



Royal College *of*
Emergency Medicine

Best Practice Guideline

**Management of Adult Patients who
attend Emergency Departments after
Sexual Assault and / or Rape**

January 2026

Summary of recommendations

1. Whenever feasible, patients presenting to the Emergency Department (ED) following sexual assault or rape should be supported to access care at a Sexual Assault Referral Centre.
2. Urgent and life-threatening injuries must be prioritised over forensic considerations in the emergency department.
3. A forensic examination should only be performed by a specially trained clinician contracted by the police for this role in an appropriate environment.
4. Person identifiable information about sexual assaults and rapes should not normally be shared without consent, except in exceptional circumstances.
5. Non-fatal strangulation should be routinely explored and clinically assessed, given its frequent association with sexual assault and rape.
6. Emergency contraception should be available when attending the ED.
7. Patients should be advised that, if indicated, screening for sexually transmitted infections should be conducted two weeks following sexual assault.
8. Risks for blood borne viruses including Hepatitis B and HIV should be assessed and appropriate treatment offered. Baseline screening should be offered in the ED, with follow-up testing recommended at 12 weeks.
9. Post-exposure antibiotic prophylaxis against STIs is no longer routinely recommended.
10. Unprotected sex in men who have sex with men and transgender women carries a risk of syphilis, so patients should be offered doxycycline as post exposure prophylaxis.

Contents

Summary of recommendations	2
Scope	4
Abbreviations.....	4
Epidemiology	4
The role of the SARC.....	4
Trauma-Informed Care in the Emergency Department.....	5
Practicalities of ED Assessment.....	5
History taking.....	5
The physical examination	6
Therapeutic needs and risk assessments	6
Non-fatal strangulation.....	7
Emergency contraception	7
Pre-transfusion blood samples.....	7
Post-exposure bacterial prophylaxis	7
Hepatitis B	7
HIV Post exposure.....	8
Confidentiality and Safeguarding	8
Conclusion	8
Authors	9
Acknowledgements.....	9
Endorsements.....	9
Review.....	9
Declaration of Interests	9
Disclaimers	9
Research Recommendations	9
Audit standards.....	9
All patients attending ED after sexual assault should be given information about the local SARC... 9	
Key words for search	9
References	10
Appendix 1: Emergency Contraception following Unprotected Sexual Intercourse (UPI) ¹⁵	12
Appendix 2: Post-exposure Hepatitis B Vaccination Schedule ¹⁸	13
Appendix 3: Summary table PEP prescribing recommendations ¹⁹	14

Scope

This guideline has been developed to assist Emergency Department clinicians caring for adult patients who have suffered rape and sexual assault. We aim for this guideline to be a “one-stop” document for the management of this important cohort of patients.

Abbreviations

SARC – Sexual Assault Referral Centre

EC – Emergency Contraception

PEPSE – Post Exposure Prophylaxis after Sexual Exposure

IFAS – Institute for Addressing Strangulation

GBMSM – Gay, Bisexual, and other Men who have Sex with Men

FSRH – Faculty of Sexual and Reproductive Health

BASHH – British Association for Sexual Health and HIV

Epidemiology

In the year ending March 2025, an estimated 900,000 adults aged over 16 in England and Wales experienced sexual assault, including attempted assaults. A higher percentage of females than males were victims of sexual assault, with a prevalence rate of approximately 3 in 100 females and 1 in 100 males in the last year.¹ Sexual offences are often considered hidden crimes and not always reported to the police, the data therefore only provides a partial picture to reflect the level of sexual assault experienced. Data is lacking to ascertain how many victims of sexual assault present first to the emergency department (ED) in the UK, but as the first port of call for those in need, this is a small but important cohort of patients.

The role of the SARC

Sexual Assault Referral Centres (SARCs) are specialist, multidisciplinary services that provide expert care to individuals of all ages who have experienced sexual assault or rape including:

- Forensic medical examination
- Sexual health screening
- Emergency Contraception (EC)
- HIV and Hepatitis B Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE)
- Access to independent emotional and practical support, including crisis advocacy²

The SARC model offers significant benefits by bringing together medical and legal support in a single setting. Patients can choose to engage with SARCs without police involvement and may be treated anonymously if they wish.

