



**Pattern of alleged sexual assault cases presenting to a tertiary care hospital:
A retrospective cross-sectional observational study.**

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ABSTRACT

Background:

Alleged sexual assault is a medical, psychological, social, and medicolegal emergency. Hospital-based data help define survivor profiles, assault characteristics, injury patterns, and service gaps.

Objectives:

To describe the sociodemographic profile, assault characteristics, clinical findings, forensic profile, immediate management, and short-term outcome of alleged sexual assault cases presenting to a tertiary care hospital.

Methods:

This retrospective cross-sectional observational study was conducted at Government Medical College, Kamareddy, Telangana, India, from January 2025 to December 2025. Records of 100 alleged sexual assault cases presenting to the tertiary care hospital were reviewed using a structured data abstraction form. Sociodemographic details, assault characteristics, clinical and forensic findings, immediate management, medicolegal actions, and short-term outcomes were analyzed using descriptive statistics after de-identification of data.

Results:

Most survivors were aged 18-25 years, female, unmarried, and from rural areas. Students formed the largest occupational group. Nearly half presented within 24 hours, and the alleged assailant was known to the survivor in most cases. Penetrative assault predominated, with vaginal assault being the commonest category. External injuries were documented in 39.0% and fresh genital injuries in 27.0% of cases. Forensic evidence collection was performed in 88.0%, and medicolegal documentation in 93.0% of cases. Follow-up attendance remained low.

Conclusion:

Young female survivors constituted the majority of cases, and known assailants were common. Although medicolegal documentation and forensic collection were achieved in most patients, gaps remained in preventive care, counseling, and continuity of follow-up.

Recommendations:

Standardized sexual assault response protocols, timely forensic and preventive services, stronger psychosocial support, and structured follow-up systems are required to improve survivor-centered hospital care.

Keywords: sexual assault; tertiary care hospital; forensic profile; medicolegal documentation; survivor care; retrospective cross-sectional observational study.

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INTRODUCTION

Sexual assault is a serious public health and human rights concern that carries immediate and long-term physical, reproductive, psychological, and social consequences[1]. Survivors often present to hospitals in circumstances that require simultaneous medical treatment, forensic documentation, crisis support, and coordination with legal authorities. Earlier hospital-based studies have shown that most patients presenting after sexual assault are young females, although males and children are also affected, and the pattern of assault often reflects a complex interaction between age, relationship to the assailant, location of assault, and time to presentation [2].

Healthcare institutions, particularly tertiary care hospitals, occupy a central role in the response to alleged sexual assault. These settings are expected to provide detailed history taking, comprehensive physical and anogenital examination, appropriate sample collection, documentation of injuries, pregnancy testing, screening for sexually transmitted infections, prophylactic treatment, counseling, and referral for ongoing support [3,4]. Timely presentation is especially important because delays can reduce the yield of biological evidence and postpone emergency contraception, HIV post-exposure prophylaxis, and STI prevention [5,6].

The clinical profile of sexual assault cases is often nuanced. A substantial proportion of survivors show no obvious external or genital injuries despite a clear history of assault, while others demonstrate minor or moderate trauma that requires careful documentation and interpretation [7]. The absence of injuries does not exclude assault, and the pattern of trauma varies with survivor age, menopausal status, type of penetration, physical coercion, and whether the assailant is known or unknown to the survivor. Similarly, medicolegal evidence has relevance beyond diagnosis alone, because properly collected forensic material and systematic documentation can contribute to investigative and judicial processes [9].

Evidence from different regions has consistently shown that many survivors know the alleged assailant, often present after a variable delay, and experience uneven access to prophylaxis, counseling, and follow-up care. In low- and middle-resource settings, hospital records also reveal important service gaps in legal certification, laboratory testing, and continuity of support after the initial visit. Local institutional data are therefore essential for evaluating

current practice, identifying missed opportunities in care, and guiding service strengthening measures within the medicolegal and public health framework.

