

7. Healthcare and Forensic Medical Examination

This section sets out the processes for undertaking a healthcare and forensic medical examination.

The primary purpose of the healthcare and forensic medical examination for rape and sexual assault is to support the health and wellbeing of individuals and identify the health care needs of the patient (European Parliament 2013). The secondary purpose is to collect evidence that would support investigation and prosecution of crime.

The options available for forensic examination and evidence collection should be communicated to the patient. Should the patient wish to have a forensic medical examination this should ideally be carried out first in order to preserve as much forensic evidence as possible. In certain cases it may be appropriate to prioritise emergency medical care despite the possibility of some compromise of forensic evidence.

7.1 Healthcare Assessment and Aftercare

Key Points

- ✓ Supporting the healthcare needs of individuals is essential.
- ✓ Healthcare should be made available to all who have experienced rape or sexual assault irrespective of whether the individual chooses to report to the police and / or undergo a forensic medical examination
- ✓ A person centred, trauma informed approach should take account of specific individual cultural and health care needs
- ✓ Should the patient wish to have a forensic medical examination this should ideally be carried out first in order to preserve as much forensic evidence as possible.
- ✓ Copper Intrauterine Device (Cu-IUD) is the most effective method of emergency contraception and should be offered to all patients when clinically indicated
- ✓ Oral emergency contraception should be given as soon as possible after unprotected sex.
- ✓ Ulipristal acetate is more effective than Levonorgestrel but there are clinical situations in which Levonorgestrel is more appropriate.
- ✓ When the prescribing of post exposure prophylaxis following sexual exposure (PEPSE) is recommended, starter packs should be commenced as soon as possible and within 72 hours of an assault.
- ✓ Hepatitis B vaccine is highly effective at preventing infection if given shortly after exposure and should be offered to all who present within 6 weeks of exposure.
- ✓ HPV vaccination should be offered to those who do not have complete vaccine history, using current national guidance
- ✓ Offer STI screening at appropriate incubation periods to allow exclusion of STIs.
- ✓ Consider prophylaxis against bacterial STIs.

Healthcare should meet both immediate and on-going health needs including:

- Treating physical injuries that have resulted from the assault.
- Safety assessment.
- Emergency contraception where appropriate.
- Testing and arranging treatment for sexually transmitted infections post exposure prophylaxis against blood borne viruses and bacterial STIs.
- Psychosocial assessment and support.

7.1.1 Assessment of Need for Emergency Contraception

Sexual assault may place women and trans-men of reproductive age at risk of unwanted pregnancy. The healthcare professional should assess the need for and provide emergency contraception. Whether emergency contraception is required and the most suitable method will depend on:

- Nature of the sexual assault.
- Time since assault.
- Any current pre-existing method of contraception.
- Menstrual status, cycle and last menstrual period (LMP).
- Other episodes of Unprotected Sexual Intercourse (UPSI) in current cycle.
- Co-existing medical conditions and medications.

Copper Intrauterine Device

- The Faculty of Sexual and Reproductive Health (FSRH) [Clinical Guidelines on Emergency Contraception](#) (2017) recommend that all people at risk of pregnancy after sexual assault are offered a Copper Intrauterine Device (Cu-IUD) if within the appropriate timeframe as it is the most effective method of emergency contraception.
- If fitted within 5 days after UPSI or ovulation, the pregnancy rate is extremely low.
- Antibiotic cover for STI should be considered if a person opts for Cu-IUD insertion.
- If a person accepts the offer of forensic examination it should be explained that clinical examination and Cu-IUD insertion should be deferred until after forensic examination has taken place in order to maximise potential for capture of assailant DNA.
- Some people may choose to prioritise pregnancy risk reduction and Cu-IUD insertion above forensic examination if there is to be a delay in arranging the latter.
- Healthcare professionals should ensure that they provide adequate information to allow a person to make an informed choice in this regard, dependent on their own priorities; it is important that their decision is respected.

- If a woman opts to have a Cu-IUD inserted after forensic examination, the Forensic Examiners should arrange for Cu-IUD insertion to be carried out without delay after the forensic examination has taken place.
- Oral EC should be offered in the interim in case the Cu-IUD cannot be inserted or the person later changes their mind about Cu-IUD insertion.

Oral Emergency Contraception

- People who choose and are eligible for oral emergency contraception after sexual assault should be offered it as soon as possible.
- There are two hormonal preparations licensed for use in the UK:
 - Ulipristal acetate licensed up to 120 hours after UPSI.
 - Levonorgestrel licensed to use up to 72 hours after UPSI.
 - Ulipristal acetate is more effective than levonorgestrel but there are some circumstances in which Levonorgestrel may be most appropriate; consult local guidance or FSRH guidance on emergency contraception (The Faculty of Sexual and Reproductive Health (FSRH) [Clinical Guidelines on Emergency Contraception](#) (2017)).

