

BASHH



British Association for Sexual Health and HIV

**National guidelines for the management of
individuals disclosing sexual violence in
sexual health services (2022)**

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GUIDELINE DEVELOPMENT GROUP MEMBERSHIP

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The Sexual Violence Special Interest Group membership includes Consultants, Speciality Trainees and Nurses working in Sexual Health Services. The current chair of the group holds the post of Associate Post Graduate Dean in Forensics for NHS Education for Scotland (NES). Representation of the Faculty of Forensic and Legal Medicine (FFLM) is reflected in the group membership that includes clinicians with membership by examination of the FFLM currently working in Sexual Assault Referral Centres (SARCs) in the UK.

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NEW IN THE 2022 GUIDELINES

- We emphasise the importance of a trauma-informed approach for all patients attending; providing a different interaction and relationship within the consultation to that experienced during the assault.
- We are clear that forensic examinations including swabs for potential DNA or semen analysis should be taken in facilities that are forensically secure e.g. a local sexual assault referral centre (SARC) only by forensically trained staff.
- We encourage efficient and effective information sharing and collaborative multi-agency working to support the decisions made by the patient.
- There is extensive detailed information within the appendices on confidentiality and information sharing.
- There is a new section on the management of survivors of exploitation & modern slavery (MSE).
- Information is included in the additional resources (AR) on accessing help and advice if an individual has experienced sexual violence abroad.
- In the additional resources section there are examples of forms and pathways available for local adaptation.
- A patient information leaflet has been developed to accompany this guidance.

Summary of recommendations for all sexual health services:

- Take sexual health histories that allow recognition of gender based or intimate partner violence.
- Ascertain and acknowledge the patient's priorities in the provision of care when a disclosure of sexual violence is made.
- Incorporate trauma informed principles of safety, choice, collaboration, empowerment and trust into patient management.
- Listen and accept the details of the account. Offer options and available resources and link with relevant support.
- Be aware of the impact and potential consequences of sexual violence and be aware and avoid potential physical or emotional triggers.
- Identify and appropriately respond to any safeguarding issues that may require appropriate referrals to statutory services.
- Explain the options available regarding police involvement and referral for forensic medical examination for the collection of potential DNA and other evidence. Remember, if a patient has chosen to be referred to a SARC for a forensic medical examination, as a self-referral or with police engagement, a genital examination should not be undertaken first in a sexual health setting.
- Undertake pregnancy and infection risk assessments and offer testing and treatment in response to details of the assault and the patient's needs.
- Assess psychological state and onward safety risk and enquire about the use of harmful coping strategies or pre-existing domestic abuse.

- Acknowledge the risk of re-traumatisation when disclosures are made. Minimise the number of times the patient must do this. Offer to share appropriate information on their behalf with other health care staff or agencies involved in their aftercare and recovery e.g. a summary letter to their GP.

SCOPE AND PURPOSE

This guidance replaces UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault 2011. It is aimed at health care workers in level 3 sexual health settings. It may also be helpful for other professionals and organisations who manage sexual violence disclosures. Many individuals do not disclose sexual violence and this guidance aims to provide guidance to support appropriate management when they do.

EDITORIAL INDEPENDENCE

This guideline was commissioned and edited by the Clinical Effectiveness Group (CEG) of the British Association for Sexual Health and HIV (BASHH), which provided funding for the literature search. No other funding was obtained.

CONFLICT OF INTEREST

All authors have declared no conflict of interest.

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/> and has been updated by

reviewing the previous UK National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault (2011) and publications since 1990.

A Google search of websites including the UK Department of Health, Crown Office, Crown Office and Procurator Fiscal Service (COPFS), Rape Crisis and British Crime Survey was conducted using the subject headings ; 'sexual assault' OR 'rape' OR 'sexual violence' OR 'sexual abuse' AND 'sexually transmitted Infections' OR "post exposure prophylaxis" OR 'HIV infection' OR Hepatitis B infection, OR 'adult' OR ' adolescent' OR 'male' OR 'client care' OR 'HPV (human papilloma virus) Vaccination' OR ' PTSD (post-traumatic stress disorder)' OR 'psychological' OR 'domestic abuse' OR 'suicide' OR 'eating disorder' OR 'sexual dysfunction' OR 'self harm' OR 'pregnancy'.

A database search of publications in the English language for the years 1990 -2018 was also undertaken. Databases included were; Ovid Medline, Medline daily update, Embase, Pubmed NelH Guidelines Database, Cochrane library.

Psychology and psychiatry (PsycINFO), Complementary medicine (AMED), British Nursing Index (BNI), Applied Social Sciences Index and Abstracts (ASSIA) were used only for the psychological queries.

Conference abstracts from IUSTI, BASHH, BHIVA, ICAAC, ASHM, ECCMID, between 2019 and 2021 were reviewed as were guidelines from the Centre for Disease Control and Prevention (CDC). Further references from articles identified were included. Article titles, abstracts and full texts of relevant articles were reviewed.

Relevant articles were prioritised and recommendations were made and graded, based on the best evidence available. There are challenges in recruiting consensually sexually active individuals as 'controls' for genital examination for research purposes or requesting re-

examination of a victim of sexual violence. The number of controlled trials and comparative studies are therefore limited.

Where there was a lack of evidence to underpin recommendations or if guidance was made on other best practice documents then good practice points (GPP) were adopted.

FUTURE GUIDANCE UPDATING

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

PATIENT AND PUBLIC INVOLVEMENT

Patient representation was sought from sexual assault referral services staff including support workers. Further feedback was requested and actively sought during the public consultation process. Patient representatives were involved in the development of the patient information leaflet that accompanies this guideline.

1. INTRODUCTION

1.1 Overview of 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 on line 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.¹

1.2 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

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 2017.⁷

1.3 Legislation and consent

Statutory frameworks for sexual offences in the UK are provided by the Sexual Offences Act 2003 (England and Wales), Sexual Offences Act (Scotland) 2009 and Sexual Offences Order (Northern Ireland) 2008. The most recent legislative changes are more 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.

In England & Wales the legal definition of consent is 'agreement by choice with freedom and capacity to make that choice'.⁸ In Scots Law the definition of consent is 'free agreement' both emphasising the absence of coercion and control.⁹ In law, there is no specific crime of child sexual exploitation. Offenders are often convicted for associated offences such as sexual activity with a child. Trafficking for sexual exploitation is an offence under The Sexual Offences Act 2003 in England and Wales.

1.4 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.¹⁰

SARCs are specifically established to manage patients following disclosure. However, initial disclosures are sometimes made in other health service settings. Sexual health services are a key area where a disclosure may be made.¹¹ Disclosures can be complex in nature and part of wider sexual and /or organised crime. There are also strong links between sexual violence and domestic abuse including forced marriage.

Recommendations:

- 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.(GPP)
- Disclosure of sexual violence is difficult and patients should be assisted as much as possible with this process.^{10,11} The structure of the service both in terms of clinic

environment and administrative processes should be considerate to the needs of patients disclosing sexual violence.(GPP)

- All sexual health services should routinely ask all users about sexual assault particularly those requesting STI screening, HIV PEP or emergency contraception and ensure these are provided in a timely fashion. This includes online services who should have appropriately trained staff and robust clinical pathways to ensure a prompt and supportive response.(GPP)

2 TRAUMA INFORMED PRINCIPLES

Trauma informed practice supports the recovery of those affected by trauma by providing them with a different experience of relationships, one in which they are offered safety rather than threat, choice rather than control, collaboration rather than coercion, and trust rather than betrayal.¹² Re-traumatisation is the vivid recall of traumatic events triggered by conditions or sensations that mimic those experienced during the original event. Following traumatic events, individuals may have heightened sensitivities to sensory stimulation. Each interaction provides an opportunity to reverse the association between trauma and relationships and is 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.^{13,14}

Recommendations:

We recommend incorporating into the consultation the trauma informed principles of Safety, Trust, Empowerment, Collaboration and Choice (GPP). This includes:

- Maintaining 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 (see [Section 5 Limits of Confidentiality and AR2](#))
- Establishing and maintaining rapport includes 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.

