72. (Services) Please describe your Sexual Assault Medical Forensic Examiner (SAMFE) and Sexual Assault Nurse Examiner (SANE) programs, including:

72a. Credentialing requirements and certification programs for military SAMFEs/SANEs;

USA	Supplemental Response: Sexual Assault Medical Forensic Examiners: There are no credentialing requirements or certification programs currently for SAMFEs. SAMFEs are physicians, physician assistants, advanced practice registered nurses who undergo specialized education in the provision of trauma related healthcare as well as the performance of forensic medical/legal examinations. Army Medicine is evaluating and exploring options for both certifying and credentialing all SAMFEs. SAMFE training supports regulatory requirements for SAFE and provides continuing health education (CHE) credit. Sexual Assault Nurse Examiners (SANE): A subset of Army Medicine SAMFEs, SANEs have the International Association of Forensic Nurses (IAFN) as a certifying body. Army Medicine encourages but does not require SANEs to obtain this certification. The IAFN has declined to serve as the Army's SAMFE certifying body. Sexual Assault Medical Forensic Examiner Training has two phases. Phase One is a 40-hour didactic portion and Phase Two is the Skills Practicum. Students receive a comprehensive education based on the Department of Justice Training Standards for Medical Forensic Examiners that prepares them to work with other responders to meet the health care, forensic, and information needs of adult and adolescent sexual assault patients who present for medical forensic examination. The course provides information on sexual violence dynamics and prevalence, skills to properly care for victims of sexual assault, the collection and preservation of evidence using the Department of Defense (DOD) Sexual Assault Evidence Collection Kit, identification of common injuries resulting from sexual assault, understanding the criminal justice system, sex offending behavior, working with military and civilian Sexual Assault Response Teams, and provides skills for testifying in military court as a fact or expert witness. Upon completion of the 40-hour didactic training, there is a post-training skills practicum requirement. Phase Two consists of a simulation case, training stations, a competency based assessment, use of a reproductive training assistant and limited availability to observe an actual sexual assault victim/suspect examination should one occur during the training period. Students learn how to perform sexual assault forensic examinations to competency; this includes male and female sexual assault medical forensic genital exams and a return demonstration.
USAF	See AFI attachment, section 16.5.6. for training and certification requirements (Tab 32)
USN	BUMEDINST 6310.11A (May 2, 2013) established a comprehensive program to provide victims of sexual assault access to Sexual Assault Forensic Exams (SAFE) at

	both 24/7 medical treatment facilities (MTFs) and non-24/7 MTFs by the end of FY13. The efforts and scope of this program, as listed below in section (vi), provide the same level of training and care in maritime and expeditionary environments for victims of sexual assault There is no program for training of Sexual Assault Nurse Examiners (SANE). However, the Navy has a comprehensive program for training and ensuring deployment capabilities for SAFEs on all Navy platforms with medical capability (submarines, ships, expeditionary commands, etc). The Naval Medical Professional Development Center (NMPDC) has deployed SAFE training packages throughout the Navy enterprise. We recognize this training evolution as a force multiplier to providing forensic and medical care. This significant undertaking will result in a capability to provide SAFEs in places that no other organization has gone before, both ashore and afloat.
USMC	BUMEDINST 6310.11A (May 2, 2013) established a comprehensive program to provide victims of sexual assault access to Sexual Assault Forensic Exams (SAFE) at both 24/7 medical treatment facilities (MTFs) and non-24/7 MTFs by the end of FY13. The efforts and scope of this program, as listed below in section vi, provide the same level of training and care in maritime and expeditionary environments for victims of sexual assault There is no program for training of Sexual Assault Nurse Examiners (SANE). However, the Navy has a comprehensive program for training and ensuring deployment capabilities for SAFEs on all Navy platforms with medical capability (submarines, ships, expeditionary commands, etc). The Naval Medical Professional Development Center (NMPDC) has deployed SAFE training packages throughout the Navy enterprise. We recognize this training evolution as a force multiplier to providing forensic and medical care. This significant undertaking will result in a capability to provide SAFEs in places that no other organization has gone before, both ashore and afloat.
USCG	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.

a. Ability to meet the SAMFEs/SANEs requirements at every military installation worldwide; specifically, does the Service:

72a(i) Provide training and staffing of SAMFE/SANEs at every installation (in house support),

USA	The AMEDD SAMFE training meets CENTCOM pre-deployment requirements for healthcare providers assigned to Role II and Role III facilities. To support pre-

	deployment and local SAMFE requirements, 7 CONUS & OCONUS sites hosted 9 courses in FY13. (See enclosed SAMFE spreadsheet). Currently 21 Army MTFs (40%) offer SAFEs in-house. The attached spreadsheet list USA Medical Command Sexual Assault Forensic Examination Services.
USAF	The AF does not have in-house SAMFE/SANE at every installation. The attached list of bases delineates which bases offer in-house exams (Tab 34, AF MTF Sexual Assault Exam Status).
USN	As of October 24, 2013, 97 Navy MTFs are now capable of conducting SAFEs. MTFs around the globe have trained a total of 324 Navy MTF SAFE providers. In US Fleet Forces, 287 providers have been trained to provide SAFE care on 123 surface, air, expeditionary and submarine platforms. In US Pacific Fleet, 191 providers have been trained to provide SAFE care on 142 surface, air, and submarine platforms. Additionally, 57 providers attached to the Military Sealift Command have undergone SAFE training. Training for these 859 personnel included 14.5 hours of standardized DVD teaching. This interactive DVD training was mapped against the Department of Justice National Protocol for Sexual Assault Medical Forensic Examination and helps ensure that all providers receive an industry standard quality training product. Program managers at the Regional and MTF level are actively engaged in laying the groundwork for sustaining proficient, confident, caring, SAFE providers to meet the needs of victims of sexual assault 24/7.
USMC	As of October 24, 2013, 97 Navy MTFs are now capable of conducting SAFEs. MTFs around the globe have trained a total of 324 Navy MTF SAFE providers. In US Fleet Forces, 287 providers have been trained to provide SAFE care on 123 surface, air, expeditionary and submarine platforms. In US Pacific Fleet, 191 providers have been trained to provide SAFE care on 142 surface, air, and submarine platforms. Additionally, 57 providers attached to the Military Sealift Command have undergone SAFE training. Training for these 859 personnel included 14.5 hours of standardized DVD teaching. This interactive DVD training was mapped against the Department of Justice National Protocol for Sexual Assault Medical Forensic Examination and helps ensure that all providers receive an industry standard quality training product. Program managers at the Regional and MTF level are actively engaged in laying the groundwork for sustaining proficient, confident, caring, SAFE providers to meet the needs of victims of sexual assault 24/7.
USCG	Answered completed under #72 main.

72a(ii) Contract with a civilian SAMFE/SANEs in the local community to travel onto the installation to provide forensic collection services, if so, describe the procedures used,

USA	Madigan Army Medical Center, Fort Lewis, WA, is the only Army MTF (2%) to utilize a contract to bring providers into the facility to provide medical forensic examination services. MAMC's MOU is with Providence Saint Peter SANE Program

	to provide sexual assault forensic examinations within the MTF Emergency Department. Providence Saint Peter also provides onsite training twice a calendar year for other sexual assault medical management providers. The contractor follows Washington State law and guidelines for SAFEs.
USAF	The AF has one base with a contract for SANE services where the SANE travels onto the installation. The same procedures are used as those at bases with in-house exams except the SANE is contacted when needed by the installation Emergency Department.
USN	Navy medicine does not have contracts with civilians outside of our MTFs to conduct exams on our installations. SAFEs are performed by our Navy trained SAFE providers on our installations. However, after hours where 24/7 care is not available in the MTF (outpatient clinics) patients of sexual assault may be cared for by civilian authorities outside the military installation per MOU/MOA or other agreements.
USMC	Navy medicine does not have contracts with civilians outside of our MTFs to conduct exams on our installations. SAFEs are performed by our Navy-trained SAFE providers on our installations. However, after hours, where 24/7 care is not available in the MTF (outpatient clinics), patients of sexual assault may be cared for by civilian authorities outside the military installation per MOU/MOA or other agreements.
USCG	Answered completed under #72 main.

72a(iii) Establish agreements and contracts with local civilian hospitals who in turn provide the SAMFE/SANE support, if so describe the procedures used and a sample of the MOU/MOAs,

USA	Thirty Army MTFs (58%) coordinate with 39 external facilities (two Air Force, One Navy, 36 civilian) to provide trauma related medical care following sexual assault. In Alaska, Bassett Army Community Hospital works with the 354th MED Group (AF) as well as Fairbanks Memorial Hospital to provide these services to the Army community. The MOUs/MOAs will provide 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 (sample MOU/MOA attached).
USAF	1. (AF) The majority of AF bases use an agreement with a downtown facility to provide SAMFE/SANE support. A sample MOU (Tab 35, Sample SANE MOU) and AFI excerpt is attached, which provides details (Tab 32, Section 16.5.) regarding support to sexual assault victims. The MOU is mandated in section 16.5.4. 2. (AF) AFI 36-6001, paragraph 2.3.5.8, requires each installation SARC, working with appropriate installation agencies, to pursue a MOU with appropriate authorities and community service providers addressing the coordination of support and adequate standard of care for Air Force personnel who seek support off the installation.
USN	BUMEDINST 6310.11A contains a sample MOU/MOA, which is attached and available online at http://www.med.navy.mil/directives/ExternalDirectives/6310.11A.pdf.

USMC	BUMEDINST 6310.11A contains a sample MOU/MOA, which is attached and available online at http://www.med.navy.mil/directives/ExternalDirectives/6310.11A.pdf
USCG	Answered completed under #72 main.

72a(iv) Prefer one of the above three models as the most efficient and effective way to obtain SAMFE/SANE support for sexual assault cases,

USA	It is important to keep in mind that these healthcare providers are caring for trauma patients; the first priority is the patient and quality of care. This is not simply a part of the investigative process. We can provide a detailed report on the medical care provided to patients following sexual assault that occurs regardless of whether there is a SAFE kit completed. There is not a one size fits all recommendation for each MTF AOR. A community needs assessment of sexual assault medical forensic examination capability for sexual assault patients (victim and suspect) in the area of operation of each Military Treatment Facility is being developed to assist with answering this question. At a minimum there must be adequate and stable funding; adequate staffing and expertise; community collaboration; and options available for accessible, competent and adequate care for sexual assault patients. The OTSG SHARP WG is assessing the best approach to this question now. The draft SAMFE standards mandate a minimum of three SAMFEs per facility which offer the service; the revised MEDCOM Reg 40-36 will reflect mandated space, equipment, personnel, supplies, training and recommended funding. There is no inexpensive way to provide this service 24/7 as mandated in the DODD and DODI regardless of where the services are performed.
USAF	The AF utilizes all three models based on which model provides the best service for the victim considering all local factors. Many AF facilities are small such that downtown facilities can provide consistent, competent support better than installation personnel can.
USN	Navy's response to providing SAFE has been an in-house capability. This in-house capability allows us to track and provide quality feedback to our SAFE providers through partnership with US Army Criminal Investigation Laboratory. This in-house capability also helps ensure that all resources available (infectious disease, behavioral health, chaplain, and other resources) are offered by our military trained providers and followed by our SAPR team.
USMC	Per instruction, the Navy medicine response to providing SAFE has been an in house capability. This in house capability allows us to track and provide quality feedback to our SAFE providers through partnership with US Army Criminal Investigation Laboratory. This in house capability also helps ensure that all resources available (infectious disease, behavioral health, chaplain, and other resources) are offered by our military trained providers and followed by our SAPR team.
USCG	Answered completed under #72 main.

72a(v) Note any particular problems with any of the three approaches listed in "i-iii" above,

USA	All Army MTF SAMFEs are collateral duty volunteers performing physically and emotionally exhausting work. It is imperative that these positions be filled with compassionate volunteers who are dedicated to helping this special patient category.

	It would be cost and staff prohibitive to provide this service at every installation globally with an inevitable inability to have true volunteers take on this challenging work. There is a need to ensure at a minimum there is adequate and stable funding; adequate staffing and expertise; community collaboration; and options available for accessible, competent and adequate care for sexual assault patients. For contractors working within the MTF, it is a dual management and leadership challenge to insure that the quality of care is high, handoff to Installation and other healthcare providers within the MTF is tightly wired, and the contractor is completely responsive to the patients' needs. While this may seem a cheap and easy alternative to growing our own or sending patients downtown, the MTF still incurs the cost of space, equipment, support staff, facility, risk management, and coordination. For civilian MOU/MOAs, it is up to the individual MTF to insure the local facility meets the minimum standards set by the DOD, that they will at minimum collect evidence up to 7 days, and that they will ensure SAMFE are trained at a minimum according to the DOJ National Training Standards for SAMFE. Few states meet the DOJ standards for training or protocols for performing a SAFE; this is a jurisdictional risk. Several civilian facilities have refused to create MOUs with Army MTFs based on a misunderstanding on TriCare reimbursement.
USAF	We don't note any problems with any of the three approaches listed above.
USN	No issues to report at this time.
USMC	Our program is new and feedback is the key. There are no problems to report at this time.
USCG	Answered completed under #72 main.

72a(vi) Please specify which installations do and do not have SAMFE/SANE capabilities on the installation;

USA	The enclosed spreadsheet list USA Medical Command Sexual Assault Forensic Examination Services CONUS and OCONUS.
USAF	By selecting the model that best fits the local support system, the AF has avoided significant problems. Based on smaller facility sizes the AF has more difficulty with making sure trained examiners have enough ongoing experience to remain competent. Because of this limitation the majority of AF facilities have chosen to enter into agreements with downtown providers who manage cases more frequently and can easily maintain competency. Victims are better served in a system that specializes in providing sexual assault care and the AF seeks to arrange that whenever possible.
USN	**NME: Navy Medicine East; NMW: Navy Medicine West**

SAFE Capable NME	SAFE Capable NMW	No SAFE Capabilities
NMC Portsmouth	NMC San Diego	NBHC Mechanicsburg
NH Camp Lejuene	NBHC Coronado	NBHC Philadelphia
NH Pensacola	NBHC Miramar	NBHC Wallops Island
NH Jacksonville	NBHC NTC	Pent BHC Washing DC
NH Beaufort	NBHC MCRD	NBHC USS Osborne

		FHCC		NBHC San Diego		NBHC Little Creek
		NH Guantanamo Bay				NBHC Norfolk Shipyard
		NH Naples		NH Camp Pendleton		NBHC Dam Neck
		NH Sigonella		NBHC Port Hueneme		Tricare Outpatient Clinics Virginia Beach and Chesapeake VA
		NH Rota		NBHC Yuma		NBHC CORFAC
		NHC Annapolis		NBHC San Onofre		NBHC Panama City
		NHBC Bancorft Hall		NH 29 Palms		NBHC Crane
		NHBC Navel Weapons		NBHC China Lake		NBHC NATCC
		NHBC Lakehurst		NBHC Bridgeport		
		NH Clinic Quantico		NH Lemoore		NBMC San Clemente
		NBMC OCS Quanitco		NBHC Fallon		NBMC Rancho Bern
		NBHC Quantico TBS				NBHC El Centro
		NBHC Sugar Grove		NH Bremerton		NBHC Kearny Mesa
		NBHC Washington NY		NBHC Bangor		NBHC Chula Vista
		NHC Pax		NBHC Everett		NBHC Chula Vist East
		NBHC Andrews		NH Oak Harbor		NBHC Point Megu
		NBHC Dahlgren				NBHC CP Area 13
		NBHC Indian Head		NH Guam		NBHC Camp Delmar
		NBMC USS Tranquility		NBMC NAVST Guam		NBHC Edson Range
		NBMC USS Red Rover		NH Okinawa		FM Oceanside
		NBHC USS Fischer		NBMC Futemna		NBHC Puget Sound
		NHC Corpus		NBMC Evans		NBHA Barking Sand
				NBMC Kinser		NBMC Hansen
						NBMC Schwab
						NBMC Yokohoma

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.

	Christi NBHC Fort Worth NBHC Kingsville NBHC Sewells Pt NBHC Oceana NBHC Chesapeak NBHC Yorktown NBMC Hadnot Pt MCB NBMC MCAS New River NBMC Camp Geiger NBMC Wayne Caron NBMC Camp Johnson NBMC French Creek NHC New England NACC Groton NBHC Portsmouth HC NBHC Saratoga Spring NBHC Milton Whiting NBHC Meridian NBHC Gulfport NBHC NO Belle Chase NBHC Mid South NBHC Kings Bay NBHC Jacksonville NAS NBHC Mayport NBHC Key West NBHC Albany		NBMC Camp Courtney NH Yokosuka NBMC Sasebo NBHC Iwakuni NBHC Atsugi NBHC Chihae NBHC Diego Garcia NBHC Pearl Harbor NBHC Wahiawa NBHC Kaneohe Bay NBHC Camp Smith	NBMA Mt Fugi

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.