Follow up arrangements for pregnancy testing should also be discussed.

7.1.2 Assessment of Pregnancy Risk and Pregnancy Diagnosis

It may become apparent that current pregnancy as a result of sexual assault is a possibility. Testing for this should be undertaken with consent either as a baseline or for diagnosis. This should include consideration of a repeat pregnancy test at an appropriate interval if required.

Both practical and emotional support for the individual should be offered. There should be pathways in place to access services which support patient choice, both for continuing with any pregnancy and options relating to termination.

A discussion regarding the forensic significance of a child or products of conception from a miscarriage or termination of any pregnancies resulting from rape can be considered if and when appropriate. The ethics and legalities in such a situation are complex and advice should be sought. Further information is available from the FFLM (2016) [Guidance on paternity testing](#).

If products of conception are seized for DNA analysis these should be in a plain container and frozen and **not placed in formalin** as is usual practice following termination.

Sharing of such sensitive clinical information with the investigating police team should be as appropriate, with the patient's knowledge and with the patient's consent.

7.1.3 Testing for, Prevention Against, and Management of Sexually Transmitted Infection

Rates of Sexually Transmitted Infection (STI)s following sexual assault vary depending on the population studied, known risk factors for STIs and the sensitivity of the test used for identifying the STI. STIs are identifiable at varying periods of time post-exposure depending on the incubation period of the infection.

The British Association of Sexual Health and HIV (BASHH) produce guidance on prevention, screening and management of STIs. Forensic Physicians should consult the most up to date publications at: <https://www.bashh.org/guidelines>

7.1.3.1 Testing for Sexually Transmitted infections

- Any screening samples for bacterial STIs (Chlamydia, Gonorrhoea and Trichomonas) should be taken **after** forensic samples. Due to incubation periods samples for bacterial STIs are not usually undertaken until 14 days after the incident. (BASHH guidelines)
- In circumstances where a positive screening sample is likely to be of forensic significance (where minimal chance that the person could have acquired infection from anyone other than the assailant can be evidenced, usually in child cases or people without than previous sexual activity), baseline samples should be taken at time of examination and again 14 days post incident
- Only samples of potential forensic significance should be sent with the chain of evidence form (see local standard operating procedures).
- Consider further advice from local Genitourinary Medicine, Sexual and Reproductive Health clinician Microbiologist (NHS Education Scotland 2017).
- Testing for some STIs (HIV, Syphilis and Hepatitis) is by blood testing. Serum samples saved immediately, or soon after the disclosure of sexual assault, can be tested after 3 months if any of the above mentioned blood tests are positive at follow up, as negative saved serum may indicate an association between the alleged assault and the acquisition of infection.

It is important that there are appropriate care pathways for testing and defined protocols for management of any STIs. See: BASHH (2012) [UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault](#).

It is important to acknowledge that the identification of an STI in the immediate period after sexual assault is seldom useful in court and wrongly risks adverse inference on the individual's character. Any request from COPFS for medical notes/ STI screening should be explored and a court order provided. Unless there is relevance to the crime on trial for the testing / result it should not be disclosed. Further information on the sharing of personal sensitive information for court proceedings can be found in the [communication released](#) by the CMO in 2016. Information sharing is being explored further by the Information Governance Group under the Taskforce.

7.1.3.2 HIV Post Exposure Prophylaxis (PEPSE)

In cases of sexual assault, risk assessment for HIV transmission is required. A risk assessment should include:

- Nature of sexual assault.
- Time since exposure.
- Current HIV status and previous exposure.
- Details of assailant if known – i.e. risk that they will be HIV positive.

Further guidance on this is available in: [UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure](#) (BASSH 2015) and in local Board protocols.

- When the prescribing of post exposure prophylaxis following sexual exposure (PEPSE) is recommended, starter packs should be commenced as soon as possible and within 72 hours of an assault.
- Baseline blood and urine testing, including HIV testing, should be undertaken before PEPSE is prescribed.
- Advice should be given on:
 - the lack of conclusive data about the efficacy and long-term toxicity of HIV PEPSE;
 - potential risks and side effects;
 - the need to continue treatment for 28 days if baseline HIV test is negative;
 - the need for a follow up HIV test at 8-12 weeks (dependent on local protocol);
- Prescribing clinicians should check for interactions with prescribed or over the counter preparations on www.druginteractions.org.
- Appropriate follow up should be in place as recommended in the most recent BASHH/BHIVA guidelines.