3. INFORMATION TO PLAN MANAGEMENT OPTIONS

The patient's needs following a sexual assault vary between individuals and alter from the time of presentation. [AR1](#) shows a summary pathway depending on the presentation and type of referral for any setting where an individual may present soon after a sexual assault. It may be adapted for local use.

A patient information leaflet available on the BASHH website has been developed to support this guidance. Patients should be offered a gender choice of clinician if possible and always offered a chaperone for examinations. Efforts should be made to explore this provision.

3.2 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. If a patient is fearful of not being believed because they are physically uninjured it may be appropriate to reassure them that an absence of injury does not negate their account.
- Ask about symptoms in order 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. Also ask about any sex since the assault.

- In those at risk of pregnancy from the assault or recent consensual sex, ask about menstrual and contraceptive history in order 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.
- There may be an opportunity to address related health promotion (e.g. HPV and/or Hepatitis A vaccine, overdue cervical cytology) and any pre-existing sexual health concerns or infections even when unrelated to the assault. For those who find genital examinations difficult following sexual violence, services such as ‘My body back’ may be helpful in maintaining good sexual health.¹⁵
- Asking 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, in order to assess the need for emotional support. For more information on services supporting those reporting sexual violence abroad see [AR 3](#).

3.3 Documentation

Careful documentation is essential. It is best practice to use standardised documentation and to record sentences verbatim where appropriate. Always remember to complete notes contemporaneously, date and time all entries and make them legible. 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.¹⁶

3.4 Forensic enquiry

Initial 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 in order to inform an individual when making their decisions. 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. For many places in the UK, this is likely to be in a SARC.

- 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 GPP

4. POLICE INVOLVEMENT

Information sharing options

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.

4.1 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 consent of the individual and only for intelligence purposes. 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.

4.2 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

possible that the police may choose to act on third party reporting information for the protection of the wider public.

4.3. 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. However, physical evidence, closed circuit television (CCTV) availability and witness accounts may lessen with the passage of time. It is recognised that victims of sexual crime are often unwilling to reveal or talk about their experiences for some time. The Crown Prosecution Service (CPS) or Crown Office and Procurator Fiscal Service (COPFS) (in Scotland) will decide on the appropriateness of progressing investigations in the public interest whatever the time frame between the incident and the crime being reported.

4.4 No information sharing

The individual may decline any option of information sharing.

Domestic Violence and Abuse Disclosure Schemes

Domestic Violence and Abuse Disclosure Schemes (also known as Clare's Law) are available in all England and Wales,¹⁷ Scotland¹⁸ and N Ireland¹⁹ and let a person (over the age of 16 years) make enquiries to police where they are concerned that their partner or the partner of someone they know (such as a friend or relative) has a history of abusive behaviour. Informing patients of this option may be of value in enabling individuals to make informed choices about information sharing that supports them staying safe.

5. 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.²⁰

- The limits of confidentiality should be made clear early in the consultation. GPP

5.1 Children (under age 18)

Any sexual abuse disclosure would normally constitute “significant harm” and warrant a referral to local authority children’s care.²¹ 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.^{22,23} 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 local safeguarding procedures.(GPP)

See [AR 2](#) for more information on Confidentiality and Information sharing in young people

5.2 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. The Law is different in Northern Ireland where Article 5 of the Criminal Law Act (NI) 1967 outlines a duty of care to share information that may identify a suspect with police and a duty of police to investigate. This has historically related predominantly to terrorist offences but may be more widely interpreted by the Police Service of Northern Ireland (PSNI).

Recommendations:

- Professionals should be aware of the possibility of coercive control influencing the level of duress which may impede the individual's ability to make a decision freely.²⁴(GPP)
- 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.(GPP)

See [AR 2](#) for more information on confidentiality and Information sharing in adults

6. MEDICAL CARE (FME)

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.²⁵ (GPP)
- Assess immediate safety, including ongoing domestic abuse and arrange treatment of injuries then follow the pathway of care is detailed in AR 1.(GPP)

7. GENITAL EXAMINATION

If the patient has chosen to be referred for a FME, in order 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 hyper or hypo stimulation, for example 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. ²⁶ (GPP)
- 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 STIs.(GPP)

- If Female genital mutilation (FGM) is identified, follow local process. Guidance for management of FGM and regulatory frameworks differ in Scotland²⁷ and Northern Ireland²⁸ to those in England and Wales.²⁹ (GPP)

7.1 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.(GPP)

8. SEXUALLY TRANSMITTED INFECTION (STI) TESTING

Signposting: 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.³⁰

- Consider appropriate incubation periods and offer appropriate testing.
- Where the finding of an STI may be of forensic significance, a chain of evidence form should accompany each sample taken.(GPP)

8.1 Evidence for STI rates after sexual assault

There is a paucity of evidence on the prevalence of STIs post sexual assault. An STI prevalence of 42% was seen in a small retrospective study of patients (n=40) aged 15-70 presenting after sexual assault in 2016 to an integrated UK sexual health service³¹. Prevalence rates of STI in child sexual abuse (CSA) cases were 19.7% (29/147) in a retrospective study of CSA cases in Hong Kong.³² In the above studies, chlamydia rates of 12.5% and 13% were described, rates of gonorrhoea 0% and 5%, rates of HSV 10% and 0.7%, rates of TV were 2.5% and 0.7%. HPV rates were not described in the adult cohort but in the child study, 1/147 (0.7%) of the children was reported to have genital warts.

8.2 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,

and “chain of evidence” documentation can be used.³³ 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 as a consequence, 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 (refer to [AR 5](#) on Forensic Significance of STIs). 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 (see [AR 6](#) for Royal College of Pathologists example form). 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.

8.3 STI testing

Patients should be offered opportunities to test at the end of the incubation period for each STI, home testing kits may be provided where appropriate. 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. 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. A pragmatic approach may have to be taken whilst balancing against unnecessary antibiotic prescribing. The additional complication of contact tracing suspects is introduced when a

patient tests positive for an STI. Undertaking this public health responsibility, whilst retaining patient confidentiality can be complicated. Any symptomatic patients should be managed as usual according to their symptoms.

8.3.5 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 (Grade 1A).
- We recommend BASHH PEP guidance is followed when considering use of PEP (Grade 1C)
- If PEP is given, the HIV follow-up testing should be conducted as recommended in the current BASHH PEP guidance.³⁴ (Grade 1B)
- We recommend that syphilis serology and Hepatitis B and C testing are offered after 3-6 months ³⁴ (Grade 1B)

9. PROPHYLAXIS FOR STIs

9.1 Prophylaxis against Bacterial STIs

Signposting: BASHH UK guidelines for specific infections

We do not recommend routine use of antibiotics for prophylaxis against STIs after sexual assault. Using bacterial prophylaxis may by exception, be indicated if the client presents during the two week incubation period for testing for chlamydia, gonorrhoea and trichomonas and is unlikely or unable to undertake timely repeat testing. The disadvantages 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. GPP
- 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, refer to the appropriate current BASHH guidelines.³⁴⁻³⁹

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

Signposting: BASHH UK Guideline for the use of HIV post-exposure Prophylaxis (PEPSE) 2021

- If the patient presents within 72 hours of sexual assault, then a risk assessment for acquisition of HIV should be performed (Grade 1D).

- Using the latest BASHH PEPSE guidelines³⁷ carry out a risk assessment for HIV. 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 (Grade 1C).
- 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.(GPP)
- Sexual health clinics should work closely with their local SARC's in immediate provision of PEPSE and/or follow up. (GPP)

The current BASHH 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>). 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. When initiating or continuing PEPSE, ensure drug-drug interactions are checked, baseline assessments have been completed and follow up arranged as per BASHH guidelines.

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 the 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, refer to Section 10.3, BASHH UK guideline for the use of HIV Post-Exposure Prophylaxis 2021.³⁴

9.3 Prophylaxis against Hepatitis A

Post exposure vaccination for Hepatitis A following sexual assault would only be recommended if within two weeks of a contact of a confirmed case or one week after onset of jaundice in the index case.^{40,41} Opportunistic hepatitis A vaccination may however be appropriately offered if falling within a risk group eg MSM, PWID or those with hepatitis B/C (see BASHH recommendations).⁴⁰

9.3 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 (anti-HBs).⁴²⁻⁴⁹ 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.^{41,50} Ideally, immunisation should commence within 24 hours of exposure, although it should still be considered up to a week after exposure.⁵⁰ 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. In addition, it is well established that most acute hepatitis B in adulthood is subclinical and the majority (>90%) clear the virus spontaneously with the development of immunity. Fulminant hepatitis B is very rare (<1%).