Referral pathways vary from centre to centre; it is unusual for these services to function as a “walk-in” in the UK; please consider this before attempting to send a patient directly to a SARC. SARCs are not equipped to manage acute medical issues. The ED’s primary responsibility is to assess and treat urgent or life-threatening injuries, which must take precedence over forensic procedures.

Where appropriate, ED staff should support patients in contacting a SARC, with their consent. If they decline, their decision must be respected. For those wanting a SARC appointment, delays may occur, so immediate clinical needs including EC, HIV and Hepatitis B PEPSE, and safeguarding support should be addressed in the ED.

Trauma-Informed Care in the Emergency Department

The ED setting, while vital for rapid clinical care, can be overwhelming and may unintentionally mirror the fear, control, or helplessness experienced during the traumatic event.³

Trauma-informed practice in ED aims to counteract this by offering patients a different relational experience, one grounded in *safety, choice, collaboration, trust, and empowerment*.⁴ By embedding these principles into routine care, clinicians can support recovery and help reduce the risk of re-traumatisation.

Key trauma-informed approaches in EDs should include:

- Creating a calm, private setting. Minimise interruption, allow ample time for consultation.
- Explaining confidentiality limits early to maintain trust and prevent feelings of betrayal.
- Using inclusive language, respecting gender identity and preferred pronouns to support rapport and affirm patient dignity.
- Explaining all available options, ensuring the patient understands and feels in control of decisions made, especially around forensic examination, safeguarding, and referrals.
- Collaboratively developing a management plan that supports the patient’s wishes, including decisions about multi-agency involvement (e.g., police, SARC, safeguarding).

In summary, trauma-informed practice in ED is not just about what is done, but *how* it is done. A calm, respectful, and collaborative approach can make a critical difference in both immediate care and long-term recovery from sexual violence.

Practicalities of ED Assessment

History taking

The history should take place in a calm, private environment. Questions about the assault are asked to establish a timeline for appropriate medical risk assessment, to consider risk factors of the assailant, and to assess the patient’s health needs. It is important to recognise traumatic events and substance misuse can impair memory and recall, meaning patients may struggle to provide accurate information.

Here is a non-exhaustive list of points to cover in history taking and related considerations:⁵

- **Brief overview of the incident:** Establish what occurred, when (including date and time if the assault was recent), where it happened, and who was involved.
- **Nature of sexual contact:** Determine whether there was oral, vaginal, or anal penetration to support the risk assessments for PEPSE.
- **Symptom and injury assessment:** Enquire about any current symptoms and injuries. Any heavy vaginal or anal bleeding or physiological upset may be best managed by the appropriate parent speciality.
- **Risk of pregnancy:** For those at risk of pregnancy due to the assault or recent consensual sex, explore menstrual and contraceptive history to assess the need for EC.
- **HIV and Hepatitis B risk:** If known, ask about the assailant's background or behaviours that may increase the risk of HIV or hepatitis B transmission.
- **Psychosocial assessment:** Explore current mood, suicidal ideation, self-harm, social support, history of mental health issues, domestic abuse, and substance use. Always check for children or vulnerable adults in the household

These cases warrant early involvement of a senior decision maker in the ED. Accurate and detailed documentation is vital in the care of individuals disclosing sexual violence.

The physical examination

Though many of these patients do end up having input from a SARC, a SARC is not able to manage acute injuries. For example, head injury, musculoskeletal complaints, imaging and follow-up care for non-fatal strangulation, ongoing mental health concerns, serious vaginal or anal bleeding.

SARC clinicians are available for advice in the management of patients who present following sexual assault. In patients with serious vaginal or anal bleeding, ensure that they are examined by the most senior or most appropriate speciality clinician. For body surface injuries, consider recording on a body chart. When carrying out any examination on a patient, apron and gloves should be worn to minimise forensic contamination.