7.1.3.3 Hepatitis A

- Given the prevalence of this virus amongst men who have sex with men consider the risk of Hepatitis A.
- Hep. A vaccine can be given up to 14 days after exposure provided the source was in the infective period (likely to be unknown in cases of sexual assault).
- Immunoglobulin is also an option if given in appropriate timeframe if history of jaundice in the contact source (unlikely to be known in sexual assault setting).
- Immunoglobulin within a few days and up to 2 weeks offers protection if in contact with infectious source. It may reduce symptoms if given up to 4 weeks.

See: [2017 Interim update of the 2015 BASHH National Guidelines for the Management of the Viral Hepatitides](#) (BASHH 2017)

7.1.3.4 Hepatitis B

Hepatitis B testing is recommended for all people who present after rape or sexual assault.

See: [United Kingdom National Guideline on the Management of the Viral Hepatitides A, B and C](https://www.bashhguidelines.org/media/1161/viral-hepatitides-2017-update-18-12-17.pdf) (BASHH 2015) updated 2017
<https://www.bashhguidelines.org/media/1161/viral-hepatitides-2017-update-18-12-17.pdf> Where there is a known risk of Hepatitis B transmission, refer to local protocols and clinical pathways.

Vaccine

- Hepatitis B vaccine is highly effective at preventing infection. Ideally immunisation should commence within 24 hours of exposure, although it should still be considered up to 6 weeks after exposure.
- A booster vaccination should be given to people who have been vaccinated and there is a history of contact with a high risk source.

Immunoglobulin

- Hepatitis B immunoglobulin is used after exposure to give rapid protection until the vaccine becomes effective.
- As the vaccine alone is highly effective, the use of Hepatitis B immunoglobulin in addition to the vaccine is **only** recommended in high-risk situations or in a known non-responder to vaccine.
- When necessary, Hepatitis B immunoglobulin should also be given at the same time as vaccine, ideally within 24 hours of vaccine, although it may still be considered up to a week after exposure (Public Health England 2017).

(See: [The Green Book Hepatitis B: chapter 18](#) Public Health England: June 2017)

7.1.3.5 Hepatitis C

- There is some evidence in high risk situations (known HCV positive source) that early treatment may be effective if there has been parenteral exposure and should be discussed with local specialist genitourinary medicine or infectious diseases clinicians. There is currently no vaccination.

7.1.3.6 Human papilloma virus (HPV)

- There is a Scottish vaccination programme in place for young women and for men who have sex with men up to the age of 45. Vaccination should be considered for eligible people who have not commenced vaccination schedule or with incomplete vaccination history.

The vaccine should be administered at the time of the initial examination, and follow-up dose administered at 1–2 months and 6 months after the first dose.

7.1.3.7 Bacterial Sexually Transmitted Infections

- In the interests of antibiotic stewardship, offering testing for STIs after the appropriate time frame - rather than antibiotic prophylaxis - should be the default.
- Sampling methods are fairly non-invasive with the option of self-taken swabs and therefore tolerance of examinations need not be a deciding factor.

- Consideration should be given to providing prophylactic treatment against bacterial STIs (Chlamydia, Gonorrhoea and Trichomonas), using a pragmatic approach based on the individual clinical picture and circumstances, for example if someone is likely to default from clinical follow up.
- Local protocols will depend on local prevalence of infection and patterns of antibiotic resistance.

See: British Association of Sexual Health and HIV (BASHH) (2012) [UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault](#) (BASHH 2012).

7.1.4 Timelines for testing for STIs and offering vaccination

Testing and prophylaxis for bacterial STIs and blood borne viruses after disclosure of rape or sexual assault		
Immediate needs - disclosure within 14 days of assault	Disclosure after 14 days	Presentation over 3 months
<ul style="list-style-type: none"> • Baseline HIV and hepatitis tests or save serum sample • Commence HIV PEPSE if appropriate (within 72 hours) • Commence Hepatitis B vaccination (and Hepatitis B immunoglobulin if assailant likely or known to be surface antigen carrier) • Consider eligibility for HPV vaccination • Arrange appropriate testing, completion of PEPSE treatment and vaccination schedules • Consider option for prophylaxis against bacterial STIs if IUD as emergency contraception or high risk of no future engagement with services 	<ul style="list-style-type: none"> • Offer of baseline testing for STIs • Adapt the follow-up schedule accordingly: <ul style="list-style-type: none"> ○ HIV serology – testing at 4 weeks after risk will identify majority of HIV positive ○ Hepatitis B serology ○ Hepatitis B vaccination (if less than 6 weeks since sexual assault / rape) ○ Hepatitis C serology (minimum of 4 weeks post incident) ○ Syphilis serology (minimum of 4 weeks post incident) ○ Arrange appropriate testing, completion of vaccination schedules and any treatment of existing STIs identified ○ Carefully consider prophylaxis for bacterial STIs 	<ul style="list-style-type: none"> • Offer tests for bacterial STIs • Offer Syphilis, Hepatitis B and C and HIV serology • Consider eligibility for vaccination schedules depending on personal and clinical circumstances of any ongoing risks of exposure.