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.⁵⁰ Vaccine should be simultaneously offered. Further details on the indications and use of HBIG are available from Public Health England guidance.⁴

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. (GRADE 2C)
- 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. (Grade1C)
- The adult dose (20mcg /1ml) is licensed for use in those 16 years or over. A licensed lower paediatric dose (10mcg / 0.5ml) of Engerix® is used in children aged 15 years and younger on three-dose regimen. Adolescents aged 11-15 who are not likely to attend for three doses and are at low immediate risk can be offered a two-dose regimen using the adult 20 mcg preparation.⁵⁰

9.4 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.⁵¹ 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. Approximately 40% of women are infected with at least one type of HPV within two years of

their sexual debut (infection by multiple types is common).⁵¹ However most infections are transient and of no clinical significance. Effective condom use can reduce but not eliminate transmission risk.⁵¹ High-risk type, HPV16 is responsible for almost 60% and HPV18 for more than 15%, of all cervical cancers in Europe.⁵¹ Cervical cancer is the most common cancer in women under 35 in the UK. High risk HPV is also estimated to account for 90% of anal cancer, 40% of vulval, vaginal and penile cancer, and up to 60% of oropharyngeal cancers.⁵¹ HPV types 6 and 11 cause around 90% of genital warts, so using a vaccine stimulating immunity to these helps protect against both anogenital cancer, genital warts as well as rarer cancers of the head and neck. The vaccine does not contain any live virus, or even killed virus or DNA from the virus, so it cannot cause cancer or other HPV-related illnesses.

HPV vaccination was commenced in the UK in 2008 for girls and 2019 for boys. It is licensed from the age of 9 years. There is good evidence emerging that these HPV vaccination programmes have led to a marked decrease in cases of anogenital warts and CIN2+ lesions. This has been evident not only in those vaccinated but also older men and women due to herd immunity.⁵² Men who have sex with men (MSM) have not benefited in the same way from the past 12 years of the girls' vaccination programme, so may be left unprotected from HPV transmission. MSM up to and including the age of 45 became eligible for free HPV vaccination on the NHS when they visit sexual health and HIV clinics since 2016.^{53,54,55,56}

A recent literature review has outlined the potential use of HPV vaccines in a variety of therapeutic settings.⁵⁷ In particular the use of Gardasil to reduce the recurrence rate of high grade anal and vulval squamous intraepithelial lesions (HSIL).⁵⁸ However 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).

In the USA, the Centers for Disease Control and Prevention (CDC)⁵⁹ have taken a pragmatic approach for HPV vaccination post sexual violence, as outlined in the following statement:

*Because persons who have been sexually assaulted are also at risk for acquiring HPV infection, and the efficacy of the HPV vaccine is high, HPV vaccination is also recommended for females and males though age 26 years. These assertions have led the CDC to recommend that the HPV vaccination is... 'administered during the initial [post sexual assault] examination.'*⁶⁰

However, following a comprehensive literature search, we would recommend the following in the UK:

Recommendations:

- HPV vaccination is not routinely given post sexual assault to all adult survivors of sexual violence (SV) in the acute, post SV 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^{56,59,61,62} are advised and signposted to commence (or complete any incomplete) HPV vaccination courses.

10. PREGNANCY RISK ASSESSMENT & EVIDENCE POTENTIAL

10.1 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.⁶³
- 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 (and sometimes earlier than this).
- 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 biopsy can assist in deciding whether to proceed with or terminate the pregnancy⁶⁴. The procedure can be arranged via a local obstetric department.
 - Using products of conception (POC) as evidence
- 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 following delivery.(GPP)
- If termination with use of POC as evidence is the preferred option of the patient,

arrangements should be made with the police demonstrating use of a chain of evidence.(GPP)

11. ONWARD REFERRAL AND PSYCHOLOGICAL SUPPORT

A detailed assessment and management of the psychological consequences of sexual assault is 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 risk of developing Post Traumatic Stress Disorder (PTSD).⁶⁵ According to the diagnostic criteria, PTSD is a disorder which can develop in response to specific traumatic events and is described as a persistence of several of these distressing symptoms including re-experiencing events, emotional dysregulation, sleeping disorders, intrusive thoughts amongst others.⁶⁵ Not all individuals exposed to traumatic events develop PTSD. Treatment includes trauma focussed cognitive behavioural therapy (CBT) or Eye Movement Desensitisation Reprocessing (EMDR). It may be possible to offer an intervention after the potentially traumatic events, but before PTSD has become established with the intention of reducing the symptoms and preventing its development.^{65,66}

Recommendations:

- Signposting and referrals for psychological assessment and intervention should be 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.⁶⁷ (GPP)
- Signpost to support, and with consent communicate with the patient's GP. (GPP)

12. DISCLOSURE OF MEDICAL NOTES

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 inline with governance requirements and Caldicott principles are followed. (GPP)
- Any third parties named in the notes, with the exception of the suspect, should be redacted along with any other unnecessary information. (GPP)
- 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.(GPP)

13. MANAGEMENT OF SURVIVORS OF MODERN SLAVERY AND EXPLOITATION (MSE)

Signposting (GPP)

Modern slavery refers to the recruitment, movement, harbouring or receiving of children, women or men, through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.⁶⁸ Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.⁶⁹ Victims are likely to present to GUM and sexual health services.

Recommendations:

- Staff should complete appropriate training including knowledge of the National Referral Mechanism (NRM) (the government's identification and support mechanism).⁷⁰ They should also familiarise themselves with the Management of Survivors of Exploitation (MSE) wheel which can be a useful tool in clinical practice. (AR 7).
- When reviewing an adult or child who has disclosed sexual violence, consider other factors that indicate the individual is also a victim of human trafficking. An inconsistent story given by the patient and a lack of relevant documentation for identification purposes should certainly raise concerns and clinical suspicion that a person has been trafficked.
- Under the Council of Europe convention on human trafficking, a person identified as a victim of human trafficking, or a suspected victim of human trafficking for whom the recovery and reflection period has not expired, is exempt from overseas visitor hospital charges. GPs also have a duty to provide, free of charge, treatment which

they consider necessary or an emergency to any individual regardless if registered. Therefore, such an individual should still be afforded all the necessary medical, forensic and police interventions, as outlined in these sexual assault guidelines without incurring any delay.

- If you suspect modern slavery, report it to the [Modern Slavery Helpline](#) on 0800 121 700 or the police on 101. In an emergency always call 999.

AUDITABLE OUTCOMES

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

1. the proportion under the age of 18 for whom there is documentation of a safeguarding assessment 97%
2. the proportion for whom there is a documented assessment and (where appropriate) the offer of hepatitis B vaccination 97%
3. the proportion having a documented assessment and (where appropriate) the offer of post exposure prophylaxis against HIV infection. 97%.
4. the proportion...
 - a. having a documented offer of baseline testing for STIs, syphilis, HIV, Hepatitis B and C 97% *and/or*
 - b. completing baseline testing for STIs, syphilis, HIV, Hepatitis B and C 80%
5. the proportion for whom there is documentation of enquiry regarding previous, current or ongoing domestic abuse 97%
6. the proportion for whom there is documentation of assessment of need for and (where appropriate) offer of emergency contraception 97%
7. the proportion for whom there is documented advice about or evidence of pregnancy testing after the appropriate interval 97%
8. Documentation of the offer of baseline testing for STIs and syphilis and blood borne viruses including HIV, hepatitis B and C infections 95%
- 9 Among those attending Sexual Health Services reporting sexual assault, the proportion for whom there is documentation of assessment for and appropriate offer of or signposting to HPV vaccination as per UK guidelines 80%

