Document Number: QH-GDL-472:2023

Guideline for the Management of care for people 14 years and over disclosing Sexual Assault

1. Purpose

This guideline provides recommendations regarding best practice to support the management of people 14 years and over who have disclosed Sexual Assault. The guideline recognises that services can be adapted as appropriate to suit local capabilities.

2. Scope

This Guideline applies to all Hospital and Health Services (HHSs).

3. Aboriginal and Torres Strait Islander considerations

Hospital and Health Services should give consideration to providing cultural and gender appropriate services, including practitioners if possible.

4. Related documents

- *Hospital and Health Boards Act 2011* (Qld)
- *Criminal Code Act 1899* (Qld)
- *Victims of Crime Assistance Act 2009* (Qld)
- *Police Powers and Responsibilities Act 2000* (Qld)
- *Guardianship and Administration Act 2000* (Qld)
- *Public Guardian Act 2014* (Qld)
- *Child Protection Act 1999*
- Queensland Health Guide to Informed Decision-Making in Healthcare
- Charter of Victims' Rights
- Queensland Government Interagency Guidelines for Responding to People Who Have Experienced Sexual Assault
- Department of Health Guideline: Conducting Child Sexual Assault Examinations
- Queensland Health Guide to Informed Decision-Making in Healthcare
- Ministerial Direction – Criss Care Process

Associated Health Service Directive

Caring for People Disclosing Sexual Assault QH-HSD-051 (2023)

Forms and Templates

https://qheps.health.qld.gov.au/hsq/forensics/response-to-sexual-assault

5. Guideline for the management for people 14 years and over disclosing sexual assault

5.1. Principles

Hospital and Health services will have systems in place to offer adults disclosing that they are the victim of a sexual assault with medical care, psychosocial support and if required, access to a forensic examination. It is recognised that there will be local variation in how this is achieved but processes will:

- Maintain the patient's safety, confidentiality and privacy.
- Minimise further impact on a traumatised person by involving the minimum number of personnel possible in the clinical care and forensic examination and where possible offering choice of gender.
- Include support from social workers, sexual assault workers, nursing staff or relevant local non-government support services. Offer interpreter services where required.
- Ensure patients understand their choices: a forensic examination with police involvement (Collect and ANALYSE), a forensic examination without police involvement (Collect and STORE), or clinical care only without a forensic examination.
- Recognise that investigation of sexual assault, a criminal offence, is a police matter. Patients will be encouraged to report the assault to police. However, where a patient with the capacity to consent is clear that they do not want police involved, they may choose to have a Collect and STORE forensic examination. This may include a child aged 14 – 17 years of age who has parental consent for the examination and/or a Gillick-competent[1] child (although mandatory reporting obligations may still be required).
- Report all reasonable suspicions of child abuse and neglect in line with the mandatory reporting and duty of care responsibilities of clinicians.
- Where possible, include a minimum number of clinicians.
- Be based on informed consent for all aspects of the management including treatment and forensic examination. Adhere to defined meanings of consent, accounting for a person's capacity to consent, including that such capacity may require assessment if the adult person has a mental health disability, intellectual impairment or is temporarily affected by substances including alcohol.
- Recognise that a forensic examination is defined as a 'personal matter', in Part 2 of Schedule 2 of the Powers of Attorney Act, that is, not a health care matter.
- Ensure that consent for forensic examination for a person with impaired capacity can only be provided by an authorised power of attorney, (general power of attorney or Enduring power of attorney), appointed Guardian or the Public Guardian. Substituted decision-making by a statutory health attorney is not authorised for forensic examinations.
- Ensure that patients are aware that they may withdraw consent at any time.
- Ensure patients understand what happens to any samples from a forensic examination, including storage, access and destruction processes.

[1] A Gillick-competent child is one who has the capacity to consent despite being under 18 years of age. To be Gillick-competent, the child must have sufficient understanding, intelligence and maturity to appreciate the nature of the care to be provided, the consequences and risks, and the alternatives. This will vary according to the significance of the decision and factors within the child such as their maturity: Gillick v West Norfolk and Wisbech Area Health Authority [1986] 1 AC 112.

5.2. Clinical Care

1. **Nursing triage** on presentation at Emergency Department is as per all presentations including assessment for injuries and vital signs. Clinical interventions will take priority over forensic examination (*See Attachment 1*).
2. Immediately notify the Senior Medical Officer for any significantly injured or potentially unstable patients to arrange **urgent medical assessment**.
3. Offer all patients psychosocial support in a private environment, if available, and discussion of options including information to inform a decision on police involvement and a forensic examination.
4. For patients under 18 years, if a reportable suspicion[2] has been formed about a child, the treating health professional is to report that to Child Safety Services in line with mandatory reporting responsibilities of clinicians.
5. Pending consent of the patient and explanation of options, clinical staff trained in providing Sexual Assault examinations collect evidence using the Forensic Medical Examination Kit (FMEK). See details in 7.3.

