Sexual assault

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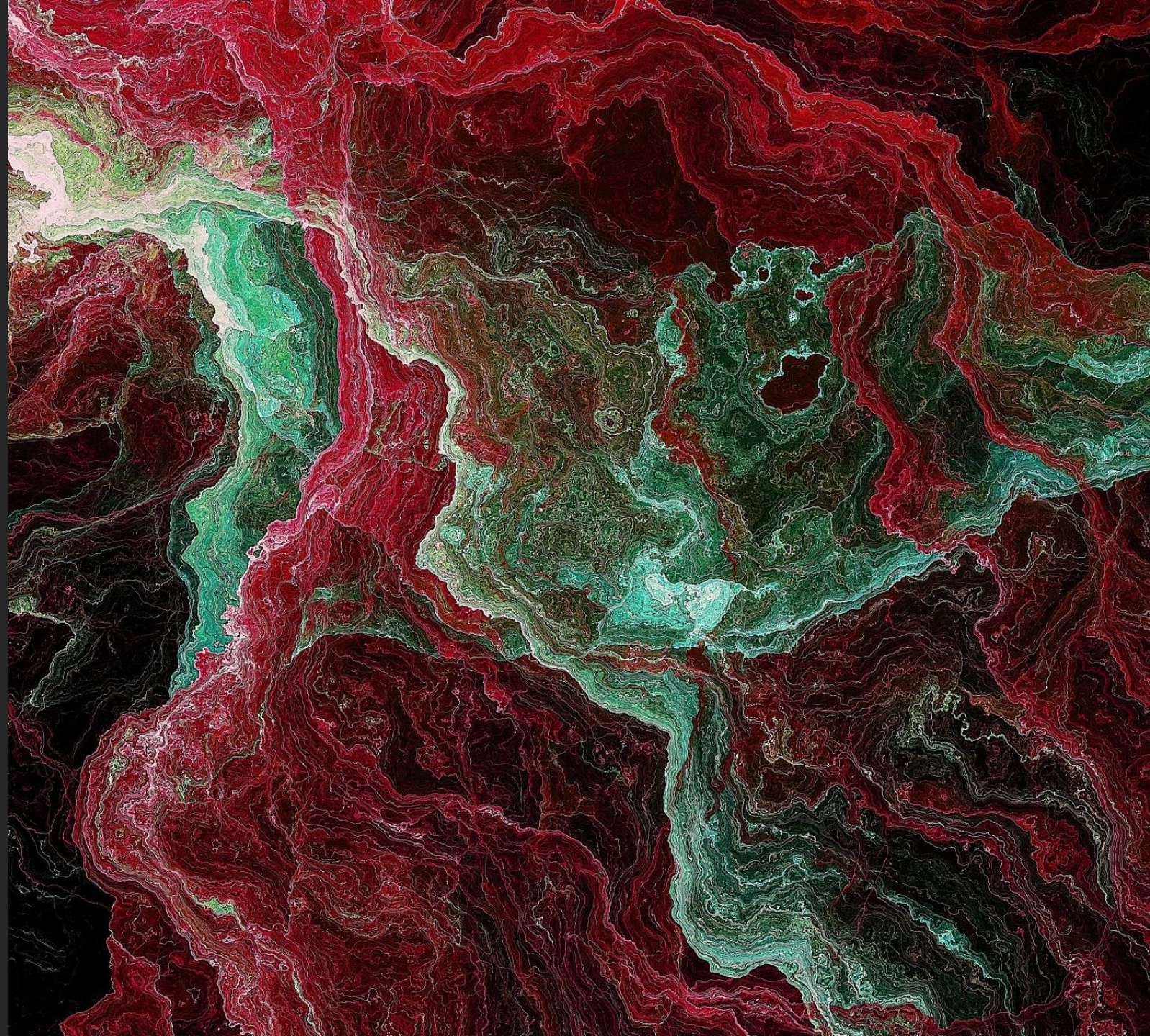
Acknowledgement of country

Content warning



Sexual assault

- Definition and epidemiology
- Management of recent sexual assault
- Medical care & follow up
- Approach to disclosure of historical sexual assault
- Referral pathways
- How to become a GP forensic examiner or sexual assault nurse examiner

Sexual assault definition

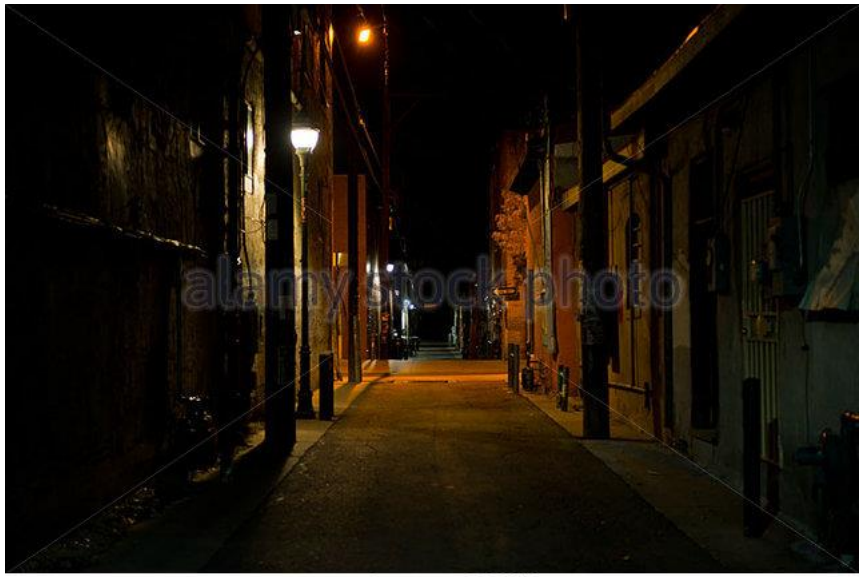
Sexual assault is when a person is forced, coerced or tricked into sexual acts against their will or without their consent, or if a child or young person is exposed to sexual activities

Sexual intercourse: "penetration to any extent of the genitalia of a female person or the anus of any person " (NSW Crimes Act 1900, S61H)

Also includes oral intercourse, penetration of surgical vagina, continuation of intercourse without consent, intercourse with someone who is unable to provide consent eg (intoxication)

Other offences in the act including indecent assault, sexual intercourse with a child under 16, and grooming a child under 16 for unlawful sexual activity

Sexual assault myths



Characteristics of sexual assault

In the most recent ***sexual assault*** *of a* ***female**** by a ***male*** in the last 10 years:

RELATIONSHIP

These women were most likely to be **sexually assaulted by a male they knew (87% or 553,700)**.

