

ACADEMIC: CLINICAL PEARL

Disclosures of sexual assault/abuse and the role of the forensic examiner

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Introduction

Sexual assault is common. As such, it behoves all medical practitioners to be aware that this issue will be a significant factor in so many of the patients they provide care for, either recently, or at some stage in their past. According to the New Zealand Crime and Victims Survey (NZCVS) conducted in 2018/19, 24% of New Zealanders had experienced sexual violence at some time during their lives.¹ The latest NZCVS from 2019/20 found that around 2% of adults had experienced a sexual assault within the previous 12 months.² Sexual assault/abuse affects individuals in all population groups. However, some individuals are at particularly high risk, e.g. people with diverse sexualities and young females.² According to the most recent NZCVS, approximately 1 in 11 females aged between 15 and 19 years were sexually assaulted in the previous 12 months.²

Long-term sequelae of childhood sexual assault/abuse (CSA) include various medical, psychological, behavioural, and sexual problems, and an increased risk of re-victimisation.³⁻⁵ Both male and female CSA survivors are affected.^{6,7} Several long-term studies and systematic reviews have confirmed an association between CSA and a lifetime diagnosis of various psychiatric disorders, including anxiety, eating disorders, post-traumatic stress disorder (PTSD), suicidality, substance abuse, and personality disorders.^{3-5,8,9} Female CSA survivors have increased rates of gynaecological disorders such as chronic, non-cyclical pelvic pain.⁹

For many health professionals, managing patients who disclose a sexual assault can be daunting. The purposes of this article are firstly to explain how sexual violation and consent are defined in the New Zealand (NZ) law. Secondly, it aims to equip clinicians with basic skills and knowledge on how to respond to a disclosure of sexual assault/abuse; how to provide therapeutic and acute medical care; and how to refer for further management, especially those who experienced a recent sexual assault. Thirdly, the article describes the work of forensic sexual assault examiners and their role as expert witnesses in court.

The New Zealand Law

The NZ Crimes Act has clear definitions of what constitutes the various sexual assault and abuse crimes, including sexual violation and indecent assault.¹⁰ In addition to the actual contact type, all such acts require the lack of consent and the lack of the presence of reasonable grounds for a belief by the alleged offender that the person consented. It should be noted that for children and young persons the issue of consent is irrelevant, as they are not legally able to consent to sexual contact, under any circumstances.¹⁰

The NZ Crimes Act also outlines circumstances where allowing sexual activity does not amount to consent.¹⁰ These include when a person allowed the activity because of force applied to them or a threat or fear of the application of force; when they are unconscious

or asleep; when they cannot consent or refuse to consent due to intoxication or an intellectual, mental or physical condition; and when they were mistaken about the identity of the person or the nature of the sexual activity.¹⁰

In recent years, there has been increasing national and international awareness that non-fatal strangulation/suffocation is commonly associated with inter-personal violence (IPV) and sexual assault/abuse.^{11,12} In an American study, prior non-fatal strangulation by an intimate partner increased the risk of completed homicide by over seven-fold.¹³ In December 2018, non-fatal strangulation and suffocation became covered by section 189A of the New Zealand Crimes Act 1961.¹⁰ Sentences include imprisonment for up to seven years if a person intentionally compromises another person's breathing and/or blood circulation through application of pressure on their throat and/or neck (strangulation) or blocking of a person's nose and/or mouth (suffocation).¹⁰

Disclosure of sexual assault/abuse and useful responses

Patients commonly do not disclose sexual assault/abuse themselves unless specifically asked. Research has found that patients who had experienced non-consensual sexual contact valued their clinician enquiring about it.¹⁴ Those who had no history of sexual assault/abuse did not mind being asked and valued the disclosure opportunity.¹⁴ The majority of clinicians who routinely enquired about sexual violence did not find that this significantly lengthened their consultation time.¹⁴

When asking about sexual assault/abuse, patients should be seen on their own or with someone they trust. Screening or discussing abuse in the presence of a partner, potential abuser, or someone who may inform the abuser, may increase the patient's risk of further harm. It is good practice to routinely ask patients about IPV and sexual assault/abuse whenever they request a test for sexually transmitted infections (STIs), emergency contraception, or when they present with acute ano-genital symptoms (e.g. pain and/or bleeding). Other opportunities for sexual assault/abuse questions include new patient consultations or any routine screening such as cervical screening.¹⁵ In adolescents, enquiring about sexual assault/abuse forms part of the HEADSSS assessment.¹⁶ Box 1 includes examples of how to frame questions about sexual assault/abuse.