Accurate and comprehensive clinical notes should be recorded in the patient's hospital record. All clinical documentation should be made in accordance with QH-POL-280 Clinical Records Management Policy as well as clinical documentation guidelines that are relevant to individual Hospital and Health Services. A forensic examination should be documented using the Forensic Medical Examination Record (FMER), which is available to download from the QHEPS website, https://qheps.health.qld.gov.au/hsq/forensics/response-to-sexual-assault.

6. The forensic record is kept separate to the patient's clinical record.
7. It is recommended that all examinations occur in the presence of an appropriate person acting as a chaperone / support person where possible. This is mandatory when the patient and the examiner are of different genders.

5.3. Clinical Interventions

5.3.1. Time-critical interventions include:

- injuries sustained during the assault
- emergency contraception
- Hepatitis B vaccination +/- immunoglobulin
- HIV Post Exposure Prophylaxis (PEP) and STI treatment where clinically appropriate (e.g. high risk patients)
- STI treatment where clinically appropriate (e.g. high risk patients)

5.3.2. Investigations include:

- for injuries as clinically indicated
- Beta-HCG if possibility of pregnancy pre-existing
- Full Blood Count (FBC), Electrolytes and Liver Function Tests (ELFTs) if commencing PEP
- other serology may be deferred until follow-up
- Sexually Transmitted Infection (STI) screening is recommended two weeks post episode by a relevant practitioner—this may be by referral to a general practitioner or sexual health service.

5.3.3. Clinical interventions (details in Attachment 2):

- Treat any injuries identified on assessment as clinically indicated.
- Consider Hepatitis B immunity.

[2] 'Reportable suspicion' about a child is defined in section 13E(2) of the Child Protection Act 1999 (Qld) as a reasonable suspicion that the child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and, may not have a parent able and willing to protect the child from the harm. If a reportable suspicion has been formed, a written report must be given to the chief executive (section 13E(3)).

- Consider HIV risk: if high or uncertain risk HIV exposure, contact Infectious Disease physician or sexual health clinic for advice regarding PEP and follow up.
- Consider Emergency Contraception: Postinor 1 (levonorgestrel 1.5mg) up to 72 hours after reported assault or if >72hrs -120 hours, consider Ulipristal acetate.
- Consider STI prophylaxis if the patient is currently symptomatic, if there is unreliable follow up or patient concern.
- Consider Tetanus Prophylaxis if indicated.
- Arrange appropriate follow up: this follow up will vary with site, reported events, individual circumstances and background medical issues.

5.4. Psychosocial Interventions:

Where available, the person should be referred to a Sexual Assault support service or Social Work service for post-acute support such as:

- assisting to the person to return to their usual level of functioning
- providing information about options available including their rights as a victim of crime.
- practical support, including contacting family members or support persons. If consent provided, talk to family members or support persons about how best to support the patient
- advice on 'common' responses, symptoms and reactions following a sexual assault
- psychosocial and risk assessment – physical, psychological and/or financial risk to patient and any noted child protection concerns
- information and referral, with consent, to relevant sexual assault support service.

The social worker, or other health professional, should also advise the patient of their right to:

- sexual health medical advice, treatment and follow up
- information about reporting options, including making a formal complaint to the Queensland Police Service
- referral to the Queensland Police Service via PoliceLink on telephone 131 444 to report the matter or attend any police station in their area to discuss their legal options
- Queensland Police Service's alternate reporting options
- referral to the state-wide Sexual Assault Helpline on telephone 1800 010 120.

For those under 18 years, report all suspected sexual assaults in line with mandatory reporting responsibilities of clinicians.

Where the sexual assault has occurred within an intimate personal relationship, family relationship or an informal care relationship, the patient should be informed of their option to seek protection under the Domestic and Family Violence Protection Act 2012. Where appropriate, the patient should also be referred to a specialist domestic violence service for support and assistance.