LOCATION

The **location** was most likely to be the **woman's home (40% or 252,400)** or **perpetrator's home (17% or 109,400)**.

INJURY

23% (144,100) of these women were **physically injured;** of which **33% (48,200)** contacted a **doctor or health professional** about these injuries.

POLICE

Approximately **nine out of ten (87% or 553,900)** of these women **did not contact the police**.

HELP & SUPPORT

Half (50% or 316,900) of these women **sought advice or support** about the most recent incident.

ANXIETY & FEAR

Over half (57% or 365,700) of these women **felt anxiety or fear for their personal safety** in the 12 months after the incident.

* Comparative data is not available for men's experiences of sexual assault by a male or female or women's experience of sexual assault by a female as the data for these types of violence are not reliable enough to report due to their low prevalence.

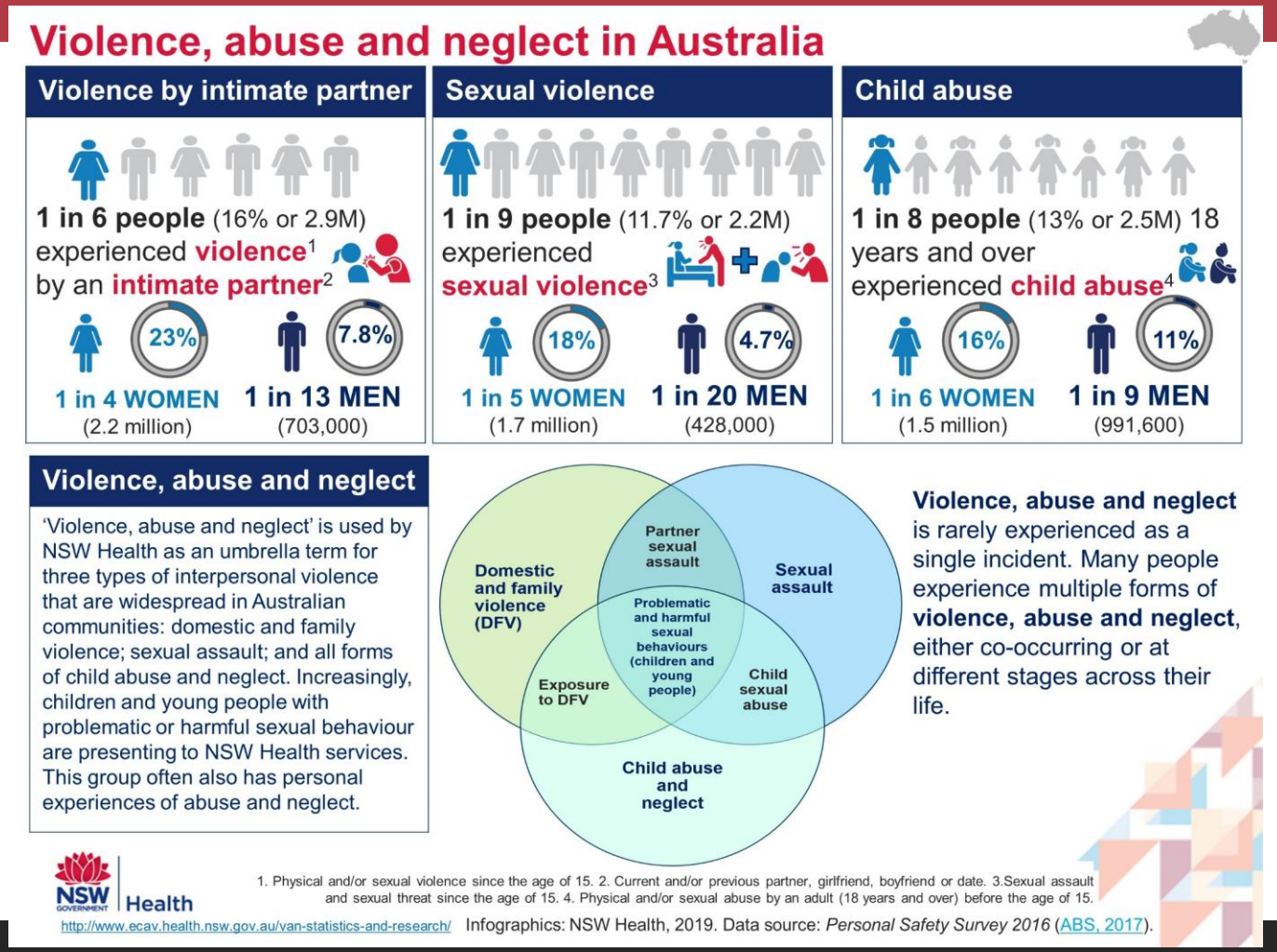
NSW GOVERNMENT Health

Infographic: NSW Health, 2019.
Data source: *Personal Safety Survey 2016* (ABS, 2017 & ABS, 2017, Table 10.1).

http://www.ecav.health.nsw.gov.au/van-statistics-and-research/

Sexual assault epidemiology

- Difficult to ascertain precise prevalence due to under reporting
- NSW Bureau of Crime Statistics and Research (BOCSAR) data for 2021:
- NSW reported sexual offences rate: **179.4 per 100,000**
- NSW reported sexual assault rate: **89.2 per 100,000**



Sexual assault epidemiology

- Spike in reporting noted in NSW in March 2021 (61% increase on usual monthly reporting)
- Media coverage of high profile sexual assaults led to 'widespread community conversation about sexual violence and consent of a scale not previously seen'

LGA	Sexual offences rate	Sexual assault rate
Newcastle	244.4	135.6
Tamworth	297.4	145.5
Armidale	407.4	232.3
Moree Plains	367.1	183.5
Gosford	666.7	395.1
NSW	**179.4**	**89.2**

