide advice regarding reporting to the police or anonymous reporting, and counselling and therapy at a later point. If the patient is aged under 18 they will need referring to the local hub for children.

In Derby/Derbyshire the local SARC is SV2 at Millfield House and can be contacted by the patient on their advice line 01773 746115 (and then choose option1). Appointments can then be made and will take place between 8am and 8pm. If the patient wants to attend the SARC but feels that they cannot make that telephone call then a health professional can call 03330 223 0099 and ask to speak to the nurse on call for Derbyshire. Patients who are attending the SARC with the police may have an appointment arranged at any time. If your patient wishes to see a male staff member then inform the staff at the time of making the appointment as this will need different arrangements.

In Staffordshire the local SARC is at Grange Park and can be contacted on 0800 970372. This SARC may be able to offer emergency contraception and assessment for infections as well as forensic medical examinations.

Police – ask the patient if they want to involve the police and offer to make that telephone call for them if they want. The police are able to arrange appointments at the appropriate SARC.

Sexual Health Clinics – Patients will need to attend their local sexual health clinic to undergo screening for sexually transmitted infections, further PEP supply and completion of Hepatitis B vaccination course. Ensure that they have the contact details when they leave the ED so they can arrange appointments.

In Derby/Derbyshire bookings can be made through an information and booking telephone line 0800 328 33883, or patients can use an online service at www.yoursexualhealthmatters.org.uk

For patients from Burton the contact phone number is 0300 124 5022, and the online service is at www.openclinic.org.uk

If the patient is attending the SARC this referral may be made for them but ensure that the patient knows to contact their local sexual health service for ongoing treatment.

Discharge – Does the patient have somewhere safe to be discharged to?

8. Disclosure of Historic Sexual Abuse

If a patient discloses that they are a victim of historic sexual abuse you will need to do the following:

1. Confirm with the patient whether they, or anyone they know is currently in danger from this perpetrator
2. If there are any immediate risks to children or other adults then contact the police
3. Listen to the patient and document what they are telling you
4. If the patient wants to report to the police they can contact 101
5. If the patient wants support they can contact their local SARC on the telephone numbers above.

5. References

1 0-18 Years: Guidance for All Doctors (GMC). Paragraphs 57-62

2 Confidentiality: Good practice in handling patient information (GMC). Paragraphs 9-25

3 Derbyshire Integrated Sexual Health Service Handbook

6. Documentation Controls

Development of Guideline:	Dr Sarah Midgley Emergency Medicine Consultant
Consultation with:	Dr Hayley Wood (Consultant in GUM/HIV) Jane O'Daly-Miller (Trust Safeguarding Lead) Kathryn Fearn (Associate Director of Legal Services)
Approved By:	Dr Peter Cull (ACD for Emergency Medicine, RDH) 9/11/2021 Dr S Hearing, Medical Division 25/11/2021
Review Date:	December 2024
Key Contact:	Dr Sarah Midgley

7. Appendices