5.5. Forensic Examinations:

- Wherever possible, the forensic examination should be provided by a suitably trained clinician such as a Forensic Nurse Examiner (FNE); Sexual Assault Nurse Examiner (SANE); Government Medical Officer (GMO); Forensic Physician; or other Medical Officer(s) who have received training in forensic examinations.
- When there is no trained clinician available, a Medical Officer can complete the examination accessing 24/7 phone support from Forensic Medicine Queensland on 07 3722 1321.
- A Forensic Medical Examination Kit (FMEK) should be used, and a Forensic Medical Examination Record (FMER) should be completed.
- Care should be taken to minimise the risk of DNA contamination from the room's fixtures and facilities. This involves DNA decontamination cleaning protocols, use of the Contamination

Reduction Kit (CRK), and appropriate evidence collection techniques (refer to the Forensic Medical Examination Handbook available on the QHEPS website).

- If the patient consents to a forensic examination but does not wish to make a formal complaint to police or wishes to defer this decision, then the examination is performed without notification to police as a "Collect and STORE". In this case, Queensland Health stores the sample centrally until such a time that the patient decides to report the sexual assault to police, or the sample is destroyed after 24 months.
- Release of patient information and specimens to police should only occur with the patient's consent (the consent form is contained within the Forensic Medical Examination Record).
- Examiners should ensure that chain of custody obligations are rigorously attended to, ensuring that the validity of collected forensic evidence is maintained.
- Forensic examiners with scope of practice in Adult sexual assault must NOT perform forensic examination for patients under the age of 14 years. Forensic examiners with a scope of practice in paediatric sexual assault may attend all patients 18 years and under.

6. Definition of terms used in the guideline

Term	Definition / Explanation / Details	Source
Hospital and Health Service	Hospital and Health Services are statutory bodies and are the principal providers of public sector health services.	*Hospital and Health Boards Act 2011*
Forensic Examination	The forensic examination consists of obtaining a history as to the nature of the assault to guide the subsequent physical examination. It also includes interpretation of injuries and the collection of forensic samples as it relates to the alleged sexual assault. A Forensic Medical Examination Kit (FMEK) is used to collect DNA and toxicology evidence	Queensland Government Interagency Guidelines for Responding to People Who Have Experienced Sexual Assault.
Child	Under the age of 18 years. For child victims of sexual assault, under the age of 14 years, sexual assault medical and forensic examinations should be performed by a medical officer with appropriate paediatric skills including child protection and/or sexual assault medical examination. training or skills.	Queensland Health Guideline: Acute medical care of paediatric patients who have experienced alleged sexual abuse/assault (Document # CHQ-GDL-02603)

Trained Clinicians	Forensic Examinations can be provided by: • Forensic Physician • Medical Officers who have received training in sexual assault examination • Medical Officers accessing phone support from Forensic Medicine Queensland • Government Medical Officers • Forensic Nurse Examiners (postgraduate qualification in Forensic Medicine) • Sexual Assault Nurse Examiners. Nurses trained in sexual assault examinations having completed a recognised short-course eg SANE 40CPD short course)	