This study was undertaken to describe the pattern of alleged sexual assault cases presenting to a tertiary care hospital in Telangana, India. The specific objectives were to assess the sociodemographic characteristics of survivors, examine the pattern and circumstances of assault, document clinical and forensic findings, evaluate immediate medicolegal and therapeutic interventions, and describe short-term outcomes, including disposition and follow-up.

METHODOLOGY

Study design and setting

This was a retrospective cross-sectional observational study conducted in the Department of Forensic Medicine and Toxicology in collaboration with the emergency department, obstetrics and gynecology services, pediatric services where applicable, laboratory services, and the medical records section of Government Medical College, Kamareddy, Telangana, India. The study period extended from January 2025 to December 2025. Government Medical College, Kamareddy, is a tertiary care government teaching hospital that provides emergency care, inpatient and outpatient clinical services, specialist referral services, laboratory support, and medicolegal examination facilities for patients from Kamareddy district and neighboring rural and semi-urban areas. Alleged sexual assault cases reach the hospital through police referral, self-presentation, or family-assisted presentation. The cross-sectional component of the design consisted of reviewing and analyzing the documented clinical, forensic, and medicolegal variables for each eligible case at the point of hospital presentation and immediate care episode.

Study population

The study population comprised all alleged sexual assault cases presenting to the institution during the study period and fulfilling the eligibility criteria. A total of 100 case records were included in the final analysis. Records were eligible when they contained essential information on age, sex, history of assault, examination findings, and immediate management. Records with grossly incomplete core medicolegal data or duplicate documentation of the same episode were excluded from analysis.



Data sources and variables

Data were extracted from medicolegal case files, casualty records, inpatient records where applicable, forensic examination sheets, laboratory registers, and discharge or follow-up notes. A structured data abstraction form was used to collect information on sociodemographic profile, mode and timing of presentation, relationship to the alleged assailant, type and place of assault, physical and genital examination findings, anal findings, presenting complaints, forensic evidence collection, pregnancy testing, STI screening, prophylactic interventions, psychological counseling, medicolegal documentation, hospital disposition, and return for follow-up.

Operational approach

For each case, available documentation was reviewed in sequence to ensure internal consistency across records. Survivor characteristics were summarized using predefined categories. Assault pattern variables included time to presentation, referral pathway, assailant category, and primary type of assault. Clinical assessment variables included both external and anogenital findings, recognizing that injury documentation after sexual assault is influenced by the timing of examination and the nature of assault [2,8,11,14]. Forensic variables included whether biological evidence was collected and whether laboratory results demonstrated semen detection or other positive evidence. Immediate management variables included administration of emergency contraception, HIV post-exposure prophylaxis, STI prophylaxis, counseling, and need for hospital admission.

Bias

Potential sources of bias included selection bias due to the inclusion of only hospital-presenting cases, information bias due to dependence on retrospective record documentation, and misclassification bias arising from incomplete or variable recording of assault characteristics and clinical findings. These were minimized by using predefined eligibility criteria, excluding duplicate records and files with grossly incomplete core medicolegal data, extracting information through a structured abstraction form, and cross-checking details across medicolegal case files, casualty records, forensic examination sheets, laboratory registers, and discharge or follow-up notes. Data were entered after de-identification and reviewed for completeness and internal consistency before analysis. As

the study was descriptive and record-based, no attempt was made to infer causality beyond the available documentation.

Data management and statistical analysis

The collected data were entered into a spreadsheet after de-identification and cross-checked for completeness and consistency. Descriptive statistical analysis was performed using frequencies and percentages because the primary purpose of the study was to characterize the pattern of presentation and care. Continuous values were not emphasized in the present dataset, as most variables were categorical. Results were organized into five tables covering sociodemographic profile, assault characteristics, clinical findings, forensic and laboratory profile, and medicolegal actions with short-term outcomes.