	NBHC Parris Island NBHC Beaufort NHC Cherry Point NHC Charleston NBHC FL Clinic NAS-2 NBHC NAV Souda Bay NBHC Bahrain NBHC Capodichino
USMC	List submitted – identical to USN.
USCG	Answered completed under #72 main.

72a(vii) Describe procedures used on any installations that do not have resident SAMFE/SANE services;

USA	Installations that do not have resident SAMFE/SANE services have a locally derived MOU/MOA in place or utilize sister service SAFE services.
USAF	See AFI attachment, section 16.5. for overall policies/procedures that apply to all bases including those without resident SAMFE/SANE services. Section 16.5.4. mandates MTFs that do not provide resident SAMFE/SANE services on base enter into a MOU with an appropriate local facility (See Tabs 32 and 35).
USN	Victim Care protocols are required at all MTFs for management of sexual assault victims regardless of staffing. During working hours at non- 24/7 MTF, SAFE providers will conduct the exam. Victim care protocols are in place in both Navy Medicine East and Navy Medicine West in various draft forms. Our goal is to collect all victim care protocols once reviewed at the command and regional levels and determine the most advantageous standardized format.
USMC	Victim Care protocols are required at all MTFs for management of sexual assault victims regardless of staffing. During working hours at non- 24/7 MTF, SAFE providers will conduct the exam. Victim care protocols are in place in both Navy Medicine East and Navy Medicine West in various draft forms. Our goal is to collect all victim care protocols once reviewed at the command and regional levels and determine the most advantageous standardized format.
USCG	Answered completed under #72 main.

72b. What resources would be helpful to improve the SAMFE/SANE support at the Services' installations – large, small, CONUS, OCONUS;

USA	The best support would come from full-time dedicated SAMFE providers who can also serve as sexual assault clinical providers or MTF SHARP program managers. This would give a clinician the time to care for patients with the attention and dedication this care requires.

	Other areas for development include communication between all SHARP team members, medical and non-medical, and all three Services. There should be one DOD SAMFE Training Curriculum with set detailed competency standards, annual or biannual competency requirements, and certification an outside regulatory agency.
USAF	The AF currently has sufficient resources to appropriately support victims of sexual assault.
USN	Currently we are still deploying and evaluating the SAFE program to determine the best procedures and programs for the naval services. We are constantly evaluating, through monthly stakeholder meetings and supporting initiatives, to ensure confidence and proficiency. At this stage of the program, our most valuable resource is time in order to enable us to understand where we need further development and how we can better support victims.
USMC	Currently we are still deploying and evaluating the SAFE program to determine the best procedures and programs for the naval services. We are constantly evaluating, through monthly stakeholder meetings and supporting initiatives, to ensure confidence and proficiency. At this stage of the program, our most valuable resource is time in order to enable us to understand where we need further development and how we can better support victims.
USCG	Answered completed under #72 main.

72c. Any statistics or other information that may be important for the Panel to know.

USA	No answer provided.
USAF	The AF currently utilizes all three approaches referenced in the request for information to provide sexual assault exams for AF patients. The AF utilizes sexual assault medical forensic examiners and sexual assault nurse examiners at military treatment facilities where appropriate. In many AF locations, community assets are available and highly trained. If civilian facilities are used then the AF facility will complete a memorandum of understanding. One facility contracts with a provider to come onto the installation to perform the exam. Of the 74 AF facilities, 22 provide examiners in house or use nearby DoD facilities with the remaining 52 using civilian facilities. A list of facilities is attached. The AF requires examiner training that meets Department of Justice recommendations (See Tab 36). Currently resources are not a constraint to provision of services at any AF facility.
USN	The Navy Medicine SAFE program is tracking the number of SAFE performed. October 2013 was the first month that this reporting has occurred. There were a total of 24 SAFE conducted: 11 conducted in NMW, 11 conducted in NME, and 2 conducted in the Fleet. Each Region is working diligently to improve this new program. Highlights from NMW have included every SAFE Program manager working with local civilian and military law enforcement and advocacy (SARC/VA). Victim Care protocols in NMW have instituted the latest Sanford Guide recommendations on HIV prophylaxis. NME SAFE program managers have conducted “mock drills” to ensure that their victim care protocols are accurate and responses are coordinated. Navy Medicine is continually working to improve their SAFE program through

	monthly stakeholder meetings and monthly newsletters. We are committed to providing exceptional care to victims of sexual assault on a global level.
USMC	The BUMED SAFE program is tracking the number of SAFE performed. October 2013 was the first month that this reporting has occurred. There were a total of 24 SAFE conducted:. 11 conducted in NMW, 11 conducted in NME, and 2 conducted in the Fleet. Each Region is working diligently to improve this new program. Highlights from NMW have included every SAFE Program manager working with local civilian and military law enforcement and advocacy (SARC/VA). Victim Care protocols in NMW have instituted the latest Sanford Guide recommendations on HIV prophylaxis. NME SAFE program managers have conducted "mock drills" to ensure that their victim care protocols are accurate and responses are coordinated. Navy Medicine is continually working to improve their SAFE program through monthly stakeholder meetings and monthly newsletters. We are committed to providing exceptional care to victims of sexual assault on a global level.
USCG	Answered completed under #72 main.

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FY13 USA Medical Command Sexual Assault Forensic Examination Services

Army Facility Name	Assault Exams within Army Facility	MOU/MOA	MOU/MOA Facility Name	MOU/MOA Date Signed	Total Sexual Assault Medical Forensic Examiner (SAMFE)	Sexual Assault Exams
Western Region Medical Command						
Bassett Army Community Hospital, Ft Wainwright, AK	N	Y	Fairbanks Memorial Hospital and 354 MED Group	1-Aug-10	NA	NA
Madigan Army Medical Center, JB Ft. Lewis McChord	Y	Y	Providence St Peters Hospital (civilian contract)	7-Nov-11	17	33
Presidio of Monterey Army Health Clinic (CALMED), CA	N	Y	Community Hospital of the Monterey Peninsula	Pending Revison	NA	NA
Weed Army Community Hospital, Ft. Irwin	Y	Y	San Bernardino Sexual Assault Services and Law Enforcement Medical Services, Inc., Fontana, CA	1-Nov-13	6	4
Evans Army Community Hospital, Ft. Carson	N	Y	Memorial Hospital	1-Oct-09	NA	NA
GLW Army Community Hospital, Ft. Leonardwood, MI	Y	N	Kids Harbor II (for child and adolescents only)	2010	5	12
Irwin Army Community Hospital, Fort Riley, KS	N	Y	Mercy Regional Health Center, Manhattan, KS; Salina Regional Health Center, Salina, KS; Stormont Vail Health Center	8-Nov-07	NA	NA
Munson Army Health Center, Ft. Leavenworth,KS	N	Y	Leavenworth Alliance Against Family Violence	17-Dec-12	NA	NA
William Beaumont Army Medical Center, Ft Bliss, TX	Y	N			6	51
Fort Richardson, Anchorage AK	N	Y	Elmendorf Air Force Base Hospital	N/A	NA	NA
Raymond W. Bliss Army Health Center, Fort Huachuca, AZ	N	Y	Sierra Vista Regional Health Center, Sierra Vista, AZ	17-May-11	NA	NA
Southern Regional Medical Command (SRMC)						
Bayne-Jones Army Community Hospital, Ft. Polk	Y	N			7	15
Bayne-Jones Army Community Hospital, Ft. Polk	N	Y	Lake Charles Rape Crisis Center, Lake Charles, LA	19-Jul-11	NA	NA
Bayne-Jones Army Community Hospital, Ft. Polk	N	Y	Beauregard Deridder, LA	4-Oct-11	NA	NA
San Antonio Military Medical Center, JBSA FSH	N	Y	Methodist Speciality and Transplant Hospital and Cristus Santa Rosa Health Systems	27-May-11	NA	NA
Darnall Army Community Hospital, Ft. Hood	N	Y	Scott & White Hospital, Temple , TX	41126	NA	NA
Reynolds Army Community Hospital, Ft. Sill	N	Y	SANE Center of Southwest Oklahoma	40919	NA	NA
Blanchfield Army CHC, Ft. Campbell	Y	N	N/A	N/A	5	40
Eisenhower Army MEDCEN, Ft. Gordon	Y	N	NA		6	7
Lyster Army HC/USA Aeromedical, Ft. Rucker AL	N	Y	Dale Medical Center Triad of AL, LLC DBA Flowers Hospital	3-Mar-08	NA	NA
Martin Army CH, Ft. Benning, GA	Y	N	NA	NA	13	14
Moncrief Army CH, Ft. Jackson, SC	N	Y	Palmetto Health Richland Hospital	30-Nov-12	NA	NA
Fox ACH, Redstone Arsenal, AL	N	Y	Crisis Service of N. Alabama	40022	NA	NA
Rodriquez AHC, Ft. Buchanan, Puerto Rico	N	Y	HIMA Hospital	41054	NA	NA
Winn ACH, Ft. Stewart	Y	N	NA		12	25
Pacific Regional Medical Command (PRMC):						
Tripler Army Medical Center, Ft. Shafter	Y	N	N/A	N/A	2	63
MEDDAC-K/BAACH/121 CSH, USAG Yongsan	Y	N	N/A	N/A	2	22
Camp Zama, Japan	N	Y	Yokosuka Naval Hospital	3-Dec-08	1	0

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FY13 USA Medical Command Sexual Assault Forensic Examination Services

Army Facility Name	Assault Exams within Army Facility	MOU/MOA	MOU/MOA Facility Name	MOU/MOA Date Signed	Total Sexual Assault Medical Forensic Examiner (SAMFE)	Sexual Assault Exams
North Atlantic Regional Medical Command (NRMC)						
Andrew Rader Army Health Clinic Fort Meyer VA	N	Y	Inova Fairfax	1-Jan-06	NA	NA
Barquist Army Health Clinic, Fort Detrick, MD	Y	Y	Fredrick Memorial Hospital	19-Aug-10	1	0
Fort Belvoir Community Hospital, Fort Belvoir, VA	N	Y	Inova Fairfax-Inova Healthcre Services	5-Feb-09	NA	NA
DiLorenzo Health Clinic, Pentagon, Wash DC	N	Y	Walter Reed National Military Medical Center and Arlinton County Hospital	29-Aug-11	NA	NA
Dunham Army Health Clinic, Carlisle Parracks, PA	N	Y	Carlisle Regional Medical Center	7-Mar-12	NA	NA
Guthrie Medical Department Activity, Fort Drum, NY	Y	Y	Carthage Area Hospital and Samaritan Medical Center	2-Oct-12	3	0
Ireland Army Community Hospital, Fort Knox KY	Y	Y	The Advocacy &Support Center, Elizabethtown, KY	3-Oct-05	6	12
Keller Army Hospital, West Point, NY	Y	N			3	0
Kenner Army Health Clinic Fort Lee VA	N	Y	St. Mary's Hospital, Richmond, VA	6-May-13	NA	NA
USA MEDDAC KACC, Fort Meade, MD	N	Y	Baltimore Washington Medical Center	Under Revision Pending Signature	NA	NA
Kirk AHC, Aberdeen Proving Ground MD	N	Y	Franklin Square Upper Chesapeake MEDCEN, Harford Memorial Hospital	1-Nov-08	NA	NA
McDonald Army Community Hospital Fort Eustis VA	N	Y	Riverside Regional Medical Center 19JUL2010;Sentara Hospital, Hampton, VA;	19-Jul-10	NA	NA
Womack Army Medical Cener Fort Bragg NC	Y	N			22	70
Europe Regional Medical Command (ERMC)						
Landstuhl Regional Medical Center (LRMC)	Y	N	N/A	N/A	14	1.3
SHAPE	Y	N	N/A	N/A	3	0
Baumholder	N	Report to LRMC	N/A	N/A	0	NA
Kleber	N	Report to LRMC	N/A	N/A	0	NA
Wiesbaden	N	Report to LRMC	N/A	N/A	0	NA
USAHC-Livorno, Camp Darby Italy	N	Report to Vicenza Medical Center	N/A	N/A	0	NA
Vicenza	Y	N	N/A	N/A	6	2
Stuttgart	N	Report to LRMC	N/A	N/A	2	3
Bavaria MEDDAC	Y	N	N/A	N/A	**33**	30
	21 MTFs offer SAFE inhouse (40%)				**175**	**404.3**
	1 MTF contracts SAMFE inhouse (2%)					
	30 MTFs coordinate with with 39 external facilities (2 AF, 1 Navy, 36 civilian) (58%)					

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DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Section 579(b) of the National Defense Authorization Act for Fiscal Year 2013 (NDAA FY 2013) requires the Secretary of Defense to collect and submit to Congress, by March 1, 2014, information and data on substantiated incidents of sexual harassment involving members of the Armed Forces for the preceding year, Fiscal Year 2013, as part of the report required pursuant to section 1631 of the Ike Skelton National Defense Authorization Act for Fiscal Year 2011.

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

A. TOTAL NUMBER OF SEXUAL HARASSMENT COMPLAINTS	
A1. Formal Complaints	
# Total formal complaints	50
# Substantiated formal complaints	21
# Unsubstantiated formal complaints	20
# Pending Formal complaints	9
A2. Informal Complaints	
# Total informal complaints referred for investigation/inquiry	32
# Substantiated informal complaints referred for investigation/inquiry	11
# Unsubstantiated informal complaints referred for investigation/inquiry	11
# Pending informal complaints referred for investigation/inquiry	10

B. COMPLAINTS INVOLVING THE SAME OFFENDER	
B1. Formal Complaints	
# Total formal complaints involving the same offender	15
# Substantiated formal complaints involving the same offender	8
# Unsubstantiated formal complaints involving the same offender	5
# Pending formal complaints involving the same offender	2
B2. Informal Complaints	
# Total informal complaints involving the same offender	3
# Substantiated informal complaints involving the same offender	1
# Unsubstantiated informal complaints involving the same offender	1
# Pending informal complaints involving the same offender	1

DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

C. NUMBER COMPLAINANTS AND OFFENDERS	
C1. Formal Complaints	
# Formal complaint investigations with one complainant and one offender	37
# Formal complaint investigations with one complainant and more than one offender	4
# Formal complaint investigations with more than one complainant and one offender	9
# Formal complaint investigations with more than one complainant and more than one offender	2
C2. Informal Complaints	
# Informal complaint investigations with one complainant and one offender	46
# Informal complaint investigations with one complainant and more than one offender	4
# Informal complaint investigations with more than one complainant and one offender	5
# Informal complaint investigations with more than one complainant and more than one offender	0
C3. Total	
# Total alleged offenders in completed investigations (informal and formal)	109

D. NUMBER REPORTS FORWARDED TO GENERAL COUR MARTIAL CONVENING AUTHROITY (GCMCA)	
# Total reports forwarded to GCMCA	50
# Reports forwarded to GCMCA within 72 Hours	35
# Reports forwarded to GCMCA beyond 72 Hours	2

E. LENGTH OF TIME BETWEEN INCIDENT AND FORMAL REPORT FOR SUBSTANTIATED COMPLAINTS	
E1. Formal Complaints	
# Total substantiated formal complaints (# from A1)	40
# Substantiated formal complaints made less than 60 days following the incident	21
# Substantiated formal complaints made more than 60 days following the incident	4
# Unknown	9
E2. Informal Complaints	
# Total substantiated informal complaints (# from A2)	20
# Substantiated informal complaints made less than 60 days following the incident	15
# Substantiated informal complaints made more than 60 days following the incident	4
# Unknown	8

DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

F. LOCATION OF SUBSTANTIATED COMPLAINTS	
F1. Substantiated Formal Complaints	
# On Duty (i.e., during duty hours)	21
# Off Duty (i.e., during time off)	5
# Location of incidents that occurred:	
# On a military installation	12
# Deployed to a combat zone or to an area where complainant drew imminent danger pay	0
# During any type of military combat training	0
# On TDY/TAD, at sea or during field exercises/alerts	1
# During military occupational specialty school/technical training/advanced individual training	10
# During recruit training/basic training	0
# During the delayed entry program	0
# During Officer Candidate or Training School/Basic or Advanced Officer Course	0
# Non-military locale	2
# State armories and reserve centers	0
F2. Substantiated Informal Complaints	
# On Duty (i.e., during duty hours)	36
# Off Duty (i.e., during time off)	4
# Location of incidents that occurred:	
# On a military installation	20
# Deployed to a combat zone or to an area where complainant drew imminent danger pay	0
# During any type of military combat training	0
# On TDY/TAD, at sea or during field exercises/alerts	0
# During military occupational specialty school/technical training/advanced individual training	20
# During recruit training/basic training	0
# During the delayed entry program	0
# During Officer Candidate or Training School/Basic or Advanced Officer Course	1
# Non-military locale	1
# State armories and reserve centers	0

DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

G. COMPLETED SEXUAL HARASSMENT INVESTIGATIONS	
G1. Formal Complaints	
# Total investigations of formal complaints as of close of FY	48
# Investigations of formal complaints pending completion as of close of FY	10
# Completed investigations of formal complaints as of close of FY	37
G2. Informal Complaints	
# Total investigations of informal complaints as of close of FY	50
# Informal complaint investigations pending completion as of close of FY	8
# Completed investigations of informal complaints as of close of FY	42

H. FINAL DISPOSITION FOR OFFENDERS IN COMPLETED INVESTIGATIONS	
H1. Formal Complaints	
# Offenders in formal complaints	40
# Offenders pending command action as of close of FY	10
# Offenders for whom command action was completed as of close of FY	
# Courts-martial	7
# Non-judicial punishments	4
# Discharges in lieu of court-martial	1
# Discharges in lieu of disciplinary action	0
# Referred to agency outside of DoD	1
# Other adverse or administrative actions	8
H2. Informal Complaints	
# Offenders in informal complaints	55
# Offenders pending command action as of close of FY	5
# Offenders for whom command action was completed as of close of FY	
# Courts-martial	0
# Non-judicial punishments	2
# Discharges in lieu of court-martial	0
# Discharges in lieu of disciplinary action	0
# Referred to agency outside of DoD	0
# Other adverse or administrative actions	24

DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

I. SUMMARY OF CHARACTERISTIC INFORMATION: FORMAL COMPLAINTS	
I1. Alleged Offender(s) by Grade and Gender	
# E1-E4:	15
# E5-E9:	24
# O1-O3:	2
# O4-O6:	3
# O7-O10:	0
# DoD/Service civilian employee	9
# GS 1 – 12	6
# GS 13 – 15	3
# SES	0
# DoD/Service civilian contractor	1
# Gender (male):	31
# Gender (female):	11

I2. Complainant(s) by Grade and Gender	
# E1-E4:	34
# E5-E9:	6
# O1-O3:	9
# O4-O6:	5
# O7-O10:	0
# Gender (male):	5
# Gender (female):	48

I3. Identify Nature of Allegation(s)	
# Substantiated Incidents of Crude/Offensive Behavior	12
# Substantiated Incidents of Unwanted Sexual Attention	18
# Substantiated Incidents of Sexual Coercion	2

I4. Relationship of Alleged Offender to Complainant	
# Military coworker:	25
# In chain of command:	16
# Military subordinate:	1
# Military person of higher rank/grade who was not in chain of command:	5
# Other military person(s):	4
# Person in the local community:	0
# DoD/Service civilian employee(s):	6
# GS 1 -12	5
# GS 13 – 15	1
# SES	0
# DoD/Service civilian contractor(s):	0
# Same unit:	28
# Same gender:	5
# Different gender:	41

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

I5. Other Comments (e.g., appeals, remedies, management actions, victim assistance)	

J. SUMMARY OF CHARACTERISTIC INFORMATION: INFORMAL COMPLAINTS	
J1. Alleged Offender(s) by Grade and Gender	
# E1-E4:	26
# E5-E9:	21
# O1-O3:	5
# O4-O6:	5
# O7-O10:	0
# DoD/Service civilian employee	12
# GS 1 -12	12
# GS 13 – 15	0
# SES	0
# DoD/Service civilian contractor	4
# Gender (male):	64
# Gender (female):	9

J2. Complainant(s) by Grade and Gender	
# E1-E4:	30
# E5-E9:	11
# O1-O3:	5
# O4-O6:	0
# O7-O10:	0
# Gender (male):	11
# Gender (female):	53

J3. Identify Nature of Allegation(s)	
# Substantiated Incidents of Crude/Offensive Behavior	23
# Substantiated Incidents of Unwanted Sexual Attention	18
# Substantiated Incidents of Sexual Coercion	0

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

J. SUMMARY OF CHARACTERISTIC INFORMATION: INFORMAL COMPLAINTS (Cont)

J4. Relationship of Alleged Offender to Complainant	
# Military coworker:	36
# In chain of command:	9
# Military subordinate:	5
# Military person of higher rank/grade who was not in chain of command:	7
# Other military person(s):	4
# Person in the local community:	1
# DoD/Service civilian employee(s):	11
# GS 1 -12	11
# GS 13 – 15	0
# SES	0
# DoD/Service civilian contractor(s):	4
# Same unit:	55
# Same gender:	14
# Different gender:	59
J5. Other Comments (e.g., appeals, remedies, management actions, victim assistance)	

K. SEE ATTACHED TAB FOR K

L. ANALYSIS

MEDCOMs data from data calls will not match HQDA ICRS data because the system may fail on the timeliness of data entry as well as Brigade SARCs providing all Sexual Harassment cases to date. With only one individual on the Installation documenting sexual harassment, there is room for errors. Currently the Installation SARC inputs Sexual Harassment cases into ICRS that is provided by Brigade SARCs. In the past the EO had a system to input data and the EOAs were given access to input EO data directly into the EO database (EORS) which captured all Sexual Harassments for each command. This type of access needs to be given to all SARCs for input into the ICRS database for an accurate account of Sexual Harassment cases across the commands.

M. DEFINTIONS

DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

Unless otherwise noted, these terms and respective definitions are for the purposes of this report.

Crude/Offensive behavior: Offensive or embarrassing verbal/nonverbal behaviors of a sexual nature.

Fiscal Year: 2013 (October 2012 – September 2013)

Formal complaint: In accordance with DoD Directive (DoDD) 1350.2, an allegation of sexual harassment that is submitted in writing to the authority designated for receipt of such complaints in Service implementing regulations.

Informal complaint: In accordance with DoDD 1350.2, an allegation of sexual harassment, made either orally or in writing that is not submitted as a formal complaint. For the purposes of this data collection, includes only informal complaints referred for investigation or inquiry.

Location: For purposes of location, please indicate where the incident occurred:
- on a military installation
- while the complainant was deployed to a combat zone or to an area where they drew imminent danger pay
- during any type of military combat training
- while they were on TDY/TAD, at sea or during field exercises/alerts
- during military occupational specialty school/technical training/advanced individual training
- during recruit training/basic training
- during the delayed entry program
- during Officer Candidate or Training School/Basic or Advanced Officer Course
- non-military locale
- state armories and reserve centers

Sexual coercion: Classic *quid pro quo* instances of special treatment or favoritism conditioned on sexual cooperation.

Sexual harassment: In accordance with DoDD 1350.2, a form of sex discrimination that involves unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

Submission to such conduct is made either explicitly or implicitly a term or condition of a person's job, pay, or career, or

Submission to or rejection of such conduct by a person is used as a basis for career or employment decisions affecting that person, or

Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creates an intimidating, hostile, or offensive working environment.

DATA COLLECTION TEMPLATE FOR SEXUAL HARASSMENT INCIDENTS

Instructions:
Enter appropriate number (#) in each column for the required fiscal year.
Where the information is available, but there are no numbers, write zero "0."
Where the information is not available, write "N/A."
The total number of complaints should equal the summed number of subcategories below each total (for example, the total number of formal complaints should equal the summed number of substantiated, unsubstantiated, and pending formal complaints).

This definition of sexual harassment emphasizes that workplace conduct, to be actionable as "abusive work environment" harassment, need not result in concrete psychological harm to the victim, but rather need only be so severe or pervasive that a reasonable person would perceive, and the victim does perceive, the work environment as hostile or offensive. ("Workplace" is an expansive term for military members and may include conduct on or off duty, 24 hours a day.) Any person in a supervisory or command position who uses or condones any form of sexual behavior to control, influence, or affect the career, pay, or job of a military or National Guard member or civilian employee is engaging in sexual harassment. Similarly, any military or National Guard member or civilian employee who makes deliberate or repeated unwelcome verbal comments, gestures, or physical contact of a sexual nature in the workplace is also engaging in sexual harassment.

Unwanted sexual attention: Unwanted attempts to establish a sexual relationship.

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K. INDIVIDUAL COMPLAINT REPORT INFORMATION

Complaint Identification Number	Days between incident & formal report	Forwarded to GCMCA	On- or off-duty	Offender Grade	Offender Gender	Complainant Grade	Complainant Gender	Allegation	Relationship	Unit	Disciplinary/Corrective Actions Taken	Other comments
na	108 days	Less than 72 hours	Off Duty (e.g. during time off)	E-8	Male	E-5	Female	Unwanted Sexual Attention	In chain-of-command	Same unit	Other adverse or administrative action	na
na	4 weeks	Less than 72 hours	Off Duty (e.g. during time off)	E-5	Male	E-3	Female	Unwanted Sexual Attention	In chain-of-command	Same unit	Non-judicial punishment	na
6402	10 days	Less than 72 hours	Unknown	E-5	Male	E-3	Female	Sexual Coercion	Military person of higher rank/grade not in chain of	Same unit	Non-judicial punishment	na
6402	10 days	Less than 72 hours	Unknown	E-5	Male	E-4	Female	Sexual Coercion	Military person of higher rank/grade not in chain of	Same unit	Non-judicial punishment	na
na	35 days	Less than 72 hours	On Duty (e.g. during duty hours)	E-4	Male	E-4	Female	Crude/Offensive Behavior	DoD/Service civilian contractor(s)	Same unit	Other adverse or administrative action	na

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12-4-1	1 Day	Less than 72 hours	On Duty (e.g. during duty hours)	Unknown	Male	E-6	Female	Other	Militayr co-worker	Same unit	Unknown	GS employee/Direct Method/received additional training
13-1-4	1 Day	Less than 72 hours	On Duty (e.g. during duty hours)	Unknown	Male	Unknown	Female	Unwanted Sexual Attention		Different unit	Other adverse or administrative action	GS Employees/Reassigned, retraining
13-2-1	1 Week	More than 72 hours	On Duty (e.g. during duty hours)	Unknown	Male	Unknown	Female	Unwanted Sexual Attention	Militayr co-worker	Same unit	Other adverse or administrative action	GS Employees/Verbal counseling, MFR
13-2-2	2 weeks	Unknowm	On Duty (e.g. during duty hours)	Multiple Offenders	Male	E-4	Female	Crude/Offensive Behavior		Same unit	Non-judicial punishment	article 15 and 4 letter of reprimand
13-2-3	1 Day	More than 72 hours	On Duty (e.g. during duty hours)	E-5	Male	E-5	Female	Unwanted Sexual Attention	Military subordinate	Same unit	Non-judicial punishment	Company grade article 15
13-3-1	1 Day	Less than 72 hours	On Duty (e.g. during duty hours)	E-4	Male	E-6	Female	Unwanted Sexual Attention	Military subordinate	Same unit	Other adverse or administrative action	LOR
13-3-2	3 Days	More than 72 hours	On Duty (e.g. during duty hours)	E-7	Male	Unknown	Female	Unwanted Sexual Attention	Person in local community	Unknown	Other adverse or administrative action	LOR

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13-3-4	1 week	More than 72 hours	On Duty (e.g. during duty hours)	O-3	Male	O-3	Female	Unwanted Sexual Attention	Militayr co-worker	Same unit	Other adverse or administrative action	Counseling statement
13-3-5	1 Day	Less than 72 hours	On Duty (e.g. during duty hours)	E-3	Male	Cadet	Female	Crude/Offensive Behavior	Other military person(s)	Unknown	Court-martial	Moved to company
13-5-6	1 Day	Less than 72 hours	On Duty (e.g. during duty hours)	Unknown	Male	Unknown	Female	Unwanted Sexual Attention	Militayr co-worker	Same unit	Other adverse or administrative action	GS Offender and GS complaintant Management Action
13-4-1	1 Day	Less than 72 hours	On Duty (e.g. during duty hours)	Unknown	Male	Unknown	Female	Unwanted Sexual Attention	Militayr co-worker	Same unit	Other adverse or administrative action	GS Offender and GS complaintant-Direct Method/received additional training
13-4-2	3 weeks	More than 72 hours	On Duty (e.g. during	O-4	Male	Unknown	Female	Crude/Offensive Behavior	Militayr co-worker	Same unit	Other adverse or administrative	Management Action
13-4-5	1 day	Less than 72 hours	On Duty (e.g. during duty hours)	Unknown	Male	Unknown	Female	Crude/Offensive Behavior	Militayr co-worker	Same unit	Other adverse or administrative action	GS Offender and GS complaintant-Management Action
na	2 weeks	Exactly 72 Hours	On Duty (e.g., during duty hours)	E-5	Male	E-3	Female	Crude/Offensive Behavior	Military co-worker	Same unit	Other adverse or administrative action	Management Action

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na	1 week	Exactly 72 Hours	On Duty (e.g., during duty hours)	E-6	Male	E-4	Female	Crude/Offensive Behavior	Military co-worker	Same unit	Other adverse or administrative action	Management Action
na	10 days	Exactly 72 Hours	On Duty (e.g., during duty hours)	Unknown	Male	Unknown	Female	Crude/Offensive Behavior	Military co-worker	Same unit	Other adverse or administrative action	GS Offender and GS complaintant-Management Action
na	30 days	Exactly 72 Hours	On Duty (e.g., during duty hours)	E-7	Male	E-4	Female	Crude/Offensive Behavior	Military co-worker	Same unit	Other adverse or administrative action	Management Action
na	30 dyas	Exactly 72 Hours	On Duty (e.g., during duty hours)	Unknown	Male	Unknown	Female	Crude/Offensive Behavior	Person in local community	Unknown	Other adverse or administrative action	GS Offender and GS complaintant-Management Action
na	4 WEEKS	Less Than 72 Hours	Off Duty (e.g., during time off)	E-5	Male	E-3	Female	Unwanted Sexual Attention	In chain-of-command	Same unit	Non-judicial punishment	NA
NA	8 Months	Less Than 72 Hours	Off Duty (e.g., during time off)	O-5	Male	O-2	Female	Unwanted Sexual Attention	Military person of higher rank/grade not in chain-of-	Not applicable	Other adverse or administrative action	GOMAR

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Less Than 72 Hours
Exactly 72 Hours
More Than 72 Hours
Unknown

On Duty (e.g., during duty hours)
Off Duty (e.g., during time off)
Unknown

E-1
E-2
E-3
E-4
E-5
E-6
E-7
E-8
E-9
W-1
W-2
W-3
W-4
W-5
O-1
O-2
O-3
O-4
O-5
O-6
O-7
O-8
O-9
O-10
Cadet
Midshipman
US Civilian
Foreign National
Foreign Military
Unknown
Multiple offenders

Male
Female
Unknown
Multiple offenders

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Crude/Offensive Behavior
Unwanted Sexual Attention
Sexual Coercion
Unknown
Other

Military co-worker
In chain-of-command
Military subordinate
Military person of higher rank/grade not in chain-of- command
Other military person(s)
Person in local community
DoD/Service civilian employee (s)
DoD/Service civilian contractor(s)
Unknown

Same unit
Different unit
Not applicable
Unknown

Court-martial
Non-judicial punishment
Discharge in lieu of court-martial
Discharge in lieu of disciplinary action
Other adverse or administrative action
Unknown

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Fiscal Year (FY) 2013 MEDCOM Sexual Assault Prevention and Response (SAPR) Program Review Data Call: Instructions and Template

Purpose: The purpose of this report is to capture congressionally required content and describe the programmatic initiatives, capabilities, oversight activities, changes, and challenges supported or experienced by your Service or Component SAPR program during FY13. Also included are outcomes of Secretary of Defense Initiatives (SDI), the Joint Chiefs of Staff Strategic Direction (JCD) to the Joint Force on SAPR (2012), and the *2013 DoD SAPR Strategic Plan* (SP) implemented in FY13. This year's report will organize SAPR program accomplishments and activities by the five Lines of Effort (LOEs) outlined in the DoD SAPR SP. The following data call reflects this structure.

