Faculty of Forensic & Legal Medicine

Recommendations for intimate sampling in pregnancy

Oct 2025 Review date Oct 2028 – check www.fflm.ac.uk for latest update

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Introduction

Recommendations for the Collection of Forensic Specimens from Complainants and Suspects[1] provides guidance on how and when to take individual forensic samples.

However, additional guidance is required when examining and taking intimate samples from those who are pregnant.

It is essential that pregnant patients receive equitable care when accessing forensic medical services. The aim of these recommendations is to provide supplementary guidance on the care of pregnant patients who may require intimate samples.

In this document the words complainant/complainer and suspect, will be referred to as patient, unless a distinction needs to be made.

The Trimesters of Pregnancy – a brief outline

The first trimester of pregnancy refers to weeks 1 (starting on the first day of the last menstrual period) to the completion of week 12.[2,3] During this trimester, fertilisation and implantation occur, the trophoblast invades the endometrium, and the blastocyst develops into a fetus. This is the stage when most organs form, and the fetus is most vulnerable to any teratogenic substances ingested by the mother. The greatest risk being the 3rd to the 11th week of pregnancy. The majority of substances are not teratogenic, as only molecules small enough to pass through the placenta can affect the developing fetus. The medications commonly provided in a SARC (emergency contraception, HIV-PEP, hepatitis B vaccinations) are not teratogenic.[4,5] This stage of pregnancy has the highest rate of natural miscarriage. Most miscarriages cannot be prevented.[6]

The second trimester is 13 to 28 weeks.[2,3] During this time the major organs have formed but are growing and maturing. After 23 weeks the baby may survive if born prematurely. Women who have rhesus negative, (RhD negative) blood may have blood tests to identify if the fetus is RhD positive or negative, using cell free fetal, (cff), DNA techniques. If the fetus is RhD negative, too, there is no risk of sensitisation, and so no need for routine provision of anti-D immunoglobulin.[7,8] If such tests are not done, or the fetus is predicted to be RhD positive, anti D would be required, at 28 weeks, or following any potential sensitising event. This reduces the risk of haemolytic disease in this and any subsequent pregnancy. Sensitising events include, but are not limited to, any vaginal bleeding, trauma to the abdomen, invasive procedures, intra-uterine death and birth, (including miscarriage or termination).

The third trimester is 29 to 40 weeks.[2,3] The fetus is likely to survive with minimal complications if premature delivery occurs.

Medical Considerations

Medical needs should always take priority over forensic examination. In the best interests of the patient, the forensic clinician may need to liaise with the hospital team, (ED, obstetricians & gynaecologists). A single, joint examination would be preferable to two separate internal examinations.

Trauma Where a patient over 12 weeks gestation has suffered trauma to their abdomen, medical and obstetric review is necessary and the need for anti-D should be considered.

Pain in early pregnancy (prior to the first scan) should prompt urgent medical review to exclude an ectopic pregnancy. A ruptured ectopic may present with unilateral or central abdominal pain and occasionally referred pain in the shoulder-tip. This is an emergency and forensic examination deferred. Pain in the later stages of pregnancy should prompt exclusion of preterm labour and or other complications such as placental abruption. Forensic examination should be deferred as medical needs should take priority.

Bleeding in pregnancy should prompt urgent medical review at any gestation.

Low Lying Placenta During the anomaly scan (usually at around 20 weeks), patients are usually informed of any specific concerns regarding the pregnancy. This may include the need for serial growth measurements or additional scans to assess the position of the placenta. Placenta praevia (a low-lying placenta) is when the edge of the placenta appears to be close to or covering the cervical os.

Cervical Cerclage In patients where there is a specific concern regarding early delivery due to cervical weakness, a suture may be placed into the cervix. This is called a cervical cerclage.

Speculum examinations and endocervical sampling in pregnancy

The examination of a pregnant woman with a speculum is considered low risk and can be performed safely by a clinician appropriately trained to perform speculum examinations.[6]

In a normal uncomplicated pregnancy, all women should be reassured that high vaginal and endocervical swabs (for forensic sampling or sexual infection screening) taken during a speculum examination can be safely carried out at any gestation.[9,10,11] As noted in the Recommendations: when sampling the endocervix, always keep the flocked end of the swab in view[1] and if the cervix is firmly closed do not use pressure to force the tip of the swab into the endocervical canal.

In a complicated pregnancy, the risk of endocervical swabbing may alter where there is a complication affecting the cervix. Additional risks could include, (but are not limited to): cervical cerclage in situ, low-lying placenta, previous cervical surgery or recent diagnosis of threatened pre-term labour or rupture of membranes, (PROM). The forensic clinician must assess the risk on a case-by-case basis and have a low threshold to seek advice.

The evidence regarding safe sampling in pregnancy should be discussed with the patient as part of a fully informed consent process.

'Blind' and self-sampling in Pregnancy

Sexual infection Screening

The Royal College of Nursing (RCN) guidance on Genital Examination in Women states: '*Swabs for sexually transmitted infections can be taken from pregnant women, without the need for a speculum examination, using a self-taken vulvovaginal swab.*'[11]

Forensic

Samples obtained for forensic DNA analysis should be obtained in accordance with the *Recommendations for the Collection of Forensic Specimens from Complainants and Suspects*[1] and the *Recommendations on the Order of Ano-genital Sampling*.[12]

Speculum examination allows direct visualisation of any injuries or unexpected findings to be identified and high vaginal and endocervical swabs to be obtained. Fully informed pregnant women may choose to decline speculum examination. 'Blind sampling' (high vaginal swabs obtained without the use of speculum), should not be taken.

Self-taken, low vaginal swabs, are considered low risk in pregnancy. However, the clinician must ensure that a full explanation on how far to insert the swab is given to the patient.

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October 2025

Produced by Dr Bernadette Butler, Dr Laura Dean, Dr Amy Hamm and Dr Marie-Elle Vooijs
on behalf of the Faculty of Forensic & Legal Medicine
With thanks to Ms Lisa Long, Consultant Obstetrician and Clinical Director of Women's Health, King's College Hospital NHS Foundation Trust, London
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Oct 2025 Review date: Oct 2028
Send any feedback and comments to forensic.medicine@fflm.ac.uk