

54. (Services) Please provide your training materials and related protocols for medical personal in emergency rooms or who are the first responders to alleged incidents of sexual assault. Please specify the procedures for interacting with and transferring information to the MCIOs.

USA	<p>Supplemental Response:</p> <p>The Office of the Surgeon General provided the following supplement to the U.S. Army response:</p> <p>Healthcare providers performing sexual assault forensic examinations (SAFEs) receive initial training, along with annual refresher training, which adheres to the U.S. Department of Justice’s National Protocol for Medical Sexual Assault Examination and the Department of Justice Training Standards for Medical Forensic Examiners. All exams are completed in accordance with Department of Justice protocols and guidelines noted above. Follow-on care is coordinated and managed through Sexual Assault Response Coordinators (SARCs), Victim Advocates (VAs), Sexual Assault Care Coordinators (SACCs) and Sexual Assault Clinical Providers (SACPs). See attached CME/CNE outlines.</p> <p>Training is provided locally by civilian organizations or centrally by the MEDCOM SHARP Program Office’s Sexual Assault Nurse Examiner lead trainer. The MEDCOM SHARP SAMFE training program is attached.</p> <p>Each Regional Medical Command is responsible for developing its own protocols for first response to sexual assault. Standardized protocols, in addition to algorithms and other products, will be published in the forthcoming revision to MEDCOM Regulation 40-36. The procedures for interacting with, and transferring information to, the MCIOs are outlined in MEDCOM Regulation 40-36, paragraph 11a(4). If the case is reported, the criminal justice system will use the medical forensic report, along with collected evidence, photographs and video images, and victim/witness statements as a basis for investigation and possible prosecution.</p> <p>When custody of forensic reports and collected evidence is transferred to law enforcement officials, DA Form 4137 (Evidence/Property Custody Document) will be used in accordance with AR 195-5.”</p> <p>If victims elect a restricted report, the SARC generates an alphanumeric restricted reporting case number that is used in lieu of personally identifying information to label the SAFE kit and track the case. The SAFE kit is released to the Provost Marshal.</p> <p>If the victim elects to not report, no information is forwarded by the SARC.</p>
USAF	<p>First responders are trained using a computer-based module hosted on the Air Force Advanced Distributed Learning Service (ADLS). It covers basic information medics need to know if they are the initial medical responder to a sexual assault victim. First responders are required to complete the training annually and compliance will be tracked through the self-assessment checklist. Medical examiners receive additional</p>

**Narrative responses have been consolidated by the Response Systems Panel (RSP). Please forgive formatting errors in text and data. Source documents for narrative responses can be obtained by contacting the RSP.**

	<p>training as required in section 16.5.6 (Tab 32, AFI 44-102 Medical Care Management excerpt). Evidence collection and interaction with legal authorities is covered in section 16.3.</p>
USN	<p>SECNAVINST 1752.4B provides comprehensive guidance on SAPR training requirements for all Department of Navy personnel. To standardize services throughout the DoD, all DON sexual assault responders receive the same baseline training. First responders include SARCs, SAPR VAs, healthcare personnel, DON law enforcement, NCIS, judge advocates, chaplains, firefighters and emergency medical technicians.</p> <p>Training With regard to healthcare personnel and providers, specialized training includes:</p> <ul style="list-style-type: none"> <li>• How to conduct a sexual assault patient interview to obtain medical history and assault information.</li> <li>• How to conduct a Sexual Assault Forensic Exam (SAFE) in accordance with U.S. Department of Justice, Office on Violence Against Women, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” including specific explanations on: <ul style="list-style-type: none"> <li>o SAFE Kit and DD Form 2911.</li> <li>o Toxicology kit for suspected alcohol or drug-facilitated cases.</li> <li>o Chain of custody.</li> <li>o Translation of findings.</li> <li>o Proper documentation.</li> <li>o Storage of evidence in Restricted Reports (e.g., Restricted Report Case Number (RRCN)).</li> <li>o Management of the alleged offender.</li> <li>o Relevant local and State laws and restrictions.</li> <li>o Medical treatment issues during deployments including remote location assistance to include: location resources including appropriate personnel, supplies (drying device, toluidine blue dye, colposcope, camera), standard operating procedures, location of SAFE Kit and DD Form 2911; and availability and timeliness of evacuation to echelon of care where SAFEs are available.</li> </ul> </li> <li>• How to deal with emergency contraception and STD/I treatment.</li> <li>• Physical and mental health assessment.</li> <li>• How to deal with trauma, to include: <ul style="list-style-type: none"> <li>o Types of injury.</li> <li>o Photography of injuries.</li> <li>o Behavioral health and counseling needs.</li> <li>o Consulting and referral process.</li> <li>o Appropriate follow-up.</li> <li>o Drug or alcohol-facilitated sexual assault, to include review of best practices, victim interview techniques, and targeted evidence collections.</li> </ul> </li> <li>• Medical record management.</li> <li>• The legal process and expert witness testimony.</li> </ul>

**Narrative responses have been consolidated by the Response Systems Panel (RSP). Please forgive formatting errors in text and data. Source documents for narrative responses can be obtained by contacting the RSP.**

	<p>A package of sexual assault medical forensic examination training and a virtual practicum for sexual assault exams is included in this RFI submission:</p> <ul style="list-style-type: none"> <li>- DVD titled "Navy Sexual Assault Medical Forensic Examiner Training"</li> <li>- Sealed DVD training package titled "Sexual Assault Forensic and Clinical Management"</li> </ul> <p>Protocols</p> <p>All MTFs, along with deployable Navy and Marine Corps units with organic medical departments, have written gender-specific protocols for the management of sexual assault victims. All MTF protocols address local procedures for providing access to SAFEs, and require each MTF to assign a healthcare provider as the primary point of contact concerning DoD, DON, and Military Service SAPR policy and for updates in sexual assault victim care.</p>
USMC	<p>The Bureau of Medicine and Surgery (BUMED) is in full compliance with DoDI 6495.02 (Sexual Assault Prevention and Response Procedures, March 28, 2013) regarding sexual assault forensic examinations (SAFEs) and the personnel qualified/trained to conduct them. BUMEDINST 6310.11A (Sexual Assault Prevention and Response Medical-Forensic Program, May 2, 2013) outlines our policy on performing SAFEs and ordering SAFE kits.</p> <p>Victim Care protocols, which are required by SECNAVINST 1752.4B, are in place and provide guidance on caring for patients of sexual assault. These protocols address victim care from triage to disposition (a draft example of a victim care protocol is attached from CA). We are working with NCIS, Advocacy, Legal and outside facilities to ensure that all efforts are coordinated and the needs of the patient are met.</p>
USCG	<p>Answer: Coast Guard medical professionals collaborate with Sexual Assault Response Coordinators (SARCs) in the support of victims and coordinate their care, addressing the emotional as well as physical injuries. The Coast Guard does not currently have sexual assault examiners, but does refer victims to military or civilian Sexual Assault Forensic Examiners (SAFEs) on an emergent basis at the nearest capable facility. The Coast Guard Health, Safety, and Work-Life Directorate is exploring opportunities for providing SAFE services to victims in accordance with Department of Justice National Protocol for Sexual Assault Medical Forensic Examinations.</p>

**Narrative responses have been consolidated by the Response Systems Panel (RSP). Please forgive formatting errors in text and data. Source documents for narrative responses can be obtained by contacting the RSP.**



**ARMY MEDICINE**  
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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## White Paper

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10 October 2011

**UNCLAS**

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## I. Executive Summary

Nearly 275,000 women have deployed in support of Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom. During our assessment, it was clear that female Service Members are participating, contributing, and excelling at all levels in the Afghanistan Theater of Operations (ATO). Women are serving on female engagement and reconstruction teams, in transportation, logistics, police, and engineering units as well as all of the health service support roles to name just a few. In order for women to be fully integrated and effective members of the team, we must ensure their unique health needs are being considered and met.

### Education and Training on Women's Health

Education and awareness of women's health issues is necessary for individual Service members, their leaders, and all levels in the military healthcare system. Major issues identified by the participants in the Afghanistan Theater of Operations Assessment were the lack of education on birth control, menstrual cycle control, and feminine hygiene during deployment. Women's health issues are compounded by the findings that many women hesitate to seek medical care when they have a female health concern.

#### Key Recommendations

- Standardized educational training in women's hygiene, contraception management and menstrual cycle control for female Soldier readiness
- Incorporate women's health issues into leaders' pre-deployment medical briefs to increase awareness and sensitivity to female Soldier health
- Create a series of Clinical Practice Guidelines (CPGs) to standardize provider care and implement in garrison and deployed environments
- Develop Women in the Military Self Diagnosis (WMSD) kits for UTI/Vaginitis
- Provide training and tools for female Soldiers to promote self-diagnosis and care of common gender specific infections
- Ensure that there are multiple mechanisms for distribution of Female Urinary Diversion Devices (FUDD) at any time in the deployment cycle

203581



# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## I. Executive Summary

### Army Uniform and Protective Gear for Females

Many women in ATO expressed concern about poor fit and functionality of the APFT uniform and body armor. Program Executive Office (PEO) Soldier is testing different sizes for Improved Outer Tactical Vest (IOTV) for small framed Soldiers, currently being trialed through the Soldier System Center.

#### Key Recommendations

- Emphasize research and development on the fit, form, and functionality of uniform and protective gear for female body proportions
- Appoint representative from Program Executive Office (PEO) Soldier to participate in Women's Health Task Force

### Psychosocial Effects of Deployment on Women

Women Service Members are concerned about preparing themselves and their Families for deployment and reintegration, the challenges of being mothers in the military, and the length of dwell time and post partum deferment periods being too short to allow adequate time with their Families and new infants.

#### Key Recommendations

- Develop deployment and redeployment preparedness programs, policies and behavioral healthcare that are tailored to meet the needs of all women
- Explore feasibility of extending the post-partum deferment policy to 12 months
- Support establishment of women support groups in Theater as well as in garrison
- Support further DoD, VA, and academic research efforts on the psychosocial effects of combat on female Service Members

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## I. Executive Summary

### Effects of Deployment on Children and Families

Women in the CJOA-A are concerned over the effects of deployments on their children and Families. There is abundant research showing that deployments affect Family psychosocial functioning and place children at increased risk for abuse and behavioral health complaints. These increases in adverse emotional and behavioral outcomes have been shown in all phases of deployment and reintegration.

#### Key Recommendations

- Systematic review of all Army health promotion, resiliency and prevention programs for Families
- Support continued training of civilian and military primary care physicians on the prevention, early detection, and treatment of common behavioral health disorders among military children and Families.
- Embed child and Family behavioral healthcare programs far forward into the community (school, Family centers)
- Commit to community based Soldier and Family resiliency programs that have been shown to positively influence parent-child interactions and decrease negative emotional and behavioral responses of children
- Further research on gender specific effects of deployment on Family members

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## I. Executive Summary

### Sexual Harassment/ Assault Response and Prevention (SHARP)

Sexual assault is not a gender specific issue, but a commander's responsibility with extensive organizational impacts. It affects ALL of our Service Members, degrades mission readiness and unit cohesion, and negatively impacts mission success. Findings in the CJOA-A suggested a lack of confidence by women in the reporting, examination, and legal processing to include mistrust in leadership that their privacy would be protected. The Army's newly revised Sexual Harassment/Assault Response and Prevention (SHARP) program has just been fully implemented and has been received very positively by Service Members and leaders across the ATO.

#### Key Recommendations

- Improve physical security measures on lodging and bathroom facilities and create female only spaces (where feasible)
- Review Theater policy regarding distribution of SAFE providers
- Convene a team of experts from the Tri-Services to fully investigate the integration of Service policies on sexual assault prevention and response programs in Theater
- Professionalize the roles of the Victim Advocate by providing national certification and continuing education
- Leverage the Comprehensive Soldier Fitness program to develop interpersonal skills and the core values that will enhance a culture of trust
- Ensure 100% implementation of the SHARP program

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## II. Introduction

Women have participated in America's military efforts since the Revolutionary War. Their roles have evolved from supportive in nature to those with direct assignment in the war zone since WWII. More recently, with the legislative changes during the first Gulf War, over 90% of roles are open to women.<sup>1</sup> Today, almost 275,000 women from all Services have deployed in support of contingency operations in the Middle East that encompass the full dimensions of the battle space.<sup>2</sup> Female Service Members are assigned to units and positions that may necessitate combat actions, like those assigned to our female engagement teams. They are fully prepared to respond, and to succeed, as they have in both Iraq and Afghanistan. The Services must ensure all of our Service Members are healthy, protected warriors regardless of gender. Deployment in support of military operations imposes unique conditions of daily living on military women that have an impact on health and wellness. This report reviews the major themes derived from the voices of female Service Members currently serving in the Afghanistan Theater of Operations and leverages existing data to set forth recommendations to ensure that the health of all Service Members is optimized for maximal combat power.

During the Health Service Support (HSS) Assessment of the Afghanistan Theater of Operations, women's concerns were heard at Town Hall meetings held at 10 locations across the Theater. The HSS Team traveled to Role 1, Role 2 and Role 3 facilities throughout the CJOA-A. The team members assessing Women's Health areas consisted of Nurse Corps Officers, an OB/GYN Physician, a Pediatrician, and a Medical Service Corps officer. In total, there were over 150 female Service Member participants. Open discussion was encouraged without limitation on the issues. All of the discussions were non-attributional, which allowed females of all ranks and services across Afghanistan to have a free and open voice. Surveys that had questions on women's health issues surrounding deployment were also distributed to females after the Town Hall meeting and were returned directly to the HSS team electronically, maintaining confidentiality of the participants.



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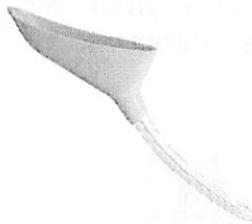


# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## III. Women's Health Education

An overarching theme of the HSS Assessment findings is that there is a lack of consistent and timely education for women's health issues and how they are impacted by deployment. Major topics identified by the participants in the Town Hall Meetings included the lack of education on birth control, menstrual cycle control, and feminine hygiene during deployment. This lack of education and counseling is evidenced by utilization practices in Theater. A Force Health Protection Assessment reported a 3% higher utilization rate for female genitourinary encounters during Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) than in garrison from January 2005 to July 2007.<sup>3</sup> It is not surprising that deployment conditions impact the prevalence of common women's health conditions. Correlations have been found between field conditions, feminine hygiene practices, and reported urinary tract infections (UTI) and vaginitis symptoms. UTI, vaginitis, and menstrual symptoms are the most common gynecologic health problems for the women serving in current conflicts.<sup>4-6</sup> Risk factors for UTI in the deployed environment include impaired voiding and impaired feminine hygiene, which are fostered by poor sanitation conditions, lack of latrines, lack of privacy, and the inconvenience of undressing in full battle gear.<sup>4, 7-10</sup> The risk is compounded by women intentionally drinking less fluid to avoid the need to urinate and postponing/delaying urination.<sup>7,8,10,11</sup>

### ***Feminine Urinary Diversion Device (Freshette ©)***



Many women were unaware of the existence of Feminine Urinary Diversion Devices (FUDDs) or their availability in the supply system, emphasizing the need for training in awareness, benefits and use of this tool. These devices can be used for urinating in a standing position without undressing.

While more often than not, female Soldiers continue to drive on with their mission, there is evidence that the symptoms of menstrual disorders and infections can impact mission readiness. Forty-eight percent of the women in one anonymous study of nearly 850 women reported that symptoms of vaginitis and UTIs compromised their duties during deployments, and 27% reported lost duty time due to their symptoms.<sup>12</sup> Similarly, military women perceive that menstrual symptoms affect performance of duties in the field setting<sup>13</sup> and contributed to lost duty days during deployments to OIF/OEF.<sup>14</sup> Appropriate counseling on menstrual cycle control, contraception, and urogenital hygiene could reduce the utilization of healthcare and disruption in mission readiness.

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## III. Women's Health Education

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Participants agreed that more education would be helpful and favored education being provided as routine training throughout the Soldier life cycle, starting with basic training and continuing over time, with further opportunities for discussion and counseling on the topics during the Periodic Health Assessment (PHA). There was limited support for including women's health education in pre-deployment training, where it would compete with other time-consuming training demands. Women also noted the importance of educating their male peers and leaders but believed learning would be best facilitated in single-sex groups. Recommendations for education are given priority in this report, since education early in the Soldier life cycle will provide the foundation of self-care required to decrease the risks of menstrual disorders, urogenital infections, and unwanted pregnancy, ultimately enhancing mission readiness.

### Recommendations:

#### Education on Women's Health Preventive Practices and Self-Care

**Incorporate the prevention and self-diagnosis of vaginitis and urinary tract infections, as well as education on menstrual disorders, contraception, urogenital hygiene, and menstrual cycle control into the Program of Instruction (POI) for Initial Entry Training (IET), Advanced Training (AIT) and Officer and NCO development courses.** While personal hygiene for all Soldiers is already included in the POI for IET, there is a limited amount of gender-specific issues; the majority of female-specific training is focused on the prevention of sexually transmitted infections. We therefore recommend that more gender-specific hygiene and self-care education for females be added to the POIs. Training should also include instruction on specific self-care practices that women can use to moderate the effects of deployment on their genitourinary health, including the use and benefits of the FUDD. Educational modules and printed materials should be packaged for Soldiers and leaders, as well as for export and utilization by our sister Services. The additional education in the POI should be delivered to both male and female Soldiers, although we recommend that it is offered in single-sex settings to encourage discussion and increased comprehension of the topics. Including the material in education sessions for males will improve their comprehension of women's health issues and foster respect among members of a unit. This training will increase awareness of women's health issues, improve sensitivity to gender specific issues and foster an expectation of respect. Additionally this knowledge will prepare males for leadership positions in which they will be responsible for ensuring the well-being of all members of their unit, including those with female health issues. Our assessment revealed that leaders desire the knowledge about the issues that affect their female Soldiers, particularly in relationship to an impending deployment. Therefore, we recommend leaders also receive specific deployment-related information on women's health issues during pre-deployment health briefings, which has been well-received at the Division level [unpublished data].

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## III. Women's Health Education

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### Recommendations:

#### Education on Women's Health Preventive Practices and Self-Care

Continuing education should be offered to female Soldiers during the PHA for the following topics: **contraception, menstrual cycle control, urinary tract infections, vaginitis and women's self-diagnosis kits.** A positive response to any of these topics on the web-based Soldier Self-Report (Part I of the PHA) would generate a patient education print-out and prompt counseling to be provided during the provider visit (Part II of the PHA). The Public Health Command (PHC) will develop the women's health patient education materials to be linked with the PHA.



In order to further standardize the education provided to female Soldiers and their leaders, PHC will revamp the *TG 281 A Guide to Female Soldier Readiness*<sup>18</sup> to promote **evidence-based preventive practices and a culture of wellness for female Soldiers.** To ensure that Soldiers and leaders receive the information, PHC will develop a dissemination strategy that includes downloadable media and support for mobile applications. Target distribution points will be at IET, AIT, Basic Officer Leader Course, Warrant Officer Leader Course, Captain's Career Course, Intermediate Level Education (ILE), as well as all pre-command and NCO and Officer Leadership courses. Collaboration with the Veteran's Administration (VA) will ensure continuum of care as Soldiers transition to the VA.

203588



# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## IV. Barriers to Seeking Care

Women's health issues are compounded by the findings that many women hesitate to seek medical care when they have a female health concern. The reasons cited at the Town Hall meetings included having to be seen by a male provider, who may be either in her chain of command or someone she works with on a daily basis. Well designed studies have supported these findings on a much larger scale and across Services. One study of 841 service women found that nearly 50% of the women (n=411) were hesitant to utilize sick call during deployment and 25% stated that they would not even go.<sup>12</sup> When specifically asked about seeking care for genitourinary symptoms, 69% of women reported that their provider was a medic or corpsman and their concerns were lack of confidence, as well as cleanliness and privacy of healthcare facilities.<sup>12</sup> This suggests that many female Service Members do not have a good understanding of how to access a licensed provider in our healthcare system. This finding also supports the need for more education as well as the need to empower women to take an educated role in the mitigation, prevention, and self-diagnosis for these conditions, where appropriate.

### Top Four Barriers to Seeking Care for genitourinary symptoms during Deployment<sup>12</sup>

- Lack of confidence in provider
- Embarrassment
- Lack of confidentiality
- Prefer female provider

In response to the barriers to seeking care, researchers investigated the use of self-tests to diagnose and treat both vaginitis and urinary tract infection, thereby avoiding the need for a healthcare visit for a gynecologic exam. When women at the Town Hall meetings were presented with the idea of doing their own self-test and diagnosis for vaginitis and urinary tract infections, there was overwhelming support. Experts who have conducted a ten-year program of research have developed a self-test kit that has been validated against diagnostic gold standards in a series of investigations, including with a military population.<sup>15,16,16a,17</sup> The kit that was tested included point-of-care testing devices for determining bacterial vaginosis or a yeast infection and /or a UTI, a thermometer, and the Women in the Military Self-Diagnosis (WMSD ©) decision-making algorithm. Education included use of the kit, a video, and scenario-based use of the decision-making guide.<sup>17</sup>

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## IV. Barriers to Seeking Care

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In preliminary analysis of data (unpublished) from the most recent of the series, the diagnostic accuracy of the testing devices with the decision-making guide for bacterial vaginosis and yeast infections approaches that of clinical diagnoses by a provider.<sup>15</sup> Furthermore, it appears to lead to accurate self treatment with oral medications, as well (unpublished data). This team also found when military women reported the classic triad of symptoms for a UTI, diagnosis both by the self-testing device and by a clinical provider were not as accurate as diagnosis by the gold standard culture;<sup>16a</sup> yet it is important to note that it is common practice to diagnose UTI and prescribe treatment over the telephone, based on reported *symptoms* only, without a culture. Therefore, the use of the self-test kit in combination with the presence of UTI symptoms is seen as a feasible alternative to a clinic visit, with similar outcomes.

It is the opinion of the subject matter experts conducting this program of research that the kit provides a feasible method for women to provide self-care and thus seek appropriate treatment without the unnecessary step of a clinician visit. Self-testing and diagnosis of UTIs and vaginitis could reduce the time women spend seeking healthcare and increase mission readiness. Not seeking healthcare, nor performing self-care testing for these conditions, could result in no treatment or inappropriate self-treatment and development of more serious complications, such as kidney or pelvic infections. In these cases, the burden on the healthcare system is increased and mission readiness is severely compromised. Given the low risk associated with the testing and low potential for misdiagnoses, in combination with the potential benefits of decreased burden on the healthcare system, it is our recommendation to pursue the development of a women's self-diagnosis kit.

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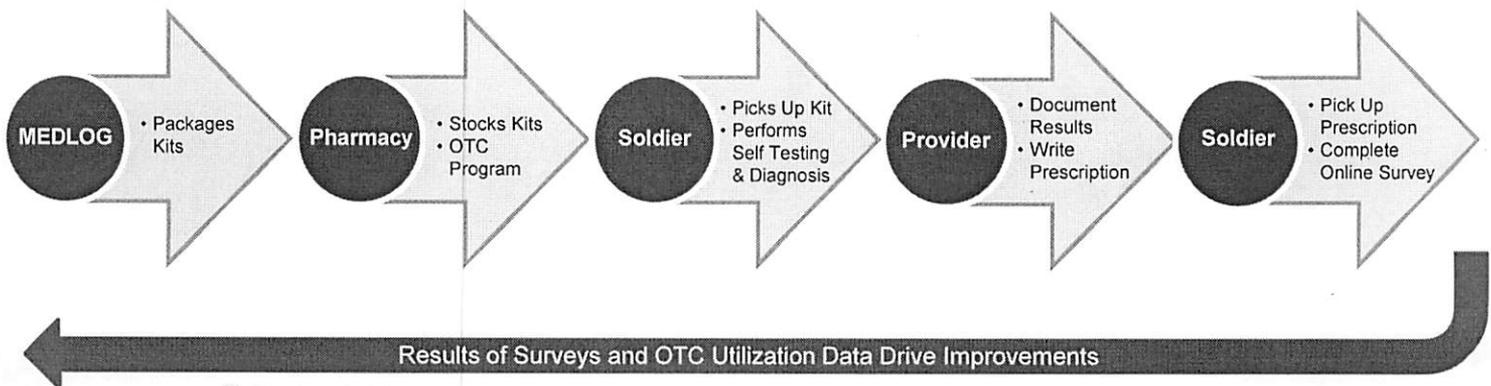
# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## IV. Barriers to Seeking Care

### Recommendations

#### Develop a Self-Diagnosis Kit for Common Conditions and make available to Women

Continue to research and develop a self-diagnosis kit for vaginitis and UTI's. Package the self-diagnosis kit for use in garrison and in Theater. In keeping with the "Train as you Fight" premise, we recommend that this kit is available in both CONUS/OCONUS medical treatment facilities and in the Theater of Operations, providing continuity in the process of how women seek healthcare for the most common gynecologic problems they encounter. In CONUS/OCONUS facilities, add this kit to the pharmacy's Over-the-counter (OTC) program. In the Theater of Operations, it should be available at the Soldiers' point of entry to care, whether it is a Role 1, 2 or 3 facility. The self-diagnosis kit will benefit the Soldier, their Unit, and the military healthcare system. By providing an easily accessible method for self-diagnosis, we will increase the ability for women to practice self-care and improve their autonomy and self-respect. This self-care initiative will decrease the reliance on appointments with healthcare providers for common issues and reduce time away from the unit, ultimately contributing to cost-savings and mission accomplishment. The kit will include point-of-care testing devices to detect vaginal pH and the presence of nitrites and leukocytes in the urine, swabs, a urine collection cup, and a thermometer. The kit will also include a decision-making algorithm to determine type of vaginitis (bacterial vaginosis or yeast) and/or UTI, a patient education handout, instructions on the use of the kit, and a field-ready form of documentation of results. Following the self-test, the Soldier can then take the test results documentation form to her healthcare provider (PA/MD/NP) for documentation in medical record and to have the appropriate prescription written. Routine quality control processes in the pharmacy will monitor and flag when an abnormal/inappropriate utilization trend is seen (i.e. infection refractory to treatment or recurrent infections).



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## IV. Barriers to Seeking Care

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**Create a series of Clinical Practice Guidelines to standardize women's healthcare for menstrual cycle control, UTI and Vaginitis self-diagnosis kits, and well woman screening (cervical and breast cancer, and Chlamydia) for providers from garrison to Theater**

Establish Clinical Practice Guidelines (CPGs) that ensures the provision of standardized care for common conditions irrespective of location (garrison or deployed) or level of provider. Topics include evidenced-based preventative screening, contraception and menstrual cycle control, vaginitis and dysfunctional bleeding.

203592



# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## V. Uniform / Personal Protective Gear Fit

Women Service Members discussed the general lack of fit of the APFT uniform and Improved Outer Tactical Vest (IOTV). In particular, the IOTV rubs on women's hips, resulting in chafing, bruising, abrasions, and limited mobility. Poor fit was also an issue with the Interceptor body armor (IBA), which generated a number of ongoing research and developmental efforts by the Product Manager-Soldier Protective Equipment (PM-SPE). They found that the current IOTV size chart does not meet the sizing requirements of female Soldiers at or below the 95% percentile size, forcing small statured female Soldiers to achieve a "best fit" in one or two sizes above what the sizing chart predicts. The problem with fit is primarily because the IOTV is too long and too big in the upper body for these Soldiers, creating standoff (gapping/opening) on both the anterior chest/shoulder and posterior shoulder.<sup>19</sup> Subsequent sizing studies led to the development of three different sizes for IOTV for small framed Soldiers, currently being trialed through the Soldier System Center. While studies are being conducted looking at the physical effects of body armor on Soldiers, women are underrepresented in those studies and correctness of fit was not independently considered.<sup>20, 21, 22</sup>

Program Executive Office (PEO) Soldier is currently working initiatives to improve the Army Combat Uniform (ACU), the Maternity Army Combat Uniform, the Flame Resistant Environmental Ensemble (FREE) for Aviators and Armor Crewmen, and the Improved Outer Tactical Vest (IOTV). There are no current initiatives to change the Modular Lightweight Load-carrying Equipment (MOLLE).

### Recommendations

#### Research and Development on improved fit / function

Support ongoing efforts to improve the fit and functionality of the protective equipment, and ensure female Soldiers are proportionally represented in studies.

#### PEO Soldier representation on Women's Task Force

Appoint representative from PEO Soldier to sit on the Army Women's Health Taskforce to enhance communication between the R&D program managers and those responsible for ensuring the health of our female Soldiers. With the lens of their multidisciplinary approach to the health and wellness of female Soldiers, the Task Force will monitor the R & D efforts of PEO Soldier to improve fit and functionality of female uniforms.

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

During the HSS Assessment Team's Town Hall meetings, female Service Members consistently voiced that they felt that their experience of deployment was inherently different from those of their male peers. Their perceptions of stressors both in Theater and at home, in all stages of the deployment cycle, as well as how to prevent and cope with these stressors is influenced by being a mother, a spouse, and a Service Member.

The concerns of the women in the ATO related to preparing themselves and their Families for deployment, being a mother while being a deployed warrior, reintegrating with their Families, and taking care of their own mental health needs during and after deployment. In particular, women perceived that deployment may result in different mental health outcomes from their male peers, and that as women, they require different pre-deployment preparation and reintegration strategies to ensure positive mental health and Family outcomes throughout the deployment cycle. While deployed, the women in the Town Hall meetings discussed how communication with other women during deployment is helpful because males "work through their issues differently" from the women; there is a perception of the general lack of sensitivity to women's issues by their leadership and male peers. Regardless of research findings, female Service Members requested that Leaders and senior enlisted receive training for the purpose of better communication skills to facilitate coping with psychosocial issues during the deployment.



Limited research exists to draw valid conclusions on whether there is a gender specific response to deployment; however there is data in the general population to suggest that women utilize more behavioral health services than men. In November 2010 the AFHSC published a report that included a comparison of crude incidence rates of mental disorder diagnoses in all active duty males and females from January 2000- December 2009. Rates of all mental disorder diagnoses were generally higher among females than males. Crude incidence rates of adjustment, anxiety, depressive, and personality disorders were more than twice as high among female Service Members as males.<sup>23</sup> However, according to the National Institute of Mental Health (NIMH) this data approximates anxiety and depression prevalence data in the U.S. adult population, where the national prevalence for anxiety and depression is 60% and 70% higher, respectively, in females.<sup>24</sup>

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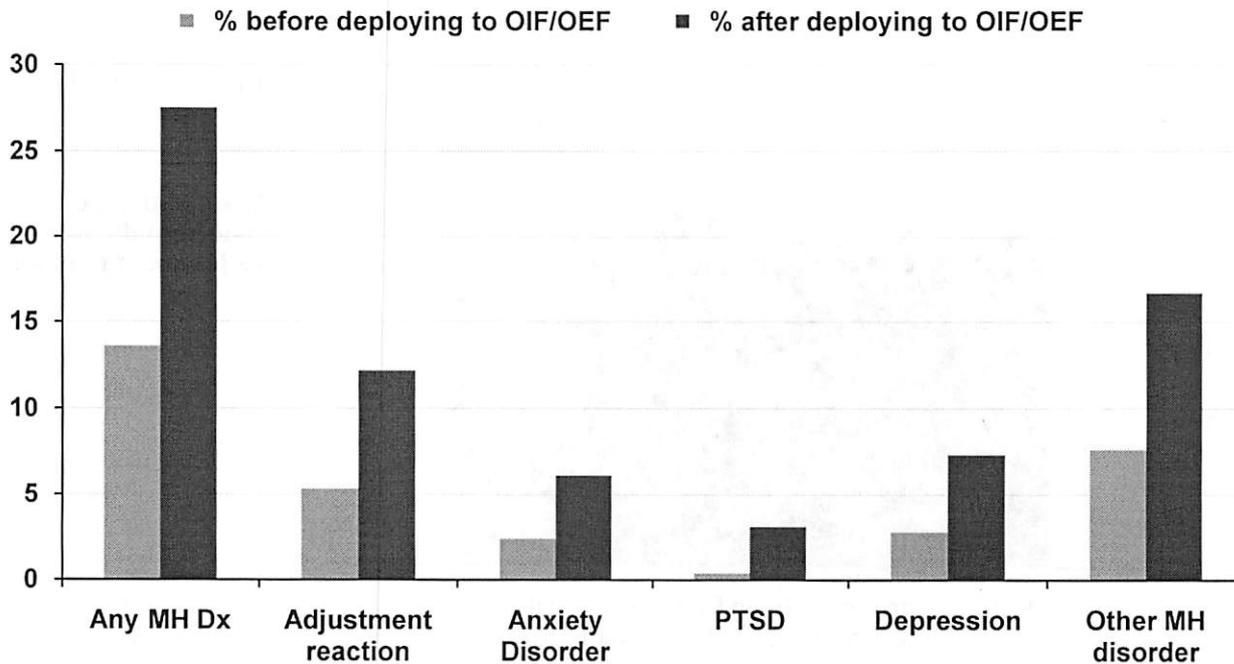


# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

In relation to deployment to OIF/OEF, AFHSC conducted two analyses that revealed mental health encounter trends in female Service Members. In February 2009 AFHSC published gender-specific healthcare utilization data of all U.S. Armed Forces in non-deployed medical treatment facilities establishing a relationship between pre-deployment and post deployment mental health encounters.<sup>25</sup> A higher percentage of females have mental health encounters following their first deployment to OIF/OEF than prior to deployment, however, it is pertinent to this assessment to note that a gender-comparison analysis of post deployment mental health utilization was not included in this report.

**Figure 1: Percentage of female Service Members with mental health diagnoses prior to and after the start of each individual's first deployment to OIF/OEF in U.S. Armed Forces Females JAN 2002 – DEC 2008.**



Source: Based on data from Armed Forces Health Surveillance Center (AFHSC) Relationships between the Nature and Timing of Mental Disorders Before and After Deploying to Iraq/Afghanistan, Active Component, U.S. Armed Forces, 2002-2008. *Medical Surveillance Monthly Report, (MSMR). 2009 FEB 16(2): 2-6.*

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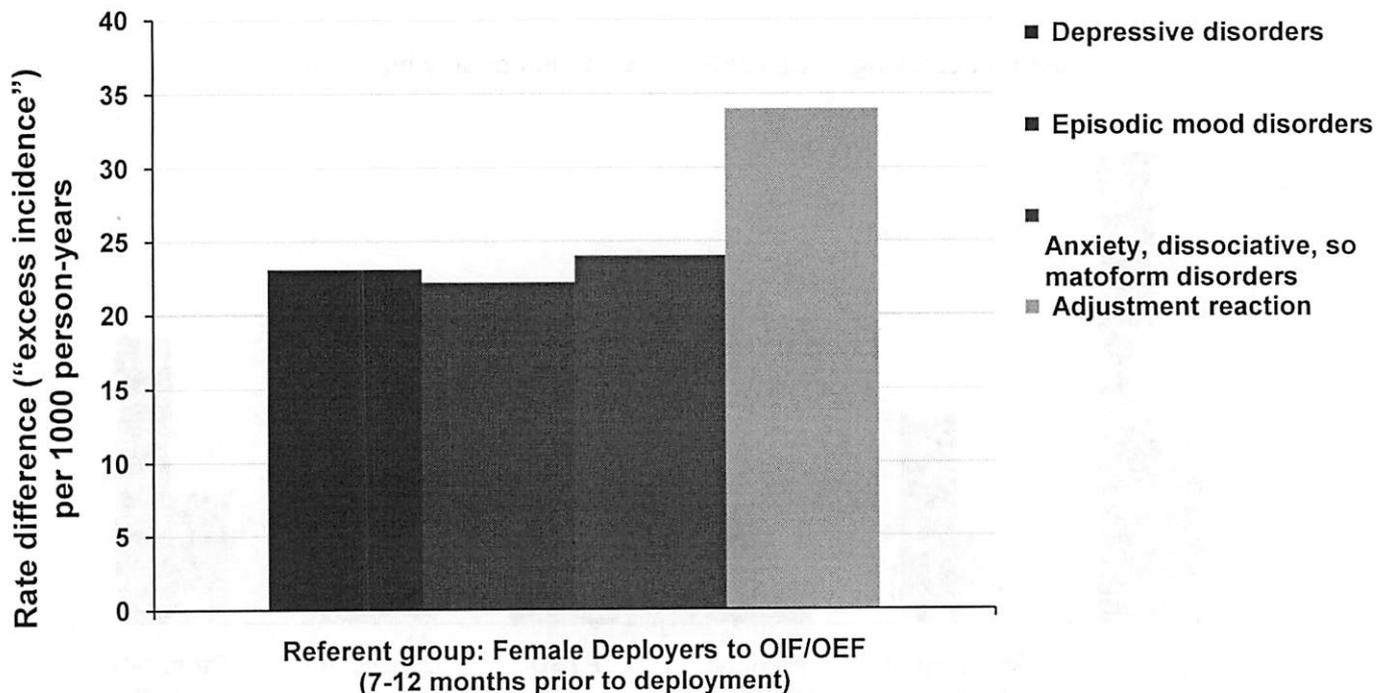


# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

In order to determine if there is a difference in female and male healthcare encounters following deployment to OIF/OEF, a targeted gender-specific analysis was conducted by AFHSC. Female OIF/OEF deployers' medical encounters at 19-24 months following deployment were compared to their own pre-deployment encounters and to the encounters of a referent group of deployed males at 19-24 months following deployment. The categories of mental illnesses that showed excessive incidence among females when compared to their pre-deployment diagnoses were depressive disorders, episodic mood disorders, adjustment reaction, and a group of anxiety, dissociative, and somatoform disorders.<sup>26</sup> This supports the previous report that women experience an increase in mental health diagnoses following deployment.

**Figure 2: Conditions with largest rate differences (“excess incidence”) among female OIF/OEF deployers, 19-24 months after returning from deployment, in comparison to adjusted referent rates for females prior to deployment.**



Source: Based on data from Armed Forces Health Surveillance Center (AFHSC) Health of Women after Deployment in Support of Operation Enduring Freedom/Operation Iraqi Freedom, Active Component, U.S. Armed Forces. *Medical Surveillance Monthly Report, (MSMR). 2009 OCT 16(10): 2-9.*

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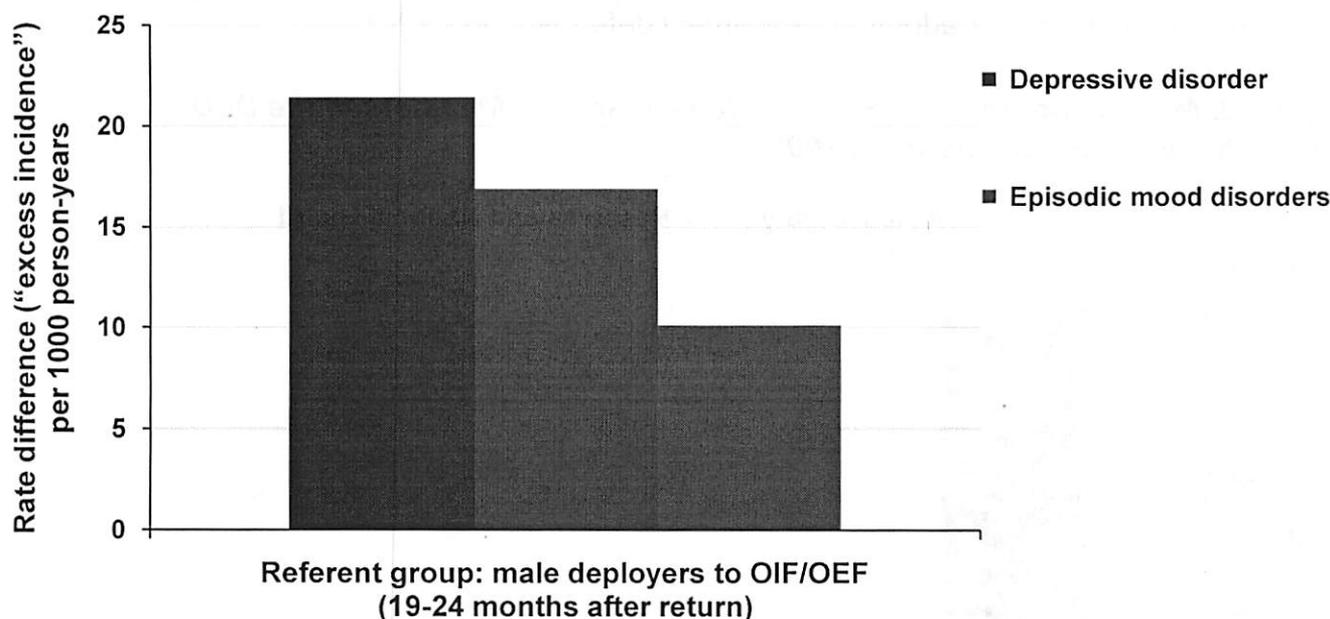


# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

When compared to the male referent group, the rate difference for mental health diagnoses for depression, anxiety, and mood disorder were 21, 17, and 10 per 1000 person-years, respectively.<sup>26</sup> This data presents a rare analysis that reveals gender-specific differences in mental health encounters in the U.S. Armed Forces healthcare system in relation to deployment to OIF/OEF. However it remains unclear if this represents a true increased incidence of mental health disorder or just a difference in utilization of the Military Healthcare System.

**Figure 3: Conditions with largest rate differences (“excess incidence”) among female OIF/OEF deployers, 19-24 months after returning from deployment, in comparison to adjusted referent rates for male deployers.**



Source: Based on data from Armed Forces Health Surveillance Center (AFHSC) Health of Women after Deployment in Support of Operation Enduring Freedom/Operation Iraqi Freedom, Active Component, U.S. Armed Forces. *Medical Surveillance Monthly Report, (MSMR). 2009 OCT 16(10): 2-9.*

Multiple studies on combat veterans that have attempted to establish a gender difference in psychological responses to combat have had mixed results, depending on how they measured levels of combat exposure and what was considered normal responses to combat.<sup>27-30</sup> The validity of applying the findings to predict a gender difference in behavioral outcomes is further questionable given the basic underlying assumptions of what is a “normal” reaction to combat stressors, for both men and women. In a 2009 review of the existing literature on gender-relevant issues with post traumatic stress symptomatology in OIF/OEF veterans, it was concluded that models used in studies to explore the psychological impact of deployment to a combat zone were built on men’s experiences in war and therefore cannot predict women’s outcomes.<sup>29</sup> Yet, a recent examination of 16 combat-related stressors and post deployment mental health *failed* to predict a gender-difference in negative outcomes, suggesting that *female OIF/OEF veterans possess resiliency to combat-related stress similar to their male peers.*<sup>31</sup>

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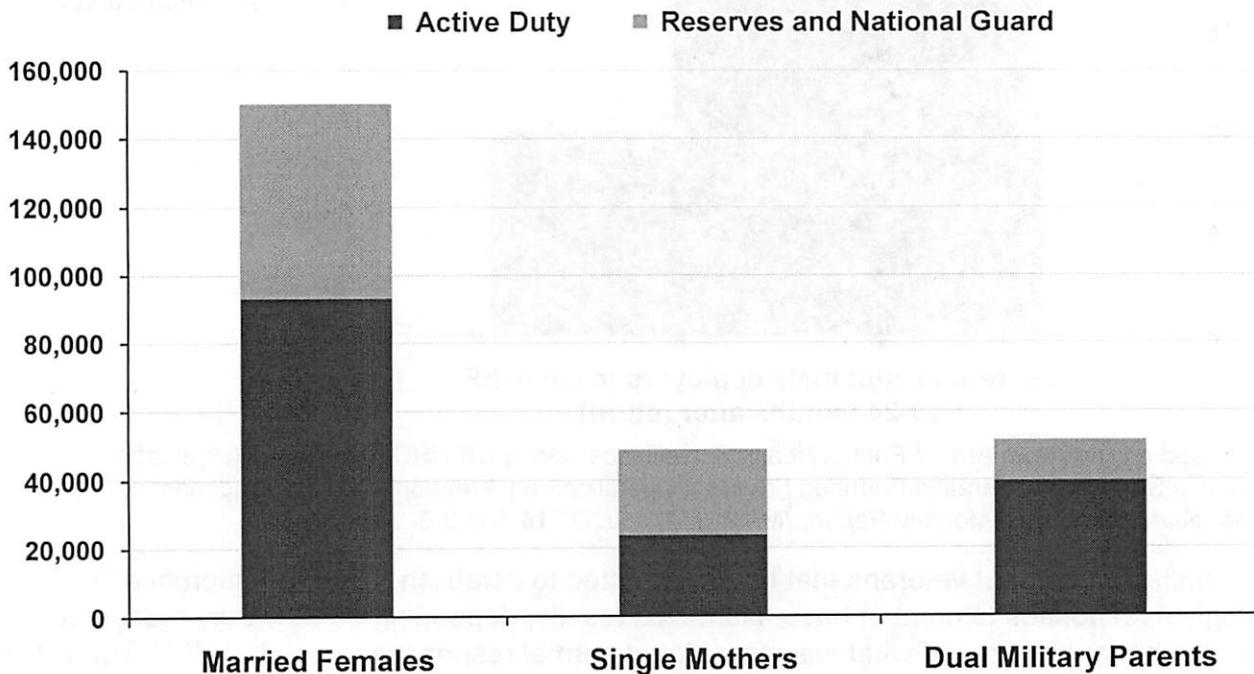


# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

Participants at the Town Hall meetings also discussed the challenges of being mothers in the military, as well as the unique challenges with being single mothers. In 2009, there were nearly 49,000 single mothers in the DoD with the potential to deploy and over 51,000 dual military parents in the DoD, where both parents could deploy at the same time.<sup>32</sup> As Soldiers, mothers, and wives; women are in roles that are divergent and often conflicting. They discussed the contrasts between their deployed and garrison roles and issues with reintegration. Similarly, the women expressed that more time was needed in the post-partum period to bond with their new infants and to return to post-partum weight and activities before being deployed. Currently the Army, Air Force and Marine policies specify a 6-month deferment for deployment following the birth or adoption of a child, while the Navy has a 12-month post partum or post-adoption deployment deferment policy.<sup>33-36</sup>

**Figure 4: Marital and Parental Status of female Service Members in the DoD (Army, Navy, Air Force, Marines) 2009.**



Data Source: Department of Defense Demographics 2009: Profile of the Military Community

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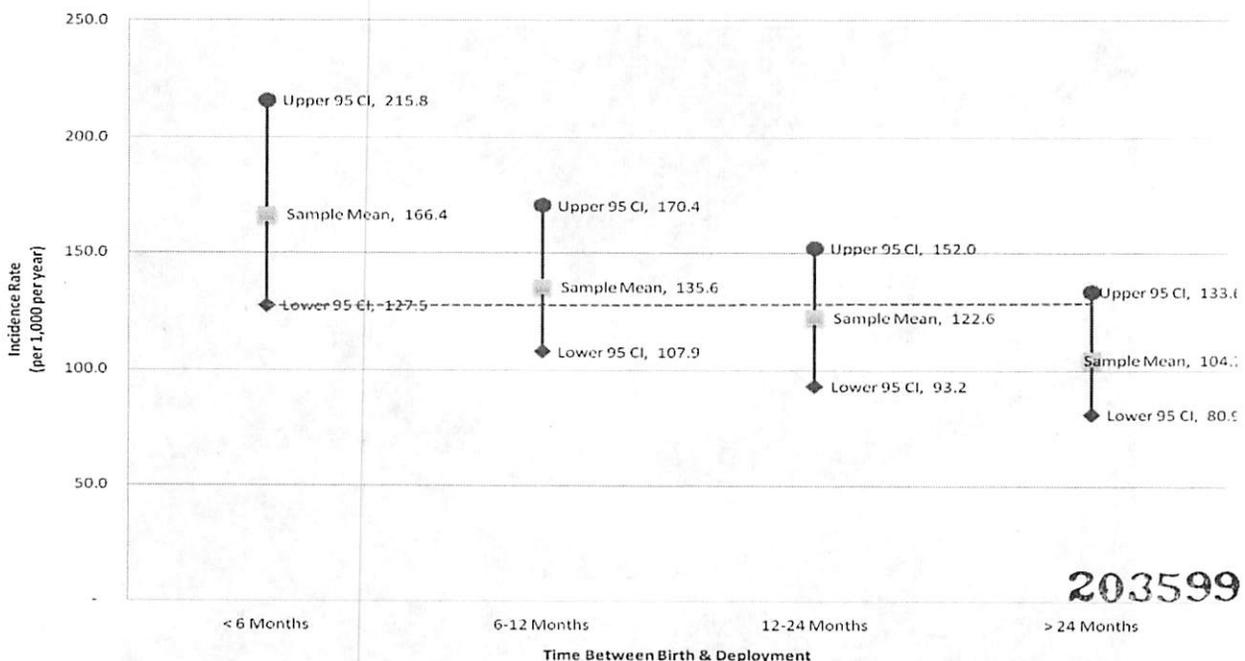
# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

The literature on the effects of early separation of mothers from infants looks at both the effects on the female Service Member as well as the effects on the infant. First, looking at the effects on the mother, a review of literature that included deployed Navy mothers concluded that separation from their children induced feelings of grief, guilt, anxiety, sadness, and depression in mothers.<sup>37</sup> Furthermore, conditions that maintain the attachment bond between mother and child, such as contact between mother and child, the mother's control over the circumstances of the separation, support for her role as a mother, knowledge that her child is in good hands, and finding a greater meaning in the separation may mitigate the impact of separation.<sup>37</sup> While not gender-specific, the literature suggests that new parents may experience grief from the loss of the first months or year of their child's life during deployment.<sup>38</sup>

The most recent data that supports a post-partum deferment policy more similar to the Navy's, looks at the incidence of behavioral health diagnoses in women within 6 months of returning from deployment. The study stratified by time of deployment after birth of a child and found a 37% higher incidence of post-deployment behavioral health encounters among mothers who deployed to OIF/OEF within six months of birth when compared to those who had longer than 6 months between birth and deployment. Rates of MH diagnoses continued to decline with increased length of time between birth and deployment. The lowest rate of behavioral health visits was found among those who deployed greater than 24 months following birth.<sup>39</sup>

**Figure 5: Incidence rates with behavioral health diagnosis after return from postpartum deployment by exposure group (Jan 2002 – June 2010).**



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Source: Based on data from Armed Forces Health Surveillance Center (AFHSC) Childbirth, deployment, and diagnoses of mental disorders among active component women January 2002- June 2009. *Medical Surveillance Monthly Report, (MSMR). 2010 NOV17(11): 17-21.*



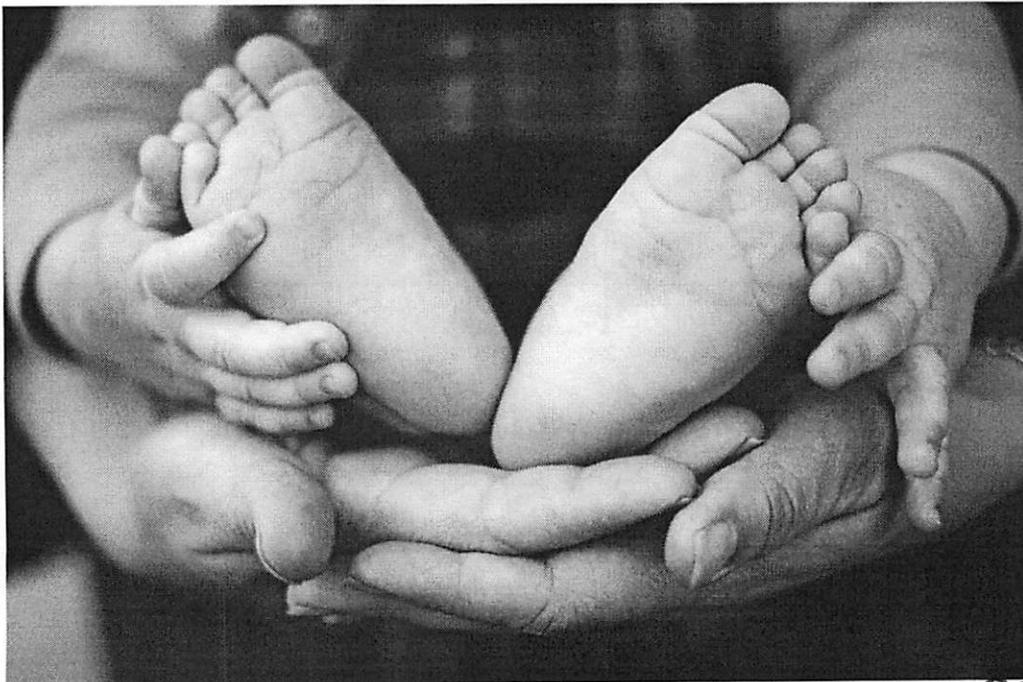
# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

The most extensive body of literature supporting a one year post-partum deferment is on breastfeeding. The advantages of breastfeeding include health, nutritional, immunologic, developmental, psychological, social, economic, and environmental benefits not only for the mothers, but for the infants, Families and society.<sup>40-43</sup> The physical health advantages for mothers related to breastfeeding include less post-partum complications, an easier time returning to pre-pregnancy weight, decreased risk of breast and ovarian cancer, and possibly a decreased risk of hip fractures and osteoporosis in the post menopausal period, with the long term effect of decreasing the burden on the healthcare system.<sup>42</sup>

However the most compelling argument for a one year post-partum deployment deferment is the benefits of breast feeding for the infant. Studies have shown a 21% reduction in post-neonatal infant mortality in breastfed infants<sup>44</sup> as well as a decrease in the incidence of a wide range of infectious diseases.<sup>42</sup> Studies have also shown decreased rates of sudden infant death syndrome, and many other childhood diseases, as well as the extent and duration of breastfeeding have been found to be inversely associated with risk of obesity in later childhood.<sup>42</sup>

A one-year deferment is consistent with the American Academy of Pediatrics (AAP) policy statement,<sup>42</sup> The Surgeon General's Call to Action,<sup>41</sup> the goals and objectives of Healthy People 2020,<sup>40</sup> and the HHS Blueprint for Action on Breastfeeding.<sup>43</sup>



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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VI. Psychosocial Effects of Deployment

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### Recommendations:

#### **Ensure that Programs Designed to Prepare our Soldiers for Deployment and Reintegration Consider Gender Specific Needs**

Further research into the psychological effects of combat on women is required in order to inform the development of intervention programs to help women prepare for, prevent, and cope with the psychological impacts throughout the deployment cycle.

#### **Consider feasibility of One Year Post-Partum Deferment for all Services**

Services should explore feasibility of extending the length of post-partum deferment for deployment to one year. The analysis should consider the cost on operational readiness as well as the cost savings to MHS in maternal and child healthcare, and factors to account for the socio-economic impacts of a successful breast feeding initiative. Goal should be to maintain a balance between protecting the health and welfare of the mother and newborn while considering the overarching goal to sustain a healthy, fit, and deployment ready Force.

#### **Community-based Support Groups for Women**

Support the establishment of community-based female Service Member support groups that facilitate discussion among women about their experiences of deployment and the psychosocial issues surrounding deployment. One such program is the Women Soldiers' Group, an 8-week structured support group that addresses issues with marriage, deployment, changing roles, childcare, and living as a dual military Family, which was initiated by the behavioral health clinic at Fort Drum. Continue partnering with VHA and community based agencies for increased accessibility to Women support services already in place. Increase awareness of community resources through Patient Centered Medical Home coordination and connection.

#### **Further Research on the Effects of Combat on Women**

Recommend partnering with the Veteran's Affairs (VA) Women's Health Research and Development Program to study women Service Members through the continuum of active duty to transition to the VA.

#### **Key research questions may include:**

- Does gender moderate the relationship between combat exposure and behavioral health outcomes?
- How do women experience combat and the stressors in a combat environment?
- How does gender difference influence healthcare utilization and provider diagnosis?

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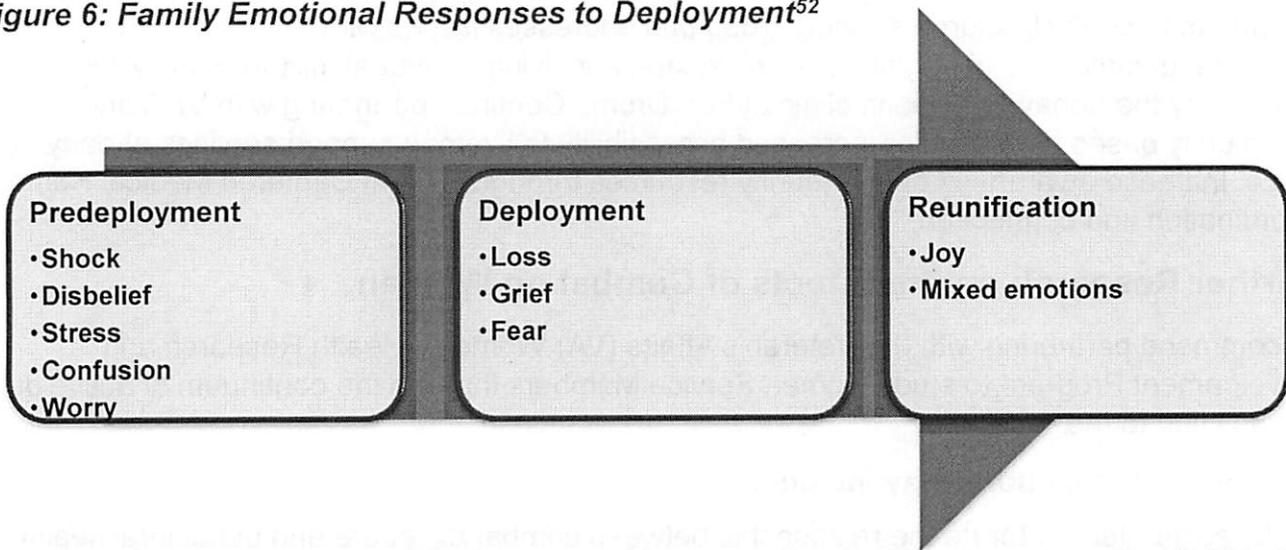


## VII. Effects of Deployments on Children and Families

**“The Army Family is the Deployable Unit”**

Speaking to Service Members across the CJOA-A, concern about their Family members at home is a common theme. This is no surprise as the effects of deployments extend beyond the Service Member. The current operational tempo has created high intensity, repeated deployments for Service Members resulting in nearly 2.2 million children affected by parents who have been exposed to relatively high rates of war-related stressors during deployment. While there is little gender specific research on Families, there is abundant research showing that deployments affect Family psychosocial functioning and increase the rates of child abuse and neglect,<sup>46,47</sup> and behavioral health complaints.<sup>48-51</sup> The relationship between war-stressors of deployed Service Members and the increases in adverse emotional and behavioral outcomes in children has been seen in all phases of deployment and reintegration.<sup>49, 52, 53, 55</sup> Families experience a range of emotions in response to deployment, varying across the deployment cycle.<sup>52,54</sup> The amount of parental distress and the cumulative months deployed to a combat zone have both been associated with child distress and negative behavioral problems.<sup>49, 52</sup>

Figure 6: Family Emotional Responses to Deployment<sup>52</sup>



Issues with reintegration are well documented however, Service Women across the CJOA-A expressed concerns about the lack of preparation and support in this area. Previously in this paper we discussed the needs of the deploying Service Member, but the preparation of Family members is equally important. MEDCOM is developing Child and Family programs that recognize the Army Family is the deployable unit and that Family Readiness supports Soldier Readiness.

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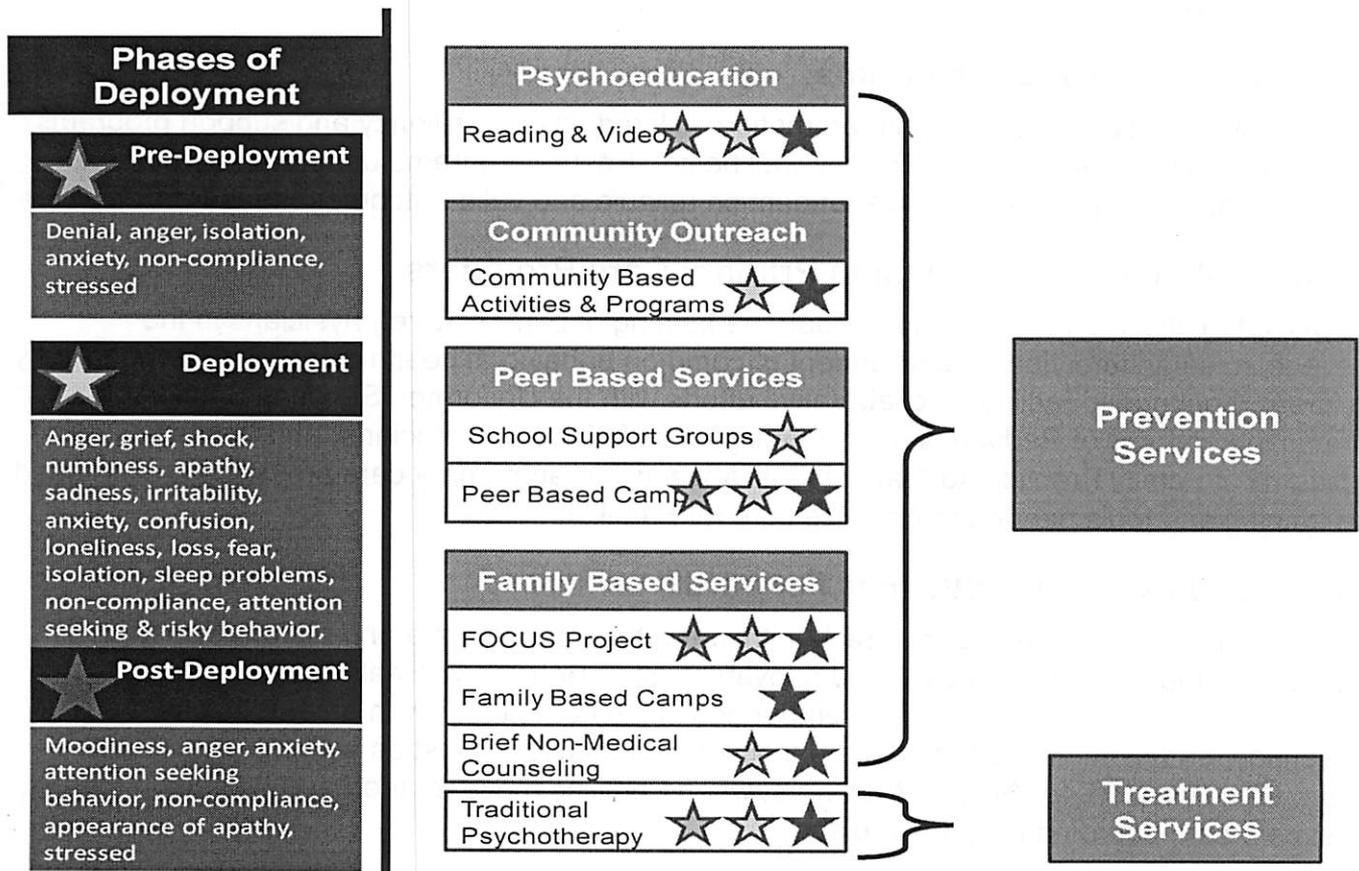


# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VII. Effects of Deployments on Children and Families

Positive outcomes in the overall behavioral health of Army Children and Families can be realized when programs that are focused on prevention, early detection, wellness, and resilience building are coordinated and integrated with dedicated healthcare services that are located in areas that are easily accessed and convenient to children and Families. A recent review of all 3-8 year olds enrolled in DEERS demonstrated that 60% of all medical visits occurred in non-military facilities<sup>51</sup> and we know that the majority of behavioral healthcare occurs within primary care settings. Therefore, behavioral health education efforts and marketing of programs needs to be targeted towards both uniformed and civilian primary care providers.

Many valuable programs such as psychoeducational videos, school-based programs, camps, and the Families Overcoming Under Stress (FOCUS) project<sup>54</sup> have been developed using evidenced based skill building techniques and are targeted at prevention. The different types of services are linked with the emotional and behavioral responses of children at certain phases of the deployment cycle (see diagram below).<sup>52</sup>



Adapted from: Esposito-Smythers C, Lemmon KM, Wolff J, Bodzy M, Swenson RR, Spirito A. Military youth and the deployment cycle: Emotional health consequences and recommendations for intervention. *Journal of Family Psychology*. 2011; 25(4):497-07.

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VII. Effects of Deployments on Children and Families

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Treatment services are also well connected to where the Family lives. Behavioral health needs of Families and children are delivered in community centers and schools which improves access and capacity for care as well as allows for an educational component designed to promote wellness.

Over 2 million children have already experienced one or more parental combat deployments. When Warriors are assured that their Family is being cared for by the community they are fighting to protect, they are able to more clearly focus on the critical combat and sustainment operations they are performing far from home. It is also likely that children who grow up in a well functioning and emotionally connected military Family are more likely to consider military service as a viable career choice. Programs that address the effects of war-stressors on all Family members will ultimately mitigate negative outcomes such as mental and behavioral health disorders and child maltreatment.

### Recommendations:

#### Systematic Review of Programs

Conduct systematic review of health promotion, risk reduction, resiliency and support programs addressing child, adolescent and Family well being. Ensure programs understand that fiscal support over the long term will be dependent on reliable and valid outcomes measures.

#### Training of Military and Civilian Primary Care Providers

MEDCOM to allocate resources to support the training of primary care physicians in the prevention, early detection, and treatment of common behavioral health disorders among military children. Continue to facilitate collaborative efforts with the Uniformed Services Section of the American Academy of Pediatrics (representing all uniformed pediatricians) and the American Academy of Family Practice so that both military and civilian primary care providers are provided the training and tools needed to optimize care for Families.

#### Embed Behavioral Health “Far Forward”

Continue to work to embed behavioral healthcare within primary care and maintain holistic approach to the entire Family as the “deployable unit.” Behavioral Health care for Family Members should be “far forward” and embedded in the community, with an emphasis on prevention, early interventions and the expectation of recovery. Just as we have stressed the “warm battle handoff” for Service Members, when Families move to another duty station there must be a care coordination plan in place.

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## The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

### VII. Effects of Deployments on Children and Families

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#### Recommendations:

##### **Evidence Based Focus on Prevention**

Identify and consolidate the existing resources to build Family resiliency to ensure that all parents are offered education that prepares them for the challenges of deployment and reintegration. Provide an ongoing commitment to community based Soldier and Family resiliency programs that have been shown to positively influence parent-child interactions and decrease negative emotional and behavioral responses of children.

##### **Research on Effects of Deployment Cycle on Families**

Research on deployment and Family reintegration must include evaluation of the effects on all Family members.

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VIII. Sexual Harassment/ Assault Response and Prevention (SHARP)

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Sexual assault is clearly not a gender specific issue as it affects male and female victims and its impact extends much broader to affect unit cohesion and degrade mission readiness. Prevention and intervention efforts also cannot be gender focused as the solutions are team based. According to the DoDD 6495.01, sexual assault in the military is defined as “intentional sexual contact, characterized by use of force, threats, intimidation, abuse of authority, or when the victim does not or cannot consent.”<sup>56</sup> The prevalence of sexual assault in the military services has been estimated at 9.5% to 33%, however true prevalence is hampered by the phenomenon of underreporting (estimated to be <10% of true occurrence),<sup>57</sup> various definitions of sexual assault, and the lack of consistent reporting systems in the military. FY10 reported rates of sexual assault Army-wide were 2.5 reported cases per 1000 active duty Soldiers, and 1.7/1000 in CENTCOM.<sup>58</sup> The majority of victims who reported sexual assault were younger (<24yo) females from the junior enlisted ranks (E1-E4). The majority (97%) of perpetrators were male, junior enlisted ranks (E1-E-4) (59%) and most (47%) were 24 years old or younger.<sup>58</sup>

The literature is clear that Service Members who experience sexual assault exhibit deleterious psychological and physical health effects including higher rates of depression and post traumatic stress symptoms, poor emotional functioning, and substance abuse.<sup>57,59</sup> Our DoD population has several risk factors for experiencing higher than average rates of sexual assault than the general population. Risk factors in the DoD include a younger population with a smaller proportion of women to men, and a higher rate of Service Members with prior sexual victimizations and prior perpetrations as compared to the civilian population.<sup>57</sup> Environmental factors in garrison and while deployed that increase the risk for sexual assault include solitary duty (especially at night), poor barracks security, and insufficient environmental lighting.

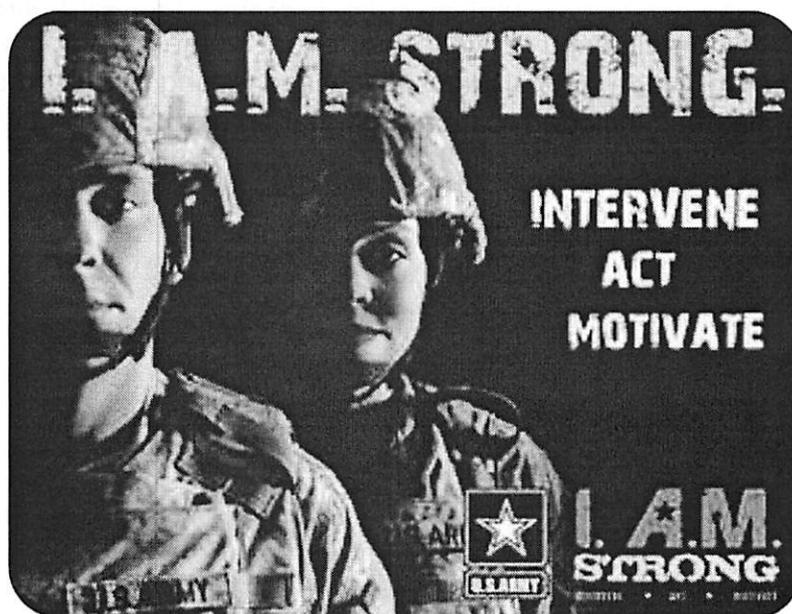
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## The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

### VIII. Sexual Harassment/ Assault Response and Prevention (SHARP)

The U.S. Army has realigned its sexual harassment and sexual assault prevention training programs into the Sexual Harassment/Assault Response and Prevention (SHARP) Program,<sup>60</sup> which supersedes the Sexual Assault Response and Prevention (SARP) and the Prevention of Sexual Harassment (POSH) training programs. Women in the ATO Town Hall Meetings were very positive about the value of the new SHARP Program and they were knowledgeable of the roles of the Sexual Assault Response Coordinator (SARC) and the Unit Victim Advocates (UVA). Several UVAs were present at our meetings (Army and Marine) and they expressed that they felt they were well trained. Many discussed ongoing educational forums where all the UVAs met monthly to discuss cases and share experience and knowledge, however even with our small sample size, we noted variations in how this was accomplished. According to DoDI 6495.02 June 2006, all DoD SARCs and VAs must receive the same baseline training, but periodic training is determined by each Service.<sup>61</sup> Health care is provided to women in Theater by specially trained providers. MEDCOM Sexual Assault Medical Forensic Examiner training meets the Department of Justice National Training Standards for Sexual Assault Medical Forensic Examiners training requirements.<sup>62</sup>



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## The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

### VIII. Sexual Harassment/ Assault Response and Prevention (SHARP)

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During our assessment, barriers to reporting sexual assault were also clearly vocalized. Concerns included a lack of trust in the fidelity of the reporting system and the confidentiality processes in place. Women conveyed fears of becoming “the talk of the unit,” that the report would be turned around to reflect negatively on them, and that reporting would cause additional suffering without likelihood that the perpetrator would be punished. This echoes the findings of larger studies which show that barriers to reporting include shame/embarrassment, the stigma and social consequences associated with sexual assault, fear of reprisal, mistrust of the process, and characteristics of the perpetrator, in particular if the perpetrator is a Family member, friend, coworker, or higher rank than the victim.<sup>63</sup>

Lastly, a common theme that was heard from women across the CJOA-A was that while they generally felt safe, they noted a lack of simple physical security measures such as locks and lighting. For example, female sleeping tents commonly have locking doors on one end and just a zipper on the other end. The lack of security measures was reconfirmed during the recent (May 2011) SHARP ATO Assessment Team visit, which led them to recommend “immediate application of locks to living quarters, showers, and latrines; noting that cipher lock codes should be changed every 90 days.”<sup>64</sup> The team recommended that “with consideration to blackout conditions, commanders should consider improved outdoor lighting on every FOB.”<sup>64</sup> The SHARP assessment team also recommended that the battle buddy system should be highly encouraged.<sup>64</sup> Many women we interviewed expressed that their male counterparts are protective of the USFOR-A females and actively ensure that women are not in vulnerable situations. Some groups from larger installations discussed feeling harassed by local nationals or Third Country Nationals - this included “cat-calling,” staring at, or ignoring women.

