SEXUAL ASSAULT REFERRAL CENTRES

“GETTING STARTED” GUIDE
Sexual Assault Referral Centres
‘Getting Started’

This paper should be read in conjunction with the joint HMCPSI/HMIC Thematic Inspection on Rape Investigation (2002)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2. History</td>
<td>3</td>
</tr>
<tr>
<td>3. Different Concepts</td>
<td>4</td>
</tr>
<tr>
<td>4. Facilities</td>
<td>6</td>
</tr>
<tr>
<td>5. Staffing</td>
<td>10</td>
</tr>
<tr>
<td>6. Training</td>
<td>12</td>
</tr>
<tr>
<td>7. Communication</td>
<td>13</td>
</tr>
<tr>
<td>8. Drugs and Medical Supplies</td>
<td>13</td>
</tr>
<tr>
<td>9. Policies and Procedure</td>
<td>14</td>
</tr>
<tr>
<td>10. Audit and Quality</td>
<td>16</td>
</tr>
</tbody>
</table>

Appendices:

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Care following Rape</td>
<td>17</td>
</tr>
<tr>
<td>2. First Aid</td>
<td>18</td>
</tr>
<tr>
<td>3. Emergency Contraception</td>
<td>19</td>
</tr>
<tr>
<td>4. Sexually Transmitted Infections</td>
<td>20</td>
</tr>
<tr>
<td>5. Hepatitis B</td>
<td>23</td>
</tr>
<tr>
<td>6. HIV</td>
<td>25</td>
</tr>
<tr>
<td>7. Cleaning Protocol for Victim Examination Suites</td>
<td>30</td>
</tr>
<tr>
<td>8. Examples of Staffing Levels</td>
<td>32</td>
</tr>
<tr>
<td>9. Contact Details</td>
<td>35</td>
</tr>
<tr>
<td>11. Further Reading</td>
<td>36</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 This paper provides advice and guidance on developing a Sexual Assault Referral Centre (SARC). It will detail the background and history of SARCs and give guidance on the different concepts. The information contained in this document has been collated from the dedicated staff connected with existing referral centres. Special thanks go to Dr Jan Welch and Detective Chief Superintendent David Gee whose input into this document has been invaluable.

There are two imperatives to service provision given by a SARC following sexual assault:

- Forensic examination so that evidence can be collected for use in the investigation of crime

  and

- Care of the victim to minimise the risk of subsequent physical and mental difficulties and promote recovery.

The unique aspect of a SARC is that victims can make use of all the facilities whilst their anonymity is preserved. The partnership between the police, the health services, and good liaison with other statutory and voluntary agencies, is therefore essential in meeting victims needs.

2. History

2.1 The first SARC in England and Wales was established in 1986 at the St. Mary’s Hospital, Manchester, jointly managed by the local Health Authority in collaboration with the Greater Manchester Police (GMP).

2.2 The background to its introduction was the treatment of victims of this type of crime that was less than professional. This was evidenced in the now infamous TV documentary in the early 1980s in the Thames Valley Police area.

2.3 Many forces recognised the relatively poor treatment of rape victims in particular and several made a determined effort to improve facilities so that the improved care afforded to victims might realise an improvement to the poor attrition rate in cases of this nature.

2.4 In addition to the above, Her Majesty’s Crown Prosecution Service Inspectorate (HMCPSI)/Her Majesty’s Inspectorate of Constabulary (HMIC) joint thematic inspection into rape investigation was published in April 2002. It identified the concept of dedicated, multi agency facilities as good practice and an area that forces should seek to develop in the quest for improved victim care. This should, in the first instance, lead to increased reporting of
offences as victims gain confidence in the Criminal Justice process. However, we should also see a commensurate increase in the conviction rate, which stood at 7% (2002)\(^1\) success for all reported offences of rape.

2.5 Services required following sexual assault will depend on the needs and wishes of victims, and the time that has elapsed since the assault. SARCs aim to provide an efficient and sensitive service to all victims of serious sexual assault.

2.6 The St. Mary’s Centre continues to flourish providing quality care for victims from the GMP area. Since its introduction, it has become the model on which similar establishments have been based and introduced in other force areas. The concept, therefore, has become reality and all bespoke centres are examples of good practice in the treatment of victims of sexual assault.

3. Different Concepts

3.1 There are now very different examples of SARCs around the country, each performing a vital role in the treatment of victims and the investigation of crime. Those SARCs situated in hospitals and other health authority premises have some additional customer benefits in terms of better access to Doctors, drugs, and links with Genito Urinary Medicine (GUM) clinics.

   *However, it is important to visualise the SARC as a concept rather than a building. Enhanced victim care is the main ingredient.*

3.2 To date over 8,900 victims have been provided with services by the centre. It provides care for victims subject of offences within the GMP area.

3.3 It is funded jointly by GMP and the Central Manchester and Children’s University Hospitals National Health Service (NHS) Trust. The cost per annum to operate the facility is around £200k. This equates to £271,555 from GMP and £108,440 from Health.

3.4 The Haven Camberwell is located within King's College Hospital in Southeast London. It opened in May 2000 to provide 24/7 services to victims of serious sexual assault. The Haven Paddington was opened in March 2004. Haven Whitechapel has an anticipated opening date of June 2004. Both centres will serve North London. The Havens offer a full range of services integrated into Sexual Health services, so that staff and facilities can be shared and supplemented by follow-up clinics staffed by the clinical team.

\(^1\) Home Office figures
3.5 The Centres are funded by the Metropolitan Police Service and the National Health Service, with the NHS contribution being ‘top sliced’ from Primary Care Trusts (PCTs). The set up costs for each centre is around £300k with running costs of up to £1 million per thousand cases per annum. During the first year of its introduction, The Haven Camberwell saw a throughput of 676\textsuperscript{2} complainants. It is anticipated that once the facilities are expanded and developed, these figures will increase year on year.