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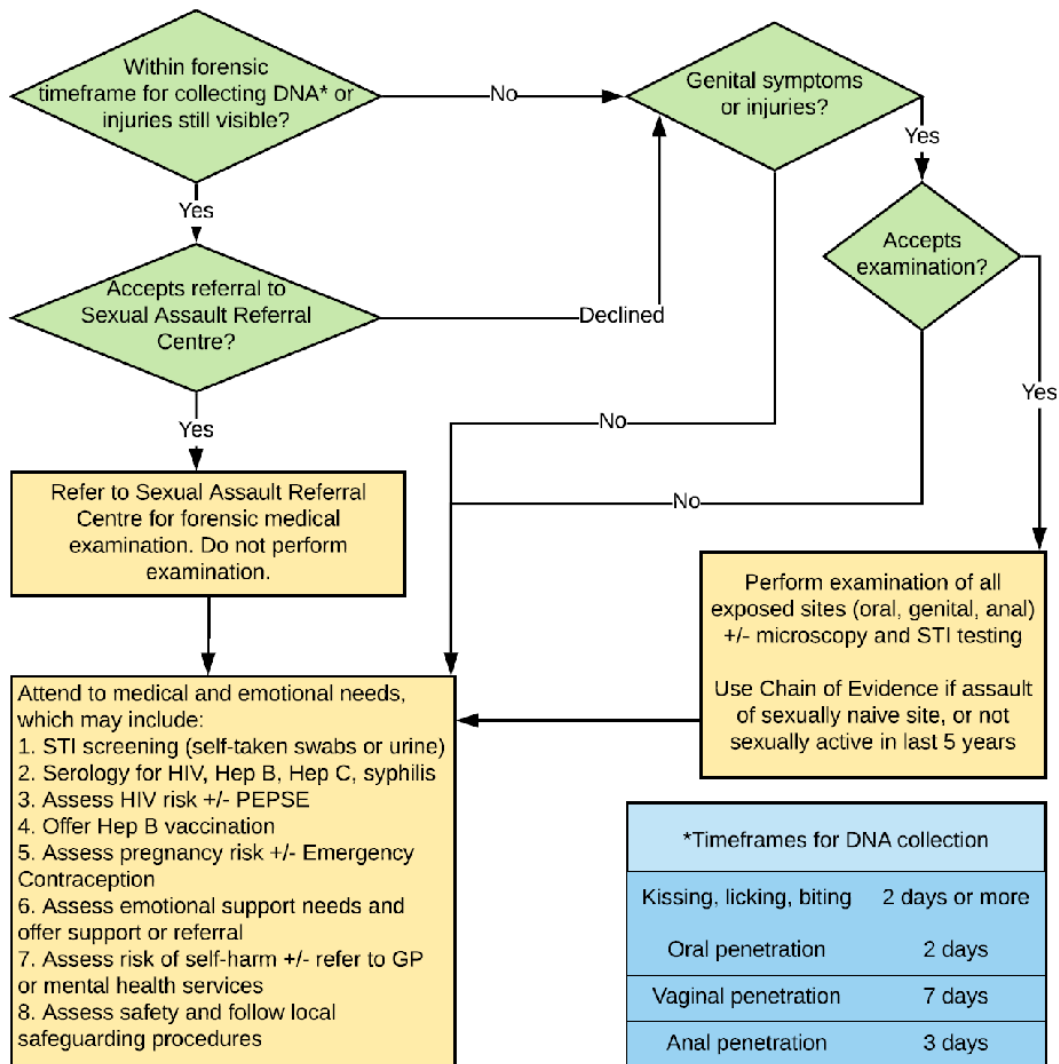
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65. Post –traumatic stress disorder guidance. National Institute for Health and Care Excellence (NICE) <https://www.nice.org.uk/guidance/ng116> Published date 5th December 2018 [2018, accessed 17 November 2022]
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70. Statutory guidance Modern Slavery: how to identify and support victims national Crime agency 2020 <https://www.gov.uk/government/publications/modern-slavery-how-to-identify-and-support-victims> (2009 updated 2022, accessed 21 November 2022)

Additional resources:

1. Pathway of Care Summary



*Timeframes for DNA collection	
Kissing, licking, biting	2 days or more
Oral penetration	2 days
Vaginal penetration	7 days
Anal penetration	3 days

2. Additional detail regarding confidentiality and information sharing

This guidance is for general information only. The law governing the use and disclosure of personal information is complex and varies across the four countries of the UK. Health professionals need to be familiar with and follow their organisation's policies for safeguarding, confidentiality and disclosure of medical records. Health professionals must adhere to professional guidance, including that produced by the General Medical Council (GMC), the Nursing & Midwifery Council (NMC) and the Health & Care Professions Council. In specific cases, health professionals should consider discussing their concerns with experienced colleagues, including local named or designated doctors or nurses, or Caldicott guardians. Doctors may seek specific advice from their medical defence union.

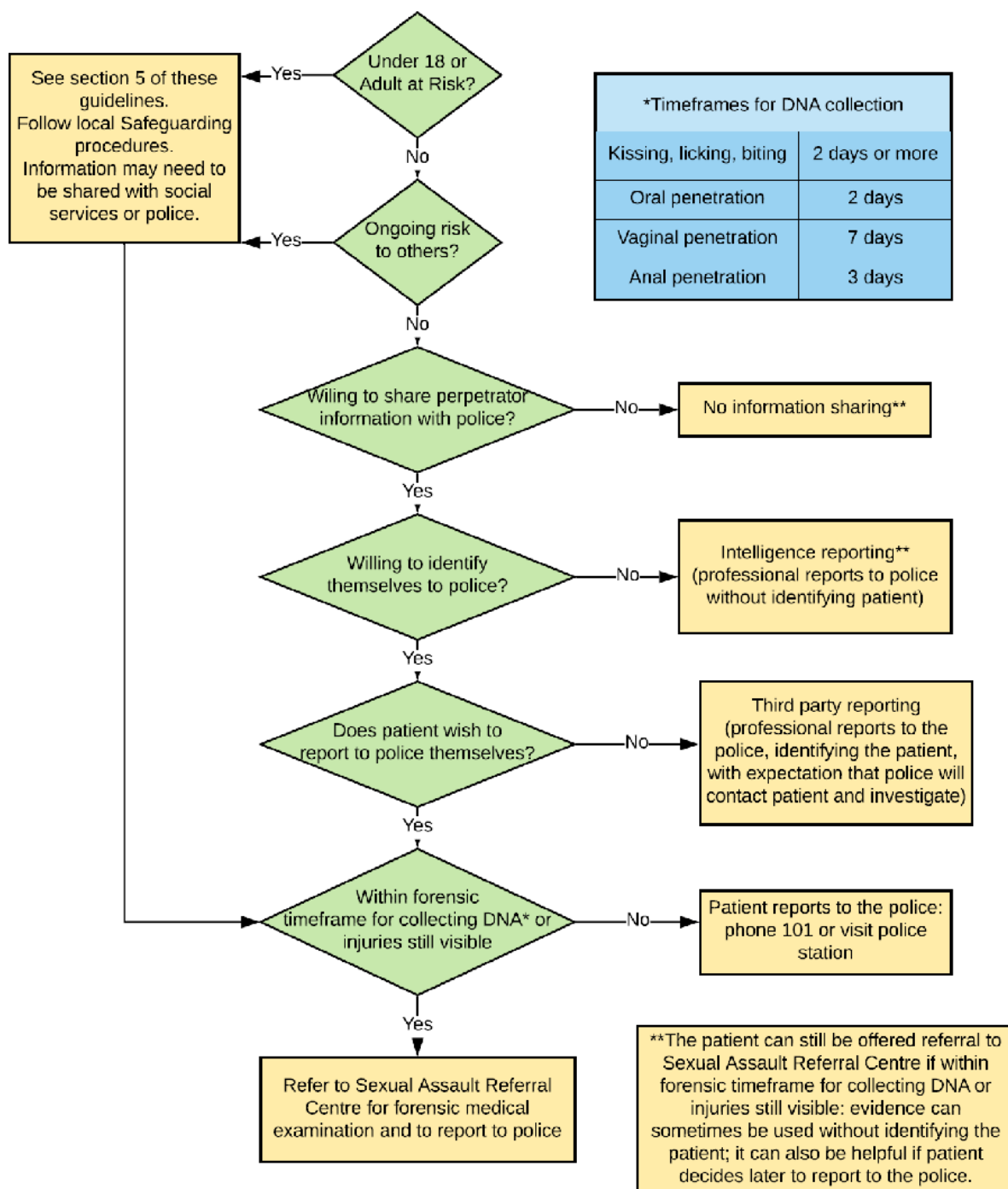
Key points:

- Trust and confidentiality are central to the relationship between patients and health care professionals.
- The right to confidentiality must be balanced against the need to protect individuals from harm.
- Information should be shared, even without consent, if it is required by law or directed by a court.
- Sharing information with police or social services without consent may also be required if it is required for safeguarding vulnerable individuals or in the public interest – such decisions must be made on a case-by-case basis, taking into account the potential harms and benefits of information sharing, both to the individual and the public.