7. Document approval details

Guideline custodian

Chief Medical Officer, Clinical Excellence Queensland

Approval officer

Deputy Director General, Clinical Excellence Queensland

Approval date: 28 November 2023

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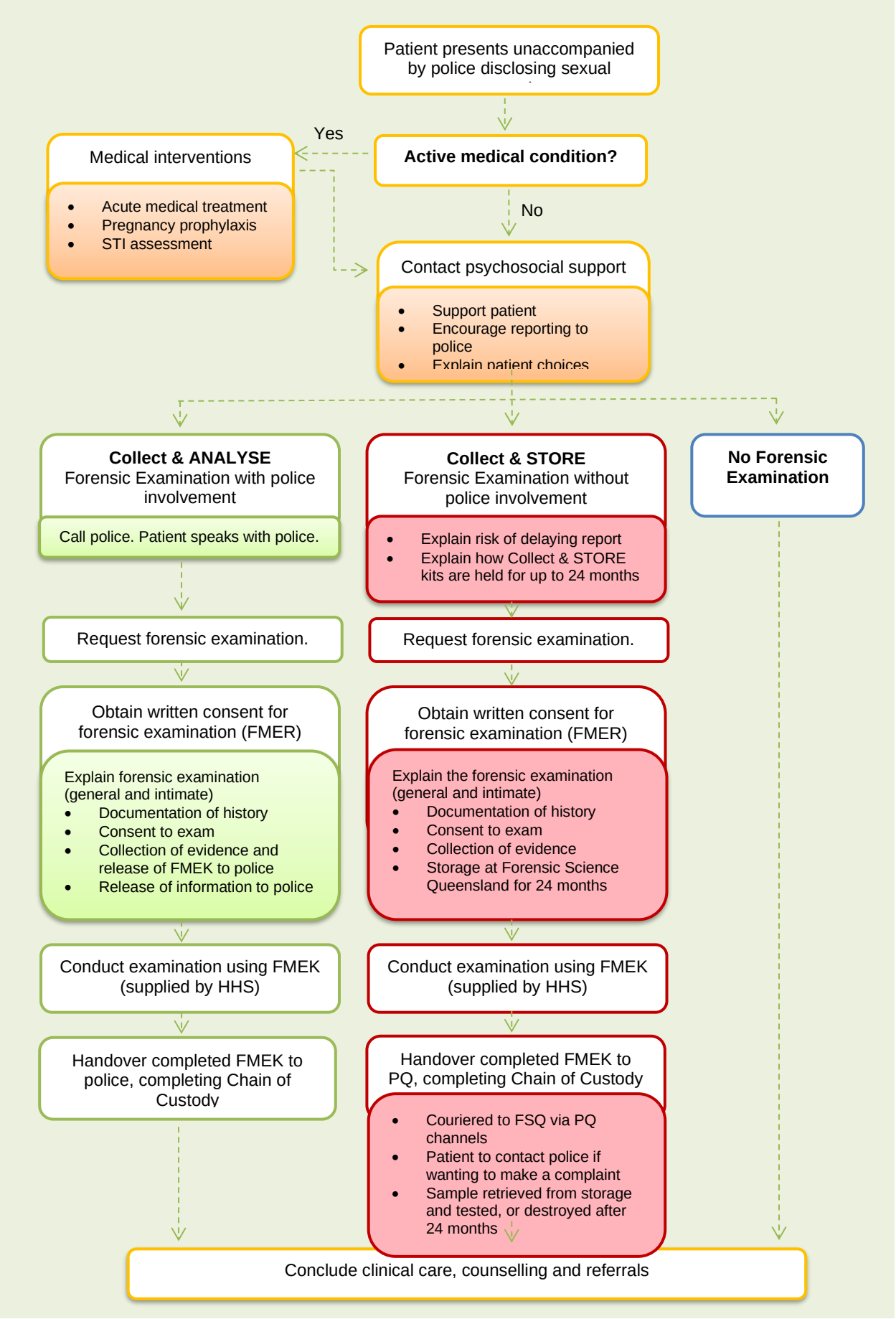
8. Version control

Version	Date	Prepared by	Comments / reason for update
1	22/07/2019	Health Support Queensland	New Guideline published as a HSD guideline
2	12/09/2019	Health Support Queensland	Transferred to QH guideline Updated to address specific considerations for patients aged 14-17 years based on input from subject matter experts
3	28/11/2023	Clinical Excellence Queensland	Updated to align with changes to Forensic Medical Examination Kits and contemporary care.

Attachment 1: Emergency Department sexual assault management pathway



Attachment 2: Detailed clinical interventions

Hepatitis B risk assessment and management post sexual assault

If immunised: pathology testing only to confirm immunity and review and follow up of Hepatitis B status. This may be done at follow up.

Hepatitis B Immunoglobulin is not routinely required.

If no previous immunisation, or incomplete immunisation then start the immunisation course or give a booster (i.e. only one or two prior doses).

Consider 400 units IM Hepatitis B IG in a non-immune patient within 72 hours particularly if exposure to member of high-risk group for Hepatitis B (Indigenous, injecting drug user, person from countries where Hepatitis B is endemic) or known hepatitis B. This is most effective administered as soon as possible after exposure, however can be delivered up to 14 days post assault. A repeat Hepatitis B IG is also required at one and six months. This may be provided at a sexual health clinic or via a General Practitioner.
https://immunisationhandbook.health.gov.au/resources/tables/table-post-exposure-prophylaxis-for-non-immune-people-exposed-to-a-source-that-is-positive-for-hepatitis-b-surface-antigen-or-has-an-unknown-status

Assessing need for HIV prophylaxis post sexual assault

The risk of HIV following sexual assault in Australia is very low. Despite the low likelihood of infection, HIV remains a concern for victims and should be discussed. Giving a realistic estimation of risks may provide reassurance to the victim.

