Written evidence submitted by the Royal College of Emergency Medicine (SPI0017)

[Note: This evidence has been redacted by the Committee. "***" represents redacted text.]

1. **About the Royal College of Emergency Medicine**
   The Royal College of Emergency Medicine (RCEM) is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to A&E departments (EDs) in the NHS in the UK and other healthcare systems across the world. If you have any questions, please contact policy@rcem.ac.uk

2. **Epidemiology of spiking**
   The Royal College of Emergency Medicine recognises and acknowledges the distress caused by spiking to victims, this is a nasty crime. The academic literature that exists on spiking in the UK concludes that the majority of people who present to EDs with concerns about spiking usually do not have illicit drugs in their blood or urine samples. It is acknowledged that alcohol can be used as a spiking agent by a perpetrator.

3. In a UK study of more than 1000 women who reported drug-assisted sexual assault, only 2% were identified as deliberate spiking cases.[1] A 2007 study of patients presenting to EDs having had a spiked drink found a total of 75 presentations over the course of the 12-month period.[2] Over half (68%) of these presentations were female, with females outnumbering males in every age group. Most patients attended the ED on a weekend, with 66% attending between 10pm and 3am. Over half (56%) of patients had urine samples obtained and analysed, and they tested positive for drugs of misuse in only 19% cases. No one tested positive for rohypnol or GHB. 94% of blood samples tested positive for the presence of alcohol. Another study carried out by the Regional Laboratory of Toxicology reported an increasing number of requests for toxicological analysis of patients presenting to their GP or ED after suspected spiking.[3] Of the 169 samples analysed from 2002-2004, 43% tested positive for drugs or alcohol. Where drugs were detected, most involved common drugs of misuse. Neither GHB nor flunitrazepam was detected in the samples analysed.

4. There have been similar studies of suspected drink spiking presentations to the ED conducted in Australia. A 2009 study of 101 patients presenting to an ED with suspected drink spiking found only nine plausible cases.[4] The study did not identify a single case where a sedative drug was likely to have been illegally placed in a drink. Additionally, there is no reliable data on the incidence of drink spiking attendances to EDs, however most academic

[1] Scott-Ham M, Burton FC. Toxicological findings in cases of alleged drug facilitated sexual assault in the United Kingdom over a 3-year period. J Clin Forensic Med 2005;12:175–86
[2] Hughes H, Peters R, Davies G, et alA study of patients presenting to an emergency department having had a "spiked drink"Emergency Medicine Journal 2007;24:89-91.
[3] 3 Elliott SP, Burgess V. Clinical urinalysis of drugs and alcohol in instances of suspected surreptitious administration (''spiked drinks''). Sci Justice 2005;45:129–34.
[4] Quigley, P., Lynch, D. M., Little, M., Murray, L., Lynch, A. M., & O'Halloran, S. J. (2009). Prospective study of 101 patients with suspected drink spiking. EMA - Emergency Medicine Australasia, 21(3), 222–228.

literature which has looked at assault victims (of any method and cause) has found that the majority of assaults that present to healthcare settings are not recorded by the police.

5. **Detection of spiking**
   There is a widespread perception among the public that EDs provide toxicology testing for patients who suspect they may have been spiked. This is not the case, and NHS England does not have a uniform policy for screening patients who suspect they may have been spiked. This is because EDs do not routinely collect blood and urine samples for drugs and only use toxicology testing if there is a clinical justification.

6. Urine toxicology tests that are available in most EDs only test for a limited number of drugs and do not include ketamine, synthetic cannabinoids, GHB, and rohypnol. These tests are only used when clinicians believe the test is necessary to change the clinical management of the patient, who may be either unconscious, psychotic or seriously unwell.

7. For patients who may have been spiked with a needle, Emergency Physicians may carry out risk assessments about the potential risk of blood borne virus transmission. Although there is a lot of uncertainty, Emergency Physicians would consider prophylactic vaccination for Hepatitis B and Post Exposure Prophylaxis for HIV. In a number of areas, this service might be carried out by the local genito-urinary medicine service.

8. Emergency Medicine staff do not routinely collect drug or alcohol samples for the police. Forensic samples of blood and urine need to be taken in line with evidence management procedures. The process of consenting for forensic sampling is different, as staff would not be taking samples for medical intervention. It is important to note that ED staff have not been trained to take samples in this manner. In most cases, forensic medical professionals are responsible for taking these samples due to the nature of testing required. Additionally, EDs are usually unable to provide adequate quality assurance of the 'chain of evidence' required by the courts. There is a risk that toxicology evidence collected by untrained ED staff would be inadmissible.

9. The Faculty of Forensic and Legal Medicine has outlined the medico-legal guidelines for the collection of forensic specimens from complainants and suspects.[5] EDs do not have the facilities to collect and store forensic samples in a way that would satisfy the courts. This responsibility sits with the police force.

10. Sexual Assault and Rape Centres (SARC) are well placed to support victims of spiking. SARC can provide emotional and holistic support to survivors of sexual assault including after care. Clinicians working in a SARC will take a detailed history of the assault and a medical history. This information is important when taking these samples as drugs decompose and may not be traceable. Clinicians working in SARCs are also better placed to make assessments about capacity and consent – and make it clear that the results from urine and blood samples are not confidential and that the information could be shared with police and CPS. The victims have the right to refuse but Emergency Medicine staff do not have the training or expertise in the legal issues around forensic samples to inform victims who may present to EDs

[5] https://fflm.ac.uk/wp-content/uploads/2021/07/Recommendations-for-the-collection-of-forensic-specimens-FSSC-July-2021.pdf

intoxicated or distressed from a suspected spiking incident. Emergency Medicine staff should not be testing for drugs unless it is for medical purposes and in their best interest.

How spiking should be prevented and addressed

11. In England, the Information Sharing to Tackle Violence (ISTV) programme requires EDs to ensure they collect and share non-confidential/non-disclosive data to Community Safety Partnerships about those attending departments following an incident involving violent crime.[6] We believe cases of spiking should be recorded under ISTV. RCEM also believes that data about recording spiking incidents can be identified in the Emergency Care Data Set.

12. The College has produced guidance on how to best support victims of sexual assault and rape.[7] This essentially advocates that, wherever possible, victims should be evaluated in Sexual Assault and Rape Centres (SARC), as this work requires significant training, expertise and time. EDs are expected to be able to direct victims easily to their local SARC.

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January 2022

[6] https://data.london.gov.uk/information-sharing-to-tackle-violence/istv-resources-for-policy-makers/

[77] Management_of_Adult_Patients_Who_Attend_-ED_After_Sexual_Assault_and_or_Rape_revised.pdf (rcem.ac.uk)