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## VIII. Sexual Harassment/ Assault Response and Prevention (SHARP)

The Military is steeped in tradition and is built on a foundation of unshakable values. The Army Values of Loyalty, Duty, Respect, Selfless Service, Honor, Integrity and Personal Courage combined with a Warrior Ethos to never leave a comrade will be the keys to combating sexual assault within our ranks. Pursuant to the HSS Assessment Team's observations and analysis of field notes, the following recommendations are made in an effort to capitalize on the participants suggestions and dovetail with DoD recommendations and strategy.

### **Recommendations:**

#### **Require Installations Assess Physical Safety Measures**

Improve physical security and monitoring on lodging and bathroom facilities. Improve lighting where tactically acceptable on Forward Operating Bases.

#### **Review Theater policy regarding distribution of SAFE providers**

Enhance competence, effectiveness, and consider the use of a regional strategy.

#### **Convene a team of experts from the Tri-Services**

Fully investigate the integration of Service policies on sexual assault prevention and response programs in Theater, including the training of SAFE providers, Sexual Assault Response Coordinators, and Victim Advocates.

#### **Professionalize the VA Roles**

Provide national certification and continuing education for Victim Advocates.

#### **Leverage and synergize with Comprehensive Soldier Fitness**

Target interpersonal skills, self esteem, assertiveness and the core values which will enhance a culture of trust, respect and unity of members.

#### **Ensure 100% implementation of the SHARP program**

Collaborate with HQDA G-1 to track objective SHARP implementation and outcome measures of effectiveness.

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

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# The Concerns of Women Currently Serving in the Afghanistan Theater of Operations

## Appendix B: Acknowledgements

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We would like to acknowledge the following people for their thoughtful contributions to this paper:

### Women's Health

LTC Julie Lomax, USA

Nancy A. Ryan-Wenger, PhD

Michael Carino, PhD

Nakia Clemmons

SFC Miller, USA

### Uniforms

MAJ Tanja Roy, USA

Laura Mitvalsky

MAJ Sequana Robinson

### Psychosocial Effects of Deployment

Dr. Charles Hoge

### Effects of Deployments on Children and Families

LTC Keith M. Lemmon, USA

Dr. Michael E. Farran

Kristen Woodward

### Sexual Assault

Wanda Hubert

Carolyn Collins

Allyson Cordoni, ARNP

1LT Kelley Souza, USA

Capt Sara Orbals, USAF

SGM Myris Callwood

### TRADOC

Ron Ellison

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Our sincere thanks to Harper Ress and 1Lt Emily Sizemore, USAF for technical and graphic support in preparing this report.

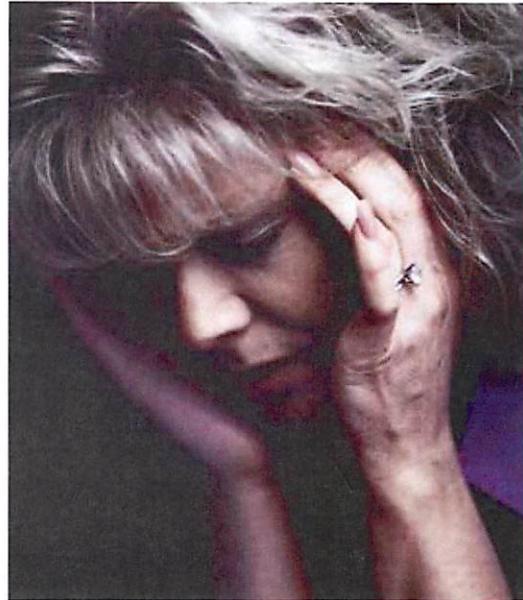
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APRIL 2013

**A National Protocol for  
Sexual Assault Medical  
Forensic Examinations  
Adults/Adolescents**

Second Edition

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**DNA**  
INITIATIVE



203615

# **A National Protocol for Sexual Assault Medical Forensic Examinations**

**Adults/Adolescents  
Second Edition**

**U.S. Department of Justice  
Office on Violence Against Women**

**April 2013**

**NCJ 228119**

**203616**

# Acknowledgments

Many individuals contributed their skills and expertise to the development of this protocol. Special appreciation goes to Kristin Littel, who served as the primary writer and researcher for the protocol. We would also like to thank the Office for Victims of Crime for initiating this project and for providing feedback and guidance throughout the drafting process. We are grateful to all of the women and men who gave their time and energy to attend the focus groups, participate in the conference calls, and review numerous drafts of the protocol; their efforts greatly enhanced the final product. We are particularly grateful for the assistance of Gail Burns Smith who, in addition to participating in focus groups and conference calls and submitting insightful comments on drafts, also was responsible for suggesting and organizing conference calls with victims to ensure the victim-centeredness of the protocol.



# Foreword

Sexual violence continues to plague our Nation and destroy lives. All members of society are vulnerable to this crime, regardless of race, age, gender, ability, or social standing. When sexual assault does occur, victims deserve competent and compassionate care. This second edition of the *National Protocol for Sexual Assault Medical Forensic Examinations* provides detailed guidelines for criminal justice and health care practitioners in responding to the immediate needs of sexual assault victims. We know that effective collection of evidence is of paramount importance to successfully prosecuting sex offenders. Just as critical is performing sexual assault forensic exams in a sensitive, dignified, and victim-centered manner. For individuals who experience this horrendous crime, having a positive experience with the criminal justice and health care systems can contribute greatly to their overall healing.

As we have learned in the years since the implementation of the 1994 Violence Against Women Act, coordinated community efforts are the best way to stop violence against women, hold offenders accountable for their crimes, and promote victim healing and recovery. That is why this protocol was designed as a guide for practitioners who respond to victims of sexual assault, including health care professionals, law enforcement officers, prosecutors, interpreters, advocates, and others. Combining cutting edge response techniques with collaboration among service providers will greatly enhance our ability to treat and support victims as well as identify and prosecute the sex offenders. We hope that this protocol lays the foundation for these efforts.

Since this protocol was initially released in 2004, the “state of the art” for forensic medical examinations has improved. This revised edition of the protocol has the same emphasis and values as the original but has been updated to reflect current technology and practice. It has also been updated to include additional information reflecting changes from the Violence Against Women Act of 2005. It also includes minor technical changes identified in May, 2013.



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# Goals of the National Protocol for Sexual Assault Medical Forensic Examinations

Sexual assault is a crime of violence against a person's body and will. Sex offenders use physical and/or psychological aggression or coercion to victimize, in the process often threatening a victim's sense of privacy, safety, autonomy, and well-being. Sexual assault can result in physical trauma and significant mental anguish and suffering for victims. In some communities, sexual violence is considered a form of oppression. Victims may be reluctant, however, to report the assault to law enforcement and to seek medical attention for a variety of reasons. For example, victims may blame themselves for the sexual assault and feel embarrassed. They may fear their assailants or worry about whether they will be believed. Victims may also lack the ability or emotional strength to access services. For example, they may not have their own transportation or access to public transportation. They may also not speak English well or fear that reporting the assault may jeopardize their immigration status.<sup>1</sup> They may lack health insurance and believe it would be too costly to get the medical care they need. They may not be aware that as a crime victim, they are eligible for financial reimbursements for certain services. Their budgets may not allow them to pay out-of-pocket expenses and then await reimbursements. Those who do have access to services may perceive the medical forensic examination as yet another violation because of its extensive and intrusive nature in the immediate aftermath of the assault. Rather than seek assistance, a sexual assault victim may simply want to go somewhere safe, clean up, and try to forget the assault ever happened.<sup>2</sup> It is our hope that this protocol will help jurisdictions in their efforts to respond to sexual assault victims in the most competent, compassionate, and understanding manner possible.

This protocol was developed with the input of national, local, and tribal experts throughout the country, including law enforcement representatives, prosecutors, advocates, medical personnel, forensic scientists, and others. We hope that this protocol will be useful in helping jurisdictions develop a response that is sensitive to victims of sexual assault and that promotes offender accountability. Specifically, the protocol has the following goals:

- Supplement, but not supersede, the many excellent protocols that have been developed by states, tribes, and local jurisdictions, as well as those created at the national level. We hope that this protocol will be a useful tool for jurisdictions wishing to develop new protocols or revise their existing ones. **It is intended as a guideline for suggested practices rather than a list of requirements.** In many places, the protocol refers to "jurisdictional policies" because there may be multiple valid ways to handle a particular issue and which one is best should be determined by the jurisdiction after consideration of local laws, policies, practices, and needs.
- Provide guidance to jurisdictions on responding to adult and adolescent victims. Adolescents are distinguished in the protocol from prepubertal children who require a pediatric exam. **Pediatric exams are not addressed in this document. This protocol generally focuses on the examination of females who have experienced the onset of menarche and males who have reached puberty.** Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances when minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. **If the adolescent victim is a minor under the jurisdictional laws, the laws of the jurisdiction governing issues such as consent to the exam, mandatory reporting, and confidentiality should be followed.**
- Support the use of coordinated community responses to sexual violence, such as Sexual Assault Response Teams (SARTs) or Sexual Assault Response and Resource Teams (SARRTs). Although

<sup>1</sup> Carolyn Ham, *Reducing Language Barriers to Combating Domestic Violence: The Requirements of Title VI*, Battered Women's Justice Project, October 2004, [http://new.vawnet.org/summary.php?doc\\_id=1621&find\\_type=web\\_desc\\_GC](http://new.vawnet.org/summary.php?doc_id=1621&find_type=web_desc_GC).

<sup>2</sup> Paragraph adapted in part from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2004, p. 2. <http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/hpr/sexual%20assault/adultprotocol2011.ashx>.

this document is directed primarily toward medical personnel and facilities, it also provides guidance to other key responders such as advocates and law enforcement representatives. This type of coordinated community response is supported by the Violence Against Women Act and subsequent legislation. Such a response can help afford victims access to comprehensive immediate care, minimize the trauma victims may experience, and encourage them to utilize community resources. It can also facilitate the criminal investigation and prosecution, increasing the likelihood of holding offenders accountable and preventing further sexual assaults.

- Address the needs of victims while promoting the criminal justice system response. Stabilizing, treating, providing social and legal services, including knowledge of immigration protections, and engaging victims as essential partners in the criminal investigation are central aspects of the protocol. Thus, this protocol includes information about concepts such as “anonymous reporting,” which may give victims needed time to decide if and when they are ready to engage in the criminal justice process. An anonymous report may also provide law enforcement agencies with potentially useful information about sex crime patterns in their jurisdictions.<sup>3</sup> The objective is to promote better and more victim-centered<sup>4</sup> evidence collection, in order to provide better assistance in court proceedings and hold more offenders accountable.
- Promote high-quality, sensitive, and supportive exams for all victims, regardless of jurisdiction and geographical location of service provision. The protocol offers recommendations to help standardize the quality of care for sexual assault victims throughout the country and is based on the latest scientific evidence. It also promotes timely evidence collection that is accurately and methodically gathered, so that high-quality evidence is available in court.

This protocol discusses the roles of the following responders: health care providers, advocates, law enforcement representatives, forensic scientists, and prosecutors, as well as interpreters. Clearly, each of these professions has a distinct and complementary role in responding to sexual assault. But rather than dictate who is responsible for every component of the response or within the exam process, the protocol is designed to help communities consider what each procedure involves and any related issues. With this information, each community can make decisions for its jurisdiction about the specific tasks of each responder during the exam process and the coordination needed among responders. The following is a general description of the responsibilities with which each responder may assist:<sup>5</sup>

- **Advocates** may be involved in initial victim contact (via 24-hour hotline or face-to-face meetings); offer victims advocacy, support, crisis intervention, information, language assistance services, including interpreters, and referrals before, during, and after the exam process; and help ensure that victims have transportation to and from the exam site. They often provide comprehensive, longer term services designed to aid victims in addressing any needs related to the assault, including but not limited to counseling, legal (civil, criminal, and immigration), and medical system advocacy.
- **Law enforcement representatives** (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence, detectives, and investigators) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the exam site as needed, interview victims in a language they understand, collect evidence from the scene, coordinate collection and delivery of evidence to designated labs or law enforcement facilities, interview suspects, and conduct other investigative activities (such as interviewing suspects and witnesses in a language they

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<sup>3</sup> States are responsible for ensuring that the costs associated with performing a medical forensic examination are paid and ensuring that all victims of sexual assault are provided the opportunity to have a medical forensic examination conducted, regardless of whether they choose to participate in the criminal justice system.

<sup>4</sup> Please see the section on “Victim-Centered Care” beginning on page 29 for more explanation of this term.

<sup>5</sup> There are instances where a case may be prosecuted concurrently in two or more jurisdictions. For example, sexual assault cases occurring on Indian reservations can be prosecuted concurrently in tribal and state or federal court. In such situations, each sovereign will likely have its own victims' advocate, law enforcement, prosecutor, and judicial/court officers. Coordination of services in multijurisdictional investigations and prosecutions is critical to the success of the criminal case and the well-being and healing of the victim.

understand, requesting crime lab analyses, reviewing medical and lab reports, preparing and executing search and arrest warrants, writing reports, and presenting the case to a prosecutor).

- **Health care providers** assess patients for acute medical needs and provide stabilization, treatment, and/or consultation. Ideally, sexual assault forensic examiners perform the medical forensic exam, gather information for the medical forensic history, collect and document forensic evidence, and document pertinent physical findings from patients. They offer information, treatment, and referrals for sexually transmitted infections (STIs),<sup>6</sup> and other nonacute medical concerns; assess pregnancy risk and discuss treatment options with the patient, including reproductive health services; and testify in court if needed. They coordinate with advocates to ensure patients are offered crisis intervention, support, and advocacy before, during, and after the exam process and encourage use of other victim services. They may follow up with patients for medical and forensic purposes. Other health care personnel who may be involved include, but are not limited to, emergency medical technicians, staff at hospital emergency departments, gynecologists, surgeons, private physicians, health care interpreters, and/or local, tribal, campus, or military health services personnel.
- **Forensic scientists** analyze forensic evidence and provide results of the analysis to investigators and/or prosecutors. They also may testify at trial regarding the results of their analysis.
- **Prosecutors** determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. A few jurisdictions involve prosecutors more actively, paging them after initial contact and having them respond to the exam site so that they can become familiar with the case and help guide the investigation.

**This document is intended only to improve the criminal justice system's response to victims of sexual assault and the sexual assault forensic examination process. It does not address the remedies that may be available to victims through the civil justice system, and does not create a right or benefit, substantive or procedural, for any party.**

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<sup>6</sup> STIs are also commonly known as sexually transmitted diseases (STDs).

# Recommendations at a Glance: A National Protocol for Sexual Assault Medical Forensic Examinations

*The National Protocol for Sexual Assault Medical Forensic Examinations* offers guidance to jurisdictions in creating and implementing their own protocols, as well as recommending specific procedures related to the exam process. *Recommendations at a Glance* highlights key points discussed in the protocol, but it is not designed to be a stand-alone checklist on exam procedures or responsibilities of each involved responder. The protocol should be read to understand and respond to the complex issues presented during the exam process. See the protocol introduction for an explanation of select terms used in this chapter and the protocol.

## Goal of the Protocol

A timely, high-quality medical forensic examination can potentially validate and address sexual assault patients<sup>7</sup> concerns, minimize the trauma they may experience, and promote their healing. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigation, resulting in perpetrators being held accountable and further sexual violence prevented.

The examination and the related responsibilities of health care personnel are the focus of this protocol. Recognizing that multidisciplinary coordination is vital to the success of the exam, the protocol also discusses the responses of other professionals, as they relate to the exam process.

## A. Overarching Issues

1. **Coordinated approach:** A coordinated, multidisciplinary approach to conducting the exam provides victims<sup>8</sup> with access to comprehensive immediate care, helps minimize trauma they may experience, and encourages their use of community resources. Such a response can also enhance public safety by facilitating investigation and prosecution, which increases the likelihood that offenders will be held accountable for their actions. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more victims to disclose the assault and seek help. (SEE PAGES 23–29)

Recommendations for jurisdictions to facilitate a coordinated approach to the exam process:

- Understand that the purposes of the exam process are to address patients' health care needs and collect evidence suitable for possible use by the criminal justice system.
- Identify key responders and their roles.
- Develop quality assurance measures to ensure effective response during the exam process.

2. **Victim-centered care:** Victim-centered care is paramount to the success of the exam process. Response to victims should be timely, appropriate, sensitive, and respectful. (SEE PAGES 30–45)

Recommendations for health care providers and other responders to facilitate victim-centered care:

- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.

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<sup>7</sup> Sexual assault patients are also referred to as victims, depending on which responders are primarily being discussed. The term "patients" is generally used by health care professionals.

<sup>8</sup> The term "victim" is not used in a strictly criminal justice context. The use of "victim" simply acknowledges that persons who disclose that they have been sexually assaulted should have access to certain services.

- Develop culturally responsive care and be aware of issues commonly faced by victims from specific populations.
- Recognize the importance of victim services within the exam process.
- Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.
- Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible.
- Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.
- Assess and respect patients' priorities.
- Integrate medical and evidentiary procedures where possible.
- Address patients' safety during the exam.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.
- Address physical comfort needs of patients prior to discharge.

3. **Informed consent:** Patients should understand the full nature of their consent to each exam procedure. By presenting them with relevant information, in a language they understand, patients are in a position to make an informed decision about whether to accept or decline a procedure. However, they should be aware of the potential impact of declining a particular procedure, as it may negatively affect the quality of care, the usefulness of evidence collection, and, ultimately, any criminal investigation and/or prosecution. They should understand that declining a particular procedure might also be used against them in any justice system proceeding. If a procedure is declined, reasons why should be documented if the patient provides such information. (SEE PAGES 47-49)

Recommendations for health care providers and other responders to request patients' consent during the exam process:

- Seek the informed consent of patients as appropriate throughout the exam process.
- Make sure policies exist to guide the process of seeking informed consent from specific populations.

4. **Confidentiality:** Involved responders must be aware of the scope and limitations of confidentiality related to information gathered during the exam process. Confidentiality is intricately linked to the scope of patients' consent. Members of a sexual assault response team (SART) or other collaborating responders should inform victims of the scope of confidentiality with each responder and be cautious not to exceed the limits of victim consent to share information in each case. (SEE PAGES 51-53)

Recommendations that jurisdictions may take to maintain confidentiality of patients:

- Be sure jurisdictional policies address the scope and limitations of confidentiality as it relates to the exam process and with whom information can be legally and ethically shared.
- Increase the understanding of relevant confidentiality issues.
- Consider the impact of the federal privacy laws regarding health information on victims of sexual assault.
- Strive to resolve intrajurisdictional conflicts.

5. **Reporting to law enforcement:** Reporting the crime provides the criminal justice system with the opportunity to offer immediate protection to victims, collect evidence from all crime scenes, investigate cases, prosecute if there is sufficient evidence, and hold offenders accountable for crimes committed. Given the danger that sex offenders pose to the community, reporting can serve as a first step in efforts to stop them from reoffending. Equally important, reporting gives the justice system the chance to help victims address their needs, identify patterns of sexual violence in the jurisdiction, and educate the public about such patterns. Service providers should discuss all reporting options with victims in a language they understand

and the pros and cons of each, including the fact that delayed reporting may be detrimental to the prosecution of an offender. Even if a victim does not get a forensic medical exam, the victim can still report the crime at a later time. However, it will be much more difficult for criminal justice personnel to investigate and prosecute the crime if evidence was not collected.

Reporting requirements in sexual assault cases vary from one jurisdiction to another. Every effort should be made to facilitate treatment and evidence collection (if the patient agrees), regardless of whether the decision to report has been made at the time of the exam. Victims who are undecided about reporting who receive respectful and appropriate care and advocacy at the time of their exam are more likely to assist law enforcement and prosecution. Because immigrant victims may be more reticent to report crimes, they need to be aware of crime victim protections for immigrants. Access to immigration relief for crime victims will enhance the ability of law enforcement to detect, investigate, and prosecute crimes. (SEE PAGES 55-59)

Recommendations for jurisdictions and responders to facilitate victim-centered reporting practices:

- Except in situations covered by mandatory reporting laws, patients, not health care workers, make the decision to report a sexual assault to law enforcement.
- Inform patients about reporting consequences.
- As a result of VAWA 2005, many jurisdictions have implemented alternatives to standard reporting procedures.
- Promote a victim-centered reporting process.

6. Payment for the examination under VAWA: Under the Violence Against Women Act (VAWA),<sup>9</sup> a state, territory, or the District of Columbia is entitled to funds under the STOP Violence Against Women Formula Grant Program only if it, or another governmental entity, incurs the full out-of-pocket cost of medical forensic exams for victims of sexual assault. "Full out-of-pocket costs" means any expense that may be charged to a victim in connection with the exam for the purpose of gathering evidence of a sexual assault.<sup>10</sup> In addition, under the Violence Against Women Act of 2005, states may not require victims to participate in the criminal justice system or cooperate with law enforcement in order to receive a forensic medical exam.<sup>11</sup> (SEE PAGES 61-62)

Recommendations for jurisdictions to facilitate payment for the sexual assault medical forensic exam:

- Understand the scope of the VAWA provisions related to exam payment.
- Notify victims of exam facility and jurisdictional policies regarding payment for medical care and the medical forensic exam.

## **B. Operational Issues**

1. Sexual Assault Forensic Examiners: These are the health care professionals who conduct the examination. It is critical that all examiners, regardless of their discipline, are committed to providing compassionate and quality care for patients disclosing sexual assault, performing the physical examination, collecting evidence competently, documenting all findings, and testifying in court as needed. (SEE PAGES 65-67)

Recommendations for jurisdictions to build the capacity of examiners performing these exams:

- Encourage the development of specific knowledge, skills, and victim-centered approaches in examiners.
- Encourage advanced education and supervised clinical practice of examiners, as well as certification for all examiners.

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<sup>9</sup> 42 U.S.C. § 3796gg-4.

<sup>10</sup> 28 C.F.R. § 90.14(a).

<sup>11</sup> 42 U.S.C. 3796gg-4(d).

- Provide access to experts on anti-sexual assault initiatives who can participate in sexual assault examiner training, mentoring, proctoring, case review, photograph review, and quality assurance.

2. **Facilities:** Health care facilities have an obligation to provide services to sexual assault patients. Designated exam facilities or sites served by specially educated and clinically prepared examiners increase the likelihood of a state-of-the-art exam, enhance coordination, encourage quality control, and increase quality of care for patients. (SEE PAGES 71-74)

Recommendations for jurisdictions to build capacity of health care facilities to respond to sexual assault cases:

- Recognize the obligation of health care facilities to serve sexual assault patients in a culturally and linguistically appropriate manner.
- Ensure that exams are conducted at sites served by examiners with advanced education and clinical experience, if possible.
- Explore possibilities for optimal site locations.
- Communities may wish to consider developing basic requirements for designated exam sites.
- If a transfer from one health care facility to a designated exam site is necessary, use a protocol that minimizes time delays and loss of evidence and addresses patients' needs.

3. **Equipment and supplies:** Certain equipment and supplies are essential to the exam process (although they may not be used in every case). These include a copy of the most current exam protocol used by the jurisdiction, standard exam room equipment and supplies, comfort supplies for patients (e.g., changes of clothes, food, and water), sexual assault evidence collection kits, an evidence drying device/method, a forensic imaging system, testing and treatment supplies, a purified water source, an alternate light source, an anoscope, and written materials for patients. A microscope and/or toluidine blue dye may be required, depending on jurisdictional policy. A colposcope or other magnifying instrument may also be used. Some jurisdictions are also beginning to use advanced technology (telemedicine), which allows examiners offsite consultation with medical experts by using computers, software programs, and the Internet. Jurisdictions using such technology should be careful to protect patient confidentiality. (SEE PAGES 75-77)

Recommendations for jurisdictions and responders to ensure that proper equipment and supplies are available for examinations:

- Consider what equipment and supplies are necessary to conduct a medical forensic exam.
- Address cost barriers to obtaining necessary equipment and supplies.

4. **Sexual assault evidence collection kit** (for evidence from victims): Most jurisdictions have developed their own sexual assault evidence collection kits or purchased premade kits through commercial vendors. Kits often vary from one jurisdiction to another. Despite variations, however, it is critical that every kit meets or exceeds minimum guidelines for contents: broadly including a kit container, instruction sheet and/or checklist, forms, and materials for collecting and preserving all evidence required by the applicable crime laboratory. Evidence that may be collected includes, but is not limited to, clothing, foreign materials on the body, hair (including head and pubic hair samples and combings), oral and anogenital swabs and smears, body swabs, blood and urine samples for possible alcohol and/or toxicology testing, and a blood or saliva sample for DNA analysis and comparison. The instruction sheet and/or checklist should guide examiners on maintaining the chain of custody for evidence collected. (SEE PAGES 79-80)

Recommendations for jurisdictions and responders when developing/customizing kits:

- Use kits that meet or exceed minimum guidelines for contents.
- Work to standardize sexual assault evidence collection kits within a jurisdiction and across a state or territory, or for federal cases.

5. **Timing considerations for collecting evidence:** Although many jurisdictions have traditionally used 72 hours after the assault as the standard cutoff time for collecting evidence, a large number of jurisdictions have

moved toward longer time frames as cut off points. Many jurisdictions have now extended the standard cutoff time (e.g., to 5 days or 1 week). The use of such timeframes is supported by empirical evidence. Advancing DNA technologies continue to extend time limits because of the stability of DNA and sensitivity of testing. These technologies are even enabling forensic scientists to analyze evidence that was previously unusable when it was collected years ago. Thus, it is critical that in every case where patients are willing, examiners obtain the pertinent medical forensic history, examine patients, and document findings. Not only can the information gained from the relevant history and exam help health care providers address patients' medical needs, but it can guide examiners in determining whether there is evidence to collect and, if so, what to collect. (SEE PAGES 81-82)

Recommendations for health care providers and other responders to maximize evidence collection:

- Recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence.
- Examine patients promptly to minimize loss of evidence and identify medical needs and concerns.
- Make decisions about whether to collect evidence and what to collect on a case-by-case basis, guided by knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected.
- Responders, examiners, and law enforcement representatives should seek education and resources to aid them in making well-informed decisions about evidence collection.

6. **Evidence integrity:** Properly collecting, preserving, and maintaining the chain of custody of evidence is critical to its subsequent use in criminal justice proceedings. (SEE PAGES 83-84)

Recommendations for health care providers and other responders to maintain evidence integrity:

- Follow jurisdictional policies for drying, packaging, labeling, and sealing evidence.
- Make sure transfer policies maximize evidence preservation.
- Make sure storage policies maximize evidence preservation.
- Document the handling, transfer, and storage of evidence.

## **C. The Examination Process**

1. **Initial contact:** Some sexual assault patients may initially present at a designated exam facility, but most who receive immediate medical care initially contact a law enforcement or advocacy agency for help. If 911 is called, law enforcement or emergency medical services (EMS) may be the first to provide assistance to victims. Communities need to have procedures in place to promptly respond to disclosures/reports of sexual assault in a standardized and victim-centered manner. (SEE PAGES 87-90)

Recommendations for jurisdictions and responders to facilitate initial contact with victims:

- Build consensus among involved agencies regarding procedures for a coordinated initial response when a recent sexual assault is disclosed or reported. Educate responders to follow procedures
- Recognize essential elements of initial response.

2. **Triage and intake:** Once patients arrive at the exam site, health care personnel must evaluate, stabilize, and treat for life-threatening and serious injuries according to facility policy. Standardized procedures for response in these cases should be followed, while respecting patients and maximizing evidence preservation. (SEE PAGES 91-92)

Recommendations for health care providers to facilitate triage and intake that addresses patients' needs:

- Consider sexual assault patients a priority.

- First perform a prompt, competent medical assessment. Then respond to acute injury, the need for trauma care, and safety needs of patients before collecting evidence.
- Alert examiners of the need for their services.
- Contact victim advocates so they can offer services to patients, if not already done.
- Assess and respond to safety concerns upon arrival of patients at the exam site, such as threats to patients or staff.
- Assess patients' needs for immediate medical or mental health intervention prior to the evidentiary exam, following facility policy.

3. Documentation by health care personnel: Examiners document exam findings, the medical forensic history, and evidence collected in the medical forensic report. (SEE PAGE 93-94)

Recommendations for health care providers to complete needed documentation:

- Ensure completion of all appropriate documentation.
- Educate examiners on proper documentation.
- Ensure the accuracy and objectivity of medical forensic reports.

4. The medical forensic history: Examiners ask the patient questions in a language the patient understands to obtain this history. This information guides them in examining the patient and collecting evidence. (SEE PAGES 95-98)

Recommendations for health care providers to facilitate gathering information from patients:

- Coordinate medical forensic history taking and investigative interviewing.
- Advocates should be able to provide support and advocacy during the history, if desired by patients.
- Consider patients' needs prior to and during information gathering.
- Obtain the medical forensic history.

5. Photography: Photographic documentation of injury or other visible evidence on the patient's body can supplement the medical forensic history and the written documentation of physical findings and evidence. (SEE PAGES 99-102)

Recommendations for health care providers and other responders to photograph documentation:

- Consider the extent of forensic photography necessary.
- Consider the equipment.
- Consider patient comfort and privacy.
- Explain forensic photography procedures to patients.
- Take initial and follow-up photographs as appropriate, according to jurisdictional policy.

6. Exam and evidence collection procedures: Examiners examine patients and collect evidence according to jurisdictional policy. Findings from the exam and collected evidence often help reconstruct the events in question in a scientific and objective manner. (SEE PAGES 103-113)

Recommendations for health care providers to conduct the exam and facilitate evidence collection:

- Recognize the evidentiary purpose of the exam.
- Strive to collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, exam findings, and instructions in the evidence collection kit.
- Be aware of and document evidence and injuries that may be pertinent to the issue of whether the patient consented to the sexual contact with the suspect.
- Understand how biological evidence is tested.

- Prevent exposure to infectious materials and risk of contamination of evidence.
- Understand the implications of the presence or absence of seminal evidence.
- Modify the exam and evidence collection to address the specific needs and concerns of patients.
- Explain exam and evidence collection procedures to patients.
- Conduct the general physical and anogenital exam and document findings on body diagram forms.
- Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.
- Collect other evidence.
- Keep medical specimens separate from evidentiary specimens collected during the exam.

7. Alcohol and drug-facilitated sexual assault: Responders must consider the possibility that drugs and/or alcohol may have been used to facilitate an assault. They must know how to screen for suspected alcohol and drug-facilitated sexual assault, obtain informed consent of patients for testing, and collect toxicology samples when appropriate. (SEE PAGES 114-118)

Recommendations for jurisdictions and responders to facilitate response in suspected alcohol- or drug-facilitated sexual assault:

- Promote training and develop jurisdictional policies.
- Plan response to voluntary use of drugs and/or alcohol by patients.
- Be clear about the circumstances in which toxicology testing may be indicated. Routine testing is not recommended.
- Toxicology testing procedures should be explained to patients.
- Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.
- Identify toxicology laboratories.
- Preserve evidence and maintain the chain of custody.

8. Sexually transmitted infection (STI) evaluation and care: Because contracting an STI from an assailant is of significant concern to patients, it should be addressed during the exam. (SEE PAGES 119-124)

Recommendations for health care providers to facilitate STI evaluation and care:

- Offer patients information in a language they understand.
- Consider the need for STI testing on an individual basis.
- Encourage patients to accept prophylaxis against STIs if indicated.
- Encourage follow-up STI exams, testing, immunizations, counseling, and treatment as directed.
- Address concerns about HIV infection.

9. Pregnancy risk evaluation and care: Patients may fear becoming pregnant as a result of an assault. Health care providers must address this issue according to facility and jurisdictional policy. (SEE PAGES 125-126)

Recommendations for health care providers to facilitate pregnancy evaluation and care:

- Discuss the probability of pregnancy with patients who have reproductive capability.
- Administer a pregnancy test for all patients with reproductive capability (with their consent).
- Discuss treatment options with patients in their preferred language.

A victim of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines. Conscience statutes will continue to protect health care providers who have moral or religious objections to providing certain forms of contraception. In a case in which a provider refuses to offer certain forms of contraception for moral or religious reasons, victims of sexual assault must receive information on how to access these services in a timely fashion.

10. Discharge and follow-up: Health care personnel have specific tasks to accomplish before discharging patients, as do advocates and law enforcement representatives (if involved). Responders should coordinate discharge and follow-up activities as much as possible to reduce repetition and avoid overwhelming patients. (SEE PAGES 129-131)

Recommendations to facilitate discharge and follow-up:

- Address issues related to medical discharge and follow-up care.
- Advocates, law enforcement representatives, and other involved responders can coordinate with health care providers to discuss a range of other issues with patients prior to discharge.

11. Examiner court appearances: Health care providers conducting the exam should expect to be called on to testify in court as fact and/or expert witnesses. (SEE PAGES 133-135)

Recommendations for jurisdictions to maximize the usefulness of examiner testimony in court:

- Encourage broad education for examiners on testifying in court.
- Promote prompt notification of examiners if there is a need for them to testify in court.
- Encourage pretrial preparation of examiners.
- Encourage examiners to seek feedback on testimony to improve effectiveness of future court appearances.

# Introduction

Sexual assault is a prevalent crime in our society that has a devastating and long-term impact on individuals from all walks of life. Although an assault can be traumatizing in and of itself, it can result in a range of problems for the victim, such as acute and chronic mental health problems, physical injuries, pregnancy, and sexually transmitted infections (STIs).<sup>12</sup> It is essential that communities offer assistance to victims in the immediate aftermath of an assault. Communities must also work to hold offenders accountable for their actions and stop them from committing further sexual violence. Elements of response typically include the following:

- Provision of a prompt medical screening exam and treatment, including stabilization and/or referral for medical care for victims as needed;
- Collection of evidence from victims and documentation of findings, which may aid investigation and prosecution;
- Responding to, documenting, and investigating sexual assault, which generally includes collection of evidence from the scene of the sexual assault, which may lead to charges against suspects and prosecution;
- Support, crisis counseling, information and referrals for victims, as well as advocacy to ensure that victims receive appropriate assistance; and
- Support and information for victims' families and friends.

This document focuses on elements of immediate response that are the responsibility of health care providers—medical care for sexual assault patients and collection of evidence from them. It seeks to assist health care personnel in validating and addressing patients' health concerns, minimizing the trauma patients may experience, promoting healing, and maximizing the collection and preservation of evidence from patients, including documentation of findings, for potential use in the legal system. (A sexual assault medical forensic examination as described in this document addresses both medical and evidentiary needs of the patient following sexual assault).

This protocol also addresses the role of advocates, law enforcement representatives, prosecutors, forensic scientists, and other responders in the medical forensic exam process. For various reasons (such as fear, stigma, lack of information, lack of access, or mental trauma), many sexual assault victims choose not to seek medical care or have evidence collected. However, coordination among professionals involved in immediate response may be instrumental in reversing this trend. It is often found that victims will seek assistance when responders work together to ensure that victims are informed of their options for assistance, encouraged to address their needs, have their spiritual and psychological needs respected, and are aided in obtaining the help they want. In addition, multidisciplinary coordination has proven to enhance medical care provided to victims as well as evidence collection and preservation efforts.<sup>13</sup>

## Background

This national protocol was developed by the Office on Violence Against Women (OVW) under the direction of the Attorney General pursuant to the Violence Against Women Act of 2000.<sup>14</sup> In developing the protocol, OVW reviewed existing protocols on sexual assault forensic examinations and consulted with national, state, local, and tribal experts on sexual assault. Experts were consulted from rape crisis centers; state and tribal sexual assault and domestic violence coalitions and programs; and programs for criminal justice, forensic

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<sup>12</sup> STI are also commonly known as sexually transmitted diseases (STDs).

<sup>13</sup> For example, when first responders explain to victims how to preserve evidence on their bodies and clothing prior to arrival at the exam site, they may increase the likelihood that the evidence will be collected rather than contaminated or destroyed.

<sup>14</sup> The statutory requirement to develop this protocol can be found in Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386. The statutory requirement also mandates the development of a national recommended standard for training for health care professionals performing these examinations, as well as related training for all health care students. These training standards were released in June, 2006 and are available at <http://www.dna.gov/>.

nursing, forensic science, emergency-medicine, law, social services, and sex crimes in underserved communities.<sup>15</sup>

Starting in the summer of 2001, the Department of Justice (DOJ) began gathering information on resources, issues, and gaps related to sexual assault medical forensic exams. The first task was to identify and obtain relevant materials and data. Existing national and jurisdictional protocols on the exam and immediate multidisciplinary responses to sexual assault were sought,<sup>16</sup> as well as documents that analyzed jurisdictional response. Input was solicited on issues, gaps, and promising practices from numerous organizations, associations, and individuals representing disciplines involved in the response to sexual assault. In addition, numerous persons were contacted who could offer perspectives on particular issues related to the exam process. State sexual assault coalitions and state government agencies that oversee violence against women programs, as well as tribal coalitions, were also contacted to gain information on their activities concerning protocol development and training. In some states, data was obtained through discussions with sexual assault forensic examiners and coordinators of examiner programs or sexual assault response teams.

A series of forums was held in the summer and fall of 2002, calling upon practitioners and policymakers involved in victim advocacy, health care, forensic science, and criminal justice fields to assist in developing a national protocol. After a draft protocol for adult and adolescent victims was developed in early 2003, it was distributed to a wide array of individuals and organizations for their review and feedback.<sup>17</sup> Comments were first solicited from the individuals who were invited to the forums. Then input was sought from sexual assault survivors, as well as tribal sexual assault and domestic violence coalitions and local advocacy programs. Members of the National Advisory Committee on Violence Against Women also reviewed the draft and provided input. After several revisions of the document, feedback was solicited during the summer of 2003 from many national and state organizations and some local agencies that deal with sexual assault issues or serve diverse populations, as well as other individuals representing relevant disciplines. Comments received were incorporated into the document where appropriate.

Many of the revisions from the original protocol are based on recommendations made by the consulted experts. Some of the recommendations are based on empirical research. Although research has been and continues to be done in many areas related to the medical forensic exam, much more research needs to be done to evaluate the impact of the exam process and specific exam components on victim well-being and criminal justice outcomes. For this revision, OVW solicited input from technical assistance providers representing the relevant disciplines, such as forensic nurses, doctors, prosecutors, law enforcement, advocates, and civil attorneys, as well as the National Institute of Justice. We also held a webinar with relevant experts.

The national protocol recommends, rather than mandates, methods for conducting the medical forensic exam.<sup>18</sup> It serves as an informational guide to communities as they develop or revise their own protocols.<sup>19</sup> In no way does it invalidate previously established jurisdictional protocols, policies, or practices.

## About This Document

**Organization.** Protocol recommendations are organized into several broad sections: A) overarching issues, B) operational issues, and C) the examination process. Each section builds on information presented in

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<sup>15</sup> Such consultation was required under Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386.

<sup>16</sup> Protocols reviewed varied in scope, focus, targeted audiences, and level of detail. Most addressed to some extent exam and evidence collection procedures, drug-facilitated assault, evidence integrity, and evaluation and care for STIs, HIV, and pregnancy. Some also addressed roles of involved responders, multidisciplinary coordination, reporting, crime lab testing, court testimony, issues related to victims' needs, working with specific populations of victims, payment for the exam, and crime victims' compensation.

<sup>17</sup> The scope of this protocol is limited to the sexual assault medical forensic exam of adult and adolescent victims. A separate protocol should be developed on child exams. Not only is child sexual victimization a complex topic in and of itself, but response to child victims can be considerably different from response to adult and adolescent victims.

<sup>18</sup> The protocol has no regulatory purpose and is not intended to nor does it provide legal advice. (Statement adapted from the *Hawaii State Sexual Assault Protocol for Forensic and Medical Examinations*, Introduction, 1999.)

<sup>19</sup> Those involved in the development of this protocol strove to create a document that addressed the many issues facing communities across the nation related to the exam process. However, there may be instances where the document falls short of adequately addressing specific needs or challenges facing a jurisdiction or a specific population of victims. See appendix A on customizing protocols for ways that jurisdictions can address these limitations when they are developing/revising their own protocols.

previous sections and comprises tasks to be addressed, issues to be considered and related recommendations. Although an effort has been made to avoid repetition of information throughout the document, there are instances where data are repeated for clarity or emphasis. The appendixes discuss the topics of protocol customization by jurisdictions and creation of sexual assault response teams.

Protocol foundation. This protocol is based on a belief that it is possible, with a victim's consent, to simultaneously address the immediate health needs of a victim and the future needs of the justice system.

Key principles underlying response to sexual assault victims as discussed in this document include:

- Recognition of victim safety and well-being as paramount goals of response.
- Recognition that victims know far more about themselves and their needs than responders.
- Respect for victims' right to make their own choices.
- Recognition that providing victims with information about their options during the exam process, expected consequences of choosing one option over another, and available resources can help them make more informed decisions.
- Recognition that all victims, regardless of differences in backgrounds and circumstances, and regardless of their decision to report the crime or not, have the right to receive a high-quality medical forensic exam and to be treated with respect and compassion.
- Respect for victims' right to confidentiality.
- Recognition of the importance of victims' feedback to improving the exam process.

Another important principle is recognition that the vast majority of sexual assaults are committed by assailants known to victims. Historically, sexual assault committed by nonstrangers was not taken seriously and interventions were less than adequate. It is imperative that all involved responders acknowledge that sexual assaults committed by persons known to victims are as grave a crime as those committed by strangers. Responders should be aware that victims' reactions to an assault are affected by a multitude of factors: one of them being the prior relationship between the victim and the offender. They should also understand that many variables may affect the relevance of certain types of evidence to a particular case, including whether an assault was committed by a stranger, a known offender who claims no sexual contact with the victim, or a known offender who claims the victim consented to the contact.<sup>20</sup>

## Use of Terms

Many terms are explained throughout the protocol to clarify the context in which they are used.<sup>21</sup> However, it may be helpful to discuss briefly the following terms in advance (in alphabetical order):

Adolescent: Adolescents are distinguished in the protocol from prepubertal children who require a pediatric exam. This document focuses on the examination of females who have experienced the onset of menarche and males who have reached puberty. However, it is important to recognize that age also plays a role in whether a person is treated as a child or adolescent. For example, some adolescent girls may not start menstruating until their later teen years. While the physical developmental level of these patients must be taken into account when performing the exam, they should otherwise be treated as adolescents rather than children. Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances in which minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. Involved responders should be well versed in their jurisdictional laws and policies regarding the above issues, screening procedures for determining whether a pediatric exam is needed (particularly in the case of younger adolescents), and local protocols for response to prepubertal victims. Exam sites are to follow the jurisdictional laws regarding parental/guardian consent.

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<sup>20</sup> For example, evidence that identifies a suspect in a stranger case, such as DNA evidence, is critical to the continuing investigation. In cases in which the victim knows the suspect, evidence that identifies suspects is important if suspects claim they had no sexual contact with victims. In cases in which suspects claim that victims consented to the sexual contact, evidence identifying suspects is less crucial and evidence and documentation related to whether force or coercion was used against victims is often more important.

<sup>21</sup> Keep in mind that these definitions may vary from those used generally or in exam protocols developed by states, territories, tribes, and local communities.

Communitywide sexual assault coordinating councils: These multidisciplinary groups typically work to facilitate a communitywide response to sexual assault that is appropriate, coordinated, and comprehensive. They tend not to be involved in direct response, but rather endeavor to improve overall services, interventions, and prevention efforts. Communitywide coordinating council is a broad term for such a group, but possibilities are endless for what a jurisdiction may call such a group. This group may be a subcommittee of an entity that more generally promotes coordinated response to violence in the community.

Coordinated community response: This term refers to immediate and longer term community response to sexual assault that is coordinated among involved responders. The idea is that while each responder provides services and/or interventions according to agency-specific policies, they also work with responders from other agencies and disciplines to ensure that they coordinate responses. The desired result is a collective response to victims and offenders that is appropriate, streamlined, and as comprehensive as possible. Coordinated community response to sexual assault is a concept that developed out of a need to reduce the historically fragmented approach to these cases and the negative impact of fragmentation on victim well-being, offender accountability, and prevention of future assault. These community responses may be known as sexual assault response teams or sexual assault response and resource teams (SARTs or SARRTs).

Culture: This term refers to a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that may be shared among members of a particular group. Aspects of a culture include its values, beliefs, customs, communication styles, behaviors, practices, and institutions.<sup>22</sup> In this document, a cultural group refers not only to an ethnic, racial, or religious group, but also to other groups with distinct cultures such as senior citizen; Deaf and hard-of-hearing communities; populations with differing sexual orientations, gender identities, or gender expressions; immigrants; refugees; the homeless; military personnel and their dependents; adolescents; prison inmates; and victims of sex trafficking or victims of commercial sexual exploitation. Individuals often belong to multiple cultural groups.

An immediate response to victims should sensitively and appropriately address their related cultural needs and concerns. It is important that responders acknowledge that victims from certain cultures in a community may be underserved, unserved, or misserved by the systems responsible for response and should work to improve response to these populations.

Disability: A person with a disability is an individual who has a physical or mental impairment that substantially limits one or more of that individual's major life activities, who has a record of such impairment, or is regarded as having such impairment.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. A major life activity also may include the operation of major bodily functions, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity in order to be considered a disability. Determining whether an impairment substantially limits a major life activity is done without regard to the ameliorative effects of mitigating measures. Mitigating measures include medication, medical supplies, equipment, appliances, prosthetics, hearing aids and cochlear implants, mobility devices, oxygen therapy equipment, use of assistive technology, and learned behavioral or adaptive neurological modifications.

An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability. An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

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<sup>22</sup> The first two sentences in this paragraph are drawn from A. Blue, *The Provision of Culturally Competent Health Care*, from the Web site of the Medical University of South Carolina College of Medicine ([http://academicdepartments.musc.edu/fm\\_ruralclerkship/curriculum/culture.htm](http://academicdepartments.musc.edu/fm_ruralclerkship/curriculum/culture.htm)).

An individual is "regarded as" a person with a disability if that individual is discriminated against because of an actual or perceived physical or mental impairment, whether or not the impairment limits a major life activity.

**Domestic violence:** This term broadly refers to any abusive and coercive behavior used to control an intimate partner (a spouse, boyfriend/girlfriend, or former spouse or boyfriend/girlfriend) and/or a family member.<sup>23</sup> Some examples of tactics employed by abusers to control victims are use of coercion, threats, and intimidation; emotional, physical, and sexual abuse; economic manipulation; use of privilege; use of children and pets; isolation of victims; minimization and denial of violence; and blaming victims for violence.<sup>24</sup> An episode of domestic violence often includes multiple actions, and the violence typically escalates over time. In this protocol, it is important to be aware that sexual assault can be a significant part of domestic violence. Response to sexual assault occurring within a domestic violence context requires understanding of the overlapping dynamics of sexual assault and domestic violence, the complex needs of victims, the potential dangerousness of offenders, the resources available for victims, and adherence to jurisdictional policies on response to domestic violence.

**Exam site:** Emergency health care facilities, such as those in hospitals, traditionally have been the setting for provision of medical forensic services to sexual assault patients. However, nonemergency health care programs, such as hospital-based or community-based examiner programs, community clinics, mobile health clinics, tribal health clinics, local health departments, military hospitals or clinics, and college and university health centers, may also offer full or partial sexual assault medical forensic services. Sexual assault forensic examiners also may conduct exams at additional health care and non-health care sites. The facility conducting the exam may be referred to in this protocol as the "exam site," in recognition of the fact that not all sites performing the exam are health care facilities. Clinical staff providing care at exam sites are broadly referred to in this document as "health care providers," "health care staff," "health care personnel," and "health care clinicians." In some communities, forensic exams may be conducted by lay health care providers, community health aides, or others who have been trained to perform forensic exams.

**Examiner:** The term refers to the health care provider conducting the sexual assault medical forensic examination. The examiner is also referred to in this document as the "sexual assault forensic examiner," "sexual assault examiner," and "forensic examiner." Many communities refer to their sexual assault examiners by more specific acronyms based upon the discipline of practitioners and/or specialized education and clinical experiences.

**First responder:** A first responder is a professional who initially responds to a disclosure of a sexual assault (there is often more than one first responder). These professionals typically must follow agency-specific policies for responding to victims. Those who traditionally have been responsible for immediate response to adult and adolescent sexual assaults include victim advocates, 911 dispatchers, law enforcement representatives, and health care providers. A wide range of other responders also may be involved, such as emergency medical technicians, public safety officials, protective service workers, prosecutors and victim/witness staff, private physicians, staff from local health care facilities, mental health providers, social service workers, corrections and probation staff, religious and spiritual counselors/advisors/leaders, school personnel, employers, qualified interpreters, and providers from organizations that address needs of specific populations (e.g., persons with disabilities, racial and cultural groups, senior citizens, the poor and homeless, runaways and adolescents in foster care, and domestic violence victims). Families and friends of victims also can play an important role in the initial response, because victims may first disclose the assault to them, ask for their help in seeking professional assistance, and want their ongoing support. However, they are not considered first responders in this document, because they are not responding to these disclosures in an official capacity.

**Forensic scientist:** The forensic scientist is responsible for analyzing evidence in sexual assault cases. This evidence typically includes DNA and other biological evidence, toxicology samples, latent prints, and trace evidence. Some forensic scientists specialize in the analysis of specific types of evidence. In this protocol, forensic scientists working in jurisdictional crime laboratories are often referred to as "crime lab/laboratory

<sup>23</sup> Drawn from M.A. Dutton, "The Dynamics of Domestic Violence: Understanding the Response from Battered Women," *Florida Bar Journal* 68(9), January 24, 1994.

<sup>24</sup> Drawn from the Power and Control Wheel developed by the Domestic Violence Intervention Project of Minnesota.

personnel” and “crime lab/laboratory scientists.” Forensic scientists analyzing drug and alcohol samples are also referred to as “toxicologists.” Forensic scientists in many communities may respond to crime scenes to collect evidence and to process the scene.

**Jurisdiction:** This term is used in two ways in the protocol. One is to broadly describe a community that has power to govern or legislate for itself. For example, a jurisdiction may be a local area, a state, a territory, or tribe. A jurisdiction may also be referred to in the protocol as a “community.” The term also describes the authority to interpret and apply laws and is used in this context mainly when identifying who has “jurisdiction” over a particular case.

**Language assistance services (LAS):** Language assistance services are oral language services for interpretation and written language services, translation of written materials into languages other than English for limited English proficient (LEP) individuals.

**Law enforcement representative:** Different types of law enforcement agencies exist at the local, state, territory, tribal, and federal levels (e.g., state, county, tribal, or local police or sheriff, sworn police on college campuses, the FBI, the Bureau of Indian Affairs (BIA), and military police). Any of these agencies could potentially be involved in responding to sexual assault cases. Also, in areas without a local law enforcement agency, public safety officials may assist in immediate response to sexual assault victims. Some agencies may have staff with specialized education and experience in sexual assault investigations, which may be dedicated to investigating sexual assault cases and/or may be part of a special unit for investigating sexual assaults. In this protocol, personnel from law enforcement agencies are referred to as “law enforcement officers” or “law enforcement representatives,” unless more specificity is required.

**Limited English Proficient (LEP):** Refers to individuals who do not speak English as their primary language and have a limited ability read, speak, write, or understand English. LEP individuals may be entitled to language assistance services to ensure they have meaningful access to a benefit, program, or service that receives federal financial assistance.

**Prosecutor:** Different types of prosecution offices exist at the local, tribal, state, territory, and federal level (e.g., tribal prosecutor’s office, county prosecutor’s office, district attorney’s office, state attorney’s office, United States Attorney’s office, and military judicial branches). Any of these offices could be involved in responding to sexual assault cases. In addition, some offices may have personnel with specialized education and experience in sexual assault prosecutions, who may be dedicated to prosecuting sexual assault cases and/or may be part of a special unit for prosecuting sexual assaults. In this protocol, attorneys from prosecution offices will be referred to as “prosecutors” unless more specificity is required.

**Sexual assault:** Generally speaking, sexual assault is the sexual contact of one person with another without appropriate legal consent. This definition includes, but is not limited to, a wide range of behavior classified by state, territory, federal, and tribal law as rape, sexual assault, sexual misconduct, and sexual battery. Refer to applicable statutes for precise definitions in a specific jurisdiction.<sup>25</sup>

**Sexual assault medical forensic examination:** The sexual assault medical forensic exam is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these patients. The examination includes gathering information from the patient for the medical forensic history; an examination; coordinating treatment of injuries, documentation of biological and physical findings, and collection of evidence from the patient; documentation of findings; information, treatment, and referrals for STIs, pregnancy, suicidal ideation, alcohol and substance abuse, and other nonacute medical concerns; and follow-up as needed to provide additional healing, treatment, or collection of evidence. This exam is referred to as the “forensic medical examination” under the Violence Against Women Act (VAWA).

**Sexual assault response team (SART) also called a sexual assault response and resource team (SARRT):** A SART/SARRT is a multidisciplinary team that provides specialized immediate response to victims of recent

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<sup>25</sup> Drawn from the American College of Emergency Physicians’ *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, Overview, p. 7.

sexual assault. The team typically includes health care personnel, law enforcement representatives, victim advocates, prosecutors (usually available on-call to consult with first responders, although some may be more actively involved at this stage), and forensic lab personnel (typically available to consult with examiners, law enforcement, or prosecutors, but not actively involved at this stage). However, SART/SARRT components vary by community. The term "SARRT" (written with two "R"s) stands for "Sexual Assault Response and Resource Team." This term is used for communities that involve a wider array of agencies and disciplines in their collaborative effort. A SARRT (with two "R"s) will thus involve all of the first responders who are typically included in a SART (with one "R"), but it may also include professionals who coordinate services for victims beyond the immediate response (e.g., representatives from mental health, public health, substance abuse treatment, and other social services). Many of these SARRTs meet monthly and often engage in systems review to ensure that the best victim-centered services are being provided in their communities.

**Suspected sex offender:** A suspected sex offender is an individual suspected of committing a sexual assault. In this document, the suspected sex offender is typically referred to as a "suspect." When litigation is discussed, the suspected sex offender may be referred to as a "defendant." When talking more broadly about sex offenders, they may be referred to as "sex offenders," "assailants," or "perpetrators."

**Victim:** A sexual assault victim is someone who has been sexually assaulted. In this document, a victim can be a female or male; a person whose gender identity may not conform to his or her sex, or may be someone who doesn't identify as either male or female; either adult or adolescent. There may be instances where individuals, such as unconscious persons or persons with cognitive disabilities, do not actually disclose that they have been assaulted, but others suspect that this may be this case and may be lawfully able to seek help for them. The term "survivor" is used in this document when referring to victims who are involved in long-term healing or have healed from sexual assault. It is important to note that because this document addresses a multidisciplinary response, the term "victim" is not used in a strictly criminal justice context. The use of "victim" simply acknowledges that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice. The term "patient" is also used when discussing the role of medical providers.

**Victim service provider/advocate:** A victim service provider/sexual assault victim advocate (also referred to as "victim advocate" and "advocate") may offer victims and their significant others a range of services during, and following, the exam process. These services may include support, crisis intervention, information and referrals, interpretation or translation, and advocacy to ensure those victims' interests are represented, their wishes respected, and their rights upheld. In addition, advocates and other victim service providers may provide follow-up services, such as support groups, counseling, accompaniment to related appointments, and legal advocacy (civil, criminal, and immigration) to help meet the needs of victims, their families, and friends.

A number of agencies may offer some or all of the services described above, including community-based sexual assault victim advocacy programs,<sup>26</sup> criminal justice system victim-witness offices, patient advocate programs at health care facilities, campus or military victim service programs, tribal social services, adult protective services, and others. Where they exist, community-based sexual assault victim advocacy programs are typically best positioned to provide these specific services. Community-based advocacy programs may use paid and/or volunteer advocates to provide services 24 hours a day, every day of the year. It is important to know that information victims share with government-based service providers usually becomes part of the criminal justice record, while community-based advocates typically can provide some level of confidential communication for victims. In addition, community-based advocates commonly receive education specific to the medical forensic exam process and sexual assault issues in general.

**Victim-centered:** A "victim-centered" approach as used in this protocol recognizes that sexual assault victims are central participants in the medical forensic exam process, and they deserve timely, compassionate, respectful, and appropriate care. Victims have the right to be fully informed in order to make their own decisions about participation in all components of the exam process. Responders need to do all that is

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<sup>26</sup> In some areas, the community-based sexual assault victim advocacy program is a component of an umbrella organization serving additional populations (e.g., a dual sexual assault/domestic violence advocacy agency, a center for women, or a mental health agency). In others, the community-based sexual assault victim advocacy program is a stand-alone organization.

possible to explain possible options, the consequences of choosing one option over another, and available resources, as well as support victims in their choices. Medical personnel may refer to this as “patient-centered care.”

Vulnerable adults: This term is used in this document to refer to adult individuals with impaired and/or reduced mental capacity who have difficulty or cannot comprehend events that occurred or will occur (e.g., the assault itself or initial response by professionals), questions they will be asked during the exam, or the exam process itself. Exam sites should have internal policies based on jurisdictional statutes governing consent for treatment for and evidence collection from such patients.



## **A. Overarching Issues**

This section presents issues that impact all or most of the sexual assault medical forensic exam process. The following chapters are included:

- Coordinated Team Approach
- Victim-Centered Care
- Informed Consent
- Confidentiality
- Reporting to Law Enforcement
- Payment for the Examination Under VAWA



# 1. Coordinated Team Approach

Recommendations at a glance for jurisdictions to facilitate a coordinated team approach:

- Understand that the purpose of the exam is to address patients' health care needs and collect evidence when appropriate for potential use within the criminal justice system.
- Identify key responders and their roles.
- Develop quality assurance measures to ensure effective response during the exam process.

Communities should ensure that victims, regardless of their backgrounds or circumstances, have access to medical, legal, and advocacy services. Use of a coordinated, multidisciplinary approach in conducting the medical forensic examination can afford victims access to comprehensive immediate care, help minimize trauma they may be experiencing, and encourage the use of community resources. Such a response can also enhance public safety by facilitating investigation and prosecution, thereby increasing the likelihood that offenders will be held accountable for their behavior and further sexual assaults will be prevented. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more victims to disclose the assault and seek the help they need.<sup>27</sup>

**Understand that the purpose of the exam is to address patients' health care needs and collect evidence when appropriate for potential use within the criminal justice system.** The medical/forensic examination in its entirety addresses the medical and evidentiary needs of the consenting patient:

- Conducting prompt examinations.
- Providing support, crisis intervention, and advocacy.
- Obtaining a history of the assault.
- Performing a complete assessment.
- Documenting exam findings.
- Evaluating and treating injuries.
- Properly collecting, handling, and preserving potential evidence.
- Providing information, treatment, and referrals for STIs and pregnancy.
- Providing follow-up care for medical and emotional needs as well as further forensic evaluation.
- Providing language assistance services for limited English proficient, Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.

It is also possible that examiners may provide the following as a routine part of their post-examination process depending upon the criminal justice system response:

- Interpreting and analyzing examination findings.
- Presenting findings and providing factual and/or expert opinion related to the medical forensic examination.

Coordination among involved disciplines is strongly recommended to simultaneously address the needs of both victims and the justice system. Ensuring that victims' needs are met often can increase their level of comfort and involvement with the legal system.

**Identify key responders and their roles.** Two types of teams are recommended to facilitate a coordinated community response to sexual assault. Some form of a sexual assault response team (SART/SARRT) is useful to coordinate immediate interventions and services, including victim support, medical care, evidence collection and documentation, and the initial criminal investigation. A communitywide coordinating group (often called a "council") can help promote efforts to improve comprehensive response to sexual violence,

<sup>27</sup> This paragraph is drawn partially from American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 7.

including prevention education and outreach,<sup>28</sup> training and technical assistance, improvement of victim services, protocol development, public policy advocacy, dissemination of materials, and evaluation of the effectiveness of these efforts.<sup>29</sup> A communitywide coordinating council may also oversee activities of a SART/SARRT. Military bases, school campuses, and tribes may develop coordinating councils or SARTs or SARRTs of their own to allow for a more specialized response tailored to the needs of their populations. Coordinating councils may also exist to encourage consistent responses across a state, territory, tribal land or region.

SART/SARRT membership. A SART/SARRT is composed of professionals involved in immediate response to disclosures of sexual assault. A core SART/SARRT commonly includes health care providers, law enforcement representatives, and victim advocates. Prosecutors and forensic scientists also are often involved, but more as consultants than first responders. Civil attorneys who represent victims are sometimes involved as well. Broad roles for SART/SARRT members include (listed in alphabetical order):<sup>30</sup>

- **Advocates** may be involved in initial victim contact (via 24-hour hotline or face-to-face meetings), offer victim advocacy, support, crisis intervention, information, translation or interpretation, and referrals before, during, and after the exam process, and facilitate transportation for the victim to and from the exam site. They often provide comprehensive, longer term services designed to aid victims in addressing any needs related to the assault, including but not limited to counseling and legal (civil, criminal, and immigration) and medical systems advocacy.
- **Civil attorneys** protect the interests of sexual assault victims, address concerns that affect immediate everyday life and long-term wellbeing of victims, and represent victims in civil legal matters. Civil legal matters may include: privacy, safety, immigration, education, housing, employment, and financial issues. Because civil attorneys represent the individual victim, and not the prosecutor, they play a very different role from that of the prosecutor.
- **Forensic scientists** analyze forensic evidence and provide results of the analysis to investigators and/or prosecutors. They may respond to crime scenes to assist in the collection and processing of evidence. They also testify at trial regarding the results of their analysis.
- **Health care providers** assess patients for acute medical needs and provide stabilization, treatment, and/or consultation. Ideally, sexual assault forensic examiners perform the medical forensic exam, gather information for the medical forensic history, collect and document forensic evidence, and document pertinent physical findings from patients. They offer information, treatment, and referrals for sexually transmitted infections (STIs), pregnancy, and other nonacute medical concerns. They may also testify in court if needed. They coordinate with advocates to ensure that patients are offered crisis intervention, support, and advocacy during and after the exam process and encourage use of other victim services. They may follow up with patients for medical and forensic purposes. Other health care personnel that may be involved include, but are not limited to, emergency medical technicians, staff at hospital emergency departments, gynecologists, surgeons, private physicians, and/or local, tribal, campus, or military health services personnel.
- **Law enforcement representatives** (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence, investigators, and federal law enforcement officers) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the exam site as needed, interview victims, coordinate collection and delivery of evidence to designated labs or law enforcement property facilities, and investigate cases (e.g., interviewing suspects and witnesses, requesting crime lab analysis, reviewing medical and lab reports, preparing and executing search warrants, writing reports, and presenting the case to a prosecutor).
- **Prosecutors** determine if there is sufficient evidence for prosecution and, if so, prosecute the case. They should be available to consult with first responders as needed. A few jurisdictions more actively

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<sup>28</sup> Although victim advocacy programs and coordinating councils often lead local prevention efforts, SARTs play a role in prevention by helping victims plan for their safety and well-being and connecting them with resources that may reduce the likelihood of their future revictimization (e.g., emergency shelters and longer term housing programs, protective orders, programs offering free cell phones that automatically dial 911 when activated, or businesses that can help change locks and install alarm systems). Initial evidence collection and investigative efforts can play a pivotal role in holding offenders accountable and preventing them from reoffending.

<sup>29</sup> American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

<sup>30</sup> Bulleted section partially adapted from Pennsylvania's *SART Guidelines*, 2002, created by the Pennsylvania Coalition Against Rape.

involve prosecutors, paging them after initial contact and having them respond to the exam site so that they can become familiar with the case and help guide the investigation.<sup>31</sup>

- **Victims' rights attorneys** ensure victims' rights are upheld during the criminal justice process. Examples in the sexual assault cases include independent motions to quash subpoenas filed in the criminal case (e.g., subpoenas for counseling, medical, educational, and employment records), independent rape shield arguments, motions to close courtrooms or limit media access, and motions for alternative means of testifying and/or support during testifying.

Each responder should be able to explain to victims the roles of other team members. Depending on the case and jurisdictional policies, other professionals or agencies - from perhaps multiple jurisdictions - may also be involved in immediate interventions and service provision. They need information about the SART/SARRT and its procedures to guide their responses and facilitate coordination of activities with the SART/SARRT. SART/SARRT members also need information about those professionals and agencies, their roles in sexual assault response, and how to contact and interact with them.

Team efforts are enhanced when SART/SARRT members reflect the communities being served. At the least, SART/SARRT members should strive to understand the needs and concerns of specific populations living in the area served. SART/SARRTs should reach out to agencies that serve these populations so that team members can promptly access their services if needed.

See *Appendix B* for more information on the creation of SARTs/SARRTs.

Membership of a coordinating council. A coordinating council typically comprises a wide array of professionals and citizens who develop the community's response to sexual assault. Organizations with an interest in or a responsibility for sexual assault victims should be considered for membership.<sup>32</sup> For example, members might include<sup>33</sup> victim advocates; legal services providers (civil, criminal, and immigration); survivors of sexual assault and their families and friends; health care workers; public health and safety officials; law enforcement personnel; prosecutors; victim/witness staff; judicial personnel;<sup>34</sup> corrections and probation staff; sex offender treatment providers; forensic lab personnel; staff from mental health agencies; personnel serving persons with disabilities; substance abuse treatment staff, staff from residential living settings such as nursing homes, assisted living programs, and group homes; educators from all levels; legislators and government policymakers; exam site administrators; religious and spiritual leaders; and the media and business community. Representation from all levels of government that potentially have jurisdiction over these cases in the area served should be involved. Equally important are members who can address the needs of diverse populations in the community (e.g., racial and cultural groups, senior citizens, persons with disabilities, immigrants, the poor and homeless, runaways and adolescents in foster care, domestic violence victims, college students, military personnel and dependents, and populations with differing sexual orientations and gender identities or expressions). Agencies that provide qualified interpreters in sexual assault cases should also be invited to participate.

Attempting to involve all agencies and individuals listed above is an enormous task and could prove to be a barrier to council formation and initial council efforts. Therefore, communities should make their own decisions about which stakeholders are critical to initial efforts and form a core membership, and then

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<sup>31</sup> In addition to seeking prosecution of offenders, victims who attend institutions of higher education may have the option of filing disciplinary charges. When that happens, members of the judiciary board review the case to decide if the institutional code of conduct has been violated and, if so, to determine sanctions. Tribes may also have their own codes related to sexual assault and/or processes through which victims can seek remedies, beyond what is available through state or federal prosecution.

<sup>32</sup> American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

<sup>33</sup> List adapted from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

<sup>34</sup> Judges' conduct in and out of the courtroom is governed by a code of judicial conduct that requires that they do nothing that would give the appearance of partiality. Depending on local interpretation of the code, the participation of judicial personnel on a council should not negate their ability to be impartial in court. In the unlikely instance that the council is involved with individual cases, judges can excuse themselves from those activities.

identify which agencies and individuals would be useful to have at the table at some point but are not essential to getting started.<sup>35</sup>

**Develop quality assurance measures to ensure effective response during the exam process.** Involved agencies should have mechanisms to ensure that the quality of discipline-specific response and coordinated response is optimal. Some tools to ensure consistent high-quality response by involved professionals include training, ongoing education, supervision, periodic performance evaluations, and peer reviews (e.g., medical forensic reports). Also useful in facilitating improvements to immediate response are feedback from victims and involved professionals and collection and analysis of data from the exam process (as discussed below). Review of both active and resolved cases provides many opportunities to improve the performance of individual team members and the team as a whole, although certain team members, such as community based advocates, may need to be careful about confidentiality in case discussions.

Obtain feedback on victim impact, the exam process, and criminal justice outcomes. All involved responders can benefit from victims' feedback about whether they felt response to the crime was adequate and if anything could have been done to improve response or better address their needs. It can be useful to talk with victims about their experiences during the exam process, including the location of the exam, and explore how the process might be changed to better minimize trauma. Victim feedback can be obtained in several ways: by requesting completion of an evaluation form (not immediately after the exam), conducting a follow-up phone survey, and inviting participation in focus group discussions. It is important to solicit feedback from diverse populations in the community (e.g., racial and cultural groups, senior citizens, persons with disabilities, persons with limited English proficiency, immigrants, the poor and homeless, runaways and adolescents in foster care, domestic violence victims, college students, military personnel and dependents, and populations with differing sexual orientations and gender identities). Ask victims prior to medical discharge if they will allow such subsequent contacts and the best method of contacting them. Responders should be careful to ask victims for a safe manner to contact them, particularly in situations involving sexual assault by intimate partners. Advocates can help design a victim feedback system that is sensitive, does not harm victims, and has mechanisms to quickly link victims with appropriate victim services if needed. Families and friends of victims may also be able to provide useful feedback.

Obtaining feedback from and facilitating dialogue among the first responders (law enforcement, advocate, medical personnel) to the sexual assault and the individual who conducted the exam is also critical. Some of this information could be routinely solicited and discussed at SART/SARRT meetings and jurisdictional sexual assault coordinating council meetings (to assess what works and what needs improvement). Also, periodic evaluation of the exam process by examiners, medical supervisors/examiner program directors, advocates, law enforcement representatives, and prosecutors can help ensure that victims' needs are addressed, problems are resolved, cutting-edge practices and technologies are utilized as much as possible, and training needs are identified. In terms of getting feedback on how the exam process impacts criminal justice outcomes, examiners can benefit from access to crime lab reports on evidence collected and feedback from crime lab personnel about improving their evidence collection techniques. Prosecutors can provide examiners and law enforcement representatives with information about the usefulness of evidence collected in case prosecution. Advocates can encourage discussion on how the exam process can affect victims' interest in and willingness to be involved in the criminal justice system. Law enforcement representatives and other first responders can discuss with examiners and crime lab personnel optimal methods to preserve evidence from victims prior to their arrival at the exam site. Again, review of both active and resolved cases by the team as a whole is a rich opportunity for improvement. These are but a few examples of how first responders could use feedback on criminal justice outcomes to improve the exam process.

Consider collecting and analyzing data from the exam process to better understand the nature of assaults in the community and evaluate effectiveness of responses. (Information that identifies victims should not be

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<sup>35</sup> The protocol does not further explore issues related to more comprehensive coordinated response to sexual assault. However, one useful resource for communities interested in the development of a multidisciplinary response is the National Center for Victims of Crime's *Looking Back, Moving Forward: A Guidebook for Communities Responding to Sexual Assault*.

included in collected data. Attention must be given to protecting victims' identity in communities where residents tend to know one another or word of a crime travels quickly). Over time, such data may help to:<sup>36</sup>

- Track the participation of involved responders, agencies, and facilities.
- Evaluate the strengths and weaknesses of agency and coordinated responses.
- Assess the effectiveness of response in different types of cases (e.g., stranger assaults versus nonstranger assaults).
- Improve the quality of the examination.
- Evaluate the impact of the collected evidence on criminal justice outcomes.
- Track and evaluate victim service outcomes.

Some jurisdictions have developed centralized databases to collect and analyze information across disciplines. **However, such a venture requires significant resources, coordination, and thought regarding how to maintain victims' confidentiality.** Coordination can be particularly challenging in communities where cross-jurisdictional issues arise frequently (e.g., in tribal lands). A centralized database may be more easily accomplished if it is built into multidisciplinary coordination planning. For example, involved agencies can together determine how to utilize existing resources, seek new funding, maintain victims' privacy, and systematically obtain data. Jurisdictions considering such databases should take into consideration the fact that pooling empirical data (such as patient age, Zip Code, or use of a weapon) is likely to be reliable while use of pooled interpretive data (such as blunt cervical trauma or findings of strangulations) is risky and may be unreliable because of uncontrollable variables in examiner training and experience.

