FACULTY OF FORENSIC & LEGAL MEDICINE

of the Royal College of Physicians, London

Registered Address
11 St. Andrews Place
Regent's Park,
London NW1 4LE
Telephone 020 7935 1174
Textphone 020 7486 5687
Facsimile 020 7487 5218

Registered Charity No: 1119599

Correspondence Address
3rd Floor
116 Great Portland Street
London W1W 6PJ

Telephone 020 7580 8490
E-mail info@fflm.ac.uk

Caroline Lewis
Community Primary Care and Health Service Policy Division
Welsh Assembly Government
Cathays Park
Cardiff
CF10 3NQ

18 February 2010

Dear Ms Lewis

Re: Draft Service Specification for services providing care to adults in Wales who have been sexually assaulted or abused

I refer to your letter of 1 December 2009 where the Faculty of Forensic and Legal Medicine welcomes the opportunity to respond to the above consultation paper. The faculty was established in 2006 by the Royal College of Physicians of London and has been founded to achieve the following objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine.
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

The faculty includes three different professional groups:

- Forensic physicians
- Medically qualified coroners
- Medico-legal advisers to the medical defence organisations

A number of forensic physician members have commented on specific areas as follows –

1. 6.5 Staffing - there is a need for FNEs working independently to have 24 hour support from & access to an experienced senior FP SOE.

   There are also concerns that the courts may not deem Forensic Nurse Examiners as being able to give expert evidence with a requirement for this to be bolstered by a forensic physician being instructed additionally.

The introduction of SANEs in the UK has not been without some difficulties and the view of the Faculty is that there is benefit to them as an adjunct rather than replacement to forensic physicians.

6.8.4 Sexually transmissible infections - should read ...All clients should be assessed and offered prophylaxis if relevant and testing for STIs at the appropriate interval...

HIV and Hepatitis B - should read - All clients should be assessed and offered prophylaxis if relevant and testing for...

2. Some suggestions: On page 15:

A copper coil can be inserted up to 5 days after an assault, regardless of the cycle time if there has been no earlier vaginal sex during that cycle, or up to day 19 if vaginal sex has occurred earlier in the cycle.

Levonelle is unlikely to work if ovulation has already occurred. A local emergency copper coil insertion service should be available.

However, Ulipristal (ellaOne) is now available for emergency contraception up to 5 days post coitus.

On page 16:
"Clients should be offered the choice between antibiotics to prevent STIs or screening for STIs."
... should be offered both (at initial presentation)!

Also: "Any screening for STIs should take place at least 10-14 days after the assault, to allow for the incubation period of newly acquired bacterial infections." Some take the view that screening for STIs as soon as possible (at initial presentation, if possible) is better because of the background prevalence (pre-existing STIs) of STIs in victims of sexual assault, and victims may not re-attend for STI testing (but may do if contacted about positive test results). This is recommended in the BASHH guideline on sexual assault but the Faculty understand this applies *if* presenting at a GUM clinic. NAATs (Nucleic Acid Amplification Tests) may detect the presence of chlamydia and gonorrhoea without the need for incubation. Follow-up, interval testing should also be supported because syphilis and HIV may not be detected until after 10-14 days. Most new HIV and syphilis is detectable by 6 weeks.

The BASHH guideline on chlamydial infection management does recommend NAATs should be taken from all the sites where penetration has occurred.

Regarding documenting a chain of evidence for STI specimen collection, there are two references for this in the BASHH Standards for the management of sexually transmitted infections.

Finally, is there any evidence or views on (supervised and witnessed) self-taken forensic specimens (vulvo-vaginal and anal)?

Another issue raised in respect to this comment is the possibility that results may become disclosable in this situation so definitive legal advice should be taken in that respect.

3. These specifications are excellent for the medical and psychological treatment of sexual assault victims.

   However I do have some concerns in the forensic context.

   Clinicians dealing with cases of sexual assault have their primary duty of care to their patients. Forensic physicians.

4. One member working in Wales expressed concerns on the difficulty in appointing Clinical Directors and the Faculty would emphasise the importance of attracting an individual of appropriate calibre to that role.

I hope these observations are of assistance but if anything here is unclear then I would be happy to try and clarify that comment.

Yours sincerely

DR C GEORGE M FERNIE
LLB MB ChB MPhil FFFLM FRCGP DFM