Anogenital examination does not preclude forensic sampling later in the patient's journey. On rare occasions, SARC clinicians may attend directly for forensic examination in situ, however this is often suboptimal both from a forensic, and more importantly patient experience.

If possible, advise the patient to retain clothing worn, sanitary products and/or bedding used at the time of the assault.⁶

If a patient is planning on attending a SARC for forensic examination, advise them to avoid washing if possible. In cases of oral assault, they should be advised to avoid brushing their teeth.

Therapeutic needs and risk assessments

Patients presenting to ED after sexual assault should have appropriate risk assessments and medical needs addressed, including EC, HIV, and Hepatitis B PEPSE, as SARC attendance may be declined or delayed.

Non-fatal strangulation

Non-fatal strangulation (NFS) is a serious yet often overlooked form of violence, frequently linked to sexual assault and coercive control. It involves external neck compression by hands, ligature, or other force restricting airflow or blood flow without causing immediate death.⁷ Over 20,000 people in the UK experience strangulation annually, and around one in eleven adult sexual assault survivors report being strangled during the incident.⁸

The [IFAS Acute & Emergency Guidelines \(2024\)](#) identify NFS as a red flag for serious internal injury and future homicide risk. It requires prompt clinical and safeguarding action.⁹ Please refer to the guidelines for history-taking and risk assessment. Always ask directly about NFS, as patients may minimise or not recognise its seriousness.

If red flags are present, escalate to a senior clinician and arrange imaging.

Emergency contraception

Emergency contraception (EC) may be indicated following sexual assault, depending on the nature of the assault and factors such as the patient's use of reliable contraception. Refer to [Appendix 1](#) and FSRH guidelines¹⁰ for guidance on appropriate choice of EC to offer.

Pre-transfusion blood samples

Pre-transfusion blood samples are not required unless taken as a baseline test to assess exposure to blood-borne viruses, in line with local policy. If requested by police, a designated forensic healthcare professional must collect the sample to ensure the integrity of chain of evidence.

Post-exposure bacterial prophylaxis

Post-exposure antibiotic prophylaxis against STIs is no longer routinely recommended in national guidelines.¹¹

Recent BASHH guidance recommends a single 200mg dose of doxycycline PEPSE (DoxyPEP) for syphilis prevention after unprotected sex in cisgender GBMSM and transgender women.¹¹ It should be given ideally within 24 hours and no later than 72 hours. Patients presenting later after sexual assault with symptoms of STIs or PID should be managed according to local policy. Advise STI screening at two weeks post-assault to reduce false negatives if done earlier, with follow-up blood-borne virus testing at 12 weeks for HIV, Hepatitis B and C and Syphilis.¹²

Hepatitis B

Following sexual assault, assess the need for Hepatitis B vaccination. Consider the Hepatitis B Virus status of the source (if known) and the patient's vaccination history.

National guidelines advise offering the vaccine to anyone potentially exposed to blood or bodily fluids, as sexual contact poses a significant transmission risk.¹³ Refer to [Appendix 2](#) for the recommended vaccination schedule.

HIV Post exposure

All patients following sexual assault should undergo a risk assessment for HIV transmission, following the latest BASHH PEPSE¹⁴, see [Appendix 3](#), and departmental guidelines. Factors that increase transmission risk include anal rape from a high-risk prevalence group, genital trauma, bleeding, and multiple assailants. Coordinate with local sexual health services and SARC's to ensure timely initiation, within 72 hours but as soon as possible after exposure, follow-up testing, and adherence to BASHH monitoring protocols. Patients should use condoms until follow-up HIV tests confirm a negative result to minimise any residual transmission risk.

Confidentiality and Safeguarding

This guidance provides general information only. The legal framework surrounding the use and disclosure of personal information is complex and may differ across the four nations of the UK.²⁰ Emergency clinicians must be familiar with, and follow, their local organisation's policies on confidentiality, safeguarding, and access to medical records. They are also expected to comply with professional standards and guidance issued by the General Medical Council (GMC) regarding information sharing and consent¹⁵.