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<sup>36</sup> Bulleted section partially adapted from the *County of San Diego Sexual Assault Response Team Systems Review Committee Report: Five-Year Review, 2005*, San Diego County, California.  
<http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/EMS-SARTRReportJuly2005.pdf>.



## 2. Victim-Centered Care

Recommendations at a glance for health care providers and other responders to facilitate victim-centered care during the exam process:

- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.
- Develop culturally responsive care and be aware of issues commonly faced by victims from specific populations.
- Recognize the importance of victim services within the exam process.
- Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious -and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.
- Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible.
- Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.
- Assess and respect patients' priorities.
- Integrate medical and evidentiary procedures where possible.
- Address patients' safety during the exam.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.
- Address physical comfort needs of patients prior to discharge.

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way.<sup>37</sup> Every action taken by responders during the exam process should be useful in facilitating patient care and healing and/or the investigation (if the case was reported).

**Give sexual assault patients priority as emergency cases.** This includes a prompt medical screening exam. Recognize that every minute patients spend waiting to be examined may cause loss of evidence and undue trauma. Individuals disclosing a recent sexual assault should be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and offered a medical forensic exam. (For more discussion on this topic, see *C.2. Triage and Intake*.) Have plans for what to do, if the examiner is not available right away. For example, is there a quiet, private place the patient can wait? Is there a phone available so the patient can talk to an advocate or a friend or family member while waiting? Jurisdictions should consider policies and training for facility staff and administration regarding what to do while sexual assault patients are waiting.

**Provide the necessary means to ensure patient privacy.** Exercise discretion to avoid the embarrassment for individuals of being identified in a public setting as a sexual assault victim. Some health care facilities use code plans to avoid inappropriate references by staff to sexual assault cases. Also, do not leave sexual assault patients in the main waiting area at the exam site. Instead, give them as much privacy as possible (e.g., a private treatment room and waiting area) and be cognizant of their sense of safety (e.g., do not examine suspects in same location at the same time). Make sure that the first responding health care providers attend to patients' initial medical needs and arrange for an on-call advocate to offer onsite support, crisis intervention, and advocacy. It may be useful to give patients the option of speaking with an advocate via a 24-hour crisis hotline (if one exists) until an advocate arrives. Health care providers should provide patients with access to a phone to contact family members and/or support persons as desired, and should promptly contact law enforcement, if not already involved, if patients want to report the assault.

<sup>37</sup> The chapter was partially built on information from the *North Carolina Protocol for Assisting Sexual Assault Victims*, 2000.

Health care providers should explain, in a language the patients understand, the scope of confidentiality during the exam process and during communication with advocates. (For information on this topic, see A.4. *Confidentiality*.)

**Adapt the exam process as needed to address the unique needs and circumstances of each patient.** Patients' experiences during the crime and the exam process, as well as their post-assault needs, may be affected by multiple factors, such as:

- Age.
- Gender and/or perceived gender identity/gender expression.
- Physical health history and current status.
- Mental health history and current status.
- Disability.
- Language needs for limited English proficient patients, Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.
- Ethnic and cultural beliefs and practices.
- Religious and spiritual beliefs and practices.
- Economic status, including homelessness.
- Immigration and refugee status.
- Sexual orientation.
- Military status.
- History of previous victimization.
- Past experience with the criminal justice system.
- Whether the assault involved drugs and/or alcohol.
- Prior relationship with the suspect, if any.
- Whether they were assaulted by an assailant who was in an authority position over them.
- Whether the assault was part of a broader continuum of violence and/or oppression (e.g., intimate partner and family violence, gang violence, hate crimes, war crimes, commercial sexual exploitation, sex and/or labor trafficking).
- Where the assault occurred.
- Whether they sustained physical injuries from the assault and the severity of the injuries.
- Whether they were engaged in illegal activities at the time of the assault (e.g., voluntary use of illegal drugs or underage drinking) or have outstanding criminal charges.
- Whether they were involved in activities prior to the assault that traditionally generate victim blaming or self-blaming (e.g., drinking alcohol prior to the assault or agreeing to go to the assailant's home).
- Whether birth control was used during the assault (e.g., victims may already have been on a form of birth control or the assailant may have used a condom).
- Capacity to cope with trauma and the level of support available from families and friends.
- The importance they place on the needs of their extended families and friends in the aftermath of the assault.
- Whether they have dependents who require care during the exam, were traumatized by the assault, or who may be affected by decisions patients make during the exam process.
- Community/cultural attitudes about sexual assault, its victims, and offenders.
- Frequency of sexual assault and other violence in the community and historical responsiveness of the local justice system, health care systems, and community service agencies.

Clearly, the level of trauma experienced by patients can also influence their initial reactions to an assault and to post-assault needs. While some may suffer physical injuries, contract an STI, or become pregnant as a result of an assault, many others do not. The experience of psychological trauma will be unique to each patient and may be more difficult to recognize than physical trauma. People have their own method of coping with sudden stress. When severely traumatized, they can appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help.<sup>38</sup>

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<sup>38</sup> Paragraph adapted from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.

Examiners should ensure they do not make credibility determinations based on myths or misconceptions about victim behavior.

In addition, patients' fears and concerns can affect their initial reactions to the assault, their post-assault needs, and decisions before, during, and after the exam process. For example, female and transgender patients may be worried about getting pregnant. If they are already pregnant or have just given birth, they may be concerned about how the assault will affect their children. Patients may be concerned about being infected with HIV or another STI. They may not want anyone to know about the assault, or may be afraid that family members and friends will reject or blame them. They may fear bringing shame to their families or be concerned that family members will seek revenge against the assailant. They may fear perceived consequences of reporting to law enforcement. They may be concerned how their cultural background could affect the way they are treated by responders. They may wonder if the assailant will harm or harass them or their loved ones if they tell anyone about the assault. They may worry about losing their home, children, ability to remain in the United States, job, and other sources of income as a result of disclosure, particularly if an intimate partner assaulted them.<sup>39</sup> They may be concerned about costs related to the exam and subsequent care of injuries.<sup>40</sup>

It is important to avoid making assumptions about patients, offenders, and the assault itself. Forms used during the exam process and discussions with patients should be framed in a way that does not assume they are of a specific background or gender identity and gender expression. Always ask questions and actively look and listen to understand patients' circumstances and tailor the exam process to address their needs and concerns. Whatever the response, it should be respectful to patients and adhere to jurisdictional policies.

Recognize that patients control the extent of personal information they share. While it is useful for responders to get a full picture of patients' circumstances, it is up to patients to decide whether and to what extent to share personal information. During the exam process, responders may ask patients to divulge some data, such as age or whether they think the assault was alcohol- or drug-facilitated. Some information, such as language needs, may be obvious. There is no reason for responders to question patients about certain data, such as sexual orientation and gender identity, immigration status, or religious or spiritual beliefs, beyond certain information that medical providers may need for appropriate care.

**Develop culturally responsive care and be aware of issues commonly faced by patients from specific populations.** Develop culturally competent and sensitive care by building awareness about and sensitivity to the ways that culture can impact a person's experience in the immediate aftermath of sexual assault and across their lifespan. Be aware and responsive to the ways in which cultural identities (e.g., race, ethnicity, gender, religion, ability/disability, language (limited English proficiency), immigration status, socioeconomic status, sexual orientation, gender identity or expression, age) may influence a person's experience during the exam process as well. Education for responders on issues facing a specific population may serve to enhance care, services, and interventions provided during the exam process. Responders should identify different populations that exist in their jurisdiction and determine what information they should have readily available to help them serve patients from these populations, including what languages are spoken by the populations and how to access interpreters for each language needed. Building understanding of the perspectives of a specific population may help increase the likelihood that the actions and demeanor of responders will mitigate victim trauma. However, do not assume that patients will hold certain beliefs or have certain needs and concerns merely because they belong to a specific population. And, as pointed out earlier, recognize that patients' experiences are affected by a plethora of other personal and external factors.

Develop policies and plans. Involved agencies and SART/SARRTs should develop policies and plans to meet the needs of specific patient populations (e.g., to obtain necessary interpreter services and translated documents for limited English proficient patients, qualified interpreters for Deaf and hard-of-hearing patients and individuals with sensory or communication disabilities, and identify legal referrals for immigrant victims of sexual assault, domestic violence, dating violence, and stalking.) When creating these plans, consider what barriers exist for patients from different populations to receiving a high-quality exam and what can be done to

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<sup>39</sup> Minors may fear being removed from their homes if suspects live with them. Persons living in residential settings, such as group homes or nursing facilities, may fear being removed from their homes if they report an assault that occurred in that setting.

<sup>40</sup> Paragraph partially adapted from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2002, p. 2.

remove these barriers. Also, consider what equipment and supplies might be needed to assist persons from specific populations (e.g., a hydraulic lift exam table may be useful with victims who have a physical disability or non-gendered body maps for transgender patients). Relevant responders need to have access to and know how to use such equipment or supplies.

Partner with those who serve specific populations. Involved responders should seek expertise from and collaborate with organizations and leaders that serve specific populations. Not only may they be willing to provide information and training on working with victims from the population they serve, but they also may be a resource before, during, and after the exam process. If responders may be involved in the immediate response to victims, they should be trained on the dynamics of sexual victimization and procedures for getting help for victims and work with the multidisciplinary response team to clarify their roles and procedures for response.

Explore the needs of specific populations. To gain a basic understanding of potential issues and concerns facing different groups of sexual assault victims, this section explores several specific populations.<sup>41</sup> Clearly, this exploration is not inclusive of all populations of victims, but a more comprehensive discussion on this topic is beyond the scope of this document.

#### —Victims from various cultural groups

- Understand that culture can influence beliefs about sexual assault, its victims, and offenders. It can affect health care beliefs and practices related to the assault and medical treatment outcomes. It can also influence beliefs and practices related to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of victims to be involved in the system.<sup>42</sup>
- Understand that some victims may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own. They may fear or distrust responders or assume they will be met with insensitive comments or unfair treatment. They may benefit from responders of the same background or at least who understand their culture. Conversely, in smaller ethnic and racial communities, victims may be more likely to know the responder and doubt the responder's ability to maintain confidentiality.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disrobe. Also, it may be uncomfortable for victims from some cultures to speak about the assault with members of the opposite sex.
- Understand that victims may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage is devastating and may render victims unacceptable for an honorable marriage. Even discussing an assault or sexual terms may be linked with intense embarrassment and shame in some cultures.
- Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, race, ethnicity, and religion may vary greatly among victims of different cultural backgrounds. Also, understand that what helps one victim deal with a traumatic situation like sexual assault may not be the same for another victim.
- Help victims obtain culturally specific assistance and/or provide referrals where they exist.<sup>43</sup>

#### —Victims with limited English proficiency<sup>44</sup>

<sup>41</sup> This section was adapted partially from Connecticut's *Technical Guidelines for Health Care Response to Victims of Sexual Assault*, 1998, pp. 12–14, and from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.

<sup>42</sup> Bullet drawn from A. Blue, *The Provision of Culturally Competent Health Care*, from the Web site of the Medical University of South Carolina College of Medicine ([http://academicdepartments.musc.edu/fm\\_ruralclerkship/curriculum/culture.htm](http://academicdepartments.musc.edu/fm_ruralclerkship/curriculum/culture.htm)).

<sup>43</sup> For example, to raise their level of hope and comfort during the exam, some patients may benefit from talking about culturally specific models of healing (where they exist) and their application to recovery from sexual assault. To facilitate such a discussion, they may wish to speak with a religious or spiritual healer from their culture.

<sup>44</sup> The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) *New & Revised Standards & EPs for Patient-Centered Communication, Accreditation Program: Hospital*, HR.01.02.01, PC.02.01.21, RC.02.01.01, RI.01.01.01, RI.01.01.03, effective January 1, 2011, [http://medicine.osu.edu/orgs/ahec/Documents/Post\\_PatientCenteredCareStandardsEPs\\_20100609.pdf](http://medicine.osu.edu/orgs/ahec/Documents/Post_PatientCenteredCareStandardsEPs_20100609.pdf) (PDF); Joint

- Be patient and understanding toward victims' language skills and barriers, which may worsen with the crisis of sexual assault.<sup>45</sup>
- Develop policies and train responders to be able to identify a victim's limited English proficiency and primary language spoken and written.
- Make every attempt to provide same language service through the use of demonstrably bilingual examiners or by providing monolingual examiners with support from professional interpretation services and translated materials for victims who are not proficient in English,<sup>46</sup> are LEP or who may prefer to communicate in a non-English language. Use qualified interpreters when possible and not victims' families or friends.<sup>47</sup> Take the victim's country of origin, acculturation level, and dialect into account when responding or arranging interpretation.<sup>48</sup> Remember to speak directly to victims when interpreters are used. Consider the victim's need for modesty and privacy when determining where interpreters should be located in the exam room.
- Train interpreters about issues related to sexual assault and the exam process<sup>49</sup> whenever they are needed to facilitate communication in these cases. Ensure that the examiners are trained in the proper utilization and ethical requirements of using an interpreter.
- Make sure that interpreters understand that they may need to testify.<sup>50</sup>
- Understand that immigrant victims may fear that assisting law enforcement may identify them to immigration authorities for deportation.
- All sexual assault victims should be provided information regarding U-Visa relief, in the event that this information would be helpful. Even if this information is not helpful to them directly, the information is often passed on to others by word of mouth and can benefit others in the future.
- Work with law enforcement partners to develop and publicize protocols precluding detention or other immigration enforcement against victims who come forward to report a sexual assault.
- Work with law enforcement to develop and publicize U-Visa certification protocols.
- While it is not appropriate to ask a victim's immigration status, anticipate that an immigrant victim will not self-identify as undocumented for fear of deportation. Such information about their rights should be offered in a non-judgmental manner to all victims and in coordination with a referral to an immigration service provider expert in working with immigrant victim populations.

#### —Victims with disabilities

- Understand that victims with disabilities may have physical, sensory, cognitive, developmental, or mental health disabilities, or a combination of disabilities. Make every effort to recognize issues that arise for victims with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.
- Be aware that the risk of criminal victimization (including sexual assault) for people with disabilities is much higher than for people without disabilities. People with disabilities are often victimized

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Commission, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care*, Appendix B, August 2010, <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>.

<sup>45</sup> Carolyn Ham, Reducing Language Barriers to Combating Domestic Violence: The Requirements of Title VI, Battered Women's Justice Project, October 2004, [http://new.vawnet.org/summary.php?doc\\_id=1621&find\\_type=web\\_desc\\_GC](http://new.vawnet.org/summary.php?doc_id=1621&find_type=web_desc_GC).

<sup>46</sup> Health care providers generally are covered by language access requirements under Title VI which requires them to take reasonable steps to provide language-appropriate health care, including the use of qualified bilingual staff, interpreters, and translators.

<sup>47</sup> Use of such informal and biased interpreters may result in unreliable communication, violate the patient's privacy, undermine the patient's claim of privilege, and jeopardize the use of the victim's statements in court. In cases of intimate partner sexual assault, it is particularly important not to use family members who are not likely to adopt a neutral stance or maintain the confidentiality necessary.

<sup>48</sup> For example, a Cuban interpreter may encounter language and trust obstacles when trying to communicate with a victim from rural Mexico. (L. Zarate, Suggestions for Upgrading the Cultural Competency Skills of SARTs, Arte Sana Web site, <http://www.arte-sana.com>, 2003.)

<sup>49</sup> Professional interpreters are expected to be familiar with confidentiality requirements and cultural issues.

<sup>50</sup> Interpreters would not be expected to act as witnesses as to what was said in the examination room if they are present solely to facilitate direct communication between the patient and examiner.

repeatedly by the same offender.<sup>51</sup> Caretakers, family members, or friends may be responsible for the sexual assault. In such cases, offenders may bring victims to the exam site, and jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.

- Respect victims' wishes to have or not to have caretakers, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of victims during the exam process. If aid is required (e.g., from a language interpreter or mental health professional), those providing assistance should not be associated with victims.
- Follow exam facility and jurisdictional policy for assessing vulnerable adults' ability to consent to the exam and evidence collection and involving protective services. Again, note that guardians could be offenders. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see A.3. *Informed Consent*.)
- Speak directly to victims with disabilities, even when interpreters, intermediaries, or guardians are present.
- Assess a victim's level of ability and need for assistance during the exam process. Explain exam procedures to victims and ask what help they require, if any (e.g., people with physical disabilities may need assistance to get on and off the exam table or to assume positions necessary for the exam, or may need an alternative to the standard table). But, do not assume they will need special aid. Ask for permission before proceeding to help them (or touch them, handle a mobility or communication device, or touch a service animal).<sup>52</sup>
- Note that not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to victims with sensory disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using such devices.<sup>53</sup> Let the individual specify the preferred method of communication. Be aware that victims with sensory disabilities may prefer communicating through an intermediary who is familiar with their patterns of speech.
- Recognize that individuals may have some degree of cognitive disability: mental retardation, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke. Speak to victims in a clear and calm voice and ask very specific and concrete questions. Be exact when explaining what will happen during the exam process and why. Be aware that victims with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions, conduct the exam in an area that is void of bright lights and loud noises. It may also be helpful if examiners and others present in the exam room refrain from wearing uniforms with ornamental designs and jewelry.
- Keep in mind that victims with disabilities may be reluctant to report the crime or consent to the exam for a variety of reasons, including fear of not being believed, fear of getting in trouble, and fear of losing their independence. For example, they may have to enter a long-term care facility if their caretakers assaulted them or may need extended hospitalization to treat and allow injuries to heal. The perpetrator may also be their caregiver and the only person they rely on for daily living assistance.
- Recognize that it may be the first time victims with disabilities have an internal exam. The procedure should be explained in detail in language they can understand.<sup>54</sup> They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.
- Some victims with disabilities may want to talk about their perceptions of the role their disability might have played in making them vulnerable to an assault. Listen to their concerns and what the

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<sup>51</sup> The above two sentences are drawn from the Office for Victims of Crime, *First Response to Victims of Crime Who Have a Disability*, 2002, p. 1.

<sup>52</sup> Examples of service animals include guide dogs and hearing-assistance dogs, and therapy dogs.

<sup>53</sup> Note that individuals may have their own assistive devices, but words needed to communicate may have to be programmed.

<sup>54</sup> Drawn from A. Conrad, *SANE/SAFE Organizing Manual*, 1998, p. 7, developed for the New York State Coalition Against Sexual Assault.

experience was like for them.<sup>55</sup> Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future.

- Recognize that the exam may take longer to perform with victims with disabilities. Avoid rushing through the exam—such action not only may distress victims, it can lead to missed evidence and information.

#### —Male victims<sup>56</sup>

- Help male victims understand that male sexual assault is not uncommon and that the assault was not their fault. Many male victims focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may help reduce their self-blame.
- Because some male victims may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process.
- Offer male victims assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender).
- Male victims may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.
- Encourage advocacy programs and the mental health community to build their capacity to serve male sexual assault victims and increase their accessibility to this population. Requests by male victims to have an advocate of a particular gender should be respected and honored if possible.<sup>57</sup>

#### —Adolescent victims<sup>58</sup>

- Adolescents may be brought to the exam site by their parents or guardians. The presence of parents or guardians creates an additional challenge for those involved in the exam process because they are often traumatized by their child's victimization.
- Understand that parents or guardians may blame victims for the assault if the victim disobeyed them or engaged in behaviors perceived as increasing risk for victimization.
- Health care providers must assess the physical development of adolescent victims and take their age into consideration when determining appropriate methods of examination and evidence collection.<sup>59</sup> Involved professionals should be well versed in jurisdictional policies related to response to minor victims.
- Be aware of jurisdictional laws governing minors' ability to consent to forensic exams and medical treatment. Follow exam facility and jurisdictional policy in obtaining appropriate consent. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see A.3. *Informed Consent*.)
- Recognize that the sexual assault medical forensic exam may be the first time an adolescent female victim has an internal exam. There may be a need to go into detail when explaining what to expect.<sup>60</sup>

<sup>55</sup> Drawn from L. Ledray, *SANE Development and Operation Guide*, 2000, pp. 82–85.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

<sup>56</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 79.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

<sup>57</sup> A national resource for male patients is Male Survivor: The National Organization Against Male Sexual Victimization. Contact information: PMB 103, 5505 Connecticut Avenue, NW, Washington, DC 20015–2601, 800–738–4181, <http://www.malesurvivor.org>.

<sup>58</sup> Adapted partially from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2011, pp. 26–27.

<http://www.fris.org/Resources/PDFs/Books/WVProtocol.pdf>.

<sup>59</sup> For example, the size of the speculum used with adolescent female victims and exam positions of victims may vary.

<sup>60</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 7.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

- Adolescence is often a time of experimentation. Reassure these victims that regardless of their behavior (e.g., using alcohol and drugs, engaging in illegal activities, or hitchhiking), no one has the right to sexually assault them, and they are not to blame for the assault.
- Ideally, attending health care providers should gather information from adolescents without parents or guardians in the room, subject to victims' consent. The concern is that parents or guardians may influence or be perceived as influencing victims' statements.
- Inform victims, particularly those who do not involve parents or guardians in the exam process, of facility billing practices (e.g., that their parents may get a bill from the medical facility for medical treatment provided or an explanation of benefits from their insurance provider).<sup>61</sup>
- Be aware of mandatory reporting laws regarding minor victims and explain to the victim any mandatory reporting obligations.

—Older victims

- Keep in mind that the emotional impact of the assault may not be felt by older victims until after the exam when they are alone in the days, weeks, and months following an attack. Older victims may feel common trauma reactions such as being physically vulnerable, reduced resiliency, and mortality. Fear, anger, and depression can be especially severe in older victims who are isolated, have little support, and live on a fixed or limited income.<sup>62</sup>
- Be aware that caretakers may sexually assault older adults. Older adults may be dependent on these sexual offenders for emotional or financial support or housing. Offenders may bring victims to the exam site. Some offenders may be charming to staff while others may be threatening or menacing. Jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.
- Note that older victims may be more physically fragile than younger victims and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities.<sup>63</sup>
- Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial trauma reaction to the assault, may render some older victims unable to make their needs known, which could result in prolonged or inappropriate treatment.<sup>64</sup>
- Do not mistake disabilities (such as hearing loss or aphasia) or acute stress reaction following assault for senility. Use of appropriate communication remedies, for example, a personal listening device, may enable an older adult with a severe hearing loss to communicate effectively. Also, be aware that older adults typically process information more slowly than younger adults and take longer to put their thoughts into words. This is a normal age-related change and should not be viewed as evidence of lack of mental capacity. Health care professionals treating elders need to speak slowly and clearly and give elders ample time to process information provided and formulate responses. If questions about the victim's capacity arise, contact trained experts to conduct an assessment.
- If a forensic medical exam has been requested by a law enforcement officer, guardian, or other authority, it is still important to obtain the victim's consent and cooperation to forensic evidence-gathering procedures. Those making the request may argue that evidence collection may be especially important because the victim may be unable to provide a statement or testify. However, when victims lack capacity and are unable to provide consent and cooperation, they should not be

<sup>61</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 98.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

<sup>62</sup> Ibid.

<sup>63</sup> Older women are at an increased risk for vaginal tears and injury when they have been vaginally assaulted. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. Because of these physiological changes, a Pedersen speculum, which is longer and thinner than the Graves speculum, should be used during the pelvic exam for evidence collection. Special care should also be taken to assess for intravaginal injury. In some older women, examiners will need to simply insert the swabs and avoid the trauma of inserting a speculum. If there are external tears in the introitus, internal injuries must also be considered. The recovery process for older victims also tends to be longer than for younger victims.

(Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 86-87.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.)

<sup>64</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 87.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

forcibly examined or subjected to forensic procedures that are not necessary for their own health and safety.

- Health care personnel should follow facility policy for assessing a vulnerable adult's ability to consent to the exam and evidence collection, as well as involving adult protective services.
- Some older victims may want to talk about their perceptions of the role their age and physical condition might have played in making them vulnerable to an assault. Others may be traumatized by being harmed sexually by a family member or trusted caregiver. Listen to their concerns and what the experience was like for them.<sup>65</sup> Assure them that it was not their fault they were sexually assaulted. If needed, encourage further discussion on this issue in a counseling/advocacy setting.
- Some older victims may be reluctant to report the crime or seek treatment because they fear losing their independence. Some older sexual assault victims may need a significant amount of time to recover from injuries that are the result of the abuse or attack. When a change in a living environment, such as placement in a residential facility, is truly needed, older victims who have not been adjudicated as lacking mental capacity and requiring guardians have the legal right to make their own decisions regarding choice of residence. Health care providers must avoid colluding with relatives who want to force older adults into unwanted lifestyle changes subsequent to assault.
- Older adults who have been sexually assaulted in care facilities often experience intense feelings of vulnerability in those facilities following sexual assault and desperately want to be relocated. Elders who rely upon others for care are likely to need the assistance of relatives and involved professionals in being safely relocated.
- Encourage use of follow-up medical, legal, and nonlegal assistance. Older victims may be reluctant to seek these services or proceed with prosecution. If barriers to accessing services or ongoing health care exist, such as lack of transportation, work with local service providers to identify potential remedies.

#### —Victims in the military<sup>66</sup>

- The military offers victims the option of restricted reporting or unrestricted reporting.<sup>67</sup> Restricted reporting allows a sexual assault victim to confidentially disclose the details of his or her assault to specified individuals and receive medical treatment and counseling without triggering the official investigative process or command notification. Restricted Reporting can be voided if the medical facility contacts law enforcement or other professionals other than advocates, chaplains, and military sexual assault response coordinators.
- Exam sites that provide exams for military installations are encouraged to draft Memoranda of Understanding to address such issues as confidentiality and storage of evidence.

#### —American Indian and Alaska Native victims

- Keep in mind that American Indian and Alaska Native victims may have unique cultural or language needs, whether they are assaulted in Indian Country or an Alaska Native village or in an urban area.
- Recognize that Indian tribes may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault. Responders should be familiar with procedures for coordinating services and interventions for victims from these

<sup>65</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, pp. 82-85.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneuide.pdf>.

<sup>66</sup> The Office for Victims of Crime (OVC) has developed a resource to assist address sexual assault in the military. *Strengthening Military-Civilian Community Partnerships to Respond to Sexual Assault* is a training curriculum and tool kit for community-based civilian rape crisis centers and state sexual assault coalitions to use in their work with the military installations in their regions. Funding for this project was provided by OVC and the Office on Violence Against Women (OVW), and was developed by the Pennsylvania Coalition Against Rape (PCAR) and the National Sexual Violence Resource Center (NSVRC) in coordination with the Department of Defense's Sexual Assault Prevention and Response Office. Through OVC's Training and Technical Assistance Center (OVC TTAC) the curriculum and tool kit will be available for communities to use in their regions to train on enhancing community response, and effectively responding to the needs of sexual assault victims in the military.

<sup>67</sup> For more information on reporting in the military, please see <http://www.sapr.mil/>.

communities and should work with community groups to develop plans for providing exams to members of Indian tribes. These plans should address evidence preservation and provide examination payment and reimbursement information. Responders within tribal communities should share resources and information to enable them to develop their own protocols and programs that address the community's unique needs.

- Promote partnerships among tribal and relevant federal and state agencies so they better coordinate responses and resources, learn from past mistakes, and strive towards a shared vision of aiding and empowering victims.
- Be aware that tribal jurisdictions may have their own SAFE protocol in place that addresses the tribe's unique needs and incorporates its cultural traditions, practices, and language.
- As in many cultures, American Indian/Alaska Native women are of central and primary importance to the family and the community. Be mindful that sexual violence against a Native woman may be seen as an assault on both the individual and her community.
- Be sensitive to victims' cultural beliefs and practices. The best practice is to always ask victims rather than assume what they need to be safe, address their health concerns, be supported in inner healing, and feel a sense of justice.
- Be aware of the tribe's history. Responders should have an understanding of the impact of history on American Indian/Alaska Native people as it may influence victims' reactions and needs. Adequate self-education combined with training by tribal members can prepare non-Native responders to be sensitive to the historical context in which victimization occurs and to avoid assumptions about victims' cultural practices.
- Recognize that there are multiple ways for victims to seek justice—through criminal justice interventions, tribal justice systems, and use of more traditional practices of the tribe related to holding perpetrators accountable, and/or other victim-identified strategies.
- Include American Indian/Alaska Native populations in Limited English Proficiency protocols for victims of sexual assault.

#### —Lesbian, gay, bisexual, or transgender (LGBT) victims

- Intake forms and other documents that ask about gender or sex should allow patients to write in a response, or include transgender and intersex options. Make sure questions appropriately distinguish between sexual orientation (the gender(s) someone is attracted to), gender identity (the internal sense of being woman, man, or gender non-conforming), and their sex.
- Always refer to victims by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
- Treat the knowledge that the person is LGBT as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBT victims may not know their gender identity or sexual orientation.

Additional suggestions specific to victims who are transgender or gender non-conforming:

- It is critical to not show surprise, shock, dismay, or concern when you are either told or inadvertently discover that a person is transgender. Be especially careful about your body language – gasping, sighing, a sharp intake of breath, or widening eyes can all be very upsetting to someone who may worry that you are making a judgment or assessment of their body.
- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Keep in mind that transgender victims may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the victim does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body

- parts at all. Reflect the victim's language when possible and use alternative means of communication (such as anatomically correct dolls or paper and pen for the victim to write or draw) if necessary
- Vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault. There may be additional layers of psychological trauma for patients with a male identity or a constructed vagina when they have been vaginally assaulted.
  - Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.
  - Transgender people may engage in self-harm as a coping mechanism. However, cutting and genital mutilations are also frequently part of anti-transgender hate crimes. Be nonjudgmental and careful when documenting such injuries.
  - Some transgender victims may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Because of their value in possible prosecutions under hate crime laws, document any anti-transgender statements the victim says were made during the assault. Otherwise, listen to the victim's concerns and what the experience was like for them. Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future.
  - Ensure that all referrals given to a transgender victim have been trained on or have significant experience with the special needs of transgender survivors of sexual assault.
  - Include opportunities for LGBT individuals to influence the development of sensitive responses for victims of sexual assault.

**Recognize the importance of victim services within the exam process.** In many jurisdictions, sexual assault victim advocacy programs and other victim service programs offer a range of services before, during, and after the exam process (see below for a description of typical services). Ideally, advocates should begin interacting with victims in a language the victims understand prior to the exam, as soon after disclosure of the assault as possible. Victims who come to exam sites in the immediate aftermath of an assault are typically coping with trauma, anticipating the exam, and considering the implications of reporting. Most responders that victims come in contact with are focused on objective tasks. Law enforcement officials gather information and collect crime scene evidence to facilitate the investigation. Health care personnel assess medical needs, offer treatment, and collect evidence from victims. Victims must make many related decisions that may seem overwhelming. Advocates<sup>68</sup> can offer a tangible and personal connection to a long-term source of support and advocacy. Community-based advocates, in particular, have the sole purpose of supporting victims' needs and wishes. Typically, these advocates are able to talk with victims with some degree of confidentiality, depending on jurisdictional statutes, while statements victims make to examiners become part of the medical forensic report.<sup>69</sup> When community-based advocates support victims, examiners can more easily maintain an objective stance.<sup>70</sup> In addition, civil attorneys may be able to help victims assess legal needs and options, including privacy, safety, immigration, housing, education, and employment issues.

Be aware of the extent of services. Services offered by advocates during the exam process may include:<sup>71</sup>

- Accompanying the victims through each component (advocates may accompany victims from the initial contact and the actual exam through to discharge and follow-up appointments).
- Serving as an information resource for victims (e.g., to answer questions; explain the importance of prompt law enforcement involvement if the decision is made to report; explain the value of medical and evidence collection procedures; explain legal aspects of the exam; help them understand their

<sup>68</sup> To prepare them to competently provide sexual assault victim services, community-based advocates are typically trained according to the policies of the sexual assault advocacy agency where they are employed/volunteer and receive supervision related to their interactions with victims. In addition, many jurisdictions have specific requirements that community-based advocates must meet in order to fit within jurisdictional confidentiality or privilege laws. Advocates should meet these requirements. System-based advocates may be required to have specific credentials based on system and jurisdictional policies and laws.

<sup>69</sup> K. Littel, *SANE Programs: Improving the Community Response to Sexual Assault Victims*, 2001, p. 6.

<sup>70</sup> Ibid. See also IAFN position statement Dated Nov 19, 2008: Collaboration with Advocates

<http://iafn.org/associations/8556/files/IAFN%20Position%20Statement-Advocate%20Collaboration%20Approved.pdf>.

<sup>71</sup> This bulleted section was drawn partially from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, p. 7, and the 1989 *Volunteer Manual of Virginians Aligned Against Sexual Assault (VAASA)*.

treatment options for STIs, HIV, and pregnancy; serve as a resource and follow-up point of contact for any future inquiries such as payment method for the exams; and provide referrals).

- Assisting in coordination of victim transportation to and from the exam site.
- Providing victims with crisis intervention<sup>72</sup> and support to help cope with the trauma of the assault<sup>73</sup> and begin the healing process.
- Actively listening to victims to assist in sorting through and identifying their feelings.
- Letting victims know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault.
- Advocating for victims' self-articulated needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting victims in voicing their concerns to relevant responders.
- Responding in a culturally and linguistically sensitive and appropriate manner to victims from different backgrounds and circumstances and advocating for the elimination of barriers to communication.
- Providing replacement clothing when clothing is retained for evidence, as well as toiletries.
- Aiding victims in identifying individuals who could support them as they heal (e.g., family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers).
- Helping victims' families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support victims may need from them.
- Assisting victims in planning for their safety and well-being.

Postexam, advocates can continue to advocate for victims' rights and wishes; offer victims ongoing support, counseling,<sup>74</sup> information, and referrals for community services; assist with applications for victim compensation programs;<sup>75</sup> and encourage victims to obtain follow-up testing and treatment and take medications as directed. They can also accompany victims to follow-up appointments, including those for related medical care and criminal and civil justice-related interviews and proceedings. They can work closely with the responders involved to ensure that postexam services and interventions are coordinated in a complementary manner and are appropriately based on victims' needs and wishes.

Contact the victim service/advocacy program immediately. Utilize a system in which exam facility personnel, upon initial contact with a sexual assault patient, call the victim service/advocacy program and ask for an advocate to be sent to the exam site (unless an advocate has already been called).<sup>76</sup> Prior to introducing the advocate to a patient, exam facility personnel should explain briefly, in a language the patient understands, the victim services offered and ask whether the victim wishes to speak with the onsite advocate. Note that some jurisdictions require that patients be asked whether they want to talk with an advocate before the advocate is contacted.<sup>77</sup> If possible, victims should be allowed to meet with advocates in a private place prior to the exam. Ideally, a patient should be assisted by the same advocate during the entire exam process.<sup>78</sup>

<sup>72</sup> Crisis intervention counseling is short term in nature, aimed at returning individuals to their precrisis state through the development of adaptive coping responses. Broadly, it entails establishing a relationship with the individual in crisis, gathering information about what is occurring, clarifying the problem, helping the individual identify options and resources so that they are able to make an informed decision as to what, if any, actions will be taken. (Adapted from the 1991 Women Helping Women *Volunteer Training Manual*, Cincinnati, Ohio.) Note: Crisis intervention is not intended to address longer term counseling and advocacy needs.

<sup>73</sup> See A. Burgess and L. Holmstrom, Rape Trauma Syndrome, *American Journal of Psychiatry*, 131: 981-986, September 1974, for a summary of the psychological, somatic, and behavioral impact of sexual assault on victims.

<sup>74</sup> Many advocacy agencies offer ongoing support and advocacy to victims. Some also provide professional mental health counseling, but many refer victims to community or private agencies.

<sup>75</sup> For more information on crime victim's compensation, please see

<http://www.ovc.gov/publications/factsheets/companassist/welcome.html>.

<sup>76</sup> Use community-based sexual assault victim advocates where possible. If not available, victim service providers based in the exam facility, criminal justice system, social services, or other agencies may be able to provide some advocacy services if educated to provide those services. Patients should be aware that government-based service providers typically cannot offer confidential communication.

<sup>77</sup> In very small communities, patients may know some or all advocates (e.g., a small, close-knit community that speaks an uncommon dialect). Some patients may feel comfortable being supported by an advocate known to them while others may not. Patients concerned about anonymity should be provided with as many options as possible. For example, ask if they would like to speak with an on-call advocate on the phone prior to making their decision about whether they want an advocate present during the exam. Another option may be for the local advocacy program to partner with an advocacy program in a neighboring jurisdiction, so they can provide one another with backup to handle situations such as this one.

<sup>78</sup> Continuity of advocates can be challenging when response by other professionals is delayed, the exam process is lengthy, or travel to the exam site is considerable. Volunteers may or may not be able to continue providing services after the end of their on-call shift.

Understandably, immigrant victims may be reluctant to discuss or report the victimization. It is inappropriate to ask patients about aspects of their health, body, legal status, or identity that are not related to the assault. It is, however, appropriate to ensure that all victims are provided with information regarding U-Visas, in the event that this relief would be appropriate.<sup>79</sup>

**Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.**<sup>80</sup> An exception would be if responders consider the request to be potentially harmful to the patient or the exam process.<sup>81</sup> Patients' requests to not have certain individuals present in the room should also be respected (e.g., adolescents may not want their parents present). Examiners should get explicit consent from patients to go forward with the exam with another person present. When others are present, appropriately drape patients and position additional persons. (It is also important to inform patients of confidentiality considerations regarding the presence of support persons during the medical forensic history. For a discussion of this topic, see *C.4. The Medical Forensic History.*)

Strive to limit the number of persons (beyond the patient, examiner, advocate, personal support person, and any necessary interpreters) in the exam room during the exam. The primary reason is to protect patients' privacy, but also because exam rooms often cannot accommodate more than a few individuals. Law enforcement representatives should not be present during the exam. When additional health care personnel are needed for consultation (e.g., a surgeon), patients' permission should be sought prior to their admittance. In cases in which examiners are supervising an examiner-in-training/licensed health care student, patients' consent should be obtained prior to the student's admittance to examine patients or observe the exam. It is inappropriate to ask patients to allow a group of nonlicensed medical students to view the exam. It is also inappropriate to ask patients about aspects of their health, body, legal status, or identity that are not related to the assault.

**Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible.** For a variety of reasons, some patients may prefer to work with a male or female law enforcement official, advocate, and/or examiner.

**Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.** In addition, it is important to explain the exam process and the purpose of the exam more generally (e.g., how the evidence may be used by the criminal justice system). A clear explanation is particularly important for individuals who may not previously have had a pelvic exam or medical care, or who have difficulty understanding what has happened and why they are being asked to undergo a medical forensic exam. Remember that some exam procedures may be uncomfortable and painful to patients, considering the nature of the trauma they have experienced. By taking the time to explain procedures and their options, patients may be able to better relax, feel more in control of what's occurring, and make decisions that meet their needs. After providing the needed information, seek patients' permission to proceed with exam procedures. (For a more detailed discussion on seeking informed consent of patients, see *A.3. Informed Consent.*)

**Address and respect patients' priorities.** Although medical care and evidence collection may be encouraged during the exam process, responders should provide patients with information about all of their options and assess and respect their priorities.

**Integrate medical and evidentiary procedures where possible.** Medical care and evidence collection procedures should be integrated to maximize efficiency and minimize trauma to patients. For example, draw blood needed for medical and evidentiary purposes at the same time. Also, coordinate information-gathering by health care and legal personnel to minimize the need for patients to repeat their statements. (For more information on coordination in information gathering, see *C.4. The Medical Forensic History.*) Consider the

<sup>79</sup> Legal Momentum has extensive resources available regarding U-Visas. See: <http://www.legalmomentum.org/our-work/immigrant-women-program/u-visa.html>. Additionally, immigrant women are entitled to emergency medical and post-assault healthcare. For a state-by-state breakdown of the benefits afforded see: [http://www.legalmomentum.org/assets/pdfs/4\\_niic\\_table\\_10.pdf](http://www.legalmomentum.org/assets/pdfs/4_niic_table_10.pdf).

<sup>80</sup> Paragraph partially drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 15.

<sup>81</sup> For example, in cases involving adolescents or vulnerable adults, caretakers should not be allowed in the exam room if they are suspected of committing the assault or of being otherwise abusive to the patient.

implications of the evolving law on hearsay exceptions when determining the level and nature of coordination. See *Appendix C* for more information on the relevant case law and how it relates to medical forensic examinations.

**Address patients' safety during the exam.** When patients arrive at the exam site, health care providers should assess related safety concerns. For example, a caretaker, partner, or family member who is suspected of committing the assault may have accompanied the patient to the facility. Some victims, including transgender people, may also fear assault or belittlement by health care professionals' and/or law enforcement officials' responses to their gender identity or expression and/or transgender body. Follow facility policy on response to this and other types of threatening situations. Also, exam sites should have plans in place to protect patients from exposure to potentially infectious materials during the examination. (See *B.1. Sexual Assault Forensic Examiners.*) Prior to discharge, assist victims in planning for their safety and well-being. Planning should take into account needs that may arise in different types of cases. For example, patients who know the assailants may not be concerned only about their ongoing safety but also about the safety of their families and friends. Local law enforcement may be able to assist facilities in addressing patients' safety needs. (See *C.10. Discharge and Follow-up.*)

**Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.**<sup>82</sup> Information should be tailored to patients' communication skill level/modality and language. This includes providing interpreter services and the translation of documents into languages other than English for limited English proficient (LEP) patients. Developing material in alternative formats may be useful, such as information that is taped, in Braille, in large print, in various languages, or uses pictures and simple language.<sup>83</sup> A victim booklet or packet that includes information about the following topics may be helpful:

- The crime itself (e.g., facts about sexual assault and related criminal statutes).
- Normal reactions to sexual assault (stressing that it is never the victim's fault), and signs and symptoms of traumatic response.
- Victims' rights.
- Victim support and advocacy services.
- Civil, criminal, and immigration legal services.
- Mental health counseling options and referrals.
- Resources for the victim's significant others.
- The examination—what happened and how evidence/findings will be used.
- Medical discharge and follow-up instructions.
- Planning for the victim's safety and well-being.
- Examination payment and reimbursement information.
- Steps and options in the criminal justice process.
- Civil and immigration remedies that may be available to sexual assault victims.
- Procedures for victims to access their medical record or applicable law enforcement reports.

**Address physical comfort needs of patients prior to discharge.** For example, provide them with the opportunity to wash in privacy (offering shower facilities if at all possible<sup>84</sup>), brush their teeth, change clothes (clean and ideally new replacement clothing should be available); get food and/or a beverage, and make needed phone calls. They may also require assistance in coordinating transportation from the exam site to their home or another location.

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<sup>82</sup> Many local sexual assault advocacy programs and state coalitions of sexual assault programs offer publications that speak to victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council could develop such literature.

<sup>83</sup> For example, one sexual assault advocacy program offers a booklet "for those who read best with few words" designed for people with developmental disabilities who have been sexually assaulted. For more information on this publication, contact the Los Angeles Commission on Assaults Against Women by phone (213-955-9090) or e-mail [info@lacaaw.org](mailto:info@lacaaw.org).

<sup>84</sup> It would be useful for the exam room to have an attached bathroom with a shower.

### 3. Informed Consent

Recommendations at a glance for health care providers and other responders for requesting patients' consent throughout the exam process:

- Seek the informed consent of patients as appropriate throughout the exam process.
- Make sure policies exist to guide the process of seeking informed consent from specific populations.

**Seek the informed consent of patients as appropriate throughout the exam process.** There are two essential but separate consent processes—one for overall medical evaluation and treatment and a second for evidence collection and release. Patients should understand the full nature of their consent to each procedure, whether it is medical or evidentiary (e.g., what the procedure entails, possible side effects, limits of confidentiality, and potential impact). The only way to put patients in the position of being able to make informed decisions about whether to allow a procedure is by presenting them with all relevant information in a language they understand. Patients can decline any part or all of the examination. However, the informed consent process includes making patients aware of the impact of declining a procedure, as it may negatively affect the quality of care and the usefulness of evidence collection. It may also have a negative impact on a criminal investigation and/or prosecution both because evidence not collected may have been useful and because defense attorneys in a civil or criminal case may use the fact that the victim declined a procedure to claim that the victim is hiding something that would have been revealed by that procedure. They should understand that declining a procedure might also be used by opposing counsel to discredit the victim at trial.

Before making any disclosures, patients should be advised whether their communications are confidential and whether the confidentiality of the statements is covered by a privilege. Understanding what will happen to the information provided and the extent to which it may be protected is an important component of informed consent.

Health care providers and other responders must refrain from any judgment or coercive practice in seeking patients' consent. It is contrary to ethical and professional practices to influence their decisions.

Seek both verbal and written consent as required by policy. In addition to verbally providing information and seeking consent throughout the exam process, written consent of patients may be needed in order to carry out specific procedures. Verbal and written consent from patients who are limited English proficient may require the use of foreign language interpreters for verbal consent and for written consent to have the interpreters provide a sight translation of written documents and the translation of consent forms and other documents into non-english languages.<sup>85</sup> It is important that jurisdictions, agencies, and exam facilities make it very clear to responders when written consent is necessary, how it should be sought, and provide appropriate checklists and forms to facilitate obtaining written consent in a consistent manner.

Methods to inform patients verbally and seek their consent vary significantly across jurisdictions and individuals requesting consent. For example, some examiners ask patients to voice their consent to each exam procedure while others explain from the start that they need patients to tell them if they want to stop at any time. While respecting the individual communication styles of responders, the process of obtaining consent can be enhanced when they are educated on how to seek verbal consent logistically in a way that is consistent across patients and helps facilitate the exam process as specified by the jurisdiction and facility.

Verbal and written information given to patients to facilitate the consent process should be complete, clear, and concise. This information, along with consent forms, should be tailored to the communication skill level/modality and language of patients. Responders should be aware of verbal and nonverbal cues from patients and adjust their methods of seeking consent to meet patients' needs. Encourage patients to ask questions and to inform relevant responders if they need a break or information repeated or do not want a particular part of the exam process done. Make sure all signatures and dates needed are obtained on written

<sup>85</sup> See The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) New & Revised Standards & EPs for Patient-Centered Communication, Accreditation Program: Hospital, RI, 01.01.03, effective January 1, 2011.

consent forms and document consent or reasons for declining to consent as appropriate (either on the medical record or forensic report forms).

Seek consent for medical evaluation and treatment in a language that the patient understands. Follow facility policy for seeking patients' consent for medical evaluation and treatment. Any written medical consent forms developed for the purpose of the exam may need to be reviewed and approved by facility administration. Documentation on consent for medical evaluation and treatment becomes part of the medical record. Informed consent of patients for medical evaluation and treatment typically is needed for the following:

- General medical care.
- Pregnancy testing and care.
- Testing and prophylaxis for STIs.
- HIV prophylaxis.
- Photographs, including colposcopic images.
- Permission to contact the patient for medical purposes.
- Release of medical information.

Seek consent for evidence collection and release in a language that the patient understands. Follow jurisdictional procedure for obtaining informed consent for the exam and evidence collection. Informed consent of patients typically is needed for:

- Notification to law enforcement or other authority (depends upon reporting requirements).
- Evidence collection and release.
- Toxicology screening.
- Release of information and evidence to criminal justice system personnel, SART/SARRT members, and partnering service providers.
- Contact with patients for reasons related to their criminal sexual assault case.
- Patient notification in case of a DNA match or additional victims.

Patients should be informed that data without patient identity can be collected from the report for health and forensic purposes by health authorities or other qualified persons with a valid educational or scientific interest for demographic and/or epidemiologic studies.

Responders should coordinate efforts to seek patients' consent. On a jurisdictional level, SART/SARRTs (or involved responders if a SART/SARRT does not exist) can identify all procedures where consent is needed during the exam process. They can make sure appropriate written consent forms are developed as well as procedures for requesting verbal and written consent. They should determine which responder has the knowledge needed to provide patients with information about each procedure and consider from whom patients might feel the most comfortable receiving this information. For example, while each responder may provide discipline-specific information to patients, advocates may provide a broad overview of all components of the exam process. Checklists that clarify discipline-specific roles in obtaining consent may be useful.

**Make sure policies exist to guide the process of seeking informed consent from specific populations.**

In order to provide informed consent, patients should be able to weigh the risks and benefits of different treatment and evidence collection options. It is always important for examiners to assess patients' ability and legal capacity to provide informed consent.<sup>86</sup> Providers should be aware of jurisdictional laws governing the ability of specific populations to provide consent (e.g. minors, individuals with cognitive disabilities, etc.).

In addition, facilities should have internal policies based on applicable jurisdictional statutes governing consent for treatment of vulnerable adult patients. The medical provider will generally need to assess whether the patient has the cognitive capacity to give consent for the examination, and, if not, the provider should follow these internal policies and jurisdictional statutes. Policies should include procedures to

<sup>86</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p.82.  
<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/sanequide.pdf>

determine whether or not patients are their own guardians; if there is a guardian, to determine the extent of the guardianship; to obtain consent from a guardian if needed; and what to do if the guardian is not available or is suspected of abuse or neglect. Exam facilities should also have policies in place to address consent for treatment in cases in which patients are unconscious, intoxicated, or under the influence of alcohol or drugs, and are therefore temporarily incompetent to give consent.

In cases of adolescent patients, jurisdictional statutes governing consent and access to the exam should be followed. For instance, a state statute may allow minors to receive care for STIs and pregnancy, but not a medical forensic examination without parental or guardian consent. In some jurisdictions, a minor may consent to the examination but not keep the results private from a parent or legal guardian. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian can't be found and the collection of evidence needs to be done quickly. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge.<sup>87</sup>

It should be clarified whether policies and statutes regarding consent for medical evaluation and treatment for the above populations encompass consent for the forensic component of the exam. If not, additional guidance from the jurisdiction is needed to develop the appropriate policies. Also, jurisdictional statutes regarding mandatory reporting to law enforcement or protective services in cases of vulnerable adult and minor sexual assault victims must be observed.

Examiners should develop policies and procedures for providing sexual assault care to the unconscious patient. Such care should respect the autonomy of the individual and be consistent with jurisdictional interpretations of emergency exceptions to informed consent. Policies should ideally be approved by hospital ethics committees. Similarly, examiners should have policies for patients that present with altered mental status, which could be from alcohol or drug intoxication or for other reasons. At a minimum, if serious problems are ruled out, the patient will likely need to be observed until consent and cooperation can be obtained which will delay the start of the examination.

In all cases, the medical forensic examination should never be done against the will of patients. Responders should not touch patients or otherwise perform exam procedures without their permission.

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<sup>87</sup> Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 97.  
<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.



## 4. Confidentiality

Recommendations at a glance for jurisdictions to maintain confidentiality:

- Be sure jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared.
- Increase the understanding of relevant confidentiality issues.
- Consider the impact of the federal privacy laws regarding health information on victims of sexual assault.
- Strive to resolve intrajurisdictional conflicts.

**Be sure jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared.** The confidentiality of records (as well as forensic evidence and photographic and video images) is intricately linked to the scope of patients' consent. Members of a SART/SARRT or other collaborating responders should inform victims of the scope of confidentiality with each individual responding to the sexual assault victim and be cautious not to exceed the limits of victim consent.

**Increase the understanding of relevant confidentiality issues.** Individuals responding to the sexual assault victim need education on the basics of maintaining the confidentiality of their patients (e.g., knowing what information is confidential and with whom confidential data can be shared, and being aware of their surroundings and who may be listening when discussing cases). They also should build their understanding of the scope and limitations of confidentiality of each agency and responder involved.

In addition, individuals responding to sexual assault victims should be aware of the laws in their jurisdiction pertaining to privileged communications.<sup>88</sup> More than half of the states have laws in place providing some level of privilege to the communications of sexual assault/rape crisis and domestic violence counselors. A few states' laws apply to victim counselors in general. In most states, counselors must complete a certain number of training hours to qualify for the privilege. However, privileges vary from state to state.

Responders should be aware that victims in the military who choose restricted reports can confidentially speak with a sexual assault victim advocate, a sexual assault response coordinator, military chaplain, or other specified military professional. Jurisdictions should be careful in their local response to protect any privileges that are available to victims. This can be done by limiting who speaks with the victim at each stage of the process, who will be present during discussions and/or interviews, and who will be the recordkeeper or notetaker.

In some jurisdictions, patients who are minors have fewer or more limited confidentiality rights than adults. For example, in some jurisdictions, minor patients have the right to grant or withhold consent to a forensic examination but not to keep the results of the exam private from their parent or legal guardian.

Involved responders should be able to explain the following to patients:

- Community-based advocates usually can provide patients with some level of confidentiality (depending upon applicable jurisdictional statutes). It is important to convey to patients the scope and limits of confidentiality of this communication. System-based advocates (such as those based in police departments, prosecutor's offices, or military installations) usually have limited or no ability to keep information confidential.

<sup>88</sup> Traditionally, many types of communication have been protected from disclosure in court. These include communication between husband and wife, physician and patient, attorney and client, clergy and parishioner, and psychotherapist and patient. Confidential communication generated in the course of a counseling relationship has more recently been afforded some statutory protection. In general, victim-counselor privilege laws enable counselors (such as community-based victim advocates) to maintain confidentiality of information revealed to them. This does not usually apply to system-based advocates, such as those in law enforcement departments or prosecutor's offices. In addition to preventing counselors from testifying in court, many privilege laws extend protection to their written records. (Drawn from *Privacy of Victims' Counseling Communications*, Office for Victims of Crime, Legal Series, Bulletin #8 (November 2002), pp. 1–2.)

- Absent a court order, patients' medical records are confidential—exam facilities typically have policies in place to protect these records. It is important that patients understand the scope and limits of confidentiality of these records.
- If the assault is reported to law enforcement, health care providers provide to the criminal justice system information collected during the examination that is related to forensic evidence.
- If the victim chooses to get an exam, but not make a police report, the evidence collection kit is typically held in a secure setting for a period of time as determined by jurisdictional policy. Patients' identity should not be revealed to law enforcement. Patients usually need to make an official report by the end of the designated period of time or the evidence and information will be destroyed.
- Information that patients share with law enforcement representatives, prosecutors, justice system based advocates, and adult/child protective services becomes part of the criminal justice record. This record is typically available to investigators and prosecutors handling the patient's case. It also may have to be provided to the defense pursuant to the government's discovery obligations<sup>89</sup> (although prosecutors may request the court to shield certain information from the defense, such as history of prior pregnancies, abortions, and STIs).<sup>90</sup>
- Each case potentially involves individuals from different agencies responding to the sexual assault victim that may have their own confidentiality policies (e.g., school counselors and mental health providers).
- Both prosecutors and defense attorneys can call witnesses, including responders, to testify in court;
- Court documents and proceedings are generally matters of public record, with the exception of certain excluded materials (e.g., some states' statutes prohibit victim contact information from appearing on public court documents).
- Patients may at some point wish to view or obtain applicable medical records and/or law enforcement reports. They should have access to such documentation, and exam site and jurisdictional procedures for accessing this data should be conveyed to patients.
- Military members can confidentially<sup>91</sup> report being sexually assaulted to specified officials within the military and therefore can be eligible to receive medical care, counseling, and victim advocacy services without requiring command notification or triggering the investigatory process. This is known as restricted reporting. Release of the information regarding the sexual assault to anyone other than the specified officials who may receive a restricted report will result in the loss of confidentiality for the victim and command and law enforcement will have to be notified of the sexual assault.

**Consider the impact of federal privacy laws regarding health information on victims of sexual assault.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and its implementing regulations (found at 45 CFR Part 160 and Subparts A and E of Part 164), established national standards for the protection of certain individually identifiable health information created or held by health plans, certain health care providers, and health clearinghouses. With respect to disclosures to victim advocacy organizations, the HIPAA Privacy Rule permits hospitals and other health care providers to alert a victim advocacy organization to the presence of a victim of sexual assault at the hospital without giving any identifying information about the victim. Further, once the advocate is at the hospital, if the victim is informed in advance and agrees or does not object, or the hospital reasonably infers from the circumstances, based on professional judgment, that the victim does not object, then the Privacy Rule permits hospital staff to introduce the advocate to the victim and share information pertinent to the advocate's involvement in the victim's care. For more information on the ability of a health care provider to communicate with persons identified by an individual as involved in the individual's care, see *A Health Care Provider's Guide to the HIPAA Privacy Rule: Communicating with a Patient's Family, Friends, or Others Involved in a Patient's Care*, available at [http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider\\_ffg.pdf](http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf).

<sup>89</sup> Discovery in a criminal case is the turning over of any evidence or information that the prosecutor is obligated by jurisdictional statute or case law to turn over to the defense. (Drawn from electronic communications with Norm Gahn, Assistant District Attorney, Office of the District Attorney for Milwaukee County, Wisconsin, during the fall of 2003.)

<sup>90</sup> Depending on jurisdictional law, law enforcement reports and reports of other governmental agencies may be subject to open public records laws or Freedom of Information Act laws. In such instances, jurisdictional policy would govern when such information could be released to the general public upon request. (Drawn from electronic communications with Robert Laurino, Deputy Chief Assistant Prosecutor, Essex County Prosecutor's Office, New Jersey, during the fall of 2003.)

<sup>91</sup> Within the U.S. Department of Defense's Restricted Reporting Policy, a military member may make a restricted report to a Sexual Assault Response Coordinator (SARC), victim advocate, or health care provider.

For more information about the HIPAA Privacy Rule generally, including the conditions under which other disclosures are permitted, visit the Department of Health and Human Services Office for Civil Rights (OCR) Web Site at <http://www.hhs.gov/ocr/privacy/> for an array of helpful guidance documents and Frequently Asked Questions.

HIPAA is not the only federal law that governs victims' privacy rights. Agencies that receive funding under the Violence Against Women Act (VAWA) must also comply with VAWA's confidentiality provisions. These provisions require that a victim's personally identifying information may not be released without a victim's written, time-limited, informed consent or a court or statutory mandate.

**Strive to resolve intrajurisdictional conflicts.** For example, maintaining confidentiality is often difficult in isolated or small communities where people know one another or word of a crime travels quickly (e.g., school campuses and tribal, military, religious, or immigrant communities). Special precautions must be taken in these situations to preserve confidentiality. Every effort should be made to avoid conflicts of interest (e.g., the investigator is the cousin of the suspect or the health care provider, or the advocate or interpreter is an acquaintance of the patient). Give patients as many options as possible to avoid these dilemmas (e.g., allow them to work with a different investigator or be examined at another site or by another examiner, if possible).



## 5. Reporting to Law Enforcement

Recommendations at a glance for jurisdictions and individual responding to the sexual assault victims to facilitate victim-sensitive reporting practices:

- Except in situations covered by mandatory reporting laws, patients, not health care workers, make the decision to report a sexual assault to law enforcement
- Inform patients about reporting consequences.
- As a result of VAWA 2005, many jurisdictions have implemented alternatives to standard reporting procedures.
- Promote a victim-centered reporting process.

Many sexual assault victims who come to health care facilities or other exam sites for the medical forensic exam choose to report the assault to law enforcement. Reporting provides the criminal justice system with the opportunity to offer immediate protection to the victim, collect evidence from all crime scenes, investigate the case, prosecute it if there is sufficient evidence, and hold the offender accountable for crimes committed. Given the danger that sex offenders pose to the community, reporting can serve as a first step in efforts to stop them from reoffending. Equally important, reporting gives the justice system the chance to encourage victims to seek assistance to address their needs, identify patterns of sexual violence in the jurisdiction, and educate the public about such patterns. Service providers should discuss all reporting options with victims and the pros and cons of each, including the fact that delayed reporting may be detrimental to the prosecution of an offender. Victims need to know that even if they are not ready to report at the time of the exam, the best way to preserve their option to report later is to have the exam performed. Information should be provided in a language victims understand.

Some victims, however, are unable to make a decision about whether they want to report or be involved in the criminal justice system in the immediate aftermath of an assault. Pressuring these victims to report may discourage their future involvement. Yet, they can benefit from support and advocacy, treatment, and information that focuses on their well-being. Recognizing that traumatic injuries heal and evidence on their bodies is lost as time passes and that they may report at a later date, victims can also be encouraged to have the medical forensic exam conducted. Victims who are recipients of compassionate and appropriate care at the time of the exam are more likely to cooperate with law enforcement and prosecution in the future.

**Except in situations covered by mandatory reporting laws, patients, not health care workers, make the decision to report a sexual assault to law enforcement.** Health care workers in some jurisdictions are bound by law to report some or all forms of sexual assault, regardless of patients' wishes.<sup>92</sup> In the remaining jurisdictions, no report should be made without the consent of patients. (Exceptions typically include cases involving vulnerable adults and minors victimized by caretakers or other authority figures). All involved health care providers should be aware of the reporting requirements in the jurisdiction in which they work.

In jurisdictions in which mandatory reporting by health care personnel is required, patients should be informed of the legal obligations of health care personnel, what triggers a mandatory report, that a report is being made, and the contents of the report. Patients should understand that even if health care personnel make a mandatory report, they are not obligated to talk with law enforcement officials<sup>93</sup>

<sup>92</sup> Some jurisdictions mandate reporting for some or all violent crimes, requiring health care workers to notify law enforcement in cases involving a gunshot or knife wound, strangulation/choking, or other serious bodily injury. They vary, however, in whether they require acts of sexual violence without serious physical injuries to be reported. Health care personnel should be aware that these reporting laws may come into conflict with military policy allowing for restricted reporting for victims in the military.

<sup>93</sup> Some victims may fear possible consequences of reporting (e.g., retaliation by offenders; rejection by family members and friends; being discriminated against if they are males). Victims may have these and other fears because they are from populations with differing sexual orientations or gender identities, or they are from racially or otherwise oppressed groups; they are inmates; or they fear being deported or refused citizenship (in the case of recent immigrants and refugees). Some recent immigrants or refugees may fear law enforcement because of past experiences of oppression by authorities in their countries of origin. In addition, many victims are not willing to deal with the humiliation, loss of privacy, and negativity they perceive would accompany reporting, an investigation, and prosecution. If an intimate partner or a family member committed the assault, victims may also be concerned about the consequences of

States are required, as a condition of eligibility for STOP Violence Against Women Formula Grant funds, to allow victims to receive examinations and to have the examinations paid for regardless of the level of participation of victims in the criminal justice process. Documentation and evidence collected could be invaluable to the investigation and prosecution if patients should report at a later date, which often occurs. Patients also have the right to receive medical care for assault-related injuries and concerns, regardless of their decision to report and/or have evidence collected, although the state is not required to pay for medical care.

Jurisdictions need to consider the challenges of storing evidence in cases where victims go through the medical forensic exam but opt not to participate with the criminal justice process. In some communities, it is a challenge to find adequate space to hold evidence in cases where a report has not been made. For more information on this topic, see *B.6. Evidence Integrity*.

In addition, under VAWA 2005 as a condition of STOP Formula Grant funding, states must also certify that law enforcement officers, prosecutors, and other government officials do not ask or require victims of sex offenses to submit to polygraph exams or other truth telling devices as a condition for proceeding with the investigation or prosecution of the offense.

**Inform patients about reporting consequences.** Prior to making a decision about reporting, patients need information about issues related to reporting. For example, they should be informed of the following:

- The process of reporting the sexual assault to law enforcement and the information that will typically be requested from the victim.
- Procedures dealing with reporting in the jurisdictional protocol for immediate response to sexual assault.
- Whether health care personnel are mandated by law to report the assault.
- The fact that the report will trigger an investigation. Depending upon the results of the investigation, the case may be referred to the prosecutor, and the prosecutor may file charges.
- The purposes of the exam and how documented injuries as well as evidence gathered could be used during investigation and prosecution.
- Types of evidence (beyond that found on patients) that may be gathered during an investigation.<sup>94</sup>
- The fact that delays in reporting, especially extended ones, can result in loss of evidence and may negatively affect the ability of the criminal justice system to investigate and prosecute a case.<sup>95</sup>
- Practices regarding prosecution of sexual assault victims for unrelated criminal charges.
- The right to accept or decline exam procedures and the possible consequences of declining.
- The right to copies of any communication or report issued to law enforcement and procedures for accessing such data.
- Policies related to payment for the exam, evidence collection, and medical care, whether or not a report is made.
- Policies on collecting/holding evidence in cases where patients are undecided about reporting, and, if evidence can be collected with no report, the amount of time they have to make a reporting decision.

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prosecution on their families (e.g., loss of income, employment, profession, attorney fees, and childcare costs) and being blamed for "tearing the families apart." Incest victims may be deterred from reporting because offender registries might indirectly identify them.

<sup>94</sup> For example, other evidence may be found on the suspect's bodies and clothing, at the locations of actual assaults, and locations victims went to immediately after the assaults.

<sup>95</sup> Prompt reporting can facilitate a thorough investigation. Collecting evidence from patients is but one piece of investigative information gathering. Other investigative activities may include, but are not limited to, identifying and collecting evidence from all crime scenes; identifying, apprehending, and interviewing suspects; interviewing witnesses (both eyewitnesses and persons to whom victims initially disclose); obtaining search warrants as needed (e.g., to search for drugs that might have been used to facilitate an assault or for evidence used during an assault such as clothing, ropes, or condoms). Investigative activities depend on the specifics of each case.

**In response to VAWA 2005, many jurisdictions have implemented alternatives to standard reporting procedures.**<sup>96</sup> Many communities have implemented alternatives to traditional reporting procedures, such as anonymous or blind reporting. These procedures are used when victims do not want to immediately report or are undecided about reporting with their own name and contact information (but are willing to report anonymously).<sup>97</sup> Government entities that mandate reporting for sexual assaults, in particular, have implemented an option of third-party anonymous reporting for mandated reports, which allow a third-party, such as the medical personnel, to make the report without including identifying information about the victim.<sup>98</sup> Although the practice of anonymous reporting is not widespread it allows victims and/or third-party reporters to share critical information about the assault with law enforcement without sacrificing privacy. It also enables investigators to gain information about sex crimes that would otherwise go unreported.

To develop an anonymous/blind reporting system, law enforcement agencies can:

- Establish and uphold a policy of victim confidentiality.
- Allow victims to disclose as little or as much information as they wish.
- Accept the information whenever victims might offer it—a delay in disclosure is not an indicator of the validity of the statement.
- Develop procedures and forms to facilitate anonymous information from third parties (e.g., examiners).
- Clarify options with victims for future contact—where, how, and under what circumstances they may be contacted by the law enforcement agency or by another agency.
- Maintain these reports in separate files from official complaints to avoid inappropriate use.

Informed consent from victims for notification should be sought during the initial report, as well as appropriate times, reasons, and methods to recontact them.<sup>99</sup> For example, a victim may want to be contacted if another victim who was likely assaulted by the same suspect comes forward.

**Promote a victim-centered reporting process.** Some approaches for communities to consider:

- Explore the myriad reasons why victims are reluctant to report and how the actions or attitudes of agencies may help perpetuate these fears. Help agencies consider how to address reluctance and fears (e.g., immigrant victims who fear deportation and immigration enforcement may benefit from immediate access to legal services or information about their rights as potential U-Visa holders). Information regarding U-Visas should be universally provided to all victims. The resource, if not appropriate for the victim being seen, may be passed along to others through word of mouth.<sup>100</sup>
- Evaluate local trends regarding reporting and victims' involvement in the criminal justice system. Based on feedback, develop and implement a plan to improve multidisciplinary response to sexual assault.
- Improve and increase professional training for first responders (e.g., training for law enforcement investigators on effective interviewing techniques for sexual assault victims, training for health care personnel on the clear use of language in documentation, training for prosecutors on strategies for

<sup>96</sup>The first two paragraphs in this section are drawn from S. Garcia and M. Henderson, *Blind Reporting of Sexual Violence*, FBI Law Enforcement Bulletin, June 1999, pp. 12–16.

<sup>97</sup> For example, the Chapel Hill, North Carolina, Police Department's blind reporting system for sexual assault enables victims to disclose as much or as little information as they want. A detective records the information but does not initiate an investigation unless victims decide to file a formal complaint. The blind reporting system has been credited with contributing to a steady increase in sexual assault reporting. The number of male victims who reported during that time also rose. (K. Littel, M. Malefyt, and A. Walker, *Assessing the Justice System Response to Violence Against Women: A Tool for Law Enforcement, Prosecution, and the Courts to Use in Developing Effective Response*, 1998, pp. 18–9.)

<sup>98</sup> For example, all health care providers in Massachusetts who attend to, treat, or examine a sexual assault patient are required to submit a third-party anonymous report (with no identifying information) to law enforcement in the community where the assault occurred as well as to the state police. This report is required even if patients report the assault themselves. (Commonwealth of Massachusetts *SANE Protocol*, 2002, pp. 8–9.)

<sup>99</sup> All those involved in immediate response, including victims, need to understand the nature of DNA evidence and how CODIS can be used to match offenders with DNA in the database. They also need to know the status of CODIS in their jurisdiction (states have varying laws regarding which crimes qualify for inclusion in the database).

<sup>100</sup> Legal Momentum has extensive resources available regarding U-Visas. See <http://www.legalmomentum.org/our-work/immigrant-women-program/u-visa.html>. Additionally, immigrant women are entitled to emergency medical and post-assault healthcare. For a state-by-state breakdown of the benefits afforded, see [http://www.legalmomentum.org/assets/pdfs/4\\_niic\\_table\\_10.pdf](http://www.legalmomentum.org/assets/pdfs/4_niic_table_10.pdf).

overcoming a consent defense, and training for first responders on effective use of interpreters when responding to sexual assault cases).

- Encourage reporting of criminal justice statistics that accurately reflect the full range of sexual assaults that are reported in a jurisdiction.
- Initiate community education, outreach, and services targeting groups that may be reluctant to seek assistance after an assault.
- Expand community collaboration to include immigrant victim advocates who can work with the local coordinating council and SART/SARRT to inform immigrant victims of their rights as soon as possible post-assault.
- Offer viable options for reimbursement of exam costs for which victims are responsible, such as costs that are purely medical in nature.<sup>101</sup>
- Ensure that victims who opt not to participate in the criminal justice process have access to the same comprehensive medical forensic examination as those who do.
- Encourage the development of a coordinating council and/or SART/SARRT to facilitate a more coordinated, victim-centered, comprehensive community response to sexual violence.
- Support the formation of specialized examiner programs, investigative and prosecution units, and sexual assault victim advocacy programs to handle these cases. Specialization can potentially increase the knowledge base and commitment of those responding to sexual assault victims, increase adherence to jurisdictional protocols for immediate response to sexual assault, encourage a victim-centered response, and positively advertise services offered.
- Develop jurisdiction-wide public information initiatives on mandatory reporting—mandatory reporters need to know applicable statutes regarding reporting sexual assault cases that involve older vulnerable adults, persons with disabilities, and minors. A toll-free hotline number exclusively dedicated to abuse reports may also help simplify reporting and ensure a written report of each case and referrals to appropriate agencies. Such a hotline could be operated at a state, tribal, regional, or local level. To encourage both reporting and follow-through, protective agencies that investigate these cases should work collaboratively with local law enforcement agencies to ensure that each case is dealt with in the best possible manner and that further harm does not occur.<sup>102</sup>
- In institutional settings such as prisons, jails, immigrant detention centers, nursing homes and assisted living programs, inpatient treatment centers, and group homes, ensure that victims can report assaults to outside agencies and are offered protection from retaliation for reporting.
- In each case, strive to create an environment in which victims are supported and respected throughout the criminal justice process and beyond.<sup>103</sup>
- After steps have been taken to identify and remove barriers to reporting sexual assaults, educate the public about the potential benefits of reporting, how to go about reporting, what happens once a report is filed, and jurisdictional legal advocacy services available (if any) for sexual assault victims. Build upon already existing public awareness efforts of local advocacy programs.