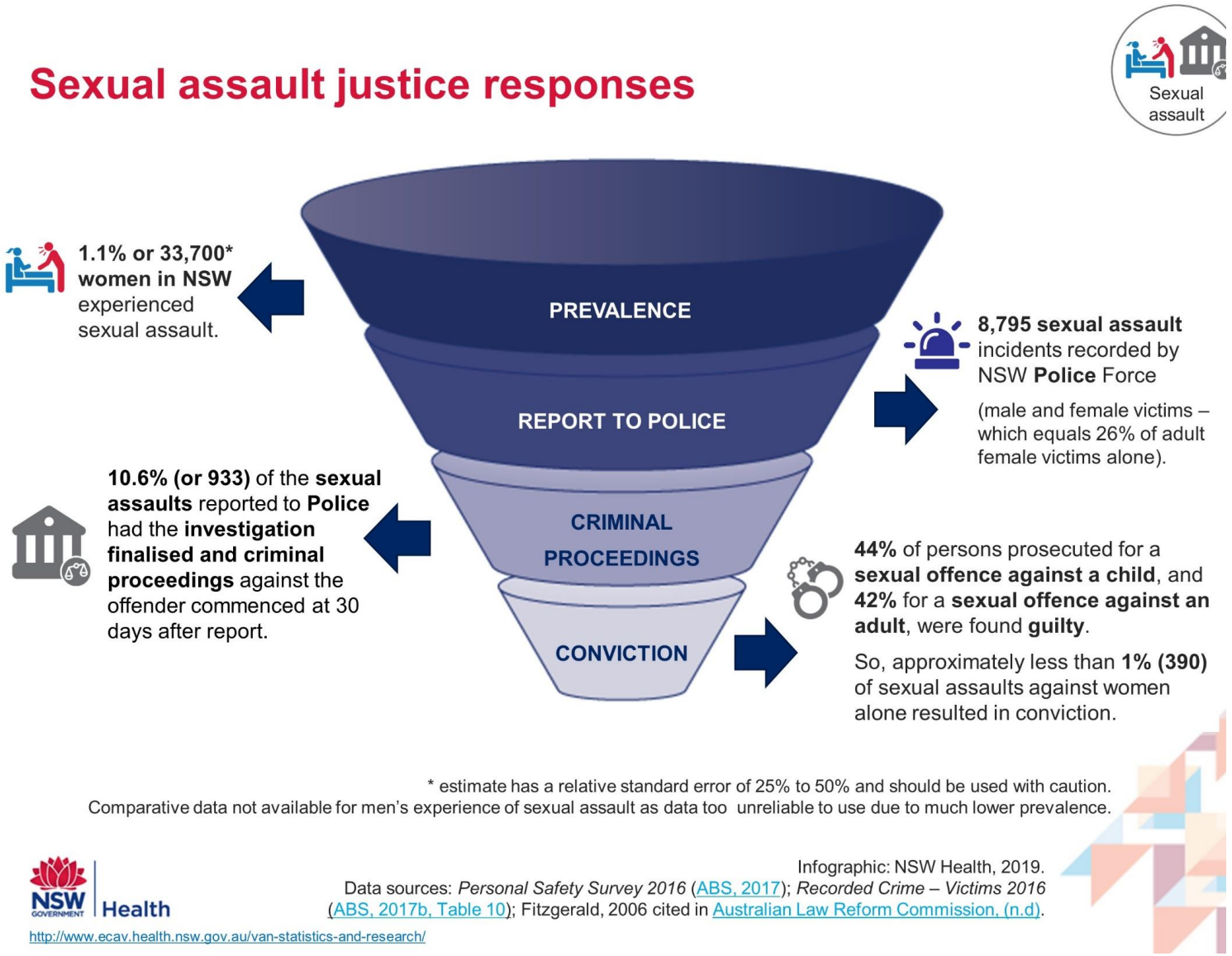
Sexual assault epidemiology

- Hunter New England data: crisis presentations to SAS services by sites providing forensic medical response 2021- it's the people we aren't seeing that we are concerned about.

	Newcastle	Tamworth	Armidale	Moree	Inverell*	Taree
Total crisis presentations	171	18	11	4	3	21
Total crisis presentations >= 14 yrs	154	13	9	4	3	17
Medical team involved	124	10	9	3		12
Forensic examinations	98					
EEKs	19	4				

A difficult crime to prove

- Likely that higher prevalence of unreported and undisclosed sexual assault than the numbers presenting.
- GP setting may prompt disclosure of recent or historical SA inadvertently
- GPs have a crucial role in supporting victim-survivors of sexual assault



Case study:
SM, 25yo female

Father of her 2 children and ex-partner released from prison 2 weeks prior

She took him into her home as he “had no where else to go, and he is the father of my children”

She experience multiple episodes of violence over the 2 week period, including an incident 9 days prior when she was driving and she wouldn’t take him to get drugs he “sliced my arm with a razor blade”

Case study:
SM, referred by police

She attended the police station regarding domestic violence. The police enquired as to whether she'd had any sexual relations she didn't consent to

She disclosed her ex-partner on multiple occasions had forced her into intercourse she didn't want

She described his habit was to wait until the children and herself were in bed, he "would lie beside me smoking a crack pipe and when he wanted it, he got it"

Response to disclosure

Trauma affects the ability of the brain to create memories

Patients may be hypervigilant, dissociating, distressed

Speak slowly and stay calm- avoid reacting emotionally to disclosure

No need to obtain detailed history of sexual assault itself* if referring on

Trauma and the Brain video: https://www.youtube.com/watch?v=4-tcKYx24aA

GP initial management of recent sexual assault

Validation

- Respond to disclosure with **validation and support**: 'thank you for telling me', 'nobody deserves to have this happen to them', 'it isn't your fault' (work from a position of belief)

When and Where

- Clarify **when** the assault happened and **what** happened (nature of the sexual acts to assess need for forensic sampling and emergency contraception)

Refer with consent

- **Refer to Sexual Assault Service** with patient consent- will assess timeframes and coordinate response.

  (Even if patient does not wish referral, SAS can provide case consultation/ advice for an anonymous patient to GPs and other health care professionals

Pregnancy & STI risk

- Consider need for **emergency contraception** and analgesia
- Ensure the **safety** of patient and any dependent children when leaving your consultation
- Consider mandatory reporting obligations

Rural hospital based care:

- Liaise with sexual assault service re any need for early evidence collection if likely delay to examination eg interhospital transfer
- Consider indications for HIV PEP

GP initial management of recent sexual assault

- Assess for potentially significant physical injury on history and document any disclosures:
- Open questions: 'Do you have any concerns about your body?', 'so I can make sure your body is OK and address your health needs, can you tell me briefly what happened to your body during the assault?'
- Direct questions: ask explicitly about
  - head injury
  - loss of consciousness/ amnesia 'memory gaps'
  - pv bleeding
  - abdominal pain
  - strangulation: 'was any pressure applied to your neck during the assault?'
  - AVOID GENITAL EXAM IF FORENSIC MEDICAL PLANNED- MAY RESULT IN LOSS OF EVIDENCE (EXCEPTION: URGENT MEDICAL CARE)

Recent Sexual Assault in Adults or Adolescents

This pathway is for sexual assault of adults or adolescents who attend general practice. If an assault occurred more than 1 month ago, see Previously Undisclosed Sexual Assault.