- If an adult (age 18 and over) with capacity to decide about information sharing refuses disclosure, that refusal should usually be respected, even if it places them (but no one else) at risk of further harm.
- If a child or young person (under 18) does not have the maturity or understanding to make their own decision about disclosure, then information may need to be shared for the purpose of protecting them from harm, if such a decision is in their best interests.
- At age 16, a young person can be presumed to have the capacity to make decisions about their health; however, the Children Act 2004 considers 16 and 17 year olds to be children, and confers a duty on healthcare professionals to safeguard and promote the welfare of children. This means that decisions regarding 16 and 17 year olds can be legally complex.
- A child under 16 may have the capacity to make decisions about their health, depending on their maturity and ability to understand what is involved.
- Decisions about information sharing without consent may be challenging and often require expert advice and careful deliberation.

It is good practice to begin any consultation about sexual assault with a discussion about the service's confidentiality policy. The discussion should include an explanation about the situations in which information may need to be shared outside of the service, and this should be documented in the notes [GPP].

Confidentiality & information sharing pathway following disclosure of sexual violence



Confidentiality: General principles

Trust and confidentiality are central to the relationship between patients and health professionals. Patients may avoid seeking help, or tell only part of their story, if they think

that their personal information may be disclosed without consent, or without the chance of having some control over the timing and amount of information shared. Confidential medical care is recognised in law as being in the public interest [1]. The right to confidentiality must however be balanced against duties to protect the welfare of patients who may be unable to protect themselves. Information should be shared, even without consent, if it is required by law or directed by a court. Information may also need to be shared without consent in order to protect a child or vulnerable adult from serious harm, or if disclosure is in the public interest, or necessary to prevent, detect or prosecute a serious crime.

Confidentiality: Principles in children and young people (under 18)

Confidential sexual health services are essential for the welfare of children and young people. Concerns about confidentiality deter young people from asking for sexual health advice, which in turn presents dangers to young people's own health and to that of the community, particularly other young people [4].

However, Serious Case Reviews have repeatedly shown that poor information sharing has contributed to the deaths or serious injury of children [5]. No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe [5].

The Mental Capacity Act 2005 states that by the age of 16 years, young people are able to make decisions about their own care [2]. Under the age of 16, health professionals need to assess the capacity of a young person to make their own decisions, based on whether they have the required understanding and intelligence to make up their own mind on the matter. This principle was set out by Lord Fraser in his judgement which specifically applied to contraceptive advice [3], but is often generalised to other medical care.

The legal position regarding consent to child protection examinations or sharing information relating to child protection concerns is also that any child or young person can give consent as long as they have the capacity to do so [4]. If a child or young person with capacity refuses to give consent, health professionals are required to respect that decision, except in cases described below.

Health professionals should share confidential information without consent if it is required by law or directed by a court. Health professionals should also disclose information without consent when disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure [4]. It is necessary to weigh the harm that is likely to result from not sharing the information against the possible harm, both to the individual and to the overall trust between health professionals and patients of all ages, arising from releasing that information. Health professionals must consider each case individually, and take into account young people's behaviour, living circumstances, maturity, learning disabilities, and any other factors that might make them particularly vulnerable [4]. Disclosure of information may be in the best interest of a child or young person who has experienced, or is at risk of serious harm. A sexual assault would usually constitute significant harm. There is further guidance about the meaning of seriously harmful sexual activity in guidance from GMC [4] and Department for Education [9]. Thresholds for judging significant harm are also set locally by Local Safeguarding Children Boards as part of their duties conferred by Children Act 2004 [12].

If children or young people with the capacity to consent to information sharing refuse to consent to a disclosure that is considered necessary for their protection, health professionals should discuss this with the young person, and explore their reasons for refusal. It would

usually be appropriate to encourage them to consent to the disclosure, to warn them of the risks of refusing consent and to explore all avenues of possible assistance [4].

Health care staff must ensure they have the relevant competences regarding safeguarding children and young people, as outlined in the Intercollegiate Document 2014 [6].

Specialist guidance may be relevant in some cases:

- Children who may have been trafficked [7]
- Forced marriage [8]
- Child sexual exploitation [9]
- Disabled children [10]

Confidentiality: Principles in adults (age 18 and over)

Decisions about how best to support and protect adult patients should be made in partnership with them, and should focus on empowering patients to make decisions in their own interests [1]. If an adult decides not to allow information sharing, that decision should usually be respected, even if it is considered unwise. If an adult refuses information sharing despite being at risk of serious harm, it would be good practice to explore their reasons for refusal and to warn them of the risks. With appropriate support, adults who initially refuse offers of assistance may change their decision over time [1]. There may be cases in which the healthcare professional judges that an adult's capacity to make decisions about their own welfare and safety are impaired by fear or abuse within the context of coercive control. In these cases it may be necessary to share information in the best interest of the patient, but

healthcare professionals must weigh this up against any harm done by taking control away from the patient, and such decisions are often complex.

Information may need to be shared without consent if it is required by law, directed by a court or in the public interest. For disclosures in the public interest, see below.

It is important to be aware that in consultations with adults, information may be disclosed which raises a concern about a child. This would include domestic abuse in a household in which children are present. In such cases information may need to be shared without the consent of the patient in order to protect a child or children.

Confidentiality: Principles in adults without capacity

All adults need to be supported as much as possible in making choices about their own care. In adults without the capacity to consent to disclosure of information, information can be shared if it is of overall benefit to a patient [1]. Decisions about what is in the best interest of the client may need to involve care givers, family, a person with a legal Lasting Power of Attorney, an Independent Mental Capacity Advocate or advocacy services. After a sexual assault it would usually be appropriate to share information with social services and the police for the purpose of preventing further harm [GPP].

Information sharing in the public interest

If it is not practicable to seek consent, and in exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm [1]. The benefits to an individual or

to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic abuse when children or others may be at risk [1]. When deciding whether the public interest in disclosing information outweighs the patient's and the public interest in keeping the information confidential, it is necessary to consider:

- the potential harm or distress to the patient arising from the disclosure, including the impact on their future engagement in health care
- the potential harm to trust in healthcare professionals generally
- the potential harm to others if the information is not disclosed
- whether the harms can be avoided without breaching the patient's privacy [1]

If a decision is made to disclose information without consent, the patient should be informed before the disclosure, if it is safe and practicable to do so [1].

Information sharing: what and how to share

Information sharing must be necessary, relevant, proportionate, accurate, and shared in a timely and secure manner, only with those that need to know. There is no legal definition of "timely", and the urgency of information sharing will depend on the likelihood and seriousness of the harm that it aims to prevent.

Decisions about whether to share information or not should be recorded in clinical notes. Good documentation would include what information was or was not shared, who made the decision and on what grounds [GPP].

Requests for disclosure of information from police or a court

If a sexual assault is disclosed to the police, the police may request disclosure of information divulged in the consultation. Such requests should always be made in writing. If a written request is received, health professionals should inform the client of the request and ask their permission for disclosure [GPP].

If the client agrees to the disclosure, this should be confirmed in writing. The relevant notes should be printed. Notes should be checked for irrelevant private, sensitive or third party information, which should then be redacted / blacked-out. The appropriate medical professional in the organisation should check and authorise release of the notes. A record should be kept of what information was disclosed to whom [GPP].