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<sup>101</sup> It would be ideal if victims did not have to cover any costs for the exam and related medical care. However, jurisdictions and exam facilities vary in the costs that victims are required to cover. In some jurisdictions, victims are responsible for the costs of treatment for injuries and possible pregnancy, STIs, and HIV infection. Some exam facilities are flexible—they may allow victims to pay as they are financially able or may be willing to waive some or all charges.

<sup>102</sup> Bullet drawn from A. Vachss, *Redefining Rape Response: When the Victim is Elderly or Has a Disability*, 2004, pp. 6 and 18.  
<http://www.nj.gov/lps/dcj/agguide/standards/standardssartsane.pdf>

<sup>103</sup> Bullet adapted from the New Jersey Office of the Attorney General's *Standards for Providing Services to Survivors of Sexual Assault*, 1998, pp. 6 and 18.

## 6. Payment for the Examination Under VAWA

Recommendations at a glance for jurisdictions to facilitate payment for the sexual assault medical forensic exam:

- Understand the VAWA provisions related to exam payment.
- Notify victims of exam facility and jurisdictional policies regarding payment for medical care and the medical forensic exam.

**Understand the VAWA provisions related to exam payment.**<sup>104</sup> Under the Violence Against Women Act (VAWA) and subsequent legislation, grantees of the STOP Violence Against Women Formula Grant Program must meet certain requirements concerning payment for the forensic medical exam in order to receive funds. The STOP Program is a formula grant program which provides funds to all states, Territories, and the District of Columbia.<sup>105</sup>

Each of these entities certifies each year that it is in compliance with the requirements of VAWA.<sup>106</sup> Specifically, the state, territory, or the District of Columbia must certify that it or another governmental entity "incurs the full out-of-pocket cost of forensic medical exams" for victims of sexual assault. If one part of a state or territory, such as a county or city, is forcing victims to incur these costs, then the state or territory will not be able to certify and will be ineligible for the grant funds. In addition, under the Violence Against Women Act of 2005, states must also certify that they do not require victims to participate with the criminal justice process in order to be provided with an exam.<sup>107</sup>

States are permitted to use STOP Program funds to pay for the exams if they meet two conditions.<sup>108</sup> First, the exam must be performed by a "trained examiner for victims of sexual assault." Second, the state may not require victims of sexual assault to seek reimbursement from their insurance carriers.

In cases of victims associated with the U.S. military services, sexual assault forensic examinations may be covered under Tricare for service members.

By regulation, "full out-of-pocket cost" means "any expense that may be charged to a victim in connection with a medical forensic examination for the purpose of gathering evidence of a sexual assault."<sup>109</sup> Examples of such expenses may include the full cost of the exam or a fee established by the facility conducting the exam, or a copayment or deductible in jurisdictions that require victims to submit the charges to insurance. Often, medical services that are not related to evidence gathering will not be covered by this requirement.

**Notify victims of exam facility and jurisdictional policies regarding payment for medical care and the medical forensic exam.** Victims must be aware of exam facility and jurisdictional policies regarding payment for other medical care related to the sexual assault. Many jurisdictions will not pay for medical care provided as part of the medical forensic examination, such as the costs of treatment for injuries or treatment for STIs, or may require victims to apply separately for crime victim compensation to be reimbursed for such

<sup>104</sup> As a result of the Violence Against Women Reauthorization Act of 2013, states can no longer pay for exams by reimbursing the victim, instead they need to either provide the exams free of charge to the victim or arrange for victim to obtain the exams free of charge to the victims.

<sup>105</sup> Its purpose is to assist these jurisdictions in developing and strengthening law enforcement and prosecution strategies to combat violence against women, as well as in developing and strengthening victim services in cases involving violence against women.

<sup>106</sup> For American Indian/Alaska Native victims, the costs of the exam will be born by either the state or in some cases the federal government. Although tribes are not directly eligible for STOP Formula Grants, they are eligible for subgrants from the states, as well as other Office on Violence Against Women grant programs that can address sexual assault.

<sup>107</sup> Under 42 U.S.C. § 10607, a federal investigating agency that conducts a sexual assault investigation shall pay for the cost of a forensic exam "which an investigating officer determines was necessary or useful for evidentiary purposes." However, in most cases where the victim does not choose to report the assault to law enforcement or to participate with the criminal justice process, a state that receives STOP funds will still be responsible for payment because at that stage there will be no federal investigation. The state's responsibility for payment applies regardless of whether the crime occurred in Indian Country or within the special maritime and territorial jurisdiction of the United States.

<sup>108</sup> 42 U.S.C. 3796gg-4(c).

<sup>109</sup> 28 C.F.R. § 90.14(a).

expenses. Individuals responding to the sexual assault victim need to be informed regarding payment policies and procedures for all aspects of the medical forensic examination, so that they can accurately inform victims.<sup>110</sup> For example, responders can help them apply for crime victims' compensation (if available) or arrange a payment plan with the exam facility.<sup>111</sup> When victims are billed by the exam facility for costs that are their responsibility, procedures to protect their privacy should be incorporated into the billing process. Personnel in facility billing departments should be educated regarding coding and billing practices in these cases, as determined by facility and/or jurisdictional policy.

Reporting to law enforcement. States, territories, and the District of Columbia must pay for sexual assault medical forensic exams without requiring victims to report the assault to law enforcement. Some victims are unable to make a decision about whether they want to report to law enforcement in the immediate aftermath of the assault. Recognizing that injuries heal and that evidence is lost as time progresses, victims should be encouraged to have the physical findings documented and evidence collected right away, and then have time to decide about reporting the crime.

See <http://www.ovw.usdoj.gov/faq-forensic-examinations.html> and <http://www.ovw.usdoj.gov/docs/stop-formula-faq.pdf> for more information on the STOP Formula Grant Program medical forensic exam payment requirement.

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<sup>110</sup> Victims in federal cases should first apply to the state or territory crime victim compensation program for reimbursement of costs that are their responsibility. If they are unable to obtain reimbursement via this channel, they should work with victim-witness specialists in the federal agency investigating or prosecuting the case to identify other possible sources of funding or reimbursement. For more information about crime victim compensation, please see <http://www.ovc.gov/publications/factsheets/companassist/welcome.html>.

<sup>111</sup> Exam facilities are sometimes willing to waive some related medical care costs that are not covered by government entities.

## **B. Operational Issues**

This section discusses components essential to conducting the sexual assault forensic examination: the health care providers conducting the exam, the facilities where exams are performed, the equipment and supplies needed during the exam, and the sexual assault evidence collection kit. It also discusses timing considerations in collecting evidence and evidence integrity during and after the exam.

The following chapters are included:

1. Sexual Assault Forensic Examiners
2. Facilities
3. Equipment and Supplies
4. Sexual Assault Evidence Collection Kit
5. Timing Considerations for Collecting Evidence
6. Evidence Integrity



# 1. Sexual Assault Forensic Examiners

Recommendations at a glance to build capacity of examiners to conduct these exams:

- Encourage the development of specific knowledge, skills, and victim-centered approaches in examiners.
- Encourage advanced education and supervised clinical practice of examiners, as well as certification for all examiners.
- Provide access to experts on anti-sexual assault initiatives who can participate in sexual assault examiner training, mentoring, proctoring, case review, photograph review, and quality assurance.

It is critical that health care providers conducting the sexual assault medical forensic exam are committed to providing compassionate and competent health care, collecting evidence in a thorough and appropriate manner, and testifying in court if needed. Their commitment should be grounded in an understanding that sexual assault is a serious crime that can have profound acute and chronic consequences for those victimized. Providers should recognize the role of advanced education and clinical experience in building competency to perform the exam.

A growing trend across the United States is the use of sexual assault nurse examiners (SANEs) to conduct the exam. SANEs are registered nurses who receive specialized education and fulfill clinical requirements to perform these exams. Some nurses have been certified as SANEs–Adult and Adolescent (SANE–A) through the International Association of Forensic Nurses (IAFN).<sup>112</sup> Others are specially educated and fulfill clinical requirements as forensic nurse examiners (FNEs), enabling them to collect forensic evidence for a variety of crimes. The terms “sexual assault forensic examiner” (SAFE) and “sexual assault examiner” (SAE) are often used more broadly to denote a health care provider (e.g., a physician, physician assistant, nurse, or nurse practitioner) who has been specially educated and completed clinical requirements to perform this exam.

All communities should strive to ensure that victims of a recent sexual assault have access to specially educated and clinically prepared examiners to perform the medical forensic exam. As much as possible, examiners should be permanent rather than on temporary assignment in a jurisdiction. It can be challenging for examiners who are temporary (e.g., at an Indian Health Service facility) to understand needs of victims from the community or to be familiar with jurisdictional policies and procedures. If they move to another job assignment, arranging for them to testify in court can be complicated.<sup>113</sup>

**Encourage the development of specific knowledge, skills, and victim-centered approaches in examiners.** Conducting a sexual assault medical forensic examination is a complex and time-consuming procedure. It is useful for examiners to have specific knowledge and skills that can guide them as they perform these exams.<sup>114</sup> For example, it is beneficial for them to know about the following:

- The dynamics and impact of sexual victimization.
- Jurisdictional laws related to sexual offenses.
- Coordinated multidisciplinary response, roles of each responding agency, and procedures for communicating with each agency during immediate response.
- The importance of examiner neutrality and objectivity during the examination.

<sup>112</sup> Eligibility criteria for IAFN SANE Adult/Adolescent certification includes: registered license as an R.N. in the United States or its Territories, or a license as a first-level general nurse in the jurisdiction of current practice; a minimum of 2 years of practice as an R.N. in the United States or as a first-level general nurse in the country of licensure; successful completion of an adult/adolescent SANE education program that includes either (a) a minimum of 40 continuing education contact hours of classroom instruction, or (b) 3 semester hours (or the equivalent) of academic credit in an accredited school of nursing, and sufficient supervised clinical practice until determined competent in SANE practice. An appropriate clinical authority, as outlined in the adult section of the IAFN *SANE Education Guidelines* (2008) must validate current SANE competency. (Drawn from the IAFN Web Site Certification Area at <http://www.iafn.org>.)

<sup>113</sup> Most hospitals or medical clinics that physicians or advanced practice nurses are employed by or affiliated with require them to apply for facility privileges. Those requesting privileges usually must agree to provide forwarding addresses when they leave. Also, medical licenses can be tracked to the state or territory where the health care provider is working.

<sup>114</sup> The next two bulleted sections are adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, pp. 25–26, produced by the California Governor’s Office of Criminal Justice Planning. Also see the National Training Standards..

- The broad spectrum of potential evidence and physical findings in these cases.
- The importance of the medical forensic history and other documentation.
- Proper evidence collection and preservation procedures.
- Preexisting needs and circumstances of patients that may affect how the exam is conducted.
- Treatment options and procedures for common concerns such as pregnancy, STIs, and HIV infection.
- Equipment, supplies, and medication typically used during the exam.
- Precautions to prevent exposure to potentially infectious materials.<sup>115</sup>
- Indications for follow-up health care and documentation of injuries.
- Applicable laws and protocols regarding performance of medical forensic exams and standardized forms used to document findings.
- Patients' needs for support, crisis intervention, advocacy, information, and referrals during the exam process, local resources for addressing these needs, and procedures for accessing resources.
- The importance of establishing vehicles to ensure the quality of the exam and related documentation.
- Examiner court testimony (what it involves and how examiners can prepare for it).
- Applicable research findings, technological advances, and promising practices.

It is critical for examiners to be able to:

- Preserve their neutrality and objectivity in each case.
- Assess patients' clinical condition (physical and psychological assessment<sup>116</sup>) and provide appropriate treatment and medical referrals (e.g., to a surgeon).
- Adapt exam procedures to address patients' needs and circumstances as much as possible.
- Take measures during the exam process to reduce the likelihood of patients' retraumatization.
- Take precautions according to facility policy to prevent exposure to potentially infectious materials.
- Contact advocates (where available) upon initial contact with patients so they can offer patients support, crisis intervention, advocacy, information, and community referrals before, during, and after the exam.<sup>117</sup>
- Explain the obligation and scope of mandatory reporting to the patient, if mandatory reporting is required.
- Gather information sensitively from patients for a medical forensic history and use the history as a guide when performing an exam.
- Explain to patients what items need to be collected for evidence and for what purposes.
- Involve law enforcement representatives promptly if patients want to report and work with them to optimize the collection of evidence from patients, suspects, and crime scenes.
- Identify and describe pertinent genital and anorectal anatomical structures and external landmarks.

<sup>115</sup> See the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) for its Bloodborne Pathogens Standard (CFR 1910.1030). It may be accessed at <http://www.osha.gov> or by calling 800-321-OSHA. According to this standard, bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. Among other things, the standard requires employers who have employees at risk for occupational exposure to bloodborne pathogens and other potentially infectious materials to develop plans to eliminate or minimize employee exposure. It also advises universal precautions that should be observed to prevent contact with blood or other potentially infectious materials (this approach treats all human blood and certain human body fluids as if they are known to be infectious). In addition, the standard requires employers to ensure that all employees at risk participate in a training program to inform them of risks, related facility policies, and necessary precautions. Employers must also establish and maintain a record for each employee with occupational exposure.

<sup>116</sup> Examiners typically assess patients' psychological functioning to determine whether there is a risk for suicide and whether patients are oriented to person, place, and time. They may request a mental health evaluation for patients, if necessary.

<sup>117</sup> It is helpful if jurisdictions clarify the specific roles of advocates and examiners during the exam process. In the absence of advocates or other victim service providers, examiners may be responsible for providing crisis intervention and support to patients. In situations where examiners are both collectors of evidence and crisis counselors, it is important to understand how these dual roles affect the perception of their ability to testify in an unbiased manner.

- Identify and document injuries and interpret physical findings; this documentation should include a diagram of the finding on an appropriate anatomic drawing, a written description of the finding (including any indication of tenderness or induration), and forensic imaging of any visible finding.
- Use enhancement techniques for detection and documentation of findings.
- Collect and preserve evidence for analysis by the crime laboratory.
- Collect and preserve toxicology samples in suspected alcohol- or drug-facilitated sexual assault cases.
- Maintain and document the chain of custody for evidence.
- Maintain the integrity of the evidence to ensure that optimal lab results are obtained.
- Evaluate the possibility of STIs and HIV infection and provide prophylactics and/or treatment.
- Assess pregnancy risk and discuss treatment options with the patient.
- Recognize evidence-based conclusions and limitations in the analysis of findings.
- Complete standard forms for documenting the medical forensic results of the exam.
- Discuss evidentiary findings with investigators, prosecutors, and defense attorneys as requested (according to jurisdictional policy).
- Testify in court if needed.

**Encourage advanced education and supervised clinical practice for health care personnel conducting the exam, as well as certification for all examiners.** Such a standard must speak to specific education and supervision needs of involved disciplines. For example, nonphysician examiners may require medical supervision and backup, in addition to completing necessary training and clinical requirements. Certification through the IAFN is currently available only to nurses trained as SANEs. When designing classroom education for examiners, make sure the examiners understand the importance of a multidisciplinary response during the exam process. Consider involving trainers from health care, advocacy, law enforcement, prosecution, judiciary, and crime laboratories.

Standardized curricula on sexual assault exams in medical school, nursing and nurse practitioner programs, and physician assistant programs are recommended. Consideration must be given to how to systematically secure, supervise, and retain examiners in/for poor, rural, or remote areas, institutional settings,<sup>118</sup> military bases, college campuses, tribal lands, migrant farm worker communities, and other areas needing increased victim outreach. Examiners need to know how to respond in a respectful manner to various populations within their community (e.g., local tribal victim service providers may be able to provide training on cultural beliefs and practices that might be relevant in sexual assault cases).

In addition, other health care providers who come into contact with patients who disclose a recent assault need information on procedures for obtaining immediate patient assistance and caring for patients prior to their arrival at the exam site.

**Provide access to experts on anti-sexual assault/violence initiatives who can participate in sexual assault examiner training, mentoring, proctoring, case review, photograph review, and quality assurance.** Access to such experts can help increase examiner competence and the consistency of high quality forensic examinations. Telemedicine may help provide this expertise, especially to rural and underserved areas.

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<sup>118</sup> Examples of institutional settings include prisons, jails, immigration detention centers, juvenile detention centers, nursing homes, assisted living and rehabilitation programs, and inpatient treatment centers.



## 2. Facilities

Recommendations at a glance to build the capacity of health care facilities to respond to sexual assault cases:

- Recognize the obligation of health care facilities to serve sexual assault patients in a culturally and linguistically appropriate manner.
- Ensure that exams are conducted at sites served by examiners with advanced education and clinical experience, if possible.
- Explore possibilities for optimal site locations.
- Communities may wish to consider developing basic requirements for designated exam sites.
- If a transfer from one health care facility to a designated exam site is necessary, use a protocol that minimizes time delays and loss of evidence and addresses patients' needs.

**Recognize the obligation of health care facilities to serve sexual assault patients in a culturally and linguistically appropriate manner.**<sup>119</sup> It is essential that all sexual assault patients who present to health care facilities be thoroughly evaluated. Treating injuries alone is not sufficient in these cases. Staff who examine these patients must be educated and clinically prepared to collect evidence and document findings while maintaining the chain of custody. They should be able to coordinate crisis intervention and support for patients, as well as provide STI evaluation and care, pregnancy assessment, and discuss treatment options. They must be aware of and follow jurisdictional reporting policies, and be able to provide court testimony if necessary.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)<sup>120</sup> requires emergency and ambulatory care facilities to have established policies for identifying and assessing possible victims of sexual assault. It also requires staff to be trained on these policies. As part of the assessment process, JCAHO requires these facilities to define their responsibilities related to the collection and preservation of evidentiary materials.<sup>121</sup> Sexual assault examiner programs are helping many health care facilities to carry out these requirements. Facilities should also familiarize themselves with the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to turn away patients with emergency medical conditions.<sup>122</sup>

**Ensure that exams are conducted at sites served by examiners with advanced education and clinical experience, if possible.** Some jurisdictions designate specific facilities as exam locations because they employ or have ready access to specially educated and clinically prepared examiners, as well as the necessary space, equipment, supplies, and policies to facilitate the exam process. Jurisdictions may rely on examiner programs to serve multiple exam sites within a specific area.<sup>123</sup> Communities can benefit from designated exam facilities and examiner programs that use specially educated and clinically prepared examiners to conduct the exam because they:

- Increase the quality of care for patients and attention to their needs.
- Increase the likelihood of a state-of-the-art examination.

<sup>119</sup> This and the next paragraph were drawn from L. Ledray, *Evidence Collection and Care of the Sexual Assault Survivor: The SANE-SART Response*, 2001, p. 1.

<sup>120</sup> JCAHO standards for accreditation address a health care organization's level of performance in specific areas—not just what the organization is capable of doing, but what it actually does. The standards set forth maximum achievable performance expectations for activities that affect the quality of care. These standards are developed in consultation with health care experts, providers, measurement experts, purchasers, and consumers, and usually are updated every 2 years. (Drawn from [http://www.jointcommission.org/standards\\_information/standards.aspx](http://www.jointcommission.org/standards_information/standards.aspx)).

<sup>121</sup> The JCAHO requirements are discussed at <http://www.mincava.umn.edu/documents/commissioned/2forensicevidence/2forensicevidence.html>.

<sup>122</sup> 42 U.S.C. § 1395dd. See <http://www.emtala.com> for more information about EMTALA.

<sup>123</sup> A mobile examiner program may be based in a health care facility—in addition to providing services at that facility, it also may contract with other exam sites to provide services as requested. Such a program may also be independent, with administrative offices only, and solely contract with exam sites to provide examiner services.

- Enhance a coordinated team approach.
- Encourage quality control (e.g., through use of competent and dedicated examiners, established procedures for evidence collection, and standards for medical care).

**Explore possibilities for optimal site locations.** SART/SARRTs (or involved agencies) should determine where exams should be conducted. Some factors to consider when identifying sites include safety and security for patients and staff, physical and psychological comfort for patients, capacity to accommodate victims with disabilities,<sup>124</sup> availability of examiners with advanced education and clinical experience, access to a pharmacy for medication, access to medical support services for care of injuries, access to lab services, and access to the supplies and equipment needed to complete an exam.<sup>125</sup> Decisions about site location should reflect the needs of victims (e.g., for accessible care close to their home and local referrals), what is most efficient for the multidisciplinary response team, and the need to maintain the neutrality and objectivity of examiners (e.g. if the site location is at a rape crisis center, it may be seen as biased against the offender). Designated facilities may be in hospitals, health clinics, mobile health units, or other alternative sites, including family justice centers<sup>126</sup> or nonprofit sexual assault victim services programs.<sup>127</sup> The majority of medical forensic exams are conducted in hospital emergency departments. This location typically offers some level of security, is open 24 hours a day, and provides access to a wide array of medical and support services. Clinical staff often have the experience and expertise to perform the exam and collaborate with appropriate disciplines. Some jurisdictions have or are developing specialized hospital or community-based examiner programs.<sup>128</sup>

SART/SARRTs may need to decide whether a tribal, local, regional, or state/territorial system of designated facilities best serves community needs. Some issues that might impact this decision include community demographics and geography; the need for and availability of specialized services; availability of local health care facilities; local capacity to secure competent examiners and necessary space, equipment, and supplies; willingness of involved disciplines to coordinate with a local facility or examiner program; distance to/from tribal, regional, or state/territorial facilities; and service capacity of tribal, regional or state/territorial facilities. Communities are encouraged to first consider using local designated exam sites. However, some may ultimately opt for tribal-, regional- or state/territorial-level facilities. For example, a small state, tribe, or sparsely populated region may establish one or more designated facilities to serve all of its localities.

Exam facilities and examiners that serve at the local level may benefit from networking with examiners in other facilities or areas for support for peer review of medical forensic reports, quality assurance, and information sharing (e.g., on training opportunities, practices, and referrals for patients).

**Communities may wish to consider developing basic requirements for designated exam sites.**

Examples of such requirements include:<sup>129</sup>

- The site will be within a reasonable distance from any point in the area it serves (“reasonable” is locally defined).
- The site will promptly alert a SART/SARRT member, if one exists, when sexual assault patients arrive.
- Urgent or emergent physical injuries (or other acute medical needs) will be treated immediately.

<sup>124</sup> Title II and Title III of the Americans with Disabilities Act explains requirements for facilities in accommodating persons with disabilities (which may vary depending on the type of facility). Title II prohibits discrimination against persons with disabilities in all programs, activities, and services of public entities. Title III requires places of public accommodation to make reasonable modification in their policies, practices, and procedures in order to accommodate individuals with disabilities. See <http://www.ada.gov/> for related information and resources.

<sup>125</sup> Drawn from L. Ledray, *SANE Development and Operation Guide*, 2000, pp.35–36.

<sup>126</sup> Particularly on tribal land that is devoid of or a significant distance from a hospital, and the tribe is serviced by an Indian Health Service (IHS) facility; consideration should be given to securing and maintaining examiners and necessary space, equipment, and supplies to conduct these exams. Ideally, all IHS facilities should have examiners and a minimum standard for examiner training.

<sup>127</sup> For more information on the President’s Family Justice Center Initiative, see <http://www.ovw.usdoj.gov>.

<sup>128</sup> The pros and cons of developing hospital versus community-based examiner programs are discussed in more detail in L. Ledray’s *SANE Development and Operation Guide*, 2000, pp.35–9; L. Ledray’s *Sexual Assault: Clinical Issues, SANE Program Pros and Cons, Journal of Emergency Nursing*, 23(2), p.183; and in K. Littel’s *SANE Programs: Improving the Community Response to Sexual Assault Victims*, pp.10–11.

<sup>129</sup> Adapted from Pennsylvania’s *SART Guidelines*, 2002, p.21.

- Responding examiners will be competent in their knowledge and skills.
- The site will ensure that admissions staff have the necessary resources and knowledge to best accommodate the patient until the examiner or victim advocate arrives.
- The site will arrange for interpretation as needed in patients' preferred languages and/or obtain devices that facilitate communication for individuals with sensory or communication disabilities.
- Patients will be provided with a comprehensive medical forensic exam and resources to address their immediate emotional and psychological needs.
- The site will provide a private, secure, and quiet waiting area for patients and for personal support persons accompanying them.
- The site will provide a private and secure setting for the investigative interview.
- The site will provide a private exam room and other measures to assure patients' privacy.
- The site will have a bathroom (preferably with shower facilities) available for patients' use following completion of the exam.
- The site or examiner program that serves the site will have/provide proper equipment and supplies to facilitate a comprehensive exam ("proper equipment and supplies" are locally defined).
- The site or examiner program that serves the site will have a mechanism to ensure that evidence collection kits are available and up to date.
- Patients will be offered medications for possible exposure to sexually transmitted infections.
- Patients will be assessed for pregnancy risk, informed about treatment options, and offered treatment.
- Patients will be offered information about how exams are paid for in their jurisdiction and reimbursement sources (if they exist) for related expenses that are their responsibility.
- Site billing departments will adhere to proper coding and billing practices for sexual assault cases, as determined by the facility and informed by jurisdictional policy.

If designated facilities or sites served by examiner programs are selected, their success depends on getting information about them to victims and agencies that provide immediate response or refer victims for treatment and evidence collection. At a minimum, the list of designated exam sites should be provided to all local hospitals, law enforcement agencies, emergency medical services, sexual assault victim advocacy programs, and protective services. Promoting community public awareness about these sites is also important given that victims may first disclose an assault to family members, friends, teachers, faith-based leaders, employers, coworkers, and others. In addition, success will depend on interagency cooperation in explaining facility options to victims and transporting them to designated exam sites (with their permission). Law enforcement representatives and advocates may need guidance on how to recommend an exam location to victims without mandating that they go to a specific site.

**If a transfer from one health care facility to a designated exam site is necessary, use a protocol that minimizes time delays and loss of evidence and addresses patients' needs.**<sup>130</sup> Avoid transferring sexual assault patients whenever possible. If transfer is necessary, explore options to ensure that the patient's comfort is prioritized. Every transfer can destroy evidence and cause patients further stress. However, if a sexually assaulted individual arrives at a health care facility that, for some reason, is not able to provide a medical forensic exam, interagency transfer procedures must be in place to transfer that individual to the nearest designated exam site. Evidence should be preserved when examining, treating, or transferring patients and providers should take care to preserve the chain of custody of such evidence. If there are acute medical or psychological injuries that must be treated immediately, treatment should be provided at the initial receiving facility. It may be helpful to offer patients support and advocacy from advocates at both the receiving facility and exam site. A copy of all records, including any X-rays taken, should be transported with patients to the exam facility. (However, it may not be necessary to send all medical records if patients' medical needs are met before they are transferred to a nonmedical exam site for evidence collection.) All health care facilities receiving federal funds, including Medicare and Medicaid payments, are required to screen patients medically before transferring them to another exam site.<sup>131</sup>

<sup>130</sup> This section was drawn from the *North Dakota Sexual Assault Evidence Collection Protocol*, 2005, p. 12, and the *Texas Evidence Collection Protocol*, 1998, p. 14.

<sup>131</sup> Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.

Patients have a right to decline a transfer. They should be aware, however, of the impact of refusing transfer, as it may negatively affect the quality of care, the usefulness of evidence collection, and, ultimately, any criminal investigation and/or prosecution. They should understand that declining a transfer might also be used to discredit them in court. Providers should carefully discuss with patients the benefits of the transfer, the possible benefits of refusing the transfer and the drawbacks of both options, so that patients can make an informed decision. Providers should avoid pressuring patients to accept a transfer.

### 3. Equipment and Supplies

Recommendations at a glance to ensure proper equipment and supplies are available for exams:

- Consider what equipment and supplies are necessary to conduct a medical forensic exam.
- Address cost barriers to obtaining necessary equipment and supplies.

Examiners should know how to use all equipment and supplies (including medications) properly during the exam. It is important that examiners and other individuals involved in sexual assault cases stay abreast of the latest research on the use of equipment and supplies used in caring for sexual assault patients and/or collecting evidence from them.

**Consider what equipment and supplies are necessary to conduct a medical forensic exam.** Plan to have the following equipment and supplies readily available for the exam, according to jurisdictional policies:<sup>132</sup>

- A copy of the most current exam protocol used by the jurisdiction.
- Standard exam room equipment and supplies for a physical assessment and pelvic exam. Access for patients with physical disabilities should be taken into account.<sup>133</sup>
- Comfort supplies for patients, even if minimal. Suggested items: clean and ideally new replacement clothing, toiletries, food and drink, and a phone or at least easy access to a phone in as private a location as possible. It is also important during the exam process to help patients obtain items they request related to their spiritual healing.<sup>134</sup> It may be useful for facilities to have items on hand that are commonly requested in that jurisdiction (e.g., things that are used for local tribal traditional healing practices) and policies for their use in the facility.<sup>135</sup>
- Sexual assault evidence collection kits and related supplies. (See *B.4. Sexual Assault Evidence Collection Kit* for information on minimal kit contents.) Related supplies might include tweezers, tape, nail clippers and scrapers, scissors, collection paper, saline solution or distilled water, extra swabs, sterile containers, envelopes, paper bags, and pens/pencils.
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. With any drying method or device used, ensure minimal contamination of evidence, and maintain the chain of custody. The kit's design can also aid in the drying process (e.g., by providing clear instructions and supplies to allow drying to occur).
- A camera and related supplies (using the most up-to-date technology possible) for forensic photography during initial and follow-up examinations. Related supplies might include digital media, batteries and/or charger, a flash, a color bar, and a scale ruler for size reference. (Also see *C.5. Photography.*)
- Testing and treatment supplies needed to evaluate and care for patients medically (follow exam facility policies). Also, testing supplies may be needed that are not included in the evidence collection kit. For example, supplies for toxicology testing are often not in the kit.
- An alternate light source (using the most up-to-date technology possible) can aid in examining patients' bodies, hair, and clothing. It can be used to scan for evidence, such as dried or moist

<sup>132</sup> All the equipment and supplies discussed will not be needed in every exam. What is appropriate in each case will depend on the circumstances of the assault and medical and forensic attention called for, patients' needs, and patients' consent to utilize equipment and supplies. Jurisdictional and/or facility policies will also influence what equipment and supplies are used.

<sup>133</sup> For example, it would be ideal to have an exam table with a hydraulic lift for persons with mobility impairments. If this exam table is not available, health care personnel must be aware of how to assist patients with physical disabilities onto standard exam tables. If it is determined that a patient can only be examined on an exam table with a hydraulic lift, procedures should be in place to get the patient to a site with such a table with as little loss of evidence as possible.

<sup>134</sup> Along with these items, patients may want the opportunity to speak with a trusted religious or spiritual leader, such as a medicine man/woman, a rabbi, a priest, or a pastor, before, during, or after the exam.

<sup>135</sup> Involved responders/facilities should be aware of local traditional healing practices and support patients if they wish to use such practices at some point before, during, or after the exam. Keep in mind that each tribe has its own traditional practices to promote healing, but not all Native people follow traditional spiritual paths. Rather, spiritual values and belief systems among Native people are as widely diverse as they are among the general population.

secretions, fluorescent fibers not visible in ambient light, and subtle injury.<sup>136</sup> While the exam can be done without a light source, it is a relatively inexpensive piece of equipment that is commonly used during exams.<sup>137</sup> (Also see *C.6. Exam and Evidence Collection Procedures.*)

- An anoscope may be used in cases involving potential anorectal penetration or anal/rectal trauma.<sup>138</sup> This instrument may be used to assist in visualizing an anal injury, obtaining reliable rectal swabs (if there is a concern about contamination), and identifying and collecting trace evidence. (Also see *C.6. Exam and Evidence Collection Procedures.*)
- Written materials for patients. (For details on this topic, see *A.2. Victim-Centered Care.*)

In addition:

- A colposcope with photographic capability may be used. Although some injuries can be detected visually by examiners without the colposcope, the colposcope is an important asset in the identification of microscopic trauma. Photographic equipment, both still and video, can be attached for forensic documentation. (Also see *C.6. Exam and Evidence Collection Procedures.*)
- A microscope. In some jurisdictions, examiners are required to prepare a wet mount slide and immediately examine vaginal/cervical secretions for motile and nonmotile sperm.<sup>139</sup> In these cases, an optically staining microscope is used to highlight cellular material and facilitate the search for sperm.<sup>140</sup> (Also see *C.6. Exam and Evidence Collection Procedures.*)
- Toluidine blue dye. In some jurisdictions, the dye is used to assist in highlighting observed genital and perianal injuries. (Also see *C.6. Exam and Evidence Collection Procedures.*)

(See *C. The Examination Process* for more discussion on use of equipment and supplies during the exam. )

Note that some jurisdictions, particularly those in rural and remote areas, are beginning to utilize advanced technology (equipment and methods) such as real-time video consultation, store and forward video consultation, and interactive video consultation to support examiners conducting exams. Using this type of technology, examiners can eliminate the barriers of geography and consult with offsite medical “experts.” (This use of such technology in medicine is sometimes called telemedicine.) Equipment needed to facilitate use of telemedicine may include, but is not limited to, computers, software programs, and the Internet.<sup>141</sup> Jurisdictions that use such technology should consider ways to protect victim confidentiality.

**Address cost barriers to obtaining necessary equipment and supplies.** Obtaining equipment and supplies that can increase the quality and quantity of evidence collected can have a significant impact on case outcomes. However, the costs of equipment and training on equipment use can be prohibitive for some jurisdictions and examiner programs. Some ideas to address cost barriers:

- Seek used or donated equipment or alternative, less-expensive equipment where it exists.

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<sup>136</sup> Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 37.

<sup>137</sup> A Wood’s Lamp is perhaps the most commonly used type of light source in sexual assault exams. Examiners should be aware of what the light sources they use will detect and their limitations. For example, many examiners find the Wood’s Lamp useful in helping to detect secretions, stains, and fibers on patients. However, one research study questioned its utility as a screening device for the detection of semen. (K. Santucci, D. Nelson, K. McQuillen, S. Duffy, and J. Linakis, “Wood’s Lamp Utility in the Identification of Semen,” *Pediatrics*, 104(6), 1999.) Continued research is needed (and being conducted) on the utility of this and other light sources in evidence collection. Ongoing refinement of these instruments is encouraged.

<sup>138</sup> The examiner should use discretion in determining whether a case warrants the use of the anoscope for medical and/or forensic purposes, as well as obtain patients’ informed consent for anoscopy. Particularly if a patient has been anorectally penetrated, that patient may be uncomfortable with the use of the anoscope and could possibly even feel revictimized by it. The discomfort this procedure may cause the patient should be weighed against its potential medical or forensic benefits.

<sup>139</sup> Wet-mount evaluation of vaginal secretions for infection (e.g., yeast infection and STIs) may be conducted if medically or forensically indicated, whether or not wet-mount evaluation for sperm is done. Hospital lab personnel rather than examiners usually analyze these samples.

<sup>140</sup> The most commonly used optically staining instrument by hospital labs is the phase contrast microscope. In jurisdictions that require examiners to do wet-mount evaluations for sperm, an optically staining microscope should be readily available to them at all times. Ideally, due to chain-of-custody issues and the fact that the slide will dry in 5 to 10 minutes, examiners should not have to leave the exam room to evaluate the slide.

<sup>141</sup> Keep in mind that telemedicine in sexual assault cases is in its infancy—further research and debate is needed to address concerns related to logistics of use, patients’ consent, confidentiality, and impact; legal implications; affordability; and accessibility.

- Apply for grant or foundation funding for equipment where eligible.<sup>142</sup>
- Ask for help from community groups in raising funds for one-time equipment or ongoing supply costs;
- Consider sharing costs and equipment with other departments in an exam facility or among other near-by local health care facilities.
- Consider the benefits of a mobile examiner program where costs of equipment, examiner education and clinical preparation, and on-call costs may be shared by multiple exam sites.
- Since the information gathered in the exam is used to investigate and prosecute the offense, ask for assistance from local law enforcement and prosecutor's offices in obtaining equipment and supplies used specifically for forensic evidence collection.

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<sup>142</sup> Funding under the STOP Violence Against Women Formula Grant Program and the Grants to Indian Tribal Governments Program may be used to cover costs of some equipment. For more information, see <http://www.ovw.usdoj.gov>.



## 4. Sexual Assault Evidence Collection Kit

Recommendations at a glance when developing/customizing kits:

- Use kits that meet or exceed minimum guidelines for contents.
- Work to standardize sexual assault evidence collection kits within a jurisdiction and across a state or territory, or for federal cases.

**Use kits that meet or exceed minimum guidelines for contents.** Many jurisdictions have developed their own sexual assault evidence collection kits (for evidence from victims) or have purchased premade kits through commercial vendors. Kits may vary from one another in types of samples collected, collection techniques, materials used for collection, and terms used to describe categories of evidence. Despite variations, however, it is critical that every kit meets or exceeds the following minimum guidelines for contents.<sup>143</sup>

- A kit container. It is suggested that this container have a label with blanks for identifying information and documenting the chain of custody. Most items gathered during evidence collection are placed into the container, after being dried, packaged, labeled, and sealed according to jurisdictional policy. Bags are typically provided for more bulky items that will not fit in the container (e.g., clothing). Some jurisdictions provide large paper bags to hold the container and additional evidence bags.
- An instruction sheet or checklist that guides examiners in collecting evidence and maintaining the chain of custody.
- Forms that facilitate evidence collection and analysis, including patients' authorization for collection and release of evidence and information to the law enforcement agency; the medical forensic history; and anatomical diagrams.
- Materials for collecting and preserving the following evidence, according to jurisdictional policy.<sup>144</sup>
  - Patients' clothing and underwear and foreign material dislodged from clothing.
  - Foreign materials on patients' bodies, including blood, dried secretions, fibers, loose hairs, vegetation, soil/debris, fingernail scrapings and/or cuttings, matted hair cuttings, material dislodged from mouth,<sup>145</sup> and swabs of suspected semen, saliva, and/or areas highlighted by alternate light sources.<sup>146</sup>
  - Hair if required in the jurisdiction.<sup>147</sup>
  - Vaginal/cervical swabs.
  - Penile swabs.
  - Anal/perianal swabs.
  - Oral swabs.
  - Body swabs.<sup>148</sup>

<sup>143</sup> The following resources were helpful in developing this list: the *Sexual Assault Evidence Collection Kit, VEC100*, by Sirchie Finger Print Laboratories, the *Texas Customized Sexual Assault Evidence Collect Kit* by Tri-Tech, Inc., the Commonwealth of Virginia's *Physical Evidence Recovery Kit*, the state of California's *Medical Forensic Report: Adult/Adolescent Sexual Assault Examination, Less than 72 Hours (OCJP 923)*, the *Ohio Department of Health's Sexual Assault/Abuse Evidence Collection Kit* (as found in their protocol), *Detailed Instructions; Connecticut's Sexual Assault Evidence Collection Kit* (as found in their protocol), and the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, pp. 101–107.

<sup>144</sup> Some samples that historically have been collected are no longer recommended in many jurisdictions, unless the medical forensic history and physical exam indicate otherwise (e.g., collection of a saliva sample for "secretor status").

<sup>145</sup> Flossing for evidence is not routinely done across jurisdictions. Any related safety risks to patients (e.g., potential increased risk of HIV exposure if there is semen in the mouth and flossing causes gums to bleed) must be considered and flossing for evidence can potentially expose the patient to that risk.

<sup>146</sup> It is acknowledged that approaches to categorizing evidence vary. For example, one kit may collect external genital swabs when gathering foreign materials, while in another kit, collection of genital swabs may be a separate category of evidence.

<sup>147</sup> Some jurisdictions collect pubic and head hair combings, others collect only pubic combings. Some also collect pubic and/or head hair reference samples. Materials should be included in the kit to collect and preserve hair evidence required by jurisdictional policy. Jurisdictions should evaluate the necessity of routinely collecting hair samples based on discussions of how often such evidence is actually useful or used in the jurisdiction.

<sup>148</sup> Material may be present on any body surfaces from contact with blood or body fluids. The swabs available as a standard in each kit varies by jurisdiction.

- Known blood, saliva sample, or buccal swab for DNA analysis and comparison.

(See C.6. *Exam and Evidence Collection Procedures* for specifics about evidence collection techniques.)

All forms included in the kit should be designed to facilitate optimal forensic evidence collection, analysis, and examiner testimony. Extra copies of forms should be available to examiners for cases when the kit is not used, but documentation of the medical forensic history is completed.

Materials and forms for collecting toxicology samples should be available to examiners (and to responding law enforcement officers and emergency medical technicians, according to jurisdictional policy).

**Work to standardize sexual assault evidence collection kits within a jurisdiction and across a state or territory, or for federal cases.**<sup>149</sup> A designated agency in the jurisdiction should be responsible for oversight of kit development and distribution.<sup>150</sup> It should:

- Ensure that facilities that conduct sexual assault medical forensic exams are involved in kit development and supplied with kits.<sup>151</sup>
- Work with relevant agencies (e.g., crime labs, law enforcement agencies, exam facilities and examiner programs, advocacy programs, and prosecutors' offices) to keep abreast of related changes in technology, scientific advances, and cutting-edge practice.
- Review periodically (e.g., every 2 to 3 years) kit efficiency and usefulness.
- Make adjustments to the kit as necessary.
- Establish mechanisms to ensure that kits at exam facilities are kept up to date (e.g., if a new evidence collection procedure is added, facilities need to know what additional supplies should be readily available).

(See B.6. *Evidence Integrity* for handling and storage of kits.)

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<sup>149</sup> It may be useful to consider developing a standardized kit across all communities, states, and territories, and for federal cases. Further analysis is needed to assess the benefits and disadvantages of such a kit and the feasibility of development and implementation. Some challenges could include building consensus across communities regarding best practices and obtaining buy-in from involved agencies.

<sup>150</sup> It is important to consider costs to the state/territory/tribe/federal agencies and local community, and ability of local communities to cover costs. In some states, one state agency (e.g., the crime laboratory) assumes the costs. In others, the costs are passed onto local criminal justice agencies.

<sup>151</sup> As a backup to having kits readily available at exam sites or with examiner programs, jurisdictions may also want to discuss the feasibility of storing a few kits at local law enforcement agencies or in law enforcement patrol cars. Before storing kits in patrol cars, however, make sure that the temperatures the kit will be exposed to will not affect kit contents.

## 5. Timing Considerations for Collecting Evidence

Recommendations at a glance for health care providers and other individuals responding to sexual assault victims to optimize evidence collection:

- Recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence.
- Examine patients promptly to minimize loss of evidence and identify medical needs and concerns.
- Make decisions about whether to collect evidence and what to collect on a case-by-case basis, guided by knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected.
- Examiners and law enforcement representatives should seek education and resources to aid them in making well-informed decisions about evidence collection.

**Recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence.** Examiners should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether or not evidence is gathered for the sexual assault evidence collection kit. The history and documentation of exam findings can help in determining if and where there may be evidence to collect and in addressing patients' medical needs. In addition, they can be invaluable in and of themselves to an investigation and prosecution if a report is made. It is also important to document patients' demeanor during the exam process using specific, concrete terms (e.g., crying, shaking) and their statements made related to the assault because if the case is reported, this information could be admitted as evidence at trial. When documenting patient statements, it is important to write down the exact wording of the statement.

**Examine patients promptly to minimize the loss of evidence and identify medical needs and concerns.** Evidence can be lost from the body and clothing through a number of mechanisms. For example, degradation of some seminal fluid components can occur within body orifices, semen can drain from the vagina or wash from the mouth, sperm can lose motility, bodily fluids can get washed away, and dried secretions and foreign materials can fall from the body and clothing.<sup>152</sup> Prompt examination also helps to quickly identify patients' medical needs and concerns.

Due to the stability of DNA and sensitivity of tests, advancing DNA technologies also continue to extend time limits. These technologies are even enabling forensic scientists to analyze stored evidence from crimes that occurred years before.<sup>153</sup> Such breakthroughs demonstrate the importance of collecting all possible evidence.

**Make decisions about timeliness issues for evidence collection on a case-by-case basis, guided by the knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected.** Examiners and law enforcement representatives, in particular, should be aware of the standard cutoff time for evidence collection in their jurisdictions, which is typically indicated in instructions in evidence collection kits. But it is important to remember that evidence collection beyond the cutoff point is conceivable and may be warranted in particular cases. In any case where the utility of evidence collection is in question, encourage dialogue between law enforcement representatives (if involved), examiners, and forensic scientists regarding potential benefits or limitations.

<sup>152</sup> Paragraph drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 29.

<sup>153</sup> When the evidence was initially collected after the assault, it was not of adequate quality to allow crime lab analysis using existing technologies. See T.S. Corey, A.R. Wetherton, P.J. Foncek, and D. Katz, Investigation of Time Interval for Recovery of Semen and Spermatozoa from Female Internal Genitalia, from the Office of the Chief Medical Examiner, the Department of Pathology and Laboratory Medicine, University of Louisville School of Medicine, and the Kentucky State Police Forensic Science Laboratory. See also K. A. Mayntz-Press, L.M. Sims, A. Hall, and J. Ballantyne, "Y-STR Profiling in Extended Interval (≥ 3days) Postcoital Cervicovaginal Samples", *Journal of Forensic Sciences*, V. 53, Issue 2, pp. 342–348, March, 2008.

Individuals responding to sexual assault victims should avoid basing decisions about whether to collect evidence on how they think patients' characteristics or circumstances will affect the investigation and prosecution. For example, the fact that an adolescent may have lied to her parents about where she was going the night of the assault should in no way influence the decision of the examiner and/or the law enforcement representative to collect evidence.

**Examiners and law enforcement representatives should seek education and resources to aid them in making well-informed decisions about evidence collection.** Examiners and law enforcement representatives require training and resources to allow them to make informed decisions about whether to collect evidence and what to collect in each case. They also need local policies and kit instructions that encourage them to make informed decisions in each case, rather than applying a limiting general standard to all.<sup>154</sup> First responders also need instructions on collecting a urine sample if there is any suspicion of alcohol- or drug-facilitated sexual assault and victims cannot wait to urinate until their arrival at the exam site.

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<sup>154</sup> For many communities, moving away from the 72-hour cutoff time represents a major shift in policy. Training and policies should discourage decision making about evidence collection that is based on extraneous factors, such as reluctance of a criminal justice agency to pay for sexual assault evidence collection in general.

## 6. Evidence Integrity

Recommendations at a glance to maintain evidence integrity:

- Follow jurisdictional policies for drying, packaging, labeling, and sealing evidence.
- Make sure transfer policies maximize evidence preservation.
- Make sure storage policies maximize evidence preservation.
- Document the handling, transfer, and storage of evidence.

**Follow jurisdictional policies for drying,<sup>155</sup> packaging, labeling, and sealing evidence.** Examiners should be educated regarding these policies. It is critical to air-dry wet evidence at room temperature in a clean, sterile environment and quick manner that prevents contamination.<sup>156</sup> A drying box or other device may be used to facilitate the drying process. Jurisdictions should have policies for handling evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, sanitary napkins, tissues, diaphragms, and condoms), as well as for liquid evidence such as urine and drawn blood samples. When packaging dry evidence, use paper containers rather than plastic, because plastic containers retain moisture and promote degradation of biological evidence. Following proper drying and packaging procedures is vital to prevent the growth of mold and bacteria that can destroy an evidentiary sample.

Keep in mind that evidentiary materials include exam documentation. Follow jurisdictional policies for documenting exam findings and the medical forensic history and for packaging, labeling, and sealing such documentation. Properly recording and preserving this information is critical for its admissibility during a trial.

**Make sure transfer policies maximize evidence preservation.** Minimize transit time between collection of evidence and storage of kits. To avoid potential degradation of evidence, it is important to transport kits containing liquid samples and other wet evidence in a timely fashion. Only a law enforcement official or duly authorized agent should transfer evidence from the exam site to the appropriate crime laboratory or other designated storage site (e.g., a law enforcement property facility). Jurisdictional procedures for evidence management and distribution must be in place and followed. Those involved in evidence management and distribution should be educated on the specifics of these procedures and their responsibilities.

**Make sure storage policies maximize evidence preservation.** Secure storage sites should be designated and storage requirements should be consistent across a jurisdiction. Storage requirements depend on what types of specimens are being collected and on jurisdictional policy. For example, kits without drawn blood or other wet evidence generally do not need to be refrigerated. Follow jurisdictional policy for refrigeration of drawn blood samples and other wet evidence. The use of dried blood samples on blood collection cards is encouraged because they do not require refrigerated storage.<sup>157</sup> Urine should be refrigerated or frozen when stored.<sup>158</sup> Those involved in storing biological evidence should be knowledgeable regarding optimal storage conditions as well as the hazards for handling and storing evidence such as blood and urine. Evidence should be retained for as long as possible, as storage space permits. Some jurisdictions require storage of evidence for the full statute of limitations of the offense.

**Make sure jurisdictional policies are in place to address evidence storage in cases where patients are undecided about reporting.** Finding adequate storage space for these kits is a challenge for many facilities and agencies (e.g., community-based or hospital examiner programs may lack the capacity for secure long-term storage of kits at their facilities). Local responders, particularly examiners, law enforcement representatives, and crime lab staff, should discuss and address these and related challenges and develop

<sup>155</sup> Dry evidence unless indicated otherwise (e.g., freezing).

<sup>156</sup> With the ever-increasing sensitivity of DNA analysis, there is a greater chance that accidental contamination and dilution by foreign DNA can be detected. Every precaution should be taken to reduce outside contamination and dilution of evidence.

<sup>157</sup> The National Institute of Standards and Technology is conducting a 10-year project on DNA storage. Thus far, it confirms that refrigeration of dried DNA is generally unnecessary.

<sup>158</sup> Liquid blood and urine are generally required for toxicology purposes. These samples require refrigeration, preferably in a locked refrigerator. If a locked refrigerator is not immediately available, these samples can be kept at room temperature for no longer than 24 hours.

procedures that allow for the secure storage of these kits without revealing patients' identity. Storing the evidence as long as necessary is the ideal (e.g., until the patient decides whether to report or until the jurisdiction's statute of limitations for retaining evidence expires). However, due to lack of storage space, kits in some jurisdictions are stored for a limited period of time (e.g., 1, 5, or 10 years) and then destroyed if no report is made. Many jurisdictions have elected to store kits for the duration of the statute of limitations for the offense. If a limited-time policy is implemented, it is important that patients are informed regarding the amount of time they have to decide to report and procedures for reporting. It is also critical that the period of time given to patients to decide allows them the chance to consider their decision thoroughly; a short time such as a week or a month may not be sufficient to make such a decision.

**Document the handling, transfer, and storage of evidence.** Examiners must maintain control of evidence during the exam, while evidence is being dried, and until it is in the kit container and sealed (and then follow jurisdictional procedures for storing evidence securely or handing it over to a duly authorized agent for transfer to a storage site). Documentation should continue with each transfer of the evidence to law enforcement, the crime laboratory, and others involved in the investigative process.<sup>159</sup> Patients, advocates, family members, and other support persons should not handle the evidence. Documentation of the chain-of-custody information is vital to ensuring that there has been no loss or alteration of evidence prior to trial. Educate all those involved in handling, transferring, and storing evidence regarding the specifics of maintaining the chain of custody. If the patient is transferred between facilities, staff at both facilities should be careful to complete this documentation.

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<sup>159</sup> Adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 34.

## **C. The Examination Process**

This section focuses on the various medical and forensic components of the exam process, starting with the initial contact with victims to the court testimony by examiners on exam findings.

The following chapters are included:

1. Initial Contact
2. Triage and Intake
3. Documentation by Health Care Personnel
4. The Medical Forensic History
5. Photography
6. Exam and Evidence Collection Procedures
7. Alcohol- and Drug-Facilitated Sexual Assault
8. STI Evaluation and Care
9. Pregnancy Risk Evaluation and Care
10. Discharge and Follow-up
11. Examiner Court Appearances



# 1. Initial Contact

Recommendations at a glance to facilitate initial contact with victims:

- Build consensus among involved agencies regarding procedures for coordinated initial response when a recent sexual assault is disclosed or reported. Educate responders to follow procedures.
- Recognize essential elements of initial response.

## **Build consensus among involved agencies regarding procedures for coordinated initial response when a recent sexual assault is disclosed or reported. Educate responders to follow procedures.**

First responders from these agencies (e.g., 911 dispatchers, law enforcement representatives, emergency medical services (EMS) technicians, hospital emergency department staff, sexual assault examiners, and advocates) need to be educated about and follow these procedures. Responders also need discipline-specific procedures (e.g., EMS procedures should stress the importance of preserving evidence when caring for acute injuries and treating victims with sensitivity).

In addition, other community professionals to whom victims may disclose need to know procedures for activating the SART/SARRT or obtaining immediate assistance for victims if a SART/SARRT does not exist. (For information on this topic, see *A.1. Coordinated Team Approach* and *Appendix B. Creation of SART/SARRTs*.) Also, recognize that some institutions and residential living programs have internal procedures for handling sexual assault disclosures. SART/SARRT members should work with these entities to ensure that their procedures address the needs of victims and are coordinated with jurisdictional multidisciplinary response.

**Recognize essential elements of initial response.** Some victims may initially present at an exam site. But most victims who receive immediate medical care for sexual assault initially contact 911, law enforcement, or an advocacy agency for help.

Law enforcement, 911, and EMS response. Steps that should be taken during initial law enforcement, 911, or EMS contact include:

- Assess victims' needs for immediate care for potentially life-threatening or serious injuries. Administer necessary first aid and request/obtain emergency medical assistance according to jurisdictional policy.
- Address safety needs of victims and others at the scene (e.g., offenders may be present), calling for assistance/backup if needed.
- Assess quickly the age, abilities, communication modality, and health condition of victims and tailor your response as appropriate (e.g., a qualified interpreter, assistive devices, or protective service worker may be needed).
- Respond to requests for victim assistance as quickly as possible.<sup>160</sup> Understand that victims need immediate assistance for many reasons: they may not be safe, may be physically injured, and/or are experiencing trauma. Be aware that time delays in response can cause loss of evidence and increased trauma.
- If injuries do not appear serious, emphasize to victims the need for medical evaluation and address related health concerns. Also, explain the purpose of the exam and what happens during the exam process, keeping in mind that the amount of information that victims want at this time varies.

<sup>160</sup> In some areas, law enforcement representatives may not respond promptly because they must travel considerable distances and through rough terrain to get to victims' locations. Some law enforcement agencies may not have enough representatives to respond to each case in a timely manner (e.g., a rural sheriff's office may only have one officer). In communities with such limitations, it is important that agencies and professionals involved in these cases advocate for increasing the capacity of law enforcement agencies to respond promptly. They also can work jointly to ensure that there is at least one responder/agency from which victims can consistently receive initial help (e.g., EMS or the advocacy program). That professional/agency should be trained in initial response and be able to access emergency medical assistance if needed and coordinate transportation to the exam facility. Information about which agency/responder to call for help must be publicized in the community.

- Inform victims about exam facility options (if options exist) and seek their consent to transport them to the facility of their choice (if they had options) for treatment and/or medical/forensic evaluation.<sup>161</sup>
- Encourage victims' interaction with advocates as soon as possible after disclosure of the assault, even if victims choose not to receive medical care and/or have the medical forensic exam. In a few jurisdictions, advocates may be dispatched directly to the scene to provide victim support and advocacy, if appropriate. Follow local procedures for activating an advocate.
- Ask victims if they would like family members or friends to be contacted.
- Explain options for interpretation and translation for victims who are not proficient in English or who may prefer to communicate in a non-English language.
- Take measures to preserve crime scene evidence, including evidence on the body and clothing of victims. Document victims' demeanor and statements related to the assault, according to jurisdictional policy.
- Explain to victims their reporting options. Keep in mind that the amount of information desired will vary per individual.
- Responding law enforcement officials should seek basic information from victims about the assault in order to apprehend suspects and facilitate crime scene preservation in a timely manner.

If victims agree to seek emergency care and/or have evidence collected:

- Explain to victims in a language they understand how to preserve bodily evidence until it can be collected (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth).
- Explain to victims in a language they understand that clothing most likely will be taken as evidence. They may wish to bring or have someone bring a clean change of clothes to the exam facility. If applicable, let victims know that replacement clothing will be available at the exam site. If they changed clothes since the assault, the clothing worn during and immediately after the assault will be needed. Follow law enforcement procedures for retrieving clothing or other items from a crime scene so that evidence is not inadvertently destroyed or contaminated.
- In suspected cases of alcohol- or drug-facilitated assault, victims' first available urine sample should be sought if they cannot wait to urinate until arrival at the exam site. (For information on procedures, see *C.7. Drug-Facilitated Sexual Assault*.) Victims might have been drugged without their knowledge. If they or their families, friends, or responders suspect alcohol- or drug-facilitated assault, a urine sample should be sought.
- Transport or arrange transportation for victims to the exam site that has the most appropriate forensic medical examination capability.<sup>162</sup> Victims with disabilities may have equipment (e.g., wheelchairs and other assistive devices) and/or service animals that also need to be transported.<sup>163</sup> Keep in mind that victims may consider such equipment as extensions of themselves, so any such equipment should be treated with care.
- Follow jurisdictional policy on alerting exam facilities about the pending arrival of patients.
- Do not take suspects to the same exam facility as victims at the same time, if possible.

**Advocate response.** If victims have initial contact with advocates, this contact typically occurs through a phone hotline call or a face-to-face meeting. Advocates should follow agency-specific and jurisdictional policy for first response. For example, advocates should assess victims' safety and need for medical assistance and call 911 in cases of serious injuries or when there is an imminent threat to someone. Advocates should describe potential medical concerns related to sexual assault, support victims in seeking care for possible injuries, provide information about their options (e.g., health care, advocacy and counseling, interpretation and translation, evidence collection, exam site options, and reporting to law enforcement), and offer referrals.

<sup>161</sup> Inform victims of the approximate amount of time it will take to travel to the facility and how long they will be at the exam site. This information can help them prepare for what to expect and make needed arrangements (e.g., childcare, getting time off from work or school, or informing family members). In some areas, it may take considerable time to get to the exam site (i.e., several hours). Involved agencies in these areas may want to consider the feasibility of having a specially trained examiner located in their community.

<sup>162</sup> Many jurisdictions have designated exam sites. For more information on this topic, see *B.2. Facilities*.

<sup>163</sup> In addition, evidence may be found on assistive devices and/or service animals.

They can explain to victims how to preserve bodily evidence for evidence collection and the importance of prompt toxicology testing if alcohol- or drug-facilitated assault is suspected. In general, advocates can help victims identify and consider how to address their needs and concerns, as well as identify individuals who might support them in dealing with the aftermath of the assault. They can activate the SART/SARRT (if one exists) with victims' permission. Alternately, advocates can offer to help victims arrange transportation to the exam site, obtain nonemergency medical care, and obtain assistance from law enforcement. They can also accompany them through medical forensic procedures.

Regardless of which agencies are first responders, responders should always be sensitive to the victim's needs and level of trauma. It is common for victims of sexual violence to have showered, eaten or taken other self-protective actions that may have destroyed evidence prior to engaging any service providers. Responders should react in an understanding and non-judgmental manner to ensure they receive appropriate care.



## 2. Triage and Intake

Recommendations at a glance for health care providers to facilitate a triage and intake process that addresses patients' needs:

- Consider sexual assault patients a priority.
- Perform a prompt, competent medical assessment. Then respond to acute injury, the need for trauma care, and safety needs of patients before collecting evidence.
- Alert examiners of the need for their services.
- Contact victim advocates so they can offer services to patients, if not already done.
- Assess and respond to safety concerns of victims upon arrival at the exam site, such as threats to patients or staff.
- Assess patients' needs for immediate medical or mental health intervention prior to the evidentiary exam, following facility policy.

**Consider sexual assault patients a priority.**<sup>164</sup> (For a discussion of this topic, see A.2. *Victim-Centered Care*.)

Utilize a private location within the exam facility for patient intakes, as well as for a waiting area for patients' family members and friends and law enforcement interviews. (Also see A.2. *Victim-Centered Care*.)

**Perform a prompt, competent medical assessment. Then respond to acute injury, the need for trauma care, and safety needs of patients before collecting evidence.** In addition to promoting physical health, sensitive and timely medical care can help reduce the likelihood of acute psychological trauma and its aftereffects, support patients' existing and emerging coping skills, and set the tone for patients' resumption of normal functioning.

Acute medical needs take precedence over evidentiary needs. Patients should be instructed to not wash, change clothes, urinate, defecate, smoke, drink, or eat until initially evaluated by examiners, unless necessary for treating acute medical injuries. If alcohol- or drug-facilitated sexual assault is suspected, and patients need to urinate prior to the arrival of examiners, ensure that the urine sample is collected properly while maintaining the chain of custody.

The forensic examiner should be involved in all aspects of the medical forensic examination of the sexual assault patient. As soon as possible after the initial triage, management, and stabilization of acute medical problems and before treating non-acute injuries, the evidentiary exam can be conducted (with patients' permission). In circumstances in which patients are seriously injured or impaired, examiners must be prepared to work alongside other health care providers who are stabilizing and treating them. In such cases, examiners may need to perform exams in settings such as a health care facility's emergency department, an operating room, a recovery room, or an intensive care unit.

**Alert examiners of the need for their services.** The SART/SARRT, if one exists, can work with exam facilities to identify acceptable timeframes to conduct a medical forensic exam after a patient's arrival and medical evaluation, management, and stabilization. If examiners are not based at the site or need to be dispatched, the facility should contact them immediately after identifying a sexual assault patient.<sup>165</sup>

<sup>164</sup> Historically, sexual assault patients who came to a health care facility (namely hospital emergency departments) for medical care and forensic evidence collection had to wait a long time to be examined. Often, they were not considered priority cases because they lacked visible physical injuries or their physical injuries were less serious than others coming into the facility. The psychological trauma they were experiencing often was not taken into account, nor was the fact that evidence can be destroyed or contaminated if collection is delayed. Many communities are addressing this problem by establishing examiner programs. At busy health care facilities that make life or death decisions about prioritizing patients, these programs can help ensure that sexual assault patients are offered and receive a medical forensic examination promptly.

<sup>165</sup> It is possible that examiners could also be dispatched by first responders at the crime scene or by health care staff after being alerted that a sexual assault patient will be arriving at their facility. Although activating examiners as early as possible seems like it would benefit these patients, such a procedure can potentially cause confusion. For example, after activating an examiner to go to a particular

Examiners are often required to arrive at the exam site within a certain period of time (e.g., 30 minutes) after being dispatched.

**Contact victim advocates so they can offer services to patients, if not already done.** (For a discussion of this topic, see *A.2. Victim-Centered Care*.)

**Assess and respond to safety concerns of victims upon arrival at the exam site, such as threats to patients or staff.** The facility should have procedures to assess such safety concerns at the exam site and to respond to such threats or dangerous situations. (For a discussion of this topic, see *A.2. Victim-Centered Care*.) Communicating any information may require a qualified interpreter<sup>166</sup> for victims who are LEP.<sup>167</sup>

**Assess patients' needs for immediate medical or mental health intervention prior to the evidentiary exam, following facility policy.** Seek informed consent of patients before providing treatment. (For more information on this topic, see *A.3. Informed Consent*.) Also, inform them that they have a right to receive medical care regardless of whether the assault is reported to law enforcement. (For more information on this topic, see *A.5. Reporting to Law Enforcement*.)

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exam facility, there may be significant delays in getting the patient to the site or changes en route to the facility. Sexually assaulted individuals may also change their minds about care or evidence collection.

<sup>166</sup> There is currently no certification process for health care interpreters or translators. For more information about qualifications including standards of practice for health care interpreters and translators, please see *What's in a Word: A Guide to Understanding Interpreting and Translation in Health Care*, National Health Law Program (2010).

<sup>167</sup> Title VI of the Civil Rights Act of 1964 and its implementing regulations require that entities that receive federal financial assistance provide meaningful access to their programs, services, and activities for persons with limited English proficiency.

### 3. Documentation by Health Care Personnel

Recommendations at a glance for completing needed documentation:

- Ensure completion of all appropriate documentation.
- Educate examiners on proper documentation.
- Ensure the accuracy and objectivity of medical forensic reports.

**Ensure completion of all appropriate documentation.** Examiners are responsible for documenting the details of the medical forensic exam and treatment provided in the medical record, as well as documenting required data for the evidence collection kit, according to jurisdictional policy. This evidence collection kit report usually includes patient consent forms related to evidence, the history of the assault, and information pertaining to evidence collection that will assist the crime lab in material identification for analysis.<sup>168</sup> (The medical forensic history and documentation of exam findings are discussed in more depth in later chapters in this section.) The only medical issues documented in this report are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings. If the case is reported, the criminal justice system will use the entire medical forensic record of the sexual assault visit, along with collected evidence, photographs and video images, and victim/witness statements, as a basis for investigation and possible prosecution. If examiners are required to testify in court, they will use the report to recall the incident.

The overall medical forensic record kept by examiners and other clinicians follows a standard approach of addressing acute complaints; gathering pertinent historical data; describing physical findings, laboratory and x-ray findings, consultation reports (if done) and evidence collection procedures; and documenting treatment (and response to treatment) and follow-up care. The complete medical forensic record of the sexual assault visit should be maintained separately from the patient's medical record to limit disclosure of unrelated information and to preserve confidentiality. The medical record is stored at the exam site. The exam site should have clear policies about who is allowed access to these records.<sup>169</sup>

The medical record is not part of the evidence collection kit and it should not be submitted to the crime lab or given to law enforcement. Much of the record is not relevant to case prosecution, and releasing it infringes upon patients' privacy rights. Although all or part of the medical record may be subpoenaed, if patients do not consent to its release, it is ultimately up to the court to decide whether such information is pertinent to the case and should be released.

**Educate examiners on proper documentation.** It is vital that the exam documentation be thorough, precise, and accurate. It is essential that examiners receive education on the importance of proper documentation and on writing reports that are relevant to their role. As previously discussed, forensic documentation must include diagrammatic rendering, written description (including assessment for tenderness and induration), and forensic imaging of any visible finding (traumatic or evidence).

Law enforcement representatives and advocates who are involved in the response should understand the importance of examiner documentation and be able to convey that importance to patients.

**Ensure the accuracy and objectivity of medical forensic reports.** It is suggested that examiners within an exam site, jurisdiction, or region devise an appropriate review process tailored to their needs. Consider having a clinical director or supervisor at the exam site systematically review documentation related to the exam. (In some jurisdictions, review of nonphysician examiner's documentation by a medical director/supervisor is required.) These reviews can serve to increase the overall effectiveness of the examiner program by ensuring that reports are completed according to policy, assessing staff training needs,

<sup>168</sup> Documentation of exam findings should include patients' demeanor and statements related to the assault not already recorded on the medical forensic history. Such documentation can be admitted as evidence at trial in most states. Local prosecutors can provide more detailed information on this type of documentation.

<sup>169</sup> Mechanisms to restrict access to records related to the exam are particularly important in small communities where exam site employees may be acquaintances, friends, and family members of patients or suspects.

considering adjustments needed to paperwork, troubleshooting for potential problems, and identifying trends in presenting the issues of patients. All identifying patient information should be removed when a document is copied for a review. The clinical director or supervisor can also be involved in broader multidisciplinary quality assurance efforts related to the exam process.

## 4. The Medical Forensic History

Recommendations at a glance for health care providers to facilitate gathering information from patients:

- Coordinate medical forensic history taking and investigative interviewing.
- Advocates should be able to provide support and advocacy during the history, if desired by patients.
- Consider patients' needs prior to and during information gathering.
- Obtain the medical forensic history.

**Coordinate medical forensic history taking and investigative interviewing.** Examiners typically ask patients to provide a medical forensic history after initial medical care for acute problems and before the examination and evidence collection. This history, obtained by asking patients detailed forensic and medical questions related to the assault, is intended to guide the exam, evidence collection, and crime lab analysis of findings. In cases where the victim reports the assault, law enforcement representatives should also collect information from patients to help in the apprehension of suspects and in case investigation.<sup>170</sup>

Gathering information from patients often takes place soon after they have experienced the assault. Not only can discussing the assault cause patients to feel re-violated, but their emotional and physical condition may make communication difficult. They may also be uncomfortable discussing personal matters with involved responders. Those seeking information about the assault should work collaboratively to create an information-gathering process that is as respectful to patients as possible and minimizes repetition of questions.<sup>171</sup> However, jurisdictions should consider the implications of the evolving law on hearsay exceptions when determining the level and nature of coordination. See *Appendix C* for more information on the relevant case law and how it relates to medical forensic examinations.

Promote a streamlined, victim-centered information-gathering process. Jurisdictions employ several methods, including the following:

- Communication and coordination among responding officers, examiners, investigators, and prosecutors as they go about their separate information-gathering processes.
- Examiners and investigators together ask patients basic questions in a language that she or he understands. One asks questions while the others listen. They then speak to patients separately to gather any remaining information required.
- The medical forensic history and investigative interviews are conducted simultaneously to the extent feasible. The SART/SARRT should determine the information-gathering process, reflecting the best use of resources and needs and consent of patients. The team may agree that a particular person or agency will be the primary interviewer.<sup>172</sup>

Whatever the method selected, jurisdictions should carefully plan how they will coordinate the logistics of medical forensic history taking and investigative interviewing.

**Advocates should be able to provide support and advocacy during the history if desired by patients.**

The presence of an advocate may help patients feel more comfortable answering questions. Advocates may also assist patients in voicing their concerns about questions being asked and clarifying their needs during this time. Advocates should be careful not to answer questions asked of patients or otherwise influence their statements.

<sup>170</sup> The website of the Violence Against Women Online Resources offers several resources on law enforcement investigation of sexual assault crimes. See <http://www.vaw.umn.edu/categories/2.8>.

<sup>171</sup> Some repetition of questions is likely to occur during the exam process.

<sup>172</sup> Caution should be exercised if combining medical forensic history taking with investigative interviewing. At the time of such information gathering, patients may not want to speak with law enforcement or be ready to go into the extensive details needed for investigative purposes. Patients may withhold information from law enforcement representatives or not want to talk with them about certain issues (e.g., their menstrual cycle or types of penetration). They might feel more comfortable talking to examiners in private about these topics. There is also a concern about questioners asking questions outside of their realm of responsibility.

Presence of family members, friends, and other personal support persons. Prior to taking the history, patients should be informed that the presence of personal support persons (other than advocates) may influence or be perceived as influencing their statements.<sup>173</sup> These individuals could be subpoenaed as witnesses in their case.<sup>174</sup> If, after receiving this information, patients choose to have personal support persons present during the history, these individuals should be advised not to actively participate in the process. For example, they should not answer questions for patients, comment on patients' answers, interrupt patients, or make facial expressions in response to patients' answers.<sup>175</sup>

**Consider patients' needs prior to and during information gathering.** Pressing issues (e.g., for treatment of serious injuries, crisis intervention and support, translation and interpretation, and childcare during the exam process) should be addressed before commencing with information gathering. Be mindful of patients' capacity to answer questions during a lengthy information-gathering process, and take breaks as needed.

The facility should have procedures in place and examiners should be educated to accommodate patients' communication skill level and preferred mode of communicating. This is particularly important for patients with communication-related disabilities and limited English proficient patients. If interpreters are necessary, they should be present prior to questioning and there should be space for them in the exam room and other rooms where information is gathered. Patients with communication-related disabilities may wish to use wordboards, speech synthesizers, or other assistive communication devices to help them communicate. The use of cards with pictures (e.g., of medical procedures and human anatomy) may facilitate communication with patients with some types of cognitive disabilities or limited vocabularies.<sup>176</sup>

It is important that examiners are aware of and responsive to verbal and nonverbal cues from patients. For example, patients may react negatively as they recall experiences during the assault or are reminded of previous violence committed upon them. (It is important to document this information.) What they may need most at this point is a break, the understanding of examiners, and opportunities to talk about what they are experiencing. Advocates can be particularly helpful to patients who are dealing with these emotions.

Use a private and quiet setting for information gathering. Ideally, there should be no interruptions and no time constraints for questioners or for use of the room where the information is being gathered. Although some facilities may lack space, an effort should be made to secure a private and quiet setting for this purpose. In many jurisdictions, history-taking takes place in the exam room prior to the exam.