3.6 The MPS has now moved to dedicated sexual offence teams (\textit{Project Sapphire}) that bridge the professional gap across London, ensuring that, in conjunction with the Haven Centres, victims in that area receive a high quality of service from both the police and other agencies. This not only encourages the reporting of more offences but also assists in providing victims with the confidence to persist with the complaint safe in the knowledge that all the necessary support and expertise is available.

\begin{itemize}
\item \textbf{The Rape Examination Advice Counselling Help Centres (REACH) – Northumbria Police Area}
\end{itemize}

3.7 Operating across the Northumbria Police Areas the two REACH Centres are based in Newcastle-upon-Tyne and Sunderland respectively. They were established in 1991 and offer the full range of services to victims of sexual assault in line with the St. Mary’s model.

3.8 Unlike St Mary’s and The Havens, the REACH centre in Newcastle is situated in an adapted 5 storey terraced house. REACH Newcastle has close links to other services such as the GUM clinics and an immediate referral system in place.

3.9 Northumbria Police, the four local Health Authorities and six Local Authorities jointly fund the Centres with the overall annual running costs amounting to £230k of which £150k is devolved directly to the Centres Manager. This funding has recently been renegotiated to incorporate a three-year deal from its previous annual review, thereby providing the funding of the Centres with a degree of longevity.

3.10 Derbyshire Constabulary will open a SARC in the summer of 2004, which will operate in line with REACH practices in Newcastle. The premises comprise two semi-detached police houses situated on a housing estate. These premises will be completely refurbished and adapted into a purpose built SARC containing full forensic facilities and managed on a day-to-day basis by Derbyshire Rape Crisis.

\textsuperscript{2} Haven figures
Juniper Lodge - Leicestershire

3.11 This facility, whilst operating with the concept of SARC ethos is an example of what can be achieved by a provincial force where resources are limited and in which the 24 hour fully staffed facility is neither desirable or necessary. Many of the start up costs have been acquired through sponsorship with local and national companies.

3.12 The unit is called the Sexual Assault Response Centre and is housed within the Leicester General Hospital complex. The services provided vary slightly to the St. Mary’s and other centres in that the facility is not open 24 hours a day but does provide 24/7 assistance on an on call basis.

SAFE Centre – Lancashire

3.13 Lancashire’s SARC is the SAFE centre and is again situated within Health Authority premises. The centre has been operational since July 2002.

3.13 The above examples give an overview of the different concepts that currently fall into the definition of a SARC. As can be seen the priority is not what the centre looks like or where it is situated but that it provides a multi-agency strategy for enhanced victim care and as a result aids any subsequent police investigation.

3.15 Given that victims of this type of offence are often more reluctant to report the occurrence, they need to have the confidence that once they have reported the offence, they will be cared for promptly, with empathy and afforded all the necessary expertise. The ideal is that necessary resources and expertise are available to victims as soon as possible after the report is received.

4. Facilities

The following guidance is based on best practice identified by existing successful SARC centres.

4.1 Access

- External and internal signage should be clear; signs in languages other than English may be necessary
- A map of the SARC should be available on the Internet as well as being available for faxing or e-mailing
- Parking for police/centre staff/clients should be nearby, marked and available 24/7
- Access areas should be clean and well lit
- Video-entryphones/ CCTV will facilitate access for clients while ensuring staff security at night
4.2 **Premises**

- Entry to the SARC should be restricted, e.g. by key pad or swipe card
- A SARC should contain one or more suites suitable for forensic use, and may also contain follow-up facilities
- Privacy is improved by enabling direct access to the SARC, rather than having to pass through other premises
- Security of premises and staff is an essential part of planning a SARC, and may include:
  
  - Nurse call system
  - Pinpoint (personal alarm) or direct police alarm system
  - Close liaison with hospital security officers or police

4.3 **Follow up facilities**

- Are welcomed by many clients as an appointment to attend can be made at the time of the initial forensic examination and clients do not need to repeat the background details
- If designed to be forensically secure, follow up suites can also be used as an overflow forensic suite, staff permitting
- A separate entrance to the follow up suite is ideal as it avoids reproducing the initial experience of attending for forensic examination
- Follow up facilities should include:
  - A welcoming reception area
  - A waiting area with comfortable seating, magazines and refreshments
  - A counselling room
  - An examination room with adjacent laboratory / primary analysis facility for urine testing, microscopy etc
  - Toilet and shower
  - An additional interview room is useful, for example for a client and police officer to meet, or for use by a psychologist
  - Availability of television / video and children’s videos. Children unless they are victims and requiring medical examination should be discouraged from attending a sexual assault referral centre, A parent/carer cannot relax knowing the child is next door. The services of victim support or similar should be considered.

4.4 Mary Newton from the Forensic Science Service (FSS) has worked as part of the working group overseeing the HMCPSI/HMIC joint thematic process. Her guidance that follows relates to the minimum standard for victim reception/examination suites.

- There should be a forensic waiting area/room as part of the suite with forensic awareness in mind i.e. wipeable chairs and flooring. Victims and relatives can wait in this area as long as it is cleaned each time the suite is used.
A generic comprehensive log book which is paginated and provides sufficient space to record the following details:

a) Number per entry  
b) Date attended  
c) Time attended  
d) Name (print and sign)  
e) Status (SOIT, Victim A/C, FME, Contractor)  
f) Memo cognitive interview Y/N  
g) Medical undertaken Y/N  
h) Cleaning request  
i) Cleaning undertaken (date/time/name)  
j) Replenish stock requested (list items and to whom)  
k) Stock replenished by (date/time/name)

A generic log must be available in all suites and located in the entrance hall. An obvious notice must advise that it should be completed each time a visit is made to the premises.

A reference folder should also contain clear guidelines on:
- cleaning protocols, removal of soiled linens from the bathroom
- H & S advice on disposal of sharps bins and contaminated waste.
- Contractor's details.
- Instruction of where to deposit keys to the rooms
- Procurement details with regard to restocking the medical room and bathroom supplies
- All the rooms should be clearly labelled with regards to their use e.g. medical examination, waiting room, bathroom etc.
- The forensic suite should have lockable doors. The bathroom should have a reversible lock, which is a useful safety feature. The rooms must be kept locked when not in use to preserve the integrity of the cleaning procedure employed.

4.5 Reversible laminated notices should be posted on the outside of all the forensic suite doors indicating that the room is either clean or requires cleaning. The suite must be cleaned between each patient and cleaning agents used must be consistent at both suites.