Clinicians may take a *proactive* or *reactive* approach to asking about sexual assault/abuse. Box 2 includes examples for both.

The way a clinician responds to a sexual assault/abuse disclosure is critical for the patient's journey to recovery. Prior to disclosure, the patient may have felt things such as fear of being judged, confusion, and a lack of trust in the system. These fears can be mitigated if the clinician responds appropriately to the disclosure.

Useful responses to a sexual assault/abuse disclosure include empathising and validating, being non-judgemental, and offering help to the patient (Box 3). Clinicians should take a few minutes to affirm the

Box 1: Framing questions for sexual assault/abuse

'I like to ask all my patients about sexual assault in order to make sure they are safe.'

'Because unwanted sexual contact can affect health, I/we are asking all our patients about it.'

'Another question that I'm asking all of my patients as part of a health check is about relationships and unwanted sexual contact.'

'I don't know whether this is a problem for you, but many women I see are dealing with abuse in their home. Some are too afraid or uncomfortable to bring it up themselves so I ask about it routinely.'

Box 2: Approaches to asking about sexual assault/abuse

Proactive

'Have you ever had sexual contact of any form when you didn't want to, or in a way that you didn't like?'

'Has anyone ever touched you in a way you didn't like or when you didn't want them to?'

'Are you in a relationship with someone who hurts or threatens you?'

Reactive

'I note that you were quite uncomfortable during your smear test. I know that some women find smears and internal exams difficult because they have had an unpleasant experience in the past. Has this ever happened to you?'

Box 3: Useful responses to a disclosure

Empathise:

'I am so sorry this has happened to you.'

Acknowledge:

'Well done for managing to tell me about it. It must have been hard for you.'

Validate:

'Many people find that... Is this something that has affected you?'
'Most people find this really hard to talk about.'

Don't judge:

'It is never OK – no matter what the circumstances. It's not your fault.'

Offer help:

'In order for me to help you, I need to ask a few more questions.'

patient for disclosing, inform them how common sexual assault/abuse is, and normalise any post-traumatic responses or symptoms.

Secondary victimisation, i.e. the re-traumatisation of the sexual assault/abuse survivor, needs to be avoided.¹⁷ Secondary victimisation is an indirect result of an assault which occurs through the responses of individuals and institutions to the individual.¹⁷ Types of secondary victimisation include victim blaming and inappropriate language by medical personnel and other organisations which the individual accesses after the assault.¹⁷

Therapeutic and acute medical care after sexual assault/abuse

After disclosure, the patient's therapeutic care is of utmost importance, especially their access to psychological support and advice on their options. The latter depends on when the sexual assault/abuse occurred, and whether the patient would like to report it to the police. If a sexual assault occurred within the past seven days, a forensic examination may be indicated. Specialist sexual assault support is known to enhance the outcome and recovery of victims.¹⁸ Specialist sexual assault support services vary throughout the country and are provided by different agencies, e.g. Sexual Abuse HELP, Rape Crisis, and their local equivalents.¹⁸ It is useful for clinicians to know their nearest Sexual Abuse Assessment and Treatment Service (SAATS) and their local crisis support service. SAATSLink (<https://medsac.org.nz/>) is a valuable resource for contact details of providers throughout NZ.¹⁹

In NZ, any person who has experienced sexual assault/abuse, regardless of whether they reported it to the police or not, can lodge a claim through the Accident Compensation Corporation (ACC). This entitles them to free counselling support sessions which can be accessed at any time after the event, even several years later. The Crisis Support services are able to provide more detailed advice on ACC support and how it is accessed.