**Obtain the medical forensic history.** The specific questions asked of patients by examiners for the medical forensic history vary from one jurisdiction to the next, as do forms used to record the history.<sup>177</sup> However, the following information should be sought routinely from patients:<sup>178</sup>

1. Date and time of the sexual assault(s): It is essential to know the period of time that has elapsed between the assault and the physical examination/collection of evidence as well as documentation of

<sup>173</sup> Ideally, these individuals should not be present when giving patients this information or when patients make the decision whether they want the support person present.

<sup>174</sup> They should also be informed that the presence of these individuals during the medical forensic history could potentially reduce the degree of confidentiality advocates can offer patients (e.g., they may be called on to provide testimony regarding the interactions between patients and family members or friends present during this time). Also, in jurisdictions that have physician/patient privilege, but not a victim advocate privilege, the advocate could be required to testify. Victims should be informed of this before disclosing non-medically relevant information.

<sup>175</sup> Requests to have family, friends, and other personal support persons present during the medical forensic history should be allowed unless it is considered potentially harmful to the exam process by the SART/involved responders. For example, in cases involving adolescents, parents or guardians should not be allowed in the exam room if they are suspected of committing the assault or of being abusive to patients.

<sup>176</sup> Carolyn Ham, *Reducing Language Barriers to Combating Domestic Violence: The Requirements of Title VI*, Battered Women's Justice Project, October 2004, [http://new.vawnet.org/summary.php?doc\\_id=1621&find\\_type=web\\_desc\\_GC](http://new.vawnet.org/summary.php?doc_id=1621&find_type=web_desc_GC).

Paragraph partially drawn from N. Baladerian, *Skills for Interviewing Adult Abuse Victims Who Have Developmental Disabilities*, p. 1.

<sup>177</sup> In some jurisdictions, examiners ask for investigative details during history taking. In others, examiners only ask for information related to treatment and collecting/interpreting physical and lab findings. One concern is that investigative details reported by examiners that differ from the law enforcement report may be used to undermine the credibility of patients. Patients should be told that if they are too uncomfortable or embarrassed to talk about something, they should say so rather than saying something that contradicts information that may be in the law enforcement report. (Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 77.) Another concern is that asking investigative questions is outside the examiner's role.

<sup>178</sup> Drawn from California's *Medical Forensic Report: Adult/Adolescent Sexual Assault Examination, Less Than 72 Hours* (OCJP 923), the *Tulsa Sexual Assault Report Form*, and the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2008, pp. 40–42.

injuries. Evidence collection may be influenced by the time interval since the assault as well as the interpretation of both the physical exam and evidence analysis.

2. **Pertinent patient medical history:** The interpretation of physical findings may be affected by medical data related to menstruation, recent anal-genital injuries, surgeries, or diagnostic procedures, blood-clotting history, and other pertinent medical conditions or treatment.
3. **Recent consensual sexual activity:** The sensitivity of DNA analysis makes it important to gather information about recent consensual intercourse, whether it was anal, vaginal, and/or oral, and whether a condom was used. A trace amount of semen or other bodily fluid, as well as genital microtrauma, may be identified that is not associated with the crime. Once identified, it may need to be associated with a consensual partner, and then used for elimination purposes to aid in interpreting evidence.<sup>179</sup>
4. **Post-assault activities of patients:** The quantity and quality of evidence is affected both by actions taken by patients and the passage of time. It is critical to know what, if any, activities were performed prior to the examination (e.g., have patients urinated, defecated, had consensual sexual intercourse, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, eaten or drank, smoked, used drugs, or changed clothing?).
5. **Assault-related patient history:** Information such as the location of nongenital injury, tenderness, pain and/or bleeding, and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care. Patients should also be questioned about strangulation since this type of injury can result in airway obstruction if swelling occurs and strangulation is a very common occurrence in sexual assault cases.
6. **Suspect information (if known):** Forensic scientists seek evidentiary items that may have had cross-contact or transfer among patients, suspects, and crime scenes. The gender and number of suspects may offer guidance to types and amounts of foreign materials that might be found on patients' bodies and clothing. Suspect information gathered during this history should be limited to that which will guide the exam and forensic evidence collection. Detailed questions about suspects are asked during the investigative interview.
7. **Nature of the physical assault(s):** Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and tactics employed by suspects is crucial to the detection, collection, and analysis of physical evidence. Tactics may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding, pinching, biting, using physical restraints, strangulation, burns (thermal and/or chemical), threat(s) of harm, and involuntary ingestion of alcohol/drugs. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood) or from suspects (e.g., bruising, fingernail marks, or bite marks).
8. **Detection of alcohol- or drug-facilitated sexual assault:** It is critical in these cases to collect information such as whether there was memory loss, lapse of consciousness, or vomiting; whether the patient was given food or drink by the suspect (if the patient knows); or whether the patient voluntarily ingested drugs or alcohol. Collecting toxicology samples within 120 hours of the suspected ingestion is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.
9. **Description of the sexual assault(s):** An accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include any:<sup>180</sup>
  - Penetration of genitalia (e.g., vulva, hymen, and/or vagina of female patient), however slight, including what was used for penetration (e.g., finger, penis, or other object);
  - Penetration of the anal opening, however slight;
  - Oral contact with genitals (of patients by suspects or of suspects by patients);
  - Other contact with genitals (of patients by suspects or of suspects by patients);
  - Oral contact with the anus (of patients by suspects or of suspects by patients);
  - Nongenital act(s) (e.g., licking, kissing, suction injury, strangulation, and biting);
  - Other act(s) including use of objects;
  - If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and

<sup>179</sup> Patients should be aware that there might be a need at a later time to obtain an elimination sample from consensual partners. Jurisdictions may have policies in place for seeking such samples within a certain timeframe following the exam.

<sup>180</sup> Specific questions asked will depend on case facts (e.g., the gender of the patient and the gender of the suspect).

- Use of contraception or lubricants.<sup>181</sup>

These questions require specific and sometimes detailed answers. Some may be especially difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic exam. They should also explain why each question is being asked.

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<sup>181</sup> Certain contraceptive preparations can interfere with accurate interpretation of preliminary chemical tests frequently used in the analysis of potential seminal stains. In addition, contraceptive foams, creams, or sponges can destroy sperm. Lubricants of any kind are trace evidence and may be compared with potential sources left at the crime scene or recovered from bodies of suspects. Knowing whether a condom was used also may be useful in explaining the absence of semen.

## 5. Photography

Recommendations at a glance to photograph evidence on patients:

- Consider the extent of forensic photography necessary.
- Consider the equipment.
- Be considerate of patient comfort and privacy.
- Explain forensic photography procedures to patients.
- Take initial and follow-up photographs as appropriate, according to jurisdictional policy.
- Consider policies on storage, transfer, and retention of photographs.

**Consider the extent of forensic photography necessary.** Taking photographs of patients' anatomy that was involved in the assault should be part of the medical forensic examination process in sexual assault cases. Such photographs can supplement the medical forensic history, evidence documentation, and physical findings.<sup>182</sup> As to the extent of photographs necessary, communities appear to take two different approaches. Some routinely take photographs, with patients' permission, of both detected injuries and normal (apparently uninjured) anatomy involved in the assault. These jurisdictions encourage examiners to collect and document all evidence and leave the determination about the value of the evidence to litigants. Other communities limit photographs to detected injuries. However, photographs should not be used to interpret subtle and/or nonspecific findings (e.g., erythema or redness) that are not noted on exam documentation. Review of photographs cannot reliably diagnose injuries not seen by examiners.

Involved prosecutors, law enforcement officials, examiners, and advocates should further discuss the extent of photography they view as critical, examine any related case law, consider their concerns on this issue and how to be sensitive to victims, and, ultimately, determine what strategy is right for their community.

**Consider the equipment.** Examiners should take these photographs, due to the highly personal nature of the photography involved. Examiners are responsible for forensic photography during the exam because patients are often more comfortable and less traumatized when they take photographs.<sup>183</sup> Any photographs taken by nonmedical personnel should include only the head and extremities and should not document findings on the torso or genital region.

Examiners should be familiar with equipment operation and be educated on forensic photography in sexual assault cases. Photographic equipment should be used that can clearly document the level of injury. Consult with local criminal justice agencies regarding the types of equipment that should be used (e.g., prosecutors can assess which types of equipment produce results that are acceptable to the court).<sup>184</sup> Also consult with local examiners, because they are often knowledgeable regarding photographic and video equipment used in these cases and their effectiveness in capturing images during the exam.

**Be considerate of patient comfort and privacy.** Minimize patients' discomfort while they are being photographed and respect their need for modesty and privacy. Drape them appropriately while taking photographs.<sup>185</sup>

Also, consider how to best provide support to patients during this time. Patients may want an advocate and/or a personal support person to be present. Take measures to avoid allegations of impropriety when photographing patients. For instance, if for some reason a male examiner is photographing a female patient, another woman should be present at this time.

<sup>182</sup> The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.

<sup>183</sup> Avoid requiring that patients go to another site (e.g., the law enforcement agency) to have initial photographs taken.

<sup>184</sup> For a discussion of the admissibility of digital photographs, please see D. Nagosky, *The Admissibility of Digital Photographs in Criminal Cases*, *FBI Law Enforcement Bulletin*, December, 2005.

<sup>185</sup> Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56, and the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 113.

**Explain forensic photography procedures to patients.** Taking photographs of patients in the aftermath of an assault can be retraumatizing. To help reduce the chances of retraumatization, examiners can help patients understand the purpose of photography in forensic evidence collection, the extent to which photographs will be taken and procedures that will be used, potential uses of photographs during investigation and prosecution (especially anogenital images if taken), and the possible need to obtain additional photographs following the exam. (Also see A.3. *Informed Consent*.)

**Take initial and follow-up photographs as appropriate, according to jurisdictional policy.**<sup>186</sup> Strive to control every element in the photograph to produce a clear, powerful statement. Photographs should be taken prior to evidence collection.

Patient identification. Link patients' identity and the date to the photographs, according to jurisdictional policy.<sup>187</sup> For example, print the patient's name, date of exam, and the examiner's name/initials on a plain sheet of paper, or using a patient label. Photograph this sheet at the beginning and end of the roll of film for identification. Some jurisdictions also photograph the face of patients for identification purposes. Some cameras offer the option of imprinting the date and/or time on the negative, and some have the ability to enter a case number so the face or name of a patient is not on the film. Digital imaging can automatically embed the date/time and a variety of other technical data in each image. This information can be accessed when the image is downloaded onto the computer.

Mechanisms should be in place (e.g., at law enforcement agencies and exam facilities) to protect patients' privacy and confidentiality related to the photographs.

Clear and accurate photographs. Use the shutter speed and lens aperture to control exposure (automated cameras and flash units can give incorrect exposures). Use adequate lighting whether the source is natural, flood, or flash. Use of flashes and lighting in the exam room can change the color of evidence; a filter may help adjust lighting so that the photograph is truer to color (noting in records any alterations to the environment to enhance photographs). Include a color bar in the photograph to ensure accurate color reproduction.

Strive for undistorted photographs with good perspective (whenever possible, use a normal focal length lens, and keep the plane of the film or digital sensor parallel to the plane of the object to be documented. Maintain sharp focus (keep the camera steady, focus carefully, use maximum depth of field, and look at the frame of the scene).

A good-quality macro lens with a ring strobe flash offers the best quality and most flexibility for forensic photography involving sexual assault.

Scale. Use a forensic scale or ruler for size reference in photographs. In addition to those photographs that identify patients and anatomical locations being photographed, take at least two photographs of each area—one with and one without scale. Taking two photographs in this manner demonstrates that the scale was not concealing anything important. Photograph evidence in place before moving it or collecting it. Do not alter or move evidence when photographing, and make every effort to minimize background distraction in photographs while maintaining the focus of areas being photographed.

Orientation of shots. Take at least two shots at three orientations:

1. Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom, or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.
2. Take closeup images of particular injuries, using the scale. When photographing a wound, show its relationship to another part of the body. Take at least three photographs involving a wound area. Shield

<sup>186</sup> This section is drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, pp. 113–115.

<sup>187</sup> The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.

uninvolved breast or genital areas when possible; highly graphic photos may be deemed inadmissible in court and make the case less credible. All injuries should be recorded with a closeup view using a macro lens or setting. Try to capture subtleties in texture and color. Document pattern injuries caused by an object. Do not use a flash function around an injured eye as it can cause retinal damage.

3. In some cases, a full body photograph may be appropriate to show scope of injury or state of clothing. However, such photos should be taken ensuring as much modesty and privacy as possible, through draping and other techniques. Photos taken solely for the purpose of identification should be done with patients fully clothed or in a gown.

Photographing skin. Closeup photographs of hands and fingernails may show traces of blood, skin, or hair. Be sure to look for damage to nails or missing nails. Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks. Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.

Bite mark evidence. Photograph bite marks, according to jurisdictional policy.<sup>188</sup>

Accountability. All photographs should be clearly labeled and the chain of custody maintained. Follow jurisdictional policy for development of film, transfer, duplication or additional prints, and storage of photographs. Do not include photographs in the evidence collection kit sent to the crime lab.

Follow-up photographs. Photography should be repeated as new or different evidence on patients' bodies is found following the exam (e.g., bruising may appear days later). Create procedures that examiners, law enforcement investigators, and patients follow to ensure this evidence is documented. In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy and nonspecific findings like redness or swelling that could be confused with acute injuries.

**Consider policies on storage, transfer, and retention of photographs.** Photographs taken by examiners should primarily be considered as part of the patient's medical forensic record and should not be automatically turned over to law enforcement. Law enforcement should be guided by the body diagrams used in documentation in deciding what photographs to subpoena.

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<sup>188</sup> When bite mark evidence is presented, it may be helpful to consult a forensic odontologist, if one is available. However, this type of evidence is controversial. It is more important to ensure swabbing of bite marks.



## 6. Exam and Evidence Collection Procedures

Recommendations at a glance to facilitate the exam and evidence collection:

- Recognize the evidentiary purpose of the exam.
- Strive to collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, exam findings, and instructions in the evidence collection kit.
- Be aware of and document evidence and injuries that may be pertinent to the issue of whether the patient consented to the sexual contact with the suspect.
- Understand how biological evidence is tested.
- Prevent exposure to infectious materials and risk of contamination of evidence.
- Understand the implications of the presence or absence of seminal evidence.
- Modify the exam and evidence collection to address the specific needs and concerns of patients.
- Explain exam and evidence collection procedures to patients.
- Conduct the general physical and anogenital exam and document findings on body diagram forms.
- Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.
- Collect other evidence.
- Keep medical specimens separate from evidentiary specimens collected during the exam.

**Recognize the evidentiary purpose of the exam.** During the exam, examiners methodically document physical findings and facilitate the collection of evidence from patients' bodies and clothing. The findings in the exam and collected evidence often provide information to help reconstruct the details about the events in question in an objective and scientific manner.<sup>189</sup> Of course, health care needs and concerns of patients may be presented in the course of the exam that should be addressed prior to discharge. However, patients must understand that the exam does not provide routine medical care. For example, a pap smear will not be done during the female pelvic exam.<sup>190</sup> (This chapter focuses on evidentiary components of the exam. Other chapters in the protocol discuss more fully medical and other related needs and concerns of patients.)

**Collect as much evidence from patients as possible, guided by the scope of informed consent, the medical forensic history, exam findings, and instructions in the evidence collection kit.** Evidence collected during the exam mainly includes biological and trace evidence. To reconstruct the events in question, evidence collected is used in four potential ways in sexual assault cases:

- To identify the suspect;
- To document recent sexual contact;
- To document force, threat, or fear; and
- To corroborate the facts of the assault.

**Be aware of and document evidence and injuries that may be pertinent to the issue of whether the patient consented to the sexual contact with the suspect.** In the majority of sexual assaults, patients know the suspects. For example, according to the National Crime Victimization Survey, in 2008, 57 percent of rapes/sexual assaults involved offenders who were nonstrangers.<sup>191</sup> Most nonstranger suspects and many stranger suspects (if confronted by professionals in the criminal justice system) will claim that the patient consented to the sexual contact.<sup>192</sup> Consent claims typically stem from a lack of evidence and documentation concerning force and coercion. Thus, evidence and documentation of physical findings related to whether

<sup>189</sup> Note that while exam findings and evidence collected from patients are important in reconstructing the events in question, during a criminal investigation, law enforcement officials look for additional evidence that will create a more complete picture of the event.

<sup>190</sup> Drawn from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 79.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneuide.pdf>, *SANE Development and Operation Guide*, 1998, p. 63.

<sup>191</sup> U.S. Department of Justice, Bureau of Justice Statistics, *Female Victims of Violence*, <http://www.bjs.gov/content/pub/pdf/fvv.pdf>

<sup>192</sup> J. Archambault and D.K. Faugno, Overcoming a Consent Defense to Sexual Assault, *Journal of Emergency Nursing*, 27:204–208, April 2001.

force or coercion was used against patients (e.g., findings that reveal injuries, alcohol or drugs taken involuntarily, or signs of a struggle) are important in these types of cases. However, the absence of physical trauma does not mean that coercion/force was not used or prove that patients consented to sexual contact.<sup>193</sup> Also, some physical findings that suggest force are not necessarily indicative of a sexual assault. It is important to remember that if an investigation takes place, law enforcement officials will look for additional evidence that may help to overcome a claim of consent.

**Understand how biological evidence is tested.**<sup>194</sup> Semen, blood, vaginal secretions, saliva, vaginal epithelial cells, and other biological evidence may be identified and profiled by a crime lab. The information derived from the analysis can often help determine whether sexual contact occurred, provide information regarding the circumstances of the incident, and be compared to reference samples collected from patients and suspects for identification purposes. A primary method used by crime labs for testing biological evidence is DNA (deoxyribonucleic acid) analysis.<sup>195</sup> The most common form of DNA analysis used in crime labs for identification is called polymerase chain reaction (PCR). PCR allows the analysis of evidence samples of limited quality and quantity by making millions of copies of very small amounts of DNA. Using an advanced form of PCR testing called "short tandem repeats" (STR); the laboratory is able to generate a DNA profile, which can be compared to DNA from a suspect or a crime scene.<sup>196</sup>

Distinguish patients' DNA from suspects' DNA. Blood or buccal (inner cheek) swabbings should be collected from patients for DNA analysis to distinguish their DNA from that of suspects. (Procedures for collecting these samples are provided later in this chapter.) If the case is reported to law enforcement, patients' biological samples and DNA profiles should be used only for investigation of the sexual assault, and their DNA profiles should not be uploaded into CODIS.<sup>197</sup> Neither biological samples nor DNA profiles should be provided to law enforcement or prosecution for another case in which patients may be suspects, inadvertently given to health insurance carriers, or used for research purposes without patients' consent.<sup>198</sup> Criminal justice agency policies should be in place and followed for the secure storage of biological samples and appropriate disposal of these samples and DNA profiles.

**Prevent exposure to infectious materials and risk of contamination of evidence.** Examiners should take precautions during the exam to prevent exposure (to both patients and health care staff) to bloodborne pathogens and other potentially infectious materials. For example, it is important to follow facility policies on washing hands, handling contaminated needles and other contaminated sharps, wearing protective equipment, and minimizing splashing, spraying, and spattering of these materials. (For more information on this topic, see *B.1. Sexual Assault Forensic Examiners*.)

With the ever-increasing sensitivity of DNA analysis, there is a greater chance that accidental contamination can be detected. Forensic evidence, which is usually small in volume, can be contaminated and diluted by foreign DNA. Every precaution should be taken by all first responders to reduce outside contamination and dilution of evidence. For example, examiners should wear non-powdered gloves<sup>199</sup> and change them throughout the exam/evidence collection whenever cross-contamination could occur or when moving to different body surface areas. Examiners and other responders should seek guidance from their crime labs on procedures to prevent contamination.

<sup>193</sup> L. Ledray, *SANE Development and Operation Guide*, 2000, p. 63.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

<sup>194</sup> Section drawn from *Understanding DNA Evidence: A Guide for Victim Service Providers* by the National Commission on the Future of DNA Evidence; the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, pp. 31–32; and the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 40.

<sup>195</sup> DNA determines each person's individual characteristics. An individual's DNA is unique except in identical twins. DNA in the cell nucleus is genetic material inherited from biological parents. (Drawn from Arkansas' *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination*, 2001.)

<sup>196</sup> There is a concern that if DNA evidence is found, prosecutors may not utilize other evidence, especially when labs have limited resources. But because persons known to victims commit the vast majority of sexual assaults, DNA findings must be used in conjunction with other forensic evidence recovered, particularly when issues of consent arise. Law enforcement investigators and prosecutors should receive training on maximizing the use of all forensic evidence collected.

<sup>197</sup> In the fall of 2003, legislation was introduced to implement the President's DNA Initiative provisions that would bar the inclusion of elimination samples in CODIS. These samples include those obtained from sexual assault victims, as well as individuals with whom they had recent consensual sex prior to the exam.

<sup>198</sup> An exception is that a forensic lab may input frequency information related to the DNA profiles in its statistical database. Victims' identity remains anonymous.

<sup>199</sup> Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.

**Understand the implications of the presence or absence of seminal evidence.**<sup>200</sup> The relevance of semen evidence in cases involving male suspects covers the spectrum, depending upon case facts. Semen is composed of cellular and liquid components known as spermatozoa (sperm) and seminal fluid. Semen evidence is valuable because it can be used to positively identify suspects.<sup>201</sup> However, it is critical to note that failure to recover semen is not an indication that a sexual assault did not occur. There are a number of reasons why semen might not be recovered in these cases: Assailants may have used condoms, ejaculated somewhere other than in an orifice or on patients' clothes or bodies, or not ejaculated at all. Semen may have been depleted by frequent ejaculation prior to the sample in question.<sup>202</sup> Chronic alcohol or drug abuse, chemotherapy, cancer, infection (e.g., mumps or tuberculosis), or congenital abnormalities also may suppress semen production. Other factors may contribute to the absence of detectable amounts of semen evidence. For example, significant time delays between the assault and collection of evidence may cause loss of semen evidence, semen may be washed away prior to the exam or improperly collected, and an object other than a penis may have been used for penetration.

**Modify the exam and evidence collection to address the specific needs and concerns of patients.** Examiners should be aware that patients' beliefs might affect whether and how certain evidence is collected. For example, patients from certain cultures or religious backgrounds may view hair or fingernails as sacred and decline collection of hair evidence. (For more information on this topic, see A.2. *Victim-Centered Care*. Accommodating mobility impairments is discussed in footnotes for this chapter. For details on accommodating communication needs and responding to verbal and nonverbal cues, see C.4. *The Medical Forensic History*.)

**Explain exam and evidence collection procedures to patients.** Whatever the methods used for seeking informed consent from patients for the exam and evidence collection, the full nature of procedures and options should be explained. Examiners may provide some basic information prior to starting the exam and additional information as the exam proceeds. For example, if specialized equipment is used, examiners can explain to patients, at some point prior to its use, what the equipment is, how it will be used, for what purpose, and how long the procedure will take. Encourage patients to ask questions and to inform examiners if they need a break or do not want a particular part of the exam or evidence collection done. (For more information on obtaining informed consent of patients, see A.3. *Informed Consent*.)

**Conduct the general physical and anogenital exam and document the physical findings on body diagram forms.**<sup>203</sup> In addition to instructions included in the evidence collection kit, the exam should be guided by the scope of informed consent and the medical forensic history.

In the course of the exam, examiners may question patients about trauma related to the assault. These questions should be specific enough to yield clinically relevant information. For example, simply asking if patients are injured or hurt anywhere is not focused enough—they may not know where they are injured until examined and/or asked questions such as if they hurt in specific body locations.

**General physical examination.** Obtain patients' vital signs, note the date and time of the exam, physical appearance, general demeanor, behavior, and orientation, and condition of clothing on arrival. Record all physical findings (which include observable or palpable tissue injuries; physiologic changes; and foreign materials such as grass, sand, stains, dried or moist secretions, or positive fluorescence) on body diagram forms. Be observant for redness, abrasions, bruises, swelling, lacerations, fractures, bites, burns, and other forms of physical trauma. Potential traumatic findings should be palpated to assess for tenderness and induration. On dark-skinned individuals, it may be difficult to identify these areas and they may need to be sought out specifically.

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<sup>200</sup> Drawn from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2082, pp. 32, and New Hampshire's *Sexual Assault: A Hospital Protocol for Forensic and Medical Examination*, 1998, pp. 26–27.

<sup>201</sup> In the absence of sperm, certain seminal fluid components may be used to identify semen.

<sup>202</sup> If assailants who had a vasectomy ejaculated, their seminal fluid would not contain sperm.

<sup>203</sup> This section on performing the exam is primarily drawn from the American College of Emergency Physicians' (ACEP) *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, pp. 103–107. Much of the ACEP exam procedures were based on the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*.

**Anogenital examination.**<sup>204</sup> During the female genital exam,<sup>205</sup> examine the external genitalia and perineal area for injury, foreign materials, and other findings in the following areas: abdomen, thighs, perineum, labia majora, labia minora, clitoral hood and surrounding area, perurethral tissue/urethral meatus, hymen,<sup>206</sup> fossa navicularis, and posterior fourchette. The use of a colposcope during the external genital exam enhances viewing microscopic trauma and may provide photographic documentation.<sup>207</sup>

Then examine the vagina and cervix for injury, foreign materials, and foreign bodies. Use a colposcope or other magnifying device if available. In some jurisdictions, toluidine blue dye may be used to highlight trauma, either with or without the use of a colposcope.<sup>208</sup> Examine the buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings. If rectal penetration is reported or suspected, an anoscope can be used as a tool to identify and evaluate trauma (it may also be used to help obtain anal swabs and trace evidence).

For male patients, examine the external and perineal area for injury, foreign materials, and other findings, including from the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Document whether patients are circumcised.

**Documentation of findings.** Record findings from the general physical and anogenital exam on appropriate body diagram forms. Detailed descriptions of findings should be provided as required. During the exam, collect evidence as specified in the evidence collection kit and photograph anatomy involved in the assault according to jurisdictional policy. Follow jurisdictional policy regarding documentation, photography, and collection of bite mark evidence.<sup>209</sup>

**Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.**<sup>210</sup> The following evidence from patients, along with completed documentation forms, typically is submitted to the crime lab designated by the jurisdiction.<sup>211</sup> Jurisdictions may require collection of additional or different

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<sup>204</sup> If patients are mobility impaired, review their history at this stage. In patients with spinal cord injury (SCI), the level of injury and any history of autonomic dysreflexia will have to be noted and given special attention. Other considerations in these patients are histories of muscle spasm and triggers for both muscle spasm and autonomic dysreflexia. Examiners should be sure to ask about things such as whether these patients have ever had a speculum exam, what this experience was like, what the most comfortable position would be for the anogenital exam, and any history of autonomic dysreflexia with a speculum exam. (Commonwealth of Massachusetts's *SANE Protocol*, 2002, p. 36.) Transgender individuals with a masculine identity and those with a constructed vagina may sustain additional physical and emotional damage when vaginally assaulted.

<sup>205</sup> Some patients may not have previously had a gynecological exam and need a detailed explanation and support during this part of the exam. (Drawn from L. Zarate, 2003, *Suggestions for Upgrading the Cultural Competency Skills of SARTs*, Arte Sana Web site, 2003.)

<sup>206</sup> The Tanner Scale of Secondary Sexual Development is a sexual maturity rating scale that defines a child's stage of puberty. (American Professional Society on the Abuse of Children, *Glossary of Terms and the Interpretation of Findings for Child Sexual Abuse Evidentiary Examinations*, p. 7.) These developmental stages are relevant to the interpretation of physical findings in child and adolescent cases. There is a relationship between Tanner Stages and hymenal development. Physical findings must be evaluated in the context of hymenal development for the interpretation of findings. (The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 61.)

<sup>207</sup> Colposcopes have magnifying lenses ranging from 4x to 30x power and can have 35-mm camera or video camera attachments. Colposcopes have a green filter that enhances the visualization of scars, unusual vascular patterns, and genital warts. Examiners can use the colposcope to obtain magnified images of the oral pharynx, genital, and rectal areas. Minor skin and/or mucosal trauma such as abrasions, lacerations, petechiae, focal edema, hymeneal tears, and anal fissures are more easily seen with magnification, and photographs can be taken for documentation. Attached video cameras can also record images. (Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 58).

<sup>208</sup> The use of toluidine blue dye is controversial in some jurisdictions (e.g., it may be perceived by the court as changing the appearance of the tissue) and not universally used. When employed, toluidine blue dye (1-percent aqueous solution) should be applied by cotton swab before any internal or digital speculum examination. Although DNA evidence will be preserved, care should be taken to avoid letting dye enter the vaginal vault. Excess dye may be blotted away with 1-percent acetic acid solution or lubricating jelly. Toluidine blue dye cannot separate consensual from nonconsensual lesions. Patients should be advised that small traces of the dye might shed in their clothing over the 2 days following the exam. (Information on use of this dye is drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 117.)

<sup>209</sup> In addition to documenting, swabbing, and photographing bite marks, an odontologist may need to make casts. Without a cast, teeth cannot be matched to suspects. The American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, pp. 111–112, offers guidelines for bite mark documentation.

<sup>210</sup> Much of this section was drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, pp. 103–107.

<sup>211</sup> In some cases, it may be appropriate to submit evidence to the FBI Laboratory. It accepts cases from any duly authorized law enforcement agency. However, if the case is not a FBI case and the jurisdiction has capability to analyze DNA, then the DNA Unit of the FBI Lab will generally not accept the case. Cases that occur on Indian reservations may be submitted directly to the FBI Lab from local or tribal law enforcement agencies, the Bureau of Indian Affairs, or the FBI and will be worked on by the Indian Country Evidence Task

specimens. Trained examiners should use the medical forensic history and the physical assessment of the patient to guide the evidence collection process. Instructions supplied in the kit may be helpful as a guide for those who are not experienced in the process of evidence collection. However, it should be recognized that the kit instructions should not be read in front of the patient, which could be cause further emotional trauma in the aftermath of the assault. If any requested evidence is not collected, examiners should note reasons on documentation forms.

Collect clothing evidence. Clothing frequently contains important evidence in sexual assault cases. It provides a surface upon which traces of foreign materials, such as semen, saliva, blood, hairs, fibers, and debris from the crime scene, may be found. While foreign matter can be washed off or worn off the body, the same substances often can be found intact on clothing for a considerable length of time following an assault. Damaged or torn clothing may be significant, as damage may be evidence of force (do not cut through any existing holes, rips, or stains on clothing). If the examiner detects damage to the clothing, ask the patient if that damage was related to the assault or present prior to the events in question. Evidence on patients' clothing can be compared with evidence collected from suspects and crime scenes. Common items collected from patients include underwear, hosiery, blouses, shirts, and pants. Coats and shoes are collected less frequently because they are less likely to have evidentiary value and their loss may represent a significant financial burden for victims.<sup>212</sup> Transgender individuals may be unwilling to part with prostheses and similar items for reasons of safety and/or cost.

Procedures for collecting clothing, underwear, and foreign material dislodged while undressing include the following:

- Place a clean hospital sheet on the floor as a barrier. Then place the collection paper on the barrier sheet. Be careful to prevent evidence transfer. Document all findings. Ask patients to disrobe (assisting them as requested and then draping them appropriately).<sup>213</sup> When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged.<sup>214</sup> If someone assists, she/he should wear gloves.
- Collect clothing pertinent to the assault. First determine if patients are wearing the same clothes worn either during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence, those items should be collected. If it is determined that patients are not wearing the same clothing that they did either during or immediately after the assault, examiners should inquire as to the location of that clothing. If that clothing has not been brought to the exam site, information on clothing location should be provided to law enforcement (if involved) so that clothing can be retrieved and examined before any potential evidence is destroyed.<sup>215</sup> In addition to collecting underwear worn at the time of or immediately after the assault, it may also be important to collect underwear patients are wearing at the time of the exam (if relevant to the case).
- Be sensitive about how much clothing to take as evidence. For example, take patients' coats or shoes only if it is determined that there may be evidence on them. The exam site can coordinate with advocacy programs to ensure that replacement clothing is available for patients in a range of

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Force. Should a jurisdictional lab not have a hair examiner but have the capability to analyze DNA, items requiring only DNA analysis should not be submitted. Items such as clothing that will be examined for both DNA and trace evidence should be submitted to the FBI Lab first. These items will be returned after processing for trace evidence and can then be sent along with DNA-only evidence to the jurisdictional lab. Do not submit items to the FBI Lab for trace evidence analysis after they have been previously examined by another lab. For more information or help submitting a case to the FBI Lab, contact your local FBI office or see the *Handbook of Forensic Services* at <http://www.fbi.gov/about-us/lab/handbook-of-forensic-services-pdf>.

<sup>212</sup> Paragraph drawn from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2008, p. 32.

<http://www.fris.org/Resources/PDFs/Books/WVProtocol.pdf>.

<sup>213</sup> If patients are concerned about disrobing in front of advocates and/or personal support persons, they can turn around, hold up a sheet to shield patients, or leave the room while patients disrobe.

<sup>214</sup> For patients with mobility impairments, put the foreign material collection sheet on the exam table and leave in place until the exam is completed. If patients prefer to disrobe in their wheelchairs, sheets can be tucked in around the wheelchair to catch debris. Avoid putting chairs on paper, as debris from wheels may contaminate evidence. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 33.)

<sup>215</sup> Paragraph drawn from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2008, p. 33.

<http://www.fris.org/Resources/PDFs/Books/WVProtocol.pdf>. In the course of the exam process, additional crime scene items that could be potential evidence may be identified and should be collected and preserved.

sizes. This clothing is critical in some instances (e.g., a patient may own only the clothing that is being collected).

- If female or transgender male patients are menstruating, collect tampons and sanitary napkins. Air-dry them as much as possible and then place them in a separate paper collection bag.
- Follow jurisdictional policy for handling and transporting wet evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, and sanitary napkins). Ensure that it is packaged in leak-proof containers and separated from other evidence when being transported. It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for its immediate analysis or further drying.<sup>216</sup>
- After drying items according to jurisdictional policy, place each piece of clothing and collection paper in a separate paper bag, label, seal, and initial the seal. If additional bags are needed, use new grocery-style paper bags only. The barrier sheet is not submitted as evidence.
- Tape/seal bags closed; label, seal,<sup>217</sup> and initial the seal.

#### Collect debris.<sup>218</sup>

- Collect obvious debris on patients' bodies (e.g., dirt, leaves, fibers, and hair) on a collection sheet—package, label, seal, and initial the seal.
- Fingernail evidence: ask patients whether they scratched the suspects' face, body, or clothing. If so, or if fibers of other materials are observed under patients' fingernails, collect fingernail clippings, scrapings, and/or swabbings, according to jurisdictional policy.<sup>219</sup> If fingernail scrapings are collected, package fingernail scrapings and tools used to obtain the sample, label, seal, and initial the seal. Cut broken fingernails at the remaining jagged edge for later comparison. If artificial fingernails or nail extensions are being worn by the patient, another nail should be enclosed as a known sample if one is missing. Package, label, seal, and initial the seals.
- If requested, assist patients in putting on exam gowns after clothing and debris are collected.

Collect foreign materials and swabs from the surface of the body. Carefully inspect the body, including head, hair, and scalp, for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat, and saliva) and other foreign material. Use an alternate light source to assist in identifying evidence. Obtain swabs from any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with longwave ultraviolet light, and any area for which patients relate a history or suspicion of bodily fluid transfer (e.g., licking, kissing, biting, splashed semen, or suction injury). Also collect swabs from potentially high-yield areas (e.g., neck, breasts, or external genitalia) if the history is absent or incomplete.

- Use a moist swab to collect dry secretions, followed by a dry swab. Swab moist secretions with a dry swab. Separate swabs should be used for every sample area collected. Follow jurisdictional policies regarding the number of swabs required to collect each specimen.
- Swab bite marks. In some jurisdictions, an initial moist swabbing followed by a dry swabbing has been shown to result in full DNA profiles.
- Optional—smear swabs onto microscope slides, according to jurisdictional policy.
- Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.
- According to jurisdictional policy, air-dry all specimens, package swabs and slides separately, label, seal, and initial the seals. Note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.
- If teeth are flossed prior to oral swab collection, package used floss (if available), label, seal, and initial the seal.

<sup>216</sup> Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.

<sup>217</sup> Do not use saliva to seal envelopes; rather, try using moistened gauze pads or paper towels. (Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.)

<sup>218</sup> Debris-containing evidence may be found on equipment, such as wheelchairs, scooters, canes, wheelchair pads, assistive communication devices, catheters, and service animals, used by some patients with physical impairments. Swab equipment and/or animals for evidence, if appropriate, according to jurisdictional policy. Always ask patients for permission to do so.

<sup>219</sup> Some jurisdictions routinely collect fingernail samples and photograph fingernail damage that may have been related to the assault.

Collect hair combings. Follow jurisdictional policy for collecting hair combings. The purpose of this procedure is to collect hair shed by suspects that may have been transferred to patients' hair. Hair combings may also reveal other foreign materials. It is important to examine head, facial, and pubic hair for secretions, foreign materials, and debris and collect as appropriate (see above for collection of debris and foreign materials). Pubic hair combings may be necessary if the assault involved the genital area of patients, according to jurisdictional policy. To collect pubic hair combings:

- Use the comb and collection paper provided for this procedure.
- Place the unfolded paper under patients' buttocks and comb hair toward paper (patients may comb).
- Fold comb with debris/hair into paper. Package paper, label, seal, and initial the seal.

Collect hair reference samples as needed.<sup>220</sup> Follow jurisdictional policy for collection of hair reference samples.<sup>221</sup> Many jurisdictions do not routinely collect plucked head and pubic hair reference samples. Some will only collect these samples if the lab requests it at a later time. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients.<sup>222</sup> Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial exam, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as if it is collected at the time of the initial exam (e.g., due to the fact that hair characteristics can change over time).

When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. Give patients the option of collecting samples themselves.

Collect oral and anogenital swabs and smears. Patients' consent, the medical forensic history, and exam findings should guide collection of oral and anogenital specimens. In general, specimens should be collected only from orifices and areas surrounding the orifices that patients report to be involved in the assault.<sup>223</sup> Keep in mind that some patients may be vague about the type(s) of sexual contact that occurred. Examiners can help clarify which orifices were involved by asking appropriate questions. If there is uncertainty about involved orifices (e.g., because patients have little memory of the assault, were unconscious or incoherent, or do not understand what occurred), collection from oral, vaginal, and anal orifices (with patients' permission) may be appropriate. In some jurisdictions, policy calls for collection from all three orifices. Again, patients' consent is needed to collect these samples. Things to note when collecting these swabs and smears:

- Caution patients who use a bathroom prior to the exam that evidence may be present in pubic, genital, and anal areas and urge them not to wash or wipe away secretions until after evidence collection.
- When taking a swab, examiners should take care not to contaminate the collection with secretions or materials from other areas, such as vaginal to rectal or penile to rectal.

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<sup>220</sup> See footnote under hair combing regarding patients with limited mobility.

<sup>221</sup> Crime labs use reference samples to determine whether or not evidence specimens collected are foreign to patients. There is a lack of consensus across jurisdictions about whether to collect these samples routinely during the initial exam. Head and pubic hair reference samples from patients can provide a source of comparative information for forensic scientists, but these samples are not needed in many cases and can be retrieved from patients at a later date if necessary. If the samples are not taken at the time of the exam, however, patients may be reluctant to return later for collection. Also, hair characteristics may change over time. For patients, gathering these samples can be a painful and embarrassing procedure that follows the trauma of the assault. But, given the choice of having samples taken at the initial exam or at a later date, many opt to get it over with during the exam. Hair pulled or cut from patients is rarely used to prosecute a case. With the advent of DNA technology, the court's use of these reference samples declined. Yet, particularly in cases where DNA evidence is not available, hair reference samples could be useful evidence. SARTs (or involved responders) should ensure that their decisions about collecting hair reference samples reflect current best forensic practices, advances in technology, and the need for sensitivity to patients.

<sup>222</sup> Note that a patient may believe hair is sacred and thus may be reluctant or decline to have hair evidence collected.

<sup>223</sup> It is important to note, however, that there is a lack of consistency across jurisdictions as to whether specimen collection from all orifices is routine or conducted on a case-by-case basis, based on the assault history and exam findings.

- Follow jurisdictional policy for collecting swabs (and the number of swabs used to collect a sample), smearing swabs on slides, and drying and packaging swabs and slides. Also, follow jurisdictional policy for timeframes in which samples should be collected unless otherwise indicated.
- Do not stain or chemically fix swabs or smears.
- When preparing slides, note that coding of evidence material must allow the crime lab to know which swab was used to prepare which slide.
- Document any foreign substance or material introduced by health care providers (e.g., lubricating jelly on a speculum or betadine prior to introduction of a catheter).

#### Oral sample<sup>224</sup>

- Place swabs together to collect specimen from oral cavity between gums and cheeks and under tongue. Remove dentures and swab with same swabs.
- Optional—smear swabs onto two microscopic slides.
- Air-dry swabs and slides.
- Package slides and swabs, place in envelope, label, seal, and initial the seal.

#### External genital sample<sup>225</sup>

- Swab external genital dry-skin areas with swabs (blind swabbing by protocol or history), at least one dry and one moistened with a drop of sterile, distilled, or deionized water, according to jurisdictional policy.
- Optional—smear swabs on two microscope slides.
- Air-dry swabs and slides.
- Package slides and swabs, place in envelope, label, seal, and initial the seal.

#### Vaginal/cervical sample

- Use swabs together to collect a sample from vaginal pool. It is prudent to collect swabs from both the vagina and cervix, regardless of time between assault and exam.
- Optional—smear swabs onto microscope slides.
- Air dry swabs and slides.
- Package slides and swabs, place in envelope, label (specifically indicating sampling site), seal, and initial the seal.

Wet-mount evaluation.<sup>226</sup> Some jurisdictions require examiners to conduct wet-mount examinations of vaginal/cervical secretions for motile and nonmotile sperm in cases in which a male suspect may have ejaculated in a patient's vagina.<sup>227</sup> Because sperm motility decreases quickly with time and removal from the vagina/cervix,<sup>228</sup> wet-mount evaluation during the exam can provide the only opportunity to see sperm motility.<sup>229</sup> The presence of motile sperm may help narrow the timeframe that the crime could have occurred.

<sup>224</sup> One jurisdiction also collects a lip/lip area swab and smear and an oral rinse if there was oral contact.

<sup>225</sup> Note that cleansing the area for catheterization and/or applying Lidocaine may dilute or contaminate the evidence. Therefore, when Lidocaine is applied to the perineal and anal areas to minimize the risk of autonomic dysreflexia, it should be done only after swabbing the external genitalia for evidence. If catheterization is required either for evidence collection or to empty the bladder for speculum examination, it should be done only after swabbing the external genitalia. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 38.)

<sup>226</sup> Note for clarity that this and the next paragraph discuss wet-mount evaluation for sperm. However, wet-mount evaluation of vaginal secretions for infection (e.g., yeast infection and STIs) may also be done during the exam if medically or forensically indicated. Hospital lab personnel usually analyze these samples.

<sup>227</sup> If and when wet-mount evaluation for sperm is done, examiners should exercise discretion conducting this procedure in the presence of patients and be sensitive in explaining the implications of positive and negative wet mounts to patients (if they want to know). Examiners should remind law enforcement investigators that a lack of sperm does not mean an assault did not occur and that the crime lab will later examine prepared slides using stains and other techniques not available to examiners. Thus, if sperm is present, the lab's rate of identification will probably be higher than it was for examiners. Providing this information might help deter misinterpretation of results.

<sup>228</sup> In most cases, sperm becomes nonmotile in the vagina within 10 to 12 hours after ejaculation. (Drawn from W. Green, M. Kaufhold, and E. Schulman, *Sexual Assault Evidentiary Exam Training for Health Care Providers*, Participant Manual, 2001, p. 39 of Module 7.) Both motile and nonmotile sperm may be found in the cervix for longer periods of time after the assault than in the vagina. Sperm may not be found after an assault for many reasons (see section in this chapter on the importance of semen evidence).

<sup>229</sup> Drawn from W. Green, M. Kaufhold, and E. Schulman, *Sexual Assault Evidentiary Exam Training for Health Care Providers*, Participant Manual, 2001, p. 39 of Module 7.

In most jurisdictions, however, the crime lab is responsible for all analysis of evidence<sup>230</sup> and examiners do not do the wet-mount evaluation for sperm.<sup>231</sup> Follow jurisdictional policy on whether wet-mount evaluation for sperm is needed and methods of evaluation. If it is required, examiners must be educated on use of the microscope, identification of sperm, and reporting their findings and have quality assurance mechanisms in place to assure the accuracy of their findings.

- If necessary, prepare a wet-mount slide according to jurisdictional policy. Dab one swab collected from the vaginal pool on a slide.<sup>232</sup> Typically, the slide is prepared by placing one drop of normal saline onto the “dab” of vaginal material just placed on the slide. Place a cover slip on the slide.
- View for presence of sperm under a microscope at 400x or by using a phase contrast or other optically staining microscope (within 10 minutes of preparing slide).<sup>233</sup>
- Air-dry this swab and slide (not removing the cover slip).
- Package swab and slide, place in envelope, label as “wet mount” (specifically indicating sampling site), seal, and initial the seal.

While the speculum is still in place and after all swabs and evidence have been collected, any necessary medical cultures may be taken, if medically indicated.

#### Penile sample

- Slightly moisten swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. Swab all outer areas of the penis and scrotum where contact is suspected. Avoid swabbing the urethral meatus.
- Gently roll the swabs over one of the microscope slides, according to jurisdictional policy.
- Air-dry swabs and slides.
- Package slides and swabs, place in envelope, label, seal, and initial the seals.

Immediately following this procedure, any necessary medical cultures should be taken.

#### Perineal area sample<sup>234</sup>

- If there was vaginal/anal contact, there may be leakage of semen in the perineal area. Use an alternate light source on the anal area and flake off or swab areas of dried secretions using a moist swab followed by a dry swab.
- Optional—smear swabs on microscopic slides, according to jurisdictional policy.
- Flaked dried secretions should be placed into the provided container. Air-dry swabs and slides and package them separately. Place in envelope, label, seal, and initial the seal.
- Avoid contaminating anal/rectal samples by cleansing the perianal area after external secretions and foreign materials have been collected.

#### Anal/rectal sample<sup>235</sup>

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<sup>230</sup> A possible exception may be toxicology analysis.

<sup>231</sup> While crime labs can reliably identify the presence of sperm on permanent stained slides, they cannot identify motile sperm due to time delays. Information about the presence or absence of sperm and motile sperm obtained at the time of the exam can impact the investigation and patients' decision making. One concern related to examiners doing wet-mount evaluations for sperm is that their findings may be different than those of crime labs (e.g., the examiner may not detect sperm, while the crime lab does).

<sup>232</sup> Alternate methods for obtaining materials for wet mounts: a sample may be collected from a vaginal aspirate or fluid from the lower bill of speculum after withdrawing it from vagina, or sperm are occasionally found on microscopic urinalysis. (W. Green, M. Kaufhold, and E. Schulman, *Sexual Assault Evidentiary Exam Training for Health Care Providers*, Participant Manual, 2001, p. 38 of Module 7.)

<sup>233</sup> Examiners rather than hospital lab personnel should view these slides. Otherwise, delays between preparation of slides in the exam room and analysis in the hospital lab could cause a negative result (e.g., sperm present, but not motile). Also, those involved in the chain of custody of this evidence should be kept to a minimum.

<sup>234</sup> See the next footnote for patients with spinal cord injury and/or history of autonomic dysreflexia.

<sup>235</sup> Note that for patients with spinal cord injury and/or history of autonomic dysreflexia, collection of anal/rectal samples is performed only with the highest level of awareness of risks and with observance of precautionary steps. Possible triggers for autonomic dysreflexia are anxiety, pelvic exam (a cold speculum or the pressure of manipulating a speculum or manipulation of the cervix and pressure on the uterus), rectal exam or swabbing, impacted bowel, urinary retention, a kinked catheter, a bladder infection, and deep skin lesion. Some symptoms are highly elevated blood pressure, nasal congestion, sudden onset of headache, flushing, sweating, shortness of breath, and muscle spasm. Precautions against a possible attack requires an empty bladder or leg bag for the exam; application of lidocaine gel to perineum and/or anal area before exam; examination performed in a semi-supine position; slow insertion and minimal manipulation of a warm speculum; constant monitoring of blood pressure and “checking in” with patients; having rapid acting anti-hypertensive

- Collect swabs from the anal cavity.<sup>236</sup> Avoid contact with external skin surfaces.
- Optional—smear swabs on microscopic slides, according to jurisdictional policy.
- Air-dry swabs and slides.
- Package swabs and slides, place in envelope, label, seal, and initial the seal.

At this time, any additional examinations or tests involving the anus should be conducted.

Known blood or saliva sample or buccal (inner cheek) swab for DNA analysis and comparison. Many samples collected during the exam contain a mixture of secretions. To interpret DNA profile results obtained from these swabs, it is essential to know the DNA profile of patients. Patients' DNA reference samples are used for this purpose. Follow jurisdictional policy regarding the type of samples accepted by the crime lab. Collection of a buccal swab or saliva sample is encouraged unless it is medically or forensically necessary to take blood. If a blood sample is collected, the most noninvasive method of collection should be used.

Buccal swabs: Decide on a case-by-case basis whether it is appropriate to collect a buccal swab reference sample for DNA typing rather than a blood sample. For example, a blood sample may not be needed or patients might not allow blood to be drawn. (Note that buccal swabs and saliva samples are not suitable for blood typing and serology.) If oral copulation is asserted or suspected, a buccal swab or saliva sample for patients' DNA reference may be contaminated. In those cases, blood is usually the better reference sample. However, examiners should consult local crime labs to ensure their collection methods reflect the lab's preferred method.

- Buccal swab: Have patients rinse their mouths with tap water and then expose the inner cheek area. Swab this area with gentle pressure. Air-dry the swab, package, place in envelope, label, seal, and initial the seal.

#### Dry Blood

- If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection and is easier to store.<sup>237</sup>
- Using a betadine swab, wipe the tip of the left or right ring finger.
- Using a sterile lancet, prick the finger.
- While holding the finger over the circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat procedure for any remaining circles as required by jurisdictional policy (it may not be necessary to fill all circles).
- Allow blood to air-dry according to jurisdictional policy. Fill out the patient's name on the first line. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.

#### Drawn Blood

- In order to minimize patients' discomfort, collect drawn blood needed for the reference sample at the same time blood is collected for medical or toxicological purposes.
- Blood for the reference sample may be collected in lavender-top and/or yellow-top blood drawing tubes. These colored tubes contain preservatives suitable for forensic blood typing. The color to use

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medication on hand; and making health care staff aware of risks and on alert. Treatment for autonomic dysreflexia includes stopping the exam, bringing patients to sitting or semi-supine position, and involving emergency medical staff immediately who can administer a fast-acting anti-hypertensive medication. (Commonwealth of Massachusetts *SANE Protocol*, 2002, p. 40.)

<sup>236</sup> If needed, an anoscope can be used to identify anal injuries and obtain anal swabs after perianal cleansing. These swabs should be obtained by direct visualization from the rectal mucosa visible above the tip of the anoscope. If patients are unable to tolerate a water-moistened anoscope or anal speculum, lightly coat the instrument with lidocaine jelly or use manual traction and obtain samples from the anal canal. If a lubricant (other than water or saline) or lidocaine jelly is used, document its use and the reason for it. (The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 48.) The examiner should use discretion in determining whether a case warrants the use of the anoscope for medical and/or forensic purposes, as well as obtain patients' informed consent for anoscopy. Particularly if a patient has been anorectally penetrated, that patient may be uncomfortable with the use of the anoscope and could possibly even feel revictimized by it. The discomfort this procedure may cause the patient should be weighed against its potential medical or forensic uses.

<sup>237</sup> Several state protocols indicate dry blood collection is an acceptable method to obtain known DNA samples.

is typically specified by the designated crime lab.<sup>238</sup> If tubes are included in the evidence collection kit, check expiration dates and replace if expired.<sup>239</sup> Mix according to jurisdictional policy.

- Write the patient's name, date and time of collection, and the collector's initials on the tube. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.

**Collect other evidence.** Other evidence may be collected beyond what is needed for the sexual assault evidence collection kit. This could include toxicology samples or other evidence based on the unique facts and circumstances of the case.

Miscellaneous swabs may be collected, depending upon the area of contact noted in the medical forensic history. Some jurisdictions are collecting wet to dry swabs from the surfaces surrounding orifices that were penetrated or that had touch contact during an assault (e.g. area surrounding the mouth in the case of an oral assault, or the inner thighs in a vaginal penetration).

Toxicology samples. Make the decision about whether to collect toxicology samples for forensic purposes, what to collect, and collection methods according to jurisdictional policy. Do not put toxicology samples in the sexual assault evidence collection kit, unless otherwise indicated. Identify which forensic labs the jurisdiction has selected to analyze these samples, choose a lab, and follow transfer policies. (See C.7. *Alcohol- and Drug-Facilitated Sexual Assault* for more information on collecting toxicology samples.)

Dental floss. Use of dental floss is not recommended for additional evidence collection in cases with oral penetration. Flossing can create increased opportunity for infection through microtrauma to the gums.

**Keep medical specimens separate from evidentiary specimens collected during the exam.** Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with patients' consent). It is not necessary to maintain the chain of custody on medical specimens—instead, follow exam facility policy for documenting medical care and storing medical records. Exam sites that perform exams for military installations should consider Memoranda of Understanding to address such issues as storage of evidence.

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<sup>238</sup> The California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims, 2001, p. 52.

<sup>239</sup> Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.



## 7. Alcohol and Drug-Facilitated Sexual Assault

Recommendations at a glance to facilitate response in suspected alcohol- and drug-facilitated sexual assault:

- Promote training and develop jurisdictional policies.
- Plan response to voluntary use of drugs and/or alcohol by patients.
- Be clear about the circumstances in which toxicology testing may be indicated. Routine testing is not recommended.
- Toxicology testing procedures should be explained to patients.
- Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.
- Identify toxicology laboratories.
- Preserve evidence and maintain the chain of custody.

**Promote training and develop jurisdictional policies.** It is essential that examiners and other relevant health care personnel, 911 dispatchers, law enforcement representatives, emergency medical technicians, prosecutors, judges, and advocates receive training and information on alcohol and drug-facilitated sexual assault. They need to be educated on the use of drugs and alcohol to facilitate sexual assault, screening for alcohol- or drug-facilitated assault, and how to handle situations in which an alcohol- or drug-facilitated sexual assault is suspected. Both agency-specific and multidisciplinary policies should be developed to guide immediate response to a suspected alcohol- or drug-facilitated sexual assault.<sup>240</sup>

First responders must recognize that although Rohypnol and gamma hydroxy butyrate (GHB) are widely publicized as the “drugs of choice” in drug-facilitated sexual assault, assailants may use numerous other substances (including alcohol) to facilitate sexual assault.<sup>241</sup> They must understand the urgency of collecting toxicology samples, if it is medically necessary, or if an alcohol- or drug-facilitated sexual assault is suspected, as well as the importance of obtaining informed consent from patients prior to sample collection. They should also be aware that collection of toxicology samples is typically separate from the sexual assault forensic evidence collection kit, and procedures for toxicology analysis may be different from that of other evidence analysis.

Ideally, the first available urine sample should be collected in suspected alcohol- or drug-facilitated sexual assault cases. Law enforcement agencies and emergency medical services should develop procedures and staff training for collection in cases where patients must urinate before arriving at the exam site. Advocates and other professionals who may have contact with patients prior to their arrival at the exam site should also be educated to provide those who suspect that alcohol or drugs were used to facilitate the assault with information on how to collect a sample if they cannot wait to urinate until they get to the site.

**Plan response to voluntary use of drugs and/or alcohol by patients.** It may be revealed during the exam process or through toxicological analysis that patients voluntarily used drugs and/or alcohol shortly prior to the assault.<sup>242</sup> Voluntary drug and/or alcohol use by patients during this period should not diminish the perceived seriousness of the assault. Law enforcement officers and prosecutors should guard against disqualifying cases in which patients voluntarily used illegal drugs or used alcohol (whether legal or illegal use). Patients should understand that information related to voluntary alcohol or drug use may be used to undermine their credibility in court, but also that in some instances it might be helpful in prosecuting a case by documenting their vulnerability (see the following section on explaining procedures). Also, before pursuing

<sup>240</sup> These policies should clarify that patients should not be responsible for costs related to toxicology testing. Testing done as part of forensic evidence collection is typically paid for by the involved government entity.

<sup>241</sup> For more information about use of Rohypnol and GHB in drug-facilitated cases, see American Prosecutors Research Institute, Violence Against Women Program, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, 1999.

<sup>242</sup> Health care personnel involved in sexual assault cases should adhere to facility policy regarding 1) asking patients about alcohol and drug use in the course of intake and treatment and 2) testing for alcohol and/or drugs if deemed medically necessary.

charges related to illegal drug or alcohol use by patients, prosecutors should give great weight to the impact that the threat of such charges may have on patients' willingness to report the sexual assault and be involved in subsequent criminal justice proceedings. Some jurisdictions have statutes protecting sexual assault victims regarding drug and alcohol testing.<sup>243</sup>

It is important to document patient voluntary use of drugs and alcohol between the time of the assault and the exam. Some patients may self-medicate to cope with post-assault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this period may affect the quality of evidence and negatively impact patients' ability to make informed decisions about treatment and evidence collection.

SART/SARRT members should have training on alcohol and substance abuse and how it is not uncommon for victims to use drugs and alcohol to cope with past sexual assault experiences or trauma. It is important to provide referrals and resources for victims who may reveal that they have a chemical dependency.

**Be clear about the circumstances in which toxicology testing may be indicated.<sup>244</sup> Routine toxicology testing is not recommended.** However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:<sup>245</sup>

- If a patient's medical condition appears to warrant toxicology screening for optimal care (e.g., the patient presents with drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills, or severe intoxication).
- If a patient or accompanying persons states the patient was or may have been drugged.
- If a patient suspects drug involvement because of a lack of recollection of event(s).<sup>246</sup>

**Toxicology testing procedures should be explained to patients.** Seek informed consent from patients to collect toxicology samples. Patients should understand the following before agreeing to toxicology testing:<sup>247</sup>

- The purposes of toxicology testing and the scope of confidentiality of results.<sup>248</sup>
- The ability to detect and identify drugs and alcohol depends on collection of urine and/or blood within a limited time period following ingestion.
- There is no guarantee that testing will reveal that drugs were used to facilitate the assault.
- Testing may or may not be limited to drugs commonly used to facilitate sexual assault<sup>249</sup> and may reveal other drugs or alcohol that patients may have ingested voluntarily.
- Whether any follow-up treatment is necessary if testing reveals the presence of drugs used to facilitate sexual assault.<sup>250</sup>

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<sup>243</sup> See Cal. Pen. Code Section 13823.11 which states that testing to determine if alcohol or other drugs were associated with an attempted or completed sexual assault as part of a forensic exam is not admissible against the victim in a civil or criminal proceeding and provides other immunity and confidentiality safeguards.

<sup>244</sup> There is some controversy related to if and when to collect toxicology samples and test patients for drug and/or alcohol use. Some jurisdictions only collect these samples if drug-facilitated sexual assault is suspected or if a medical need arises. They seek to minimize patients' discomfort and avoid collecting unnecessary items. Other jurisdictions collect toxicology samples from every patient (with permission) and analyze these samples as case facts and jurisdictional policy dictate. In addition to cases of suspected drug-facilitated assault, some jurisdictions may request a toxicology sample if there is indication that patients voluntarily used drugs and/or alcohol prior to the assault. One rationale for such a policy is that prosecutors will want all information on drug and alcohol use to prepare for the case. When developing jurisdictional policy about when and if to collect toxicology samples, involved professionals should consider the perspective of patients and the criminal justice system and make thoughtful, victim-centered decisions.

<sup>245</sup> Bullets drawn from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.

<sup>246</sup> Often, drugs used to facilitate sexual assault are mixed with alcohol and other beverages to further incapacitate patients, usually without their knowledge. Once patients recover from the effects of drugs and/or alcohol, anterograde amnesia may make it difficult to recall events. Consequently, patients may not be aware of the assault or even of how they were drugged. (Drawn from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.)

<sup>247</sup> List adapted partially from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.

<sup>248</sup> If the patient authorizes the release of toxicology testing results to law enforcement and/or prosecution, this information will most likely be discoverable by the defense. If toxicology testing is done for purely clinical purposes and results are documented only in the patient's medical records, the results are typically more difficult, but not impossible, for the defense to discover.

<sup>249</sup> In some jurisdictions, examiners may be able to request testing for specific drugs used to facilitate sexual assault. In others, tests for specific drugs are not done, rather, toxicology samples are screened for all ingested drugs and alcohol.

<sup>250</sup> For example, patients with health conditions that may be affected by drug or alcohol intake may need information on possible impact of involuntary drug/alcohol ingestion and what to do to identify, treat, or avoid potential problems.

- Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired patients' consent and prevented legal consent).<sup>251</sup>
- Whether there is a local prosecution practice of charging sexual assault victims with a crime for illegal voluntary drug and/or alcohol use revealed through toxicology screening.
- Declining testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution.<sup>252</sup>
- When and how they can obtain information on the results from toxicology testing.
- Who will pay for toxicology testing.
- If toxicology testing can proceed without a report to law enforcement.

Care should be taken when providing the above information to patients. In particular, they may need to hear repeatedly from examiners that voluntary use of drugs and/or alcohol, if any, does not reduce the seriousness of the assault. Under no circumstances should the medical forensic exam and treatment be conditioned upon patient consent to toxicology testing. Victims should be given access to the results of any toxicology screening performed and should be given information on how to obtain a copy of the results.

**Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.** The length of time that drugs used for drug-facilitated assault remain in urine or blood depends on a number of variables (e.g., the type and amount of drug ingested, patients' body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated).<sup>253</sup> Urine allows for a longer window of detection of drugs commonly used in these cases than does blood.<sup>254</sup> The sooner a urine specimen is obtained after the assault, the greater the chances of detecting substances that are quickly eliminated from the body.<sup>255</sup>

Immediately collect a urine sample when appropriate. If patients may have ingested a drug used for facilitating sexual assault within 96 hours prior to the exam, a urine specimen of at least 30 milliliters but preferably 100 milliliters (about 3 ounces) should be collected<sup>256</sup> in a clean plastic or glass container (follow jurisdictional policy). The urine sample does not have to be a clean catch (e.g., bacteria in the urine will not compromise test results). If patients cannot wait to urinate until their arrival at the exam facility, first responders should ask them to provide a sample and bring it to the facility, documenting the chain of custody. It is suggested that law enforcement officers and emergency medical technicians keep specimen cups readily available, according to agency policy.

Ideally, patients should not urinate until after evidence is collected. However, the number of times that patients urinated prior to collection of the sample should be documented.

Collect a blood sample when appropriate. If ingestion of drugs used to facilitate sexual assault may have occurred within 24 hours prior to the exam, a blood sample of at least 20 milliliters should be collected in a gray-top tube (contains preservatives sodium fluoride and potassium oxalate<sup>257</sup>) according to jurisdictional policy. A blood sample taken within this time period may pinpoint the time when drugs were ingested.<sup>258</sup> If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample. If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion, according to jurisdictional

<sup>251</sup> The prosecutor can work to minimize the possibility that information about voluntary alcohol and/or drug use will be used against patients, particularly if patients are truthful from the start about their preassault drug/alcohol use and consent to testing.

<sup>252</sup> For example, if there is a suspicion that the assault was drug-facilitated and there were no toxicology tests, investigators and prosecutors may lack critical evidence, making it difficult to prosecute the case. Prosecutors might choose not to go forward with such a case. Refusal to get tested may also be used by the defense to discredit the patient and question the validity of the charges.

<sup>253</sup> American Prosecutors Research Institute, Violence Against Women Program, 1999, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, Chapter 2, p. 1.

<sup>254</sup> M. LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults, *Forensic Science Communications*, 1999, p. 3.

<sup>255</sup> *Ibid.*

<sup>256</sup> *Ibid.*

<sup>257</sup> *Ibid.*

<sup>258</sup> American Prosecutors Research Institute, Violence Against Women Program, 1999, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, Chapter 2, p. 2.

policy. (If blood has already been taken due to suspected drug ingestion, that sample can be used to determine blood-alcohol level. An additional sample usually is not needed.)

Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation.<sup>259</sup> Collect and preserve according to jurisdictional policy.

Package samples as appropriate. Package each toxicology sample according to the policy of the lab doing the analysis, place in envelope, label, seal, and initial the seal.

**Identify toxicology laboratories.** Exam facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small quantities).<sup>260</sup> Information about these labs (e.g., contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives investigating these cases, exam facilities, and examiner programs.

If toxicology tests are needed purely for the medical evaluation of patients, the exam facility lab typically performs these tests. Lab results are recorded in patients' medical records, according to facility policy. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the exam facility lab and another for analysis by the identified forensic lab. Take samples at the same time to avoid more discomfort to patients than is necessary.

**Preserve evidence and maintain the chain of custody.** Involved health care personnel should be aware of the toxicology lab's requirements on collection, packaging, labeling, storage, handling, transportation, and delivery of specimens.<sup>261</sup> Policies should be in place for storage of these samples when patients are undecided about reporting. As with any forensic evidence, the chain of custody must be maintained.

Refer to the current *Forensic Toxicology Laboratory Guidelines* by the Society of Forensic Toxicologists, Inc., and the American Academy of Forensic Sciences for detailed guidance on proper collection, labeling, handling, submission, and analysis of toxicology samples.<sup>262</sup>

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<sup>259</sup> M. LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults, *Forensic Science Communications*, 1999, p. 3.

<sup>260</sup> American Prosecutors Research Institute, Violence Against Women Program, 1999, Video supplement, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*.

<sup>261</sup> Refrigerate toxicology samples according to jurisdictional policy. In general, drawn blood should be refrigerated when it is stored. Urine should be refrigerated or frozen when stored.

<sup>262</sup> These guidelines are available at <http://www.soft-tox.org>.

## 8. STI Evaluation and Care

Recommendations at a glance to facilitate evaluation and treatment of STIs:

- Offer patients information in a language they understand.
- Consider the need for STI testing on an individual basis.
- Encourage patients to accept prophylaxis against STIs if indicated.
- Encourage follow-up STI exams, testing, immunizations, counseling, and treatment as directed.
- Address concerns about HIV infection.

Contracting a sexually transmitted infection (STI), also commonly known as a sexually transmitted disease or STD, from assailants is typically a significant concern of sexual assault patients. Because of this concern, it should be addressed as part of the medical forensic exam. Mechanisms should be in place in any setting where these patients are examined for STIs to ensure continuity of care (including timely review of test results) and monitor compliance with and adverse reactions to any therapeutic or prophylactic regimens.<sup>263</sup>

**Offer patients information in a language they understand.** Include information about the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until treatment is completed), follow-up care, and referrals as needed.<sup>264</sup> Referrals should include free and low-cost testing, counseling, and treatment offered in various sections of the community. Patients should be aware of the scope of confidentiality related to information in their medical records related to STIs.<sup>265</sup> The level of detail needed when providing this information verbally varies (e.g., some patients may be aware of risks and want treatment, while others may not be as knowledgeable of risks or their options).

**Consider the need for STI testing on an individual basis.** Testing at the time of the initial exam does not typically have forensic value if patients are sexually active and an STI could have been acquired prior to the assault. Also, despite rape shield laws, there may be a concern that positive test results could be used against patients (e.g., to suggest sexual promiscuity). There may, however, be situations in which testing has legal purposes, as in cases where the threat of transmission or actual transmission of an STI was an element of the crime. Or, for nonsexually active patients, a baseline negative test followed by an STI could be used as evidence, if the suspect also had an STI.

Trichomoniasis, bacterial vaginosis (BV), gonorrhea, and chlamydial infection are the most frequently diagnosed infections among sexually assaulted women.<sup>266</sup> Their presence does not necessarily indicate acquisition during the assault, since these infections exist among some sexually active women.<sup>267</sup> The medical forensic exam presents an opportunity to identify preexisting STIs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment. Testing for STIs at the time of the exam also gives examiners and patients the option of deferring treatment until it is needed.

Seek the informed consent of patients for testing, if indicated, following CDC guidelines. (For more information on this topic, see A.3. *Informed Consent*.)

<sup>263</sup> Sexually Transmitted Diseases Treatment Guidelines, *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, December 17, 2010, 9(RR-12), p. 91. Available at <http://www.cdc.gov/STD/treatment/> (CDC general phone: 800-311-3435). Much of the information in this chapter was drawn from these guidelines. Note that the guidelines are updated periodically. In addition to the guidelines, the CDC Web site at <http://www.cdc.gov> offers information on related research, news, and Internet links.

<sup>264</sup> Drawn partially from Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 92.

<sup>265</sup> Laws in all states limit the evidentiary use of a patient's prior sexual history, including evidence of previously acquired STIs, as part of an effort to undermine the credibility of a patient's testimony. Evidentiary privilege against revealing any aspect of the exam or treatment is enforced in most states. In unanticipated, exceptional situations, however, STI diagnoses may later be accessed. (Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 90.)

<sup>266</sup> Chlamydial and gonococcal infections in women are of particular concern due to the possibility of ascending infection. In addition, post-assault testing can detect hepatitis B virus (HBV) and human immunodeficiency virus (HIV) infection (Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91).

<sup>267</sup> The prevalence and incidence of STIs vary across societies and subpopulations defined by age, gender, race and ethnicity, and socioeconomic status (Fenton, Johnson, and Nicoll 1997)

**Encourage patients to accept prophylaxis against STIs if indicated.** If prophylaxis is accepted at the time of the exam, testing is usually not indicated medically. Routine preventive therapy after a sexual assault is often recommended because follow-up with these patients can be difficult.<sup>268</sup> It also may reduce the need for more expensive/extensive treatment if an STI is discovered at a later time. Meet or exceed current CDC guidelines for STI preventive therapy for your geographic area.<sup>269</sup> (The CDC suggests a regimen to protect against chlamydia, gonorrhea, trichomonas, and BV, as well as the hepatitis B virus.) If prophylaxis is declined at the time of the initial exam, it is medically prudent to obtain cultures and arrange for a follow-up examination and testing (it is recommended that all patients are reexamined—see the section on follow-up activities). Document patients' decisions and rationales for declining prophylaxis in their medical records.<sup>270</sup>

If patients' clinical presentation suggests a preexisting ascending STI, such as fever, abdominal or pelvic pain, and/or vaginal discharge, they should be evaluated and treated for the ascending infection. This treatment should be based on specific treatment options for sexually transmitted infections in the local community.

**Hepatitis B virus (HBV) and postexposure prophylaxis (PEP).** See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunizations, prevaccination antibody screening, postexposure prophylaxis, and special considerations.<sup>271</sup> Patients who have completed a full hepatitis B vaccination regimen prior to the assault are protected from HBV infection and do not need further doses. (See the CDC recommended regimen for adolescents and adults.) For those who were not fully vaccinated prior to the assault, the vaccine should be completed as scheduled. Patients unvaccinated prior to the assault or unsure of whether they have been vaccinated should receive active postexposure prophylaxis (e.g., hepatitis B vaccine alone) upon the initial clinical evaluation. Follow-up doses should be given 1 to 2 and 4 to 6 months after the first dose. Unless suspects are known to have acute hepatitis B, HBIG (hepatitis B immune globulin) is not required. (When HBIG is needed, use CDC recommended doses.)

Examiners must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Advocates should also be educated about the possibility of patients receiving prophylaxis against HBV and encourage those who start the vaccine regimen to follow up for required additional doses.

**Obtain informed consent from patients for treatment.** (For information on this topic, see A.3. *Informed Consent*.) Patients should be aware of the benefits and toxicity associated with recommended regimens.

