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Original communication

Injuries and allegations of oral rape: A retrospective review of patients presenting to a London sexual assault referral centre

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ABSTRACT

A retrospective review was carried out of patients seen at the Haven sexual assault referral centre in South East London between January 2009 and September 2010 to determine the frequency and nature of oral injuries found in people reporting oral rape. Ninety five eligible patients were identified and relevant information was extracted from standardised Haven forms completed during forensic medical examination. The main outcome measures were prevalence, type and location of oral injury. Eighteen (19%) were found to have sustained an oral injury. The most common injury was abrasions, followed by bruising and petechiae. The lips were the most common site of injury followed by the soft palate and the inside of the cheeks. It was concluded that injuries in the mouth were not common after an allegation of oral rape. Injuries were minor and did not require treatment.

1. Introduction

In England and Wales, oral rape is defined in the Sexual Offences Act (2003)[1] as non-consensual penetration of the mouth with a penis. Much research has been devoted to injuries associated with sexual assault[2] but there has been little work looking at injuries sustained during oral rape specifically. This is probably because it usually occurs in addition to other sexual acts such as vaginal rape, rather than in isolation. Furthermore, the existing literature on injuries discusses either body injuries or anogenital injuries, with little specific attention paid to the mouth area.

Some useful information can be extrapolated from work on injuries sustained during consensual oral intercourse, which suggests that injuries are subtle and may occur to the frenula, palate, gums and buccal surfaces of the cheek. Injuries include abrasions, burns, bruises, petechiae and lacerations.[3] Case reports of consensual oral intercourse mention the presence of small splits to the corner of the mouth, and bruises and abrasions to the palate and one case of a circular haemorrhagic lesion located on the soft palate consisting of erythema, petechiae and vesicles, which was painless and lasted 1–2 weeks.[4] The mechanism of injury was direct traumatic action associated with negative pressure produced at the point of contact of the penis with the soft palate. A similar injury in a person reporting a sexual assault was demonstrated on a television programme featuring St Mary's sexual assault referral centre in Manchester, UK.[5] Injuries can also occur during consensual oral sex to the tongue or in the form of tears to the frenulum under the tongue. Gagging can be stimulated by the penis being pushed too deeply into the throat or could be triggered by the taste of a condom, ejaculate in the throat, smell of the sexual partner or could be a psychological reaction, and the pressure generated by gagging can lead to petechiae in the palate or throat or other parts of the head and neck. Other consensual sexual activities that can lead to oral injuries include suffocation during fellatio and aspiration of semen.[6] In a sexual assault, oral injuries may also result from a blow to the mouth or pressure of a perpetrator's hand in or over the victim's mouth.[3] It remains unclear to what extent the injuries observed following consensual oral intercourse are similar to, or different from, those observed following non consensual oral intercourse. The aim of the present study was therefore to report the prevalence, type and location of oral injury in patients who reported an oral rape to the Haven sexual assault referral centre in Camberwell, south east London.

The Havens are London-based sexual assault referral centres that were set up as a joint initiative between the Metropolitan Police Service and the NHS. Three Havens provide a 24/7 service to any adult or child, male or female, in greater London who has been sexually assaulted. The first Haven opened in Camberwell in 2000, followed by the Havens in Paddington and Whitechapel in 2004. The Havens provide comprehensive services; clients can receive a

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forensic examination, emergency contraception and drugs to prevention infections, including HIV, follow-up care including sexual health screening, psychosocial support and practical advice. There is also the opportunity for patients to meet a specially trained police officer who will obtain more information about the assault and help them make a decision about whether to formally report the incident to the police. The Havens see people of any age and accept police referrals, self referrals or third party referrals.

2. Methods

This was a retrospective review of people aged 16 years and over who had reported oral rape to the Haven Sexual Assault Referral Centre, Camberwell, between January 2009 and September 2010. All had attended the Haven after reporting that an oral rape had occurred within the previous seven days and had a forensic medical examination carried out by a sexual offences examiner (SOE). All SOEs are doctors with at least two years' experience in general practice, obstetrics and gynaecology, genitourinary medicine or reproductive and sexual health. On appointment at the Haven, they attend theory courses on examination and aftercare of alleged sexual assault victims and on the management of domestic violence and they attend a witness and court skills course. They also take part in a day of simulation training, where actors are employed to represent patients either in a clinic setting or acting as a patient on the telephone. SOEs are then shadowed by senior staff for a number of forensic medical examinations until they are deemed competent to work independently.