Ethical considerations

The study was approved by the Institutional Ethics Committee, Government Medical College, Kamareddy, Telangana, India. Confidentiality of all case records was maintained throughout the study. Personal identifiers were not entered into the analytical dataset, and the findings are presented only in aggregated form. The retrospective review was undertaken after institutional approval for record-based analysis, and the study followed the principles of privacy, respectful handling of sensitive information, and survivor-centered interpretation consistent with accepted forensic examination practice [6,11].

Informed consent

The requirement for individual informed consent was waived by the Institutional Ethics Committee because the study was retrospective in nature and used anonymized data extracted from existing hospital and medicolegal records. No direct patient contact was made for the purpose of this study, and no personal identifiers were used during analysis or reporting.

RESULTS

A total of 100 alleged sexual assault cases were identified and included in the retrospective analysis. Most survivors were aged 18-25 years [41.0%], followed by 12-17 years [28.0%]. The majority were female [96.0%], unmarried [72.0%], and from rural areas [58.0%]. Students constituted the largest occupational group [34.0%], followed by unemployed individuals [26.0%] and



homemakers [18.0%]. The sociodemographic profile of the study population is shown in Table 1.

Table 1. Sociodemographic characteristics of alleged sexual assault cases [n = 100]

Variable	Category	n	%
Age group [years]	<12	8	8.0
	12-17	28	28.0
	18-25	41	41.0
	26-35	16	16.0
	>35	7	7.0
Sex	Female	96	96.0
	Male	4	4.0
Marital status	Unmarried	72	72.0
	Married	26	26.0
	Widowed/Separated	2	2.0
Residence	Rural	58	58.0
	Urban	42	42.0
Occupation	Student	34	34.0
	Homemaker	18	18.0
	Employed	22	22.0
	Unemployed	26	26.0

With respect to presentation pattern, 46.0% of cases reported to the hospital within 24 hours of the alleged incident, while 32.0% presented between 24 and 72 hours, and 22.0% presented after 72 hours. Most survivors were brought by police referral [61.0%], whereas 39.0% attended directly or through relatives. In 68.0% of cases, the alleged assailant was known to the survivor. When categorized more specifically, acquaintances formed the largest assailant

group [31.0%], followed by intimate partners [14.0%], neighbors [12.0%], and relatives [11.0%], while strangers accounted for 32.0% of cases. Penetrative assault was documented in 74.0% of cases, and vaginal assault was the most common assault category. The majority of incidents occurred in the survivor's residence [44.0%] or the assailant's residence [23.0%]. These findings are presented in Table 2.

Table 2. Pattern of assault and presentation characteristics [n = 100]

Variable	Category	n	%
Time to presentation	<24 hours	46	46.0
	24-72 hours	32	32.0
	>72 hours	22	22.0
Mode of referral	Police referred	61	61.0
	Self/Family referred	39	39.0
Relationship to alleged assailant	Known to survive	68	68.0
	Stranger	32	32.0
Assailant category	Acquaintance	31	31.0
	Intimate partner	14	14.0
	Neighbor	12	12.0
	Relative	11	11.0
	Stranger	32	32.0
Type of assault	Penetrative	74	74.0
	Non-penetrative	26	26.0
Primary assault category	Vaginal	58	58.0
	Anal	9	9.0
	Oral	7	7.0
	Non-penetrative	26	26.0
Place of occurrence	Survivor's residence	44	44.0
	Assailant's residence	23	23.0
	Isolated outdoor place	18	18.0
	Workplace/Institution	9	9.0
	Other	6	6.0

Clinical examination showed external physical injuries in 39.0% of survivors, while 61.0% had no obvious external injury. Among those with documented bodily trauma, upper limb injuries were the most frequent. Fresh



genital injuries were noted in 27.0% of cases, old healed tears in 18.0%, and no significant genital findings in 49.0%. Anal injuries were documented in 6.0% of survivors. Pain

[42.0%] was the commonest presenting complaint, followed by bleeding [19.0%] and vaginal discharge [11.0%]. The examination profile is summarized in Table 3.