**Encourage follow-up STI exams, testing, immunizations, counseling, and treatment as directed.**<sup>272</sup> Although patients may be reluctant to go for follow-up exams for STIs, such exams are essential because they provide an opportunity to detect new infections acquired during or after the assault, complete hepatitis B immunization, if indicated, and complete counseling and treatment for other STIs. Examinations for STIs for all patients should be repeated according to exam facility policy—the CDC recommends a follow-up appointment within 1 to 2 weeks of the assault. If patients tested negative at the time of the medical forensic exam and chose not to receive prophylaxis, follow-up testing should be conducted.<sup>273</sup> The CDC recommends that in this case the follow-up exam be done within a week to ensure that positive test results are discussed promptly with patients and treatment is offered. The CDC recommends follow-up testing for patients who received treatment only if they report having symptoms consistent with an STI. (However, patients who were treated should be informed of the option of follow-up testing to confirm the presence or lack of infection.) The CDC recommends that testing for syphilis and HIV infection should be repeated 6 weeks, 3 months, and 6 months after the assault if initial test results were negative and if these infections are likely to be present in assailants (see the upcoming section on evaluating risk for exposure to HIV).

<sup>268</sup> Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91.

<sup>269</sup> Antibiotic prophylaxes are updated periodically and are usually tailored to specific regions (because, for example, one part of the country may be resistant to a certain antibiotic).

<sup>270</sup> Nonphysician examiners providing STI prophylaxis typically must operate within the boundaries of a protocol and have access to medical supervision, consultation, and review.

<sup>271</sup> Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91. This section was drawn from this document.

<sup>272</sup> This paragraph is drawn from Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91.

<sup>273</sup> Infectious agents acquired through the assault may not have produced sufficient concentrations of organisms to result in positive test results at the medical forensic exam. (Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91.)

It is important that follow-up communication with patients (particularly by examiners and advocates) include a reminder to go to follow-up exams and receive STI-related testing, immunizations, and treatment as directed. Advocates and health care personnel may be able to assist patients in making follow-up appointments, obtaining transportation to and from appointments, and determining how to pay for expenses involved with follow-up testing and care. Some jurisdictions may cover follow-up treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more apt to seek follow-up treatment. Advocates may also be able to accompany patients to these follow-up appointments.

**Address concerns about HIV infection.** Although the risk of human immunodeficiency virus (HIV) infection<sup>274</sup> from a sexual assault appears to be low,<sup>275</sup> it is typically of grave concern for sexual assault patients.

Provide information and referrals.<sup>276</sup> Examiners should talk with patients about their concerns regarding the possibility of contracting HIV.<sup>277</sup> Although a definitive statement of benefit cannot be made regarding Post Exposure Prophylaxis (PEP) after sexual assault, the possibility of HIV exposure from the assault should be assessed at the time of the examination. The possible benefit of PEP in preventing HIV infection should also be discussed with the patient if the details of the assault pose an elevated risk for HIV exposure. These particular factors may include: the likelihood that the assailant has HIV, the time elapsed since the event, the exposure characteristics, and local epidemiology of HIV/AIDS. A specialist consultation on PEP regimens is recommended if HIV exposure during the assault was possible and PEP is being considered. The sooner PEP is initiated after exposure, the higher the likelihood it will prevent HIV transmission if exposure occurred. The CDC recommends offering the patient a 3-5 day supply of PEP if the medication is judged to be necessary and the patient decides to utilize the treatment.<sup>278</sup>

As with other STIs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence or barrier use (condoms) during sexual intercourse until any treatment received is completed. Include local referrals for testing/counseling and comprehensive HIV services in the community and region. This information can help patients make decisions about testing and treatment based on facts rather than fear.<sup>279</sup>

Discuss testing options. Baseline HIV testing is not typically an exam component. However, if the assault is considered a high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by health care personnel. However, even if the assault is not considered a high risk for HIV exposure, some patients may still wish to be tested.

HIV testing should be done in settings where counseling can be offered to explain results and implications. When providing testing referrals, let patients know whether testing services are free, anonymous, and/or confidential.<sup>280</sup> Confidential and anonymous testing is recommended.

Assess the need to offer HIV postexposure prophylaxis.<sup>281</sup> In certain circumstances, the likelihood of HIV transmission may be reduced by postexposure therapy for HIV with antiretroviral agents. Postexposure

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<sup>274</sup> HIV refers to any of a group of retroviruses that infect and destroy helper T-cells of the immune system. AIDS (acquired immunodeficiency syndrome) can be triggered by infection with HIV. (Drawn from Arkansas' *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination*, 2001, p. B2.)

<sup>275</sup> Although HIV-antibody seroconversion has been reported among individuals whose only known risk factor was sexual assault or sexual abuse, the risk for acquiring HIV infection through a single episode of sexual assault is likely low. The overall probability of HIV transmission during a single act of intercourse from a suspect known to be HIV-infected depends on many factors. In specific circumstances, the probability of transmission could be high. These factors may include the type of sexual intercourse (oral, vaginal, or anal), presence of oral, vaginal, or anal trauma (including bleeding), site of exposure to ejaculate, viral load in ejaculate, and presence of a STI or genital lesions in assailants or patients. (Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 92.)

<sup>276</sup> A useful referral is the CDC's National HIV/AIDS Information Hotline at 800-342-AIDS. For Spanish speakers, call 800-344-SIDA. For Deaf and hearing-impaired persons, call the TTY/TDD Hotline at 800-AIDS-TTY. Also see the Revised Guidelines for HIV Counseling, Testing, and Referral, *Morbidity and Mortality Weekly Report*, CDC, September 22, 2006, 55(RR-14). This document is available through [aidsinfo.nih.gov/guidelines/](http://aidsinfo.nih.gov/guidelines/) or by calling the CDC's HIV/AIDS Information Hotline (see below footnote).

<sup>277</sup> Some states statutes provide for mandatory HIV testing of suspected sex offenders upon arrest and/or conviction. Patients should be advised of the availability of such testing.

<sup>278</sup> This paragraph is drawn from Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 92.

<sup>279</sup> L. Ledray, *SANE Development and Operations Guide*, 2000, p. 74.

<sup>280</sup> Drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 126.

therapy with zidovudine has been associated with a reduced risk for HIV infection and has become the standard of care for health workers who have percutaneous (e.g., needle stick) exposure to HIV, but whether these findings can be extrapolated to other exposure situations, including sexual assault, is unknown.

The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with its possible adverse side effects.<sup>282</sup> Health care personnel must evaluate patients' risk of exposure to HIV and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of postexposure therapeutic agents should consult with a specialist in HIV treatment. Numerous factors may influence the decision to offer treatment, such as the time since the exposure occurred; the probability that the assailant is infected with HIV; the likelihood that transmission could occur from the assault; and the prevalence of HIV in the geographic area or institutional setting (e.g., a prison) where the assault occurred.<sup>283</sup>

Offer postexposure prophylaxis for HIV to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. If offered, the following information should be discussed with patients:<sup>284</sup>

- The unknown efficacy of postexposure prophylaxis for HIV in cases of sexual assault.
- The known side effects and toxicity of antiretroviral medications.
- The need for frequent dosing of medication and the follow-up care necessary.
- The importance of compliance with the recommended therapy.
- The necessity for immediate initiation of treatment for maximum effectiveness.
- The estimated costs of the medication and monitoring.<sup>285</sup>

When given following a sexual assault, postexposure prophylaxis is the same as for occupational exposure to HIV. Refer to CDC recommendations for postexposure antiretroviral therapy<sup>286</sup> and consult with an HIV specialist where possible. Careful monitoring and follow-up by a health care provider or agency experienced in HIV issues is required. Patients should be alerted to symptoms of primary HIV infection (e.g., fever, fatigue, sore throat, lymphadenopathy, and rash) and seek care if these symptoms arise.

Seek informed consent of patients to administer treatment. The decision to begin or withhold treatment should be made by patients and health care personnel after patients have been adequately informed of the risks and benefits of treatment options. (For information on this topic, see A.3. *Informed Consent*.)

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<sup>281</sup> The following two paragraphs were drawn from Sexually Transmitted Diseases Treatment Guidelines, p. 70, L. Ledray, *SANE Development and Operations Guide*, 2000, p. 74, and the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, pp. 93-4. See also Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Non Occupational Exposure to HIV in the United States, *Morbidity and Mortality Weekly Report* 2005, 54 (RR-2).

<sup>282</sup> A table listing primary side effects associated with specific antiretroviral agents is provided in the CDC's Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, *Morbidity and Mortality Weekly Report* 2001, 50 (RR-11), p. 13. Some examples of known shorter term adverse symptoms of antiretroviral medications include nausea, vomiting, diarrhea, and other gastrointestinal effects. Protease inhibitors may cause lipid abnormalities, diabetes mellitus, and hyperglycemia and lead to diabetic ketoacidosis in previously diagnosed diabetics. Combination therapy has lead to some serious side effects, including hepatitis, nephrolithiasis, and pancytopenia. (The American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 125.)

<sup>283</sup> Paragraph drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 125.

<sup>284</sup> Bullets drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 93.

<sup>285</sup> Patients may be able to obtain reimbursement for some or all related costs through state crime victims' compensation programs. (L. Ledray, *SANE Development and Operation Guide*, 2000, p. 74.)

<sup>286</sup> See [aidsinfo.nih.gov/guidelines/](http://aidsinfo.nih.gov/guidelines/) for the CDC's Guidelines for the following documents: *Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents* (July 14, 2003); the Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, *Morbidity and Mortality Weekly Report* 2001, 50(RR-11), and Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy, Public Health Statement, *Morbidity and Mortality Weekly Report* 1998; 47(RR-17).

## 9. Pregnancy Risk Evaluation and Care

Recommendations at a glance to evaluate and treat pregnancy:

- Discuss the probability of pregnancy with patients with reproductive capability.
- Administer a pregnancy test for all patients with reproductive capability (with their consent).
- Discuss treatment options with patients in their preferred language.
- A victim of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines. Conscience statutes will continue to protect health care providers who have moral or religious objections to providing certain forms of contraception. In a case in which a provider refuses to offer certain forms of contraception for moral or religious reasons, victims of sexual assault must receive information on how to access these services in a timely fashion.

Becoming pregnant from a sexual assault is a significant concern of sexual assault patients, and patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Most programs offer pregnancy prevention or interception for sexual assault patients if they are seen within 120 hours of the assault. Examiners and other involved health care personnel must be careful not to influence patients' choices of treatment.

**Discuss the probability of pregnancy with patients with reproductive capability.** The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent, similar to the risk of pregnancy from a one-time sexual encounter. The 2005 National Crime Victimization Study<sup>287</sup> reported 64,080 female victims of rape; therefore, statistically speaking, up to 3,204 pregnancies could have resulted from the rapes. Any female of reproductive capability (Tanner Stage 3 and above, irrespective of menarche) can potentially become pregnant from any single exposure. Determination of the probability of conception also depends upon other variables, for example, the use of contraceptives, regularity of the menstrual cycle, fertility of the victim and the perpetrator, time in the cycle of exposure, and whether the perpetrator ejaculated intravaginally. Pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim, so victims' fears should be taken seriously.<sup>288</sup> Although many transgender male individuals believe they are infertile as a result of using testosterone, cases have been reported of unexpected pregnancies. Therefore, if a transgender male individual has not had a hysterectomy, is still within childbearing years, and the nature of the assault suggests it, the possibility of pregnancy should be discussed, even if he has not been menstruating.

**Administer a pregnancy test for all patients with reproductive capability (with their consent).**<sup>289</sup> An exception is if a patient clearly is pregnant. If a patient is pregnant, the pregnancy may affect what medications can be administered or prescribed in the course of or after the exam. Follow policies of the medical facility for pregnancy testing. Sensitive beta-HCG pregnancy tests can be utilized. Most commercially available urine pregnancy tests are sensitive to about 50 milli-international units/ml and will detect pregnancy 8 to 9 days after conception, before a menstrual period is missed. Blood pregnancy tests will detect HCG at very low levels. If the pregnancy test is positive, emergency contraception is contraindicated and decisions about other medications (e.g., STI prophylaxis) must be made in consideration of the pregnancy. If the test is negative and the patient has had unprotected intercourse within the last 10 days and would continue that pregnancy if conception has occurred, then she may be considered to be pregnant and emergency contraception would not be administered.

**Discuss treatment options with patients in their preferred language, including emergency contraception.**<sup>290</sup> In cases of sexual assault, pregnancy is often an overwhelming and genuine fear. Therefore, discuss treatment options with patients, including emergency contraception. An immediate option

<sup>287</sup> Bureau of Justice Statistics Bulletin, 9/2005 NCJ 214644.

<sup>288</sup> L. Ledray, *SANE Development and Operation Guide*, 2000, p. 75.

<sup>289</sup> Preexisting pregnancy may raise patient privacy issues. If the case is prosecuted, the prosecutor should work to address concerns such as this one.

<sup>290</sup> The National Sexual Violence Resource Center (877-739-3895 or 717-909-0710) offers more detailed information about sexual assault and pregnancy on their Web site at <http://www.nsvrc.org/>.

is to offer hormone therapy (emergency contraception pills or EC).<sup>291</sup> Another option is to forgo immediate treatment and have the patient follow-up with their primary care provider. Discuss options with the patient and information regarding the timeframe for emergency contraception provision, so she can make an informed decision. Inform the patient that the provision of any emergency contraception will not prevent sexually transmitted infections. The conversation with the patient should include a thorough discussion, including mechanism of action for each treatment option, side effects, dosing, and follow-up. This information should also be provided in writing in the preferred language of the patient, if possible.

**A victim of sexual assault should be offered prophylaxis for pregnancy, subject to informed consent and consistent with current treatment guidelines.** Conscience statutes will continue to protect health care providers who have moral or religious objections to providing certain forms of contraception. In a case in which a provider refuses to offer certain forms of contraception for moral or religious reasons, victims of sexual assault must receive information on how to access these services in a timely fashion.

Offer/provide the patient with emergency contraception pills and anti-nausea medication if they are at risk, according to facility policy.<sup>292</sup> Emergency contraception is a hormonal method of preventing pregnancy that can be used after sexual assault. There are multiple products available for EC. It is recommended, however, that levonorgestrel,<sup>293</sup> a synthetic hormone,<sup>294</sup> be used.<sup>295</sup> This option is recommended for its higher efficacy rate and ease of dosing, and the fewest number of side effects, particularly nausea and vomiting.<sup>296</sup> Levonorgestrel will not end a pregnancy that is already in progress and is considered a safe and easy treatment for victims of assault in preventing a pregnancy. Levonorgestrel is *most* effective if used within 120 hours and can reduce the risk of pregnancy by up to 89 percent.<sup>297</sup> Traditional dosing of levonorgestrel includes administering two doses of 0.75 mg taken orally 12 hours apart. However, some studies indicate that single dosing with 1.5 mgs of levonorgestrel are just as effective and better tolerated by the patient.<sup>298</sup>

Follow-up Care: The patient should be informed that following the use of EC, there may be a heavier or lighter menses than usual and the menses onset may not occur at the expected time. If no bleeding has occurred within three weeks, the patient should be reevaluated and a repeat pregnancy test performed. The patient must be advised not to have unprotected intercourse until after the menses has occurred, or the repeat pregnancy test is negative.

If the facility chooses not to provide EC on site, the patient should be given prescriptions for EC and anti-nausea medications, with a list of pharmacies that stock the medication.<sup>299</sup>

If the facility is not willing to provide EC or write the needed prescriptions, it is recommended that the patient be given local referrals to medical facilities that can *immediately* assist with alternative treatment.

If no referral is available, provide the patient with the following phone numbers: 1-888-not2late or the online reference: <http://not-2-late.com>.<sup>300</sup>

<sup>291</sup> Copper Bearing Intra-Uterine Devices (IUDs) may also be an option, however, they are much less recommended because of the risk of infection in certain cases, the potentially painful insertion procedure, and the need for follow-up care.

<sup>292</sup> CA Protocol

<sup>293</sup> Task Force on Postovulatory Methods of Fertility Regulation. Randomized controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet*. 1998;352:428-433.

<sup>294</sup> FDA website: <http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm>.

<sup>295</sup> Relative contraindications for birth control, caution must be exercised when providing any EC with estrogen. Plan B does not contain estrogen, but contraindications should still be noted. The only absolute contraindication for the use of Plan B is preexisting pregnancy.

<sup>296</sup> H.B. Croxatto, L. Devoto, M. Durand, E. Ezcurra, F. Larrea, C. Nagle, et al. Mechanism of Action of Hormonal Preparations Used for Emergency Contraception; a Review of the Literature. *Contraception*. 2001; 63:111-121

<sup>297</sup> <http://www.planbonestep.com/plan-b-prescribers/index.aspx>

<sup>298</sup> Alternative dosing for Plan B includes administering the tablets together in a one time dose. A study done by WHO found that the effectiveness of administering single doses of levonorgestrel was as effective as administering the doses 12 hours apart. Helena von Hertzen, Gilda Piaggio, Juhong Ding et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomized trial. *The Lancet*: December 7, 2002; Vol 360 (9348):1803-10.

<sup>299</sup> J.S. Gardner, J. Hutchings, T.S. Fuller, D. Downing. Increasing access to emergency contraception through community pharmacies: lessons from Washington state. *Family Planning Perspective*. 2001;33(4):142-175.

<sup>300</sup> This hotline and website are operated by the Office of Population Research at Princeton University and by the Association for Reproductive Health Professionals.

## 10. Discharge and Follow-up

Recommendations at a glance to facilitate discharge planning and follow-up with patients:

- Address issues related to medical discharge and follow-up care.
- Advocates, law enforcement representatives, and other involved responders can coordinate with health care providers to discuss a range of other issues with patients prior to discharge.

Health care personnel have important tasks to accomplish prior to discharging patients, as do advocates and law enforcement representatives (if involved). These responders should coordinate their activities as much as possible to reduce repetition and avoid further overwhelming patients.

**Address issues related to medical discharge and follow-up care.** Health care personnel (preferably examiners) should address the following issues with patients prior to discharge:

Make sure patients' medical and mental health needs related to the assault have been addressed. Discuss with patients whether they have any other medical and/or mental health concerns related to the assault.<sup>301</sup> If injuries or trauma have not been treated yet, examiners should refer patients to exam facility clinicians (e.g., hospital emergency department staff) for care or provide the appropriate community referrals prior to discharge.

Provide patients with oral and written medical discharge instructions. Include a summary of the exam (e.g., evidence collected, tests conducted, medication prescribed or provided, information provided, and treatment received), medication doses to be taken, follow-up appointments needed or scheduled, and referrals. The discharge form could also include contact information and hours of operation for local advocacy programs.

Arrange follow-up appointments for patients. Follow-up may be indicated to document developing or healing injuries (for example, bruising) and complete resolution of healing. Forensic follow-up may also be indicated to further evaluate nonspecific findings (such as redness, swelling, or cervical abnormalities) that may be related to acute trauma or may be normal variants. (A jurisdictional policy describing the indications and procedures for follow-up for documentation purposes should be in place.) Appointments may also be needed to address ongoing medical concerns. If appointments are not scheduled, at least indicate to patients which appointments are needed and if sites are different than the initial exam. Make it clear that patients do not have to disclose the assault to receive follow-up medical care. Follow-up appointments may include:<sup>302</sup>

- For patients with evidence of acute trauma: A short-term follow-up appointment to reexamine and document the development of visible findings and photograph areas of injury; and an exam 2 to 4 weeks later to document resolution of findings or healing of injuries.
- For all patients: Repeat exams for STIs according to facility policy (see *C.8. STI Evaluation and Care*).
- Primary health care providers or other nonacute care providers can provide longer term care as needed (e.g., for HIV testing, STI testing, and administering doses of Hepatitis B vaccine).

Discuss follow-up medical contact procedures. Discuss with patients whether they would like health care providers to provide a follow-up call and, if so, the best method and time for this contact (maintaining patients' privacy and safety). The main purposes of such a call are to check on medical status and remind patients about the necessity of follow-up testing and care. An optimal time for a first medical follow-up contact is 24 to 48 hours following discharge. Personnel following up with patients should be familiar with the case, confidentiality issues, and potential medical needs.<sup>303</sup>

<sup>301</sup> Care should be taken to ensure that mental health professionals can appropriately and respectfully handle patients from minority and/or stigmatized groups such as specific cultural groups or transgender individuals.

<sup>302</sup> Bullets drawn partially from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 98.

<sup>303</sup> When appropriate, advocates may assist health care personnel in encouraging patients to seek the follow-up medical care they need. They also may encourage patients to discuss with health care providers their concerns about initial and follow-up medical care.

**Advocates, law enforcement representatives, and other involved responders can coordinate with health care providers to discuss a range of other issues with patients prior to discharge.** Involved responders should come to agreement about who is responsible for each step below and where coordination is necessary. For example, while advocates usually explain advocacy services and law enforcement representatives explain the investigative process, each responder may have a role in helping patients plan for their safety and well-being. If health care personnel are the only responders involved, however, they may need to provide patients with much of the information below.

After the exam is finished, address patients' physical comfort needs. (For a discussion of this topic, see A.2. *Victim-Centered Care*.)

Help patients plan for their safety and well-being. Jurisdictional and exam site policies should be in place to facilitate this process. Assist patients in developing a postexam plan that addresses their physical safety and emotional well-being. Screen for domestic and dating violence and others forms of abuse. Assist patients in considering things such as:

- Where are they going after being discharged? With whom? Will these individuals provide them with adequate support? Is there anyone else they would like to contact? (Provide information about available community resources for obtaining support and help in making the contact if needed.)
- Will their living arrangements expose them to the threat of continued violence or harassment? Is there a need for emergency shelter or alternative housing options? (Provide options and help obtain if needed.)
- Are they eligible for protection orders? (Provide information and help obtain if desired.)
- Is there a need for enhanced security measures? (Discuss options and help obtain if desired.)
- If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan.)

Planning must take into account the needs and concerns of specific populations. For example, if patients with physical disabilities require shelter, the shelter must be accessible and staff able to meet their needs for personal assistance with activities of daily living.<sup>304</sup> If patients living in institutional settings have been assaulted by another resident, a staff person, or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that patients have to come into contact with the assailant again. It should also ensure them access to services designed to promote their recovery.

Explain follow-up contact procedures of all responders involved. Coordinate follow-up contact of involved agencies as much as possible, keeping the number of responders contacting patients to a minimum. Explain if contact procedures are different for patients with limited English proficiency or specific communities or institutions (e.g., schools, military bases, prisons, or residential programs may have their own procedures). Consider offering patients prepaid phone cards they can use to call a contact person with concerns or questions.

Explain advocacy and counseling services. Sexual assault advocacy programs typically offer a host of services for victims and their significant others, in addition to those provided during the exam process. (For more information on services, see A.2. *Victim-Centered Care*.) Advocates can describe and offer patients, their family members, and friends these services, as well as explain options for counseling in the jurisdiction and offer referrals. Some advocacy programs provide professional mental health counseling, but many refer patients to community or private agencies. Before being discharged, advocates should ask patients if they can follow up with them. If they agree, they can determine optimal methods and times for the contacts. During follow-up contacts, advocates can help patients reassess their safety; offer support and crisis counseling; answer their questions and provide additional referrals and information; and help coordinate other advocacy services and counseling based upon identified needs.

Explain the investigative process. If law enforcement is involved, inform patients that investigators will request an interview with them, if not already done, explain the criminal justice process and victims' rights, reassess their safety and provide assistance as warranted, and then recontact them as needed as their case

<sup>304</sup> Drawn from M. Nosek and C. Howland, *Abuse and Women with Disabilities*, 1998, p. 3.

progresses.<sup>305</sup> Explain if contact procedures are different for patients with limited English proficiency or for specific communities or institutions. Patients should receive contact information of involved law enforcement representatives and agencies and a case report number. They should feel free to call their investigator with any new relevant information, if new signs of injuries appear, about suspects' compliance with protection orders or bond conditions, if suspects try to contact them, or with other related questions or concerns. They should be aware that they will be contacted by the prosecution office if their case goes forward. (Patients should be aware that it is their decision whether to report their case and talk with law enforcement officials and prosecutors.)

If evidence has been gathered and law enforcement is involved, the law enforcement representative can discuss with patients the possibility of a match being found through DNA analysis or of other victims of the same assailant being identified. Ask patients if they want to be contacted by law enforcement in these situations and, if so, determine the best contact method.

For patients who have not made a report and when law enforcement is not involved, patients should be given information on who to contact and how if they decide that they do want to make a report. They should also be given information on where the kit will be stored and how it will be tracked (for example if there is a tracking number, it should be provided).

Provide information. Offer patients clear and concise information, both orally and in writing.<sup>306</sup> Information should be tailored to patients' communication skill level/modality and language. (For more information on the types of information that patients might find useful, see A.2. *Victim-Centered Care*.)

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<sup>305</sup> Some patients may want information, either during the exam process or after, about the amount of time it takes to process cases in the criminal justice system. It can be helpful for them to know the range of time it typically takes in that jurisdiction for evidence to be analyzed and for cases to be forwarded to prosecution or tried in court. This information may help them prepare for their justice system involvement. At the same time, they must understand that every case is different and typical time estimates from the past may not apply.

<sup>306</sup> Many local sexual assault advocacy programs and state coalitions of sexual assault programs offer publications that speak to victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council could develop such literature.



# 11. Examiner Court Appearances

Recommendations at a glance for jurisdictions to maximize the usefulness of examiner testimony:

- Encourage broad education for examiners on testifying in court.
- Promote prompt notification of examiners if there is a need for them to testify in court.
- Encourage pretrial preparation of examiners.
- Encourage examiners to seek feedback on their testimony to improve effectiveness of future court appearances.

It should be expected that examiners will be called on to testify in court as either fact and/or expert witnesses,<sup>307</sup> even though in some cases, a plea bargain may be agreed upon, or the prosecuting attorney may decide not to try the case. Examiners should always conduct and document each examination knowing that legal testimony may ultimately be required.

## Encourage broad education for examiners on testifying in court:<sup>308</sup>

- Provide them with information about courtroom proceeding basics (e.g., criminal justice process and terms, who typically is present,<sup>309</sup> and prosecution and defense strategies).
- Educate them about different types of testimony (including what can and cannot be said during testimony). This information should assist examiners in explaining to patients during the exam their potential role as a witness should the case be prosecuted.
- Help them understand that testifying in court can be a difficult experience. In almost every case that is litigated, cross-examination after initial testimony will occur. Cross-examination is a part of our constitutional framework, but as defense counsel represent alleged offenders, their questions may be perceived by examiners as intimidating and hostile. It is critical that examiners are prepared to effectively handle such situations and have a support system in place to help them prepare for and deal with related stress they may experience.
- Provide them with pretrial preparation (see the section below on this topic).

Involve trainers from health care, prosecution, and the judiciary in trainings on court testimony. Also, include defense attorneys who can educate examiners on defense perspectives. In addition to attending trainings, examiners should stay abreast of cutting-edge practices and related case law (e.g., rulings that impact the scope of issues they can testify on in court).<sup>310</sup>

<sup>307</sup> An expert witness is person who has training, education, and experience on a particular subject and who is formally found to be qualified as an expert by a judge. Expert witnesses may give opinions in court on matters in which their expertise is relevant. Nonexpert witnesses normally cannot give opinions in response to questions in court, but can only testify to the facts (what has been observed, collected, or heard). (Drawn from San Diego County's *SART Standards of Practice*, 2001, p. 40.)

<sup>308</sup> This section is partially adapted from the International Association of Forensic Nurses, *SANE Education Guidelines*, 1999. One useful resource for SANEs and attorneys who utilize SANEs for testimony is L. Ledray and L. Barry, Sexual Assault Clinical Issues: SANE Expert and Factual Testimony, *Journal of Emergency Nursing*, 24(3), June 1998, pp. 284–287.

<sup>309</sup> The following may be present in the courtroom: the judge, prosecutor, defense attorney, jury, bailiff, clerk, court reporter, law enforcement investigator, victim, defendant, and victim advocate.

<sup>310</sup> This section focuses on preparing examiners for court testimony. Beyond preparing examiners, it is critical to encourage training for attorneys who try these cases on how to properly interpret and use the medical forensic examination. In addition, they need an accurate understanding about the education and clinical preparation, roles, and responsibilities of the forensic examiner. Like examiners, they can benefit from participating in mock trials and need ongoing education to stay abreast of the latest best practices and related case law. Prosecutors should be aware of and share related case law and protocol guides with judges as references to qualify examiners as expert witnesses. They can also share questions they plan to ask to establish credentials of these witnesses. Additionally, prosecutors must understand how to educate the jury about evidence that will be presented (e.g., a lack of physical injury does not equal lack of sexual assault). Similarly, it is important to encourage judicial education on issues related to examiner testimony. Judges may not understand all that occurs during the exam process or the full extent of examiner expertise. *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, is a useful resource for prosecutors and judges (for more information, see <http://www.legalmomentum.org/our-work/njep/njep-sexual-assault.html>). The National Judicial Education Program (NJEP) offers this resource. It also offers a judicial curriculum on sexual assault trials.

**Promote prompt notification of examiners if there is a need for them to testify in court.** Examiners should be informed well in advance of a trial if they are being called as witnesses. It may be helpful for attorneys calling them (both prosecutors and defense attorneys) to first develop relationships with coordinators of examiner programs, if they exist, or staff that oversee examiners at the exam site. In some facilities, they may need to reach out to risk management departments, which oversee all potential areas of liability for the facility. The first time an attorney contacts the witness should not be through a subpoena. Unexpected subpoenas can cause examiners a great deal of anxiety.<sup>311</sup>

Attorneys should regard examiners they call as witnesses with respect for the knowledge and expertise examiners offer to the court. They also should work to minimize the amount of time examiners wait to testify, allowing them to return to their work as quickly as possible. Judges also should be aware of the need to give examiners priority in the scheduling of testimony.

**Encourage pretrial preparation of examiners.**<sup>312</sup> Examiners should be prepared for both direct examination and cross examination. When preparing to testify, the following suggestions may be useful to examiners:

- Although the criminal justice record includes the medical forensic report, photographs, and the results of evidence analysis, medical records are confidential in most jurisdictions. Before examiners or other involved health care providers can talk with an attorney about information in patients' medical records, those records must be successfully subpoenaed. Health care facilities and/or independent examiner programs typically have procedures in place for handling subpoenas.<sup>313</sup>
- It is critical that examiners meet in advance with the attorney(s) calling them as witnesses, in order to prepare for testimony in individual cases. Not only should they review and discuss the initial examination of the patient, but also any subsequent contacts between the patient and the examiner.
- Prior to testifying, examiners should review records of the exam and keep a log of materials reviewed.
- Expert witnesses should be prepared to educate the court, particularly jurors. They should consider terminology and descriptions that will most clearly advise lay persons in the courtroom.
- Examiners should keep in mind that anything they write about the case is potentially discoverable.
- Examiners should be prepared to prove qualifications and ready to discuss educational background, clinical experience, and prior experience as expert witnesses. They may also need to explain qualifications if they are testifying to facts in a case. They should keep a portfolio that lists education, experience, and previous appearances as a witness.<sup>314</sup>
- Examiners should understand that they may not testify as to whether patients consented to sexual contact; that is for the jury to decide. However, some jurisdictions allow expert testimony that speaks to the consistency between patients' statements and injuries rather than attempting to draw conclusions about how injuries were caused or whether a sexual assault occurred.<sup>315</sup>

During testimony, examiners should consider the following:

- The role of the examiner in court is to educate judges and juries.
- Business attire is appropriate for court appearances. Limit excessive jewelry and other accessories which can be distracting.
- Be sincere, polite, and appear in control. Being nervous is normal, even for examiners who have testified previously. Make eye contact with those doing the questioning as well as with the jury.
- Listen to the questions carefully. Allow time to compose answers before speaking. Be concise and correct in responses. Avoid terms such as "I believe" or "I think."

<sup>311</sup> This paragraph was drawn from the video reference guide for *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, pp. 17–18.

<sup>312</sup> Section partially adapted from Arkansas's *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination*, 2001, pp. L1–3.

<sup>313</sup> This bullet was drawn from the video reference guide for *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, pp. 17–18.

<sup>314</sup> See L. Ledray and L. Barry, *Sexual Assault Clinical Issues: SANE Expert and Factual Testimony*, *Journal of Emergency Nursing*, 24(3), June 1998, pp. 284–87, for more discussion on qualifying as an expert witness.

<sup>315</sup> This bullet was drawn from the video reference guide for *Understanding Sexual Violence: Prosecuting Adult Rape and Sexual Assault Cases, Video Library I: Presenting Medical Evidence in an Adult Rape Trial*, 2002, pp. 19–20.

- Avoid medical jargon to the extent possible. If it is needed, define its usage.
- Answer only questions that are asked. Ask the questioning attorney for clarification or to restate the question if needed.
- If the answer to a question is not known, say so. There is no reason for examiners to explain why they do not know the answer. They can ask to refer to records if their memories need refreshing.
- Let the attorney guide the questioning. Answer only questions that are asked. Ask the questioning attorney for clarification or to restate the question if needed. Do not elaborate unless the attorney or judge asks for more information.
- If it is realized that an error or omission occurred in testimony, acknowledge it politely.

Although it is most likely that examiners will be called by the prosecution, they may also be called by the defense. In either case, examiners are expected to give objective testimony. In addition to the previous tips, examiners should consider the following:

- Seek guidance from the prosecutor regarding appropriate interaction with the defense attorney prior to testimony.
- When disagreeing with the questioning attorney, do so without argument or interruption.
- Be aware of the phrasing of questions by the cross-examining attorney that may be designed to place doubt on examiner testimony. For instance, if a compound question is asked, the answer to one part may be "yes" and to the other part may be "no." Be sure to divide answers as appropriate.
- If the questions of the cross-examining attorney include incorrect interpretation of previous examiner testimony or documentation, the erroneous information should be corrected.
- Be careful to provide consistent answers, especially if cross-examining attorneys ask the same question several times, using different wording.

**Encourage examiners to seek feedback on their courtroom testimony to improve the effectiveness of future court appearances.** For example, after the legal proceedings have been completed, examiners may wish to meet with prosecutors for feedback and evaluation of their testimony. Examiners might also want to observe other experts testify in these cases.



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# Appendix A. Developing Customized Protocols: Considerations for Jurisdictions

Jurisdictions starting from scratch in developing their own exam protocols are encouraged to consider the recommendations in this national protocol in their entirety and tailor them to fit local needs, challenges, statutes, and policies. Jurisdictions that have existing protocols can consider whether any of the protocol recommendations or the tasks below could serve to improve their immediate response to sexual assault or address gaps in services or interventions.

Form a protocol planning team. At the least, this team should include those responders involved in the exam process, including health care personnel, exam facility administrators, law enforcement representatives, victim advocates, prosecutors, and forensic laboratory personnel. Organizations serving specific populations in the community should also be involved at some level to make sure the protocol speaks to the needs of victims of diverse backgrounds. Team participants should have authority to make policy decisions on behalf of their agencies. Bringing together such a team can be challenging, particularly in jurisdictions with multiple sexual assault victim advocacy programs, exam facilities, law enforcement agencies, prosecution offices, and court systems (or where several levels of government may be involved in investigation and prosecution of sexual assault cases). Although representation from all involved disciplines and agencies is encouraged, at some point the team assembled will have to move ahead with planning efforts. Try to keep those absent informed of team activities and offer them opportunities to provide feedback on protocol development and revision.

Assess needs.<sup>316</sup> Before initiating policy changes, it is important that the planning team assess the jurisdiction's current response to sexual assault, with a focus on the exam process. Some activities that may help:

- Compare statistics on sexual assault within the community as captured by represented agencies.
- Identify community demographics, including the various populations that make up the area.
- Review existing feedback from victims about their experiences and satisfaction with immediate response.
- Seek input from professionals involved in the exam process on current gaps, problems, and challenges.
- Evaluate the adequacy of policies pertaining to each aspect of immediate response.
- Review systemic breakdowns that have occurred in immediate response.
- Evaluate the capacity of each discipline to support a coordinated immediate response.
- Evaluate the effectiveness of response to victims from diverse backgrounds or in certain types of cases.
- Evaluate the adequacy of related trainings and resource materials.
- Identify related jurisdictional statutes and evaluate their adequacy in supporting effective response.

Devise an action plan. The protocol planning team can take what it learns through needs assessments and translate it into an action plan for improving the exam process and creating a protocol. The plan should clearly identify what needs to happen, who is responsible for coordinating or carrying out each action, possible resources,<sup>317</sup> desired outcomes, and how the effectiveness of the action will be evaluated. The plan can be revisited periodically to assess progress and evaluate outcomes.

<sup>316</sup> Section drawn from K. Littel, M. Malefy, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, pp. 240 and 246, and American College of Emergency Physicians, *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 21.

<sup>317</sup> Funding under the STOP Violence Against Women Formula Grant Program and the STOP Violence Against Indian Women Discretionary Grant Program may be used to cover costs related to protocol development and implementation. For more information, see <http://www.ovv.usdoj.gov/>.

Create a protocol. To promote an effective protocol development process, consider the following:<sup>318</sup>

- Who should lead efforts to create and implement the protocol?
- What process will be used to facilitate decision making on protocol development or revision?
- What process will be used for facilitating adoption of the protocol by individual agencies or communities?
- How will protocol compliance be monitored and what mechanisms will be put into place to solve problems as they arise?

The planning team should review the national protocol to determine what it wants to cover in its customized protocol and the appropriateness of national recommendations for the jurisdiction. It must consider what jurisdictional statutes and policies need to be discussed and how to address community-specific needs and challenges. Once a draft has been developed, it should be made available to relevant professionals, agencies, survivor groups, and organizations serving specific populations across the jurisdiction. Their feedback should be solicited and then incorporated into the draft to the extent possible. Once a final protocol is created, the team should consider pilot testing and revising it based on feedback from the tests. Then the protocol should be implemented, as per recommendations of team members and others from whom input has been sought.

Distribute the protocol. The planning team should determine the most efficient method to disseminate the protocol to all professionals in the jurisdictions who are involved in the immediate response to sexual assault. The planning team needs an up-to-date contact list of these professionals, and it should agree upon a specific distribution plan (e.g., mailing or handing out hard copies and/or providing access to the protocol via the Internet). If the Internet is used to distribute the document, make sure that professionals who do not have Internet access get a hard copy.

Build the capacity of agencies to implement the protocol.<sup>319</sup> A protocol's effectiveness depends on individual agencies having adequate resources (e.g., funding, personnel, multilanguage capacity, equipment, supervision, training, professional development opportunities, and community partnerships) to carry out their responsibilities and coordinate efforts with other involved responders. Agencies can assist one another in building individual and collective capacity to respond to sexual assault and participate in coordinated interventions. For example, together they can seek opportunities for technical assistance, training, and grants and share costs, personnel, equipment, expertise, and information. Also, each jurisdiction most likely will encounter a variety of barriers and difficulties in protocol implementation. Overcoming such problems requires a willingness on the part of involved agencies to individually and collaboratively understand the unique needs of victims in their community and to think "outside the box" to identify solutions.

To help with implementation, consider asking responding agencies to supplement the protocol with interagency agreements or memorandums of understanding. Using the protocol as a basis, these agreements can outline roles and articulate how responders should work together to coordinate response. These documents should be jointly developed, agreed upon, and signed by agency policymakers. They can be revised and signed on a periodic basis to ensure all professionals involved in the response are aware of protocol changes and to reaffirm their commitment to carrying out agreements.

Promote training. Agency-specific and multidisciplinary trainings are crucial components of protocol implementation. Involved responders must be informed of any changes in how they carry out agency-specific responsibilities during the exam process and understand why these changes are needed. If they are being asked to coordinate their efforts formally with other agencies, they must understand their role in coordination, the benefits of a collaborative response, the challenges such an effort involves, and ways to overcome challenges.

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<sup>318</sup> Bulleted section drawn from K. Littel, M. Malefyt, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, p. 242.

<sup>319</sup> Section drawn from K. Littel, M. Malefyt, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, p. 241.

Set up an evaluation system. The planning team should take the time to consider how to best compile data related to the exam process (while maintaining victims' anonymity) and how to use it to evaluate effectiveness of response and make improvements to the protocol as needed.

Revise the protocol periodically. Revisions may be based on feedback from responders and victims, evaluation recommendations, changes in laws, identification of new crime trends and prevention efforts, technology, research, and identification of new promising practices. The planning team should keep track of protocol areas needing improvement and meet periodically to discuss pertinent issues such as language to be used, how to resolve controversies, and, ultimately, to make needed changes.



# Appendix B. Creation of Sexual Assault Response and Resource Teams

**Create a SART/SARRT to facilitate coordination among involved disciplines.**<sup>320</sup> After identifying members and defining roles, members can plan how to operate their team to best serve community needs.

Determine how the SART/SARRT is activated. Activation procedures should take into account that victims enter the “system” at different points (e.g., through a call to 911 or a 24-hour advocacy hotline, arrival at an exam site, or disclosure to a community professional). The SART/SARRT must determine how to publicize its services to community professionals who may have frequent contact with individuals disclosing sexual assaults. These professionals might include, but are not limited to, private physicians, health clinic staff, mental health and social service program staff, personnel serving persons with disabilities, substance abuse treatment program staff, school personnel, personnel from faith-based communities, corrections and probation staff, and staff from residential living programs and emergency shelters. It also should publicize its services more broadly to the public, explain the dynamics of sexual assault, and encourage victims to seek help.

Plan SART/SARRT response to varying circumstances facing victims. The team should consider and plan for modifications to the exam process to address specific needs and concerns of victims. For example, in order to respond to non-English-speaking victims, team members must be able to speak their language or promptly arrange for certified interpretation. For victims thought to have cognitive disabilities, team members must know who to contact for assistance and ensure they receive the same access to services that other victims would obtain. Some victims may request advocates and other responders of a specific gender or from specific cultures. Procedures should be in place to ensure response to minors follows jurisdictional statutes. SART/SARRTs should be prepared to deal with multijurisdictional coordination issues that may arise when assaults occur on military sites or to soldiers in the field, school campuses, tribal lands, prisons, and residential programs. Involving relevant agencies as soon as possible according to agreed-upon procedures may help quickly determine who has jurisdiction over a case and how to best assist each victim.

Meet regularly. Outside of an immediate response, the SART/SARRT should meet regularly<sup>321</sup> for two distinct purposes. The first is to review immediate response in individual cases in order to improve overall team performance. These reviews allow team members the opportunity to give each other feedback on effectiveness of response during the exam process, problems needing resolution, and areas needing improvement. Cases are typically reviewed anonymously,<sup>322</sup> without using victims' names or other identifying information.<sup>323</sup> During these discussions, it is important that the team respect the confidentiality of information in patients' medical records and shared with community-based advocates. Secondly, the SART/SARRT can utilize meetings of members to maintain and enhance the quality of the SART/SARRT. This task involves addressing system issues, such as creating and revising policies and procedures in response to local changes in governmental or community-based agencies, scientific or technological advances, and feedback

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<sup>320</sup> A more in depth discussion of SART development and maintenance than is provided is beyond the scope of this document. However, resources do exist on this topic. For example, numerous jurisdictions have published guidebooks on organizing a SART and/or protocols for SART response. Some sexual assault coalitions offer information, technical assistance, and training for communities interested in starting SARTs. Since 2001, a national SART training conference has been held biannually (see <http://www.sane-sart.com/> for information). More information, including a SART Toolkit, is available at <http://www.nsvrc.org>.

<sup>321</sup> “Regularly” is locally defined. Some teams meet monthly, while others meet every 6 weeks or quarterly. Teams might meet on a regular basis for case review and get together less frequently to discuss more systemic issues.

<sup>322</sup> In California, there is a law to protect discussions of individual cases during SART meetings. These discussions are technically characterized as medical quality-assurance activities.

<sup>323</sup> Case reviews usually include only those SART members typically involved in immediate response. But, even if all or most SART members were involved in a particular case and were aware of victims' identity, there is still no reason to reveal victims' identity during SART case reviews. SARTs may choose not to take notes about cases reviewed to ensure that the case-related information is not shared with anyone outside of the meeting. In situations where victims' identity might be easily deduced during a case review by members not involved in response (e.g., if there had only been one case handled during the time period being reviewed), comments should be kept as broad as possible and avoid case specifics. In communities where residents tend to know each other and news about crime travels quickly, it may be challenging to not inadvertently reveal victims' identity during SART case reviews. SARTs in these jurisdictions should consider how to best approach case reviews in a way that reduces the likelihood of revealing victims' identity.

from victims. It also involves sharing general information related to the SART/SARRT and facilitating the continuing education of the team.

Although it might be difficult to involve all relevant responders in SART/SARRT meetings (e.g., crime labs may be a considerable distance from the community and lack resources to respond to local inquiries), consider options such as teleconferencing to include their perspectives.

**Encourage education for SART/SARRT members on coordinated response during the exam process.**  
For example:

- Discipline-specific training that advances responder skills and emphasizes a team approach is crucial.
- Multidisciplinary training sessions can describe the SART/SARRT process, stress the need for a prompt exam, explain the roles and challenges of each discipline, emphasize a victim-centered approach, and make clear where coordination among disciplines is needed and how it should occur. They can describe multidisciplinary policies, interagency agreements, standardized forms, and other related materials.
- Multidisciplinary training can also build members' understanding of needs, values/beliefs, and practices of specific populations in their community. They can raise awareness of how different populations respond to disclosures of sexual assault and work to build the capacity of involved professionals to be sensitive to the needs of victims from those populations.
- Cross-training sessions are useful to allow responders from one discipline to educate those from another discipline about the specifics of how they intervene in these cases and answer questions that may arise. For example, law enforcement investigators can educate examiners and advocates about what is involved in a thorough investigation, stressing that the forensic exam of the victim is but one part of the investigation. In jurisdictions that border Indian Country, federal prosecutors can educate other responders regarding federal Indian law and how it applies to sexual assault cases.
- Multidisciplinary trainings and cross-trainings can provide a forum for staff from different agencies to get to know and respect one another, build common goals, and increase their comfort in working together. Collaboration among agencies and individuals can provide responders with a broader network of support as they do this work. These trainings can also stress the difficulty of working on sexual assault cases and the secondary trauma that responders can experience. They can facilitate discussion among responders about self-care and preventing or coping with secondary trauma, so they in turn can provide optimal interventions and assistance to victims.
- There are more informal educational opportunities and tools that can foster coordination among SART/SARRT members. For example, all key responders, especially those newly involved in sexual assault cases, may find it useful to tour sites and offices involved in SART/SARRT response. Such tours and discussions with site/office staff can help build knowledge of what response by each discipline entails and the logistics of that response. Sharing related educational materials and literature is an easy way to continuously expand the base of common knowledge among SART/SARRT members. Tools such as flow charts and discipline-specific checklists that help SART/SARRT members understand the continuum of response and appropriately coordinate their interventions may also be useful.

**Trainers.** In addition to involving representatives from health care, advocacy, law enforcement, prosecution, the judiciary, and crime and toxicology laboratories as SART/SARRT trainers, include defense attorneys to educate participants on defense tactics. Utilize local agencies and leaders that serve specific populations to educate the SART/SARRT on the needs of residents and services they offer relevant to victims of sexual assault.

**Outreach to rural, remote, and poor communities.** It may be difficult for rural, remote, and poor communities to offer training for SART/SARRT members, due to lack of resources and/or expertise. States, Territories, and tribes may want to consider forming specialized teams that can offer multidisciplinary training consistent with cutting-edge practices across all of their jurisdictions. These teams can work with local responders to ensure that the training sessions they offer address unique community needs and challenges.

## Appendix C. Impact of *Crawford v. Washington*, *Davis v. Washington* and *Giles v. California*

*Crawford v. Washington* and subsequent related court cases are only an issue when a victim is unavailable for cross-examination at trial, which occurs infrequently in sexual assault cases. A prosecutor will rarely be able to prosecute successfully a sexual assault of a competent adult victim without the victim's cooperation because of the difficulty in overcoming the consent defense. The term "competent adult" is used to describe an adult victim who is viewed by the legal system as able to understand and participate in the criminal proceedings, i.e., know the role of all the players. It is important to refer to state laws for definitions or interpretations of what constitutes a competent adult in a given jurisdiction.

In the rare instance in which a sexual assault of a competent adult is prosecuted without the victim's cooperation, examiners' testimony may be objected to as "testimonial" hearsay under *Crawford v. Washington*<sup>324</sup> and *Davis v. Washington*<sup>325</sup> under the theory that the examiner was acting as an arm of law enforcement. In *Crawford*, the Court held that testimonial statements of an unavailable witness could be admitted at trial only when the defendant has had a prior opportunity to cross-examine that witness. Although the *Crawford* holding offers examples of both testimonial and nontestimonial statements, it did not include a specific definition.

In *Davis*, the Court defined statements that are made to government agents for the primary purpose of receiving assistance in an ongoing emergency as nontestimonial. It defined as testimonial statements made under circumstances that objectively indicate there is no ongoing emergency and the primary purpose of the interrogation is to establish or prove past events potentially relevant to a later criminal prosecution. Forensic examiners who perceive their primary role as law enforcement and conduct their practice with law enforcement rather than medical goals risk having their statements excluded as testimonial under *Crawford* and *Davis*. Forensic examiners should be asked about and must be able to articulate a practice philosophy that is patient-centered and medically focused.

In cases in which it is established that the victim's lack of cooperation is the result of a defendant's actions that are designed to cause the unavailability of a victim in order to prevent that victim from testifying in a current or future prosecution, the prosecution may introduce a witness' hearsay statements in a prosecution based on the doctrine of forfeiture by wrongdoing.

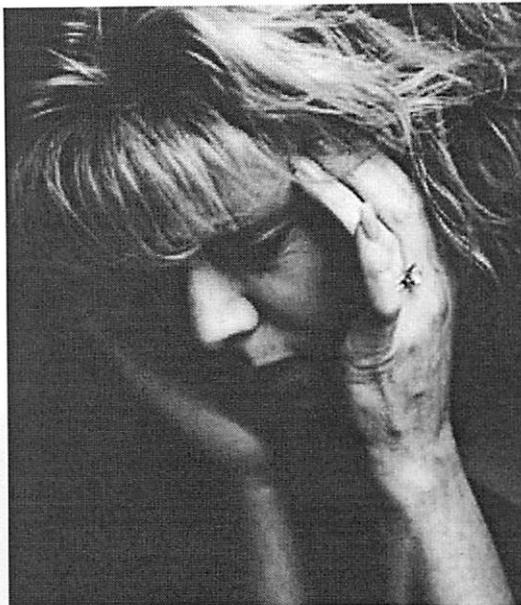
For health-care providers, *Crawford* and its progeny do not change the priorities of the medical-forensic examination, which should continue to hold the health and well-being of patients of primary importance. The problem arises when clinicians are perceived to be investigators rather than health-care providers. Even in cases in which a victim is cooperating in the prosecution of the perpetrator, statements made to the examiner for the purpose of medical diagnosis and treatment may still be excluded as hearsay if it is established that the examiner is acting as an arm of law enforcement rather than acting primarily as a medical treatment provider.<sup>326</sup>

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<sup>324</sup> 541 U.S. 36, 124 S.Ct. 1354, 158 L.Ed.2d 177 (2004).

<sup>325</sup> 126 S. Ct. 2266 (2006).

<sup>326</sup> *Giles v. California*, 128 S. Ct. 2678 (2008).



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# **National Training Standards for Sexual Assault Medical Forensic Examiners**

**U.S. Department of Justice  
Office on Violence Against Women**

June 2006  
NCJ 213827

**203762**

## **Acknowledgments**

Many individuals contributed their skills and expertise to the development of this training standard. Special appreciation goes to Kristin Littel and Jennifer Markowitz for their efforts in the drafting of the standard as well as to the International Association of Forensic Nurses for their advice and guidance. We are grateful to the many experts who took the time to review and comment on these standards.

## Foreword

*A National Protocol for Sexual Assault Medical Forensic Examinations* was released in September 2004; it provides details on the roles of responders to sexual assault as part of a coordinated community response. *National Training Standards for Sexual Assault Medical Forensic Examiners* is a companion to the protocol and includes recommendations for training objectives and topics that will enable an examiner to carry out the recommendations. The protocol and standards both take a victim-centered approach to sexual assault forensic examinations and also emphasize offender accountability. We hope the addition of these standards will be useful for communities that wish to establish or enhance training programs for forensic examiners.

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# Introduction

*National Training Standards for Sexual Assault Medical Forensic Examiners* offers a framework for the specialized education of health care providers who wish to practice as sexual assault forensic examiners (SAFEs).<sup>1</sup> The standards provide guidelines to prepare SAFE candidates to work in coordination with other responders to meet the health care, forensic, and information needs of adult and adolescent sexual assault patients who present for the medical forensic examination.<sup>2</sup> They are intended to guide those who develop, revise, coordinate, and/or conduct SAFE training regarding the minimum levels of instruction necessary to prepare candidates for their role. This is intended as a suggested guideline and it is not required.

Although these standards do not make a recommendation regarding the length of time that should be allotted for initial SAFE education, it is currently accepted among most organizations and individuals who provide basic training that the didactic portion should be at least 40 hours or the equivalent of a semester/quarter.

## Background

The Office on Violence Against Women (OVW) developed the standards under the direction of the Attorney General pursuant to the Violence Against Women Act of 2000.<sup>3</sup> They are based on recommendations in *A National Protocol for Sexual Assault Medical Forensic Examinations (Adults/Adolescents)*,<sup>4</sup> which describes the examination process and associated responsibilities of health care personnel, as well as the responses of other professionals related to this process.<sup>5</sup> In creating these standards, OVW collaborated with the International Association of Forensic Nurses (IAFN) to gather input from veteran SAFE trainers and SAFEs (both nurses and physicians), sexual assault survivors, sexual assault victim advocates, law enforcement representatives, prosecutors, and forensic scientists. Feedback on drafts of the standards was sought from the above individuals as well as from a number of national, state, and local organizations that deal with sexual assault issues.

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<sup>1</sup> Some communities refer to SAFEs by different terms/acronyms based on the discipline of practitioners and/or specialized education and clinical experience. For example, sexual assault nurse examiners (SANEs) are registered nurses and advanced practice nurses (can include nurse practitioners and nurse midwives) who receive specialized education and fulfill clinical requirements to perform these exams. Some nurses have been certified to perform adolescent and adult exams (referred to as SANE-Adult and Adolescent or SANE-A) through the International Association of Forensic Nurses (IAFN). Others are specially educated and fulfill clinical requirements as forensic nurse examiners (FNEs), enabling them to collect forensic evidence for a variety of crimes. SAFEs and sexual assault examiners (SAEs) are often used broadly to denote health care providers (e.g., physicians, physician assistants, nurses, nurse practitioners, or midwives) who are specially educated and clinically prepared to perform this examination.

<sup>2</sup> The term "patient" is commonly used in this document to denote persons who disclose that they recently have been sexually assaulted and who present for a medical forensic examination. There are occasions, however, where the term "victim" is used rather than "patient." The use of the term "victim" is simply meant to acknowledge that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice.

<sup>3</sup> The statutory requirement to develop a national recommended standard for training health care professionals who perform these examinations can be found in Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386. The statutory requirement also mandates the development of a national protocol for these examinations and related recommended training for all health care students.

<sup>4</sup> In the protocol and in this document, adolescents are distinguished from prepubertal children who require a pediatric examination. The focus of both these documents is on the examination of females who have experienced the onset of menarche and males who have reached puberty. However, age can play a role in whether a person is treated as a child or as an adolescent. For example, some adolescent girls may not menstruate until their later teen years. Although the physical development level of these patients must be taken into account when performing the examination, they should otherwise be treated as adolescents rather than children. Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances in which minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. Involved responders should be well versed in their jurisdictional laws and policies regarding the above issues, screening procedures for determining whether a pediatric examination is needed (particularly in the case of younger adolescents), and local protocols for response to prepubertal victims. Examination sites should follow jurisdictional laws regarding parental/guardian consent.

<sup>5</sup> Refer to the protocol for an explanation of terms as well as recommendations specific to each component of the examination process.

The standards recommend, rather than mandate, minimum guidelines for didactic and clinical preparation of SAFEs. This document is meant to be a tool to assist in the development or revision of SAFE training programs across the country. Because the standards are minimum recommendations, they enable those that create and provide basic SAFE education to mold training programs that address community-specific needs and issues.

OVW intends that use of these standards across all U.S. jurisdictions<sup>6</sup> will result in increased uniformity of SAFEs' knowledge and skills. The goal is that every person who reports or discloses a recent sexual assault will have access to a specially educated and clinically prepared SAFE who can validate and address their health concerns, minimize their trauma, promote their healing, and maximize the detection, collection, preservation, and documentation of physical evidence related to the assault for potential use by the legal system. Uniformity in SAFE training can aid in evaluating the effectiveness of examiner response. In addition, the use of these standards is meant to support a coordinated community response to sexual assault and promote responses that recognize and address the unique needs and circumstances of each patient.

## Overall Recommendations

A number of broad-based recommendations are offered below to help those involved in the development, revision, coordination, and/or delivery of training programs for SAFEs.

### 1. Create a foundation for training that supports a coordinated multidisciplinary approach.

The training team should be multidisciplinary. Clearly, education for SAFE candidates should include training and information from health care providers who are veteran SAFEs. Training and information should also come from seasoned practitioners from disciplines beyond health care who have a role in the examination process. These practitioners primarily include community-based sexual assault victim advocates (from local programs and state, territorial, and tribal sexual assault coalitions),<sup>7</sup> law enforcement representatives, prosecutors, and forensic scientists. Others may be involved in the training program, depending on the topical area discussed (e.g., emergency medical services (EMS) technicians, hospital emergency department staff, forensic photographers, vendors for specific products used during the examination, toxicologists and pharmacologists, criminal justice-based victim-witness specialists, and responders who can address the needs of specific populations in the community such as military personnel and their dependents and college students). The involvement of these practitioners in training should be more than an introduction of their agencies and roles. All responders must learn how to work collaboratively throughout the examination process to assist patients and facilitate collection of evidence. Coordination and collaboration can be demonstrated through role modeling of trainers. Involving trainers from other

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<sup>6</sup> The term "jurisdiction" may be used in two ways in this document. One is to broadly describe a community that has power to govern or legislate for itself. For example, a jurisdiction may be a locality, state, territory, tribal land, or federal land. The term also describes the authority to interpret and apply laws and is used in this context mainly when identifying who has "jurisdiction" over a particular case.

<sup>7</sup> Jurisdictions developing a SAFE training program that do not have a local community-based sexual assault advocacy program may question the appropriateness of using trainers who represent other victim service entities (e.g., those based in the criminal justice system, examination facility, social services, or other agency). Although it may be helpful to include them on the training team, it is recommended that they not replace trainers who are community-based sexual assault victim advocates. It is critical that SAFE candidates understand what victim advocacy for sexual assault patients fully entails and its relevance to a victim-centered examination process. Trainers who are community-based sexual assault victim advocates are typically best positioned to help candidates meet this objective due to their training; primary mission of supporting victims' needs and wishes; range of services they are accustomed to providing victims and their significant others before, during, and after the examination process; and capacity to talk with patients with some degree of confidentiality. (See the protocol, pages 18–19 and 34–35, for a discussion of the roles of victim service providers/advocates.) If a local community-based advocacy program does not exist, the state, tribal, or territorial sexual assault coalition that serves the jurisdiction may be willing to be involved in the training. Alternately, a community-based advocate trainer from another jurisdiction might be considered. It is recommended that any involved advocates/victim service providers coordinate their presentations so that SAFE candidates appreciate the scope and limitations of each of their roles and how they can work together to provide optimal services to patients.

disciplines that have a role in the examination process also helps SAFE candidates understand that they have partners in this work and additional support networks.

To help ensure the cohesiveness of a training program involving multiple presenters, it is helpful to use a facilitator who is a SAFE to oversee the entire training process and highlight the connections between topical areas. Other disciplines and agencies, such as community-based sexual assault programs and state, territorial, or tribal sexual assault coalitions, might be involved in coordination that involves sponsoring the training; recruiting, screening, and registering trainees; and handling other logistics.

Training should stress the importance of SAFEs understanding their roles and the roles of other members of the sexual assault response team (SART).<sup>8</sup> This information can build SAFEs' knowledge of how to maintain professional boundaries and preserve their objectivity throughout the examination process and beyond. It can help avoid problems that sometimes arise when disciplines are asked to coordinate and/or collaborate, such as the blurring of roles or collusion among responders (rather than each working in the best interests of patients).

## **2. Find ways to incorporate the voices of survivors of sexual assault into training.**

Incorporating survivor input into the training program can help SAFE candidates learn about patients' experiences during the examination process. It also will allow the candidates to hear first hand what was helpful and not helpful to patients and what could be improved to help them in the future. There are numerous ways to involve survivors in training. They may be willing to be panelists or individual speakers (either in person or through video or audio conferencing) or they may prefer to provide input without being physically present at the training (e.g., by providing a letter about their experiences that could be read aloud to SAFE candidates or providing a videotape or audiotape recording that could be aired). Some survivors may want to offer input but remain anonymous. It can be useful to work with the community-based advocacy program to solicit survivor involvement—advocates may be able to help identify survivors who are willing and able to provide input, help them prepare, and provide them with emotional support if needed.

## **3. Establish trainer qualifications and methods to ensure the quality of trainers and training.**

Trainer qualifications should be developed. It is essential that SAFE trainers, as well as those involved in the development, revision, and coordination of training programs:

- Recognize that female and male health care providers from a variety of disciplines in health care can be educated and clinically prepared to be SAFEs (noting that the examination should be done with equal competence regardless of the health care discipline of the examiner);
- Recognize that SAFE trainers can come from a variety of disciplines in health care;<sup>9</sup>
- Understand that medical forensic examinations of sexual assault patients are performed within a health care framework governed by professional standards of care;
- Embrace a holistic approach to restoring and promoting the biological, psychological, and social health of patients throughout the examination process; and

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<sup>8</sup> A SART provides multidisciplinary, specialized, and immediate response to persons who disclose they recently have been sexually assaulted. The team typically includes health care personnel, law enforcement representatives, community-based victim advocates, prosecutors, and forensic scientists (although prosecutors and forensic scientists are usually available for consultation rather than actively involved at this stage). Where they exist, these types of teams vary in what they are called, how they operate, the extent of their activities, and the composition of members. Jurisdictions that do not have a SART may have a more informal network of professionals who work together to respond to these cases.

<sup>9</sup> SAFEs and SAFE trainers might be registered and advanced practice nurses, physicians, and physician assistants.

- Understand the crucial role that SAFE training programs play in educating SAFEs to provide objective<sup>10</sup> forensic evaluation and health care in a competent, compassionate, and victim-centered manner.

In particular, trainers should:

- Have significant experience in the topical areas in which they are providing training (e.g., trainers who are SAFEs should have considerable experience in all aspects of care for sexual assault patients, including performing examinations, evaluating and managing patients, coordinating responses with other professionals, and preparing for and testifying in court);<sup>11</sup>
- Provide training appropriate to their expertise and discipline-specific role (e.g., training that addresses legal issues and the impact of evidentiary findings on a legal case should be done primarily by an attorney, although a SAFE may assist with this discussion);
- Be familiar with pertinent medical, scientific, and forensic literature (including the ability to understand the scientific methods described and to critically evaluate the literature);
- Be aware of variations in practices and policies related to the examination process across the country;
- Be skilled in how to sensitively and appropriately address cultural concerns that arise for patients during the examination process, knowledgeable about how to teach SAFE candidates these skills, and able to address SAFE candidates' cultural needs and concerns during training;<sup>12</sup>
- Evaluate, on an ongoing basis, any myths and biases they personally hold related to sexual violence that could hinder their ability to train SAFE candidates; and
- Have experience in facilitating group discussions, knowledge of/experience with adult learning theory, and the capacity to help trainees evolve in attitude, knowledge, and ability.

Methods to ensure the quality of training and trainers should be developed. It is imperative to evaluate the quality of education provided through each training program. Programs are urged to develop measurable learning objectives that specify the desired knowledge, skills, or attitudes that SAFE candidates are to gain through each training module. Evaluation can help ensure that these training objectives are being met and facilitate continuous improvement of the program. Examples of some evaluative tools include pretests of SAFE candidates; posttraining evaluations of SAFE candidates that focus on their level of knowledge of the examination process, their fit with the field, and their level of satisfaction with the training and trainers; and longitudinal evaluation of the effectiveness of the training program in preparing SAFE candidates for their role.

<sup>10</sup> The terms "objectivity"/"objective" and "neutrality"/"neutral" are used interchangeably in the protocol, but it is important to recognize that there is some difference in opinion in the field about whether these terms have the same meaning when referring to SAFE activities.

<sup>11</sup> Currently, there is no national standard accepted across health care disciplines that quantifies a minimum level of education and clinical experience required for SAFE trainers, except that they should have completed the necessary basic education and clinical practice to become a SAFE. However, those who contributed to the development of this document expressed concern about the quality of education provided and subsequent competency of SAFE candidates if trainers do not have sufficient expertise.

<sup>12</sup> In this document and in the protocol, discussions about cultural issues refer not only to ethnic, racial, and religious groups, but also to any group that has "learned beliefs, traditions, and guides for behaving and interpreting behavior that are shared among members" (A. Blue, The Provision of Culturally Competent Care, from the Medical University of South Carolina Web site at [www.musc.edu/deansclerkship/recultur.html](http://www.musc.edu/deansclerkship/recultur.html)). Examples of other groups might include, but are not limited to, senior citizens, deaf and hard-of-hearing communities, populations with differing sexual orientations, the homeless, military personnel and their dependents, adolescents, and prison inmates. Individuals often belong to multiple cultural groups.

**4. Consider how to recruit and screen SAFE candidates, assess their needs prior to training, provide opportunities to apply skills learned, and maintain competency after the initial training.**

A plan to recruit and screen health care providers interested in becoming SAFEs should be established. Some initial questions to answer when creating a plan include who will conduct the recruitment and screening (e.g., individual examiner programs or those coordinating trainings) and what selection criteria will be used. Jurisdictions should strive to recruit SAFEs who collectively represent the diversity of the community they serve. Planners should make sure that recruiting and screening approaches used do not perpetuate biases against particular groups. Through recruitment and screening, potential candidates should be fully informed of what being a SAFE involves (e.g., initial and ongoing education and clinical practice needed, the work itself, and the time commitment).

In preparation for each training program, trainers should assess the needs of attending SAFE candidates. The assessment might entail understanding the level of candidates' experiences and competency; becoming familiar with local, state, territorial, tribal, and federal statutes and protocols that affect examination procedures, local practices, and forms related to the examination; and learning about the needs of specific populations in the community.

Opportunities to practice skills learned during the didactic training should be provided. A great deal of information is presented to SAFE candidates during classroom education. To increase their capacity to absorb and apply this information, candidates should have sufficient and varied chances to translate knowledge into action. Opportunities can be provided during classroom education through mechanisms that include, but are not limited to, role play, use of case studies, demonstrations using models, mock trials, and periodic testing. In addition, the clinical practicum should include more extensive hands-on opportunities (see *Clinical Practice Content—Recommendations*). Those developing training curriculums must carefully consider which training tools are best suited to maximize absorption and application of information for each topic area.

Jurisdictions and examiner programs should consider how to enhance competencies of SAFEs after the initial didactic training and clinical practice. Continuing education is necessary to build upon SAFEs' knowledge; keep them current with technology, science, documentation, and promising practices; and refresh skills that were gained in basic training. One-on-one supervision and mentoring is critical to allow veteran examiners to evaluate the individual performance of newer SAFEs, answer case-specific questions that arise, and consider how to promote their professional development. Quality assurance and peer review processes should be implemented in some form to help maintain the highest quality care for patients.

**5. Build the capacity of SAFE candidates to provide culturally competent care.**

A culturally competent SAFE sensitively and appropriately addresses patients' cultural needs and concerns. To build SAFE candidates' capacity to be culturally competent, trainers are encouraged to incorporate cultural issues into each training module. To that end, each section under *Didactic Content—Recommended Topics* in this document includes a bulleted list of "cultural competency issues." In addition, *A.2. Victim-Centered Care* looks more broadly at cultural and other individual considerations that may affect how the examination is conducted. Trainers also should discuss with SAFE candidates approaches to rectifying situations in which sensitive and culturally appropriate responses may have been lacking. Those developing training programs are urged to seek out the expertise of professionals who can speak to the cultural issues facing the jurisdictions to be served by the SAFE candidates. Not only can they suggest information and resources that

are critical for SAFE candidates, they also may be willing to serve as presenters. To be most effective, this self-exploration should be ongoing and supported by local SARTs.

**6. Incorporate evidence-based information into the training program as much as possible.**

SAFE candidates should be educated about cutting-edge research and evidence-based information on best practices (to the extent it is available) that can guide evidence collection and care of sexual assault patients. Evidence-based information and education can also be used to correct victim-blaming attitudes that SAFE candidates may hold. Not only should SAFEs have access to this type of data during training, they should also be encouraged to stay informed about new research/data that could impact their work.

**7. Instruct SAFE candidates to select language that fits their role and is unbiased.**

Not only is careful selection of words critical in examination documentation, but it is also important in verbal communications between SANEs, patients, and other responders. For example, SAFEs should be taught to avoid saying that a patient “alleged” or “claimed,” since these terms could be perceived as implying that they question the veracity of the patient’s account. “Said” might be a more objective choice for SAFEs. Trainers should encourage SAFE candidates to use language that accurately and precisely reflects the patient history, medical forensic findings, and evidence-based conclusions within the scope of the SAFE role.

**8. Incorporate into training discussions on controversies regarding best practice.**

Although there is much agreement across the country regarding acceptable and best practices in the examination process, SAFE candidates must understand that there are also areas of disagreement among practitioners (many of which are recorded in the protocol). For example, there is some debate about whether asking for pubic hair samples on a case-by-case basis is more appropriate than routinely asking for them during the initial examination (see the protocol, page 95). Trainers must stay current on areas for which there is no consensus about best practices and must help SAFE candidates understand the importance of following jurisdictional laws and policies as well as working with the local SART (or, if a SART does not exist, other involved responders) to make decisions about an appropriate response in a particular situation.

## Didactic Content—Recommended Topics<sup>13</sup>

**Note:**<sup>14</sup> As a prerequisite or foundation for the didactic training, SAFE candidates should be educated about basic issues related to sexual violence. Information might include, but not be limited to, data on the incidence and prevalence of sexual violence (focusing on the crime itself, the offenders, and the victims), common myths and facts, the dynamics and impact of sexual victimization, offender typology and treatment approaches, community resources and protocols for comprehensive response, and the relationship of sexual violence to/differences from domestic violence, dating violence, and stalking.

At some point during training, SAFE candidates should be taught about stress reactions they may experience in the course of working as a SAFE. Methods to prevent and cope with these reactions should be identified. Possible topics of discussion include, but are not limited to, an explanation of vicarious trauma and compassion fatigue, factors that could potentially impact a SAFE's capacity to cope with trauma and stress, the importance of debriefing after examinations and court testimony and building networks of support, and other resources for SAFEs if they experience these types of reactions. It is important to acknowledge that examiners differ in the amount of secondary trauma they can handle at any given time, in how they cope when working with traumatized patients and with suspects, in what helps them defuse, in what triggers their feelings of being traumatized, and in what will help them when they are experiencing trauma.

### SECTION A. OVERARCHING ISSUES

#### 1. Coordinated Team Approach (See page 23 of the protocol.)

**Trainers.** Representation from the local SART/responding agencies, including a SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), a law enforcement representative, a prosecutor, a forensic scientist, and a SART coordinator if one exists. Including others as trainers may depend on who else frequently is involved in local response to sexual assault cases (e.g., EMS technicians or emergency department staff) and the unique characteristics of the jurisdiction (e.g., if it includes tribal lands, colleges, or military installations that have their own response systems for these types of cases). Also, consider including professionals who can address cultural competency issues. Trainers should have experience working in coordination with responders from other disciplines to assist sexual assault patients and facilitate evidence collection. It would be useful to create a forum during training so that survivors can provide SAFE candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Differentiate between the dual purposes of the examination, which are to address the needs of both the patient and the justice system.
2. Understand how a coordinated, multidisciplinary approach to the examination process can help to simultaneously achieve these dual purposes.
3. Identify key responders and their roles and boundaries.
4. Understand the importance of measuring the effectiveness of coordination efforts.