About recent sexual assault

Red flags

- Signs of serious strangulation, e.g. visible external signs, hoarse voice, loss of consciousness, incontinence
- Profuse bleeding
- Head injury

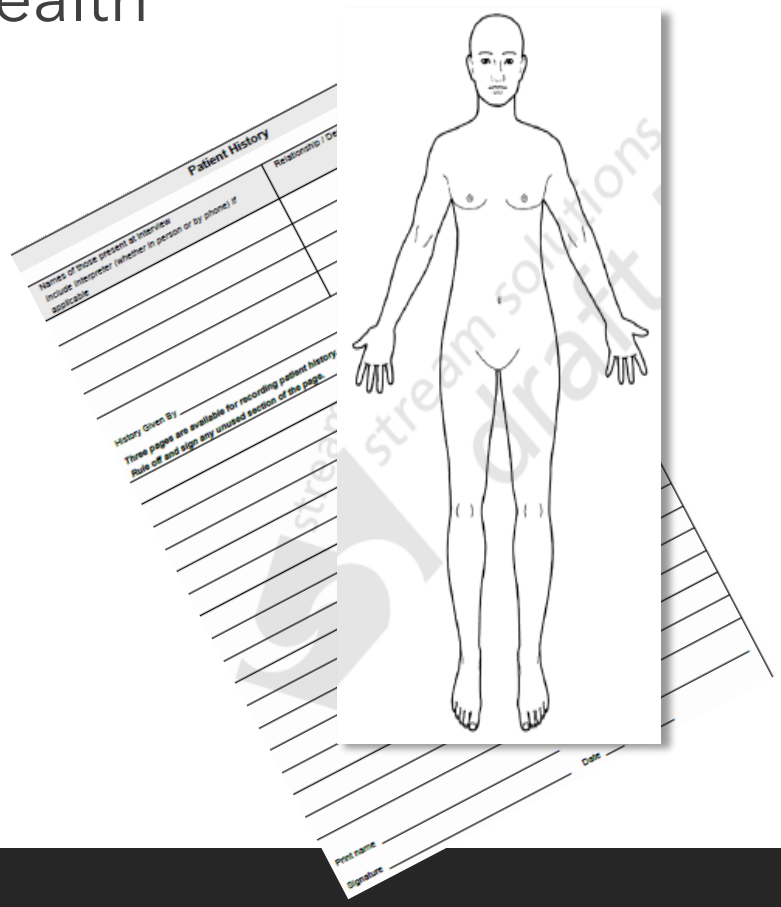
Assessment

1. Assess patient for indicators of recent sexual assault and provide immediate psychosocial support.
2. Gather triage information to help you decide on next steps.
3. Assess patient for red flags and need for urgent medical attention, and refer to the emergency department if required. The Emergency Department will contact the sexual assault service who will meet with the patient to assess them.
4. Strongly encourage the involvement of the specialist sexual assault service, to coordinate acute medical and/or forensic response and offer specialised counselling:
   - The patient may choose to have a:
     - general medical examination and not a forensic examination.
     - forensic examination and release evidence to police immediately.
     - a forensic examination and have the evidence kept by the sexual assault service until they decide whether to release to police or not.
   - A crisis support worker from the local sexual assault service can help a patient decide whether to involve the police and support them if they go ahead.
5. Offer to involve police. If the patient does not want the sexual assault service to be involved, you can help them report to police directly. Support services are available to assist victims during the court process.
   - Reporting to the police
   - How to involve the police if requested (either anonymously or with contact details)
   - Patient's rights when involving the police
   - Give the patient the NSW Rape Crisis – Reporting to Police information sheet.
6. Preserve forensic evidence.

patient's immediate safety from the alleged perpetrator.

Sexual assault team crisis response:

- Receive referrals from patients, police, GPs and health
- Team approach (counsellor + forensic examiner/ paediatrician)
- Options explained around:
  - examination
  - release to police
  - reporting
  - immediate safety planning



Options after recent sexual assault

No obligation for patient to go to police to access medical and forensic care from sexual assault service

No obligation to have a forensic examination, can have medical care only

GP led medical care if refusing/ unable to access sexual assault service

Early evidence collection some sites

Can make a police report anonymously

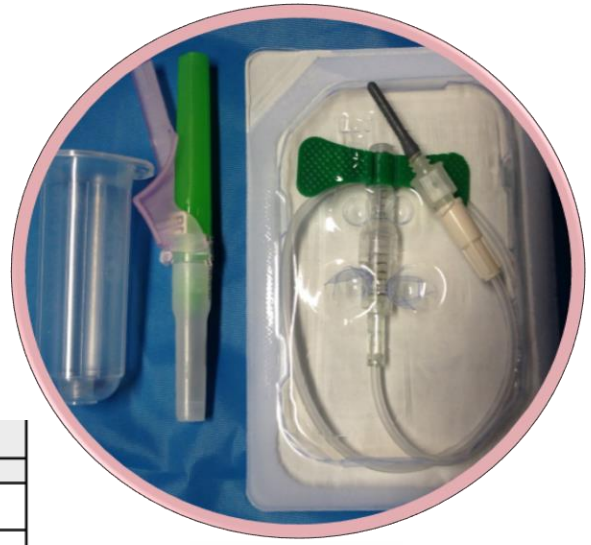
Can make a police report and not go on to make a statement

Can make a statement and choose not to proceed further with investigation

Can have a forensic examination and release evidence to lab so DNA on database, without proceeding to formal investigation

Acute sexual assault team response

- Forensic documentation and collection of evidence
- Photography of injuries
- Acute medical care (incl EC, HIV PEP prn)
- Counselling
- Drug testing for DFSA
- Mandatory reporting
- Letter for GP explaining f/up



Female Genital Samples			
Specimen	Swab	Slide	Comments
External Labial (skin)	☐	☐	
Vulval (inner aspects of lower labia minora and fossa navicularis)	☐	☐	
Low Vaginal	☐	☐	
High Vaginal	☐	☐	☐ Used speculum ☐ Did NOT use speculum (tick one)
Endocervical	☐	☐	
Other	☐	☐	
Other	☐	☐	

Case study: SM Initial Discussion

- 2 parts to the assessment:
  - Medical checkup – STI screening, contraception, address injuries, mental health review....
  - Forensic Examination: Collection of evidence
- Take a history
  - Where, when, assailant/s, weapons, physical assault/restraint including strangulation, penetration, positions, ejaculation, condoms, defensive actions, post assault activity, drug and alcohol history, current symptoms
  - Medical history, mental health, including contraception
- Examination/evidence collection: depends on the history
- Photography
- Consent: must gain consent to each individual part above. Often victims only consent to some elements of assessment