The initial management after a recent sexual assault focuses on any urgent medical needs. This is particularly important in cases where a physical assault occurred as well, maybe including non-fatal strangulation/suffocation. While the vast majority of patients are stable, some require an initial specialist assessment, e.g. by the gynaecology team in cases of severe vaginal bleeding.

Medical care after a recent sexual assault/abuse includes baseline screening for STIs (e.g. genital swabs and a blood test for human immunodeficiency virus (HIV), syphilis, and Hepatitis B), for women a pregnancy test and provision of emergency contraception, antibiotic STI prophylaxis, and consideration of HIV post-exposure prophylaxis. HealthPathways is a useful resource (where available).²⁰ In addition, all SAATS can provide advice regarding acute care to primary and secondary care clinicians.

It is important to be aware, however, that the majority of genital examinations after an alleged sexual assault are normal, and significant genital injury is uncommon. It is also important to be aware that injury can occur in consenting sexual contact. Therapeutic care always takes precedence over forensic care. In situations where the patient is complaining of possibly significant genital symptoms, it may be necessary to, at a minimum, conduct an external genital exam before the patient is transferred to a SAATS.

Forensic medical examination

In NZ, acute forensic examinations are performed by a forensic examiner with the assistance of a forensic nurse. If possible, a crisis support worker is present during the examination as well. Providing culturally safe, therapeutic care within the forensic environment is always prioritised. The Pōwhiri model of care is introduced to all forensic clinicians during their specialist training through Medical Sexual Assault Clinicians (MEDSAC) Aotearoa, the national organisation providing the training and accreditation of forensic examiners.¹⁹ This Pōwhiri model, which enables a culturally sensitive approach from start to finish, ensures that Māori and all patients receive the best therapeutic care possible.

On arrival at the SAATS, police provide the clinicians with an overview of the alleged events, and advise on the patient's immediate needs and any forensic issues requiring urgent attention, e.g. time-sensitive toxicology specimens. Concurrently, the crisis support worker usually spends time on their own with the complainant. Afterwards, the crisis support worker informs the clinicians of any important issues, e.g. past or present mental health issues or suicidality.

At the start of the forensic examination, the clinicians confirm that the patient understands what the examination entails and stress that it is entirely their choice whether to proceed or not. Moreover, the patient is assured that they can withdraw their consent at any time during the examination. Occasionally, patients are too intoxicated to consent to an examination. In these cases, the examination is deferred until are able to give informed consent.

Most SAATS offer "Just-in-case" forensic examinations. Rather than handing forensic specimens to the police after the examination, they are safely stored, thereby giving the patient extra time (typically for three to six months) to decide whether or not they would like to continue with a criminal investigation. The patient may also opt to just have a therapeutic medical examination without collection of forensic specimens, and with a sole focus on their psychological and medical needs.

During the forensic examination, a Medical Examination Kit (MEK) is used. This contains a Medical Examination Record (MER) as well as various swabs, slides, and other equipment for the collection of forensic evidence. The forensic examiner takes a detailed history including the patient's medical history, any consumption of alcohol and/or drugs (voluntary and/or involuntary), any recent other sexual contact, and the history of the alleged events. The purpose of the latter is to guide the examination and the collection of specimens.