The Haven forensic medical examination takes around 3 h and involves visual inspection of injuries, with the aid of a colposcope for magnification if necessary. Injuries are documented in writing and drawn on body diagrams and if the patient consents, a recording of the injuries can be saved on a DVD or CD. If photography of body injuries is required, the London Metropolitan Police Service currently provides a trained photographer. Haven sexual offences examiners are trained to describe injuries seen and to classify them as set out by Slaughter[7] and Sommers.[8,9] Injury is defined as any visible tissue changes as a result of trauma and any breaks in tissue integrity such as fissures, cracks, lacerations, cuts, gashes or rips. Petechiae are pinpoint flat round red spots under the skin surface caused by intradermal bleeding into the skin and are tiny (less than 3 mm in diameter) and do not blanch when pressed upon. Abrasions are defined as skin excoriations caused by the removal of the epidermal layer and with a defined edge. Redness is erythematous skin that is abnormally inflamed due to irritation or injury and can be without a defined edge or border. Swelling is oedematous or transient engorgement of tissues. Additional injuries that also may be found on victims of sexual assault include stab wounds, burns and bites.

Haven patients sign a consent form for the use of their anonymised information for research; those who did not consent were not included. During the study period, 1120 people reported a sexual assault to the Haven Camberwell, of whom 95 were eligible for inclusion in the present study. Reasons for exclusion were as follows: 680 patients reported no oral rape, 103 were under the age of 16, 8 did not consent to their information being used for research, 60 did not have a complete examination so information was limited and 140 either had no recollection of the offence or could not remember if an oral assault took place. Of the remaining 129 records, 20 were excluded as they reported consensual oral sex within the ten days prior to the forensic medical examination (thus possibly confounding any findings) and 14 were excluded as oral rape had been attempted and not completed. Eighteen SOEs examined the 95 eligible patients and had a range of experience, from six months to ten years in post.

All information, including details of the patient, the assault and the examination, is documented on a standardised proforma. For the present work, information was retrieved by a sexual offences examiner and a health advisor/counsellor. Data collected included sex, age and ethnicity of the patient, the use of drugs and alcohol around the time of the assault, the time between the assault and the examination, the nature of the offence, relationship with perpetrator, additional violence, verbal threats, weapon use, and the prevalence, type and location of oral injuries. Presence or absence of body and anogenital injuries was also noted.

3. Results

Table 1 shows demographic and other patient-related details. Table 2 shows assault and perpetrator details. The majority of patients reported that oral rape occurred in addition to another sexual offence; just 11 (12%) reported oral rape as the only offence. The majority knew the perpetrator before the assault.

Table 3 shows the number of patients found to have oral, body, genital and anal injuries during the forensic medical examination. The number of oral injuries per person ranged from 1 to 5. Six people had one injury, three people had two injuries, three had three injuries, four people had four injuries and two people had five injuries. Of the 18 who sustained an oral injury, 16 (88.9%) also had a body injury and 4 (23.6%; N = 17) sustained a genital injury. One patient with oral injury was found to have an anal injury. Seventy seven patients did not sustain oral injury. Of these, 60 (77.9%) were found to have sustained a body injury and 19 (26.8%; N = 71) a genital injury.

Table 4 shows the presence of injuries in relation to the number of days post assault that the patient was examined. The majority (74; 77.9%) were examined within two days of the assault and of these, 16 (22%) were found to have sustained an oral injury.

Table 5 shows the type and location of oral injuries, the total number of injuries at each location and the number of patients with an injury at each location. The most common injury site was the lips with 9 patients sustaining a total of 20 injuries and the most frequent injury to the lips was abrasions. Other injuries sustained to the lips were a swollen mouth and a healing laceration; two ulcers were found in the corner of the mouth; three blisters to the hard palate; and a bleeding gum. No injuries were found on the frenulum tongue, frenulum upper lip, the teeth, the tongue upper surface or the tongue under surface.

Table 1
Patient details.

	N = 95	%
Sex: female	87	**91%**
Age		
Max	61 years	
Mean (SD)	27.8 (SD 10.3)	
Median	26 years	
Ethnicity		
White	68	**72%**
Black	18	**19%**
Mixed	6	**7%**
Asian	1	**1%**
Chinese	1	**1%**
Alcohol around time of assault	53	**56%**
Illicit drugs around time of assault	35	**37%**
Time between assault and FME		
Min	4 h	
Max	7 days	
Median	19 h	

Table 2
Assault and perpetrator details.

	N = 95	%
Oral rape only	11	**12%**
Other assaults accompanying oral rape		
Vaginal rape single perpetrator	57	**60%**
Vaginal rape and anal rape	13	**14%**
Anal rape	5	**6%**
Digital vaginal penetration	4	**5%**
Vaginal rape multiple perpetrators	3	**4%**
Vaginal rape and attempted anal rape	1	**1%**
Attempted anal rape	1	**1%**
Perpetrator relationship with victim		
Known casually	58	**61%**
Partner/ex-partner	22	**23%**
Stranger	12	**13%**
Multiple perpetrators	3	**3%**
Condom used		
Throughout assault	8	**8%**
Started with then removed	1	**1%**
Not known	14	**15%**
Additional violence during assault: yes	68	**72%**
Verbal threats	39	**41%**
Weapon used	11	**12%**

Table 3
Prevalence of injuries.