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<sup>13</sup> The standards do not make recommendations about the order of presentation of topical areas during training, methods of presentation, or when an issue that may be common to several topical areas should be discussed.

<sup>14</sup> The two topical areas in this note are recommended for discussion, but were not included as chapters in the protocol.

### **Topics:**

- The medical forensic examination in the context of a comprehensive community response to sexual assault. The scope of the examination process in terms of addressing the needs of the patient and the justice system. Its connection to other components of response.
- Related jurisdictional laws and policies. If applicable, related cross-jurisdictional issues (e.g., if an incident occurs on tribal land, a tribal agency may initially respond but the case becomes the jurisdiction of the state or federal agencies).
- Definition of a SART and an overview of models and options.
- Development and implementation of a SART, including any jurisdictional mandates.
- Sustenance of an existing SART.
- Roles, goals, and boundaries of typical SART members.
- Additional local professionals who might be involved in response during the examination process.
- Multidisciplinary communication procedures during the initial response. (Also see *C.1. and C.2. Initial Contact/Triage and Intake.*)
- Collaboration without collusion.
- Approaches to keeping up to date on research, technology, and promising practices.
- Quality assurance measures of coordinated response.

### **Cultural competency issues:**

- SARTs representing the diversity of the community being served, with an understanding that diversity is more than simply ethnicity, race, and religion (see footnote 12).
- Identifying and addressing the diverse needs of the community and adjusting operations and practices as appropriate.

## **2. Victim-Centered Care (See page 27 of the protocol.)<sup>15</sup>**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience and a community-based advocate (see footnote 7). It would be particularly useful to create a forum during training so that survivors can provide SAFE candidates with input on this issue. Also, consider including professionals who can address cultural competency issues.

**Training objectives.** To teach SAFE candidates to:

1. Identify key elements of a victim-centered medical forensic examination.
2. Understand how to deliver victim-centered care to patients.
3. Understand the importance of and methods to fully inform patients of their options during the examination process, affirm their right to make their own decisions, and respect their choices. (Also see *A.3. Informed Consent.*)
4. Identify information that patients may find useful during and after the examination process.

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<sup>15</sup> A "victim-centered" approach as used in the protocol and in these standards recognizes that sexual assault patients are central participants in the medical forensic examination process and deserve timely, compassionate, respectful, and appropriate care. They have the right to be well informed in order to make decisions about their participation in the various components of the process. A victim-centered approach also recognizes that the response must be adapted to address the needs and circumstances of each patient.

### **Topics:**

- Use of the term “victim” instead of “patient” in this training module (“victim” acknowledges that individuals who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice).
- Triage procedures and issues such as prioritizing these cases and offering privacy and support. Patient safety, privacy, and comfort throughout the examination process.
- Extent of victim services offered, differences between community-based and system-based advocates, and procedures for involving advocates.
- Interaction with patients and their significant others: empathy/reflective listening, helping patients maintain their dignity, identifying and addressing patients’ needs in conjunction with other responders, and SAFEs’ professionalism and objectivity.
- Explanation to patients regarding what is entailed in the examination, its purpose, and available options.
- Affirmation of patients’ rights to make their own decisions related to the examination process and respect for their choices (in this regard, SAFE candidates must be careful not to allow their experiences to influence patients’ decisions).
- Cultural and other individual considerations that may affect how the examination is conducted. Appropriate questions to ask so that a patient’s needs and circumstances can be determined.
- Information that patients can review at their convenience.<sup>16</sup>
- Variation in level of information that patients may want at the time of the examination, methods of delivery of the information, and their capacity to make informed decisions during the examination (e.g., due to being overwhelmed or frightened).

### **Cultural competency issues:**

- Identifying and respecting patients’ individual/cultural differences.
- Providing culturally and developmentally appropriate explanations to patients.
- The ability of responders and patients to speak a common language and to have appropriate alternative methods to communicate (e.g., language interpretation by a trained interpreter rather than a patient’s family member or friend as well as provision of translated materials). It is critical that interpreters be linguistically and culturally competent.
- Training interpreters to work with sexual assault patients and to understand the scope of their role during the medical forensic examination. Encouraging interpreters to participate in communitywide SAFE/SART trainings.
- SAFE education on the diversity of the community, including recognizing and addressing differences within specific populations.
- SAFE education on myths, biases, and issues of diversity and oppression (recognizing that SAFE candidates bring their own biases to the examination process).
- Recognizing that some patients may request an examiner of a specific gender, race, etc., and the possible reasons for such requests. Paying attention to patients’ verbal and nonverbal behaviors for signs of resistance and/or fears that suggest an examiner of a specific background might be helpful. Such requests should be respected if possible (e.g., if staffing is available to accommodate the request).

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<sup>16</sup> Topics might include: information about the crime itself, common reactions to sexual assault along with signs and symptoms of traumatic response, safety planning options, consent issues, scope of confidentiality, availability and benefits of community-based advocates, reporting to law enforcement, participation in a criminal investigation, specifics of examination procedures, local and facility practices related to payment for the examination, presence of family and friends during the examination, testing and treatment options related to sexually transmitted infections (STIs), HIV, and pregnancy, and other applicable resources (e.g., for counseling) and remedies (e.g., civil).

### **3. Informed Consent (See page 39 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), a law enforcement representative, and a civil attorney (e.g., from a state, territorial, or tribal sexual assault coalition or a hospital). Consider including professionals who can address cultural competency issues.

**Training objectives.** To teach SAFE candidates to:

1. Identify information that patients need so they can make informed decisions about their medical care and forensic evidence collection, as well as their involvement in the legal system.
2. Identify local regulations and statutes concerning informed consent.
3. Understand the dynamics of providing patients with information to make informed decisions before and throughout the examination.

#### **Topics:**

- Related state, territorial, tribal, and federal laws, guidelines, and regulations, including those that apply to youth and vulnerable adults. If applicable, related cross-jurisdictional issues.
- Related facility/examiner program policies and procedures.
- Logistics of seeking verbal and written consent, including forms and the need to balance patients' potentially traumatized state with the requirement of informed consent.
- Use of interpreters when seeking informed consent.
- Coordination with other responders to seek patients' informed consent.
- Impact of the patient accepting or declining part or all of the examination (e.g., on the legal case, quality of care, or payment for the examination by the jurisdiction).<sup>17</sup> Providing this information to patients in a nonjudgmental way. Respect for patients' choices.
- Procedures that apply when authorization from guardians/parents is needed beyond patients' consent (noting that the examination should never be done against the will of the patient).
- Procedures in situations where patients do not or cannot consent themselves (e.g., due to being unconscious or drug impaired or having a disability that effects their cognitive capacity).

#### **Cultural competency issues:**

- Addressing language differences and barriers, literacy issues, and disability issues with regard to consent forms and communicating information to patients.
- Providing culturally and developmentally appropriate explanations to patients.
- Recognizing and addressing related concerns about immigration/legal status.

### **4. Confidentiality (See page 43 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a civil attorney (e.g., from a state, tribal, or territorial sexual assault coalition or a hospital).

**Training objectives.** To teach SAFE candidates to:

1. Identify the extent and limits of confidentiality surrounding the medical forensic examination.

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<sup>17</sup> Note the potential for examiner or system bias if a patient chooses not to proceed with part or all of the examination. SAFE candidates should strive to remain objective, respect patient decisions, and avoid becoming biased.

2. Understand how to address the confidentiality issues that arise in these cases.

**Topics:**

- Jurisdictional laws related to the release, distribution, and duplication of medical records, forensic documentation, forensic photographic and video images, and forensic evidence. If applicable, related cross-jurisdictional issues.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA): how to navigate it and issues and concerns as they apply to the examination process.
- Procedures for seeking authorization to release information/evidence. Explanation of adequate release.
- Scope of confidentiality of different SART members and systems that patients interact with in the course of the examination process. Explanation of the scope to patients.
- Difference between community-based and system-based advocates in terms of confidentiality. Difference between “confidential” and “privileged” communications between individuals who disclose sexual assault and community-based advocates. Applicable jurisdictional laws related to privileged communications.
- Scope of confidentiality/policies when patients appear intent on harming themselves or someone else.
- Confidentiality in difficult/complex situations (e.g., in communities that have small populations or are isolated, residents tend to know one another and word of a crime may travel quickly).
- Confidentiality when providing followup care and forensic documentation.
- Confidentiality when debriefing about cases.
- Confidentiality issues related to identifying data when using case information during trainings or peer reviews (e.g., discuss the need to get a patient’s signed consent if identifying data will be used).
- Patient consent for trainee participation in the examination process (including medical/nursing students, licensed health care providers in formal training, and examiners in training).
- Applicable facility/examiner program policies (e.g., restricted access to medical records related to the examination, response to subpoenas, and procedures for film development).

**Cultural competency issues:**

- Providing culturally and developmentally appropriate explanations to patients.

**5. Reporting to Law Enforcement (See page 45 of the protocol.)**

**Trainers.** A law enforcement representative, a prosecutor, a SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a SART coordinator if one exists. Also, consider including professionals who can address cultural competency issues.

**Training objectives.** To teach SAFE candidates to:

1. Be familiar with relevant statutes and regulations concerning sexual assault.
2. Be familiar with the patients’ bill of rights and the crime victims’ bill of rights.
3. Understand how to articulate to patients their options regarding reporting and the potential impact of their decisions.
4. Understand common issues and concerns that patients may have related to making the decision to report and why some choose not to report.

**Topics:**

- Related laws and regulations. Existing mandatory reporting laws for sexual assault incidents.
- Reporting requirements and payment for the examination.
- If applicable, related cross-jurisdictional issues.
- Components of a criminal investigation. Note that the examination is one part of a comprehensive criminal investigation.
- Issues and fears that individuals who disclose sexual assault incidents may have about reporting.
- Blind reports and nonidentifying reports.<sup>18</sup>
- Delayed reporting and whether there are jurisdictional statutes of limitations for reporting. Maintenance of chain of custody of evidence and evidence storage issues in unreported cases.
- Potential consequences of reporting and not reporting. Provision of this information to patients and respect for their decisions on reporting. (See A.6. *Payment for the Examination Under VAWA* for more information on how reporting/not reporting can impact payment.)
- Issues that may arise with patients who are illegal immigrants.
- Potential impact on a case if a patient has outstanding warrants.

**Cultural competency issues:**

- Understanding the fear and/or distrust of law enforcement by some patients and differing views of the criminal justice systems that different populations may hold.
- Providing culturally and developmentally appropriate explanations to patients.

**6. Payment for the Examination Under VAWA (See page 49 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a relevant government entity.<sup>19</sup>

**Training objectives.** To teach SAFE candidates to:

1. Identify links between the examination and payment for services.
2. Understand the VAWA provisions related to payment for the examination.
3. Understand how to help patients access crime victim compensation and other financial assistance resources.
4. Recognize the importance of maintaining victim-centered care despite reimbursement issues.

**Topics:**

- Jurisdictional and/or facility/examiner program policies addressing coverage of examination costs: who is responsible to pay for the various components of the examination, impact of

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<sup>18</sup> See the protocol, page 46.

<sup>19</sup> Under the Violence Against Women Act (VAWA), grantees of the STOP Violence Against Women Formula Grant Program must meet certain requirements concerning payment for the forensic medical exam in order to receive funds. The STOP Program is a formula grant program that provides funds to all states, territories, and the District of Columbia. Each of these entities certifies each year that it is in compliance with the requirements of VAWA. Specifically, the state, territory, or the District of Columbia must certify that it or another governmental entity "incurs the full out-of-pocket cost of forensic medical exams" for victims of sexual assault. The particular government entity responsible for payment differs from state to state.

reporting/not reporting on payment, and specifics for billing each entity.<sup>20</sup> If applicable, related cross-jurisdictional issues.

- Applicable provisions and definitions relating to payment for the examination under VAWA and other relevant legislation.
- Crime victim compensation process: eligibility, access, and who can assist patients with navigating this process. Other financial assistance resources.
- Issues and concerns related to payment: patient and provider perspectives.

***Cultural competency issues:***

- Socioeconomic status and the ability to pay for services should not be an issue.
- Providing culturally and developmentally appropriate explanations to patients.

**SECTION B. OPERATIONAL ISSUES**

**1. Sexual Assault Forensic Examiners** *(See page 53 of the protocol.)*

**Note:** This document does not include standards corresponding to this portion of Section B in the protocol because it involves only a few training issues that are covered sufficiently in other sections of this document.

**2. Facilities** *(See page 57 of the protocol.)*

**Note:** This document does not include standards corresponding to this portion of Section B in the protocol because it involves only a few training issues that are covered sufficiently in other sections of this document.

**3. Equipment and Supplies** *(See page 61 of the protocol.)*

**Note:** This document does not include standards corresponding to this portion of Section B in the protocol because it involves only a few training issues that are covered sufficiently in other sections of this document.

**4. Sexual Assault Evidence Collection Kit** *(See page 65 of the protocol.)*

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist/crime lab representative (from labs designated by the jurisdictions involved to process sexual assault evidence collection kits), and a law enforcement representative and/or prosecutor. Also, consider including professionals who can address cultural competency issues. Trainers should be familiar with kits used by jurisdictions in which SAFE candidates intend to serve. It would be useful to create a forum during training so that survivors can provide candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Understand how to complete evidence collection (as required by the kit) in an effective and efficient manner.

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<sup>20</sup> In many jurisdictions, medical and forensic examination components are interwoven and one entity assumes most or all of the costs (with the exception of expenses they deem unrelated to evidence gathering). In other jurisdictions, these components may be differentiated in payment and documentation structures.

2. Identify kit components (requested evidence and information) and rationale for collection of each component according to jurisdictional policy.
3. Understand that while the kit is a tool of the criminal justice system to facilitate the standardized collection of evidence and information, the medical forensic history is critical in determining what evidence should be collected in each case.

**Topics:**

- Jurisdictional and facility requirements and protocols related to the kit. If applicable, related cross-jurisdictional issues.
- Process of acquiring a kit (e.g., knowing how to obtain it), storage requirements, securing the chain of evidence, and any issues regarding expiration date.
- Components of the kit and rationale (research based where applicable) for evidence collection.
- Integration of evidence collection into the examination (how and why).
- Techniques in accordance with local protocol for evidence collection, handling, and labeling. (Also see *C.6. Examination and Evidence Collection Procedures.*)
- Potential impact of each piece of collected evidence on a criminal investigation.
- Forms included in the kit and how forensic scientists use supplied documentation.
- Importance of the medical forensic history in determining what is collected in each case.
- Identification and collection of evidence not guided by or requested in the kit.
- Explanation to patients of each step of kit collection, rationale behind collection, and potential postexamination uses of the kit (how and by whom it is used).

**Cultural competency issues:**

- Providing culturally and developmentally appropriate explanations to patients.
- Understanding how cultural issues can influence a patient's choice of what should be collected (e.g., a patient may believe that hair is sacred and therefore be reluctant to provide a hair sample), how it is collected (e.g., cultural beliefs may preclude a member of the opposite sex from being present when a patient disrobes), or how comfortable a patient is with having certain evidence collected.
- Understanding body image issues and building patients' comfort in having evidence collected for the kit.
- Adaptation and/or modification to the evidence collection process, which may be needed to address patients' individual needs.

**5. Timing Considerations for Collecting Evidence and Patient Care (See page 67 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist, a law enforcement representative, and a community-based advocate (see footnote 7).

**Training objectives.** To teach SAFE candidates to:

1. Be familiar with local protocols and current science and technology related to outside limits for obtaining forensic evidence.
2. Recognize that the case history, the timeliness of the initial examination, and the examiner's critical thinking skills determine when to collect evidence and what evidence to collect (along with patients' reactions to the process and willingness to have evidence collected).
3. Understand that timing of the examination can also impact patient care and that timing is important in followup patient care.

**Topics:**

- Relevant jurisdictional policies and protocols. If applicable, related cross-jurisdictional issues.
- Factors that influence when to collect evidence and what evidence to collect (case-by-case consideration).
- The importance of prompt examination and documentation to minimize loss of evidence.
- Current science and technology related to timing considerations for detecting and collecting evidence, time sensitivity when collecting different types of evidence (e.g., DNA evidence on clothing might be found even after the clothing is laundered), and jurisdictional access to current science and technology.
- Items that the local crime lab deems mandatory (e.g., reference DNA), regardless of timing considerations.
- The role of other responders in timely evidence collection (e.g., law enforcement representatives conducting the field investigation) and coordination among them to make forensic decisions and share information, as appropriate.
- Timing of followup forensic documentation, if indicated (e.g., explanation about if and when documentation of the developing or healing injuries and resolution of healing should occur). (Also see *C.10. Discharge and Followup*.)
- Issues in caring for patients that may be impacted by the timing of the examination and followup testing/treatment (e.g., whether prophylactic medications will be effective or followup medical appointments are recommended).
- Provision of information to patients on the impact of timing on evidence collection and care.

**Cultural competency issues:**

- Explaining timing issues related to evidence collection and patient care in a culturally competent and developmentally appropriate manner.

**6. Evidence Integrity (See page 69 of the protocol.)**

**Trainers.** A team of a SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist, a law enforcement representative, and a prosecutor.

**Training objectives.** To teach SAFE candidates to:

1. Identify the role of the SAFE in maintaining the integrity and chain of custody of the evidence.
2. Understand how to maintain evidence integrity and the chain of custody of evidence.

**Topics:**

- Explanation of the importance of maintaining evidence integrity and the chain of custody in these cases.
- Jurisdictional policies for drying, packaging, labeling, and sealing evidence.
- Ways in which evidence can be lost biologically or rendered inadmissible. Steps necessary to prevent such a loss of evidence.
- Jurisdictional policies for transferring evidence to a law enforcement representative, appropriate crime lab, or other designated storage site.
- Jurisdictional storage policies, including policies in cases where patients are undecided about reporting (e.g., whether evidence in undecided cases can be stored, and where/for how long it can be stored). Procedures for patients to request return of personal items held as evidence.
- Maintenance and documentation of chain of custody.

- Jurisdictional policies about destroying evidence when a report is not made and law enforcement does not take custody of the evidence.
- If applicable, related cross-jurisdictional issues.

## **SECTION C. THE EXAMINATION PROCESS**

### **1. Initial Contact** *(See page 73 of the protocol.)*

### **2. Triage and Intake** *(See page 77 of the protocol.)*

**Trainers.** A team that minimally includes a SANE–A or SAFE with equivalent training/clinical and forensic experience, a law enforcement representative, and a community-based advocate (see footnote 7). It may also be helpful to include trainers from other disciplines who are frequently involved in initial contact/triage and intake in the jurisdictions where the SAFE candidates will serve (e.g., an EMS technician or relevant hospital emergency department staff). Consider including professionals who can address cultural competency issues. It would be particularly useful to create a forum during training so that survivors can provide SAFE candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Identify roles and boundaries of each responder during initial contact and during triage/intake.
2. Understand the importance of a multidisciplinary coordinated response at this stage.
3. Recognize critical elements of initial response, triage, and intake.
4. Understand how to carry out SAFE responsibilities during initial contact/triage and intake, paying particular attention to the immediate needs and concerns of each patient.

#### **Topics:**

- Related roles and boundaries of each discipline (e.g., role of health care providers upon initial contact with patients to assess acute medical needs).
- Collaboration among responders during initial contact with patients and during triage/intake. Some built-in flexibility in the response protocol may be necessary; the key is to ensure that deviation from the protocol does no harm to patients.
- Relevant jurisdictional statutes and policies, including those that determine response during initial contact and during triage/intake (e.g., who has authority) and those that support multidisciplinary coordination. If applicable, related cross-jurisdictional issues.
- Critical elements of initial response that facilitate safety, meet emergent medical needs, offer support, preserve evidence, and secure the chain of custody of evidence.
- Initial assessment of patients' language; physical, mental, and developmental abilities; and need for assistance.
- Provision of nonjudgmental, compassionate, competent, and culturally sensitive response to patients during initial contact and during triage/intake. (Also see A.2. *Victim-Centered Care*.)
- Patient empowerment to make choices about reporting, evidence collection, and health care; acceptance of patients' decisions (e.g., they may not feel ready to report to law enforcement); and respect for their choices.

### ***Cultural competency issues:***

- The elements of a culturally competent initial response and how such elements can be realized.
- Providing culturally and developmentally appropriate explanations to patients.
- Assessing the cultural makeup of the community.
- Using available resources for various patient populations.
- Recognizing individuals' right to self-identify needs.
- Understanding issues that can arise when agencies from more than one jurisdiction are involved in a case (e.g., on Indian reservations, military installations, national parks or other federal government property, school campuses, in federal cases, or when case circumstances cross jurisdictional boundaries).

### **3. Documentation by Health Care Personnel (See page 79 of the protocol.)**

***Trainers.*** A health care provider, a SANE–A or SAFE with equivalent training/clinical and forensic experience, and a prosecutor.

***Training objectives.*** To teach SAFE candidates to:

1. Identify all components of medical and forensic documentation necessary within the jurisdiction/facility/examiner program.
2. Understand how to produce thorough, precise, accurate, unbiased, and objective documentation for the medical forensic record.
3. Be familiar with quality assurance<sup>21</sup> plans of the jurisdiction/facility/examiner program and relevant jurisdictional regulations or interpretations related to SAFE documentation, such as peer review, meeting activities, attendants, incident reports, and supervision.

### ***Topics:***

- Jurisdictional, facility, and examiner program policies related to what to document and how to document.
- Methods of recording information—written (checklists, narratives, forms or other notation that is handwritten, typewritten, computer generated, or transcribed from dictation), diagrammatic (drawn or indicated on anatomic diagrams), and photographic (film or digital; still or video).
- Confidentiality issues, including HIPAA concerns. (Also see A.4. *Confidentiality.*)
- Documentation of patients' informed consent or lack of consent to any part or all of the examination. Documentation of release of information.
- Documentation of forensic/medical history.
- Documentation of examination findings.
- Consistency between written and diagrammatic documentation and photography.
- Jurisdictional and facility/examiner program policies on access, management, and distribution of records. (See C.11. *Examiner Court Appearances* for information on response to subpoenas.) If applicable, related cross-jurisdictional issues.
- SAFE objectivity and accuracy.
- Terminology and language.
- Options for quality assurance and review and improvement of SAFE documentation.

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<sup>21</sup> The health care field might find it more appropriate to use the terms "continuous quality improvement" (CQI) or "performance improvement" (PI).

### **Cultural competency issues:**

- Reviewing documentation for inappropriate language and biases.

### **4. The Medical Forensic History (See page 81 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), a law enforcement representative, and a prosecutor. Also, consider including professionals who can address cultural competency issues. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Define the difference between medical and forensic history taking.
2. Be aware of the potential emotional impact of the history taking process on patients.
3. Be familiar with the roles of individuals who can provide support and advocacy to patients during history taking or who can gather information from patients, as well as the possible impact of their involvement in this process.
4. Understand how to obtain and document a comprehensive forensic history as it relates to the assault, including pertinent medical and developmental history.
5. Build their forensic history interviewing skills.

### **Topics:**

- Medical history related to the assault versus general medical and developmental history.
- Potential impact of trauma on memory, cognitive functioning, and communications.
- Patient needs prior to and during history taking and possible emotional impact of this process.
- Jurisdictional methods/protocols used to obtain and record information. If applicable, related cross-jurisdictional issues.
- Elements of the medical forensic history according to relevant jurisdictional protocols.
- The importance of an accurate and unbiased account.
- Boundary issues for SAFEs (e.g., be careful not to influence patient's answers or ask investigative questions).
- Connection between the history and subsequent examiner actions (e.g., if a patient indicated that the assailant had contact with a specific body area, the SAFE should examine that area using the most appropriate techniques for visualization of injuries and then document findings).
- Scope of confidentiality of different SART members during the medical forensic history. (Also see *A.4. Confidentiality.*)
- Roles and responsibilities of advocates during the medical forensic history.
- Decisionmaking related to who can be present during the examination and related to history taking. Potential impact on the legal case of different individuals being present during history taking (e.g., a community-based advocate, systems-based advocate, family members, friends, or other support persons).<sup>22</sup>
- Coordination between law enforcement representatives and SAFEs regarding the logistics of medical forensic history taking and investigative interviewing.

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<sup>22</sup> Patients should be aware that government-based service providers/advocates typically cannot offer confidentiality to patients, whereas community-based advocates usually can provide some degree of confidentiality. If a victim service provider/advocate who is not from a community-based program offers to accompany a patient during the medical forensic history or other parts of the examination, the SAFE examiner and patient should understand the potential impact of the victim service provider/advocate's presence on the legal case (e.g., they might be asked to testify as to what the patient said or how the patient behaved). See the protocol, pages 18–19 and 34–35, for more information on the roles of victim service providers/advocates.

**Cultural competency issues:**

- Cultural safety for patients throughout the history taking process.
- Asking questions in culturally and developmentally appropriate ways.
- Unbiased history taking and documentation that is free of inappropriate language.

**5. Photography (See page 85 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a prosecutor, a forensic photography expert, a law enforcement representative, a community-based advocate (see footnote 7), and related vendors. Also, consider including professionals who can address cultural competency issues. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Use basic forensic photography techniques.
2. Understand the appropriate uses of forensic photography in these cases.
3. Understand how to identify and obtain additional photographic expertise/resources as needed.

**Topics:**

- Local policies related to the extent of forensic photography necessary in these cases and to photographers (e.g., who can take these photographs). If applicable, related cross-jurisdictional issues.
- Choice of equipment and resources.
- Basic photographic skills.
- Specialized forensic photography skills.
- Potential use of photodocumentation by the criminal justice system.
- Informed consent to take and release photographs. Potential impact on patients.
- Management of photographs taken during the initial examination (e.g., maintaining the chain of custody, film development, storage, handling requests for photographs, and privacy).
- Followup photographs and their management.
- Resources for documentation needs (e.g., to fully document bite marks).
- Photographic quality assurance, including technical (exposure, lighting, sharpness, color fidelity, and composition) and content (adequate views, consistency with written/diagrammatic descriptions, and proper interpretation) review.

**Cultural competency issues:**

- Explaining the purpose of and procedures for forensic photography in a culturally and developmentally appropriate manner.
- Recognizing ways in which culture may influence patients' decisions regarding photography.

**6. Exam and Evidence Collection Procedures (See page 89 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience, a forensic scientist (from the jurisdictional crime lab), a community-based advocate (see footnote 7), a law enforcement representative, and a prosecutor. Also, consider including professionals who can address cultural competency issues. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Define the purpose of the medical forensic examination.
2. Understand how to appropriately collect forensic evidence from patients.
3. Take steps to anticipate, identify, collect, document, preserve, label, and store all potential evidence with attention to the chain of custody.
4. Understand how to perform a comprehensive physical examination and document findings.

**Topics:**

- Integration of the comprehensive physical assessment and evidence collection with compassion and emotional support.
- Mechanisms of injury, normal variations, and terminology.
- Prevention of exposure to potentially infectious materials.
- Avoidance of contamination in every medical or evidentiary procedure.
- Broad spectrum of potential evidence and physical findings in these cases and the potential impact of evidence on an investigation.
- Limitation of the SAFE's capacity to identify DNA evidence and match trace evidence and the role of the forensic scientist/crime lab in identifying and determining the presence of biological or trace evidence.
- Evidence pertinent to the issue of whether a patient consented to sexual contact with a suspect.
- Steps involved in evidence collection.
- Equipment needed and techniques for the visualization of injuries and evidence.
- Adaptation of the examination and evidence collection due to patients' individual needs.
- Documentation of patient behavior during the examination and evidence collection for forensic purposes (e.g., to support excited utterances).
- Maintenance of the chain of custody of evidence. (Also see *B.6. Evidence Integrity*.)
- Methods to explain procedures to patients and seek informed consent throughout the examination and evidence collection.
- Patients' right to accept or decline any or all parts of the examination and potential impact of their decisions on criminal justice proceedings. (Also see *A.3. Informed Consent*.)
- Role of advocates during the examination and evidence collection.<sup>23</sup>
- Interpretation of visible examination findings and conclusions according to local policies.
- Language used to relate findings to law enforcement representatives.
- Issues that may arise when conducting suspect examinations (e.g., coordination with law enforcement, what to collect, costs, location of examinations, access to suspect evidence collection kits, and understanding that suspects may be the best source of probative evidence).

**Cultural competency issues:**

- Adaptation and/or modifications to the examination process that may be needed to address patients' individual needs.
- Providing culturally and developmentally appropriate explanations to patients regarding the purpose of the examination and evidence collection procedures.
- Ways in which culture may influence patients' decisions, the manner in which evidence is collected (e.g., cultural beliefs may preclude a member of the opposite sex from being present

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<sup>23</sup> See footnote 22.

when a patient disrobes), or what is collected (e.g., a patient may believe that hair is sacred and be reluctant or decline to have hair evidence collected).

## **7. Drug-Facilitated Sexual Assault (See page 101 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience (or another healthcare provider with expertise in this area) and other knowledgeable individuals from law enforcement, community-based advocacy (see footnote 7), crime lab/toxicology, and/or pharmacology. It would be useful to create a forum so that survivors can provide SAFE candidates with input on this issue.

**Training objectives.** To teach SAFE candidates to:

1. Define drug-facilitated sexual assault.
2. Identify and document signs and symptoms of a clinical presentation of drug-facilitated sexual assault.
3. Understand the circumstances in which toxicology collection and testing may be indicated.
4. Understand how to seek informed consent from patients to collect toxicology samples.
5. Understand how to collect toxicology samples.
6. Be aware of relevant jurisdictional procedures on collecting, packaging, storing, and transferring these samples.

### **Topics:**

- Definition of drug-facilitated sexual assault and differences between investigating a drug-facilitated case from other types of sexual assault cases.
- Clinical presentation, including signs and symptoms.
- Circumstances in which toxicology testing may be indicated and the difference between need for sample for medical purposes versus forensic purposes.
- Full range of issues related to informed patient consent to collect and release toxicology samples. (*Also see A.3. Informed Consent.*) Potential impact of toxicology testing on the patient and on criminal justice proceedings.
- Situations in which patients are unable to provide informed consent (e.g., if a patient is under the influence of a controlled substance or is unconscious).
- Jurisdictional issues related to collecting, documenting, packaging, storing, and transferring samples and maintaining the chain of custody. If applicable, related cross-jurisdictional issues.
- Techniques for the collection of toxicology samples.
- Voluntary versus involuntary ingestion and the impact on testing, investigating, and prosecuting drug-facilitated sexual assault.
- Toxicology lab options and payment responsibility.
- History taking in drug-facilitated cases (e.g., there may be gaps in a patient's memory).
- Importance of working as a team with other involved professionals to respond in a way that is victim centered and useful in facilitating the criminal investigation. Benefits of an advocate's presence in these cases.

### **Cultural competency issues:**

- Conducting an investigation that is not judgmental of the patient.
- Understanding the prevalence of recreational drug use in a specific community, as well as the offender population that targets recreational drug users.
- Providing culturally and developmentally appropriate explanations to patients.

## **8. Sexually Transmitted Infection (STI) Evaluation and Care (See page 105 of the protocol.)**

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience (or another healthcare provider with expertise in this area) and a community-based advocate (see footnote 7).

**Training objectives.** To teach SAFE candidates to:

1. Identify and document signs and symptoms of the clinical presentation of STIs.
2. Be knowledgeable about the prevalence of STIs in the local community.
3. Be familiar with strengths and limitations of the most currently accepted testing and treatment methodologies and techniques.
4. Understand how to evaluate and treat patients for STIs.
5. Understand how to articulate to patients what they need to know about STIs and HIV.
6. Identify resources for STI and HIV testing, including confidential sites.
7. Identify resources that may assist with financial concerns related to STI and HIV testing and care (e.g., crime victims' compensation) and how to help patients access these resources.

### **Topics:**

- Signs, symptoms, and transmission of STIs.
- Incidence/prevalence and morbidity in a specific community according to age, gender, and ethnicity. Any known related drug resistance in the community.
- Current guidelines for testing, prophylaxis, and treatment (initial and followup screening/care).
- Related policies of the jurisdiction, facility, and examiner program. If applicable, related cross-jurisdictional issues.
- Specific information related to testing (i.e., indications for testing and testing methods and techniques, including strengths and limitations of each). Potential legal impact of test results.
- Specific information related to prophylaxis and treatment (i.e., methods and techniques, including strengths, limitations, and side effects of each). Willingness of a patient to follow up for assessment and care and/or the location in which the assault occurred may influence the choice of medical prophylaxis/treatment offered.
- Risk of exposure to HIV and assessment of the need for postexposure prophylaxis. Treatment and followup medical care. Importance of providing patients with all pertinent information to aid them in making an informed decision about prophylaxis.
- Followup medical screening and care related to the risk of STI transmission.
- Community resources. Regulations concerning confidential testing and mandatory reporting.
- Financial assistance resources (e.g., crime victim compensation) for costs related to testing for and care of STIs and HIV (e.g., hepatitis B shots).
- Approaches for articulating to patients the prevalence of STIs in their community and their risk, their partners' risk, testing, prophylaxis, treatment options, followup medical screening and care, financial assistance, and referrals.

### **Cultural competency issues:**

- Addressing cultural beliefs, if any, related to STIs and HIV.
- Discussing STIs and HIV with patients in a culturally and developmentally appropriate manner.

## 9. Pregnancy Risk Evaluation and Care (See page 111 of the protocol.)

**Trainers.** A SANE–A or SAFE with equivalent training/clinical and forensic experience (or another healthcare provider with expertise in this area) and a community-based advocate (see footnote 7). Also, consider including professionals who can address cultural competency issues.

**Training objectives.** To teach SAFE candidates to:

1. Understand how to convey to patients the science behind reproduction.
2. Understand how to assess belief systems (examiner and patient) related to reproduction.
3. Understand how to recognize patients' level of understanding related to pregnancy and how to articulate medical definitions of terms that may be confusing.
4. Understand how to discuss with patients the full range of treatment options and potential outcomes for each option.
5. Be familiar with local resources.

### **Topics:**<sup>24</sup>

- Infertility/fertility of the assailant and patient.
- Sexual function and dysfunction.
- Treatment options and outcomes.
- Followup care.
- Resources available, both at the facility and locally.
- Relationship building with individuals who have the resources and coping with resource limitations.
- Discussion of pertinent information with patients.

### **Cultural competency issues:**

- Discussing the possibility of pregnancy and treatment options in a culturally and developmentally appropriate manner.
- Understanding cultural (particularly religious) beliefs related to pregnancy in the community being served and relaying the science behind reproduction in a format that is culturally understandable.
- Understanding patients' individual beliefs related to pregnancy.

## 10. Discharge and Followup (See page 113 of the protocol.)

**Trainers.** A team that includes, at a minimum, a SANE–A or SAFE with equivalent training/clinical and forensic experience, a community-based advocate (see footnote 7), and a law enforcement representative. These team members often provide patients with discharge instructions or followup information at the time of their release from the examination facility.

**Training objectives.** To teach SAFE candidates to:

1. Be familiar with the safety, medical, law enforcement, advocacy, mental health, and other (e.g., housing) issues to be addressed with patients at the time of discharge.

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<sup>24</sup> The National Sexual Violence Resource Center offers detailed information about sexual assault and pregnancy on its Web site at [www.nsvrc.org](http://www.nsvrc.org). The American College of Emergency Physicians also offers guidance on this topic in its publication *Evaluation and Management of the Sexually Assaulted or Abused Patient*, available through its Web site at [www.acep.org/NR/rdonlyres/11E6C08D-6EE7-4EE2-8E59-5E8E6E684E43/0/sxa\\_handbook.pdf](http://www.acep.org/NR/rdonlyres/11E6C08D-6EE7-4EE2-8E59-5E8E6E684E43/0/sxa_handbook.pdf).

2. Understand how to discuss with patients all aspects of postexamination care and forensic documentation, and recommended followup appointments and procedures. Recognize that one approach will not fit all patients; rather, patients will require tailor-made discharge plans that address their individual needs and circumstances and the specifics of their cases.
3. Understand the scope of multidisciplinary coordination needed during the discharge process.

**Topics:**

- Related policies of the jurisdiction, facilities, and examiner programs.
- How the discharge plan will be designed. Forms and multidisciplinary checklists.
- Safety planning.
- Medical and forensic discharge instructions.<sup>25</sup>
- Medical and forensic followup (viewed as part of the medical forensic examination process).
- Discharge instructions and followup related to victim advocacy and mental health care.
- Discharge instructions and followup related to the criminal justice system (beyond forensic documentation).
- Discharge instructions and followup related to payment for examination costs and use of crime victim compensation.
- Other referrals.
- Multidisciplinary coordination needed during the discharge process. If applicable, related cross-jurisdictional issues.

**Cultural competency issues:**

- Using culturally and developmentally appropriate terms.
- Providing discharge instructions in community-specific languages.

**11. Examiner Court Appearances (See page 117 of the protocol.)**

**Trainers.** A prosecutor; a SANE–A or SAFE with equivalent training/clinical, forensic, and testimony experience; a forensic scientist; other attorneys; a community-based advocate (see footnote 7); and a victim-witness specialist from the criminal justice system.

**Training objectives.** To teach SAFE candidates to:

1. Understand the SAFE's role in the courtroom as an expert or factual witness.
2. Develop basic testimony skills.

**Topics:**

- Preparation for testimony, including review of reports, anticipation of likely defense and prosecution questions, and creation of a curriculum vitae, reference lists (e.g., of supporting articles and case rulings), and a summary of testifying experience.
- Differences between an expert and a percipient or factual witness.
- Use of documentation in court and avoidance of inappropriate language.
- Potential outcomes/impact of SAFE testimony. Court rulings in related cases.

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<sup>25</sup> Several other training areas address specific issues related to followup, including A.2 *Victim-Centered Care*, A.4 *Confidentiality*, B.5 *Timing Considerations for Collecting Evidence and Patient Care*, C.5 *Photography*, C.8 *STI Evaluation and Care*, and C.9 *Pregnancy Risk Evaluation and Care*.

- Subpoenas: the process, including the differences between criminal and civil investigations and appropriate response procedures to subpoenas in each case, and consequences of not sharing requested information or of subpoenaed individuals who do not show up for court.
- Basic judicial process, including players' roles, legal terminology, and the differences between criminal and civil processes.
- Proper behavior and appropriate attire in court.
- Use of plain language to explain medical forensic terms and processes.
- Maintenance of an objective status.
- Pretrial communication/contact with attorneys.
- High-profile cases: effective approaches to dealing with these cases, potential impact of these cases on the field, and management of the stress of being involved in such a case.
- Mock trial and other tools to demonstrate the judicial process and testimony skills.

***Cultural competency issues:***

- Providing nonbiased testimony.
- Using culturally and developmentally appropriate terms when testifying.

## Clinical Practice Content—Recommendations

These clinical practice recommendations are meant to supplement the didactic training recommendations. It is important to note that the recommendations in this section reflect minimal clinical practice content. Each jurisdiction/examiner program can evaluate the standards set forth and consider if there should be additional training requirements for their SAFEs.

It is useful if clinical practice is completed shortly after the completion of didactic training (e.g., within 6 months) to maximize the retention of knowledge and skills gained during the training.

**Trainers.** See areas of clinical practice below. Need varies for certain types of instructors, observers, and/or demonstrations by different responders.

**Training objectives.** To provide SAFE candidates supervised opportunities to:

1. Apply information and practice skills learned during the didactic training in order to prepare for their role as examiners.
2. Practice the general clinical skills that may be used in the course of a sexual assault medical forensic examination process.

### **Areas of clinical practice:**

- Application of general related clinical skills (e.g., visual, palpation, and auditory) to be completed with instruction by an experienced SAFE, registered or advanced practice nurse, or physician. Skills include but are not limited to:
  - Performing a detailed anogenital and oral evaluation and using a speculum, visualization, palpation, and other supportive techniques and equipment (e.g., tongue depressor or anoscope);
  - Physical diagnosis (especially in anogenital and oral examinations);
  - Determining normal, abnormal, and normal variant; and
  - Understanding mechanisms of injury and forming differential diagnoses.
- Application of clinical skills related to the examination: performing sexual assault medical forensic examinations of both female and male patients, including kit collection and documentation per jurisdictional protocols and procedures. This should be observed by and demonstrated to an experienced SAFE.
- Performance of required clinical skills until competency is demonstrated (competence is defined by the standards set by the local SAFE program and the legislated or professional organization from which the candidate is seeking certification).
- Practice in photodocumentation with supervision and evaluation by an experienced SAFE.
- Observation of sexual assault criminal trial proceedings.
- Observation of the related procedures and processes in the crime lab, law enforcement agencies, advocacy agencies, and other relevant agencies.
- Practice in documentation/chart review and involving experienced colleagues in the review process, with the goal of improving documentation.

- Ongoing education (both refresher courses and advanced training), supervision, and mentoring to facilitate consistently high-quality performance by SAFEs.

***Cultural competency issues:***

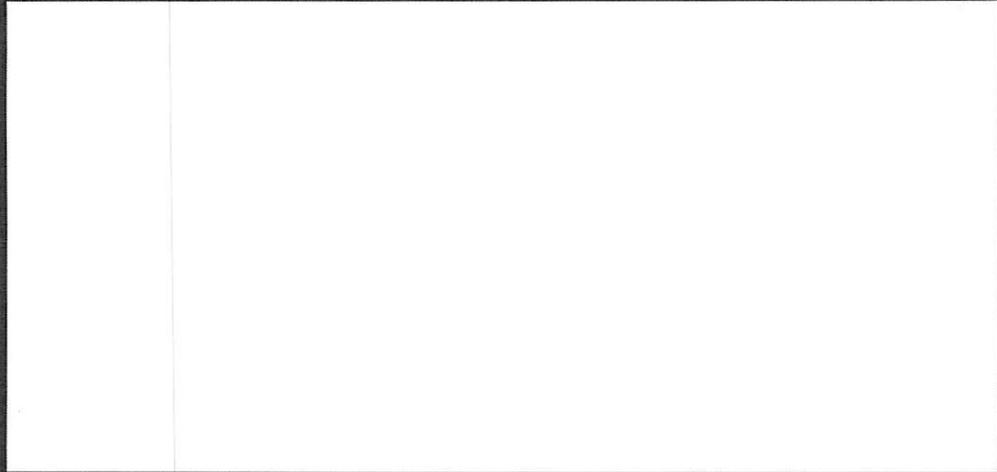
- See issues presented under the *Didactic Content—Recommended Topics*.

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Bureau of Justice Assistance  
Office of Community Oriented Policing Services  
Federal Bureau of Investigation  
Office for Victims of Crime  
National Institute of Justice



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\*MEDCOM Reg 40-36

DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2050 Worth Road  
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation  
No. 40-36

21 January 2009

Medical Services  
**MEDICAL FACILITY MANAGEMENT OF SEXUAL ASSAULT**

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CL-H.

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\*This regulation supersedes MEDCOM Regulation 40-36, 23 December 2004.

**\*MEDCOM Reg 40-36**

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**1. History.** This is the third issue of this regulation and publishes a major revision.

**2. Purpose.** This regulation implements the U.S. Army Medical Command (USAMEDCOM) policy to provide timely, accessible, and comprehensive medical management of sexual assault victims to include compassionate, confidential treatment aimed at restoring health and well-being.

**3. Applicability.** This regulation pertains to all USAMEDCOM personnel who are directly or indirectly involved in the provision of care to victims of sexual assault.

**4. References.** References are listed in appendix A.

**5. Explanation of Abbreviations and Terms.** Abbreviations and special terms used in this regulation are provided in the glossary.

## **6. Responsibilities**

a. The director, health policy and services is responsible for establishing policy and providing guidance for the timely, compassionate, and expected standard of care for victims of sexual assault.

b. The military treatment facility (MTF) commander will—

(1) In accordance with this regulation, ensure that all patients who present to the MTF with an allegation of sexual assault receive a uniform standard of care which is monitored and tracked until the provision of health care related to the sexual assault is completed.

(2) Ensure that the MTF's management of sexual assault victims is compassionate, sensitive, and not burdensome upon the patient.

(3) Ensure that all victims of sexual assault, upon initial encounter with the MTF, have immediate access to assessment by a provider trained in performing forensic examination and evidence collection. The forensic examiner may be a member of the MTF medical staff or available outside the MTF by established memorandums of understanding (MOUs)/memorandums of agreement (MOAs).

(4) Ensure appropriate MOUs/MOAs are established with local non-military medical treatment facilities and medical support activities. The MOUs/MOAs will ensure adequate and comprehensive response and care of victims and will incorporate appropriate administrative procedures to ensure victims who receive care in civilian hospitals are not charged for any aspect of that care. MOUs/MOAs should always be coordinated beforehand with the regional medical command/MTF agreement managers

(normally in the resource management division) and the servicing staff judge advocate. See the MOU/MOA template at appendix B.

(5) Ensure that a sexual assault clinical provider (SACP) manages each sexual assault patient's medical treatment— as directly related to the sexual assault incident— from initial presentation to completion of all follow-up visits.

(6) Ensure that initial and follow-up evaluations/treatments are clinically appropriate for each individual patient consistent with his/her clinical diagnosis, circumstances, and needs and are in accordance with this regulation.

(7) Ensure that all healthcare providers and MTF personnel participate in annual sexual assault awareness and responder training (see appendix C).

(8) Designate a representative to the Installation Sexual Assault Review Board to ensure appropriate information is provided to assist in the case management process.

(9) Ensure that each sexual assault victim is assigned to an SACP.

(10) Assign sexual assault care coordinators (SACCs) to assist SACPs with the delivery of a uniformed standard of care.

(11) Ensure assigned SACCs utilize the Sexual Assault Response Program Tracking Application (SARPTA) (see appendix D) or future enterprise-wide military health system (MHS) applications to maintain the requisite MTF commander database.

(12) Ensure that resources are available to support the standards of practice outlined in this regulation.

(13) Ensure that all clinical staff respond to allegations of sexual assault with sensitivity and compassion.

(14) Ensure unit leaders understand the seriousness and potential consequences of sexual assault and know the proper procedures for referring victims for medical treatment, counseling, and obtaining other services available to them in accordance with Department of Defense (DOD) and Department of the Army (DA) confidential reporting policies.

(15) Ensure the appropriate number of unit victim advocates (UVAs) is appointed on orders to support victim services.

(16) Ensure and maintain collaborative, supportive relationships with relevant installation agencies that have vested interests in the sexual assault victim (for example, the criminal investigation division (CID), Victim Advocacy Program, and the judge advocate general).

(17) Ensure that all providers document (in AHLTA) encounters associated with sexual assault patients according to applicable regulations.

(18) Ensure all those involved in the handling, transferring, and collection of evidence regarding a sexual assault maintain the chain-of-custody according to applicable regulations.

(19) Annually submit questionnaires, including all applicable documentation (no later than 15 Oct for the previous fiscal year), in accordance with Section 113, Title 10, United States Code (USC) and the Department of Defense Instruction (DODI) 6495.02 as related to sexual assaults involving members of the Army (see appendix E of this regulation).

c. The deputy commander for clinical services will—

(1) Ensure that MTF clinical personnel are adequately trained in the standard of care for victims of sexual assault.

(2) Ensure that those who function as forensic sexual assault examiners are trained to the standard of care as provided in this regulation, to include the use of the evidence collection kit.

(3) Ensure that all sexual assault records are reviewed to ensure compliance with established standards of care and that corrective actions are taken when standards of care are not met.

(4) Designate a sufficient number of privileged healthcare providers on orders to be SACPs to ensure adequate, comprehensive continuity of care and management of sexual assault patients according to this regulation.

(5) Designate a sufficient number of healthcare providers on orders to be SACCs so they can assist the SACPs with the delivery of care and management of sexual assault patients according to this regulation.

(6) Develop, maintain, and disseminate a sexual assault standing operating procedure (SOP) for MTF medical personnel consistent with the standards of practice as contained in this regulation. Ensure appropriate State and local jurisdictional laws are considered and incorporated in the medical response and evidence collection portion of the SOP.

(7) Review the MTF SOP and MOUs/MOAs on an annual basis and update as needed in order to meet the objectives of this regulation.

*d.* The chief, obstetrics/gynecology will ensure that a gynecologist is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

*e.* The chief, urology will ensure that a urologist is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

*f.* The chief, pediatrics will ensure a pediatrician is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

*g.* The chief, family practice will ensure a family practitioner is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

*h.* The chief, pathology/laboratory services will—

(1) Ensure that all forensic material forwarded to their service is appropriately labeled, handled, and stored according to applicable regulations.

(2) Ensure that laboratory personnel receive mandatory annual sexual assault awareness training in order to promote the standard of care requiring that sexual assault victims be treated with sensitivity and compassion.

*i.* The chief, patient administration division will—

(1) Ensure that reports and records of sexual assault patients are received and processed during both duty and nonduty hours in an appropriate and timely manner.

(2) Ensure that clinical encounters of all sexual assault patients documented “sensitive” in AHLTA receive special handling and management according to applicable regulations.

(3) Ensure that patients’ diagnoses are identified with the appropriate International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code and tracked by this code (see appendix F).

(4) Ensure release of records requested by the CID or civilian law enforcement agencies, in accordance with applicable regulations.

(5) Ensure that electronic and paper records are appropriately retired.

*j.* The chief, social work service will—

- (1) Ensure that an on-call staff roster is provided to all departments where examiners are located.
- (2) Ensure that a provider physically reports to the examiner location to assist the victim and their caretakers when the victim is a child.
- (3) In instances of assault on an adult, ensure that the on-call provider offers a response to the examiner when no other provision for a victim advocate is available and when the victim requests an advocate.
- (4) Ensure that all sexual assault victims seen by providers are screened for traumatic stress upon initial contact.
- (5) Ensure mental health follow-up care is provided to sexual assault victims, as needed. (In the event that mental health resources are unavailable, the SACC will facilitate mental health care within the community.)
- (6) Ensure social work follow-up care is provided to sexual assault victims as needed.
- (7) Ensure behavioral health encounters are documented in the AHLTA medical record according to applicable regulations.

*k.* The sexual assault clinical provider will—

- (1) Be responsible for the primary medical management of all identified victims of sexual assault from initial contact to completion of care related to the sexual assault incident according to this regulation.
- (2) Ensure that the patient obtains comprehensive, timely, and appropriate medical care (including follow-up care) relevant to medical conditions arising from the sexual assault incident. This includes, but is not limited to, specialty care and referrals, ancillary support services, and diagnostic testing.
- (3) Coordinate and collaborate with the SACC and installation agencies (for example, Victim Advocacy Program and CID), as needed.
- (4) Be a fully privileged healthcare provider of the MTF medical staff, able to address the medical needs of sexual assault victims.
- (5) Develop an individualized patient management care plan in collaboration with the patient and SACC.

(6) Document the patient's complete care and management according to the provisions of this regulation.

*l.* The sexual assault care coordinator will—

(1) According to this regulation, monitor and track the healthcare management of each identified victim of sexual assault who presents to the MTF.

(2) Collaborate and coordinate with the SACP to ensure the patient's healthcare needs are addressed from the time of his/her initial MTF encounter until completion of all health care related to the sexual assault incident.

(3) Collaborate and coordinate with the installation sexual assault responses coordinator (SARC) to facilitate resolution of related issues.

(4) Facilitate the timely completion of the patient's comprehensive individualized care plan in a timely manner to include supportive and responsive interaction with the patient.

(5) Maintain the requisite MTF commander database, SARPTA, or future enterprise-wide MHS applications in order to manage sexual assault victims.

(6) Be directly responsible to the MTF commander.

(7) Explain advocacy and counseling services and assess acute stress reaction.

*m.* The forensic examiner will—

(1) Be a fully privileged healthcare provider of the MTF medical staff, able to address the medical needs of the sexual assault victim.

(2) Be qualified to evaluate, diagnose, and treat a victim of sexual assault.

(3) Ensure continuity of care and appropriate follow up for each patient by direct contact with and referral to the SACP. The best means of achieving this requirement is for the SACP to be the forensic examiner.

(4) Be trained in the performance of forensic examination and evidence collection. (Note: Most of the sexual assault research has shown that the best and most compassionate care is obtained from an individual who is trained and routinely performs these examinations. Sexual assault nurse examiner training is one method that has been shown to accomplish the level of expertise required.)

(5) Perform the forensic examination of all victims/alleged victims of sexual assault. The MTF may, through established MOUs/MOAs, use an alternative provider to perform

the forensic examination and collection of evidence. The SACP must ensure the patient's continuity of care.

n. First responders (emergency medical services/emergency department personnel) will—

(1) Assess the victim's need for treatment of potentially life-threatening or serious injuries, administer necessary first aid, and request/obtain emergency medical assistance according to jurisdictional policy.

(2) Address safety needs of the victim and others at the scene (for example, offenders) and call for assistance/backup, if needed.

(3) Quickly assess the age, abilities, communication modality, and health condition of the victim and tailor response as appropriate (for example, a language interpreter or child protective service worker may be needed).

(4) Notify the SARC (if not present with the victim) to coordinate and respond to requests for victim assistance as quickly as possible. Understand that a victim needs immediate assistance for many reasons: he/she may not be safe, may be physically injured, and/or is experiencing trauma. Be aware that time delays in response can cause loss of evidence and increased trauma.

(5) If injuries do not appear serious, emphasize to the victim the need for medical evaluation and address related health concerns. Also, explain the purpose of the assessment and what happens during the examination process, keeping in mind that the amount of information that the victim wants at this time varies.

(6) Inform the victim about examination facility options (if options exist) and seek the victim's consent for transportation to the facility of his/her choice.

(7) Ensure timely interaction among the victim and victim advocates as soon as possible after disclosure of the assault, even if the victim refuses medical care and refuses the medical forensic examination. Follow local procedures for activating an advocate.

(8) Ensure preservation of crime scene evidence, including evidence on the victim. Document the victim's demeanor and statements related to the assault.

(9) If a victim agrees to seek emergency care and/or have evidence collected—

(a) Explain to the victim how to preserve bodily evidence until it can be collected (for example, do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth).

(b) Explain to the victim that clothing most likely will be taken as evidence. He/she may wish to bring or have someone bring a clean change of clothes to the examination facility. If applicable, let the victim know that replacement clothing will be available at the examination site. If he/she changed clothes since the assault, clothing worn during and immediately after the assault will be required for evidence. Follow law enforcement procedures for retrieving clothing or other items from a crime scene so that evidence is not inadvertently destroyed or contaminated.

(c) In suspected cases of drug-facilitated assault, the victim's first available urine sample should be sought if he/she cannot wait to urinate until arrival at the examination site. (The victim may have been drugged without his/her knowledge.) If the victim or his/her family, friends, or responders suspect a drug-facilitated assault, a urine sample should be sought.

(d) Transport or arrange transportation for the victim to the examination site. A victim with disabilities may have equipment (for example, wheelchairs and other assistive devices) and/or service animals that also need to be transported. Equipment should be treated with care because victims may consider equipment as extensions of themselves.

(e) Follow the MTF's SOP and applicable jurisdictional policy on alerting examination facilities about the pending arrival of patients.

(f) Ensure that suspects and victims are not in the same examination facility at the same time, if possible.

## **7. Policy**

a. USAMEDCOM policy is to treat victims of sexual assault and to ensure that MTF personnel are professionally trained to intervene in sexual assault cases. Since incidents of sexual assault constitute violations of the law, DA policy also recognizes a commander's authority to take disciplinary or administrative action in appropriate cases.

b. Medical personnel will execute the requirements of this regulation (for example, the forensic history and examination) in a nonjudgmental manner exemplifying the USAMEDCOM's commitment to establish a healthcare environment that is sensitive, compassionate, responsive, and supportive to sexual assault victims.

## **8. Confidentiality and reporting options**

a. Sexual assault is the most under reported violent crime in our society and in the military. Although the victim's decision to report is a crucial step, reporting is often precluded by the victim's desire that nobody else know about the incident. Assuring privacy and providing a confidential disclosure option for sexual assault victims is critical.

*b.* Confidentiality or confidential reporting allows a Uniformed Service member to report a sexual assault to designated individuals. Confidential reporting consists of restricted and unrestricted reporting (see appendix G).

(1) Restricted reporting. A Soldier who is sexually assaulted desires medical care, counseling, and victim advocacy without initiating the investigative process should use the restrictive reporting option. Restricted reporting allows a sexual assault victim to confidentially disclose the details of his/her assault to designated individuals and receive medical treatment and counseling, without triggering the official investigative process. Restricted reporting is intended to give victims additional time and increased control over the release and management of their personal information, to empower them to seek relevant information and support, and to allow them to make more informed decisions about participating in the criminal investigation. This additional reporting avenue gives commanders a clearer picture of the sexual violence within their command and enhances a commander's ability to provide a safe environment that contributes to the well-being and mission readiness of its members.

(2) Unrestricted reporting. A Soldier who is sexually assaulted desires medical treatment, counseling, and an official investigation of his/her allegation. Details regarding the incident will be limited to personnel who have a legitimate need to know.

*c.* Regardless of whether the Soldier elects restricted or unrestricted reporting, confidentiality of medical information will be maintained in accordance with current Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(1) Improper disclosure of covered communications, improper release of medical information, and other violations of this policy are prohibited and may result in disciplinary actions under the Uniform Code of Military Justice, loss of credentials, or other adverse personnel or administrative actions.

(2) Healthcare providers may convey to the command any possible adverse duty impact related to the victim's medical condition and prognosis in accordance with DOD 6025.18-R. Such circumstances, however, do not otherwise warrant an exception to policy, and, therefore, the specific details of the sexual assault will still be treated as covered communication and may not be disclosed.

(3) Additional exceptions are outlined below in cases in which victims elect restricted reporting.

*(a)* Command or law enforcement officials when disclosure is authorized by the victim in writing.

*(b)* Command or law enforcement officials when disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the victim or to another.

(c) Disability retirement boards and officials when disclosure by a healthcare provider is required in determining fitness for duty and disability retirement qualifications. Disclosure is limited to information that is necessary for processing the disability retirement determination.

(d) SARC, victim advocates, or healthcare providers when disclosure is required for the supervision of direct victim services.

(e) Military or civilian courts of competent jurisdiction when disclosure is ordered or required by Federal or State statute. SARC, victim advocates, and healthcare providers will consult with the servicing legal office in the same manner as other recipients of privileged information to determine if the criteria apply and if they have a duty to obey. Until those determinations are made, only non-identifying information should be disclosed.

## **9. Sexual assault forensic examinations**

a. A sexual assault victim has the option to have a sexual assault forensic examination (SAFE) in addition to the general medical care provided as a result of the sexual assault.

b. Healthcare providers performing the SAFE will use the approved DOD Sexual Assault Evidence Collection Kit to gather and preserve evidence. The DOD SAFE kit can be ordered through the MTF medical logistics division.

c. The same process is used for the collection and preservation of sexual assault evidence under the restricted and unrestricted reporting option; however, the restricted reporting option will not trigger the official investigative process and any evidence collected will be documented in a way that ensures the confidentiality of the victim's identity.

(1) For restricted cases, the SARC will generate an alphanumeric restricted reporting case number (RRCN) unique to each incident that will be used (in lieu of personal-identifying information) to label and identify the potential evidence collected from a SAFE, the accompanying documentation, as well as the evidence container (that is, SAFE kit).

(2) Upon completion of the SAFE, the healthcare provider will package, seal, and label the potential evidence container(s) with the RRCN and notify the supporting provost marshal or appropriate agency designated by local policy.

(3) Restricted evidence will be stored for 1 year from the date of the victim's report of the sexual assault.

## **10. Triage and intake**

### **a. Priority cases.**

(1) Sexual assault patients, with or without overt physical injury, will receive priority medical attention.

(2) A private location within the examination facility will be used for taking histories and performing the physical examination of sexual assault victims. This designated area will facilitate meeting the patient's healthcare needs as well as maximizing his/her safety and privacy.

(3) MTF personnel will immediately notify the SACP and SACC to coordinate care of identified sexual assault victims, irrespective of when and where the patient presents for care.

(4) Medical evaluation and treatment of acute injury, trauma care, and safety needs take precedence over the forensic examination and SARC notification. Medical personnel have an affirmative responsibility to preserve forensic materials and evidence in conjunction with any and all administered medical care.

### **b. Notification of sexual assault responders.**

(1) Alert the SACP and SACC of the sexual assault victim's presence and his/her status.

(2) Alert the identified sexual assault forensic examiner of the need for their services. The examiner may be an MTF staff member, such as the SACP, or may be a forensically trained provider outside the MTF per MOUs/MOAs.

(3) Examiners should be available to evaluate a sexually assaulted patient within 2 hours of notification, or a patient should be transported to the designated site for forensic examination within 30 minutes.

(4) Contact the SARC, if not already done.

(5) Contact the on-call social work provider. The social work provider will report for all child cases and, as requested by the examiner, for all adult cases when no other provision for a victim advocate is available and when the victim requests an advocate.

### **c. Immediate medical and mental health interventions.**

(1) Assess the patient's need for immediate medical or mental health intervention prior to the medical forensic examination.

(2) Once any emergent medical injuries have been treated, the SARC or victim advocate (VA) will—

(a) Advise the victim of the reporting options available to him/her.

(b) Explain the benefits and limitations of each option, especially the impact of any State mandatory reporting laws on restricted reporting.

(c) Document the reporting option the victim selects using DD Form 2910 (Victim Reporting Preference Statement).

(3) The SARC or VA will inform the victim about the availability of an optional SAFE. If a victim chooses to undergo a SAFE, and the healthcare provider determines a SAFE is indicated by the facts of the case, the healthcare provider at MTFs that possess a SAFE capability will conduct the examination.

(4) The SARC or VA will also ensure that the victim is aware of any local or State mandatory sexual assault reporting requirements that may limit the possibility of restricted reporting prior to proceeding with the SAFE at the off-base, non-military facility.

## **11. Documentation by healthcare personnel**

### **a. Medical forensic report.**

(1) Examiners are responsible for documenting forensic details of the examination in the medical forensic report, according to jurisdictional policy.

(2) The medical forensic report is documented on DD Form 2911 (Forensic Medical Report: Sexual Assault Examination) provided at DOD Web site: <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2911.pdf>: This form guides the examination and methodical documentation of physical findings and collection of evidence putting together a picture of what happened in an objective and scientific way.

(3) The only medical issues documented in this report are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings.

(4) If the case is reported, the criminal justice system will use the medical forensic report, along with collected evidence, photographs and video images, and victim/witness statements as a basis for investigation and possible prosecution. When custody of forensic reports and collected evidence is transferred to law enforcement officials, DA Form 4137 (Evidence/Property Custody Document) will be used in accordance with AR 195-5.

(5) If examiners are required to testify in court, they will use the report to recall the incident.

(6) Forensic examination records will be maintained separately from the outpatient treatment record to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The examination site should have clear policies about personnel allowed access to these records according to the HIPAA requirements.

(7) It is vital that the examination documentation be thorough, precise, and accurate.

*b. Medical records.*

(1) The medical record is not part of the evidence collection kit, and it should not be submitted to the crime lab.

(2) SACPs, SACCs, and all healthcare providers will document the encounter as "sensitive" in AHLTA to protect and promote the welfare of the patient. Paper records will be treated as "sensitive" (that is, maintained in a locked file).

**12. The medical forensic history**

*a. Coordination of history taking and investigative interviewing.* The examiner obtains a detailed forensic and medical history by asking questions related to the assault. Such information is intended to guide the examination, evidence collection, and crime lab analysis of findings.

*b. Presence of advocates during the history.* Victim advocates will provide support and advocacy during the history, if desired by patients.

*c. Patient's needs.*

(1) Consider the patient's needs before gathering the history.

(2) The facility should have procedures in place and examiners should be educated to accommodate the patient's communication skill level and preferred mode of communicating.

(3) It is important that examiners are aware of and responsive to verbal and nonverbal cues from patients.

(4) Use a private and quiet setting for information gathering.

*d. Obtaining the history.*

(1) The following information should be routinely obtained from patients:

(a) Date and time of the sexual assault(s).

(b) Pertinent patient medical history.

(c) Recent consensual sexual activity.

(d) Post-assault activities of patients. (For example, have patients urinated, defecated, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, ate or drank, smoked, used drugs, or changed clothing?)

(e) Assault-related patient history (for example, memory loss; lapse of consciousness; vomiting; nongenital injury, pain, and/or bleeding; and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care). Note: Collecting toxicology samples is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.

(f) Suspect information (if known). Suspect information gathered during this history should be limited to that which will guide the examination and forensic evidence collection.

(g) Nature of the physical assault(s), information about the physical surroundings of the assault(s) (for example, indoors, outdoors, car, alley, room, rug, dirt, mud, or grass), and methods employed by suspects are crucial to the detection, collection, and analysis of physical evidence. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (for example, blood) or from suspects (for example, bruising, fingernail marks, or bite marks).

(h) Description of the sexual assault(s) including an accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include whether or not there was any—

1 Penetration of genitalia (for example, vulva, hymen, and/or vagina of female patient), however slight;

2 Penetration of the anal opening, however slight;

3 Oral contact with genitals (of patients by suspects or of suspects by patients);

4 Other contact with genitals (of patients by suspects or of suspects by patients);

5 Oral contact with the anus (of patients by suspects or of suspects by patients);

6 Nongenital act(s) (for example, licking, kissing, suction injury, and biting);

7 Other act(s) including use of objects;

8 Ejaculation and location(s) of ejaculation (for example, mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and

9 Use of contraception or lubricants.

(2) The above questions require specific and sometimes detailed answers. Some may be difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic examination. They should also explain why each question is being asked.

### **13. Photography**

a. Extent. Taking photographs of those parts of a patient's anatomy involved in the assault can supplement the medical forensic and physical findings in sexual assault cases.

b. Photographers and equipment. Photographers should be familiar with equipment operation and be educated on forensic photography in sexual assault cases. Jurisdictional and/or local policy will determine which types of equipment produce acceptable results.

c. Patient comfort and privacy.

(1) Minimize the patient's discomfort while they are being photographed and respect their need for modesty and privacy.

(2) Drape the patient appropriately while taking photographs. Take measures to avoid allegations of impropriety when photographing patients. For instance, when a male photographer is photographing a female patient, another woman should be present.

d. Explanation of photography procedures.

(1) Photographers will explain forensic photography procedures to patients. Taking photographs of patients in the aftermath of an assault can be re-traumatizing.

(2) To help reduce the chances of re-traumatization, help patients understand the purpose of photography in forensic evidence collection, the extent to which photographs will be taken and procedures that will be used, potential uses of photographs during

investigation and prosecution (especially anogenital images if taken), and the possible need to obtain additional photographs following the examination.

e. Taking photographs.

(1) Photographers will—

(a) Take initial and follow-up photographs as appropriate.

(b) Strive to control every element in the photograph to produce a clear, powerful statement. Photographs should be taken prior to evidence collection.

(c) Link patient's identity and the date to the photographs. For example, print the patient's name, date of examination, and the photographer's name/initials on a plain sheet of paper. Photograph this sheet at the beginning and end of the roll of film for identification. Also photograph the face of patients for identification purposes. Some cameras offer the option of imprinting the date and/or time on the negative, and some have the ability to enter a case number so the face or name of a patient is not on the film. Mechanisms should be in place (for example, at law enforcement agencies and examination facilities) to protect the patient's privacy and confidentiality while photos are being taken.

(d) Take clear and accurate photographs by using the shutter speed and lens aperture to control exposure (automated cameras and flash units can give incorrect exposures). Use adequate lighting whether the source is natural, flood, or flash. Use of flashes and lighting in the examination room can change the color of evidence; a filter may help adjust lighting so that the photograph is truer to color (noting in records any alternations to the environment to enhance photographs). Include a color bar in the photograph to ensure accurate color reproduction.

(e) Strive for undistorted photographs with good perspective (whenever possible, use a normal focal length lens, keep the camera level, and photograph the subject at eye level). Maintain sharp focus (keep the camera steady, focus carefully, use maximum depth of field, and look at the frame of the scene). A good quality macros lens with a ring strobe flash offers the best quality and most flexibility for forensic photography involving sexual assault.

(f) Use an inch scale or ruler for size reference in photographs. In addition to those photographs that identify patients and anatomical locations being photographed, take at least two photographs of each area—one with and one without scale. Taking two photographs in this manner demonstrates that the scale was not concealing critical evidence. Photograph evidence in place before moving it or collecting it. Do not alter or move evidence when photographing, and make every effort to minimize distraction in photographs while maintaining the focus of areas being photographed.

(g) Photograph bite marks.

(h) Take at least two shots at three orientations—

1 Take full-body images (anterior, posterior, and lateral) with the patient's face visible and clearly identifiable. Position patients approximately two feet from the corner of the room, using walls to reflect and diffuse flash illumination. When photographing the backs of patients, turn their faces toward the camera so that they can be recognized.

2 Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.

3 Take close-up images of particular injuries, using the scale. When photographing a wound, show its relationship to another part of the body. Take at least three photographs involving a wound area. Shield uninvolved breast or genital areas when possible; highly graphic photos may be inadmissible in court and make the case less credible. All injuries should be recorded with a close-up attachment. Try to capture subtleties in texture and color. Document pattern injuries caused by an object. Do not use an external light source around an injured eye as it can cause retinal damage.

(2) Close-up photographs of hands and fingernails may show traces of blood, skin, or hair. Be sure to look for damage to nails or missing nails. Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks. Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.

(3) All photographs should be clearly labeled and the chain-of-custody maintained. Follow jurisdictional policy for the development, transfer, and duplication of film and storage of photographs. Do not include photographs in the evidence collection kit sent to the crime lab.

(4) Follow-up photographs may be necessary. Additional photographs should be taken as new or different evidence on the patient's body is found following the examination (for example, bruising may appear days later). Create procedures for examiners, law enforcement investigators, and patients that ensure this evidence is documented. In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy that could be confused with acute injuries.

#### **14. Examination and evidence collection procedures**

**a. Forensic examination.**

**(1) Purpose of the forensic examination.**

**(a)** Patient healthcare needs and concerns discovered in the course of the examination should be addressed prior to discharge. However, patients must understand that the examination does not provide routine medical care. For example, a pap smear will not be done during the female pelvic examination.

**(b)** Every precaution should be taken by all first responders to reduce outside contamination and dilution of evidence. For example, examiners should wear nonlubricated gloves and change them throughout the examination/evidence collection whenever cross-contamination could occur.

**(c) Examiners should—**

**1** Collect as much evidence as possible.

**2** Be aware of evidence that may pertain to whether or not the patient consented to the sexual contact with the suspect.

**3** Modify the examination and evidence collection to address the patient's needs and concerns.

**4** Explain examination and evidence collection procedures to patients.

**(2) Procedures.**

**(a)** In addition to instructions included in the evidence collection kit, the examination should be guided by the scope of informed consent and the medical forensic history. In the course of the examination, examiners may question patients about trauma related to the assault. These questions should be specific enough to yield clinically relevant information. For example, simply asking patients if they are injured or hurt anywhere is not as specific as asking if they hurt in specific body locations.

**(b) During the general physical examination—**

**1** Obtain the patient's vital signs.

**2** Note the date and time of the examination; physical appearance; general demeanor, behavior, and orientation; and condition of clothing on arrival.

3 Record all physical findings (which include observable or palpable tissue injuries; physiologic changes; and foreign materials such as grass, sand, stains, dried or moist secretions, or positive fluorescence) on body diagram forms.

4 Use an alternate light source to assist in identifying findings.

(c) During the female genital examination, evaluate—

1 The external genitalia and perineal area for injury, foreign materials, and other findings in the following areas: abdomen, thighs, perineum, labia majora, labia minora, clitoral hood and surrounding area, perurethral tissue/urethral meatus, hymen, fossa navicularis, and posterior fourchette. The use of a colposcope during the external genital examination enhances viewing microscopic trauma and may provide photographic documentation.

2 The vagina and cervix for injury, foreign materials, and foreign bodies. Use a colposcope or other magnifying device, if available. In some jurisdictions, toluidine blue dye may be used to detect trauma, either with or without the use of a colposcope.