4.6 Wall mounted storage system bins can be used to hold individual modules in the medical room, which should be placed on wall areas away from the medical examination couch and avoid placing over radiators if at all possible. Label the individual bins with regard to their content. Put a reminder notice on the wall to remind users to order depleted stocks and to complete the logbook.

4.7 Ensure miscellaneous stocks of doctors' equipment, first aid items and exhibit packaging is the same at each suite and at all sites. Storage cupboards and or drawers need to be provided to house these supplies. An under table storage unit (4’) would be a sensible choice so that the tabletop
could be used to label and package exhibits. Cupboards and drawers need to be clearly labelled with regard to their content and the labels and order of storage should be generic at all suites.

4.8 Laminate an enlarged version of the “Guidelines for collection of specimens” and place on the medical room wall as reference for the Forensic Medical Examiner/Officer who performs the first line response role.

4.9 Provide wall mounted soap and paper towel dispensers above the sink in the medical room as standard.

4.10 Provide a wipeable privacy screen in both medical rooms beside the couch for the doctor to work behind.

4.11 Provide a step for the patient to get on to the couch

4.12 Provide a pillow with disposable pillow protectors to be placed on the head end of the couch

4.13 Ensure the clinical waste bin is labelled and instructions on where to dispose of the waste is noted on the bin. Contact a clinical waste contractor to ask if it can provide a large storage bin for outside the suites which will be emptied on a regular basis and can therefore be used to place the bin liners in each time the medical rooms are used.

4.14 Provide coat hooks on the internal door surface of both the medical room and the bathroom.

4.15 Decide whether a freezer/fridge unit is needed within the medical room to store intimate items prior to the force collection service/movement of items. If this is a requirement the unit should have a larger freezer than fridge. A log should also be completed listing items retained every time the freezer/fridge is used and this should be signed when items are removed.

4.16 Establish whether a wall mounted lockable drugs cabinet is required at all in the medical examination rooms. This could be used to house standard drugs normally issued by prescription and medicine that can be issued over the counter e.g. paracetamol. Discuss whether this is required with the FMEs that serve the force.

4.17 Standardise towels and dressing gowns at all suites and replace with white stocks where possible. Ask the laundry contractor to provide cleaned towels and bath mats in sealed plastic bags. Laundered bathrobes should also be repacked in this way.

4.18 Provide a laundry basket containing a liner in all bathrooms or outside the room with a notice attached to direct the deposit of used/dirty laundry.

4.19 Provide single use toiletries for each patient to include:
• Bath/shower gel
• Toothpaste
• Toothbrush
• Comb

4.20 Provision of sanitary wear in all toilets/bathrooms. Make provision for a small number of free size tracksuits, underwear and footwear as replacement clothing when the victim does not have a change of clothing with them. These items should be provided and considered non-returnable. Provision of a chair in the bathroom for the patient’s use is beneficial.

4.21 An audit should be made periodically i.e. every 3 months, in order to check standards of cleanliness and equipment provided. The audit should be recorded and any areas for attention addressed.

Funding

4.22 The key issue when seeking to establish a SARC is the provision of sustainable funding. There are examples where the NHS and the Police have collaborated to achieve joint funding (MPS and GMP) and examples of sponsorship and joint working with voluntary organisations to achieve the same aims. This is an essential element to ensure both the efficacy and the longevity of any SARC project. Advice is available from those experienced within existing facilities.

5. Staffing

5.1 The number and type of staff will obviously depend on the number of clients likely to be seen by the SARC. Without a regular commitment from appropriate staff it is not possible to co-ordinate clients needs, maintain stocks of essential supplies or even provide a forensically secure environment.

5.2 Working with people who have been sexually assaulted long-term can be very draining, and lead to burnout. The risk of this can be minimised by having staffing structures, which enable staff to carry out a range of activities, for example by integration with a sexual health service, as well as by effective and responsive management and the availability of staff supervision and support.

5.3 A team of two people is ideal for conducting a forensic examination, enabling the taking of swabs, bagging of samples etc to be conducted quickly and efficiently while supporting the client through the examination. The presence of two clinical staff, such as a doctor and a crisis worker, frees up the attending police officer to be writing up notes while the examination is taking place. Teamwork also helps the clinical staff and may thereby assist retention: for example a new doctor may find it very helpful to work with an experienced crisis worker particularly during and following traumatic examinations.
5.4 **Staff likely to be required** (full or part-time)

- Doctors (including paediatricians)
- Nurses / crisis workers
- Health advisors / counsellors / support workers / psychologist
- Manager
- Administrator
- Cleaner
- Management Committee

5.5 Additional staff performing different roles would be needed depending on factors such as the numbers of clients attending the centre, high levels of core funding etc etc.

**Doctors/Forensic Medical Examiners (FMEs)**

5.6 One of the key components in the investigation process is the provision of quality forensic services. Within *Speaking up for Justice, 1998*, there was a recommendation that victims should have a choice of gender of FME. There are inherent difficulties with the implementation of this in that across England and Wales there are relatively few female FMEs. In 2002 a total of 35% of General Practitioners (GPs) are female whereas only 18.2% of FMEs are female (208 out of 1145)\(^3\)

5.7 Research suggests that the majority of rape victims prefer to be examined by a female FME. When one excludes the dedicated suites, the reality is that this function is carried out by predominantly male GPs often unavailable throughout the daytime and some of who are not trained to the level required.

5.8 This gap in service provision leads to delays for traumatised victims and, in some cases a less than ideal approach to victim care. This becomes more acute when one considers the more diverse character of our population.\(^4\) When one adds the other duties of the majority of FMEs that combine their role as general practitioner with the wider Police Surgeon role, it quickly becomes apparent that to add another expertise, that of treating rape victims, has the potential to dilute the quality of that service.

**Sexual Offence Examiners (SOE’s)**

5.9 In already established centres, the majority of FMEs are female and are specialist in this particular field, providing an on-call facility without the constraints of other generalist Police Surgeon duties. This is a bonus for both the victim and the FME in terms of their timely response and the quality of their service provision.