If the client does not consent to release of information, the requesting agency should be informed. Information may still need to be disclosed if directed by a court or in the public interest.

Requests for disclosure of information for public protection

Services may receive requests for information about patients who may pose a risk of serious harm to others. For example, multi-agency public protection arrangements (MAPPA) in England, Wales and Scotland and public protection arrangements in Northern Ireland (PPANI) exist to protect the public from violent and sex offenders, and healthcare professionals should seriously consider their requests. Information may also need to be disclosed for formal reviews (such as inquests and enquiries, serious or significant case reviews, case management

reviews, and domestic homicide reviews) that are established to learn lessons and to improve systems and services [1].

[1] Confidentiality: good practice in handling patient information 2017. Manchester: General Medical Council

[2] Mental Capacity Act 2005

[3] Gillick vs West Norfolk, 1985

[4] 0–18 years: guidance for all doctors 2007. Manchester: General Medical Council.

[5] Reference 5 (page 19) needs to be changed to Working Together to Safeguard Children 2018: A guide to inter-agency working to safeguard and promote the welfare of children. London: HM Government

[6] Safeguarding children and young people: role and competences for health care staff. Intercollegiate Document. 2014. London: Royal Colleges of Paediatrics and Child Health.

[7] Safeguarding children who may have been trafficked 2011. London: Department for Education.

[8] The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage 2014. London: Foreign & Commonwealth Office

[9] Child sexual exploitation: definition and guide for practitioners 2017. London: Department for Education

[10] Safeguarding disabled children: practice guidance 2009. London: Department for Education

[11] Protecting children and young people: The responsibilities of all doctors 2012. Manchester: General Medical Council

[12] Children Act 2004

3. Sexually assaulted whilst abroad

The response to sexual violence varies between countries.

Individuals may wish to seek advice on the options available to them depending on the country where the assault took place.

An anticipated negative response may result in an informed choice to return home without making a disclosure.

The link below provides information for British nationals who have been affected by sexual violence abroad, including how to contact the Foreign and Commonwealth Office, and how to access medical attention and legal advice when returning to the UK.

<https://www.gov.uk/government/publications/rape-and-sexual-assault-abroad-returning-to-the-uk/rape-and-sexual-assault-abroad-returning-to-the-uk>

In addition, LBT Global (formerly the Lucie Blackman Trust), provides support for individuals and their families.

This organisation has experience of supporting victims of violent crime, including serious sexual assault, that occur whilst overseas in various ways including financial burden's incurred from returning to engage in criminal justice process or interpreting services.

<https://www.lbt.global/>

4. Example of a Letter for General Practitioner

MEDICAL IN CONFIDENCE

Dear Dr _____ ,

Personal Details

Last name:..... First
name:.....

Date of birth: /..... /..... Age:

Gender.....

Current
address:.....

.....Postcode:
.....

Contact telephone No:.....Preferred method of
contact:.....

Is it OK to leave a message Yes No

Our patient was seen aton.....and disclosed sexual violence that took place on date

A summary of care provided to date is below – actions required in primary care:

.....

Police engagement : Yes No

Brief History of Incident

.....

.....

.....

.....

Current

medication.....

.....

Current health

problems.....

.....

.....

Drug

allergies.....

.....

Contraception Management Plan

HIV post exposure prophylaxis – commenced/outside window period/not required

Hep B Vaccination

Not Indicated Already Vaccinated 1st Dose Given Declined

Any additional relevant information:

.....
.....
.....
.....

Yours sincerely

.....
.....

Print

Name:.....
.....

Professional registration number:.....

5. The forensic significance of STIs

The identification of an STI rarely assumes evidential importance, as the possibility of the infection pre-dating the incident would need to be excluded.

The presence of an STI may assume evidential value when diagnosed in someone who;

- is otherwise previously sexually inexperienced (eg child),
- has had a period of abstinence (>5 years) or
- has been penetrated in a sexually naïve site (for example anal penetration by a penis in a man who has not previously had anal penetration)

Female genital anatomy and movement of discharge from the vagina may result in transfer of infection and as a consequence, 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 and therefore may not be of evidential value. It may support though not in itself confirm such a disclosure and would require consideration alongside other results including the presence or absence of a co—existing vaginal infection.

If presenting within the incubation period, confirm if any recent sexual contacts other than the suspect(s) and consider the possibility of an undiagnosed STI pre-dating the sexual assault.

If the possibility of a pre-existing infection is unlikely, discuss the potential evidential value of testing both within and after the incubation period and comparing results.

There now remains two main potential outcomes of repeat screening in this scenario:

Screening tests performed and sent with an accompanying chain of evidence forms after the assault, and before the end of the incubation period may demonstrate a negative result.

Repeating testing after the incubation period with a subsequent positive result, is supportive of a newly acquired infection, and could be attributed to the assault if no other sex has occurred since the assault.

An alternative outcome might be that the first tests performed within the incubation period and in the absence of previous sexual experience, tests positive for a bacterial STI.

A positive result from someone tested within the incubation period does not negate their account, neither does it conclude that they have had previous sexual contact that they have declined to disclose.

If a sexually transmitted infection has been acquired from a suspect, at some point in the incubation period the test will be detectable as positive. Depending on the infection this may be as early as day 2 onwards for productive infection or earlier if infective organism DNA was deposited at the time of the assault.

Testing of suspects would then be recommended with interpretation of results by a Genitourinary Medicine physician / Medical Microbiologists / both.

The majority of the small proportion of forensically significant STIs are likely to be captured in this first group.

Alternative explanations would include the possibility that ejaculate from the infected suspect may have been sampled, in particular if examined very soon after the incident. The possibility of a false positive result is an additional consideration.

It may be that the nucleic acid amplification test (NAAT) test was taken during a forensic examination at the SARC and you are being asked for advice on interpretation of the result. Liaison between the local SARC and forensic biologist may ascertain if semen was detected on swabs taken during the same examination to inform interpretation.

It may be a consideration to have further discussion with a local microbiologist or virologist as appropriate.

Example 1. Immediate awareness that STI result may be of significance to investigation

Elderly female abstained from sex since widowed 10 years ago, presents within two hours of vaginal rape.

Baseline STI screen within four hours of assault; negative.

No male DNA was isolated from genital swabs although suspect DNA was found in her underwear.

The suspect initially denied penetration and reported ejaculation onto the complainer, a potential 'lesser' charge of sexual assault

Repeat screen at two weeks; positive for Chlamydia.

Result supported mucosal contact and penetration.

The suspect was charged with rape and subsequently made a guilty plea before the case was tried before a jury.

The evidence of infection and hence penetration, provided an opportunity to seek a pre-trial plea that resulted in the patient being spared the need to appear as a witness, when her mental well-being had already significantly deteriorated since the assault.

Example 2. Delayed presentation of potential forensic significant STI

A fifteen year old male attended a local SARC two days after a sexual assault.

He disclosed no previous sexual contact.

2 weeks later he presented to the sexual health clinic with anal discomfort and was diagnosed clinically with genital herpes.

Following discussion with the SARC, samples were sent with a chain of evidence. HSV 2 was isolated.

Liaison with virology requested HSV antibody testing on the serum save sample stored at the time of the forensic examination. This was negative.

Repeat serology a few weeks later demonstrated the development of HSV antibodies supporting acquisition within the timeframe of the incident.

Results were shared with investigating officers with the consent of the patient.

The suspect's serology could then be tested.

A negative antibody test in a suspect had potential to exclude possible suspects.

Officers were advised that positive serology in a suspect did not in itself conclude he was the perpetrator since the prevalence of HSV-2 seropositivity in Europe is 5-15%. Positive HSV serology in a suspect in this case along with additional evidence would be supportive that the suspect was the perpetrator.

Example 3 Screening with chain of evidence from sexually naive sites

A fourteen year old female denied previous sexual contact other than several episodes of rape by her stepfather.

This information suggested the step father as the source of infection and NAAT testing with a chain of evidence form, was sought from the female voluntarily and the suspect (with a court order).