Useful resources

British Association of Sexual Health and HIV (2012) [UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault](#)

British Association of Sexual Health and HIV (2015) [United Kingdom National Guideline on the Management of the Viral Hepatitides A, B and C](#)

British Association of Sexual Health and HIV (2015) [UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure](#)

British Association of Sexual Health and HIV (2017) [2017 Interim update of the 2015 BASHH National Guidelines for the Management of the Viral Hepatitides](#)

Centre for Disease Control and Prevention (2015) [Sexual Assault and Abuse and STDs](#)

Faculty of Sexual and Reproductive Health (2017) [Clinical Guidance: Emergency Contraception](#).

Faculty of Forensic and Legal Medicine (2016) [Guidance on paternity testing](#)

Public Health England: (June 2017) [The Green Book Hepatitis B: chapter 18](#)

7.2 Psychosocial Risk Assessment

7.2.1 Assessment

It is important to ascertain the immediate and future safety of people who have experienced rape or sexual assault.

This should include:

- Mental health and psychological needs.
- Risk of suicide and use of harmful coping strategies.
- Any previous self-harm or recent suicidal ideation.
- Safety and ongoing risk particularly in vulnerable patients. This should include stalking. Their home may be a crime scene and / or the perpetrator may know where the person lives and they may feel at ongoing risk as a result.
- Domestic abuse, including coercive control.
- Alcohol and drug history.
- Risk to others
- Child protection issues (for further details on this, please [see national guidance](#)).

In cases associated with domestic abuse a risk identification checklist should be used, such as the one developed by Third Sector Organisation SafeLives Risk Identification Checklist (RIC) should be completed and appropriate information

sharing and referral undertaken. This is included in Appendix B. Guidance and further information can be found on the [Safe Lives](#) website.

The RIC forms part of the clinical record and is not part of the forensic documentation.

Where there is police involvement, Police Scotland will use a domestic abuse questionnaire (DAQ). Where issues of risk are identified, this should be shared appropriately between agencies, according to local protocol, to avoid duplication and aid management.

Alternative safe accommodation may need to be sourced with assistance from investigating Police Officers, Violence Against Women services or Local Authority Social Work or Homeless services.

Legislation, as outlined in the [Adult Support and Protection \(Scotland\) Act 2007](#), may require sharing information in particular circumstances with Social Work. The Act defines an adult at risk as are adults who-

- are unable to safeguard their own well-being, property, rights or other interests.
- are at risk of harm.
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

An adult is at risk of harm if:

- another person's conduct is causing (or is likely to cause) the adult to be harmed, or
- the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

It is important to consider if child protection is an issue. If the person affected by sexual violence is the main carer of children and their psychological wellbeing is affected they may require additional support. Check out current support resources in place. Where there are concerns and a lack of current support systems, discuss additional support options with Social Work to allow for child protection procedures to be followed. [See national and local guidance for child protection.](#)

7.2.2 Support and psychological care

Contact by a support worker in the days following the forensic consultation offers the opportunity to discuss with the patient any aftercare needs and identify any new health or social care needs or concerns. Timely referral to further support or counselling can take place if support mechanisms are in place to monitor when normal coping mechanisms fail to resume.

Anxiety and depression after sexual assault appear early and are common. The majority recover whilst a minority will go on to develop Post Traumatic Stress Disorder (PTSD).

Resources

The [Safe Lives](#) Dash Risk Identification Checklist

7.2.3 Consideration of specific health care needs

It is beyond the scope of this pathway to include consideration of all conditions that may require consultation and examination to be adapted to suit the individual's needs. All individual specific health care needs should be assessed, managed and supported in accordance with all respective guidance and pathways.

Local pathways should be in place for use of interpreters including British Sign Language interpreters, for support for those with learning difficulties. See Section 8 for information specific to adults with incapacity.

Useful Resources

General Medical Council (2018) [Transhealthcare](#)

Rape Crisis Scotland (2014) [Supporting LGBTI survivors of sexual violence](#)

Scottish Government (2016) [Scotland's National Action Plan to Prevent and Eradicate FGM](#)

7.3 Preserving Forensic Evidence

Forensic examination and evidence collection supports the judicial process. The options available for forensic examination and evidence collection should be communicated to the individual.

Should the individual wish to have a forensic medical examination this should ideally be carried out before health care examination in order to preserve as much forensic evidence as possible. See section 7.1 for examples of health care needs that might require prioritisation in particular clinical circumstances (treatment of wounds, emergency contraception). The forensic medical element of the examination will depend on whether the person consents to samples being taken and tested, for criminal justice purposes.