---

\(^3\) HMCPSI/HMIC Thematic report on Rape Investigation 2002

\(^4\) As above
5.10 **Core competencies** (these may be present at appointment or inculcated by training)

- Sexual / reproductive health experience / skills
- Family planning expertise
- Expertise in the prevention and management of sexually transmitted infections including HIV, and in care following sexual assault
- Good verbal and written communication skills
- Ability to work as part of a multi-professional team
- Enthusiasm for developing the skills to provide evidence in court

With regard to acceptable qualifications, additional guidance can be obtained from Dr Welch.

5.11 **Crisis workers** – core competencies

- Qualified nurse, or experience as a health advisor in genitourinary medicine or equivalent experience) OR experienced/qualified counsellors
- Understanding of the needs of someone who has been sexually assaulted
- Good verbal and written communication skills
- Ability to work as part of a multi-professional team

5.12 **Centre Managers**

SARC managers are employed by various funding streams. Some SARC centre managers are directly employed by the police authority in that area whilst others are employed by PCTs. Others are financed jointly by the police and Health Authority. Some managers are salaried by the voluntary agency that manages the counselling and day to day running of the centre.

6. **Training**

6.1 The following training will be required for all new clinical staff such as doctors and crisis workers, and may also be valuable for other staff

- Sexual offences training
- Paediatric training (if children are to be seen)
- Court training

6.2 In addition, ongoing support and training is necessary, for example:

- Monthly topic-based meetings
- Opportunities for new clinical staff to shadow examinations, and then to conduct examinations under the supervision of more experienced staff
- Opportunities for new doctors to have their statements reviewed by more experienced doctors, and to discuss forthcoming court cases
- Peer review
- Yearly basic life support training, infection control
Other professional training, e.g. teaching skills, risk management

Doctors may also wish to study for formal qualifications, for example the Diploma in Medical Jurisprudence (DMJ).

6.3 Training for other persons connected with the SARC should also be considered, these include:

- Police - First line trained staff often referred to as Sexual Offence Liaison Officers (SOLO) or Sexual Offence Investigation Trained (SOIT)
  - Call centre and enquiry office staff - the do’s and don’ts when an offence of rape or sexual assault is reported to them

- A & E Departments - Front line staff

7. Communication

7.1.1 Effective communication is an essential ingredient to the successful running of a SARC. The following should be considered:

- Appoint a police liaison officer who can be the centre’s avenue of communication with the police
- Appoint a health liaison officer who can be the centre’s avenue of communication with the health authority.
- If the administration officer or centre manager are employed by the police they will have access to internal communication facilities which will aid liaison with the officer in the case
- Ensure the management board has the relevant muti-agency members
- Consideration should be given to how information is to be shared. Each centre has its own protocols which should be set out in the policies and procedures
- Effective communication also includes how gathered intelligence is shared by all concerned parties

8. Drugs and medical supplies

8.1 All SARCs are likely to experience some medical emergency. For example some clients will have been given drugs that may precipitate a respiratory arrest or a fit, and so essential medication should be available and restocked regularly, especially before weekends and public holidays.

8.2 Medication for clients to take home should be provided in pre-packed form. Pre-packs are commonly used in hospital departments such as
Accident & Emergency or Sexual Health; using the same pre-packs will minimise administrative difficulties and expense. Additional medication, e.g. in syrup / suspension form, will be required if young children are to be seen in the SARC.

8.3 General and emergency stock

- Pregnancy test kits
- EMLA cream 5% (local anaesthetic for skin)
- Lignocaine gel 2% (15 ml)
- Sodium chloride ampoules 0.9% (5 ml)
- Water for injections ampoule BP (10 ml)
- Diazepam rectal tubes 5mg
- Adrenaline shock pack ampoule 1 in 1000 or equivalent
- Hydrocortisone
- Cleaning materials for DNA decontamination

Examples of pre-packed medication (may vary according to local practice/protocols):

- Azithromycin 250mg x 4 (single-dose for chlamydia)
- Clotrimazole pessaries and cream (thrush treatment)
- Chlorphiramine 4mg x 10 (anti-histamine)
- Doxycycline or other medication for pelvic infection
- Erythromycin or other medication for pelvic infection, pregnancy risk
- Ibuprofen 200mg x 24, painkiller
- Metoclopramide / domperidone – anti-sickness
- Metronidazole 400mg x 10, antibiotic
- Levonorgestrol 0.75 mg x 2, emergency hormonal contraception
- Paracetamol, 500mg x 32
- Salbutamol inhaler (200 dose), anti-asthma
- Trimethoprim 200mg x 10, antibiotic
- Daktocort cream, 30g
- Diphtheria, tetanus PFS vaccine 0.5 ml
- Hepatitis A vaccine
- Hepatitis B vaccine
- Human immunoglobulin (also possibly hepatitis B immunoglobulin)
- PEP packs (e.g. Combivir + nelfinavir x 3 days)
- Water for irrigation (1 l pour bottle)

9. Policies and Procedures

9.1 Having agreed operational policies and procedures in place is vital to the smooth running of the SARC. These ensure that each important area of service provision has been addressed and give clear guidelines as to how the
centre deals with these aspects. A nominated force ‘champion’\(^5\) is essential for ongoing support together with an identified police liaison officer for day to day issues. Areas that should be considered are:

- Management of telephone enquiries
- Information to be elicited / advice to be given to police / self referrals making appointments for examination
- Arrangements for children / people with special needs / people requiring interpreters
- Arrangements for examinations needing to be carried out elsewhere e.g. A&E, domiciliary
- Contacting staff on call
- Security of premises and staff
- Travel arrangements out of hours, and car parking
- Forensic examination
- Self-referral examination
- Paediatric examination
- Medical emergencies e.g. respiratory arrest, fits
- Diagnosis and management of STIs, including chain of evidence for STI investigations
- DNA decontamination of premises, and associated documentation
- Ensuring supplies of equipment, drugs etc
- Making arrangements for follow up
- Confidentiality and consent to release information / disclosure
- Management of requests for statements
- Leave arrangements, both internal and liaison with CPS
- Data entry and security
- Media enquiries

9.2 **Client information**

The following written information should be available for clients:

- Advice for women and/or men who have been sexually assaulted, including details of relevant support organisations
- Contact details of the SARC, including the names of staff who saw the client
- Leaflet on emergency contraception
- Information on any medication given

*There will also need to be clear information drawn up for police officers about working with the SARC, supported by training*

\(^5\) Senior Officer of Superintendent rank or above
10. Audit and quality

It is essential that audits are conducted and statistics collated on the various aspects of service provision at the SARC. These will evidence its effectiveness and can assist in attracting long term funding. Areas that should be considered are:

♦ Availability of forensic examination within one hour
♦ User satisfaction surveys (police / clients if can be achieved sensitively)
♦ Quality of samples and labelling
♦ Availability and functionality of equipment and supplies
♦ Recording of data, e.g. number of women at risk of pregnancy and proportion offered emergency contraception
♦ Management information
Appendix 1

Medical care following rape

Idealised schedule; should be adapted as necessary to meet the needs and wishes of the complainant.