Table 3. Clinical findings on examination [n = 100]

Variable	Category	n	%
External physical injuries	Present	39	39.0
	Absent	61	61.0
Site of external injuries	Upper limbs	16	16.0
	Face/Neck	11	11.0
	Trunk	7	7.0
	Lower limbs	5	5.0
	No external injury	61	61.0
Genital findings	Fresh genital injuries	27	27.0
	Old healed tears	18	18.0
	No significant genital findings	49	49.0
	Not applicable/Male or non-genital assault	6	6.0
Anal findings	Present	6	6.0
	Absent	94	94.0
Presenting complaints	Pain	42	42.0
	Bleeding	19	19.0
	Vaginal discharge	11	11.0
	No specific complaint	28	28.0

Forensic evidence collection was performed in 88.0% of cases, indicating that biological sampling was feasible in the majority of presentations. Positive forensic biological evidence was documented in 14.0% of cases, whereas pregnancy test positivity was found in 6.0% and reactive

STI screening in 4.0%. Emergency contraception was provided to 52.0% of survivors, HIV post-exposure prophylaxis to 36.0%, and STI prophylaxis to 48.0%. The forensic and laboratory profile is detailed in Table 4.

Table 4. Forensic and laboratory profile [n = 100]

Variable	Category	n	%
Forensic evidence collection	Done	88	88.0
	Not done	12	12.0
Forensic biological evidence	Positive	14	14.0
	Negative	74	74.0
	Not collected	12	12.0
Pregnancy test	Positive	6	6.0
	Negative	70	70.0
	Not applicable/Not done	24	24.0
STI screening	Reactive	4	4.0
	Non-reactive	78	78.0
	Not done	18	18.0
Emergency contraception	Given	52	52.0
	Not given/Not indicated	48	48.0
HIV post-exposure prophylaxis	Given	36	36.0
	Not given/Not indicated	64	64.0
STI prophylaxis	Given	48	48.0
	Not given/Not indicated	52	52.0

Regarding medicolegal and immediate outcome parameters, medicolegal documentation and police intimation from the hospital were completed in 93.0% of cases. Psychological counseling was documented in 64.0% of survivors. Most cases were managed on an outpatient

basis [71.0%], whereas 29.0% required admission for observation, treatment, or social reasons. Follow-up compliance was limited, with only 38.0% returning for scheduled review. Outcome details are shown in Table 5.



Table 5. Medicolegal actions and short-term outcome [n = 100]

Variable	Category	n	%
Medicolegal documentation	Completed	93	93.0
	Incomplete	7	7.0
Police informed by the hospital	Yes	93	93.0
	No	7	7.0
Psychological counseling	Provided	64	64.0
	Not documented	36	36.0
Disposition	Outpatient management	71	71.0
	Admitted	29	29.0
Follow-up attendance	Returned for follow-up	38	38.0
	Did not return	62	62.0

Overall, the results indicate that alleged sexual assault cases presenting to this tertiary care hospital predominantly involved young, unmarried female survivors, with a substantial proportion being adolescents and young adults. Most survivors knew the alleged assailant, nearly half presented within the first 24 hours, and penetrative assault was the dominant pattern. Although forensic evidence collection and medicolegal documentation were achieved in the majority of cases, clinical injuries were absent in a considerable proportion, and follow-up attendance remained suboptimal.

DISCUSSION

The present study showed that alleged sexual assault cases at a tertiary care hospital in Telangana were concentrated among adolescents and young adults, with a marked female predominance and a high proportion of unmarried survivors. This pattern is consistent with hospital-based and forensic series reporting that survivors presenting for medical evaluation are predominantly young females, although males and children are also represented [12,13]. The prominence of students in the present cohort further suggests vulnerability during late adolescence and early adulthood, a period characterized by increased mobility, peer interaction, and dependency.

An important finding was that the alleged assailant was known to the survivor in more than two-thirds of cases. This observation agrees with prior evidence showing that acquaintance, intimate partner, and other familiar assailants often outnumber strangers in clinical sexual assault populations [7]. Known-assailant cases are frequently associated with hesitation in disclosure, family pressure, and social stigma, factors that contribute to delayed presentation and complicate the medicolegal process. In the current study, although nearly half presented within 24 hours, more than one-fifth reported after 72 hours, indicating persistent barriers to timely care.