Instructions: Each submission must include a completed Executive Summary Template, not to exceed 1000 words, and a completed FY13 SAPR Program Review Data Call Template. The final document must have a title of "FY13 DoD Sexual Assault Prevention and Response Program Review: (insert your Service or Component)", Arial font, size 12, sans watermarks, such as *DRAFT* or *FOUO*. The final document should be submitted in PDF format no later than March 1, 2014. Required changes will be made by your Service or Component.

Unless otherwise indicated, only include activities or accomplishments undertaken in FY13 (October 1, 2012 through September 30, 2013.) Where possible, please identify how an activity or accomplishment promotes the LOE under which it is listed. Please avoid repeating activities or accomplishments, or duplicating examples across the five LOEs. The term "Component" in this template refers to the National Guard Bureau.

Executive Summary

The following Executive Summary Template should be used to capture a summary of your Service or Component FY13 SAPR Program Review. This overview should include information such as:

- **Authorizing regulations and/or instructions and dates of publication.**
- **General organizational structure of your SAPR program and personnel (e.g., Brigade, Installation, Regional, and/or Major Command Sexual Assault Response Coordinator [SARC] and SAPR Victim Advocate [VA] structure, mid-level program management [if any], and program management) as well as a brief description of how this structure changes in deployed and joint environments.**
- **Other personnel involved and their respective roles in your SAPR program.**
- **A summary of the progress made and principal challenges confronted by your SAPR program in FY13.**
-

Fiscal Year (FY) 2013 MEDCOM Sexual Assault Prevention and Response (SAPR) Program Review Data Call

The Army Medical Department (AMEDD) Sexual Harassment/Assault Response and Prevention (SHARP) Program Office provides regulatory guidance and oversight for the dual goals of provision of medical care to all sexual assault victims and the prevention and response of sexual harassment/assault in support of Medical Command (MEDCOM) Soldiers and their eligible Family Members.

The AMEDD SHARP Program Office consists of three civilian employees (Program Manager, Program Advisor and a Nurse Administrator) plus a borrowed military Senior Enlisted Advisor (SGM). There are two hires pending (required and authorized) for a Data Analyst and a Program Support Specialist.

Prevention of sexual assault is a command program enacted through the MEDCOM SARCs and VAs in compliance with AR 600-20. MEDCOM Regulation 40-36 (21 Jan 2009), Medical Facility Management of Sexual Assault, directs the health care team in the provision of timely, accessible and comprehensive medical management of all sexual assault patients at each Army Military Medical Treatment Facility (MTF). The multidisciplinary medical team provides immediate and ongoing treatment to patients and coordination of those services.

Sexual assault patients are given expert, emergency treatment. Regardless of evidence of physical injury, all patients presenting to an MTF with an allegation of sexual assault receive comprehensive and compassionate expert treatment. They are offered a sexual assault forensic examination (SAFE) completed by a trained and competent Sexual Assault Medical Forensic Examiner (SAMFE) provider at the MTF or at a local facility through a memorandum of agreement. All exams are completed in accordance with Department of Justice protocols and guidelines. 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).

Every MTF has an informal sexual assault medical management program with a Deputy Commander for Clinical Services (DCCS) providing oversight to the SAMFE, the sexual assault care coordinator (SACC) and sexual assault clinical provider (SACP). This team works with Sexual Assault Response Coordinators (SARC) and Victim Advocates (VA) to insure comprehensive and coordinated care to all patients following sexual assault. Currently, there are over 300 healthcare providers trained as SAMFE, SACCs and SACPs across 50 MTFs.

The AMEDD sexual assault medical management team is designed to provide immediate and long term patient care, from assessment of risk for pregnancy, options for emergency contraception, risk of sexually transmitted infections, including HIV prophylaxis, to necessary follow-up care and services. All patients are offered a referral to Behavioral Health at their first medical encounter, and encouraged to receive psychological care and victim advocacy. In addition, there are long-term care plans tailored to the meet the individual patient's medical and behavioral health care needs.

203927

AMEDD's SAMFE 80 hour training is based on DOJ National Training Standards to educate Physicians, Physician Assistants, Advanced Practice Nurses, and Registered Nurses to conduct forensic exams. A 40 hour didactic training prepares candidates to meet the health care needs of adult and adolescent sexual assault patients followed by a second week of clinical competency training.

SAMFEs, SACCs, SACPs, local SHARP leaders, and MEDCOM SARCs and VAs are given annual training through the AMEDD Sexual Assault Medical Management Course, a 40 hour course in support of both medical management following sexual assault and the MEDCOM Command program.

The AMEDD SAMFE training meets CENTCOM pre-deployment requirements for healthcare providers assigned to Role II and Role III facilities. To support pre-deployment and local SAMFE requirements, 7 CONUS & OCONUS sites hosted 9 courses in FY13. Additionally, AMEDD increased the number of behavioral health personnel in theater to approximately 1 provider for every 800 Soldiers.

The Army SHARP expanded harassment/prevention mission will impact funding, hiring of civilian staff, SHARP training (currently at 80 hrs.), credentialing and policy revisions. Upon revision of the Army Regulation 600-20, 100% of MEDCOM policies will require revision/updating during FY14.

MEDCOM was authorized 34 new SARC positions in FY13 to meet NDAA 2013 and DoD Instruction and Directive guidance. All hiring actions are initiated.

In May 2013 The Army Surgeon General (TSG) established a SHARP Work Group (WG) with internal subject matter experts to augment the SHARP Program Office to integrate, coordinate, plan, prepare and assess implementation of the DoD SAPR Strategic Plan, Department of the Army SHARP directives, and to further develop the AMEDD SHARP Program. The AMEDD exempted all SHARP related personnel from furlough to include SARCs, VAs, SACCs, SACPs and SAMFEs.

The AMEDD SHARP Program is revising MEDCOM Reg 40-36 for compliance with 2012-2013 regulatory updates to AR 600-20 (Army Command Policy), DoD Instruction 6495.02 (Sexual Assault Prevention and Response Program Procedures), DoD Directive 6495.01 (Sexual Assault Prevention and Response Program), and the Department of Justice (DOJ) April 2013 "A National Protocol for Sexual Assault Medical Forensic Examinations". The AMEDD SHARP Program already meets the DOJ "National Training Standards for Sexual Assault Medical Forensic Examiners".

Other initiatives 2013 through 2014 include formalizing the MTF sexual assault medical management office with a medical director, responsive to the DCCS. The MEDCOM SARC and VA remain responsive to the Commander. The Surgeon General's vision is to have all sexual assault program medical providers meet the same enhanced and expanded background checks as SARCs and VAs. Medical personnel engaged in care

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to patients following sexual assault are, indeed, in positions of trust. AMEDD is leading a national conversation on a SAMFE Gold Standard. Experts from DOJ, International Association of Forensic Nurses, U.S. Army Criminal Investigation Lab, DoD, Navy, Criminal Investigation Division, Provost Marshal Office and across Army Medicine support this collaborative effort.

In support of Soldiers, the Medical Command Commander supported expansion of the MEDCOM SARC/VA program which now has over 500 SARC/Victim Advocate personnel. The MEDCOM Commander mandated four hour reporting to her on all MEDCOM related sexual assaults, creation of a centralized database to track and trend available sexual assault and sexual harassment data, and routine reporting on all aspects of sexual assault and harassment to her senior leaders and command teams, And lastly, the MEDCOM Commander/Surgeon General directed a review of the support to all sexual assault victims, inclusive of those covered by SHARP, Family Advocacy, or with no programmatic support services (e.g., retirees).

1. Line of Effort (LOE) 1—Prevention—The objective of prevention is to "deliver consistent and effective prevention methods and programs."

1.1 Summarize your Service or Component's efforts to achieve the Prevention Endstate: "cultural imperatives of mutual respect and trust, professional values, and team commitment are reinforced to create an environment where sexual assault is not tolerated, condoned, or ignored."

TSG SHARP Policy Memo dated 9 Sept 2013 outlines the command goals to reduce sexual assaults and harassment by creating a climate that respects the dignity of every member of the Army Family; reduces stigma of reporting; increases prevention, investigation, and prosecution capability; increases training and resources; and refines and sustains response capability.

In May 2013 The Army Surgeon General (TSG) established a SHARP Work Group (WG) with internal subject matter experts to augment the SHARP Program Office to integrate, coordinate, plan, prepare and assess implementation of the DoD SAPR Strategic Plan, Department of the Army SHARP directives, and to further develop the AMEDD SHARP Program.

1.2 Identify the ways you are changing organizational prevention-based practices.

MEDCOM OPORD 13-52 (MEDCOM, SHARP Prevention Plan) implements the CoS of the Army SHARP guidance ie. Command Climate Survey, 24 Hour Hotline Assistance, Barracks security, sponsorship and on-boarding of new employees.

TSG SHARP Policy Memo dated 9 Sept 2013 directs that prevention of sexual harassment/assault may be achieved through immediate intervention of any act that is perceived to be sexual in nature and unprofessional. Bystanders should speak-up to stop sexual harassment at an early stage before potential sexual assault develops.

1.3 Describe your efforts to comply with DoD SAPR core competencies for all SAPR training to ensure consistency. Include Professional Military Education,

Pre-Command, and Senior Enlisted training.

All courses, BOLC/HPSP/USUHS/BOLC-RC/PCC, receive SHARP training (1 1/2 hours didactic, followed by 1 1/2 hours of the Sex Signals presentation). They also receive the leader engagement training as well. Leader Engagement Training is a separate requirement, but it"s done in conjunction with the didactic portion, typically during in processing for the long course.

The task for SHARP is "Implement the Army's Sexual Harassment/Assault Response and Prevention Program (SHARP) - BOLC-B". The task number is 805C-COM-0104. The lesson ID is 805C-0104. The TSP number is 805C-G1-0104.

AMEDD Advanced Leader Course and Senior Leader Course

During an in-processing lesson, using the small group methodology, students in the Advance Leader Course receive an initial briefing on the DOD Sexual Assault Prevention and Response program by senior leaders. The assigned SHARP representative then engages students in a 10-20 minute dialogue on Victim Focus, Prevention Centered Environment, peer-to-peer, subordinate, and superior accountability and Incident Reporting. Students are encouraged to use critical thinking with each topic that is presented in a scenario-based context. Students are provided with contact cards with the SHARP POC's listed.

In the Senior Leader Course the same information is covered in a separate class under lesson plan 805C-SLC TSP 805C-G1-0107.

1.4 Describe your progress in implementing the findings and recommendations from the SAPR Initial Military Training reviews. Include your efforts to enhance accession training by including SAPR policies and implementation of SAPR training within 14 days of entrance to active duty.

MEDCOM OPORD 13-52 (FRAGO 11): Response to Army Directive 2013-17 (SHARP in Initial Military Training)

The Initial Military Training (IMT) applies only to the Army Medical Department Center and School (AMEDDC&S). The AMEDDC&S is 100% in compliance with the following actions:

a. Initial Military training trainees/students receive SHARP training within the first 14 days of arriving at training.

b. Ratios of platoon sergeants to trainees/students are reviewed to ensure an appropriate number of female cadre is available.

c. Institutional safeguards to prevent the abuse of power, sexual harassment and assault, unprofessional and prohibited relationships/ and maltreatment are reviewed and implemented. Institute acceptable reporting procedures and address all of these areas at the beginning of all IMT.

d. 32nd Medical Brigade Enlisted Training policies are updated to reflect that the "Battle Buddy System" applies to both the IMT trainees/students and to platoon sergeants and cadre when counseling or interacting with IMT personnel outside the classroom or training environment.

1.5 Identify specific SAPR monitoring, measures, and education that impart individual skills associated with bystander intervention and appropriate risk reduction that does not blame victims.

Annual SHARP Training, Team Bound, and MEDCOM OPORD 13-52 (FRAGO 4) Leader and SARC/VA Refresher Training

TSG SHARP Policy Memo dated 9 Sept 2013 directs that prevention of sexual harassment/assault may be achieved through immediate intervention of any act that is perceived to be sexual in nature and unprofessional. Bystanders should speak-up to stop sexual harassment at an early stage before potential sexual assault develops.

1.6 Describe your efforts to establish policies that create and sustain safe environments free of sexual assault. Include policies and practices that address alcohol consumption and barracks/dormitories visitation.

Reference: ALARACT 135/2013 – HQDA EXORD 149-13: Sexual Harassment/Assault Response and Prevention Program Army Workplace/Barracks Inspection.

Commanders and Supervisors in United States Army Medical Command (USAMEDCOM) and the Office of The Surgeon General (OTSG) have conducted comprehensive visual inspections of all MEDCOM workplaces. No unlawful materials were discovered. However, in some areas magazines revealing body parts along with books derogatory messages and personal photos babies/children with no shirt in photos were removed with no seizure or follow-on action. Copies of visual inspections results are maintained at the Regional Medical Commands. Attached is the Consolidation Worksheet for MEDCOM/OTSG. Barracks security and safety. Commanders with responsibility for barracks and assigned personnel living in barracks will direct command teams to reinforce their presence and interest by conducting checks regularly in barracks, especially over weekends and holidays, to increase awareness and accountability and to set a climate of professionalism and zero tolerance for harassment or abuse. All barracks personnel and Charge of Quarters (CQ) personnel must be empowered to stop unacceptable behavior and to report immediately to the chain of command. Commanders will develop and report on "visitation and visibility" plan by memorandum

MEDCOM OPORD 13-52 (MEDCOM, SHARP Prevention Plan) implements the CoS of the Army SHARP guidance ie. Command Climate Survey, 24 Hour Hotline Assistance, Barracks security, sponsorship and on-boarding of new employees.

Additionally 32d Medical Brigade:
-Instituting policy that prohibits alcohol consumption in the AIT footprint. Alcohol is prohibited in the barracks as well (to include the Officers' barracks for those residing on post). Successfully got alcohol sales eliminated from the AAFES shoppette that is

within the AIT footprint on Fort Sam Houston and from the new Tri-Service Student Activities Center on the Medical Education and Training Campus (METC).

-Submitting requirements to establish SHARP hotlines in each of the Brigade's barracks. 92 total hard-wired phones throughout the footprint have been submitted through the chain of command for approval . As an interim solution, government cell phones have been issued to all organizational Victim Advocates and SARC personnel within the Brigade.

-Seeking funding for improving digital monitoring systems in barracks, especially in common areas. Higher headquarters has authorized $523K for short term improvements to our current equipment, and we are working closely with the Joint Base and Senior Army Commander for lock replacements within some of our older barracks buildings.

-Implementing Battalion level policies banning other Service trainees or opposite gender personnel from entering barracks.

-Increasing the frequency of Brigade-level Command Climate Surveys and including SHARP-specific questions in the Command Climate/DEOMI surveys.

-Aggressively resetting the Brigade's barracks footprint to achieve gender specific barracks throughout the Brigade to achieve TRADOC's preference of gender separation by barracks. We accomplished this for two of the three AIT Battalions to date and will achieve the same end-state for the third Battalion in Spring of 2014 upon completion of the construction of a new facility for part of the population.

-Instituting a Sexual Assault Prevention Working Group to address prevention measures following an unrestricted report. This working group meets within two weeks following the report of an unrestricted case that occurs while the victim is assigned to the Command and is focused on determining immediate actions that the Chain of Command could implement to prevent a recurrence.

-Instituting TRADOC's 2007 guidance to conduct Cadre Training Courses for that cadre who operate in and around trainees (we are currently on our third course iteration).

-Establishing an Organizational Inspection Program (OIP) within the Brigade and added SHARP programs as inspectable items within the OIP.

-Standing up a Brigade Staff Duty Program with the requirement for the SDO to maintain a presence within the footprint and conduct courtesy patrols of known problem areas while on duty.

1.7 Describe progress, assessment, efforts, and/or approved plans for requiring commanders to conduct an organizational climate assessment within 120 days of

assuming command and annually thereafter. Include policy for providing results to the next level in the chain of command.

MEDCOM OPORD 13-52: MEDCOM Commanders will report on the most recent command climate survey, the date of its completion, the command level at which the survey was reviewed, whether any SHARP concerns were identified, and whether corrective actions have been completed and assessed for effectiveness.