- For adults (18 years and over)¹⁶ who have capacity to make decisions, a refusal to share information should generally be respected even if this places them at risk of future harm.
- For children and young people under 18,¹⁷ if they lack the maturity or capacity to decide about information sharing, disclosure may be justified to protect them from harm, provided it is in their best interests.
- Young people aged 16 and 17 are usually considered capable of making healthcare decisions. However, under the Children Act 2004, they are still legally defined as children, and healthcare professionals have a duty to safeguard and promote their welfare.¹⁸ This can make decisions around confidentiality more complex.
- Children under 16 may have decision-making capacity if they demonstrate sufficient maturity and understanding (i.e. Gillick competence) and should be assessed individually.¹⁹

Disclosing information without consent can be challenging and may require advice from safeguarding leads, Caldicott guardians, legal services, or senior colleagues. Where needed, doctors may also consult their medical defence organisation for case-specific guidance.

Conclusion

This guideline outlines a comprehensive approach to managing adult patients presenting to the ED following sexual assault. By applying trauma-informed care, respecting autonomy, and ensuring prompt assessment and intervention emergency clinicians support both immediate clinical and psychological needs and long-term recovery. Early, respectful, and coordinated care can significantly improve health outcomes, trust in healthcare, and access to justice.

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Endorsements

None.

Review

Usually within three years or sooner if important information becomes available.

Declaration of Interests

None.

Disclaimers

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing reside with the treating clinician.

Research Recommendations

None.

Audit standards

All patients attending ED after sexual assault should be given information about the local SARC.

Key words for search

Sexual Assault, Rape.

References

1. Office for National statistics (ONS), released 4 November 2025, ONS website, statistical bulletin, [Sexual offences in England and Wales overview: year ending March 2025](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/yearendingmarch2025) <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/sexualoffencesinenglandandwalesoverview/yearendingmarch2025>
2. Saint Mary's Hospital Sexual Assault Referral Centre. SARC provides forensic, counselling, aftercare, emergency contraception, sexual health screening, HIV PEP, hepatitis B vaccination, crisis support for adults and children. Manchester University NHS Foundation Trust; 2025
3. Phillips J, Burns-Nader SA, Boudreault M. Trauma-informed responses to sexual assault. Justice Canada; 2022.
4. Ashworth H, Lewis-O'Connor A, Grossman S, et al. Trauma-informed care (TIC) best practices for improving patient care in the emergency department. *Int J Emerg Med.* 2023;16:38. <https://doi.org/10.1186/s12245-023-00509-w>
5. British Association for Sexual Health and HIV. National guidelines for the management of individuals disclosing sexual violence in sexual health services. *Sexual violence 2022.* Lichfield: BASHH; 2022. Available from: https://www.bashh.org/userfiles/pages/files/resources/bashh_sv_2022.pdf
6. Forensic Science Regulator. Guidance: Sexual Assault Examination – Requirements for Assessment, Collection and Recording of Forensic Science Related Evidence FSR-G-212 Issue 1. Birmingham; 2019. Available from: <https://www.gov.uk/government/publications/forensic-medical-examination-of-sexual-offence-complainants>
7. Sauvageau A, Boghossian E. Classification of asphyxia: The need for standardization. *J Forensic Sci.* 2010;55:1259–67.
8. Institute for Addressing Strangulation. UK Prevalence of strangulation and suffocation. March 2023.
9. Institute for Addressing Strangulation. Clinical Guidelines for Non-Fatal Strangulation in Acute & Emergency Settings. IFAS; February 2024. Available from: <https://ifas.org.uk/resources/>
10. Faculty of Sexual and Reproductive Healthcare. Emergency Contraception. FSRH Clinical Guideline. January 2023. Available from: <https://www.fsrh.org/standards-and-guidance/current-clinical-guidance/emergency-contraception/>
11. BASHH_UK. (2025). *Doxycycline Post-Exposure Prophylaxis 2025 - NEW Guideline.* Available from: https://www.bashh.org/resources/141/doxycycline_postexposure_prophylaxis_2025
12. Healthcare Improvement Scotland. Clinical Pathways to Support Adults Who Experienced Sexual Assault – Scotland. NHS Scotland; 2018. Available from: <https://www.gov.scot/publications/clinical-pathways-guidance-healthcare-professionals-working-support-adults-having-experienced-rape-sexual-assault-scotland/>
13. UK Health Security Agency. Hepatitis B, the Green Book, Chapter 18. Available from: <https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18>