Clinical findings in this study emphasize that the absence of injury is common and does not negate assault. External injuries were present in 39.0%, and fresh genital injuries in 27.0%, while many survivors had no overt trauma or no significant genital findings. Similar observations have been reported in earlier studies, which showed that genital and extragenital injuries can be absent, subtle, or minor even in penetrative assaults [8,10,14]. These findings support careful history taking, systematic examination, and precise documentation rather than reliance on visible trauma alone.

The forensic and service-related findings are important from a systems perspective. Forensic evidence collection was completed in most cases, and medicolegal



documentation was strong overall, which is encouraging because appropriate evidence collection and structured documentation improve the legal utility of the medical encounter [3,9,11]. However, the present study also revealed incomplete coverage of counseling, HIV post-exposure prophylaxis, STI prophylaxis, and follow-up review. Comparable concerns regarding delayed presentation, variable prophylactic care, and weak continuity of support have been reported from tertiary hospital settings in other regions [6,7,12]. Low follow-up attendance in this cohort likely reflects stigma, logistic barriers, fear of repeated disclosure, and the absence of robust tracking systems.

Generalizability

These findings are relevant to tertiary government hospitals serving mixed rural and semi-urban populations where survivors reach care through police referral as well as self-presentation. Although exact proportions will differ across settings, the observed pattern of young female predominance, frequent known assailants, uneven prophylactic uptake, and poor follow-up is likely to be seen in comparable public-sector referral centers in India and other resource-constrained regions.

CONCLUSION

This retrospective cross-sectional observational study highlights the clinical and medicolegal pattern of alleged sexual assault cases presenting to the Government Medical College, Kamareddy. The survivor profile was dominated by young, unmarried females, and most assaults involved a person known to the survivor. Penetrative assault accounted for the majority of cases, yet visible injuries were not universal, underscoring the importance of careful examination and documentation. Forensic evidence collection and medicolegal reporting were achieved in most patients, but important gaps remained in counseling, prophylactic treatment, and follow-up care. The findings support the need for integrated, standardized, and survivor-centered hospital protocols that extend beyond initial evaluation to include psychosocial support and continuity of care.

LIMITATIONS

The study was limited by its retrospective cross-sectional design and dependence on the completeness of hospital records. It represents findings from a single tertiary care center and therefore reflects local referral practices.

Long-term psychological outcomes, judicial outcomes, and survivor experiences beyond the documented follow-up visit were not captured. The descriptive dataset also restricted deeper analytical exploration of associations between assault characteristics and clinical or forensic outcomes.

RECOMMENDATIONS

Tertiary care hospitals should implement a standardized sexual assault management pathway that integrates emergency care, forensic evidence collection, pregnancy prevention, STI prophylaxis, HIV post-exposure prophylaxis, counseling, and scheduled follow-up. A dedicated one-stop crisis response model, supported by trained multidisciplinary staff, can improve continuity of care. Uniform medicolegal documentation formats, regular clinical audits, and survivor-sensitive communication training should be institutional priorities. Community awareness, rapid referral networks, and structured follow-up reminders are also needed to reduce delays in presentation and improve completion of medical, psychological, and legal support services. Periodic review of service indicators should guide quality improvement and accountability.

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Abbreviations

ED: Emergency Department
GMC: Government Medical College
HIV: Human Immunodeficiency Virus
PEP: Post-Exposure Prophylaxis
STI: Sexually Transmitted Infection

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Conflict of interest

The authors declare no conflict of interest.



Author contributions

ZAH-Concept and design of the study, results interpretation, review of literature, and preparing the first draft of the manuscript. Statistical analysis and interpretation, revision of manuscript.

GCD results interpretation, review of literature, preparing the first draft of the manuscript, and revision of the manuscript.

KR-review of literature and preparing the first draft of the manuscript, revision of the manuscript.

Data availability

Data available on request

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