Case study: SM consent to forensic examination

- SM consented to taking of forensic history of assault, top to toe physical examination to document injuries, collection of forensic specimens and photographic documentation if required
- SM initially declined a vaginal speculum due to fears of discomfort
- DNA contamination risk was reduced by cleaning the room with bleach and use of decontamination kit DNA-free gown and gloves

Case study:
SM forensic history

- The most recent sexual assault had occurred 4 days prior in her own home. She had gone to bed at 11pm, her ex-partner climbed into bed sometime between 12 and 2am
- She was sleeping on her side and he initiated penile-vaginal intercourse from behind her. She woke up and tried to move away. He grabbed her legs and forced himself up onto his knees between her legs.
- She described the intercourse as rough and painful. She tried to move backwards but her head was against the bed rails.
- He threatened her “if you try and move away, I’ll make it rougher”

Case study:
SM forensic history

- He did not use a condom. He ejaculated in her vagina. She denied any other injury and did not recall any pressure applied to her neck during the assault

- He forced her into vaginal and oral intercourse 2 or 3 times in the preceding 2 weeks

- She stated "I didn't know it was illegal for him to do this, I thought he could since he's the father of my children"

Case study:
SM medical history

- No significant medical history, history of domestic violence in a previous relationship
- 2 children aged 7 months and 4 years
- Non-drinker and denied any drug use
- IM depo-ralovera last given 4 weeks prior to assault (12months), amenorrhoiec

Case study:
SM post assault symptoms

- dysuria and blood on the toilet paper when wiping after the incident.

- new painful vaginal lesions since POI had returned from prison

Case study:
SM forensic examination

- Physical examination findings:

  - partially healed 3cm linear incised wound on left outer forearm
  - multiple ulcers on the labia majora, approx 1cm in diameter, tender to swab, appearance typical of HSV lesions
  - two vertical superficial lacerations on the perineum, not actively bleeding
  - pv bleeding noted, consent obtained to speculum examination to locate source, however due to discomfort the speculum exam was terminated before the site of bleeding was identified
  - bright red clot seen in lower vagina

Case study:
SM forensic examination

- Forensic examination and evidence collection:
  - Swabs (for DNA) and slides (for semen) from vulva, low vagina, high vagina
  - Medical photographs taken of ulcers and laceration

- Medical investigations:
  - STI
    - lesion swabs collected for HSV PCR
    - high vaginal swab for chlamydia
  - Urine M/C/S and bHCG
  - Opportunistic screening for HIV, HCV, HBV, syphilis RPR

Medical care after sexual assault

- Pregnancy risk assessment and emergency contraception
- HIV risk assessment and HIV PEP
- Consider STI testing
- Mental health needs
- Assessment other physical injuries : (strangulation, head injury)
- Domestic violence risk assessment & safety plan
- Follow up plan (incl wk 2 STI screen)

Emergency contraception

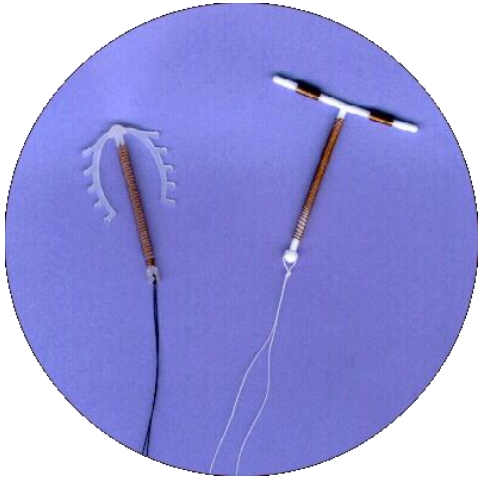
Risk of pregnancy 6-7% after SA (20% with intimate partner SA)

Lower use of regular contraception in age group with highest reported rate SA (15-19 yrs)

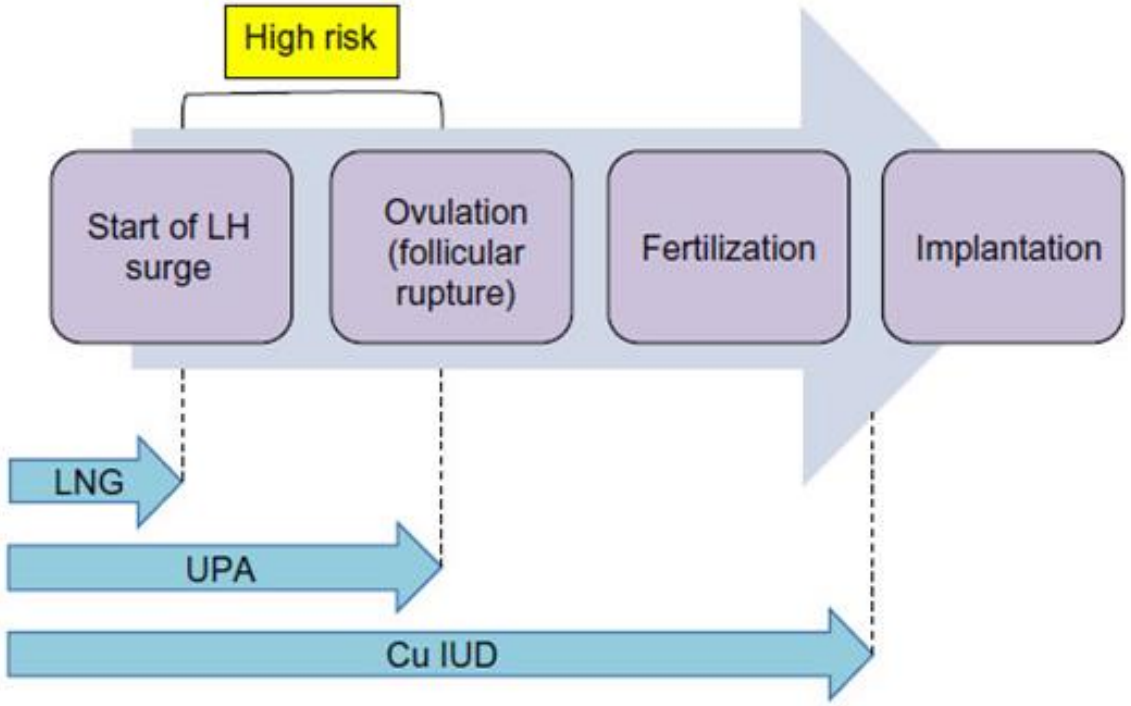
Ulipristal acetate (EllaOne) 30mg po, $$, effective up to 5 /7, OTC, more effective