- 14.** British Association for Sexual Health and HIV. UK Guideline for the Use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE). London: BASHH; 2021. Available from: https://www.bashh.org/userfiles/pages/files/resources/pep2021_2023amendment.pdf
- 15.** NHS England. Consent to using and sharing patient information. April 2023. Available from: <https://www.england.nhs.uk/long-read/consent-to-using-and-sharing-patient-information/>
- 16.** General Medical Council. Confidentiality: good practice in handling patient information. December 2024. Available from: <https://www.gmc-uk.org/professional-standards/confidentiality>
- 17.** NHS. Consent to treatment in children and young people. December 2022. Available from: <https://www.nhs.uk/conditions/consent-to-treatment/children/>
- 18.** Children Act 2004. Available from: <https://www.legislation.gov.uk/ukpga/2004/31>
- 19.** Medical Defence Union. Guide to Gillick competence. February 2025. Available from: <https://www.themdu.com/guidance-and-advice/guides/an-introduction-to-confidentiality>

Appendix 1: Emergency Contraception following Unprotected Sexual Intercourse (UPI)¹⁵

Emergency Contraception	Indication	Consideration
Copper Intrauterine Device (Cu-IUD)	<p>Most effective method of ED & provides ongoing contraception</p> <p>Action: Inhibits fertilisation & prevents fertilised egg implantation</p> <p>Timing: Inserted 5 days following UPI since Last Menstrual Period</p> <p>OR</p> <p>Up to 5 days after likely date of ovulation</p>	<p>If a patient chooses a coil, offer oral EC if insertion is delayed.</p> <p>If a patient plans to have a forensic medical examination at a SARC, coil fitting must wait until after the examination.</p>
Levonorgestrel (1.5mg)	<p>Action: Inhibits ovulation</p> <p>Timing: Offered up to 72hrs (3 days) following UPI</p>	<p>Dosing: Provide double dose i.e. 3mg if</p> <ul style="list-style-type: none"> • Weight >70kg • BMI>26kg/m² • Taking enzyme inducing drugs*
Ulipristal Acetate (30mg)	<p>Action: Selective progesterone receptor modulator-delays ovulation</p> <p>Timing: Offered up to 120hrs (5 days) following UPI</p>	<p>Avoid in severe asthma controlled by glucocorticoids</p> <p>Effectiveness could be reduced with recent use of progesterone & taking enzyme inducing drugs (do not offer a double dose, use of Levonorgestrel should be considered)</p> <p>Effectiveness can be reduced if progesterone is used in 5 days following administration and should be avoided</p>

*Offer Cu-IUD if patient on enzyme inducing drugs as oral EC may be less effective.

- Oral EC administered after ovulation has been shown to be ineffective.
- Advise all patients provided with oral EC or those outside timeframe for EC a follow-up pregnancy test 3 weeks following date of assault.

Appendix 2: Post-exposure Hepatitis B Vaccination Schedule¹⁸

- First dose is recommended to be provided within 24 hours following exposure.
- Vaccination can be provided up to one week after exposure.
- 16 years and over prescribe 20mcg dose.
- Hepatitis B immunoglobulin (HBIG) recommended in i.e. known non-responders to vaccine or high-risk situations.
- Advice regarding follow-up vaccinations should be provided, this can be organised by patients GP or GUM services.