	N = 95	%
Oral injury	18	**19%**
Body injury[a]	76	**80%**
Genital injury	23/88[b]	**26%**
Anal injury	1/20[c]	**5%**

[a] Body injury includes face, head and neck but not mouth.
[b] 7 patients did not have a genital examination.
[c] Only 20 patients had an anal examination.

Table 4
Days post assault and presence of injuries.

Time between assault and FME		N patients examined	N patients with oral injury
Day	Hours		
Day 1	Up to 24 h	55	14
Day 2	25–48 h	19	2
Day 3	49–72 h	6	0
Day 4	73–96 h	6	0
Day 5	97–120 h	2	0
Day 6	121–144 h	2	0
Day 7	145–168 h	4	1
Not known	–	1	1

4. Discussion

This is the first study to look specifically at the prevalence, type and location of oral injuries sustained during alleged oral rape. 95 cases were reviewed of oral rape reported to the Haven sexual assault referral centre between January 2009 and September 2010. Just 11 patients reported that oral rape was the only offence; the remaining 84 reported oral rape alongside other sexual offences, most frequently vaginal rape by a single perpetrator. Eighteen patients (19%) were found to sustain a total of 47 oral injuries. The finding of relatively few oral injuries could be because the cavity of an open mouth is large compared to a penis and the mouth is usually adequately lubricated reducing the incidence of direct trauma and friction. It should be noted, however, that while the rate of oral injury found here was low, it is possible that the Haven actually sees over-inflated levels. When oral rape is reported to the police, the police officer will take swabs from the mouth, face, neck and hands as soon as they meet the complainant before bringing them to the Haven, enabling the collection of vital, short-lived forensic evidence. However, if oral rape is reported as the only offence, any oral injuries will be evident to the police officer and they may be less likely to seek a referral to the Haven if the person does not have an obvious injury. Further investigation into this is needed in conjunction with the police to establish the extent to which they receive reports of rape but do not then bring the complainant to the Haven. Additionally, as patients are examined at the Haven up to seven days post assault, it is possible that some injuries will heal during this time, before the forensic medical examination. Our data suggests that oral injuries may be more readily identified within the first two days post assault, however this needs further investigation as relatively few attended more than two days post assault (74 attended within 2 days; 20 attended on days 3–7 post assault).

Relatively high rates of body injury (80%) and violence additional to the sexual assault (72%) were found in the present work. Rates of body injury were slightly higher in those who sustained oral injury (89%) than in those who did not (78%). Conversely, rates of genital injury in those with oral injury were slightly lower (24%) than in those without oral injury (27%). Sugar et al.[2] reported that rates of body injury ranged from 40% to 82% of sexually assaulted adults and suggest that this broad range may be due to differences in patient populations, injury definition, examiner training and experience and examination technique. Additionally, Sugar et al. found that presence of body injury was strongly and independently associated with oral penetration, use of a weapon and more violent attacks. Further work is needed to understand more about the nature of oral rape, specifically whether it forms part of a more violent assault and its relationship with all injuries, not just those in the mouth.

Abrasions were identified as the most common type of injury, with a total of 15 abrasions found across 8 patients. Abrasions occur due to frictional scraping of skin layers. Thus movement of the mouth or head during an oral rape would involve shearing or frictional force thus resulting in an abrasion. Eleven areas of erythema were identified across 8 patients, however this should be interpreted with caution as it is the injury most likely to have other causes such as infection or inflammation and is often seen in the palate of a hay fever sufferer. The lips sustained by far the greatest number of injuries, with a total of 20 injuries identified in 9

Table 5
Types and locations of injuries.

	Abrasions	Bruises & petechiae	Erythema	Other	Total N of injuries	N of patients with injury
Lips	11	6	1	2	20	9
Soft palate	0	1	5	0	6	6
Inside cheeks	3	2	1	0	6	2
Corner of mouth	1	2	0	2	5	2
Hard palate	0	1	1	3	5	2
Tonsils/pharynx	0	0	2	0	2	2
Gum	0	0	1	1	2	2
Frenulum lower lip	0	1	0	0	1	1

patients. It would make mechanical sense for the lips to be the most injured as forcing an erect penis against the lips or forcing a victim's lips apart or a victim trying to keep his or her mouth closed may cause injury. Furthermore, the lips are dry so would be more likely to sustain a frictional injury. A total of 6 injuries to the soft palate were found in 6 patients, and a total of 6 injuries to the inside of the cheeks in 2 patients, both of which can occur due to pressure from sucking action. No injuries were found to the frenulum tongue, frenulum upper lip, the teeth, the tongue upper surface or the tongue under surface. It is possible that injuries to the tongue or frenula may be more commonly sustained during consensual oral sex than during oral rape, as in the former there may be more enthusiastic suction by the recipient. Further work would be helpful here comparing injury patterns in oral rape and consensual oral sex.

5. Conclusion

In the present study, oral injury occurred in a small but not insignificant proportion of patients who reported oral rape. Oral injuries were minor, the most common of which were abrasions and the most common location of injury was the lips.

Conflict of interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

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Ethical approval

None declared.

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