Levonorgestrel 1.5mg po cheaper, up to 3/7, used off label up to 5/7 OTC

Copper IUD most effective but barriers to access

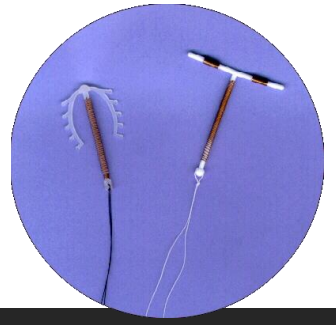


Emergency contraception



- Levonorgestrel ineffective post LH surge
- Both hormonal methods ineffective post ovulation
- Advise pregnancy test in 3-4 weeks

www.inhousepharmacy.vu



HIV post-exposure prophylaxis (PEP)

- where assault within previous 72 hours and meets criteria for higher risk
- Risk of exposure x estimated community HIV prevalence of population of contact
- Risk HIV acquisition from penile-vaginal intercourse with Caucasian Australian heterosexual male is < 1 in 1,000,000 (will not need HIV PEP)
- HIV PEP starter packs available free from emergency departments
- High risk sexual assault situations where HIV PEP recommended:
  - Anal assault by MSM assailant (consider in vaginal assault)
  - Assault by assailant from high HIV prevalence country* (>1%)
  - Assailant known to have HIV (viral load unknown or detectable)

HIV PEP

- https://ashm.org.au/products/product/978-1-920773-47-2
- Refer to HIV PEP community healthpathways page
- Will need ongoing supply to complete 1 month
- Follow up needed via s100 prescriber eg sexual health clinic or ID- can do phone consult for rural/remote for free HIV PEP
- Follow up appts via GP or sexual health for repeat BBV screen at 4-6wks and 12 wks (as well as the usual 2 wk STI screen recommended post SA)

Table 4. PEP recommendations after NON-OCCUPATIONAL exposure to a source with UNKNOWN HIV status

Type of exposure to source with unknown HIV status	Estimated risk of HIV transmission per exposure	PEP recommendation
Receptive anal intercourse (RAI) - ejaculation - withdrawal	 1/700* 1/1550*	2 drugs if source MSM or from high prevalence country (HPC)
Shared needles and other injecting equipment	1/12,500† (1/1250 – 1/415‡ if source MSM)	2 drugs if source MSM or from HPC
Insertive anal intercourse (IAI) (uncircumcised)	1/1600*	2 drugs if source MSM or from HPC
Insertive anal intercourse (IAI) (circumcised)	1/9000*	Consider 2 drugs if source MSM or from HPC, particularly if concurrent STI, trauma or blood
Receptive vaginal intercourse (RVI)	1/1,250,000^	Not recommended Consider 2 drugs if source MSM or from HPC
Insertive vaginal intercourse (IVI)	1/2,500,000^	Not recommended Consider 2 drugs if source from HPC
Receptive or insertive oral intercourse	Not measurable	Not recommended
Mucous membrane and non-intact skin exposure	< 1/10,000* (MSM exposure)	Not recommended
Needlestick injury (NSI) from a discarded needle in community	Not measurable	Not recommended

* Based on estimated seroprevalence 10% (9.6%) in MSM.
† Based on estimated seroprevalence 1.0%.
‡ Based on estimated seroprevalence of 29%.
^ Based on estimated seroprevalence 0.1%.

Strangulation

Manual, chokehold, ligature

Occlusion of air flow and/or occlusion of blood flow due to external compression of vital structures in the neck

https://www.youtube.com/watch?v=AgbwP6Hn-lM

Note patient **may not recall** loss of consciousness or strangulation itself

Approx 6.8 seconds to LOC, 1-6 minutes to death

Strangulation

Underreported by sexual assault patients

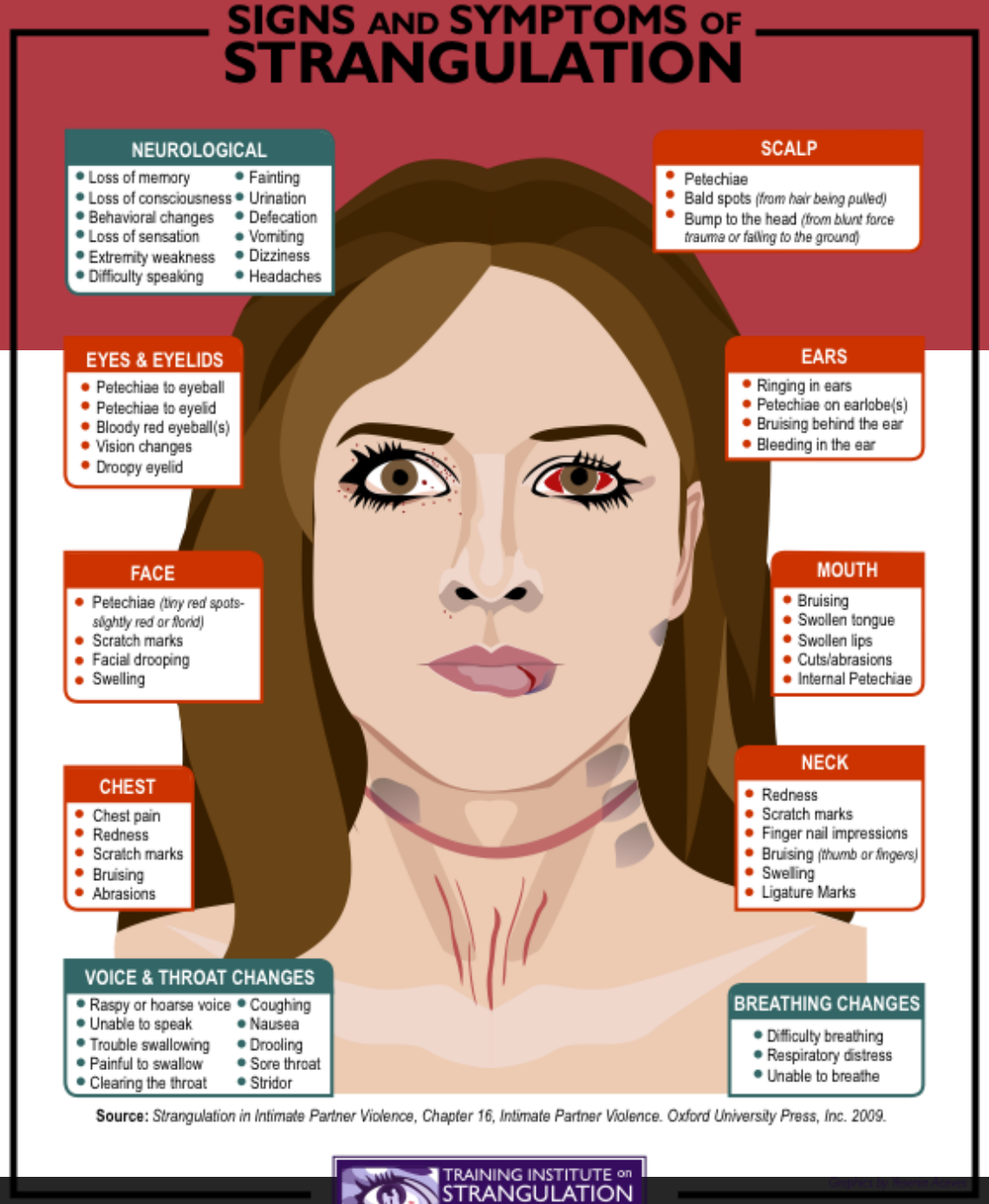
Carotid dissection prevalence 1% in case series of NFS