HIV prophylaxis is infrequently required following sexual assault but should be considered if offender was known to be: HIV positive, a male who has sex with males (MSM), an Intravenous Drug User (IVDU) or was from a high HIV risk country such as Sub-Saharan Africa, South East Asia or Papua New Guinea. Transmission risk is also higher if the sexual assault resulted in bleeding from genito-anal injury. *Refer to the Australasian Society for HIV Medicine (ASHM) guidelines for table summarising quantitative risks in different sexual activity scenarios which can be found at:
http://www.pep.guidelines.org.au/index.php/assessment-of-the-risk-of-hiv-transmission/what-is-the-hiv-transmission-risk-exposure#table1

Routine baseline status for HIV should be undertaken. For pre-HIV counselling please refer to the HIV-pre and post-test counselling information and patient brochures located at:

https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/hiv-aids

For high-risk cases or any concerns, discuss each case individually with on call Infectious Disease consultant or local Sexual Health Clinic. Many will not be recommended Post Exposure Prophylaxis (PEP). Risk of exposure should be considered depending on sexual assault type and potential sero-prevalence of perpetrator. PEP Guidelines for non-occupational exposure to HIV can be obtained from the ASHM website.

https://pep.guidelines.org.au/

Post-exposure prophylaxis starter drug packs should be available for the Emergency Department. These are authorised by the Infectious Disease consultant or Sexual Health Consultant who will advise which

starter pack to use. Most will require Pack A (two drugs) and it is important to follow correct procedures in its administration and documentation. They must be instituted within 72 hours. Follow up of these patients is as an outpatient to Infectious Disease or Sexual Health Clinic or other local arrangement depending on facility location.

Common side effects are nausea, headaches, lethargy (up to 1/3 of patients cease these drugs before completion due to side effects). More serious side effects include liver toxicity. Baseline full blood count (FBC) and electrolytes and liver function tests (ELFT) are required before starting.

Emergency Contraception post sexual assault

If patient has good effective contraception this is not required, e.g. Implanon, Depo provera, Mirena coil in situ, no missed oral contraceptive in last menstrual cycle.

Discuss benefits of “morning after pill”. Generally, this is very safe and should be given if there is any risk of pregnancy.

If indicated, Postinor 1 (Levonorgestrel 1.5mg) up to 72 hours should be taken immediately. It is only effective IF USED WITHIN 72 HOURS OF ALLEGED ASSAULT. It is more effective, the earlier it is used. Consider offering oral maxalon if patient is known to have nausea with the drug. However, very few patients (1.4 – 5.0 per cent) vomit with the progesterone-only emergency contraceptive and antiemetics are not routinely recommended.

If presentation is >72 hours and less than 120 hours, an alternate drug - Ulipristal acetate is likely to be more effective. It is contraindicated in patients with liver disease, asthma requiring steroids, with breast feeding and less-effective if using antacids or Proton Pump inhibitors.

Advise pregnancy test if next period late or different from normal.

Prophylaxis of Sexually Transmitted Infection post sexual assault

Overall risk of STI such as chlamydia, gonorrhea and trichomonas is low. Options of treatment prophylactically in Emergency Department or STI screens in two weeks should be considered depending on patient demographics, likely patient compliance and patient choice.

Chlamydia is the most frequently encountered STI that would be amenable to prophylaxis in patients who might be lost to follow-up. After urine PCR (or swabs including throat and rectal if applicable) are collected, Doxycycline 100mg orally daily for 7 days can be given prophylactically. Alternatively, if there is concern about patient compliance, Azithromycin 1gm orally stat can be given prophylactically in the Emergency Department .

These patients still require follow up STI screening with a urinary PCR at two weeks post sexual assault as the above does not prevent other infections.

Other bacterial STIs have a very low prevalence in metropolitan Queensland. For high-risk or complex exposures (e.g. multiple perpetrators, perpetrators from population group with high rates of STI), contact Sexual Health Service or Infectious Disease consultant for advice.

If risk is significant, compliance with follow up low or if advice unavailable for such cases give the following two-drug therapy (Please be mindful of Ceftriaxone Resistant Gonorrhoea – if prescribed collect a first pass urine sample for Microscopy, culture and sensitivity (MC&S) and PCR prior to treatment):

1. Ceftriaxone 500mg IM with 2mls 1 per cent lignocaine/Ceftriaxone 500mg IV stat - same if pregnant **AND**

2. Azithromycin 1gm orally stat - same if pregnant.

Follow up after reported sexual assault

All patients should be referred for follow up including pathology results and recommended ongoing testing. Most patients are suitable for medical follow up with their general practitioner, but they should be offered a choice of follow up options.

Patients with more complex or high-risk exposures should be referred to a Sexual Health Clinic or an Infectious Disease specialist for follow-up. A Sexual Health Clinic may also be offered to patients with concerns about confidentiality or those who require access to a free service.

Patients who are commenced on HIV post-exposure prophylaxis should be urgently referred to the Infectious Disease team or the local Sexual Health Service clinic for ongoing supply of medication and specialised management of antiretroviral drugs.

Refer to appropriate Sexual Assault Support Service and/or other psychosocial services such as referral to National Sexual Assault Helpline (NSAH) - 1800 737 732 which operates 24/7 and can provide phone counselling sessions.