3 The buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings. If rectal injury is suspected, an anoscope can be used as a tool to identify and evaluate trauma (it may also be used to help obtain anal swabs and trace evidence).

(d) For male patients, examine the external and perineal area for injury, foreign materials, and other findings, including the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Document whether or not the patient is circumcised.

(e) Record findings from the general physical and anogenital examinations on appropriate body diagram forms. Detailed descriptions of findings should be provided as required. During the examination, collect evidence as specified in the evidence collection kit.

b. Collection of biological evidence.

(1) Collect clothing evidence. Paragraphs (a) through (g) below provide procedures for collecting clothing, underwear, and foreign material dislodged while undressing.

(a) Place a clean hospital sheet on the floor as a barrier. Then place the collection paper on the barrier sheet. Be careful to prevent evidence transfer. Document all findings. Ask patients to disrobe (assisting them as requested and then draping them appropriately). When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged. If someone assists, he/she should wear gloves. If patients are concerned about privacy while disrobing,

advocates and/or support personnel can turn around, hold up a sheet to shield patients, or leave the room.

(b) Collect clothing pertinent to the assault. First, determine if patients are wearing the same clothes they wore during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence, those items should be collected. If it is determined that patients are not wearing the same clothing, examiners should inquire as to the location of the original clothing. If the original clothing is not at the examination site, information on clothing location should be provided to law enforcement personnel (if involved) so that clothing can be retrieved before any potential evidence is destroyed. In addition to collecting underwear worn at the time of or immediately after the assault, collect underwear patients are wearing at the time of the examination (if relevant to the case).

(c) Be sensitive about how much clothing to take as evidence. For example, take the patient's coat or shoes only if it is determined that there may be evidence on them. Examination site personnel can coordinate with advocacy programs to ensure that replacement clothing is available for patients in a range of sizes. This clothing is critical in some instances (for example, a patient may own only the clothing that is being collected).

(d) If female patients are menstruating, collect tampons and sanitary napkins. Air-dry them as much as possible and then place them in a separate paper collection bag.

(e) Follow jurisdictional policy for handling and transporting wet evidence that cannot be dried thoroughly at the examination site (for example, wet clothing, tampons, and sanitary napkins).

(f) Ensure wet evidence is packaged in leak-proof containers and separated from other evidence when being transported. It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for immediate analysis or further drying. After drying items according to jurisdictional policy, place each piece of clothing and collection paper in a separate paper bag. Label, seal, and initial seal. If additional bags are needed, use new grocery-style paper bags only. The barrier sheet is not submitted as evidence.

(g) Package evidence in bags. Label, seal, and initial the seal.

(2) Collect debris.

(a) Collect obvious debris on the patient's body (for example, dirt, leaves, fibers, and hair) on a collection sheet. Package, label, seal, and initial seal.

(b) For fingernail evidence, ask patients whether or not they scratched the suspect's face, body, or clothing. If so, or if fibers of other materials are observed under the patient's fingernails, collect fingernail clippings, scrapings, and/or swabbings. If fingernail scrapings are collected, package fingernail scrapings and tools used to obtain the sample. Label, seal, and initial seal. Cut broken fingernails at the remaining jagged edge for later comparison. Collect a fake nail as a known sample if one is missing. Package, label, seal, and initial the seals.

(c) If requested, assist patients in putting on examination gowns after clothing and debris are collected.

(d) Collect foreign materials and swabs from the surface of the body.

1 Carefully inspect the body—including head, hair, and scalp—for dried or moist secretions and stains (for example, blood, seminal fluid, sweat, and saliva) and other foreign material.

2 Use an alternate light source to assist in identifying evidence. Obtain swabs from any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with longwave ultraviolet light, and any area for which patients relate a history or suspicion of bodily fluid transfer (for example, licking, kissing, biting, splashed semen, or suction injury).

3 Also collect swabs from potentially high-yield areas (for example, neck, breasts, or external genitalia) if the history is absent or incomplete.

4 Flake off dried secretions and/or swab-dried secretions with a swab moistened with one drop of water. Swab moist secretions with a dry swab. Separate swabs should be used for every sample area collected. Follow local policies regarding the number of swabs required to collect each specimen.

5 Swab bite marks.

6 Optional: Smear swabs onto microscope slides, according to local policy.

7 Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.

8 According to local policy, air-dry all specimens and package swabs and slides separately. Label, seal, and initial seals. Note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.

9 If teeth are flossed prior to oral swab collection, package the used floss. Label, seal, and initial the seal.

(3) Collect hair combings.

(a) The purpose of this procedure is to collect hair shed of suspects that may have been transferred to the patient's hair. Hair combings may also reveal other foreign materials. Some jurisdictions collect head hair combings only if indicated. Whether or not head hair combings are collected, it is important to examine head, facial, and pubic hair for secretions, foreign materials, and/or debris and collect as appropriate. Pubic hair combings are typically collected if the assault involved the genital area of patients.

1 Head and hair combings. Use the comb and collection paper provided for this procedure. Place the unfolded paper under patient's head. Comb head hair towards paper (patients may comb). Fold comb with debris/hair into paper and package paper. Label, seal, and initial the seal.

2 Pubic hair combings. Use the comb and collection paper provided for this procedure. Place the unfolded paper under the patient's buttocks and comb hair toward paper (patients may comb). Fold comb with debris/hair into paper and package paper. Label, seal, and initial the seal.

(b) Collect hair reference samples as needed. Follow local policy for collection of hair reference samples. Many jurisdictions do not collect pubic hair reference samples routinely. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients. Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial examination, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as it is if collected at the time of the initial examination due to the fact that hair characteristics can change over time.

(c) When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. Give patients the option of collecting samples themselves.

(4) Collect oral and anogenital swabs and smears.

(a) With the patient's consent, the medical forensic history and examination findings should guide collection of oral and anogenital specimens. In general, specimens should be collected only from orifices and areas surrounding the orifices that patients report as being involved in the assault. Some patients may be vague about the type(s) of sexual contact that occurred. Examiners can help clarify which orifices were involved by

asking appropriate questions. If there is uncertainty about involved orifices (for example, because patients have little memory of the assault, were unconscious or incoherent, or do not understand what occurred), collection from oral, vaginal, and anal orifices (with the patient's permission) may be appropriate. In some jurisdictions, policy requires collection from all three orifices. In all cases, the patient's consent is needed to collect these samples.

(b) When collecting these swabs and smears—

1 Caution patients who use the bathroom prior to the examination that evidence may be present in pubic, genital, and anal areas and urge them not to wash or wipe away secretions until after evidence collection.

2 When taking a swab, examiners should take care to not contaminate the collection with secretions or materials from other areas, such as vaginal to rectal or penile to rectal.

3 Follow jurisdictional policy for collecting swabs (and the number of swabs used to collect a sample), smearing swabs on slides, and drying and packaging swabs and slides. Also, follow local policy for timeframes in which samples should be collected (for example, in one jurisdiction, oral and penile samples are only collected within 24 hours of the assault) unless otherwise indicated.

4 Do not stain or chemically fix swabs or smears.

5 When preparing slides, note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.

6 Document any foreign substance or material introduced by healthcare providers (for example, lubricating jelly on a speculum or betadine prior to introduction of a catheter).

(c) Oral sample.

1 Place swabs together to collect specimen from oral cavity between gums and cheeks and under tongue. Remove dentures and swab with same swabs.

2 Optional: Smear swabs onto two microscopic slides.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label, seal, and initial the seal.

(d) External genital sample.

1 Swab external genital dry-skin areas with swabs (blind swabbing by protocol or history), at least one dry and one moistened with a drop of sterile, distilled, or deionized water, according to jurisdictional policy.

2 Optional: Smear swabs on two microscope slides.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label, seal, and initial the seal.

(e) Vaginal/cervical sample.

1 Use swabs together to collect a sample from vaginal pool. It is prudent to collect swabs from both the vagina and cervix, regardless of the time between assault and examination.

2 Optional: Smear swabs onto microscope slides.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label (specifically indicating sampling site), seal, and initial the seal.

(5) Wet-mount examinations.

(a) Some jurisdictions require examiners to conduct wet-mount examinations of vaginal/cervical secretions for motile and nonmotile sperm when a male suspect may have ejaculated in a patient's vagina.

(b) Because sperm motility decreases quickly with time and removal from the vagina/cervix, wet-mount evaluation during the examination can provide the only opportunity to see sperm motility.

(c) The presence of motile sperm may help define the timeframe in which the crime occurred. In other jurisdictions, however, the crime lab is responsible for all analysis of evidence and examiners do not conduct the wet-mount evaluation for sperm.

(d) Follow jurisdictional policy on whether wet-mount evaluation for sperm is needed and methods of evaluation. If it is required, examiners should be educated on using the microscope, identifying sperm, and reporting their findings.

1 Prepare a wet-mount slide according to jurisdictional policy. Smear one swab collected from the vaginal pool on a slide. Typically, the slide is prepared by placing one drop of normal saline onto the slide. Roll the swab into the drop and place a cover slip on the slide.

2 View for presence of sperm under a microscope at 400x or by using a phase contrast or other optically staining microscope (within 10 minutes of preparing slide).

3 Air-dry this swab and slide (not removing the cover slip).

4 Package swab and slide and place in envelope. Label as "wet mount" (specifically indicating sampling site), seal, and initial the seal. Immediately following collection of vaginal/cervical samples and any necessary wet-mount evaluation, the pelvic examination should be performed and any necessary medical cultures taken.

(e) Penile sample.

1 Slightly moisten swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. Swab all outer areas of the penis and scrotum where contact is suspected.

2 Gently roll the swabs over one of the microscope slides, according to jurisdictional policy.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label, seal, and initial the seals.

5 Immediately following this procedure, any necessary medical cultures should be taken.

(f) Perineal area sample.

1 If there was vaginal/anal contact, there may be leakage of semen in the perineal area. Use an alternate light source on the anal area and flake off or swab areas of dried secretions.

2 Optional: Smear swabs on microscopic slides, according to jurisdictional policy.

3 Flaked dried secretions should be placed into the provided container. Air-dry swabs and slides and package them separately and place in envelope. Label, seal, and initial the seal.

4 Avoid contaminating anal/rectal samples by cleansing the perianal area after external secretions and foreign materials have been collected.

(g) Anal/rectal sample.

1 Collect swab from the anal cavity. Avoid contact with external skin surfaces.

2 Optional: Smear swabs on microscopic slides, according to jurisdictional policy.

3 Air-dry swabs and slides.

4 Package swabs and slides and place in envelope. Label, seal, and initial the seal.

5 At this time, any additional examinations or tests involving the anus should be conducted.

(6) Buccal swabs, saliva, and blood for deoxyribonucleic acid (DNA) analysis and comparison.

(a) DNA reference samples. Many samples collected during the examination contain a mixture of secretions. To interpret genetic typing results obtained from these swabs, it is essential to know the genetic profile of patients. The patient's DNA reference samples are used for this purpose. Follow jurisdictional policy regarding the type of samples accepted by the crime lab. Collection of a buccal swab or saliva sample is encouraged unless it is medically or forensically necessary to take blood. If a blood sample is collected, the most noninvasive method of collection should be used.

(b) Buccal swabs.

1 On a case-by-case basis, decide whether it is appropriate to collect a buccal (inner cheek) swab reference sample for DNA typing rather than a blood sample. For example, a blood sample may not be needed or patients might not allow blood to be drawn. A saliva sample is an alternative to the buccal swab. (Note that buccal swabs and saliva samples are not suitable for blood typing and serology.) If oral copulation is asserted or suspected, a buccal swab or saliva sample for the patient's DNA reference may be contaminated. In those cases, blood is usually the better reference sample.

2 To collect, have patients rinse their mouths with tap water and then expose the inner cheek area. Swab this area with gentle pressure. Air-dry the swab, package, and place in envelope. Label, seal, and initial the seal.

(c) Saliva sample.

1 Have patients saturate with saliva the inner circle of a folded piece of absorbent paper (for example, filter paper).

2 Allow the paper to air-dry according to jurisdictional policy.

3 Without touching the inner circle, package the paper and place in envelope. Label, seal, and initial the seal. (Patients should not eat, drink, or smoke for at least 15 minutes prior to the saliva sample collection.)

(d) Dry blood.

1 If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection.

2 Using a betadine swab, wipe the tip of the left or right ring finger.

3 Using a sterile lancet, prick the finger.

4 While holding the finger over one of four circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat the procedure for the remaining circles as required by jurisdictional policy (it may not be necessary to fill all four circles).

5 Allow blood to air-dry according to jurisdictional policy. Write the patient's name on the first line. Package according to jurisdictional policy and place in envelope. Label, seal, and initial the seal.

(e) Drawn blood.

1 In order to minimize the patient's discomfort, collect drawn blood needed for the reference sample at the same time blood is collected for medical or toxicological purposes.

2 Blood for the reference sample may be collected in lavender-top and/or yellow-top blood drawing tubes. These colored tubes contain preservatives suitable for forensic blood typing. The color to use is typically specified by the designated crime lab. If tubes are included in the evidence collection kit, check expiration dates and replace if expired. Mix according to jurisdictional policy.

3 Write the patient's name, date and time of collection, and the collector's initial on the tube. Package according to jurisdictional policy and place in envelope. Label, seal, and initial the seal.

(f) Collect other evidence. Other evidence may be collected beyond that required for the sexual assault evidence collection kit.

c. Toxicology samples.

(1) Make the decision about whether to collect toxicology samples for forensic purposes, what to collect, and collection methods according to jurisdictional policy.

(2) Do not put toxicology samples in the sexual assault evidence collection kit, unless otherwise indicated. Identify which forensic labs the jurisdiction has selected to analyze these samples, choose a lab, and follow transfer policies.

(3) Keep medical specimens separate from forensic specimens obtained during the examination. Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with the patient's consent).

(4) It is not necessary to maintain the chain-of-custody on medical specimens; instead, follow examination facility policy for documenting medical care and storing medical records.

## **15. Drug-facilitated sexual assault**

### **a. Training and development of policies.**

(1) MTF providers must recognize that sexual assault assailants may use numerous drugs (including alcohol) to facilitate sexual assault, and providers must also understand the urgency of collecting toxicology samples, if medically necessary, or if a drug-facilitated sexual assault is suspected.

(2) MTF providers should also be aware that collection of toxicology samples is typically separate from the sexual assault forensic evidence collection kit, and procedures for toxicology analysis may be different from that of other evidence analysis.

(3) Ideally, the first available urine sample should be collected in suspected drug-facilitated sexual assault cases.

(4) Law enforcement agencies and emergency medical services should develop procedures and staff training for collection in cases where patients must urinate before arriving at the examination site. Advocates and other professionals who may have contact with patients prior to their arrival at the examination site should also be educated to provide those who suspect that drugs were used to facilitate the assault with information on how to collect a sample if they cannot wait to urinate until they get to the examination site.

### **b. Response to voluntary use of drugs and/or alcohol.**

(1) It may be revealed during the examination process or through toxicological analysis that patients voluntarily used drugs and/or alcohol just prior to the assault.

(2) Voluntary drug and/or alcohol use by patients during this period should not diminish the perceived seriousness of the assault. Law enforcement officers and prosecutors should guard against disqualifying cases in which patients voluntarily used illegal drugs or illegally used alcohol.

(3) Patients should understand that information related to voluntary alcohol or drug use may be used against them in court, but also that in some instances it might be helpful in prosecuting a case (see para d below on explanation of procedures). Also, before pursuing charges related to illegal drug or alcohol use by patients, prosecutors should give careful consideration to the impact that the threat of such charges may have on the patient's willingness to report the sexual assault and be involved in subsequent criminal justice proceedings.

(4) Some patients may self-medicate to cope with post-assault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this period may affect the quality of evidence and impede the patient's ability to make informed decisions about treatment and evidence collection. Such voluntary use of drugs and alcohol between the assault and the examination must be documented.

c. Circumstances in which testing may be indicated.

(1) Routine toxicology testing is not recommended. However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:

(a) If a patient's medical condition appears to warrant toxicology screening for optimal care (for example, the patient presents with drowsiness, fatigue, light-headedness, dizziness, decreased blood pressure, memory loss, impaired motor skills, or severe intoxication);

(b) If a patient or accompanying persons (for example, family member, friend, or law enforcement representative) states the patient was or may have been drugged; and/or

(c) If a patient suspects drug involvement due to a lack of recollection of event(s).

(2) Patients should be questioned about involuntary drug/alcohol use only if determined to be medically necessary or if there is a suspicion the assault was drug-facilitated.

d. Explanation of testing procedures.

(1) Seek informed consent from patients to collect toxicology samples. Patients should understand the following before agreeing to toxicology testing:

(a) The purposes of toxicology testing and the scope of confidentiality of results;

(b) The ability to detect and identify drugs and alcohol in the blood and urine can only occur during a limited time period following ingestion;

(c) There is no guarantee that testing will reveal that drugs were used to facilitate the assault;

(d) Testing may or may not be limited to drugs commonly used to facilitate sexual assault and may reveal other drugs or alcohol that patients may have ingested voluntarily;

(e) Whether or not any follow-up treatment is necessary if testing reveals the presence of drugs used to facilitate sexual assault;

(f) Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired the patient's consent and prevented legal consent);

(g) Whether or not there is a local prosecution practice of charging sexual assault victims for illegal voluntary drug and/or alcohol use revealed through toxicology screening;

(h) Failure or refusal to undergo testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution;

(i) When and how to obtain information on the results from toxicology testing;

(j) Who will pay for toxicology testing; and

(k) Whether or not patients have the opportunity to revoke their consent to toxicology testing.

(2) Care should be taken when providing the above information to patients. In particular, they may need to hear repeatedly from examiners that voluntary use of drugs and/or alcohol, if any, does not reduce the seriousness of the assault. Under no circumstances should the medical forensic examination and treatment be conditional based on whether or not the patient consents to toxicology testing.

e. Collecting samples.

(1) Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.

(2) The length of time that drugs used for drug-facilitated assault remain in urine or blood depends on a number of variables (for example, the type and amount of drug

ingested, the patient's body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated).

(3) Collect a urine sample.

(a) Urine allows a longer window for detection of drugs commonly used in these cases than does blood. The sooner a urine specimen is obtained after the assault, the greater the chances of detecting drugs that are quickly eliminated from the body.

(b) Immediately collect a urine sample when appropriate. If patients may have ingested a drug used for facilitating sexual assault within 96 hours prior to the examination, a urine specimen of at least 30 milliliters but preferably 100 milliliters (about 3 ounces) should be collected in a clean plastic or glass container (follow jurisdictional policy).

(c) The urine sample does not have to be a clean catch (for example, blood in the urine will not compromise test results). If patients cannot wait to urinate until their arrival at the examination facility, first responders should ask them to provide a sample and bring it to the facility, documenting the chain-of-custody. It is suggested that law enforcement officers and emergency medical technicians keep toxicology screening kits readily available, according to local agency policy.

(d) Ideally, patients should not urinate until after evidence is collected. However, the number of times that patients urinated prior to collection of the sample should be documented.

(4) Collect a blood sample when appropriate.

(a) If ingestion of drugs used to facilitate sexual assault may have occurred within 24 hours prior to the examination, a blood sample of at least 20 milliliters should be collected in a gray-top tube (contains preservatives sodium fluoride and potassium oxalate) according to jurisdictional policy.

(b) A blood sample taken within this time period may pinpoint the time when drugs were ingested. If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample.

(c) If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion, according to jurisdictional policy. (If blood has already been taken due to suspected drug ingestion, that sample can be used to determine blood-alcohol level. An additional sample usually is not needed.)

(5) Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation. Collect and preserve according to jurisdictional policy.

(6) Package all samples as appropriate, but pay particular attention to toxicology samples and package according to the policy of the lab doing the analysis and place in envelope. Label, seal, and initial the seal.

*f.* Toxicology labs.

(1) Examination facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small quantities). Information about these labs (for example, contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives, examination facilities, and examiner programs investigating these cases.

(2) If toxicology tests are needed purely for the medical evaluation of patients, the examination facility lab typically performs these tests. Lab results are recorded in the patient's medical record, according to facility policy. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the examination facility lab and another for analysis by the identified forensic lab. Take samples at the same time to minimize patient discomfort.

*g.* Preservation of evidence and chain-of-custody.

(1) Involved healthcare personnel should be aware of the toxicology lab's requirements on collection, packaging, labeling, storage, handling, transportation, and delivery of specimens.

(2) Policies should be in place for storage of these samples when patients are undecided about reporting. As with any forensic evidence, the chain-of-custody must be maintained.

**16. Sexually transmitted infections: evaluation and care**

*a.* Information on sexually transmitted infections (STIs).

(1) Offer patients information to include the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until treatment is completed), follow-up care, and referrals as needed.

(2) Patients should be aware of the scope of confidentiality related to STI information in their medical records. The level of detail needed when providing this information verbally varies (for example, some patients may be aware of risks and want treatment, while others may not be as knowledgeable of risks or their options).

*b.* STI testing.

(1) The medical forensic examination presents an opportunity to identify preexisting STIs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment. Testing for STIs at the time of the examination also gives examiners and patients the option of deferring treatment until it is needed.

(2) Trichomoniasis, bacterial vaginosis, gonorrhea, and chlamydial infections are the most frequently diagnosed infections among sexually assaulted women.

(3) Seek the informed consent of patients for testing, if indicated, following Centers for Disease Control and Prevention (CDC) guidelines.

(4) The identification of STIs after an assault is usually more important for psychological and medical management than for forensic purposes.

*c.* STI prophylaxis.

(1) Encourage patients to accept STI prophylaxis, if indicated.

(2) Routine preventive therapy after a sexual assault is often recommended because follow up with these patients can be difficult. It also may reduce the need for more expensive/extensive treatment if an STI is discovered at a later time.

(3) Meet or exceed current CDC guidelines for STI preventive therapy.

(4) If prophylaxis is declined at the time of the initial examination, it is medically prudent to obtain cultures and arrange for a follow-up examination and testing (it is recommended that all patients are reexamined (see para d below on follow-up activities)).

(5) Document, in their medical record on either SF 600 (Chronological Record of Medical Care) (outpatient) or SF 509 (Medical Record Progress Notes) (inpatient) or the electronic equivalent(s), the patient's decision and rationale for declining prophylaxis.

(6) For nonsexually active patients, taking a prophylaxis may prevent development of STIs that could be used as evidence if the suspect had an STI. In all cases, the patient's medical needs take priority over collection of forensic evidence. However, patients should understand the consequence of taking the STI prophylaxis and be able to make their own decisions about treatment.

(7) If the patient's clinical presentation suggests a preexisting ascending STI, such as fever, abdominal or pelvic pain, and/or vaginal discharge, they should be evaluated

and treated for the ascending infection. This treatment may differ from suggested STI prophylaxis.

(8) Hepatitis B virus (HBV) and postexposure prophylaxis.

(a) See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunizations, prevaccination antibody screening, postexposure prophylaxis, and special considerations.

(b) Patients who have completed a full hepatitis B vaccination regimen prior to the assault are protected from HBV infection and do not need further doses. For those who were not fully vaccinated prior to the assault, the vaccine should be completed as scheduled.

(c) Patients unvaccinated prior to the assault or unsure of whether they have been vaccinated should receive active post-exposure prophylaxis (for example, hepatitis B vaccine alone) upon the initial clinical evaluation. Follow-up doses should be given 1 to 2 and 4 to 6 months after the first dose. Unless suspects are known to have acute hepatitis B, hepatitis B immune globulin (HBIG) is not required. (When HBIG is needed, use CDC recommended doses.)

(d) Examiners must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Advocates should also be educated about the possibility of patients receiving HBV prophylaxis and encourage those who start the vaccine regimen to follow up for required additional doses.

(e) Obtain informed consent from patients for treatment. Patients should be aware of the benefits and toxicity associated with recommended regimens.

d. Follow-up care.

(1) Encourage follow-up STI examinations, testing, immunizations, counseling, and treatment as directed. Although patients may be reluctant to go for STI follow-up examinations, such examinations are essential because they provide an opportunity to detect new infections acquired during or after the assault; complete hepatitis B immunization, if indicated; and complete counseling and treatment for other STIs. STI examinations for all patients should be repeated according to examination facility policy. The CDC recommends a follow-up appointment within 1 to 2 weeks of the assault. If patients tested negative at the time of the medical forensic examination and chose not to receive prophylaxis, follow-up testing should be conducted. The CDC recommends that in this case the follow-up examination be done within a week to ensure that positive test results are discussed promptly with patients and treatment is offered. The CDC recommends follow-up testing for patients who received treatment only if they report having symptoms consistent with an STI. (However, patients who were treated should

be informed of the option of follow-up testing to confirm the presence or lack of infection.) The CDC recommends that testing for syphilis and human immunodeficiency virus (HIV) infection be repeated 6, 12, and 24 weeks after the assault if initial test results were negative and if these infections are likely to be present in assailants.

(2) It is important that follow-up communication with patients (particularly by examiners and advocates) include a reminder to go to follow-up examinations and receive STI-related testing, immunizations, and treatment as directed. Advocates and healthcare personnel may be able to assist patients in making follow-up appointments, obtaining transportation to and from appointments, and determining how to pay for expenses involved with follow-up testing and care. Some jurisdictions may cover follow-up treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more likely to seek follow-up treatment. Advocates may also be able to accompany patients to these follow-up appointments.

e. Concerns about HIV infection.

(1) Although the risk of HIV infection from a sexual assault appears to be low, it is typically of grave concern for sexual assault patients.

(2) Provide information and referrals. Examiners should talk with patients about their concerns regarding the possibility of contracting HIV. As with other STIs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence from sexual intercourse until any treatment received is completed. Include local referrals for testing/counseling and comprehensive HIV services in the community and region. This information can help patients make decisions about testing and treatment based on facts rather than fear.

(3) Discuss testing options. Baseline HIV testing is not typically an examination component. However, if the assault is considered at high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by healthcare personnel. Even if the assault is not considered at high risk for HIV exposure, some patients may still wish to be tested.

(4) HIV testing should occur in settings where counseling can be offered to explain results and implications. When providing testing referrals, let patients know whether testing services are free, anonymous, and/or confidential. Confidential and anonymous testing is recommended.

(5) Assess the need to offer HIV post-exposure prophylaxis. In certain circumstances, the likelihood of HIV transmission may be reduced by post-exposure therapy for HIV with antiretroviral agents. Post-exposure therapy with zidovudine has been associated with a reduced risk for HIV infection and has become the standard of care for health workers who have percutaneous (for example, needle stick) exposure to

HIV, but whether these findings can be extrapolated to other exposure situations, including sexual assault, is unknown.

(6) The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with its possible adverse side effects. Healthcare personnel must evaluate the patient's risk of HIV exposure and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of postexposure therapeutic agents should consult with an HIV treatment specialist. Numerous factors may influence the decision to offer treatment, such as the time since the exposure occurred, the probability that the assailant is infected with HIV, the likelihood that transmission could occur from the assault, and the prevalence of HIV in the geographic area or institutional setting (for example, a prison) where the assault occurred.

(7) Offer post-exposure HIV prophylaxis to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. If offered, the following information should be discussed with patients:

(a) The unknown efficacy of postexposure prophylaxis for HIV in cases of sexual assault;

(b) The known side effects and toxicity of antiretroviral medications;

(c) The need for frequent dosing of medication and the follow-up care necessary;

(d) The importance of compliance with the recommended therapy;

(e) The necessity for immediate initiation of treatment for maximum effectiveness; and

(f) The estimated costs of the medication and monitoring.

(8) When given following a sexual assault, post-exposure prophylaxis is the same as for occupational exposure to HIV. Refer to CDC recommendations for post-exposure antiretroviral therapy and consult with an HIV specialist where possible. Careful monitoring and follow up by a healthcare provider or agency experienced in HIV issues is required. Patients should be alerted to symptoms of primary HIV infection (for example, fever, fatigue, sore throat, lymphadenopathy, and rash) and seek care if these symptoms arise.

(9) Seek informed consent from patients to administer treatment. The decision to begin or withhold treatment should be made by patients and healthcare personnel after patients have been adequately informed of the risks and benefits of treatment options.

## 17. Pregnancy

a. Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Examiners and other involved healthcare personnel must be careful not to influence the patient's choices of treatment.

b. Discuss the probability of pregnancy with female patients. The risk of pregnancy from sexual assault is estimated to be two to five percent. However, pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim; victims' fears, therefore, should be taken seriously. Discussion with patients should include treatment options and reproductive health services.

c. Plan B (Levonorgestrel) is the approved U.S. Food and Drug Administration emergency contraceptive drug for the prevention of pregnancy after a contraceptive failure, unprotected sex, or sexual assault. It is available as both a prescription and over the counter (OTC) product and can be considered for use following a sexual assault. Follow local policy governing the distribution, documentation, and patient accessibility to Plan B with the following age restrictions:

(1) Women who are 18 years of age and older can obtain the drug without a prescription from a pharmacy as an OTC drug product.

(2) Women who are 17 years of age and under will require a prescription.

d. Conduct a pregnancy test for all patients with reproductive capability (with their consent). An exception is if a patient clearly is pregnant. If a patient is pregnant, the pregnancy may affect which medications can be administered or prescribed in the course of or after the examination.

**18. Discharge and follow up.** This paragraph discusses discharge and follow up of sexual assault victims following the initial presentation at the MTF.

a. Medical discharge and follow-up care. Healthcare personnel have important tasks to accomplish prior to discharging patients, as do advocates and law enforcement representatives (if involved). Medical personnel should coordinate their activities with all vested parties (for example, CID) to minimize repetitive actions and to avoid overwhelming the patient.

(1) Forensic examiner. The forensic examiner (preferably an SACP) will address the following issues with patients prior to discharge:

(a) Ensure that the patient's medical and mental health needs related to the assault have been addressed.

(b) Provide the patient with oral and written medical discharge instructions. Include a summary of the examination (for example, evidence collected, tests conducted, medication prescribed or provided, information provided, and treatment received), medication doses to be taken, follow-up appointments needed or scheduled, and referrals.

(c) Provide the patient with the name and contact information, as well as date and time of a follow-up appointment with the SACP and SACC. Follow-up appointments must be made within two duty days of discharge. The patient's immediate follow-up care and planning will be provided by the designated SACP.

(2) Offer patients clear and concise information, both orally and in writing. Information should be tailored to the patient's communication skill level/modality and language.

b. Coordination among responders.

(1) The SACP.

(a) At the initial visit, the SACP will develop an individualized plan of care for the victim. The SACP will work in collaboration with the SACC and patient to schedule necessary appointments as indicated by the individualized plan of care. The SACP will ensure that the patient understands his/her right to confidentiality and nondisclosure and that he/she does not have to disclose the assault to additional providers in order to receive follow-up medical care.

(b) For those with evidence of acute trauma, a short-term follow-up appointment will be scheduled to reexamine and document the development of visible findings and photograph areas of injury. An examination will be scheduled 2 to 4 weeks later to document resolution of findings or healing of injuries.

(c) Repeat examinations for STIs according to established documented guidelines and protocols.

(d) SACPs or other nonacute care providers can provide longer-term care as needed (for example, for HIV testing, STI testing, and administering doses of hepatitis B vaccine).

(e) The SACP will work in collaboration with the Installation Victim Advocacy Program.

(f) The SACP will assist in explaining support services as discussed in paragraph (2) (e) below.

(2) The SACC.

(a) The SACC will monitor the provision of care for victims of sexual assault until the completion of care related to the sexual assault and will follow the established case management criteria. Upon completion of all sexual assault related care, the SACP will document in the outpatient treatment record the resolution and/or the need for the continuation of care related to the sexual assault.

(b) Personnel following up with patients should be familiar with the case, confidentiality issues, and potential medical needs. Explain follow-up contact procedures of all responders involved. Coordinate follow-up contact of involved agencies as much as possible, keeping the number of responders contacting patients to a minimum. Explain if contact procedures are different for non-English-speaking patients.

(c) After the examination is finished, address the patient's physical comfort needs. Jurisdictional and examination site policies should be in place to facilitate this process. Assist patients in developing a post-examination plan that addresses their physical safety and emotional well-being.

(d) Planning must take into account the needs and concerns of specific populations. For example, if patients with physical disabilities require shelter, the shelter must be accessible and staff able to meet their needs for personal assistance with activities of daily living. If patients living in institutional settings have been assaulted by another resident, a staff person, or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that patients have to come into contact with the assailant again. It should also ensure them access to services designed to promote their recovery.

(e) Review and explain available supportive services. The SACP and SACC will explain to the patient the role of the Victim Advocacy Program in his/her health care. The SACC can describe and offer patients, their family members, and friends these services, as well as explain options for counseling in the community and offer referrals. The SACP and SACC will explain/reinforce the patient's role and responsibilities in the continued care and management of his/her health care related to the sexual assault. Before being discharged, the SACC should ask patients if they can follow up with them. If they agree, they can determine optimal methods and times for the contacts. During follow-up contacts, the SACP and SACC can help patients reassess their safety, offer support and crisis counseling, answer their questions and provide additional referrals and information, and help coordinate other advocacy services and counseling based upon identified needs.

(f) The SACC will work in collaboration with the SACP and patient to schedule necessary appointments as indicated by the individualized plan of care.

(g) The SACC will work in collaboration with the Installation Victim Advocacy Program to assist patients in considering things such as—

1 Where are they going after being discharged? With whom? Will these individuals provide them with adequate support? Is there anyone else they would like to contact? (Provide information about available community resources for obtaining support and help in making the contact, if needed.)

2 Will their living arrangements expose them to the threat of continued violence or harassment? Is there a need for emergency shelter or alternative housing options? (Provide options and help obtain, if needed.)

3 Are they eligible for protective orders? (Provide information and help obtain, if desired.)

4 Is there a need for enhanced security measures? (Discuss options and help obtain, if desired.)

5 If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan.)

(h) Closing a case (that is, making it inactive) involves disengaging the patient from services. Reasons for closing a case may include one or more of the following:

1 Ability to function independently.

2 Achievement of treatment goals.

3 Exhaustion or termination of benefits.

4 Inability to contact patient.

5 Patient refusal of services.

6 Patient relocation or transfer to another region/MTF.

7 Routine care or services no longer needed.

8 Transfer of care to another case manager/facility.

(i) Ensure all outstanding items in the patient case file are closed out, to include notification of the SACP and any specialty providers, as applicable. The summary note should include the reason for case closure; a final functional assessment; and information of services, resources, or interventions provided. A copy of the summary note should be placed in the main outpatient record.

**APPENDIX A**  
**References**

**Section I**  
**Required Publications**

There are no entries in this section.

**Section II**  
**Related Publications**

**AR 25-50**  
Preparing and Managing Correspondence

**AR 40-66**  
Medical Record Administration and Healthcare Documentation.

**AR 195-5**  
Evidence Procedures

**AR 600-20**  
Army Command Policy

**AR 608-18**  
The Army Family Advocacy Program

**DOD Regulation 6025-18-R**  
DOD Health Information Privacy Regulation

**DOD Directive 6495.01**  
Sexual Assault Prevention and Response (SAPR) Program

**DODI 4000.19**  
Interservice and Intragovernmental Support

**DODI 6495.02**  
Sexual Assault Prevention and Response Program Procedures

**MEDCOM Suppl 1 to AR 190-45**  
Serious Incident Report

**TB MED 293**  
Procedures for Medicolegal Examinations in Alleged Sex Crimes.

\*MEDCOM Reg 40-36

**The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook.**

**U.S. Department of Justice, Office on Violence Against Women, A National Protocol for Sexual Assault Medical Forensic Examinations.**

**U.S. Department of Justice, Office on Violence Against Women, National Training Standards for Sexual Assault Medical Forensic Examiners.**

**Section III  
Prescribed Forms**

There are no forms prescribed by this regulation.

**Section IV  
Referenced Forms**

**DA Form 4137**  
Evidence/Property Custody Document

**DD Form 448**  
Military Interdepartmental Purchase Request

**DD Form 1144**  
Support Agreement

**DD FORM 2910**  
Victim Reporting Preference Statement

**DD FORM 2911**  
Forensic Medical Report: Sexual Assault Examination

**SF 509**  
Medical Record Progress Notes

**SF 600**  
Chronological Record of Medical Care

**APPENDIX B  
MOU/MOA Template**

**MEMORANDUM OF UNDERSTANDING (or AGREEMENT)<sup>1,2,3</sup>  
BETWEEN  
(INSERT NAME OF THE OFFICE OF THE SURGEON GENERAL (OTSG)/MEDCOM  
ORGANIZATION)  
AND  
(INSERT NAME OF OTHER PARTY)**

**SUBJECT:** Quickly identifies to readers what the agreement covers.

**1. REFERENCES.** Include references directly relating to the agreement and authorities or statutes governing it. Per AR 25-50, order references as they appear in the agreement; when not mentioned in agreement, list in order by date (oldest to most recent). Examples follow (insert references as appropriate).

a. The Economy Act, 31 USC 1535.

b. DOD Instruction 4000.19, Interservice and Intergovernmental Support, 9 August 1995.

c. Army Regulation X-XX.

d. MEDCOM Memorandum of Instruction, date, subject: XXXXXXXXXX.

**2. PURPOSE.** Provide a brief statement defining purpose of the agreement. For example, "To establish terms and conditions of an agreement between XXXXX and XXXXX for...."

**3. BACKGROUND.** Present a clear, concise statement of the issue being addressed by the MOU/MOA. Include a brief background and why the agreement is necessary.

**4. APPLICABILITY AND SCOPE.** Identify who the MOU/MOA applies to— who are the parties and how they relate? How far-reaching is the MOU/MOA? Does it cover the entire subject area or just a small aspect of it?<sup>4</sup>

**5. RESPONSIBILITIES.** List responsibilities and understandings of each party involved in the agreement and what each party will do in relation to the other.

a. (Name of MEDCOM/OTSG organization) will—

b. (Name of other party) will—

## 6. RESOURCES

a. Identify resources required to implement the agreement, if any. Include funding and manpower requirements for budget years and for POM out-years. For agreements involving resource transfers, either within the same appropriation (for example, Army to Army, DHP to DHP) or between different appropriations (Army to DHP, DHP to Army), use the format at enclosure 2; include in paragraph 6 or as a separate enclosure to the MOA.

b. If reimbursable support is involved, indicate whether a separate document (other than the agreement) will be used to certify and obligate funds (for example, DD Form 448 (Military Interdepartmental Purchase Request)). If the agreement itself is to serve as the funds obligating document, the agreement must include the fund citation and signature of the fund certifying authority (the fund certifying authority and approving authority for the agreement cannot be the same person).

c. Specify the procedure and frequency for billing by supplier and for payment by customer. Include year-end reconciliation procedures between supplier and customer, if necessary. NOTE: Collections and payments between Federal agencies will use the Treasury's Intragovernmental Payment and Collection System.

d. For MOAs involving reimbursable support, include the statement, "The undertakings described in this MOA are subject to availability of appropriated funds."

e. If the MOU/MOA involves no resource expenditures, insert the following statement: *"Any resource requirements (funding, personnel, supplies, equipment, etc.) associated with this MOA will be executed within available funding allocations (including supplemental funding) and programmed funding of the parties. No exchange of resources or reimbursement is required between the two parties. If these conditions should change, the MOA will be formally amended beforehand."*

## 7. EFFECTIVE DATE, TERMINATION, MODIFICATION, AND REVIEW

a. This MOU/MOA is effective on the date of final signature by all parties, hereto, and will remain in effect until XXXXX (or indefinitely).

b. The parties agree to review the MOU/MOA (insert review frequency). It will be subject to review at any time upon written request by either party. <sup>5</sup>

c. Either party may unilaterally modify, suspend, or terminate the MOA upon written notice to the other party. Under normal circumstances, the party unilaterally modifying, suspending, or terminating the MOA will provide 180 days prior written notice to the other party.

d. Should a dispute arise between the parties, it will be worked at the lowest possible level. If the issue cannot be resolved, it will be elevated to (insert appropriate organizations).

8. PRIMARY POINTS OF CONTACT<sup>6</sup>

MEDCOM Activity Name  
Office Symbol  
Street Address, City, State, ZIP  
Phone (Commercial/DSN)  
Organizational Email, if available

Other Party's Activity Name  
Office Symbol  
Street Address, City, State, ZIP  
Phone (Commercial/DSN)  
Organizational Email, if available

FOR (MEDCOM/OTSG Organization):<sup>7</sup>  
FOR (Name of Other Party):

\_\_\_\_\_/S/\_\_\_\_\_

\_\_\_\_\_/S/\_\_\_\_\_  
I.M. TUFF

U.R. KNOTT  
Colonel, MS

Director of Data Analysis  
ACS for Information Management

U.S. Army Signal Command  
DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

## MOU/MOA Footnotes

<sup>1</sup> Per DOD Instruction 4000.19, a memorandum of understanding (MOU) defines general areas of understanding between two or more parties when support is not conditional (that is, what each party does is not dependent on what the other party does) and when no reimbursement is involved. A memorandum of agreement (MOA) defines areas of conditional agreement between two or more parties (that is, what one party does depends on what the other party does) and/or reimbursement is involved.

<sup>2</sup> This template can apply to agreements between DOD activities (*interservice* support agreements) or agreements between DOD and non-DOD Federal agencies (interagency/intragovernmental agreements).

- Interservice agreements are generally documented on an MOU/MOA or a DD Form 1144 (Support Agreement).
- Any agreement involving an “order” for reimbursable support must include all the essential elements of information (EEI) as required by DOD Financial Management Regulation, Vol 11A, Section 010204. For Interservice Support Agreements (intra-DOD) documented via an MOA instead of a DD 1144, all EEI is mandatory; otherwise, a determination and finding must be approved by a general officer or senior executive service (SES) (FAR 17.5).

EEI includes:

Firm, clear, specific, and complete description of goods or services ordered.

Generic descriptions are not acceptable.

Specific performance or delivery request.

Proper fund citation.

Payment terms & conditions (for example, direct or reimbursable fund cite).

Specific statutory authority (for example, Economy Act, Franchise Funds (PL 103-356 or Title IV / Section 403), etc.).

DOD Activity Address Code of ordering activity.

- Include the following statement in an interservice MOA: “MEDCOM and (other DOD party) have determined that the requested support is in the best interest of the U.S. Government and can be obtained most efficiently and effectively from (other party). (Other party) has determined it is capable of providing the requested support without jeopardizing its assigned missions.”
- If reimbursement is involved, funding is typically handled via a DD Form 448 (Military Interdepartmental Purchase Request, or MIPR). A MIPR alone does not suffice as, and should not be used in lieu of, an agreement. An agreement formally establishes specific terms of the relationship, standards of support, and other important information not necessarily included in a MIPR. A MIPR primarily

functions as a funding reimbursement document and can also be used between DOD and other non-DOD Federal agencies.

- Interagency agreements can be documented as an MOU/MOA if the DOD activity prepares the agreement. A non-DOD agency may use its own form or an interagency format if it prepares the agreement. While there are no set rules, the supplying (vs. requesting) activity generally should prepare the agreement since it sets the terms of supplying the support, the cost basis, and the billing and payment process to be used to ensure correct crediting to its accounting system. All Essential Elements of Information (EEI) are required as described for Interservice Support Agreements above. If OTSG/MEDCOM is the supplying agency, then the requesting agency should provide OTSG/MEDCOM a copy of its approved determination & finding (D&F) statement.
- Interagency agreements involving reimbursement require specific statutory authority, and it should be cited in the references. In the absence of other specific authority, the Economy Act (31 USC 1535) is the legal authority to collect reimbursements from other Federal agencies. Agreements citing the Economy require a D&F statement by a General Officer/SES before approval (see DODI 4000.19, para 4.4). In addition, interagency agreements involving use of non-DOD contracts (both direct and/or assisted acquisitions, regardless of dollar amount) require a separate written Certification for Use of Non-DOD Contract by the head of the requiring activity (06/GS15 or higher) prior to approval of the agreement. More information is at–
  - SAAL-PP memo, 12 Jul 05, subject: Proper Use of Non-DOD Contracts, at <https://www.alt.army.mil/portal/page/portal/oasaalt/documents/armypolicyuseofnon-dodcontracts.doc>
  - MEDCOM memo, 4 Jan 06, sab, at <https://www.us.army.mil/suite/doc/5142679>.
  - Army Contracting Agency (ACA) Policy Memo P-0010, subject: Proper Use of Non-DOD Contracts, at [http://aca.saalt.army.mil/ACA/docs/Community/memo\\_p0010.pdf](http://aca.saalt.army.mil/ACA/docs/Community/memo_p0010.pdf).
- For interservice or interagency agreements involving regularly recurring support (for example, base operations support), a support agreement (DD Form 1144) should be prepared in lieu of, or in addition to, an MOA. The DD 1144 is used to document specific standards of support; basis of reimbursement, billing, and payment procedures; and other details. It can include both reimbursable and non-reimbursable items of support.

<sup>3</sup> For training agreements, either training affiliation agreements or gratuitous training agreements, separate formats apply and can be found at [https://www.us.army.mil/suite/collaboration/folder\\_V.do?foid=681860](https://www.us.army.mil/suite/collaboration/folder_V.do?foid=681860). (NOTE: To

correctly link to this site, you need to first sign in to Army Knowledge Online (AKO) before navigating to this Web link.)

<sup>4</sup> If the scope involves potential use or disclosure of Protected Health Information between MEDCOM and non-DOD parties, certain language is mandated in the agreement under the Health Insurance Portability and Accountability Act (HIPAA). For specific guidance on the HIPAA language, also go to [https://www.us.army.mil/suite/collaboration/folder\\_V.do?foid=681860](https://www.us.army.mil/suite/collaboration/folder_V.do?foid=681860) on AKO; see the files *HIPAA ROE* and *HIPAA Cut & Paste*. If all parties in the agreement are DOD, then you need only cite DOD Regulation 6025-18 as a reference to satisfy HIPAA requirements - no separate HIPAA language is needed.

<sup>5</sup> Agreements involving reimbursable support will be reviewed annually and should be done as part of the activity's annual budget process. Otherwise, agreements should be reviewed when changing conditions may require substantial modification of the agreement.

<sup>6</sup> As a minimum, point of contact information should point to the primary functional manager for the program(s) involved in the agreement (for example, director of logistics, assistant chief of staff for health policy and services, etc.). In addition, specify a separate point of contact for resource management.

<sup>7</sup> The approval authority for the agreement should normally reside at the lowest level possible, as long as the responsibilities, commitments, and resources covered under the agreement are within the signer's scope of authority. Signers for each party should be roughly at the same grade level.

**MOU/MOA Format for Resource Transfers  
(Intra-Army, Intra-DHP, DHP-to-Army or Army-to-DHP)**

EXAMPLE involving transfer for execution year (FY07) and POM FY08-FY13:

SAMPLE ONLY								
Manpower Auth's	PE	FY07	FY08	FY09	FY10	FY11	FY12	FY13
FROM:								
Army OMA								
US Direct Hire Civilian	433709000	-1	-1	-1	-1	-1	-1	-1
Authorizations Subtotal		-1	-1	-1	-1	-1	-1	-1
TO:								
Army DHP (O&M, Def)								
US Direct Hire Civilian	847714000	1	1	1	1	1	1	1
Authorizations Subtotal		1	1	1	1	1	1	1
Net Change		0	0	0	0	0	0	0
Dollars (in \$000s)	PE	FY07	FY08	FY09	FY10	FY11	FY12	FY13
FROM:								
Army OMA								
CivPay	433709000	-68	-70	-73	-75	-78	-81	-83
Contract Personnel	433709000	-86	-88	-91	-94	-97	-99	-102
Mission	433709000	-119	-123	-126	-130	-134	-138	-142
Appropriation Subtotal		-273	-281	-290	-299	-309	-318	-327
TO:								
Army DHP (O&M, Def)								
CivPay	847714000	68	70	73	75	78	81	83
Contract Personnel	847714000	86	88	91	94	97	99	102
Mission	847714000	119	123	126	130	134	138	142
Appropriation Subtotal		273	281	290	299	309	318	327
Net Change		0	0	0	0	0	0	0

## **Appendix C**

### **Sexual Assault Healthcare Training Requirements**

1. The objective of sexual assault prevention and response training is to eliminate incidents of sexual assault through a comprehensive program that focuses on awareness and prevention, education, victim advocacy, reporting, response, and follow up. This appendix addresses the unit level training and mandatory training for healthcare response groups outlined by DOD and DA regulations.

2. Unit level training.

a. All Soldiers will attend and participate in unit level Sexual Assault Prevention and Response training annually. Training should be inclusive of real life situations to demonstrate the entire cycle of reporting, response, and accountability procedures.

b. Ensure unit level Sexual Assault Prevention and Response Program training is conducted annually and documented on unit training schedules

3. Healthcare provider training.

a. All personnel assigned to the MTF involved in the direct or indirect delivery of health services or patient care will receive initial and annual refresher training.

b. The Sexual Assault Prevention / Response Training For Healthcare Providers: 6H-F39/300-F33(DL) course is available through the Army Training Requirements and Resources System Self Development Portal. The goal of this training is to inform appropriate Army MTF medical personnel and ancillary staff on the management of medical, medicolegal, and psychological aspects of assisting sexual assault victims.

c. There are seven modules associated with this course (one introduction and six modules of lesson materials). Upon completion of the course examination, the user will receive a certificate of completion for training documentation.

4. Healthcare providers performing sexual assault forensic examinations.

a. The following healthcare providers are most likely to be called upon to provide medical treatment to a sexual assault victim, to include performing SAFEs: licensed physicians; advanced practice nurses with specialties in midwifery, women's health, family health, pediatrics; physician assistants trained in family practice or women's health; and registered nurses with documented education, training, and clinical practice in sexual assault examinations.

b. In addition to the training outlined above, the healthcare providers performing sexual assault forensic examinations will, at a minimum, receive initial and annual

refresher training that will adhere to the U.S. Department of Justice's National Protocol for Medical Sexual Assault Examination.

c. An interactive training digital video device, Sexual Assault Forensic Examination (SAFE) Virtual Practicum created the by Dartmouth Interactive Media Laboratory based on the U.S. Department of Justice's National Protocol for Medical Sexual Assault Examination supports the SAFE training requirements outlined in DODI 6495.02 Enclosure 6 and AR 600-20 chapter 8, appendix I. However, clinical guidance will not be solely limited to this resource.

5. Designated SACCs and SACP's will receive training annually focused on enhancing the medical management of sexual assault to facilitate the operational effectiveness of the AMEDD Sexual Assault Prevention and Response Program.

## **Appendix D Sexual Assault Response Program Tracking Application**

1. SARPTA is a secured access, Web-based program. The Patient Administration Systems and Biostatistics Activity (PASBA) developed SARPTA to track medical treatment for sexual assaults committed against active duty Army personnel. When active duty Soldiers allege sexual assault and receive treatment at Army MTFs—including combat support hospitals for deployed units—SARPTA is currently the database of record.
2. Designated SACCs and SACPs use SARPTA to record and update incidents. SARPTA records all subsequent treatment of the patient. Users of SARPTA can flag subsequent treatment as NOT related to the sexual assault.
3. To apply for SARPTA access, go to the PASBA Web site at: <https://pasba3.amedd.army.mil/login/login.fcc>. In order to access the PASBA Web site, the user must log on using his/her AKO user name and password.
  - a. On the left hand menu, select Request Access.
  - b. Scroll to Sexual Assault Response Program Tracking Application (SARPTA).
  - c. Select Access Request Form.
  - d. Complete the online application.
  - e. Print the application and security acknowledgement, and get the required signatures.
  - f. Fax the completed application to the MEDCOM Sexual Assault Prevention and Response Program Office for final verification and approval. All approved applicants will receive an e-mail from PASBA notifying them that their access has been approved.
3. A SARPTA Help file is located on the upper right of the SARPTA Web page. Click Help to find information about how to use SARPTA.

## **Appendix E**

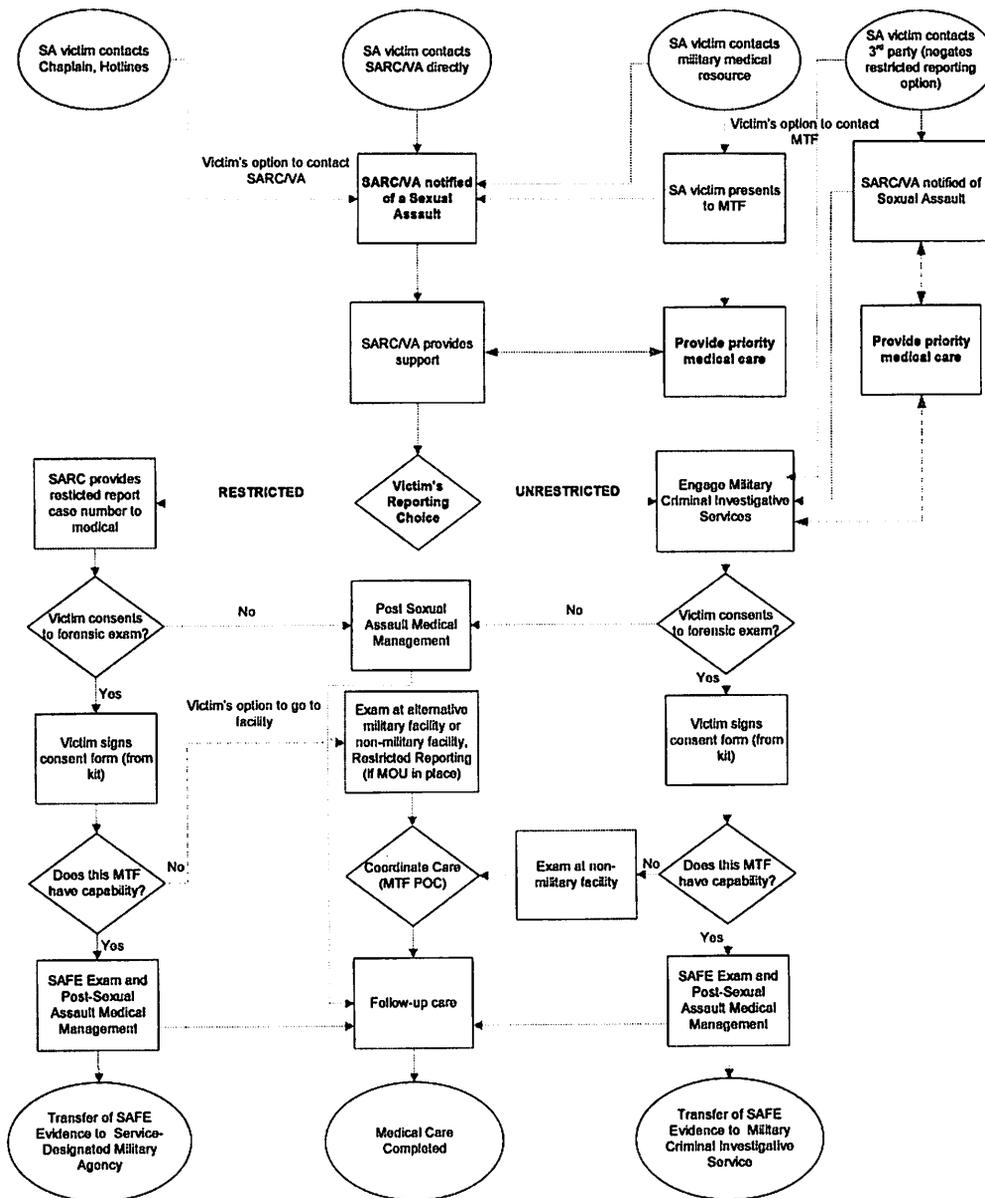
### **Annual Sexual Assault Prevention and Response Program Assessment**

1. In accordance with the Section 113, Title 10, USC and the Department of Defense Instruction 6495.02, the Secretary of the Army will submit to the Secretary of Defense an annual assessment report on the sexual assaults involving members of the Army.
2. The SAPR annual program assessment provides a unifying assessment framework for documenting and capturing how well the MEDCOM is implementing its SAPR Program and providing insight as to where program improvements can be made.
3. The annual MEDCOM Sexual Assault Program assessment report will be submitted to the DCS, G-1 SAPR program manager NLT 1 December for the previous fiscal year inclusive of collected data, findings, and recommendations.
4. The annual MEDCOM Sexual Assault Program assessment report will address—
  - a. General findings from the evaluation of medical services related to sexual assault cases.
  - b. SAPR-related policies and/or procedures implemented during the year.
  - c. SAPR-related initiatives/actions planned for the coming year.
  - d. Recommendations for changes to Army SAPR Program or policy.
  - e. Any resource shortfalls and the potential implications they carry with respect to impact on standards of care and possible solutions to overcome these shortfalls.
  - f. Availability at medical treatment facilities of supplies needed for the treatment of sexual assault victims who present at an MTF, including rape kits/SAFE kits and supplies for testing and treating sexually transmitted infections and diseases— including HIV—and testing for pregnancy.
  - g. Status of healthcare provider responder training.

**Appendix F**  
**AMEDD Sexual Assault Response Program ICD-9-CM Coding Guidance**

1. The coding mechanism established to capture the complete, accurate, and timely collection of relevant clinical information regarding victims of sexual assault is via International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM).
2. Document cases appropriately with the following codes:
  - a. 995.83: Adult Sexual Abuse.
  - b. 995.53: Child Sexual Abuse.
  - c. E960.1: Rape.
  - d. V71.5: Observation Following Alleged Rape or Seduction.
  - e. V15.41: Personal History of Sexual Assault.
3. If the victim sustains physical injuries, the primary diagnosis that identifies the assault is 995.83 (Adult Sexual Abuse) or 995.53 (Child Sexual Abuse). The cause of injury E-960.1 will be reported for all sexual assault incidents.
4. When a victim presents for treatment and has no physical findings, use V71.5 (Observation Following Alleged Rape or Seduction) as the primary diagnosis.
5. When a victim presents for follow-up care related to the sexual assault, the reason for the encounter is coded as the primary diagnosis along with code V15.41: (Personal History of Sexual Assault).

# Appendix G Sexual Assault Response Pathway



## **Glossary**

### **Section I Abbreviations**

**ACA**

Army Contracting Agency

**AKO**

Army Knowledge Online

**CID**

criminal investigation division

**CDC**

Centers for Disease Control and Prevention

**DA**

Department of the Army

**D&F**

determination & finding

**DNA**

deoxyribonucleic acid

**DOD**

Department of Defense

**DODI**

Department of Defense Instruction

**EEI**

essential elements of information

**HBIG**

hepatitis B immune globulin

**HBV**

hepatitis B virus

**HIPAA**

Health Insurance Portability and Accountability Act

**HIV**  
human immunodeficiency virus

**ICD, CM**  
International Classification of Disease, Clinical Modification

**MHS**  
military health system

**MIPR**  
military interdepartment purchase request

**MTF**  
military treatment facility

**MOA**  
memorandum of agreement

**MOU**  
memorandum of understanding

**OTC**  
over the counter

**OTSG**  
Office of the Surgeon General

**PASBA**  
Patient Administration Systems and Biostatistics Activity

**RRCN**  
restricted reporting case number

**SACC**  
sexual assault care coordinator

**SACP**  
sexual assault clinical provider

**SAFE**  
sexual assault forensic examination

**SAPR**  
sexual response prevention and response

\*MEDCOM Reg 40-36

**SARC**

sexual assault responses coordinator

**SARPTA**

Sexual Assault Response Program Tracking Application

**SES**

senior executive service

**SOP**

standing operating procedure

**STI**

sexually transmitted infection

**USAMEDCOM**

U.S. Army Medical Command

**USC**

United States Code

**UVA**

unit victim advocate

**VA**

victim advocate

**Section II**

**Terms**

**Chain-of-custody.** Documented proof—from initial receipt through final disposition—of the transfer and safekeeping of identified articles between receipt and disposition to prevent tampering with or contamination of evidence (DA Form 4137).

**Evidence collection kit.** Contains devices used for collecting and preserving medical evidence in support of sexual assault investigations. It includes directional notes to the physician and investigator and the medical examination report with consent authorizations. NOTE: This kit would not be appropriate for victims of chronic sexual abuse without a recent incident; however, a colposcopic examination would be relevant.

**Forensic examination.** The medical examination, care, and collection of relevant physical evidence in conjunction with supportive medical laboratory testing.

**Military treatment facility.** All U.S. Army Medical Centers, medical department activities, U.S. Army health clinics, troop medical clinics, and other healthcare facilities authorized to provide medical care.

## **Responders**

**First responder.** MEDCOM personnel who have the initial contact or encounter with the victim of sexual assault.

**Sexual assault responder.** Those personnel directly involved in the care and management of sexual assault victims to include the SACP, the SACC, the forensic examiner, VAs, social worker, and others as deemed appropriate.

**Sexual assault.** Sexual assault includes rape, sodomy, indecent acts with another, and indecent acts or liberties with a child.

**Sexual assault care coordinator.** When available, a social worker (BSW or MSW) or nurse (licensed vocational nurse or registered nurse), familiar with both sexual assault victim dynamics and medical treatment facility procedures. Knowledge of community resources related to services for sexual assault victims and their families is critical.

**Sexual assault clinical provider.** A privileged healthcare provider (physician, nurse practitioner, or physician assistant) who has been designated by the deputy commander for clinical services to manage each sexual assault patient's medical treatment related to the sexual assault incident from initial presentation to completion of all follow-up visits.

## **Section III**

There are no entries for this section.

**The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-H, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.**

FOR THE COMMANDER:



HERBERT A. COLEY  
Chief of Staff

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Assistant Chief of Staff for  
Information Management

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## **44-102 Medical Care Management**

### **16.3. Biological Specimens in Administrative or Judicial Proceedings.**

16.3.1. **Specimens as Evidence:** Since the results of examinations of biological specimens as well as the specimens themselves may be used as evidence in military and civilian judicial or administrative proceedings, the AFMS must cooperate in collecting and presenting such evidence.

16.3.2. **Principles Governing Handling of Biological Specimens.**

16.3.2.1. Medical personnel may take biological specimens IAW the Air Force drug testing program and IAW the AF Sexual Assault Prevention and Response Program.

16.3.2.2. The donor must normally consent to any medical personnel taking and using biological specimens as evidence.

16.3.2.3. Where the donor does not consent:

16.3.2.3.1. Consult SJA before drawing blood.

16.3.2.3.2. Medical personnel may take blood without the donor's consent and without a search warrant or search authorization only when there is a clear indication that evidence of crime will be found and law enforcement authorities have reason to believe that the delay that would result if a warrant or authorization were sought could result in the destruction of the evidence. In addition, medical personnel may also take blood without the donor's consent and without a search warrant or search authorization when there is a clear indication that evidence of crime will be found and authorities (Wing/CC, SJA) have reason to believe that the delay would result in the destruction of evidence.

16.3.2.3.3. Involuntary extraction of blood must be performed in a reasonable fashion by personnel with appropriate medical qualifications. Unless unsafe, medically trained personnel may restrain a donor. Security Forces personnel shall assist medically trained personnel when appropriate.

16.3.2.3.4. Medical personnel may take biological specimens requiring visual examination of the unclothed body (such as pubic hair samples and dried fluids from the pubic area) without consent of the patient if they meet the requirements noted above for blood extraction:

16.3.2.3.4.1. With a search warrant or search authorization.

16.3.2.3.4.2. Without a search warrant or search authorization only when there is a clear indication that evidence of crime will be found and law enforcement authorities have reason to believe that the delay that would result if a warrant or authorization were sought could result in the destruction of the evidence.

16.3.2.3.5. The nonconsensual taking of other biological specimens that do not require visual examination of the unclothed body, or intrusion into the body, such as fingernail scrapings and hair samples from the head, does not require a search warrant or search authorization. A competent authority may order such nonconsensual takings. The SJA shall be consulted in matters such as this.

16.3.2.3.6. Military medical personnel may not take biological specimens solely at the request of and for the use of civilian law enforcement authorities.

16.3.2.3.7. MTF/CC will ensure procedures are in place to ensure that witnesses can identify specimens.

16.3.2.3.8. MTF/CC will ensure specimens are kept either in the exclusive custody of an identifiable person or secured in an identifiable, tamper-proof location from the time personnel

collect the specimen to the time it is offered as evidence. MTF/CC must be able to demonstrate that these precautions were taken.

#### **16.4. Reporting Serious Incidents.**

16.4.1. Healthcare providers will report all sexual assaults against Active Duty to the Sexual Assault Response Coordinator (SARC) for determination of restricted versus unrestricted reporting. The SARC will NOTIFY AFOSI as appropriate. Healthcare providers (including mental health providers), will also report child abuse, spousal abuse, SEXUAL ASSAULTS NOT INVOLVING ACTIVE DUTY MILITARY PERSONNEL, homicides, suicides, attempted suicides, robbery, aggravated assault, intentional prescription drug overdose and narcotic overdose episodes to the appropriate law enforcement or/and command authorities.

#### **16.5. Medical Response for Sexual Assault Victims.**

16.5.1. The following information is supplemental to Department of Defense Instruction (DODI) 6495.02, 23 June 2006, *Sexual Assault Prevention and Response (SAPR) Program Procedures* and AFI 36-6001, *Sexual Assault Prevention and Response (SAPR)*. It details training requirements for Health Care Providers (HCP) and Registered Nurses with appropriate sexual assault training conducting Sexual Assault Examinations (SAE).

16.5.2. Each MTF must have a written plan describing the medical response for sexual assault victims.

16.5.2.1. The plan should be gender sensitive in order to avoid situations such as evaluating a male victim in the women's health clinic.

16.5.3. Each MTF will establish protocols describing the provision and documentation of medical care to a victim of sexual assault.

16.5.3.1. Medical record documentation under restricted reporting must have special protection to avoid unauthorized release of information.

16.5.3.1.1. The following wording in bold type should be placed in each notation in the electronic or paper record: **"Restricted from disclosure unless and until determined to be releasable by the MTF Commander or designee. Do not release without specific patient authorization or as specifically authorized by DOD or AF policy."**

16.5.3.1.2. Electronic records in AHLTA must also be secured via a —break the glass function (sensitive box checked) in addition to the above notation.

16.5.3.2. Documentation in the medical record must follow a standard approach of addressing acute complaints, gathering pertinent historical data, describing findings, and documenting treatment and follow-up care. Providers must insure the documentation includes information regarding the physical and emotional injuries resulting from the assault. The level of detail should be sufficient to provide continuity of care.

16.5.3.3. Forensic examination documentation must remain with the evidence kit and copies of evidence kit documentation should not be included in the medical record.

16.5.4. MTFs that do not provide SAE must have a Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) with a local medical facility where the SAE can be performed by an appropriate provider; trained registered nurse or health care provider.

16.5.5. Timely medical response to a sexual assault victim is essential. The MTF will appropriately triage patients on presentation and make every effort to minimize the time until actual SAE.

16.5.6. MTFs must insure providers and staff are appropriately trained to respond to sexual assault victims.

16.5.6.1. MTFs that provide SAE must insure sexual assault (SA) examiners receive initial and refresher training.

16.5.6.1.1. HCPs may include, but are not limited to physicians, advanced practice nurses and physician assistants with clinical privileges to perform pelvic examinations.

16.5.6.1.2. Registered nurses performing SAE in AF MTFs will at least be trained as a Forensic Nurse Examiner (FNE). They will meet the minimum requirements determined in this instruction. This additional capability shall be noted as a competency, not as a credential or privilege.

16.5.6.2. Privileged HCP initial and refresher training for those performing SAE:

16.5.6.2.1. The minimum requirement for initial training is attendance at a 3 day forensic sexual assault course and one case/mock exam reviewed by a competent SA examiner.

16.5.6.2.2. Annual refresher training is required. Several options for refresher training include: Forensic Sexual Assault course on DVD or Forensic Sexual Assault course on line and three cases/mock exams a year reviewed by a competent SA examiner.

16.5.6.3. FNE initial and refresher training:

16.5.6.3.1. The minimum requirement for initial training will include attendance at a 5 day didactic course and three cases/mock exams reviewed by a competent SA examiner.

16.5.6.3.2. The minimum requirement for refresher training will include three cases/mock exams a year reviewed by a competent SA examiner and a minimum of five CEUs every 3 years covering forensic exam topics.

16.5.6.4. Each MTF will have its healthcare personnel take First Responder Training annually.

16.5.6.4.1. Healthcare personnel are defined by Instruction (DODI) 6495.02, 23 June 2006, *Sexual Assault Prevention and Response (SAPR) Program Procedures* as all healthcare providers and also includes persons assisting or otherwise supporting healthcare providers in providing healthcare services (e.g., administrative personnel assigned to a military medical treatment facility).

16.5.6.4.2. All health care personnel will take First Responder Training by on-line CBT located in ADLS Med+Learn.

16.5.7. Deployed Environment

16.5.7.1. Each Expeditionary Medical Support (EMEDS) facility must have a written plan describing medical response for Armed Forces sexual assault victims.

16.5.7.1.1. The written plan will establish protocols for providing and documenting medical care.

16.5.7.2. Medical documentation of restricted reporting will have special protection in IAW para 16.5.3.1.

16.5.7.3. EMEDS/CCs will designate a SA examiner to be the primary POC for conducting SAE. If the EMEDS does not have a trained SA examiner, in-place training will occur using the Sexual Assault: Forensic and Clinical Management DVD ordered through the EMEDS Theater Medical Logistics. Training will be documented in the SA examiner's deployed credential or competency folder as appropriate.

16.5.7.4. Sexual assault victims who exceed the local EMEDS capabilities will be transported to the appropriate level of care IAW established aeromedical evacuation standards.

16.5.7.5. The SA examiner will review procedures with the SARC and OSI, or comparable offices, upon designation.

16.5.7.6. An adequate supply of Sexual Assault Forensic Examination (SAFE) kits will be maintained at each deployed location.

# Sexual Assault Forensic and Clinical Management

This new, interactive program provides expert instruction for healthcare professionals who may care for sexual assault patients – and may be called to testify about that care. The training's designed for registered nurses, advanced practice nurses, physicians, physician assistants, midwives, and students in these professions.

Others may find certain sections of the program of benefit, including victim advocates, licensed vocational/practical nurses, counselors, EMS and law enforcement personnel, officers of the court, and forensic scientists.



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**CNE credits:** Completion of this educational activity will provide 12.5 nursing contact hours.

The International Association of Forensic Nurses is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation (COA).

**CME credits:** The Dartmouth-Hitchcock Medical Center is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Dartmouth-Hitchcock Medical Center designates this educational activity for a maximum of 12 AMA PRA Category 1 Credits.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.

This project was supported under the President's DNA Initiative by Cooperative Agreement Number 2004-UJ-CX-K041, awarded to the Interactive Media Laboratory at Dartmouth College and administered by the U.S. Department of Justice. Points of view or opinions in this program are those of the author and do not represent the official position or policies of the U.S. Department of Justice. We thank the United States Department of Justice and the President's DNA Initiative for their support for the critical portions of this program involving DNA and evidence gathering in sexual assault cases.

#### SYSTEM REQUIREMENTS

Supported OS: Windows® 7, XP SP2, Vista  
Processor: 1.5 GHz required (2 GHz recommended)  
RAM: 512 MB required (1GB recommended)  
Video: 800 x 600, 32-bit color  
Sound Card: Any  
DVD-ROM: Any  
Hard Drive Space: 2GB  
Peripherals: Keyboard and mouse or touchpad

Developed and produced by the Interactive Media Laboratory at Dartmouth Medical School.



Dartmouth Medical School



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MEDICAL CENTER



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ISBN-13: 978-0-9789874-1-1  
ISBN-10: 0-9789874-1-1

NAV 054  
12.5 CNE or  
12 CME credits

# Sexual Assault Forensic and Clinical Management

A Virtual Practicum™ based on the  
National Protocol for Sexual Assault  
Medical Forensic Examinations

This DVD must be installed on a computer using a Windows 7, XP, SP2, or Vista operating system. Each DVD may only be installed on one computer, but multiple users may access the training asynchronously.

Learners should create a login using their first and last name. Login name automatically populates the certificate of completion.

For network security, verify the box "periodically check for updates" is deselected during installation.

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