MEDCOM Policy 13-049, Command Climate Surveys- The results of Command Climate Surveys must be provided to the next higher level commander; Commanders will provide a monthly compliance verification to the MEDCOM EO Office;

OTSG/MEDCOM Policy Memo 13-049 on Command Climate Surveys published on 26 August, 2013 requires MTF Battalion/Brigade-level Commanders to conduct a unit Command Climate Survey within 30 days of assuming command, again after 6 months and annually thereafter. To enhance accountability of Commanders, the results of mandatory and voluntary Command Climate surveys will be provided to the next higher level of command. Upon initiating a Command Climate Survey, the requesting Commander must provide a valid e-mail address of his/her supervisor to ensure that the supervisor receives the results directly from the Defense Equal Opportunity Management Institute, the agency that administers command climate survey for Department of Defense.

1.8 Describe collaboration efforts concerning prevention with external experts, federal partners (e.g. NATO), advocacy organizations, and educational institutions, to include prevention subject matter experts. Describe results and/or implementations of lessons learned from collaboration efforts.

Sexual Assault Medical Management Training: External presenters discussed Cultural Responsive Care in Sexual Assault and special populations, Human Trafficking and a survivor story to include panel discussion.

Gold Standard Workgroup: brought in external agencies to work on a policy standard for Sexual Assault Medical Forensic Examiners and conducting SAFEs in the Army MTF.

1.9 Describe your efforts to establish and implement policies that prevent individuals convicted of a Federal or State offense of rape, sexual abuse, sexual assault, incest, or other sexual offenses, from being provided a waiver for commissioning or enlistment in the Armed Forces.

In conjunction with the USAREC Health Services Directorate, the Medical Recruiting Brigade conducts background checks required by Department of Defense Instruction 1402.5 (Criminal History Background Checks on Individuals In Child Care Services). This requires a review of all potential applicants and their security records to include a FBI fingerprint check and State Criminal History Repository checks of residences listed on employment or certification applications.

Prior to any applicant being boarded for appointment, we query and review three sources:

1. The National Sex Offender Public Website. (The State Criminal history check for sex

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crimes is now a national check)

2. We also perform the LiveScan fingerprint check, which is required to be within 120 days of the Joint Personnel Adjudication System (JPAS) submission. LiveScan queries the FBI fingerprint database.

3. The JPAS/ENSQ submission includes the Installation Record check required by the DODI. This consists of a local record check on an individual for a minimum of 2 years before the date of the application. This record check includes, at a minimum, police (base and/or military police, security office, criminal investigators, or local law enforcement) local files checks, Drug and Alcohol Program, Family Housing, Medical Treatment Facility for Family Advocacy Program Service Central Registry records and mental health records, and any other record checks as appropriate to the extent permitted by law.

The results for the above three checks are part of the application for appointment. If the person has a match and it is verified, they are disqualified from commissioning.

1.10 Describe your plans for FY14 that pertain to delivering consistent and effective prevention methods and programs, including how these efforts will help your Service plan, resource, and make progress in your SAPR program.

Revision of MEDCOM Regulation Update 40-36, Medical Facility Management of Sexual Assault.

Publish: Army Gold Standard for Sexual Assault Medical Forensic Examiners (SAMFE)to define training, competency verification and roles of Army SAMFEs.

AR 40-68, Clinical Quality Management revision will include a section on verification of clinical competencies for the SAMFE.

2. LOE 2—Investigation—The objective of investigation is to "achieve high competence in the investigation of sexual assault."

2.1 Summarize your Service or Component's efforts to achieve the Investigation Endstate: "investigative resources yield timely and accurate results."

This LOE falls outside the responsibility of the US Army Medical Command. (MCJA)

2.2 Describe your Service or Component's implementation plan for the establishment of a Special Victim Capability (SVC), comprised of specially trained investigators, judge advocates, administrative paralegal support, and victim-witness assistance personnel.

This LOE falls outside the responsibility of the US Army Medical Command. (MCJA)

2.3 Describe your efforts to enhance training and/or plans for enhanced training for investigators of sexual violence. Include your measures of effectiveness or means by which you are measuring enhancements.

This LOE falls outside the responsibility of the US Army Medical Command. (MCJA)

2.4 Describe your Service's efforts to participate in Defense Enterprise Working Group of Military Criminal Investigation Organizations and Defense Criminal Investigative Services to assess and validate joint investigative technology, best practices, and resource efficiencies benchmarked against external law

enforcement agencies.
This LOE falls outside the responsibility of the US Army Medical Command. (MCJA)
2.5 Describe your Military Criminal Investigative Organization's (MCIO) progress on establishment of a Working Group to review initial baseline, periodic refresher, and advanced sexual assault investigation training in order to establish common criteria, measures of effectiveness, and leverage training resources and expertise. If already in progress or completed, briefly describe recommendations, results, and ongoing efforts.
This LOE falls outside the responsibility of the US Army Medical Command. (MCJA)
2.6 Describe and provide documentation of your Service or Component's implementation of policy for retention of sexual assault documentation (e.g. DD Forms 2910 and 2911). Documentation should be included as an appendix.
IAW MEDCOM Reg 40-36 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. 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", maintained in a locked, secured container, and identified as a Special Category record by Patient Administration Division.
2.7 Describe your efforts to review and implement policies and procedures that ensure all Unrestricted Reports of sexual assault (and attempts) against adults will be immediately reported to the MCIO, regardless of the severity of the allegation.
IAW MEDCOM OPORD 13-52 FRAGO 3 and FRAGO 10 Commander Reporting Requirements are: (1) Notification to The Surgeon General will be made within four (4) hours of learning about a possible sexual assault. Information on initial notification will include the victim, alleged offender, and incident information requirements. (2) Commanders will report sexual assaults in accordance with (IAW) MEDCOM Sup. 1 to AR 190-45 paragraph 8-6 with MEDCOM FORM 104-R. Sexual Assaults are a Category 3 reporting requirement. (3) Commanders will submit the USAMEDCOM Sexual Assault Seven-Day Brief within seven calendar days upon discovery or notification of a possible sexual assault to OPNSCENTER21 OPNS.
2.8 Describe efforts, policies, and/or programmatic changes undertaken to improve Service member confidence and/or victim participation in the investigative and military justice process, as well as how you are addressing the number of victims declining to participate. Include rate of conversion from Restricted to Unrestricted reporting.
This LOE falls outside the responsibility of the US Army Medical Command. (MCJA)
2.9 Describe your plans for FY14 that pertain to the achievement of high competence in the investigation of sexual assault.

Not applicable to U.S. Army Medical Command (MCJA).
3. LOE 3—Accountability—The objective of accountability is to "achieve high competence in holding offenders appropriately accountable."
3.1 Summarize your Service or Component's efforts to achieve the Accountability Endstate: "perpetrators are held appropriately accountable."
This LOE falls outside the responsibility of the US Army Medical Command and is more appropriately addressed by The Judge Advocate General. (MCJA)
3.2 Describe your efforts to enhance training and/or plans for enhanced SAPR training for attorneys and military judges. Include your efforts to monitor training requirements to ensure the optimal number receive enhanced SAPR training and your measures of effectiveness.
This LOE falls outside the responsibility of the US Army Medical Command and is more appropriately addressed by The Judge Advocate General. (MCJA)
3.3 Describe your Service's efforts to conduct an assessment of DoD Pilot Program for Special Victims Counsel. If an assessment has been completed, explain findings and recommendations.
This LOE falls outside the responsibility of the US Army Medical Command and is more appropriately addressed by The Judge Advocate General. (MCJA)
3.4 Describe your efforts to expand the availability, sequencing, and scope of commander's legal courses. Include your measures of effectiveness.
This LOE falls outside the responsibility of the US Army Medical Command and is more appropriately addressed by The Judge Advocate General. (MCJA)
3.5 Describe your efforts to assess the effectiveness of the policy to elevate initial disposition authority to a Special Court Martial Convening Authority in the grade of O-6 or higher. Provide documentation in the appendix. If assessment complete, briefly describe results and recommendations.
This LOE falls outside the responsibility of the US Army Medical Command and is more appropriately addressed by The Judge Advocate General. (MCJA)
3.6 Describe any treatment or rehabilitation programs implemented by your Service or Component for those members who have been convicted of a sexual assault. Include any pertinent referrals such as drug and alcohol counseling, or other types of counseling or intervention.
The Army has increased its evidence-based practice training efforts through the Army Medical Department Center and School, offering evidenced based centralized training to Army healthcare providers. Evidenced based practice training currently available includes: Prolonged exposure (PE); Eye movement desensitization reprocessing (EMDR) and Cognitive processing therapy (CPT), all of which are identified as current best practice in support of sexual assault victims.
3.7 List updates or efforts to update policies requiring the processing for administrative separation of any member convicted of a sexual assault. Include documentation in the appendix.
This LOE falls outside the responsibility of the US Army Medical Command and is more appropriately addressed by The Judge Advocate General. (MCJA)
3.8 Describe your plans for FY14 that pertain to the achievement of high competence in holding offenders appropriately accountable.
This LOE falls outside the responsibility of the US Army Medical Command and is more

appropriately addressed by The Judge Advocate General. (MCJA)
4. LOE 4—Advocacy/Victim Assistance–The objective of advocacy/victim assistance is to "deliver consistent and effective victim support, response, and reporting options."
4.1 Summarize your Service or Component's efforts to achieve the Advocacy/Victim Assistance Endstate: "DoD provides high quality services and support to instill confidence and trust, strengthen resilience, and inspire victims to report."
MEDCOM was authorized 34 new SARC positions in FY13 to meet NDAA 2013 and DoD Instruction and Directive guidance. All hiring actions are initiated.
4.2 List the total number of full-time SARC/SAPR VAs serving at brigade or equivalent level. If not at 100%, describe your efforts to achieve 100% fill.
BDE Level full time SARC:34 BDE Level fulltime VA:34
4.3 List the total number SARCs and SAPR VAs certified in FY13. If not at 100%, describe your efforts to achieve 100% certified.
Out of 546 SARC/VA 387 are certified and 159 are pending the next review board.
4.4 Describe your efforts to develop victim continuity of care protocol in collaboration with the Department of Veterans Affairs and external Veterans Service Organizations.
The Department of Veterans Affairs to include the local representatives support annual medical management training and patient/victim care.
4.5 Describe your efforts to improve the portability and availability of victim services in deployed environments, ensuring continuity of victim care. Include a description of the steps taken during that year to ensure that trained personnel, appropriate supplies, and transportation resources are accessible to deployed units in order to provide an appropriate and timely response in any case of reported sexual assault in a deployed unit, location, or environment.
Collaborated with the CENTCOM Surgeon in the revision of CENTCOM Policy for the pre-deployment training requirements for conducting the SAFE. SAMFE training meets the pre-deployment training requirements for role II/III facilities.
4.6 Describe revised policies and/or procedures developed that allow Reserve Component Service members who are victims of sexual assault while on active duty to remain on active duty status to obtain the treatment and support afforded active duty members. Include documentation in the appendix.
Not applicable
4.7 Describe your efforts to enhance sexual assault training for health care providers. Include requirements that ensure training conforms to "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents"; how to handle a Restricted Report; and how to conduct the SAFE exam.
Internal MEDCOM Assessment of current MEDCOM SAMFE training to meet future Army Gold Standard.
4.8 Describe sexual assault related health care initiatives undertaken by your Service in FY13. Include mental health treatment programs and follow-up procedures that are gender-responsive, culturally competent, and recovery-oriented.

The AMEDD sexual assault medical management team is designed to provide immediate and long term patient care, from assessment of risk for pregnancy, options for emergency contraception, risk of sexually transmitted infections, including HIV prophylaxis, to necessary follow-up care and services. All patients are offered a referral to Behavioral Health at their first medical encounter, and encouraged to receive psychological care and victim advocacy. In addition, there are long-term care plans tailored to the meet the individual patient's medical and behavioral health care needs.
4.9 List the number of victims, if any, whose care was hindered due to lack of SAFE kits or timely access to appropriate laboratory testing resources and describe the measures you took to remedy the situation.
The ability of our providers in all operational environments to conduct the forensic examination of a sexual assault victim was not hindered by lack of availability of a SAFE kit or other medical supplies.
4.10 List initiatives and programs implemented to reduce the stigma and overcome barriers associated with reporting sexual assault.
100% Small group Leader Engagement Training, 100% SARC/VA Refresher Training Additionally the Army has put significant resources in enhancing its capability to provide ongoing behavioral health support for all beneficiaries requiring mental healthcare services. We have increased our clinical behavioral health provider inventory and currently transforming our behavioral health delivery system as we convert to a behavioral health system of care under our behavioral health service line effort. This will substantially enhance our ability to provide immediate access and care to victims of sexual assault at all level as we move our behavioral health program infrastructure out of the Medical Treatment Facilities and embedded at the unit and primary care level.
4.11 Describe what measures have been taken by your Service to ensure that Service members are informed in a timely manner of the member's option to request a Military Protective Order (MPO) from the command of assignment. Include documentation that requires law enforcement agents to document MPOs in their investigative case files, to include documentation for Reserve Component personnel in title 10 status.
SARCs/VAs are guided by DOD form 2910 "Victim Reporting Preference Statement" to ensure and provide MPO options to the victim.
4.12 Describe and provide documentation of your Service or Component's expedited victim transfer request policy, including measures taken to ensure victims are informed in a timely manner of their right to request an expedited transfer. Documentation should be included as an appendix.
MEDCOM utilizes the May 2013 version of the DD 2910 which requires the victim advocate to describe the expedited transfer during the unrestricted reporting section. MEDCOM has an expedited transfer flowchart and the commanders are informed on the process of an expedited transfer.
4.12.1 Pertaining to temporary and/or permanent local expedited transfers (a different location within their assigned command or installation), provide: - **The number requested**

- **The number approved as the victim requested**
- **The number approved different than the victim requested**
- **The number denied and a summary of why**
- **The number moved within 30 days of approval**
- **The number moved after 30 days of approval**
-

MEDCOM:
-Number requested: 1
-Number approved as the victim requested: 0
-Number approved different than the victim requested: 0
-Number denied and a summary of why: Unsure why the transfer was denied was not the SARC at the time of the request. Historical data was not passed along.
-Number moved within 30 days of approval: 0
-Number moved after 30 days of approval: 1

4.12.2 Pertaining to permanent requested expedited transfers (from their assigned command or installation), provide:

- **The number requested**
- **The number approved as the victim requested**
- **The number approved different than the victim requested**
- **The number denied and a summary of why**
- **The number moved within 30 days of approval**
- **The number moved after 30 days of approval**

MEDCOM
-Number requested: 2
-Number approved as the victim requested: 2
-Number approved different than the victim requested: 0
-Number denied and a summary of why: 0
-Number moved within 30 days of approval: 2
-Number moved after 30 days of approval: 0

4.13 Describe your plans for FY14 that pertain to delivering consistent and effective victim support, response, and reporting options.

The AMEDD SHARP Program is revising MEDCOM Reg 40-36 for compliance with 2012-2013 regulatory updates to AR 600-20 (Army Command Policy), DoD Instruction 6495.02 (Sexual Assault Prevention and Response Program Procedures), DoD Directive 6495.01 (Sexual Assault Prevention and Response Program), and the Department of Justice (DOJ) April 2013 "A National Protocol for Sexual Assault Medical Forensic Examinations". The AMEDD SHARP Program already meets the DOJ "National Training Standards for Sexual Assault Medical Forensic Examiners".