Her NAAT testing result was positive for Chlamydia on first testing.

The stepfather also tested positive for Chlamydia.

In addition, her mother had given birth to the stepfather's child 6 weeks previously. She had not been sexually active with the suspect for several months. Both the mother and the baby were negative for Chlamydia infection.

These results were supportive, although not conclusive of the step father having had sexual contact with the fourteen year old. As an isolated result, it does not conclude the step father as being a perpetrator as described although it remains an important piece of potential evidence to corroborate the fourteen year old's version of events.

6. Example of a chain of evidence form

Appendix Laboratory 'chain of evidence' form (LCOEF)

Please complete a separate LCOEF for **each** sample and **each** aliquot derived from a sample.

Staple the LCOEF to the request form.

Date sample taken	Time taken (24-hour clock)	Name of doctor
Patient details (name, unique identifier, date of birth, gender)		Signature of doctor

Sample type/ description
Test(s) requested

ALL NAMES MUST BE ACCOMPANIED BY A SIGNATURE

Procedure	Name	Signature	Date	Time
Sample taken by				
Sample delivered to laboratory by				
Received by (on-call Y/N)				
Senior scientist check at receipt				
Processing/storage/disposal steps (please specify each procedure)				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
Senior biomedical scientist check on completion				
Consultant check on completion				

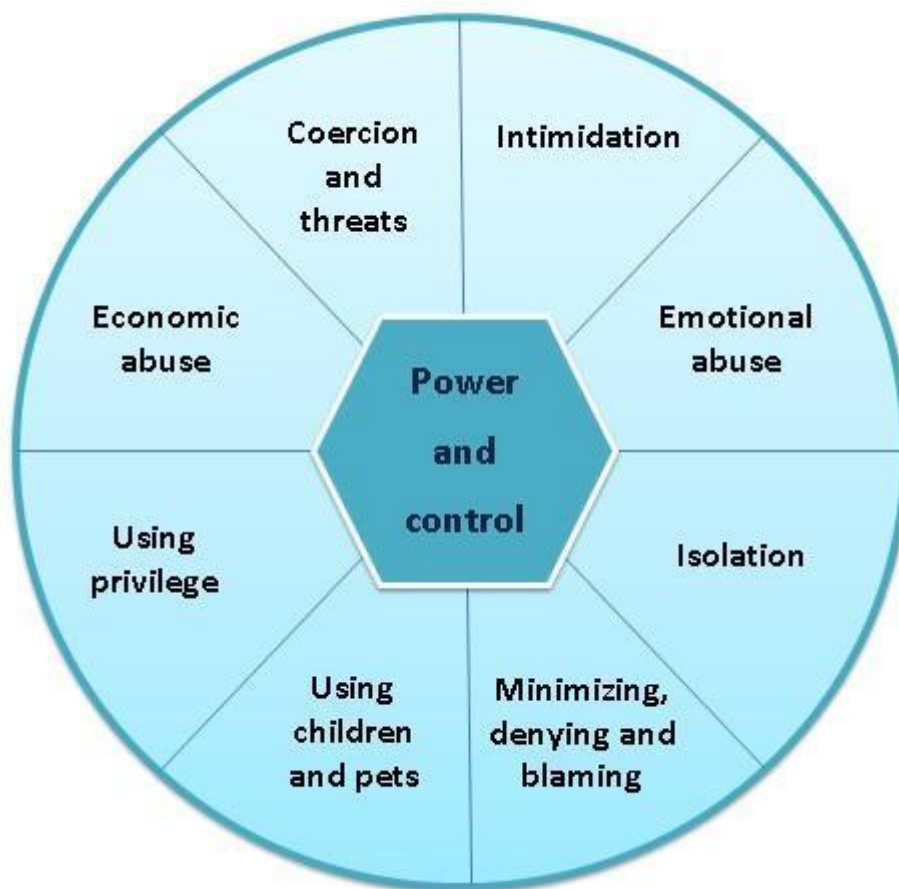
Details of any other staff handling sample

ALL NAMES MUST BE ACCOMPANIED BY A SIGNATURE

Procedure	Name	Signature	Date	Time

BMS check on completion				
Consultant Scientist check on completion				

7. Management of survivors of modern slavery & exploitation (MSE) wheel



8. Case studies

The five scenarios described are to aid understanding and learning alongside the guidelines. They provide five different scenarios healthcare professionals may come across in the sexual health services. Although the discussion following each case study does not intend to be exhaustive, it does aim to assist the healthcare professional's understanding of the topic area and should be used in line with local policies. In addition to these guidelines, please also refer to FFLM guidelines <https://fflm.ac.uk/publications/recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-3/> that provide more detail on the forensic examination.

In every case we would like to highlight the importance of a trauma-informed approach for all patients attending; providing a different interaction and relationship within the consultation to that experienced during the assault. Gaining trust and collaborating on available choices to offer a management plan that empowers the patient, giving control in a safe environment.

Case study 1

A 28 year old female attends requesting an asymptomatic sexual health screen following the end of an 18 month relationship one month ago. On routine enquiry she confirms the relationship was both physically and sexually abusive and that the ex-partner who was male, raped her on several occasions. She is nulliparous and has a Mirena IUS in situ as long acting reversible contraception (LARC). She does not want police involvement as fearful of repercussions.

Management

Acknowledge the abuse and collaborate to identify her priorities and discuss the options available to her.

1. Information sharing: discuss options for reporting to the police, including intelligence reporting or third party reporting via Police Domestic Abuse Disclosure Scheme (Clare's Law) available in all UK jurisdictions (see section 4.5 of the guidelines). It is important for the sexual health care professional to be aware of these options and to signpost the patient to services such as Rape Crisis that are able to support these choices. Confirm she has no children as information sharing to Children's services may be required if she has.
2. STIs and blood borne viruses: she is out of the "window period" for all infections and can be offered testing. Consider Hepatitis B vaccination only if ongoing risk.
3. Contraception and Pregnancy risk: none in this case provided the IUS in situ is within licence limits
4. Psychological wellbeing and support needs. Explore if she disclosed to anyone and if she has, has she had positive reactions to disclosure in her own support network. Inform of local support and counselling services for future reference. Ask her what support she would like from the clinic and arrange an onward referral. Ask permission to explore her mood, and any history of mental health difficulties or self-harm.
5. Safety: what kind of repercussions does she fear, and why? What could she do if the ex-partner makes contact? Discuss safety plans and what to do if an ex-partner makes contact. Be aware that a high-risk time for escalation of violence (including murder) is when an individual has left an abusive relationship. Follow local Domestic Abuse guidelines, which may include referral to an Independent Domestic Violence Adviser (IDVA), if consent is gained. A risk assessment (e.g. using CAADA DASH or Risk Indicator

Checklist) should be performed either by a trained member of the team, an IDVA or through a local organisation. Depending on the risk level identified, a referral to a Multiagency Risk Assessment Conference (MARAC) may be required.

Case study 2

A 15 year old female attends the sexual health clinic on Monday morning seeking emergency contraception. She was drinking alcohol at a party on Saturday evening and went to lie down on a bed upstairs as she was intoxicated. She woke to find one of the males at the party penetrating her vagina with his fingers. She becomes tearful and tells you she received a text yesterday from the male saying, 'I'm sorry'. She doesn't have any memory of penile vaginal penetration but is concerned as not using any contraception and not previously sexually active. She noted a small amount of blood staining on her underwear yesterday. She hasn't disclosed the incident to anyone else.

Management

Assess Fraser competency. Explore whether she is willing to involve parents, carers or another trusted adult in supporting her. Ask if she wishes to involve the police.

1. Forensic Medical Examination (FME):

CONSIDER FORENSIC MEDICAL EXAMINATION (SEE also FFLM guidance)

Discuss the option of referral to a SARC for a forensic medical examination to document injuries and take samples for DNA testing. If considering FME, advise to avoid washing.

Keep any clothes (even if laundered), text messages and other evidence. If she is

considering a FME we would advise contacting your local SARC to discuss their policies on information sharing with Social Care and the police.