**Initial presentation (e.g. for forensic examination)**
- Psychosocial support
- Consider post-coital contraception
- Consider post-exposure prophylaxis for HIV (PEP) and hepatitis B
- Discuss follow up arrangements
- Consider prophylactic antibiotics if declines follow up

**First follow up (3–14+ days after assault)**
- Post-coital contraception/post-exposure prophylaxis follow-up
- Offer genital screen for infection (samples for gonorrhoea, chlamydia, trichomoniasis) plus pelvic examination if indicated
- Offer prophylactic antibiotics if declines above or further examinations
- Consider starting hepatitis B vaccination
- Baseline syphilis serology; HIV serology if taking post-exposure prophylaxis
- Serum save (usually stored in virology, can be tested in parallel with later samples for HIV and hepatitis B and C)
- First meeting with counsellor or health adviser; offer further counselling

**Second follow up (2 weeks later)**
- Post-coital contraception/post-exposure prophylaxis follow-up
- Give results of previous tests
- Offer repeat genital screen for infection
- Discuss subsequent follow up

**Third follow up (3 months after assault)**
- Pre-test discussion for HIV, syphilis; offer tests
- Psychosocial support / offer further counselling

**Final health check (6 months after assault)**
- Pre-test discussion for hepatitis B and C, offer tests
- Offer additional HIV test if high-risk incident; offer further counselling

The above is considered as best practice and achievable within a sexual health setting. As a number of the new SARCs will be small and unable to provide this level of service, access to sexual health services or immediate referral agreements should be the minimum standard.
Appendix 2

First Aid

- General body trauma is more common than genital trauma in people who have been sexually assaulted.
- In Riggs’ series of 1076 cases, 64% of all sexual assault victims had general body trauma, with arms and legs most commonly injured, followed by the head and neck; 53% had evidence of genital trauma and 20% had no injuries documented.
- Other physical injuries are rarely severe, although occasionally assessment of major trauma, such as head injury, or examination and suturing of genital injuries under anaesthesia is required.
- If the client is to have a general anaesthetic then samples for forensic examination and photographs should if possible be taken, with consent, at the same time.
- Minor physical injuries are common and may require medical attention. Facilities for dressing of minor injuries and tetanus prophylaxis etc. should therefore be available at the site of forensic examination, rather than the client needing to attend an accident and emergency unit for additional treatment.
- Good liaison with local Accident and Emergency departments is crucial in encouraging appropriate referrals as well as supporting the use of early evidence kits to prevent loss of DNA in emergency medical care. The use of an algorithm is recommended.
Appendix 3

Emergency contraception

- Emergency post-coital contraception should be considered for all women of reproductive age following rape.
- In the USA, the rape-related pregnancy rate was estimated at 5.0% per rape among those of reproductive age.
- In one sample, 47% of 34 cases of rape-related pregnancy had received no medical attention related to the rape and 32% did not discover they were pregnant until the second trimester; most were adolescents.
- The sooner that emergency contraception is started, the more effective it is.
- Levonorgestrel 0.75mg, started as soon as possible within 72 hours and given 12 hours apart, is effective and well tolerated, although the patient should be advised that no contraceptive method is 100% reliable.
- A single 1.5mg dose of Levonorgestrol may be equally effective, and of value up to 120 hours after unprotected intercourse.
- Insertion of a copper-containing intrauterine contraceptive device (IUD) is even more effective in preventing pregnancy and should be considered for women presenting after 72 hours but within five days (120 hours) after their most likely expected date of ovulation, based upon their previous shortest cycle length.
- Antibiotic prophylaxis to cover gonorrhoea and Chlamydia trachomatis should be considered, especially following high-risk assaults such as those involving multiple assailants.
- Arrangements should be made for the medical follow up of women receiving emergency contraception, either in the SARC or elsewhere, e.g. GP, family planning clinic.
Appendix 4

Sexually transmitted infections

Risks

- Rape is often a major risk for transmission of sexually transmitted infection
- Addressing these risks can minimise some of the common anxieties expressed by victims of sexual assault.
- It is important to consider each client individually, as concerns and risks may be very different, for example related to whether the assailant was a previous partner or a stranger.
- Although often impossible to determine whether the infection was pre-existing or acquired from the assault, STIs that are evident within 72 hours of the assault probably antedate it.
- Studies of STIs in women who have been raped have shown rates of 3.9-56.0%, with the most common infections being those commonly seen in the local community, including gonorrhoea, trichomoniasis and C. trachomatis.
- STIs are often multiple, and the finding of one infection should prompt the search for more.
- A significant proportion of infections are not identified on initial investigation but only diagnosed at follow-up.
- As with all laboratory tests, those for STIs carry a small chance of being incorrect. Errors may occur at any stage, from collection and labelling of the sample, to analysis and reporting.
- Investigations are not 100% sensitive nor 100% specific, meaning that they may occasionally fail to pick up an infection (false negative) or give a positive result when no infection is present (false positive).
- Good practice is to confirm results by repeating tests with major implications for the client (for example, a positive HIV test) or when the initial result seems improbable.

Laboratory diagnosis and chain of evidence

- The diagnosis of an STI may be relevant evidence in the sexually inexperienced and at the extremes of age, or when a sexually inexperienced orifice is involved.
- If the results of investigations are likely to be used medico-legally, the types of tests used and the management of the sample becomes especially important.
- This should be discussed in advance with local laboratories and a policy agreed for medico-legal samples.
- Tests used should ideally be well validated for medico-legal use and capable of confirmation, such as culture for gonorrhoea and chlamydia.
Chlamydia culture is now not generally available, however, as newer more sensitive investigations such as nucleic acid amplification tests (NAATs) are adopted.