While awaiting forensic medical examination and collection of forensic evidence, depending on individual circumstances, this guide should be followed as closely as possible providing there is no interference with the individual's safety and they feel able to consent. The length of time productions with personal information will be held for should be in line with local policies and GDPR.

Where forensic medical examination is planned, every effort should be made to preserve forensic evidence and avoid contamination. There may however be situations where immediate clinical needs override this, in which case Forensic Physicians should be informed that this has occurred, and this should be recorded.

Consult: [FFLM Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) (July 2018).

If a police SOLO has been appointed they will take care of all the elements below. This limits the potential for contamination and ensures that the chain of evidence requirements is met.

If there is no police involvement, these principles should be followed to maintain forensic integrity of any productions that are to be stored in case of later police involvement. Further guidance will be developed for the management of people who wish forensic examination but have not chosen police involvement.

7.3.1 For All Types of Rape / Sexual Assault

- The type of seat the person sits on should be 'wipeable'.
- The person should be requested to avoid baths/showers/douching.
- If a condom was used, it should be retained.
- Where possible the person should be asked to avoid eating, drinking, including alcohol or smoking after the assault if it included oral penetration.

7.3.2 Vaginal & Anal Rape/Sexual Assault

If possible:

- Any sanitary protection worn at the time of the assault or afterwards should be saved.
- It is preferable to remove the tampon as part of forensic examination after external genital swabs taken.
- The person may prefer to remove the tampon themselves.
- If the person opts to remove before examination begins, explain that the forensic evidence on the skin may be lost.
- Document the order of swabs in relation to any tampons removed during the course of examination.

If possible, the person should not:

- Pass urine and/or open their bowel before forensic examination.
- Wipe the genital/anal area if they have to go to the toilet.

7.3.3 Oral Rape/Sexual Assault

If possible, the person should avoid:

- Brushing their teeth or use gargle in their mouth.
- Taking fluid or food.
- Smoking.

7.3.4 Clothing

If possible, the person should:

- Change out of the clothes worn at the time of the rape/sexual assault as soon as possible.
- Place each item of clothing in a separate paper bag (not plastic).
- Label immediately with identifying details, date and name of person labelling.
- Underwear, worn at the time of or after the incident, should also be collected and placed in a separate paper bag.

Healthcare professionals should avoid handling clothing. If clothing must be handled by health professionals it should be with double gloved hands.

If clothing has to be cut:

- It should be cut along the seams of the item.
- Do not cut through any damaged areas or breaks in a garment; which may be the result of the assault or use of weapons.
- Do not cut through blood, semen or fluid marks.

7.3.5 Wounds and Blood/Saliva/ Semen Stains

Blood, saliva or semen stains and injuries should have forensic swabs taken prior to cleansing wherever possible.

7.3.6 Collection of firearms residue and trace samples

E.g. Weapons, Restraints, Tape, Bullets, Paint, Glass, Soil:

- Do not talk, cough or sneeze over any specimens.
- Do not handle specimens, but if specimen must be handled then do so with double gloved hands.
- If bullets are handled then use double gloved hands – metal forceps should **not** be used.
- Contact forensic scientist on call for advice.

7.3.7 Early Evidence Kits

Early Evidence Kits - where made available - assist with the preservation of forensic evidence both for DNA (saliva and mouth swabs where oral sex has occurred) and for toxicology (collection of urine specimen in cases of suspected drug or alcohol facilitated sexual assault while forensic medical examination is awaited).

Usual content for Early Evidence Kits include:

- DNA free Gloves.
- Face mask.
- Mouth swab module.
- Mouth rinse module.
- Urine kit for toxicology.
- DNA free wipe.

- Paper evidence bags for collection of clothing.
- Chain of custody labelling & form.

Where appropriate Police, or in cases without Police involvement, certain healthcare professionals trained in evidence collection, should retrieve early evidence in all cases with consent while forensic medical examination is being arranged.

If / when a Forensic Medical Examination is carried out on the individual, the Forensic Examiners should be informed that the Early Evidence Kit was used and whether urine and/or oral swabs have been taken.

7.4 Forensic Medical Examination

7.4.1 Introduction to the forensic medical examination

Using trauma informed principles:

- Ensure safety and build trust.
- Offer choice and control where possible.
- Maintain the individual's privacy and dignity at all times.
- Minimise re-traumatisation by avoiding identified triggers.
- Keep the individual informed of processes and changes.

This examination may include:

- a detailed head to toe examination.
- identifying the presence or absence of injury – any injuries requiring immediate medical treatment.
- identifying any medical conditions that may affect interpretation e.g. skin conditions, bleeding disorders.
- contributing to informing an opinion on timing, mechanism and causation of injury.
- documenting and interpretation of any forensically relevant features or injuries.
- collection of appropriate forensic specimens in accordance FFLM [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) (FFLM 2018).

