Faculty of Forensic & Legal Medicine

Care of Suspects of Sexual Assault in Police Custody

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Medical History

It is important to conduct a full assessment so that any vulnerabilities are identified and any medical issues that may become relevant in the case, for example a history of diabetes or certain medications that can affect potency. The Forensic Clinician will also need to provide the usual assessment of fitness to be detained and interviewed and manage risks.

Mental Health History and Risk Assessment

Being arrested for sexual offences, especially child sex offences or possession of indecent images, confers a higher risk of suicide on release from custody.[1] This risk can be increased further if there is a history of mental disorder or self-harm. All detainees need to have a thorough mental health and risk assessment and a plan put in place for support services on release if needed. The Lucy Faithfull Foundation[2] contains some useful resources for people accused of child sexual offences in addition to sources of support provided in primary care and secondary mental health services.

As always when assessing suicide in police custody it is important to explore what this arrest means for this person. The vast majority of cases will be released on police bail and it is known that this can be highly stressful and be a risk factor for suicide.[3]

Men with autistic spectrum disorder and learning disabilities can be over represented in sexual offenders. This is due to a normal drive to develop intimate relationships but poor social skills to allow them to negotiate the complex social interactions necessary. These men may not be known to services and onward referrals should be made from Police Custody.

Many other physical and mental health problems such as dementia or organic brain disorders can present with sexual disinhibition which can lead to arrest.

In healthcare models where the service is provided by a mix of professionals such as Registered General Nurses or Paramedics there should be availability of a suitably competent Healthcare Professional to provide more detailed assessment of mental health and risk.

Safeguarding

Although the Police should ensure the safety of children that a suspected abuser has access to, the Forensic Clinician should take a full social history, identify areas of risk and make appropriate safeguarding referrals. It is the Forensic Clinician's responsibility to identify these issues and make the referrals.[4]

Similarly a child suspect is likely to have a wide range of vulnerabilities and the Forensic Clinician needs to take full responsibility for assessing these and contacting the relevant Safeguarding Board to make sure that these are addressed and also to prevent delay in release due to the need for secure accommodation etc. Forensic Clinicians are reminded of the *FFLM's safeguarding referral pro forma.*

Forensic Examination of Suspects

A Forensic Clinician should never examine a suspect and a complainant of the same sexual assault allegation. There is the risk of cross contamination if this is the case.

If in exceptional circumstances this is necessary the Forensic Clinician must take precautions against cross contamination, record these precautions in their contemporaneous notes and the reasons for this being necessary.* The forensic laboratory and later the Courts must be made aware of this.

On occasion liaison with the Forensic Clinician conducting the examination of the complainant can be helpful, particularly if a complainant may have caused injury to the suspect.

Providers should ensure staff are trained in forensic recovery and that the rooms used[5] for sampling are cleaned to a high enough standard with suitable cleaning materials to prevent DNA cross contamination.

Thorough examination for the presence or absence of injuries and careful documentation of any injuries should take place. Photography should be undertaken by a suitably trained professional if relevant.[6] Similarly a note of any distinguishing marks around the genital area such as piercing/the presence or absence of pubic hair/birth marks should be noted.

The collection of intimate samples as per s64 Police and Criminal Evidence Act 1984 requires lawful authorisation by an officer of the rank of Inspector or above and specific written consent.

Further consent needs to be taken from suspects aged 17 and below.[7]

The Forensic Clinician should consider the guidance regarding chaperones, provided by their regulatory body.

Sampling should be in accordance with the FFLM Recommendations[8] which are updated twice yearly.

Samples should be labelled and submitted in line with the FFLMs recommendations.[9]

Sexual Health Aftercare

All persons engaging in unprotected sexual intercourse should have regular sexual health checks. In cases of alleged sexual assault all suspects should be advised to attend a GUM clinic for STI screening. Some sexual encounters are higher risk than others and if the allegation may confer a higher risk of serious infection such as HIV or Hepatitis B a suspect has the right to access post exposure prophylaxis in a timely fashion.[10]

Matters of confidentiality can be critical and each case must be assessed on its merits. It is recommended that the case be discussed with the local Infectious Diseases Consultant on call out of hours or a Genito Urinary Medicine Consultant within hours who are able to advise on such matters.

** FSR-G-207, DNA anti-contamination guidance; 6.1.2. anti-contamination measures: In exceptional circumstances (for example, very remote locations) where it becomes necessary to use the same forensic practitioner/healthcare professional, the reason and rationale behind the decision and the steps that have been undertaken to reduce the risk of contamination shall be documented. For example, cleaning of mobile equipment including the outer surface of a medical bag; showering including hair wash; and a change of clothes shall be recorded and documented in the sexual assault referral centre (SARC) and/or custody record as appropriate and disclosed in any subsequent report or statement.*

References

1. Independent Office for Police Conduct
Deaths during or following police contact: Statistics for England and Wales 2019/20

The Police Investigations and Review Commissioner (PIRC) Scotland
Investigations

Police Ombudsman for Northern Ireland
Deaths in custody/following police contact

Webb R, Shaw J, Stevens H, Mortensen PB, Appleby, L, Qin P (2012)
Suicide risk among violent and sexual criminal offenders
Journal of Interpersonal Violence, Vol. 27, No. 17, 11.2012, p. 3405-3424

2. The Lucy Faithfull Foundation
lucyfaithfull.org

3. Kothari R, Key R, Lawrenson J, Squire T, Farnham F, Underwood A (2021)
Understanding Risk of Suicide among perpetrators who view child sexual abuse (CASM)
Journal of Forensic and Legal Medicine, May 2021, 81:102188, DOI: 10.1016/j.jflm.2021.102188

4. FFLM
Child Safeguarding: Information Sharing Guidance for Healthcare Professionals working in Police Custody
May 2020

5. FFLM
Operational procedures and equipment for medical rooms in police stations
December 2019

6. FFLM
PICS Working Group Guidelines on Photography
February 2020

7. FFLM
Consent from children and young people in police custody in England and Wales for medical examinations
August 2018

8. FFLM
Recommendations for the collection of forensic specimens from complainants and suspects
See website for latest version

9. FFLM
Labelling forensic samples
January 2019

10. BASHH
UK guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure
2020

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