Historically underdiagnosed as a risk factor for stroke

Risk of anoxic brain injury

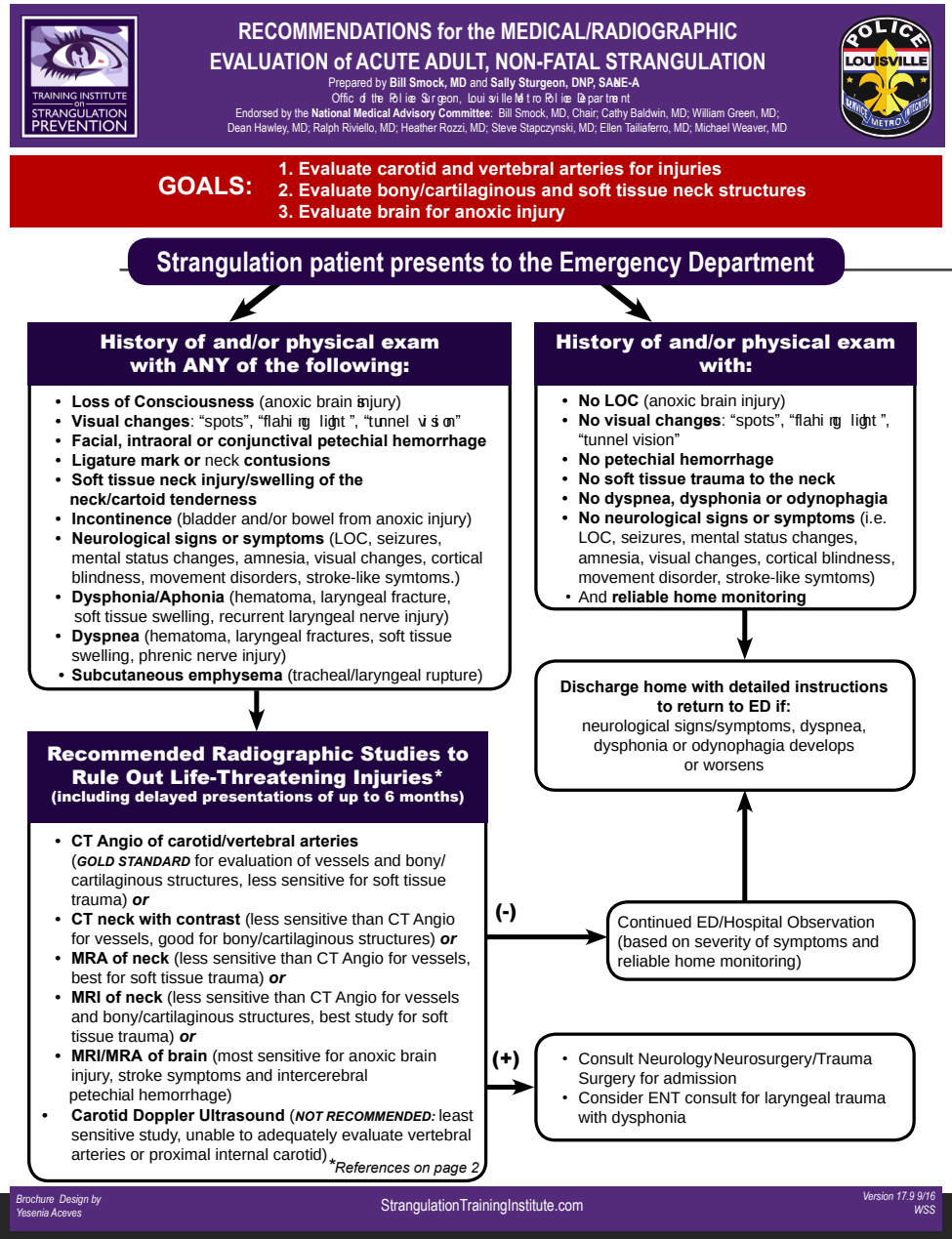
Serious injury may be present with no external sign of injury

7.48 x increased risk of homicide if strangled by intimate partner



Strangulation red flags (refer to ED):

- LOC, seizures, focal neurological changes, amnesia
- Incontinence
- Dyspnoea, hoarse voice, pain/ difficulty swallowing, soft tissue neck swelling, subcut emphysema
- Visible ligature marks, bruising, neck pain, carotid tenderness
- Petechiae above level of occlusion (face, eyes, oropharynx), conjunctival haemorrhages



- CT carotid angiogram indicated if red flags for carotid injury present
- Carotid Doppler USS not sensitive enough
- Consider ENT review if dysphagia/
- CT neck if laryngeal fracture
- Period of observation for delayed swelling

Case study:
SM further management

- Provided empiric Rx for presumed HSV (valaciclovir 500mg BD for 10 days)
  - No emergency contraception required
  - Simple analgesia for vaginal discomfort
- Psychosocial follow up and assistance with Victims of Crime application forms with SAS counselling service
- Discharged home with first session pack (information regarding court process, help available, medical follow up)
- Mandatory reporting obligations attended re children
- Followed up with GP (me) for results of Ix + repeat STI screen at 2 wks
  - HSV positive
  - Chlamydia positive – Azithromycin 1g