It is important the clinician does not re-traumatise the individual by re-interviewing or straying into the role of investigator.

Should the patient wish to report to the Police, the full history of the incident and recording of the statement is the remit of Police Scotland, not the Forensic Physician.

The following information should be recorded prior to commencing the examination:

- Date and time when healthcare services contacted.
- Date and time (24 hour clock) of the examination.

- Date and time (24 hour clock) of incident.
- Time interval from incident until examination.
- Location of the examination.
- Name of any other person present (e.g. interpreter).
- Where the police are involved – the SOLO's details.

7.4.2 Key elements in a forensic medical history

The purpose of taking a history in forensic medical examination is to determine any information that may assist with both assessing therapeutic needs of the individual and to aid interpretation of forensic findings.

General History

- Past relevant medical/surgical/psychiatric/family history
- Allergies
- Medications
- Social history:
 - alcohol intake/cigarettes
 - drug use, including illicit and prescription substances
- Vulnerabilities
 - learning/ developmental disabilities
 - Sexual orientation / identity
 - Cultural issues
 - Harmful coping strategies
- Home circumstances, with a view to discharge planning
- Menstrual cycle
- Date of last menstrual period
- Tampon/sanitary pad use
- Obstetric history (including details of multiple and still births and miscarriages)

The patient is asked if they had sexual intercourse within the last 7 days

If yes:

- Type and frequency of sexual experience.
- Use of a condom.
- Contraceptive use.
- Possibility of current pregnancy.

Forensic History

- Number and identity of the reported attacker(s), if known.
- Date and time of the incident and the time lapse from the incident.
- Location where incident took place.

Type of sexual acts that the patient reported occurred:

- For a female: contact with the vagina/anus/mouth/breasts and other locations on the body.

- For a male: contact with the mouth/anus/genitalia or other parts of the body
- Consideration as to whether and where ejaculation took place.
- Use of a condom.
- Use of objects to achieve penetration.
- Reported use of weapons or restraints.
- Any bites or other wounds.
- Any bleeding:
 - Menstrual bleeding.
 - Bleeding due to genital/anal injury.
 - Tampon/pad in place during incident.
 - Tampon/pad worn after incident.
 - Bleeding from any other part of the body at the time of the incident.
- After the incident, document whether the patient has:
 - Eaten/brushed teeth/washed out mouth (If the oral cavity was involved).
 - Bathed/showered.
 - Changed clothes, including panties/underpants.
 - Opened their bowel (If anal involvement).
 - Passed urine, if yes, how many times since the incident and the time they last urinated.
- Actual, threatened or perceived violent behaviour used in the course of the incident.

7.4.3 Forensic examination procedure

- The forensic examiner and the corroborating witness on the recommended personal protective equipment (PPE) in order.
- PPE should be donned in the following order:
 - Face mask and beard snood (if applicable)
 - Mob cap
 - Disposable gloves (pair 1)
 - Gown/coveralls or disposable sleeves Disposable gloves (pair 2)
 - Safety glasses or goggles (optional)

In addition to the examiner wearing the recommended PPE including facemask, powder free double gloves (nitrile) should be worn throughout the sampling process and when handling samples (including the tamper proof bags) with the top pair of gloves changed between sampling each different body area.

- If the examinee is wearing the same **clothing** and/or has not washed since event the individual being examined is asked to stand on the paper **ground sheet** provided when undressing to allow recovery of body fluids or foreign particles that may fall from clothing or body during examination.

- The clothing and ground sheet are then submitted as evidence. Similar consideration may be given to submitting any **couch cover** or **seat cover** if deemed likely to be relevant.
- Any condoms, sanitary wear (tampons or pads) or incontinence pads should be submitted as appropriate.
- The examinee is given a DNA free modesty gown to wear.
- The Forensic Examiner undertakes a detailed top to toe external examination to ascertain the presence of any injuries or their sequence. These should be measured and documented on body diagrams using recognised terminology for the type of injury and position detailed relevant to anatomical landmarks.
- Detailed genital and ano-genital examination should be undertaken with additional lighting and magnification ideally with colposcopy digital video documentation - see section 7.5.
- The [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) should be followed.
- The history and nature of the assault and timing of exposure or contact will determine which forensic samples are relevant to take.
- On Completion of the Forensic Evidence Collection:
 - Double Gloves are worn until the tamper evidence bag is sealed.
 - Check each sample is correctly labelled.
 - Patient's name.
 - Patient's Date of Birth (DOB).
 - Date and time sample was taken.
 - Sample description e.g. If related to a swab - Endocervical (1).
 - The Forensic Examiner signs each sample.
 - Each sample should also be signed the corroborating witness, or Police Scotland SOLO if present.
 - All specimens are packed in the tamper evident bags provided in the kit (except toxicology specimens).
 - The Forensic Examiner should complete all relevant information on the SPA support form and the form is signed and dated.
 - The form is attached to the outside in a sealed bag, with the patient's name, DOB identifiers and the date and time of examination on the outside.
 - Keep the toxicology specimens separated from the Sexual Offences Examination Kit i.e. they are not packaged together.
 - The Forensic Examiner and corroborating witness should provide witness statements to the police.