After the history taking and recording of general observations, a thorough head-to-toe physical examination follows. Any findings are documented in the body diagrams of the MER. Acute injuries, e.g. bruises, abrasions, and lacerations, are described in detail, including their size, colour, shape, and associated features, e.g. tenderness and/or swelling. Identifying and documenting the correct injury type is important, as it often allows comment in regard to the mechanism of injury.²¹ This is particularly important for skin disruptions. For example, "lacerations" are sustained through application of a blunt force which causes a full-thickness tear of the skin with typically ragged, bruised, and irregular wound edges.²¹ In contrast, "incisions" are sustained by sharp objects or cutting-type implements, e.g. a knife or glass. The sharp edge of the object cuts through the skin layers, with wound margins which are typically regular, straight, and unbruised.²¹

The anogenital examination forms the last part of the forensic examination. The external anogenital area is closely examined, and in females, a speculum is used to assess the vagina and cervix. In addition, proctoscopy is typically offered after an alleged anal penetration. Throughout the examination, the crisis support worker acts as an advocate for the patient and ensures that they are not re-traumatised.²²

Which specimens are collected depends on the circumstances and type of the alleged assault, the timeframe, whether the alleged offender is known or not, and post-assault hygiene, such as taking a shower, or consumed food/drinks. Reference samples from the patient are also commonly collected, e.g. hair and a buccal swab or blood for their deoxyribose nucleic acid (DNA). In 1920, forensic scientist Dr Edmond Locard developed Locard's Principle, which states that "every contact leaves a trace."²³ Nowadays, laboratory technologies are so sensitive that DNA profiles can be compiled, and an alleged offender can even be identified, from skin swabs obtained from locations where they touched the complainant's skin.

After the examination, the patient is able to take a shower. This can be an important part of the immediate recovery for all patients, and holds a special significance for Māori. This is called *whakanoa* (cleansing).

All relevant items of clothing worn at the time of the alleged assault are individually bagged, and all forensic specimens are signed, sealed,

and placed into the MEK. Everything is handed over to the police unless the complainant is undecided as to whether to report the alleged offence, in which case the specimens are securely stored.

The forensic examiner's expert witness role

Police determine whether a case goes to trial by applying the Solicitor-General's Prosecution Guidelines.²⁴ These require that the evidence "is sufficient to provide a reasonable prospect of conviction" (Evidential test), and that "prosecution is required in the public interest" (Public interest test).²⁴

The forensic examiner may be asked to write a Formal Statement as an expert witness. In general, "ordinary witnesses" may only provide evidence regarding facts of what they saw or heard.²⁵ In contrast, "expert witnesses" are able to provide opinion evidence.²⁵ The Evidence Act defines an expert as "a person who has specialised knowledge or skill based on training, study, or experience."²⁶ All expert witnesses are "agents of the court," rather than advocates for the party who called them.²⁷ They need to be impartial and abide by the High Court Rules 2016 Schedule 4 — Code of Conduct for Expert Witnesses.²⁷

In the Formal Statement, all acute findings from the forensic examination are discussed, and an overall opinion is formed. It is often not possible to comment on whether an injury was sustained during the alleged assault.²⁸ For example, most bruises cannot be aged, and their appearance does not usually allow any comment in regard to the exact circumstances during which they occurred.²⁹

If a case goes to trial, the forensic examiner may be called to give evidence in court. They are often asked to dispel myths and give so-called counter-intuitive evidence. There is a commonly-held assumption within the general population that any non-consenting sexual contact will result in injury to the genital area which the examiner can see. However, it is in fact normal and common for sexual contact to occur without causing injury, and for complainants to have a normal genital examination after an alleged sexual assault.³⁰⁻³² Likewise, it must be noted that consensual sexual contact can also result in injury.^{32,33}

In general, the findings of a medical examination after an alleged sexual assault are often not able to confirm whether or not sexual contact occurred. If sexual contact occurred, a medical examination cannot determine whether such contact was consenting or non-consenting.

Conclusion

It needs to be recognised that the lifetime prevalence of sexual assault/abuse is high. Experiencing sexual violence often has a huge impact on an individual's wellbeing. It is important for clinicians to routinely screen for IPV and sexual assault/abuse. If done effectively, this can make a positive impact on the patient's overall journey to recovery. After any disclosure, it is also important to ensure that the patient is informed about all options available to them with respect to therapeutic and forensic care, and that they are able to access appropriate crisis support. There is a wide range of support, information, and further education available to all clinicians through MEDSAC and via their local SAATS.

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