Other initiatives 2013 through 2014 include formalizing the MTF sexual assault medical management office with a medical director, responsive to the DCCS. The MEDCOM SARC and VA remain responsive to the Commander. The Surgeon General's vision is to have all sexual assault program medical providers meet the same enhanced and expanded background checks as SARCs and VAs. Medical personnel engaged in care to patients following sexual assault are, indeed, in positions of trust. AMEDD is leading

a national conversation on a SAMFE Gold Standard. Experts from DOJ, International Association of Forensic Nurses, U.S. Army Criminal Investigation Lab, DoD, Navy, Criminal Investigation Division, Provost Marshal Office and across Army Medicine support this collaborative effort.
5. LOE 5—Assessment—The objective of assessment is to "effectively standardize, measure, analyze, assess, and report program progress."
5.1 Summarize your Service or Component's efforts to achieve the Assessment Endstate: "DoD incorporates responsive, meaningful, and accurate systems of measurement and evaluation into every aspect of the SAPR program."
Command Organizational Inspection Program and Staff Assistance Visits continue to be viable evaluation tools. Medical Education and Nurse Education student surveys also provide evaluation feedback.
5.2 Describe oversight activities during FY13 that assess the SAPR program effectiveness. Include frequency, methods used, findings and recommendations, corrective action taken (e.g., program management review and Inspector General inspections), and other activities. Include documentation of published reports in appendix.
MEDCOM IG Inspection provided TSG overall findings and recommendations for improvement on MEDCOM SHARP processes. MEDCOM IG is also responding to this report through Army IG channels.
5.3 Describe any and all implementations of Government Accountability Office (GAO) and Defense Task Force-Sexual Assault in the Military Services (DTF-SAMS) recommendations. Include any assessments of implementation.
Revision of MEDCOM Regulation Update 40-36, Medical Facility Management of Sexual Assault. Publish: Army Gold Standard for Sexual Assault Medical Forensic Examiners (SAMFE) to define training, competency verification and roles of Army SAMFEs. AR 40-68, Clinical Quality Management revision will include a section on verification of clinical competencies for the SAMFE.
5.4 Describe your efforts to ensure integrity of data collected in the Defense Sexual Assault Incident Database.
At this time MEDCOM does not have access to DSAIDs and are in the process of gaining access through the Army G-1 SHARP Program Office. This is managed at the Installation level which requires collaboration with the Installation SARC and the MEDCOM SARCs for data collection and input.
5.5 Describe any measures your Service or Component has established to assess and manage your SAPR program. If you have begun assessing your program based on these measures, describe your findings thus far and actions taken.
IAW MEDCOM OPORD 13-52, FRAGO 4: MEDCOM Commanders conducted local broadened screening for full-time and collateral duty SARCs and VAs. Broadened screening includes: Army Substance Abuse Program (ASAP) Files and Family Advocacy/the Army Central Registry. Commanders will conduct a review of qualifications of SARCs and VAs (both collateral

and full-time) to ensure all proper screening is complete and then identify and correct any shortcomings Broadened screening includes: Army Substance Abuse Program (ASAP) Files and Family Advocacy/the Army Central Registry.
5.6 Provide a summary of your research and data collection activities conducted in FY13. Include documentation in the appendix.
Not applicable
5.6.1 Describe your efforts to develop and harmonize sexual assault focused survey efforts to align with DoD and other Services.
Command Climate Surveys.
5.7 Describe your plans for FY14 that pertain to effectively standardizing, measuring, analyzing, assessing, and reporting program progress.
Develop Survey Tools to evaluate Health Care Providers training effectiveness and conduct Staff Assistance Visits.
6. Overarching Tenet: Communication and Policy
6.1 Summarize your Service or Component's efforts to synchronize and standardize the SAPR program across the Joint Force (from Joint/Service basing to forward stationed deployed units worldwide).
Not applicable
6.2 Describe your efforts to post and widely disseminate sexual assault information (e.g., hotline phone numbers and internet websites) to Service members, eligible dependents, and civilian personnel of the DoD.
IAW OPORD 13-52 FRAGO 7 the intent is that MEDCOM subordinate commands provide government cellular duty phones to MEDCOM assigned Sexual Harassment/Assault Response and Prevention (SHARP) Sexual Assault Response Coordinators (SARCs) and Victim Advocates (VAs) as another means to insure prompt victim support. Providing timely, compassionate medical care of sexual assault victims is a critical priority for the command. All MTFs will ensure 100% capability for medical responsiveness to sexually assaulted persons assuring availability of Sexual Assault Care Coordinators (SACCs), Sexual Assault Clinical Providers (SACPs) and Sexual Assault Medical Forensic Examiners (SAMFEs) for such an event. Government Issued Cellular Phones be issued to USAMEDCOM units to provide status and numbers for government cellular phones currently assigned to MEDCOM SHARP SARCs and VAs. Units will ensure cellular phone numbers are permanently associated with SARC and VA support, posted appropriately within the MTF or agency with other SARC and VA contact information, incorporated into local training, and reported to the MEDCOM SHARP program office. Units will immediately initiate planning to issue one duty cell phone for SARCs and one for VAs.
6.3 Describe your development and implementation of specialized medical and mental health care policy for sexual assault victims. Include a copy of your implementation plan in the appendix.
Revision of MEDCOM Regulation Update 40-36, Medical Facility Management of Sexual Assault Publish: Army Gold Standard for Sexual Assault Medical Forensic Examiners (SAMFE)to define training, competency verification and roles of Army SAMFEs.
6.4 Describe your efforts to review, revise, update, and issue policy pertaining to:

- **The record of dispositions of unrestricted reports.**
- **General education for correction of military records when victims experience retaliation.**

Provide documentation in the appendix.

Not applicable

6.5 Describe your efforts to establish policy for General or Flag officer review of and concurrence in adverse administrative actions and separation of victims making an Unrestricted Report of sexual assault in FY13.

Not applicable

6.6 Describe your plans for FY14 that pertain to synchronizing and standardizing the SAPR program across the Joint Force (from Joint/Service basing to forward stationed and deployed units worldwide).

IAW MEDCOM OPORD 13-52 FRAGO 6: MEDCOM verified that there was 100% geographic coverage of SARCs/VAs for every region.

7. Secretary of Defense Initiatives

7.1 Enhancing Commander Accountability—Describe your efforts thus far to develop methods to assess the performance of military commanders in establishing command climates of dignity and respect and incorporating SAPR prevention and victim care principles in their commands, and hold them accountable.

MEDCOM Policy 13-049, Command Climate Surveys- The results of Command Climate Surveys must be provided to the next higher level commander; Commanders will provide a monthly compliance verification to the MEDCOM EO Office.

7.2 Improving Response and Victim Treatment—Describe your efforts thus far to implement and monitor methods to improve victim treatment by their peers, co-workers, and chains of command.

FRAGO 7: All MTFs will ensure 100% capability for medical responsiveness to sexually assaulted persons assuring availability of Sexual Assault Care Coordinators (SACCs), Sexual Assault Clinical Providers (SACPs) and Sexual Assault Medical Forensic Examiners (SAMFEs). Government cellular phones currently assigned to MEDCOM SHARP SARCs and VAs. Units will ensure cellular phone numbers are permanently associated with SARC and VA support, posted appropriately within the MTF or agency with other SARC and VA contact information, incorporated into local training.

FRAGO 4: conduct refresher SHARP training for military and civilian personnel; and conduct leader engagement with all Soldiers and civilians on specific SHARP related topics. These engagements will be small group discussion versus large one-way forums.

7.3 Ensuring Safety—Describe your efforts to improve the effectiveness of SAPR programs in recruiting organizations, Military Entrance Processing Stations, and the Reserve Officer Training Corps. These assessments will include: 1) the selection, SAPR training, and oversight of recruiters; 2) the dissemination of SAPR program information to potential and actual recruits; and 3) the prevention and education programs in ROTC environments and curricula.

Not applicable

7.4 Ensuring Appropriate Command Climate—Describe your efforts to ensure DoD facilities promote an environment of dignity and respect and are free from materials that create a degrading or offensive work environment. Include findings and actions taken from regular visual inspections.
IAW AR 600-20- Conduct Staff Assistance Visits (SAV)/ Organizational Inspection Programs (OIP), focus groups and interviews for inspected facitlies. Findings: Cultural Pacific Islander photo of female exposed breast exhibited in PRMC Auditorium; Sexaullay explicit magazies being sold in AAFES Shoppette located inside San Antonio Military Medical Center. Both findings were reported to command team during SAV/ OIP outbrief and noted in EO Trip Reports.

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DEPARTMENT OF THE ARMY
CARL R. DARNALL ARMY MEDICAL CENTER
36000 DARNALL LOOP
FORT HOOD, TEXAS 76544-4752

REPLY TO
ATTENTION OF:

MEMORANDUM OF AGREEMENT
BETWEEN
CARL R. DARNALL ARMY MEDICAL CENTER, FORT HOOD, TEXAS
AND
SCOTT AND WHITE MEMORIAL HOSPITAL, TEMPLE, TEXAS

SUBJECT: Guidance and Procedures for Medical Support for Alleged Sexual Assault Victims.

1. REFERENCES.

a. OTSG/MEDCOM Policy Memo 09-055, Military Treatment Facility (MTF) Management of Reported Alleged Sexual Assault Cases – Payment for Exams and Kits, 14 July 2009.

b. DODI 6495-02, Sexual Assault Prevention and Response Program Procedures, 23 June 2006, incorporating Change 1, 13 November 2008.

c. Medical Facility Management of Sexual Assault, 23 December 2004.

d. DOD Regulation 6025-18R, DOD Health Information Privacy Regulation, 24 January 2003.

2. PURPOSE. To establish an agreement between Carl R. Darnall Army Medical Center, Fort Hood, Texas, hereinafter CRDAMC, and Scott and White Memorial Hospital, Temple, Texas, hereinafter SWH, to provide guidance and procedures for medical support for alleged sexual assault victims who are Department of Defense (DOD) health care beneficiaries.

3. BACKGROUND. CRDAMC has limited resources to treat eligible DOD beneficiaries who are victims of sexual assault and provide follow-on support for such patients. Continual communication between CRDAMC, the Office of the Armed Forces Medical Examiners, and the III Corps Staff Judge Advocate is critical in ensuring alleged sexual assault victims receive timely medical support by providers trained and privileged in performing sexual assault examinations and in completing legally sufficient protocols.

4. UNDERSTANDINGS, AGREEMENTS, SUPPORT, AND RESOURCE REQUIREMENTS:

a. Upon presentation at SWH for sexual assault of:

(1) Active Duty Military – SWH will notify the Fort Hood Installation Victim Advocate (VA) at 254-702-4953. This is a 24-hour seven days a week crisis line. The VA will inform the service member of their rights to restricted and unrestricted reporting.

(2) Military Eligible Beneficiaries – SWH will ask victims their preference for a Fort Hood Installation VA or a VA from the local community Families In Crisis (FIC). If a VA from FIC is selected, SWH will notify FIC at 254-634-1184 to request victim advocacy services. If the Fort Hood VA is requested, SWH will notify the Fort Hood VA at the above listed number. The VA from FIC and Fort Hood will assist with the coordination of all follow-up services; to include medical and counseling.

b. In cases where the service member chooses restricted reporting, SWH will request the restricted report case number from the Fort Hood VA. SWH will use this number for identification of the Sexual Assault Nurse Examiner (SANE) exam, annotation in the case record and as appropriate on SANE legal documentation, and for billing purposes.

c. SWH will provide disposition of evidence from the examiner to the Installation Provost Marshal Office. (SARC or Fort Hood VA notifies Military Police Investigations to collect evidence on restricted cases and secure evidence in compliance with Texas Evidence Collection and Protocol as required by the Texas Attorney General's Office).

d. In rare cases where return transportation is not available, SWH will notify the CRDAMC Department of Emergency Medicine (DEM) social worker at 254-288-8335 to assist with transportation planning.

e. Sexual assault examinations performed by privileged providers need to encompass five general areas, and should be accomplished for all alleged victims. The key components are as follows:

(1) Complete documentation of history provided by the alleged victim

(2) Trace evidence collection (hairs, fibers, soil, grass, etc.)

(3) Search and collection of biologic evidence (saliva, semen, blood)

(4) Written and photographic documentation of injuries

(5) Collection of known standards from both the victim and subject/alleged perpetrator (hair and blood)

(6) Additional tests that should be considered include:

(a) Screening for drug-facilitated sexual assault (blood alcohol and urine toxicology)

(b) Sexually Transmitted Disease screen(c) Pregnancy

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f. Chain of custody must be legally sufficient. Law enforcement involvement may influence deletion or addition of particular tests during the examination. Subject's examination will be completed, as necessary. The subject in question will be escorted until her/his examination is conducted, thus preventing the potential loss of physical evidence.

g. If a DOD Sexual Assault Evidence Collection Kit is not used, SWH will ensure the kit used meets the medical-legal expectations.

h. All providers, regardless of location, must be privileged for the use of sexual assault kits, and must be trained and qualified to fulfill state standards.

i. CRDAMC, Department of Social Work (DSW), Sexual Assault Care Coordinator (SACC) will be responsible for arranging and/or providing support for physical/psychological pain and other medical issues related to the alleged sexual assault. The SACC can be reached through the main DSW phone number 254-288-6474.

j. To assist with the above and other concerns related to continuity of care, SWH will provide the DSW, SACC with a copy of the SWH "Discharge Instructions for Sexual Assault Victims." The discharge instructions can be faxed to the DSW's secure fax line, 254-618-7990.

5. Privacy of Protected Health Information (PHI). Medical records created in conjunction with sexual assault examinations are subject to the appropriate privacy rule implemented in response to the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. These medical records containing private health information (PHI) are releasable to law enforcement under 45 CFR 164.512 and DOD 6025.18-R, paragraphs C7.6 – C7.6.6.2. The law allows for a covered entity to release PHI in compliance with an administrative request, including an authorized investigative demand or similar process. SWH will facilitate the procurement of the victim's written consent for release of medical records to law enforcement.

6. REIMBURSEMENT.

a. Effective August 17, 2009, a Final Rule was published in the Federal Register implementing Section 701 of the John Warner National Defense Authorization Act for FY 2007, Public Law 109-364. Pursuant to the Federal Victims of Crime Act (VOCA), the primary payer for forensic examinations following a sexual assault or domestic violence for eligible beneficiaries is a federal or federally funded program (such as Medicare, Medicaid, TRICARE, or the Department of Veterans Affairs). Section 701 authorizes coverage of forensic examinations following a sexual assault or domestic violence for eligible Department of Defense beneficiaries and is listed as a covered benefit under TRICARE.

b. Claims should be filed to TRICARE South Region, P.O. Box 7031, Camden, South Carolina 29020. Reimbursement for forensic examinations provided to all eligible Department of Defense beneficiaries will be made in accordance with the existing TRICARE rates. Claims should not be sent to the Department of Defense beneficiary.

7. EFFECTIVE DATE, TERMINATION, MODIFICATION AND REVIEW.

a. This MOA is effective on the date of final signature by all parties, hereto, and will remain in effect for three (3) years after the date of final signature.

b. The parties shall review the MOA annually, and it may be modified or cancelled at any time by mutual consent of the parties concerned. This agreement may also be cancelled by either party upon giving at least 180 days written notice to the other party in accordance with DODI 4000.19, paragraph 4.7.

CARL R. DARNALL
ARMY MEDICAL CENTER

STEVEN E. BRAVERMAN
Colonel, Medical Corps
Commanding

3 Aug 10
(Date)

Scott & White Healthcare

ALFRED B. KNIGHT, M.D.
President and CEO

August 05, 2010
(Date)

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Welcome: Jennie Johnson | Logout

Continuing Medical Education

Home | Planner Home | Current Activities | Plan Activity

Activity Id: 2013-0961 | Activity Title: Sexual Assault Medical Forensi ... (Single) | Status: Approved

Planning Document (Phase 1) | Pre-Activity (Phase 2) | Post-Activity (Phase 3)

- Committee Members
- Select Faculty
- Agenda
- CML SPT/Exhibit Fees
- Faculty Correspondence
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- Course Director Reviews
- Planning Log
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- Syllabus/Course Handouts
- Web Registration
- Activity Validation
- Attendee Roster
- Search Disclosures

Activity
ID: 2013-0961
Title: Sexual Assault Medical Forensic Examiner Training
Activity Date: 8/12/2013 - 8/16/2013
Approved # of credits: 40.75
CME Planner: Jennie Johnson
Approval Status
Planning Document:
Approved on 8/9/2013
Brochure:
Approved on 8/9/2013
Syllabus:
Approved on 8/9/2013
After-Action Report:
Not yet submitted.

Agenda

To build your agenda, complete all fields under "Add/Update Presentation." The system will chronologically add your agenda in order by date and by time. The CME Director will award credits to each item based on your objective/description of each presentation. Credits are awarded in quarter increments (i.e. 10 , 15 or 20 minutes = .25; 25, 30 or 35 minutes = .50; 40, 45 or 50 mins = .75; 55 or 60 minutes = 1.0). No credits will be awarded for breakfast, lunch, dinner, breaks, and administrative announcements.