- Facility for the individual to wash/shower after examination should be offered. Food, drink and additional clothing may need to be offered.
- Individuals should have control in determining their own needs and arrangements for follow up care and support should be made. The person should be discharged to a safe environment, ideally accompanied by a family member, guardian, friend or support person. Consent to contact the person to remind them of future appointments and arrangements should be confirmed and the preferred method documented prior to discharge.
- If not already in contact, consent with Care Coordinator and Rape Crisis advocacy worker should be obtained.
- Information about support services should also be provided in an appropriate format.
- Detailed documentation is completed and report prepared.

7.4.4 Forensic sampling and sequence

Materials such as clothes and samples such as hair, blood, saliva, or sperm should only be taken if they can be used and processed according to available laboratory and legal requirements; if this is not possible then samples should not be taken

In general terms - relating to swabs for DNA, semen, blood, other body fluids or debris - two plain swabs should be taken from each relevant site, labelled with the two swabs numbered sequentially in the order taken as (1) or (2).

Follow the table outlined in the most recent [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#) (FFLM 2018).

Swabs from dry areas e.g. skin: the first swab to be taken should be moistened with sterile water and with moderate pressure rolled over the skin for 10 -15 seconds followed by the second dry swab rolled over the same area for 10 – 15 seconds. The swabs are then placed in the swab sleeve / tube and into the tamper evident bag.

National, standardised forensic kits should be available to assist with the following samples, which when taken should be done so in the sequence listed. In general non-intimate samples are taken before intimate samples and at the time of top to toe examination followed by the genital examination.

Useful resources

Faculty of Forensic and Legal Medicine (2018) [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#).

7.5 Role of Colposcopy in Sexual Assault Forensic Examination

An [Overview of the worldwide best practices for rape prevention and for assisting women victims of rape](#) undertaken by the European Parliament (2013 pg. 61) advises that 'forensic evidence collection should include colposcope examination'. In Scotland, the *National Guidance on the delivery of police custody healthcare and forensic medical services*, developed in partnership between the NHS, Police Scotland and the Crown Office and Procurator Fiscal Services states that:

“Colposcopes should be used where consent has been provided. The DVD recording from video Colposcopy provides the best quality of forensic evidence in relation to intimate examinations and enables the Crown to obtain, where necessary, the opinion of a medical expert not present at the examination. It also affords any defence medical experts an opportunity to view the recording”

Superior magnification and lighting provided by colposcopes increases the rate of injury detection. Colposcopy allows recording and imaging for peer review purposes and the potential to be used for second expert medical opinion and/or defence medical opinion. Colposcopes should therefore be available in every location where a forensic medical examination for individuals who have experienced sexual assault takes place. Colposcopic images cannot in themselves provide corroboration of the findings of forensic medical examinations.

Storage and Retention of Digital Images

In line with [Guidance for best practice for the management of intimate images that may become evidence in court](#) from the Royal College of Paediatrics and Child Health and the Faculty of Forensic and Legal Medicine, intimate images form part of the medical record and are retained by the NHS Boards (RCPCH and FFLM 2014). NHS Boards are therefore the Data Controller for the images. Images are stored in line with legislative requirements set out in the Data Protection Act 2018 and GDPR. All images should be coded and stored securely with password protection. Sharing of intimate images that form part of the medical record should only be done in circumstances where there is appropriate informed consent, or they are ordered to by a Judge or there is a public interest.

Further work on the storage and retention of digital images is being developed at this time and will be updated within the pathway once information is available.

Photographic Evidence

Photography of injuries may be useful addition to body map documentation and description of findings.

Consideration should be given to relevant photography by a trained individual if the examinee gives consent for their use as part of the clinical and/or forensic record. When seeking consent it should be made clear that photography is an important part of the investigatory process. When there is police involvement, photography will be undertaken by SPA photographer.

Consent to Photographs for use as Evidence

Before photographic evidence is taken, the patient must have given written consent and must be fully aware that the photographs may be shown in any subsequent court proceedings although this is unlikely. COPFS do not disclose copies of intimate photographs to the defence; disclosure would be facilitated by allowing the defence to come to a Procurator Fiscal's office to view the images.

7.6 Immediate and Long Term Follow Up

Key Points

- ✓ Services should have access to a broad range of immediately available services/expertise.
- ✓ It is not appropriate to expect people to coordinate multiple appointments themselves.
- ✓ Follow up appointments should be organised by the Service, including to other agencies such as Housing, Social Work and third sector organisations.
- ✓ All healthcare staff have a responsibility to act to make sure that all children and young people are protected from harm. This responsibility includes acting on concerns about a child or young person even if the child or young person is not your patient.