Although medico-legal experience with NAATs is currently limited, such tests are increasingly well validated for routine practice, and arrangements can usually be made to carry out a confirmatory test from the original sample.

The sample should be accompanied to the laboratory by a form documenting the chain of evidence:

- details of the sample
- when and where it was taken
- by whom and from whom
- a record of everyone handling the sample in its journey.

This process should continue in the laboratory, where laboratory investigations should be supervised by senior staff. They can arrange for additional confirmatory and other tests, and be prepared to give evidence should this prove necessary.

In the case of gonorrhoea, isolates should be saved in duplicate locally, ideally at -70°C, or sent promptly to the reference laboratory so that they can be stored adequately as well as being typed. Typing is invaluable if gonorrhoea has also been isolated from the alleged assailant, as it enables comparison between the two isolates.

**Diagnosis and management**

- Potential visits and investigations are summarised in the table; it is important to recognise that many clients do not wish to attend repeatedly.
- Before carrying out any genital examination the client’s comfort and feelings should be considered and a clear explanation given about what the examination entails and why it is necessary.
- Privacy is crucial; ideally there will be curtains round the examination couch to ensure this even if the examination room door is opened.
- Insertion of a cold metal speculum (used for follow-up but not for forensic examination) is uncomfortable for a woman and may increase her anxiety; this can be avoided if the speculum is warmed with tap water.
- If a client is unable, unwilling or unlikely to return for follow up, the use of empirical prophylactic antibiotics should be considered.
- The aim is to prevent gonorrhoea and chlamydial infection and their serious sequelae, such as pelvic inflammatory disease. There is little evidence of the efficacy of prophylaxis but national guidelines (CEG) recommend the use of: ciprofloxacin 500mg plus azithromycin 1g immediately, or, if pregnant or breastfeeding: amoxicillin 3g immediately plus probenecid 1g immediately plus erythromycin 500mg twice a day for 14 days.
First follow up visit: 3-14+ days

- If a case of rape is being investigated by the police, the victim is likely to have not only undergone a forensic examination but also to have spent many hours giving a detailed statement.
- Assessment for STIs is therefore usually best deferred until one - two weeks after the assault; this also takes account of the incubation period of common infections.
- At follow-up, avoidance of waiting, privacy and a supportive environment are crucial in minimising additional trauma.
- Many clients are reassured to have a full genital examination and samples taken for infections, providing that this is done sensitively. Others feel that the examination is an additional violation, in which case the use of prophylactic antibiotics should be considered, as above.
- As even one full set of investigations will miss up to 12-15% of STIs, prophylactic antibiotics should also be considered for clients unwilling to return for a further set of tests, especially following high-risk incidents such as gang rape.
- At this visit, samples should be taken for gonorrhoea (ideally swabs for culture from cervix, urethra, rectum, and throat if fellatio occurred), chlamydia (method depends on local methods available; ideally a cervical sample) and trichomoniasis (high vaginal sample).
- NAATs for chlamydia and gonorrhoea are becoming increasingly available and may be much more acceptable to the woman, since they can be carried out on a urine test or perineal swab.
- Baseline syphilis serology should also be taken and a sample stored in the laboratory for later testing, should the woman later be found to have HIV or viral hepatitis, in order to assist in dating seroconversion.

Subsequent health checks

- At subsequent health checks earlier treatment, such as post-coital contraception, anti-bacterial and antiviral prophylaxis, can be reviewed.
- There are also opportunities for further psychosocial support and referral, where necessary, and STI screening including serology after three to six months.

Role of genitourinary medicine

- Additional support and health care for those who have been sexually assaulted is available from departments of genitourinary medicine or sexual health; many departments are able to provide a fast-track service.
- Such departments can also provide local advice for those providing acute care and forensic examination.
- Their staff may also be able to provide immediate and continuing psychosocial support, as well as information about other local sources of support and referral as necessary.
Appendix 5

Hepatitis B

- Hepatitis B acquisition following rape has been described but it is rare in the UK. National GUM guidelines suggest that hepatitis B vaccine should be offered to all victims of sexual assault, but this is based on limited evidence. The Department of Health guidance (the Green Book) does not recommend its use for this purpose.

- We would recommend that the decision to give hepatitis B vaccine is based on an individual risk assessment and the views of the client, along the lines outlined below for HIV.

- It is not known how long after the assault this may be effective but, as hepatitis B has a long incubation period, it may be of value up to six weeks later.

- A full course of vaccine comprises 4 intramuscular injections over 1 year, and costs about £50.

Risk factors for hepatitis B carriage (2-10%)

- Injecting drug use
- Homosexual / bisexual men
- Origin in a high prevalence area e.g. Far East, India, sub-Saharan Africa, South America, Caribbean

When to consider hepatitis B vaccine

- Assailant known to be a hepatitis B carrier
- Assailant having risk factors
- Assault within 3 weeks
- Anal rape
- Trauma and bleeding
- Multiple assailants
- Client wishing to be vaccinated, and to reattend the centre or GP for repeated injections
- Client not known to be immune to hepatitis B following vaccination

Hepatitis B vaccine

Accelerated schedule: 1 ml vaccine im into the deltoid, given at presentation, 7 days, and 14 days
OR presentation, one month and two months with a booster at one year in either case.
Previous vaccination

Increasing numbers of people have now been vaccinated for occupational or other reasons; if there is a good history of at least three vaccinations having been given, and ideally of a subsequent check for immunity, then vaccine need not be given but a blood sample recommended to check for immunity (anti-HBs).

Hepatitis B immunoglobulin

Specific hepatitis B immunoglobulin 500 i.u. intramuscularly (HBIG) may be administered to a non-immune contact after single unprotected forced sexual exposure if the assailant is known or strongly suspected to be infectious. This works best within 48 hours and is of no use after more than seven days.
Appendix 6

HIV post-exposure prophylaxis

1) Background

- Acquisition of HIV following rape is rare in the UK
- There is limited evidence, but it seems likely that giving anti-retroviral drugs for post-exposure prophylaxis (PEP) will reduce the risk of acquiring HIV by about 80%
- PEP, if given, should be started as soon as possible after the assault and is unlikely to be of benefit if started more than 72 hours later
- It may be difficult to access drugs and expertise to provide immediate post-exposure prophylaxis for HIV, especially at night. If post-exposure prophylaxis is to be offered as part of a service, arrangements for this should be made in advance.