2. Information sharing: Consider your responsibility to protect a child from harm and follow local safeguarding procedures. Be honest about the fact that you need to discuss the case with local safeguarding leads and that you may need to share information with a social worker as part of a child safeguarding referral, however, you will make every effort to consult with her at every step of the process.

Discuss options for reporting to the police and that attendance at a SARC may require police involvement. There is variation across SARCs with respect to the age cut off for forensic self-referrals with some SARCs accessible to self-referred cases aged 14 and over.

3. STIs and blood borne viruses: Consider Hepatitis B vaccination. Offer testing after the window periods for sexually transmitted infections. In this case the patient describes a period of blackout where sexual activity may have taken place. In light of this, also consider possible risk factors for HIV of assailant/s. HIV PEP is not indicated unless high risk indicators are identified.

4. Contraception and Pregnancy risk: Despite the absence of recall of penile vaginal penetration, she describes intoxication and there may be amnesia of events. It would be prudent to offer emergency contraception including emergency IUD as the most effective method. Offer ongoing contraception. Offer a pregnancy test in 3 weeks.

5. Psychological wellbeing and support needs: Ask about mood, and any history of mental health difficulties or self-harm. Ask about alcohol use over recent weeks. Discuss local support services (e.g. follow up with a young persons' worker at your local SARC), GP and CAMHS support.

6. Safety: Complete a holistic assessment of vulnerability to child sexual exploitation, based on BASHH/Brook "Spotting the signs" tool. This will involve discussion with others e.g. local child safeguarding team. Ask about the perpetrator and any age gap or power imbalance. Explore how she can keep herself safe in future, including from this perpetrator.

Case study 3

An 18 year old male attends for his first sexual health screen. He states his last sexual contact was last night He becomes upset during the consultation and discloses he met a man on Grindr and on visiting his flat felt coerced into taking an unknown drug after drinking more alcohol than he states he is used to. He states he became disoriented and was anally penetrated without his consent. He has pain in the rectal area and did initially have bleeding which is settling. He lives with two flat mates and states he cannot tell anyone as he feels it is his fault for agreeing to meet a stranger.

Management

Acknowledge his mis-directed feelings of guilt and emphasise he is not to blame.

1. Forensic Medical Examination (FME)

CONSIDER FORENSIC MEDICAL EXAMINATION (SEE also FFLM guidance)

Discuss the option of a forensic medical examination to document injuries and take samples for DNA testing at the SARC. If considering FME, advise to avoid washing. Keep any clothes, messages and other evidence. Discuss options outlined in Section 4 on reporting to the police.

2. STIs and blood borne viruses: Ask if the patient is using PrEP. Ensure adequate and appropriate continued dosing or if inadequate dosing or not taking PrEP, offer post-exposure prophylaxis for HIV. Discuss benefits of forensic examination prior to examination in the sexual health clinic. Hepatitis B, Hepatitis A and HPV vaccination can be offered as per national guidelines. As he is symptomatic STI testing should be offered now (unless proceeding with forensic medical examination in which case offer review directly after forensic examination). NOTE: If the bleeding was felt to be significant, management of this takes priority over the forensic examination. Offer repeat testing after the window period for each infection.

3. Psychological wellbeing and support needs: explore his feelings of blame and his understanding of consent. Ask him what support he would like from the clinic and onward referrals. Ask permission to explore his mood, and any history of mental health difficulties or self- harm.

4. Safety: Discuss safety planning and consider what he could do if the alleged assailant makes contact

Case study 4

A 32 year old patient responds to a routine enquiry in a sexual health service and discloses they have experienced sexual abuse in the past. During the consultation it becomes clear they experienced this while attending secondary school and they become tearful and tell you it was a teacher, Mr. Brown, who used to call them to the classroom after school ended. They disclosed to no one previously and do not wish to report to police.

Management

Be empathic in your response. Allow the patient to remain in control of the disclosure during the consultation. Empower the patient by acknowledging their decision and the enormity of this disclosure.

1. Information sharing: Be honest about the fact that they have given you information which makes you think that other children may currently be at risk of ongoing sexual abuse. Explore reservations regarding police involvement and whether any concerns may be allayed. Explain that you have a duty in law to prevent serious crime, and that this duty has to be weighed against your duty to preserve their confidentiality. Explain that you will need to discuss the case with your safeguarding team, but that you will need to disclose the information to the police and social care (in England it would be the Local Authority Designated Officer who has responsibility to investigate allegations against professionals).

Be aware of GMC guidance on Confidentiality: good practice in handling patient information, and in particular of paragraph 22, Disclosures in the Public Interest; '...there can be a public interest in disclosing information if the benefits to an individual or society

outweigh both the public and the patient's interest in keeping the information confidential. For example, as per GMC guidance, 'disclosure may be justified to protect individuals or society from risks of serious harm, such as from serious communicable diseases or serious crime.'

Discuss ways in which information can be disclosed to the police, including third party reporting. Offer Independent Sexual Violence Adviser (ISVA) support with disclosure and as far as possible try to ensure the patient is in control and informed, at every step in the process. This includes any decisions to share information in the absence of consent.

2. STIs and blood borne viruses: Offer testing now if the patient consents.
3. Contraception and Pregnancy risk: Offer contraceptive care as appropriate, although not relevant to the abuse disclosed
4. Psychological wellbeing and support needs: Ask what support they would like from the clinic and onwards referrals. Ask permission to explore their mood, and any history of mental health difficulties or self-harm.
5. Safety: Ask about whether there are any fears for themselves or others which make them reluctant to report.

Case Study 5

A 20 year old female Eritrean asylum seeker attends the clinic requesting a screen and blood borne virus (BBV) testing. She can speak reasonable English. She is a refused asylum seeker and has no recourse to public funds. She has been sleeping in a church or in a park. She reports after sensitive questioning a history of penetrative sexual assault four days ago. She does not wish to attend the SARC and is worried about attending the clinic due to concerns around her immigration status.

Management

Explore her concerns about her immigration status. Inform her that all NHS care related to previous sexual assault (including FGM) is exempt from charging, and this includes abortion and antenatal care. Inform her that all sexual and reproductive healthcare and primary care is free. Ensure that she is registered with a GP – lack of address and immigration status should not be a barrier to GP registration. (Doctors of the World in London have information on healthcare access <https://www.doctorsoftheworld.org.uk/>)

1. Forensic Medical Examination and Information sharing:

Although she presents saying she does not wish to attend a SARC it is important to ensure she is fully aware of her options so she can make an informed decision. Outline that she could attend a SARC in safety (with or without the police in the first instance) for a forensic medical examination to document injuries and take samples for DNA testing. Discuss options for reporting to the police, including intelligence reporting. You may need the support of an independent translation service to enable the patient to understand.

2. STIs and blood borne viruses: Offer STI testing now (unless proceeding with forensic medical examination). Offer Hepatitis B vaccination. Post-exposure prophylaxis for HIV is not relevant as after the 72 hour window period for PEPSE. Offer repeat testing after the window period for each infection..

3. Contraception and Pregnancy risk: offer emergency contraception including consideration of emergency IUD as the most effective method. Offer ongoing contraception. Offer a pregnancy test in three weeks' time.

4. Psychological wellbeing and support needs: Refugee, asylum-seeking and undocumented migrant women experience high rates of sexual and gender based violence. She may also have experienced trauma in Eritrea. Ask about her mood, and any history of mental health difficulties or self-harm.

5. Safety: her homelessness puts her at ongoing risk of sexual violence. Doctors of the World may have information on local refugee organisations and local services for undocumented migrants for example, <https://www.doctorsoftheworld.org.uk/> Local guidelines should be followed. Consider referral to an IDVA who will be able to link her in with other key agencies e.g. NASS (National Asylum Support Service)

Qualifying statement

We recommend reference to the current updated guidance on clinical and forensic issues by the British Association of Sexual Health and HIV (BASHH), The Faculty of Sexual and Reproductive Healthcare (FSRH) and The Faculty of Forensic and Legal Medicine (FFLM).

A patient information leaflet has been developed to accompany this guidance.

Time scale for next revision

An author group will be invited by the BASHH CEG to review and revise the guidance in 5 years from publication using the BASHH framework for guideline development. However, addenda may be added sooner than this in response to new information and data.