Scheduled Presentations

Title	Date/Time	Faculty Presenter(s)	Presentation Description	Physician	Credit Hours Assigned
Introduction to Sexual Assault Medical Forensic Examiner Role	8/12/2013 0700-0830	Kandice Ray	1. Define sexual assault medical forensic examiner. 2. Identify the roles and responsibilites of the sexual assault medical forensic examiner 3. Identify different forensic specialities. 4. Describe the sexual assault forensic process. 5. Prepare proper sexual assault medical forensic examiner curriculum vitae.	N	1.5
Department of Defense (DoD) Sexual Assault Prevention and Response and Sexual Assault Care of Victi	8/12/2013 0830-0930	Wanda Hubert Jennie Johnson	1. Discuss Department of Defense (DoD) Joint Task Force Program and policy objective for Sexual Assault Prevention and Response Program and Sexual Harassment/Assault Response and Prevention Program. 2. Describe response capability for sexual assault. 3. Identify Military Treatment Facility (MTF)/clinic specific policy, procedures, and local regulations and statutes. 4. Discuss the overview and goals of the sexual assault program.	N	1
Sexual Assault Response Team (SART) Teams	8/12/2013 0945-1045	Kandice Ray Stephanie DeLeon	1. Describe the Roles of the Sexual Assault Team members. 2. Explain sexual assault case management and the fundamentals of sexual assault data management. 3. Define Sexual Assault Response Team (SART) and the programs development. 4. Identify and describe roles and responsibility and requirements of the Sexual Assault Response and Program Tracking Application (SARPTA) users. 5. Identify sexual assault operational issues and options for program development. 6. Examine how sexual assault medical forensic examiners function with other team members to include role with the Sexual Assault Review Board. 7. Discuss how to properly code sexual assault exams.	N	1
Victim Advocacy Program and Options for Reporting	8/12/2013 1045-1145	Sergio Perez	1. Describe the roles and responsibility of the Sexual Assault Response Coordinator and the Victim Advocate. 2. Identify the emotional needs of the sexual assault patient and how to meet them. 3. Discuss techniques for crisis intervention with the sexual assault patient. 4. Identify component of the psychological safety in assisting a patient.	N	1
PTSD and Rape Trauma Syndrome	8/12/2013 1300-1400	Gail Heather-Greener	1. Discuss the phases of the emotional response to sexual assault. Differentiate between short-term and long term emotional responses of sexual assault. 2. Describe the effect of rape to include Rape Trauma Syndrome and Post Traumatic Stress Disorder 3. Describe reasons for unreported sexual assault. 4. Identify sexual assault myths and facts. 5. Identify and define Sexual assault in terms of clinical characteristics and extent of occurrence particularly in the Armed Services. 6. Discuss diagnostic information related to the relationship between sexual assault and Post Traumatic Stress Disorder (PTSD). 7. Identify and discuss treatment issues and approaches utilized.	N	1
Sexual Assault and Contingency Opertations/ Deployment	8/12/2013 1400-1500	Pauline Gross	1. Discuss sexual assault health care during contingency operations/deployment 2. Outline sexual assault care challenges and best practices utilized during deployment. 3. Discuss reintegration and follow up care for the service member following a sexual assault during contingency operations/deployment	N	1
Domestic Violence/Intimate Partner	8/12/2013 1515-1545	Rene Robichaux Kathleen Foreman	1. Identify policy requirements. 2. Identify key risk factors and screening question in domestic violence and sexual assault. 3. Identify management and counseling consideration when working with domestic violence and sexual assault. 4. Identify family violence and sexual assault. 5. Describe the impact of domestic violence on society. 6. Identify background history of intimate partner/marital sexual assault and how it contributes to	N	0.5
Culturally Responsive Care in Sexual Assault and	8/12/2013 1545-1715	Kandice Ray Leticia Sprinkle	1. Discuss and understand health practice and communication within varying cultural life 2. Discuss how to how to reduce cultural pain and communication barriers 3. Discuss how to deliver cultural competent care to vulnerable populations 4. Discuss cultural and ethical issues encountered in caring for patients of	N	1.5

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Special Populations			sexual assault. 5. Identify myths surrounding same sex sexual assault and discussing same sex assault in the healthcare setting		
Psychology of the Offender and Investigative Aspect of Sexual Assault Violence	8/13/2013 0730-0900	Kandice Ray	1. Differentiate between deviant sexual behavior and criminal sexual behavior. 2. Review rapist typologies of sex offenders and detailed profiling. 3. Identify approaches and controls used by rapists. 4. Identify types of victim resistance. 5. Identify reactions to resistance. Name rapist categories. 6. Identify the specifics of working with sex offenders. Describe two elements of crime necessary for a charge of rape. 7. Discuss the purpose of the investigative process and describe the steps a victim goes through in an investigation 8. Discuss false allegations of stranger rape.	N	1.5
Interviewing the Sexual Assault Patient	8/13/2013 0900-1030	Leticia Sprinkle Kandice Ray	1. Define the difference between medical and forensic history taking with a sexual assault examination. 2. Discuss preparation for a forensic interview. 3. Discuss key components of a comprehensive forensic interview, to include patient consent and medical history. 4. Understand how to obtain and document the comprehensive forensic history as it relates to the details of the assault.	N	1.5
Anatomy and Physiology of the Sexual Assault Examination-Female/Male Anatomy, Genital/ Anogenital Tr	8/13/2013 1045-1245	Kandice Ray Leticia Sprinkle	1. Identify and describe pertinent female/male anatomy and genitalia, appearances and variances; including Tanner staging and effects of puberty and aging. 2. Discuss hormonal influences on anatomical structures. 3. Identify injury patterns with sexual assault and healing stages with human tissue and structures. 4. Identify key events in the human sexual response for females and males.	N	2
Medical Legal Examination-The Adult/Adolescent Sexual Assault Exam	8/13/2013 1345-1515	Leticia Sprinkle	1. Discuss head to toe assessment and injury documentation of the sexual assault patient. 2. Identify steps to anticipate, identify, collect, document, preserve, and label and store all potential evidence of the sexual assault exam, to include oral, genital and rectal/perianal exams. List steps for conducting the oral, genital, and rectal/perianal examinations, including speculum use. 3. Identify exam room hygiene, examiner preparation and patient privacy when initiating medical forensic examinations. 4. Identify techniques to facilitate patient comfort and decrease anxiety during medical forensic examinations. 5. Identify the difference between routine pelvic examinations vs. forensic evidence collection. 6. Identify special patient populations that require modificati	N	1.5
Medical Legal Examination-The Adult/Adolescent Sexual Assault Exam (CONT)	8/13/2013 1530-1715	Leticia Sprinkle	1. Discuss head to toe assessment and injury documentation of the sexual assault patient. 2. Identify steps to anticipate, identify, collect, document, preserve, and label and store all potential evidence of the sexual assault exam, to include oral, genital and rectal/perianal exams. List steps for conducting the oral, genital, and rectal/perianal examinations, including speculum use. 3. Identify exam room hygiene, examiner preparation and patient privacy when initiating medical forensic examinations. 4. Identify techniques to facilitate patient comfort and decrease anxiety during medical forensic examinations. 5. Identify the difference between routine pelvic examinations vs. forensic evidence collection. 6. Identify special patient populations that require modificati	N	1.75
Forensic Injury Identification and Documentation	8/14/2013 0730-1000	Kandice Ray Leticia Sprinkle	1. Identify oral, genital and rectal/perianal injuries using correct terminology, differentiating between routine healthcare examinations versus medical forensic examinations. 2. Identify how to produce through, precise, accurate, unbiased, and objective documentation for the medical forensic record. 3. Distinguish between sharp force and blunt force pattern of injury 4. Differentiate between a patterned injury and pattern of injury. 5. Discuss strangulation, bite marks and common areas of injury with sexual assault. 6. Identify the science around accurately dating bruises, incorporating the stages of healing and patient age, culture and health status into the comprehensive examination 7. Discuss the significance of bite mark evide	N	2.5
Principles of Forensic Photography	8/14/2013 1015-1215	Leticia Sprinkle Kandice Ray	1. Apply principles of forensic photography use and documentation, with the medical forensic examination. 2. Identify equipment utilized in forensic photography. 3. List elements of exposure, white balance and depth of field in forensic photography and medical legal documentation. 4. Describe alternate lighting techniques, appropriate use and documentation. 5. Identify correct labeling methods, chain of custody, proper storage and handling of sexual assault photography.	N	2
Forensic Evidence, Processesing and Analysis in Sexual Assault Cases-The Criminal Investigative La	8/14/2013 1330-1430	Kandice Ray Leticia Sprinkle	1. Describe the roles and responsibility of the criminal investigation laboratory. 2. Identify basic structures and function of Deoxyribonucleic Acid (DNA), two types of DNA markers and the types of DNA analysis/procedures used by USA Criminal Laboratory in the processing of forensic evidence. 3. Identify the purpose and structure of Combined Deoxyribonucleic Acid Index System (CODIS) in Deoxyribonucleic Acid (DNA) data banking, and implications of DNA with forensic profiling. 4. Identify types of trace evidence	N	1

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			specific to sexual assault.		
Suspect Exam and Considerations in Evidence Collection	8/14/2013 1430-1530	Leticia Sprinkle Kandice Ray	1. Discuss the importance of a suspect exam. 2. Legal requirements for a suspect exam. 3. Identify the steps for conducting a suspect examination.	N	1
Sexual Assault Exam Process: Sexually Transmitted Infections, Human Immunodeficiency Virus (HIV),	8/14/2013 1545-1715	Kandice Ray Leticia Sprinkle	1. Identify essential signs and symptoms in the clinical presentations of Sexually Transmitted Infections (STI's). 2. Identify how to evaluate and treat sexual assault patients at risk for Sexually Transmited Infections (STI's), incorporating current practice principles/guidelines for prophylactic therapy and medical treatment utilizing CDC guidelines. 3. Discuss risks for acquiring Human Immunodeficiency Virus (HIV) from Sexual assault and post exposure prophylaxis. 4. Discuss Emergency Contraception options for sexual assault patients. 5. Discuss Post examination care, forensic documentation, and recommended follow up appointments and procedures.	N	1.5
Drug Facilitated Sexual Assault (DFSA) and Toxicology	8/15/2013 0730-0900	Kandice Ray Leticia Sprinkle	1. Identify signs and symptoms of Drug Facilitated Sexual Assault (DFSA) and patient healthcare management related to complications from the drugs. 2. Describe challenges of Drug Facilitated Sexual Assault (DFSA) with forensic evidence collection and examinations. 3. Discuss the pharmacology of important Drug Facilitated Sexual Assault (DFSA) drugs (Alcohol, Ketamine, Rohypnol and Gamma-Hydroxybutyrate (GHB)). 4. Identify guidelines for reference samples in Drug Facilitated Sexual Assault (DFSA) and discuss toxicology procedures used with evidence collection. 5. Identify proper forms and chain of custody for toxicology collection, packaging, storing, transferring and testing.	N	1.5
Case Studies and Peer Review	8/15/2013 0915-1045	Leticia Sprinkle Kandice Ray	1. Be familiar with quality assurance plans of the facility/examiner program. 2. Identify relevant regulations or interpretations related to Sexual Assault Forensic Examination documentation. 3. Identify the purpose of peer review, case studies, meeting activities, attendants, incident reports, and supervision.	N	1.5
Compassion Fatigue/Vicarious Trauma and Self Care	8/15/2013 1045-1145	Beth Echols	1. Identify compassion fatigue and vicarious trauma recognizing sources of emotions in your environment. 2. Identify sources of burnout in your environment. 3. Discuss self care strategies and identify appropriate measures to take.	N	1
Introduction to Sexual Assault Forensic Examination and the Sexual Assault Evidence Collection Kit	8/15/2013 1300-1400	Leticia Sprinkle	1. Describe use of the DOD sexual assault evidence collection kit in collecting and preserving evidence. 2. Identify essential equipment needed for the forensic kit, timing of the kit, and additional trace evidence that can be collected based on special circumstances and populations. 3. List preferred order of evidence collections based on the patient population and circumstances surrounding the assault. 5. Distinguish between known standards and unknown samples in the sexual assault evidence collection kit. 6. Demonstrate procedure for a sexual assault vaginal speculum exam. 7. Demonstrate and View steps and equipment needed to conduct a sexual assault forensic examination utilizing the DoD Sexual Assault Kit. 7. Describe manageme	N	1
Introduction to Sexual Assault Forensic Examination and the Sexual Assault Evidence Collection Kit(C	8/15/2013 1415-1715	Leticia Sprinkle	1. Describe use of the DOD sexual assault evidence collection kit in collecting and preserving evidence. 2. Identify essential equipment needed for the forensic kit, timing of the kit, and additional trace evidence that can be collected based on special circumstances and populations. 3. List preferred order of evidence collections based on the patient population and circumstances surrounding the assault. 5. Distinguish between known standards and unknown samples in the sexual assault evidence collection kit. 6. Demonstrate procedure for a sexual assault vaginal speculum exam. 7. Demonstrate and View steps and equipment needed to conduct a sexual assault forensic examination utilizing the DoD Sexual Assault Kit. 7. Describe manageme	N	3
Sexual Assault and the Criminal Justice System	8/16/2013 0730-0830	Charles Orck	1. Describe the military criminal justice system. 2. Name basic requirements for evidence to be admissible, including correct labeling and chain of custody. 3. Describe progress of typical felony case through criminal justice system. 4. Identify Role of Sexual Assault Medical Forensic Examiner in courtroom. 5. Describe how to provide effective testimony.	N	1
Prosecuting Sexual Assault	8/16/2013 0845-1015	Charles Orck	1. Explain the value of objectivity and neutrality on the part of medical expert's sexual violence. 2. Discuss the implications of Crawford vs. Washington United States Supreme Court case where statements made to medical providers are concerned. 3. Provide experts with the practical strategies and tips for maintaining both the fact and appearance of objectivity while conducting all the duties of a forensic medical provider expert.	N	1.5
Forensic Testimony	8/16/2013 1015-1145	Charles Orck	1. Identify proper interaction with the legal system, including prosecutors and defense attorneys, throughout the course of the litigation from the examination to the day of trial. 2. Identify basic courtroom procedures on how best to prepare for effective and comfortable direct and cross examination testimony. 3. Discuss practical strategies and tips for testifying as experts, including differentiating from being a fact witness and	N	1.5

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			qualifying as an expert witness.		
LEGAL	8/16/2013 1300-1400	Charles Orck	1. Identify the foundation for current medical legal challenges impacting the management of the sexual assault program. 2. Facilitate discussion on the legal challenges in addressing sexual assault prevention and response. 3. Recognize the challenges and the forensic examiner role in the legal process of sexual assault.' 4. Identify storage, transportation and destruction of evidence. 5. Identify payment method for forensic medical exams	N	1
Mock Court Martial and Examiner Court Appearances	8/16/2013 1415-1715	Charles Orck	1. Discuss pre-trail preparation for court. 2. Discuss the role of the expert witness when testifying in a court of law. 3. Describe tips for testifying as an expert medical forensic examiner in a sexual assault case 4. Describe the sexual assault testimony techniques at a mock trail and develop useful knowledge about the law, questioning techniques, critical thinking, and oral advocacy skills.	N	3
					Total: 40.75

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Continuing Nursing Education

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Activity Id: AR13-0326 | Activity Title: Sexual Assault Medical Forensi ... () | Status: Approved

Planning Document (Phase 1) | Pre-Activity (Phase 2) | Post-Activity (Phase 3)

- Committee Members
- Select Faculty
- Agenda
- CML SPT/Exhibit Fees
- Faculty Correspondence
- Disclosures
- Nurse Planner Reviews
- Planning Log
- Syllabus/Course Handouts
- Web Registration
- Validation/Submission
- Attendee Roster
- Search Disclosures

Activity
ID: AR13-0326
Title: Sexual Assault Medical Forensic Examiner Training
Activity Date: 8/12/2013 - 8/19/2013
Approved # of credits: 47.5
CNE Planner: Teresa Duquette-Frame
Approval Status
Planning Document:
Approved on 8/6/2013
Brochure:
Approved on 8/6/2013
Syllabus:
Approved on 8/6/2013
After-Action Report:
Not yet submitted.