Historical sexual assault disclosure

Validation and belief

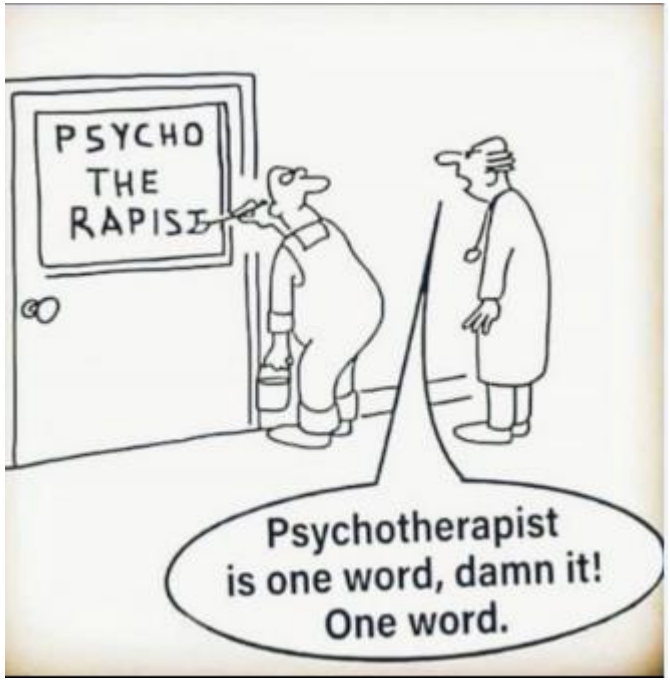
Consider need for STI screening

Referral for specialised counselling/ advice (SAS or private)

Victims of Crime – support for counselling, may be eligible for compensation payments

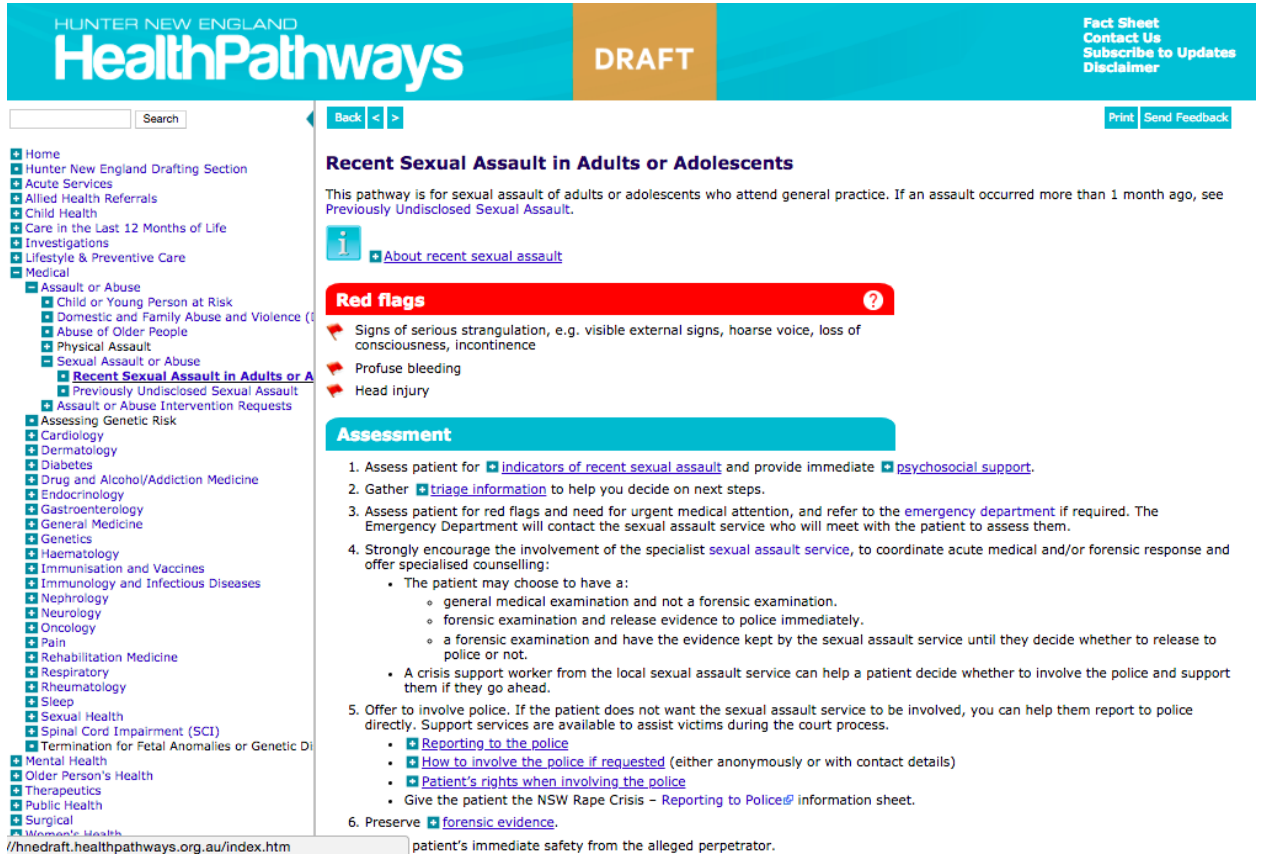
Consider acquired brain injury or carotid artery dissection if disclosure previous/ repeated strangulation

Consider undisclosed previous SA in a range of physical and mental health presentations and when gaining consent for genital examination



Referral pathways

- Contact your local Sexual Assault Service for coordination of acute forensic medical response and psychosocial assessment, and referral for ongoing counselling after a recent SA
- Consider Victims of Crime counsellors or private mental health clinicians with a trauma-informed practice for psychosocial follow up for acute or historical sexual assault
- Emergency department for assessment of recent strangulation with red flags (see Strangulation HealthPathway) or forensic / medical sexual assault response (if within timeframes)



Sexual assault is common

Sexual assault has ongoing adverse effects on health across the life course (not just on mental health)

Exposure to childhood trauma increases vulnerability (both to SA and health sequelae)

Patients disclosing for the first time will remember what you say for years

Use opportunity when examining patients or doing routine check ups to reinforce/ model messages around consent

Sexual assault forensic examiner training

- Training provided by LHD to support GPs to become forensic examiners to provide after hours sexual assault forensic response via on call roster
- Ongoing support via quarterly meetings, GP peer education CPD group, debrief and case review
- Support with preparation of expert opinion certificates and court attendance
- Education Centre Against Violence basic training and Grad Cert course (prereq for SANEs)
- Master of Forensic Medicine course (Monash/ VIFM)
- FAMSACA membership
- Helpful: Family Planning or Sexual Health courses, Forensic or Legal medicine courses

Dr Maelle Morgan: recently joined the forensic examiner team in Moree

Why I wanted to train in Forensic Examination:

1. To improve access for forensic examination and care for victims

2. To utilise my skills in women's health and family planning, including IUD insertion and mTOP

What I've gained from it:

1. Rewarding being able to offer the service locally

2. Further developed my skills in examinations: speculum exams, swab collections, bruise and injury identification

3. Apply these skills to other areas, for example documentation of general assaults and expert certificates

4. Satisfies my obsession with criminal investigations and the legal process behind crimes

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