7.6.1 Referrals and Follow-up Care

Services need to have systems in place to enable patients to have access to a broad range of immediately available services/expertise, should the need arise e.g. Emergency Departments, gynaecology and mental health services, support and advocacy services, housing services.

Follow up appointments should be organised by the Service and support should be available to facilitate attendance at follow up appointments. Local arrangements will need to be developed, depending on the service model described above.

A multi-agency response may include agencies such as Housing, Social Work services, and third sector specialist services such as Rape Crisis. People with particular needs, e.g. homelessness or adults requiring support and protection, should be referred, with consent, to the appropriate Social Work Department. If the patient has previously been attending Social Work, then with the patient's permission the referral is made through their allocated Social Worker, to facilitate continuity of care.

It is not appropriate to expect people to coordinate multiple appointments themselves.

If concerns exist regarding domestic abuse/stalking/ongoing sexual violence/interpersonal violence, it is vital that as well as being provided with a place of safety if required, the patient should also be given information on their local support services including, but not limited to social work services, Police and sexual violence services.

After assessment, relevant examination and immediate treatment, a plan should be made with the individual for return to a safe environment, ideally accompanied by a family member, guardian, friend or support person. Consent to contact the patient to remind them of future appointments etc. should be confirmed and the preferred method documented prior to discharge.

7.6.2 Summary of attendance given to the individual

Information Leaflet in appropriate format which should include: <ul style="list-style-type: none"> • Date of attendance. • Tests/procedures performed. • Medications given. • Follow-up appointment date and time, and what will take place at that appointment.
Contact details for the service, and Police Scotland (where appropriate)
Instruction on the care of any injuries.
Medication instructions, if applicable.
Information re: Social Work referral.
If the patient consents a letter is provided for the G.P.
Letter for work, college, school, if required.
Phone number and printed information leaflet from Rape Crisis Scotland (in relevant accessible format).
Relevant information about relevant services, tailored to the person's needs, e.g.: <ul style="list-style-type: none"> • Domestic abuse • Interpersonal violence • Drug and Alcohol programmes

7.6.3 Where children are involved

Where concerns are raised about the potential significant harm to a child or young person they should be considered child protection concerns. All healthcare staff have a responsibility to act to make sure that all children and young people are protected from harm. This responsibility includes acting on concerns about a child or young person even if the child or young person is not your patient (Scottish Government 2013).

Appropriate referrals to social services should also be made for children who may be indirectly affected by an adult's attendance, e.g. where a child has witnessed a

sexual assault, alcohol and drug use in the home, children of patients with mental health concerns, or any child identified as being at risk by a perpetrator of sexual violence.

Children and young people living with domestic abuse are at increased risk of significant harm, both as a result of witnessing the abuse and being abused themselves. Children can also be affected by abuse even when they are not witnessing it or being subjected to abuse themselves. Domestic abuse can profoundly disrupt a child's environment, undermining their stability and damaging their physical, mental, and emotional health.

Problematic parental substance use can involve alcohol and/or drug use (including prescription as well as illegal drugs). It is important that all practitioners working with parents affected by problematic drug and/or alcohol use know the potential impact that this has on children, both in terms of the impact on the care environment through direct exposure to alcohol and/or drug use, and also the potential practical and emotional challenges presented in terms of the recovery process.

Each NHS Board / Local Authority should have policies and guidance in place for the identification, assessment and management of children affected by parental problematic alcohol and/or drug use.

For further information see:

- [National Guidance for Child Protection in Scotland](#) (Scottish Government 2014)
- [Child Protection Guidance for Health Professionals](#) (Scottish Government 2013)

Health Scotland defines Adverse Childhood Experiences (ACE's) as stressful events occurring in childhood including:

- domestic violence.
- parental abandonment through separation or divorce.
- a parent with a mental health condition.
- having experienced abuse (physical, sexual and/or emotional).
- having experienced neglect (physical and emotional).
- a member of the household being in prison.
- growing up in a household in which there are adults experiencing alcohol and drug use problems.

Further information on ACE's can be found on the [Health Scotland website](#).

7.6.4 Feedback

An anonymous feedback mechanism should be in place, whereby the person who has experienced a rape or sexual assault is given a feedback form (usually at the follow-up visit). If the patient wishes to participate in giving feedback regarding the

care they received, they may post back or deposit the completed feedback form in a designated collection box.

Useful Resources

Scottish Government (2014) [*National Guidance for Child Protection in Scotland*](#)

Scottish Government (2013) [*Child Protection Guidance for Health Professionals*](#)