Hepatitis B Accelerated Vaccine Schedule:



Hepatitis B Super-Accelerated Vaccine Schedule:



Appendix 3: Summary table PEP prescribing recommendations¹⁹

	Index HIV positive		Index of unknown HIV status	
	HIV VL unknown or detectable	HIV VL undetectable	From high prevalence country / risk-group (e.g. MSM) ^a	From low prevalence country / group
SEXUAL EXPOSURES				
Receptive anal sex	Recommend	Not recommended ^b	Recommend	Not recommended
Insertive anal sex	Recommend	Not recommended ^b	Consider ^{c,d}	Not recommended
Receptive vaginal sex	Recommend	Not recommended ^b	Generally not recommended ^{c,d}	Not recommended
Insertive vaginal sex	Consider ^c	Not recommended	Generally not recommended ^{c,d}	Not recommended
Fellatio with ejaculation	Not recommended	Not recommended	Not recommended	Not recommended
Fellatio without ejaculation	Not recommended	Not recommended	Not recommended	Not recommended
Splash of semen into eye	Not recommended	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recommended	Not recommended	Not recommended	Not recommended
OCCUPATIONAL AND OTHER EXPOSURES				
Sharing of injecting equipment	Recommended	Not recommended ^b	Generally not recommended ^e	Not recommended
Sharps injury	Recommended	Not recommended ^b	Generally not recommended ^{c,e,f}	Not recommended
Mucosal splash injury	Recommended	Not recommended ^b	Generally not recommended ^c	Not recommended
Human bite	Generally not recommended ^g	Not recommended	Not recommended	Not recommended
Needlestick from a discarded needle in the community			Not recommended	Not recommended
<p>Recommended: the benefits of PEP are likely to outweigh the risks, PEP should be given unless there is a clear reason not to.</p> <p>Consider: the risk of HIV transmission is low, the risk / benefit balance of PEP is less clear. The risk should be assessed on a case by case basis taking into consideration factors shown in footnotes c and d below.</p> <p>Generally not recommended: the risk of HIV transmission is very low, the potential toxicity and inconvenience of PEP is likely to outweigh the benefit unless there is a clear specific extenuating factor which increases the risk (see footnotes c, d, e, f below). We anticipate PEP should very rarely be given when the risk has been assessed and discussed (section 6.1.2 and 6.2.1.2)</p> <p>Not recommended: the risk of HIV transmission is negligible and PEP should not be given</p>				
^a High prevalence countries or risk-groups are those where there is a significant likelihood of the index case individual being HIV-positive. Within the UK at present, this is likely to be MSM (men who have sex with men), people who inject drugs from high-risk countries (see d below) and individuals who have immigrated to the UK from areas of high HIV prevalence, particularly sub-Saharan Africa (high prevalence is >1%). HIV prevalence country specific HIV prevalence can be found at https://aidsinfo.unaids.org				
^b The index case has been on ART for at least 6 months with an undetectable plasma HIV viral load at the time of last measurement and within the last 6 months) with good reported adherence. Where there is any uncertainty about HIV VL results or adherence to ART then PEP should be given. The viral load threshold considered 'undetectable' in the PARTNER 1 and 2 and HPTN052 studies was <200 copies/ml.				
^c Factors that influence decision-making in <u>all exposures</u> : More detailed knowledge of local HIV prevalence within index case sub-population ² . The recommendations relate to high-risk groups living in the UK (based on the known prevalence of detectable HIV viraemia in the UK, guideline table 1). Where the index case is from a high risk group and normally resides outside the UK, the risk may be greater and where there is doubt PEP should be given.				
^d Factors that may influence decision-making include in <u>sexual exposures</u> :				
<ol style="list-style-type: none"> 1. Breaches in the mucosal barrier such as genital ulcer disease and anal or vaginal trauma following sexual assault or first intercourse 2. Multiple episodes of exposure within a short period of time e.g. group sex 3. Sexually transmitted infection in either partner 4. Individuals at higher risk of acquiring HIV e.g. transgender 				



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