2) Recommended practice

- Risk assessment should be carried out (as reassuringly as possible) and documented for all clients and should cover:
  - The type of assault (e.g. vaginal and anal intercourse)
  - Any additional factors increasing or reducing risk (e.g. trauma or defloration increases risk, use of a condom reduces risk)
  - Any known or overt risk factors associated with the assailant or assailants
- If, after discussion with the client, the decision is made to start PEP, a 3-day (6 if e.g. public holiday) course of medication should be given and arrangements made to see the client again in 2-3 days
- If the client declines PEP in the presence of overt risk factors, this should be documented
- Clients should sign a consent form for the use of PEP, and should receive written information about the drugs used
- Haven data suggests that about 5% of clients will accept PEP, of whom >50% will not continue medication beyond 3 days
3) When to consider PEP

Assailant with HIV or risk factors for HIV, or multiple assailants AND

- Assault within 72 hours
- Forced unprotected anal or vaginal intercourse, and/or forced oral intercourse with ejaculation

*especially* if trauma and bleeding are present

AND

- Client wishes to take prophylaxis and able to be adherent to treatment

**NB:** the risk for male rape is often especially high – see examples below

4) Risk assessment

*The risk of HIV transmission = risk that source is positive *x* risk of exposure*

**Examples:**

**Woman** raped vaginally (risk 1 in 1000 – 2000 if overt trauma absent) by **man with no overt risk factors** (risk 1 in 1000 for UK, more in London)

= 1 in 1 000 000 (UK) / 1 in 100 000 in London

**Woman** raped vaginally (risk 1 in 1000- 2000 if overt trauma absent) by **injecting drug user** (risk 1 in 20)

= 1: 20 000 – 40 000

**Man raped anally** (risk 1 in 30 to 150)

by **three men** outside gay club (risk of each man having HIV 1 in 6)

= 1 in 180 – 900 for one man x 3 = 1 in 60 – 300 without trauma
Risk that the source is HIV positive

<table>
<thead>
<tr>
<th>Community group</th>
<th>HIV seroprevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Homosexual men</strong>*</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>15%</td>
</tr>
<tr>
<td>Scotland</td>
<td>2.5%</td>
</tr>
<tr>
<td>Elsewhere</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Heterosexuals</strong></td>
<td></td>
</tr>
<tr>
<td><strong>UK</strong></td>
<td>0.1%</td>
</tr>
<tr>
<td>Sub Saharan Africa</td>
<td>0.1-39%</td>
</tr>
<tr>
<td>SE Asia</td>
<td>&lt;0.1-2.7%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1.2-6.1%</td>
</tr>
<tr>
<td>Latin America</td>
<td>0.1-2.7%</td>
</tr>
<tr>
<td><strong>Eastern Europe and Central Asia</strong></td>
<td>&lt;0.1-1%</td>
</tr>
<tr>
<td><strong>Injecting drug users</strong>*</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>4.7%</td>
</tr>
<tr>
<td>Elsewhere in the UK</td>
<td>0.23%</td>
</tr>
</tbody>
</table>

The risk of HIV transmission following an exposure from a known HIV positive individual

<table>
<thead>
<tr>
<th>Type of exposure</th>
<th>Estimated risk of HIV transmission per exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive anal intercourse</td>
<td>0.1-3.0% 6,7</td>
</tr>
<tr>
<td>Receptive vaginal intercourse</td>
<td>0.1%-0.2% 7-12</td>
</tr>
<tr>
<td>Receptive oral sex (fellatio)</td>
<td>0-0.04% 13</td>
</tr>
<tr>
<td>Needle–stick injury</td>
<td>0.3% (95% CI 0.2%-0.5%) 14-16</td>
</tr>
<tr>
<td>Mucous membrane exposure</td>
<td>0.09% ((95% CI 0.006%-0.5%)) 18</td>
</tr>
</tbody>
</table>

The risk of transmission is increased by:

- Trauma or other causes of breaches in mucous membranes
- Defloration (loss of virginity)

High risk body fluids (in context of sexual assault)

- Blood
- Semen
- Saliva (if blood stained)
- Vaginal secretions
Low risk body fluids

- Faeces
- Saliva
- Urine
- Vomit

5) Investigations if starting PEP

If PEP is commenced the following baseline investigations should be taken, either at the time of initial presentation or at follow up after 2-3 days:

- 10 mls blood for serum save, sent to virology
- hepatitis B serology
- FBC
- U&E, LFTs, amylase, glucose, lipids

6) Drugs for PEP

<table>
<thead>
<tr>
<th>Drug</th>
<th>Form</th>
<th>Dose</th>
<th>Course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combivir (Zidovudine / Lamivudine)</td>
<td>Combined tablet</td>
<td>One bd</td>
<td>28 days</td>
</tr>
<tr>
<td>Nelfinavir</td>
<td>250mg tablet</td>
<td>5 tablets with food bd</td>
<td>28 days</td>
</tr>
</tbody>
</table>

The cost of a course of PEP is about £600. At least 50% of those who start PEP after rape will stop the medication, and so a full course should not be issued initially. The drugs used are unlicensed for PEP.

Women taking oral contraception should be advised that PEP may reduce its effectiveness.

In addition the following (or equivalent) should be routinely prescribed to control common side effects:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Form</th>
<th>Dose</th>
<th>Pack of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoclopramide</td>
<td>10mg tablet</td>
<td>1 tab tds PRN</td>
<td>30</td>
</tr>
<tr>
<td>Loperamide</td>
<td>2mg</td>
<td>Two tabs at the first sign of diarrhoea then one tab PRN – max 8 in 24 hours</td>
<td>30</td>
</tr>
</tbody>
</table>
7) Variations to standard PEP

Specialist advice, e.g. from an on-call HIV physician or on call pharmacist, should be sought before deviating from standard PEP.

Special considerations:

- There are a number of drug interactions with PEP, especially nelfinavir: these are summarised in Appendix 1 of the British National Formulary

- Pregnancy does not preclude the use of HIV PEP but should be considered in the decision making process, in conjunction with specialist medical advice

8) Follow up (2-3 days)

- Blood tests as above (5) at baseline
- Further weekly prescriptions via Haven follow up clinic
- FBC and LFTs at 2 weeks
- Offer of HIV test at 3 months and 6 months
Appendix 7

Cleaning Protocol for victim examination suites

The suite needs to be cleaned after each use to prevent DNA contamination. The cleaning should include the forensic waiting room, the medical examination room, the bathroom and toilet within the facility. Within the medical examination room the floor, couch (even if covered with a protector at the time of the medical), worktop, writing desk, sink and taps need to be cleaned each time the room is used.

The following is the advice and contact details of the DNA Site Manager at the London Laboratory regarding suitable disposable equipment and cleaning agents:

- Use Mediwipe (Seton Healthcare Group) – an alcohol based wipe with organic content for wiping down vinyl chairs in waiting room area and for the medical examination couch. These are used by the FSS in the DNA units for cleaning scissors and forceps and have instantaneous action.

- Use Virusolve disinfectant as a general cleaning reagent. This is suitable for all hard work surfaces such as counter tops and sinks. The product is also available as a ready to use spray and as disposable wipes. The disinfectant is meant to be in contact for at least 10 minutes to be effective. The FSS never use the solution itself neat. It is purchased as a concentrate that is diluted down – 10% solution. Once diluted it has a limited shelf life. On that basis a 10% solution would be suitable for floors and other surfaces as it is “left on”. The product in use at the moment is Microsol 3 and is purchased from Anachem.

Anachem House
Charles Street
Luton, Bedfordshire
LU2, OEB
01582 745 000
Met Lab rep-Kate Scanlan

This product is also available as a ready to use spray and disposable wipes.

- Use disposable white paper towels for cleaning surfaces with the Microsol disinfectant. (Any of the coloured varieties can cause fluorescence problems in the DNA process.) Cleaning of any surfaces which could potentially collect dust etc e.g. exposed storage shelves, should be cleaned on a weekly basis at least.

- The DNA units use Flash to clean the vinyl floors in the lab as this is very effective at removing the build up of dirt.

- Microsol should be used to clean the sinks wiped afterwards with J cloth type wipes. The cleaning cloths should be used once and be restricted to one room.

- The Medical examiners and Chaperones must wear disposable powder free gloves. The product used by the FSS is a “Premier” product which confirms to DHSS standards and is supplied by :

  Western Lab service Ltd
  Unit 8 Redan Hill Est
  Redan Rd, Aldershot, Hants
  EV 12, 4JS
  01252-312-128

- Trigene is a general purpose disinfectant produced by Med-Chem. It is being used by a number of Police Forces as a cleaning agent within victim examination suites. The FSS do not hold any information with regard to efficacy against DNA contamination. Details with regard to this product can apparently be obtained through Anachem.

- Hibiscrub is a product used as a general disinfectant by the NHS and is utilised by the St Mary’s Rape Suite in Greater Manchester for cleaning. DNA testing of swabs taken from the suite after cleaning had taken place yielded negative results. It therefore appears that this disinfectant is efficient as a cleaning agent. Further details can be obtained from the distributor:

  SSL International PLC
  Toft Hall
  Knutsford
  Cheshire
  WA 16 9PD
Appendix 8

Examples of Staffing levels

St. Mary’s Centre, Manchester:

- Clinical Director - 3 days per week
- Centre manager - full time
- 3 Counsellors - full time
- Centre Support Worker - full time
- Forensic Nurse Examiner - full time
- Research and Development Officer - full time
- 8 Crisis Workers - on call
- 11 female FMEs - on call

Haven Centres - Metropolitan Police Area
(estimated staffing for each of the 3 Havens)

- One associate specialist - full time
- One junior clinical fellow - full time
  (doctor on rotation with obstetrics and gynaecology)
- One clinical nurse specialist - full time
- Two nurses - full time
- One health advisor - full time
- One centre manager - full time
- One administrator - full time
- 8-10 female forensic gynaecologists - on call
- 11 crisis workers - on call

These are supplemented by follow-up clinics staffed by the clinical team.

The Rape Examination Advice Counselling Health Centres
(REACH) – Northumbria Police Area

- Centres Manager - full time
- 4 Counsellors - part time
- Administration Clerk - full time
• Case Tracker - full time
• 10 female Forensic Specialists - on call
• 4 male FMEs (also generalist police surgeons) - on call

The SAFE Centre - Lancashire

• Centre Manager - full-time
• Clinical Director - part-time
• Two Admin Support Officers - full-time
• Nine Crisis workers - on call
• Six female Specialist Forensic Examiners - on call
• One male Specialist Forensic Examiner - on call
• One further male FME - on call

Juniper Lodge - Leicestershire

• 13 FMEs (8 male, 5 female) - on call
• 1 Manager - full time
• 1 Admin Officer - part time
• 20 unpaid volunteers (support work) - on call
Appendix 9

Contact Details

If further advice and guidance is needed please contact the below. If your query cannot be answered, or further advice is required outside the scope of this document, you will be signposted to the relevant source.

Dave Gee  
Detective Chief Superintendent  
Derbyshire Constabulary  
david.gee@derbyshire.pnn.police.uk  
Tel: 01773 572115

Julie Sproson  
Detective Sergeant  
Derbyshire Constabulary

julie.sproson@derbyshire.pnn.police.uk  
Tel: 01773 572129
Appendix 10

Useful books for a SARC


British National Formulary (available from a hospital pharmacy)


Medical Evidence: a handbook for doctors. Clements et al. RSM Press


Forensic Medicine Clinical and Pathological Aspects Edited by Jason Payne-James GMM Press

Forensic Pathology. Bernard Knight

Recommended

A textbook of each of the following

Gynaecology
Atlas –Gynaecology and Forensic Medicine
Dermatology
Sexually Transmissible Infections
Surface Anatomy
Further Reading


5  United Kingdom Guideline for the Use of Post-Exposure Prophylaxis for HIV following Sexual Exposure. Clinical Effectiveness Group (British Association of Sexual Health and HIV) 2004, in preparation