Agenda

To build your agenda, complete all fields under "Add/Update Presentation." The system will chronologically add your agenda in order by date and by time. The Nurse Peer Review Leader (NPRL) will award credits to each item based on your objective/description of each presentation. Contact hours are determined in a logical and defensible manner. Contact hours are awarded to participants for those portions of the educational activity devoted to the learning experience and time spent evaluating the activity. One contact hour is a 60-minute hour. Activities must be a minimum of 30 minutes. No fewer than 0.5 contact hours can be awarded for an educational activity. If rounding is desired in the calculation of contact hours, the provider must round down to the nearest 1/10th or 1/100th (e.g., 2.758 should be 2.75 or 2.7, not 2.8)". (ANCC, 2011)

Scheduled Presentations

Title	Date/Time	Faculty Presenter(s)	Presentation Description	Credit Hours Assigned
Introduction to Sexual Assault Medical Forensic Examiner (SAMFE) Role	8/12/2013 0730-0830	KANDICE RAY Leticia Sprinkle	1. Describe the requirements for healthcare providers to serve as a sexual assault medical forensic examiner(SAMFE). 2. Identify the roles and responsibilites of the SAMFE. 3. List the different types of forensic specialties. 4. Describe the components of the sexual assault forensic examination process. 5. Discuss the importance of preparing a proper SAMFE Curriculum Vitae to establish credibility as a witness in court appearances.	1
DoD Sexual Assault Response Prevention (SHARP) Program	8/12/2013 0830-0930	Wanda Hubert Jennie Johnson KANDICE RAY	1. Analyze the evolution of the Department of Defense's sexual assault program. 2. Discuss the overview and goals of a sexual assault program. 3. Describe the response capability for a sexual assault. 4. Examine the difference between local regulations and statutes and the military criminal justice system's regulations.	1
Sexual Assault Response Team (SART) Teams	8/12/2013 0945-1045	Stephanie DeLeon KANDICE RAY	1. Describe the roles of members of a sexual assault team. 2. Explain sexual assault case management including the fundamentals of sexual assault data management. 3. Describe the development of the Sexual Assault Response Team (SART). 4. Identify requirements of the Sexual Assault Response and Program Tracking Application (SARPTA). 5. Identify operational considerations when establishing a sexual assault program. 6. Explain how the sexual assault medical forensic examiner functions within a sexual assault program and review board. 7. Code sexual assault exams using the Statistical Classification of Disease and Related Health Problems (ICD-9 Codes).	1
Victim Advocacy Program and Options for Reporting	8/12/2013 1045-1145	Sergio Perez	1. Describe the roles and responsibilities of the Sexual Assault Response Coordinator and Victim Advocate. 2. Recognize the emotional needs of the sexual assault patient. 3. Demonstrate therapeutic interventions utilized during crisis with the sexual assault patient. 4. Identify components of psychological safety in support of the sexual assuait patient.	1
Post Traumatic Stress Disorder (PTSD) and Rape Trauma Syndrome	8/12/2013 1300-1400	Gail Heather-Greener Jane Madison	1. Describe the phases of an emotional response to sexual assault. 2. Recognize the effects of rape on assault patients including Rape Trauma Syndrome and Post Traumatic Stress Disorder. 3. Analyze reasons for unreported sexual assaults. 4. Compare and contrast sexual assault myths with facts. 5. Describe the characteristics and extent of the occurrence of sexual assaults, particularly in the Armed Services. 6. Distinguish the relationship between sexual assault and Post Traumatic Stress Disorder. 7. Describe evidence-based treatment issues and approaches for sexual assault.	1
Sexual Assault and Contingency/Deployment Operations	8/12/2013 1400-1500	Pauline Gross	1. Discuss sexual assault health care options during contingency operations/deployment. 2. Describe sexual assault best practices utilized during deployment. 3. Indicate reintegration and follow up care for the service member following a sexual assault during contingency operations/deployment.	1
Domestic Violence and Intimate Partner Violence	8/12/2013 1515-1545	Rene Robichaux Kathleen Foreman	1. Define domestic/intimate partner violence. 2. List common signs and symptoms of domestic violence. 3. Describe the management and counseling considerations when working with domestic violence and sexual assault patients. 4. Describe the effects of family violence and sexual assault on family members. 5. Explain the impact of domestic violence on society. 6. Identify the social stigmas associated with intimate	0.5

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			partner/marital sexual assault.	
Culturally Responsive Care in Sexual Assault and Special Populations	8/12/2013 1545-1715	Leticia Sprinkle KANDICE RAY	1. Describe health practices and communication within varying culturals in relation to sexual assault. 2. Discuss methods to reduce cultural pain and communication barriers in relation to sexual assault. 3. Demonstrate how to deliver culturally competent care to vulnerable populations of sexual assault. 4. Discuss cultural and ethical issues encountered in caring for sexual assault patients. 5. Identify myths surrounding same sex sexual assault.	1.5
Psychology of the Offender and Investigative Aspect of Sexual Assault Violence	8/13/2013 0730-0900	Shawn Fatula	1. Differentiate between deviant sexual behavior and criminal sexual behavior. 2. Review rapist typologies of sex offenders and detailed profiling. 3. Identify approaches and controls used by rapists. 4. Identify types of victim resistance. 5. Identify reactions to resistance exhibited by the rapist. 6. Describe two elements necessary to investigate a rape charge. 7. Describe the investigative process from the victim's perspective. 8. Discuss why false allegations of stranger rape exist. 9. Classify rapists. 10. Describe the investigative process of a rapist.	1.5
Interviewing the Sexual Assault Patient	8/13/2013 0900-1030	KANDICE RAY Leticia Sprinkle	1. Describe the purpose of a sexual assault medical forensic examination. 2. Discuss interview methods for a sexual assault medical forensic history. 3. Discuss key components of a comprehensive forensic interview. 4. Describe how to obtain and document the comprehensive forensic history as it relates to the details of the assault.	1.5
Anatomy and Physiology of the Sexual Assault Examination-Female/Male Anatomy, Genital/ Anogenital Tr	8/13/2013 1045-1245	Leticia Sprinkle KANDICE RAY	1. Describe pertinent female/male anatomy and genitalia, appearances and variances, including Tanner staging and effects of puberty and aging in sexual assault cases. 2. Identify hormonal influences on anatomical structures which may mimic injury. 3. Recognize physcial assessment findings resulting from non assault injury and infections. 4. Describe changes in the human sexual response exhibited by sexual assault patients.	2
Medical Legal Examination-The Adult/Adolescent Sexual Assault Exam	8/13/2013 1345-1715	Leticia Sprinkle KANDICE RAY	1. Demonstrate the physical assessment procedures required for the sexual assault patient. 2. Calculate special evidence collection considerations for a forensic examination. 3. Implement interventions to facilitate patient comfort and decreased anxiety during the medical forensic examination. 4. List the diagnostic tests utilized during an anogenital examination. 5. Recognize special patient populations requiring modification of care during examination procedures.	3
Forensic Injury Identification and Documentation	8/14/2013 0730-1000	Leticia Sprinkle KANDICE RAY	1. Discuss mechanisms and types of sexual assault injury. 2. Discuss documentation of physical injury. 3. Distinguish between sharp force and blunt force pattern of injury 4. Describe pattern of injury in sexual assault cases. 5. Discuss common areas of injury with sexual assault. 6. Discuss challenges with accurately dating bruises. 7. Discuss generalized bite mark pattern evidence information. 8. Explain the role of dentistry in forensic identification. 9. Describe generalized bite mark pattern evidence information including documentation, photographic considerations, and evidence collection.	2.5
Principles of Forensic Photography	8/14/2013 1015-1215	Leticia Sprinkle KANDICE RAY	1. Apply principles of forensic photography use, including documentation, to the medical forensic examination. 2. Discuss equipment utilized in forensic photography. 3. Decribe camera basics required for forensic photography. 4. Restate the correct labeling method, chain of custody, proper storage and handling of sexual assault photography.	2
Forensic Evidence, Processesing and Analysis in Sexual Assault Cases-The Criminal Investigative La	8/14/2013 1330-1430	Leticia Sprinkle KANDICE RAY	1. Describe criminal investigation laboratory sections and functions. 2. Describe the function of Deoxyribonucleic Acid (DNA) in sexual assault cases 3. Identify the purpose and structure of Combined Deoxyribonucleic Acid Index System (CODIS) in Deoxyribonucleic Acid (DNA) data banking. 4. Describe types of trace evidence specific to sexual assault.	1
Suspect Exam and Considerations in Evidence Collection	8/14/2013 1430-1530	Leticia Sprinkle KANDICE RAY	1. Recognize the importance of a suspect examination. 2. Explain the legal requirements for conducting a suspect examination. 3. Recognize evidence collection consideration when conducting a suspect examination.	1
Sexual Assault Exam Process: Sexually Transmitted Infections, Human Immunodeficiency Virus (HIV), a	8/14/2013 1545-1715	KANDICE RAY Leticia Sprinkle Pauline Gross	1. Recognize the signs and symptoms of Sexually Transmitted Infections (STIs). 2. Provide current best practice interventions for the prophylaxis and treatment of Sexually Transmitted Infections in sexual assault. 3. Discuss risks for acquiring Human Immunodeficiency Virus (HIV) from sexual assault. 4. Identify emergency contraception and abortion options for a sexual assault patient. 5. Describe post initial examination care and necessary follow up plans for a sexual assault patient.	1.5
Drug Facilitated			1. Describe the implications for Drug Facilitated Sexual Assault (DFSA). 2. Describe the challenges of Drug Facilitated Sexual Assault	

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Sexual Assault (DFSA) and Toxicology	8/15/2013 0730-0900	Leticia Sprinkle KANDICE RAY	(DFSA) in processing the forensic evidence collection. 3. Discuss commonly used drugs used to commit Drug Facilitated Sexual Assault (DFSA). 4. Discuss toxicology specimum collection.	1.5
Case Studies and Peer Review	8/15/2013 0915-1045	Leticia Sprinkle KANDICE RAY	1. Discuss tools available for quality mangament of sexual assault cases. 2. Discuss the importance of conducting quality management reviews. 3. Discuss ways to conduct peer reviews.	1.5
Compassion Fatigue/Vicarious Trauma and Self Care when Working with Sexual Assault Patients	8/15/2013 1045-1145	Beth Echols	1. Describe compassion fatigue and vicarious trauma for care providers of sexual assault patients. 2. Identify sources of burnout for care providers of sexual assault patients. 3. Select self care strategies for care providers of sexual assault patients.	1
Introduction to Sexual Assault Forensic Examination and the Sexual Assault Evidence Collection Kit	8/15/2013 1300-1715	KANDICE RAY Leticia Sprinkle	1. Describe the use of a sexual assault evidence collection kit in collecting and preserving evidence. 2. Describe preferred order of evidence collections based on the patient population and circumstances surrounding the assault. 3. Discuss the correct method of evidence collection given a variety of sexual assault scenarios. 4. Describe procedures for male and female anogenital examination for sexual assault patients. 5. Describe how to conduct a sexual assault forensic examination utilizing the DoD Sexual Assault Kit. 6. Describe management of sealed kit for restricted and unrestricted reporting.	4
Sexual Assault and the Criminal Justice System	8/16/2013 0730-0830	Charles Orck Calandra " Callie" Woolam	1. Describe what constitutes a sex crime in the military and civilian criminal justice system. 2. Describe progress of typical felony case through criminal justice system. 3. Discuss the role of Sexual Assault Medical Forensic Examiner in courtroom. 4. Describe how to provide effective testimony. 5. Demonstrate the ability to provide expert and effective testimony during the prosecution of a sex crime.	1
Prosecuting Sexual Assault	8/16/2013 0845-1015	Charles Orck Calandra " Callie" Woolam	1. Decipher the importance of the medical forensic examiner's ability to remain impartial while providing testimony. 2. Discuss the implications of Crawford vs. Washington United States Supreme Court case. 3. Describe how the medical forensic medical examiner can maintain objectivity while conducting all duties including investigation and providing expert opinion.	1.5
Forensic Testimony	8/16/2013 1015-1145	Charles Orck Calandra " Callie" Woolam	1. Discuss the appropriate interactions between the medical forensic medical examiner and justice system personnel involved in litigation. 2. Describe courtroom procedures to ensure effective direct and cross examination testimony. 3. Discuss practical strategies and tips for testifying as a fact or expert witness.	1
Legal	8/16/2013 1300-1400	Charles Orck	1. Identify current medical legal considerations impacting management of sexual assault programs. 2. Describe the legal limitations associated with restricted and non-restricted reporting. 3. Describe the appropriate storage, transportation and destruction of forensic evidence. 4. Explain the impact of the Violence Against Women Act (VAWA) on reimbursement for forensic medical examinations.	1
Mock Court Martial	8/16/2013 1415-1715	Charles Orck Calandra " Callie" Woolam Leticia Sprinkle KANDICE RAY	1. Recite the correct the steps in a crimial court proceding. 2. Demonstrate the ability to effectively testify in front of an audience/jury/panel. 3. Analyze the strong and weak points of historical court cases. 4. Appraise sexual assault testimony techniques utilized during court proceedings.	3
Sexual Assault Medical Forensic Examination Practical Examination	8/19/2013 0800-1700	Leticia Sprinkle Pauline Gross KANDICE RAY	1. Perform a comprehensive sexual assault medical forensic examination including evidence collection.	8
				Total: 47.5

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Air Force Military Treatment Facility Sexual Assault Exam Status

Utilizes Civilian Facility

Air Combat Command
Beale AFB, CA
Davis-Monthan AFB, AZ
Dyess AFB, TX
Ellsworth AFB, SD
Holloman AFB, NM
Langley AFB, VA
Moody AFB, GA
Mountain Home AFB, ID
Nellis AFB, NV
Offutt AFB, NE
Seymour Johnson AFB, NC
Shaw AFB, SC
Tyndall AFB, FL

Air Education Command
Altus AFB OK
Columbus AFB, MS
Goodfellow AFB, TX
Lackland AFB, TX
Laughlin, AFB, TX
Luke AFB, AZ
Maxwell-Gunter AFB, AL
Randolph AFB, TX
Sheppard AFB, TX
Vance AFB, OK

Air Force District Washington
Andrews AFB, MD
Bolling AFB, DC

Air Force Materiel Command
Hill AFB, UT
Kirtland AFB
Robins AFB GA
Tinker AFB, OK

Air Force Special Operations
Cannon AFB, NM

Air Force Space Command
Buckley AFB, CO

Los Angeles AFB, CA
Patrick AFB, FL
Peterson/Schriever AFB, Cheyenne Mountain, CO
Vandenberg AFB, CA

Air Mobility Command
Charleston AFB, SC
Dover AFB, DE
Fairchild AFB, WA
Grand Forks AFB, ND
Little Rock AFB, AR
McConnell AFB, KS
MacDill AFB, FL
McGuire Joint Base McGuire-Dix-Lakehurst, NJ
Scott AFB, IL

Global Strike Command
Barksdale AFB, LA
Minot AFB, ND
F. E. Warren AFB, WY
Malmstrom AFB, MT
Whiteman AFB, MO

Pacific Air Forces
Eielson AFB, AK
Joint Base Elmendorf Richardson, AK

US Air Force Academy
USAFA, CO

In House Exams

Air Force Materiel Command
Eglin AFB, FL - SANE
Wright Patterson AFB, OH - SAMFE/SANE

Air Mobility Command
Travis AFB, CA - SANE

Pacific Air Forces
Kunsan AB, Korea - SAMFE
Misawa AB, Japan - SANE
Osan AB, Korea - SANE
Yokota AB, Japan - SANE

US Air Force Europe
Aviano AB, Italy - SANE
Incirlik AB, Turkey – SAMFE/SANE
Lajes Field, Azores - SAMFE
Lakenheath AB, England - SANE
Landstuhl AB, Germany - SANE

Utilizes Nearby DoD Facility

AF Special Operations
Hurlburt Field, FL

Air Mobility Command
McChord AFB, WA
Pope AFB, NC

US Air Forces Europe
Geilenkirchen NATO Air Base, Germany
RAF Croughton, England
RAF Menwith Hill, England
RAF Upwood, England
Ramstein AB, Germany
Spangdahlem AFB, Germany

Pacific Air Forces
Andersen AFB, Guam

MEMORANDUM OF UNDERSTANDING
BETWEEN
MCCONNELL AIR FORCE BASE
AND
VIA CHRISTI HOSPITALS WICHITA, INC.'S FORENSIC NURSING SERVICES

PURPOSE: To establish a written agreement between McConnell Air Force Base and Via Christi Hospitals Wichita, Inc.'s Forensic Nursing Services (FNS), defining procedures for the coordination of medical care and examination of military personnel of the Armed Forces who have been sexually assaulted and wish to make a restricted report. All other military health beneficiaries seeking medical care and examination for sexual assault will be managed under existing procedures.

GENERAL: This Memorandum of Understanding (MOU) does not create additional jurisdiction or limit or modify existing jurisdiction vested in the parties. This MOU provides guidance and documents an agreement for general support between McConnell Air Force Base and Via Christi Hospitals Wichita, Inc.'s Forensic Nursing Services (FNS) Program.

DEFINITIONS:

a. What is a Restricted Report. Restricted reporting allows a military sexual assault victim, on a confidential basis, to disclose the details of his/her assault, to specifically identified individuals and receive medical treatment and counseling, without triggering the official investigative process.

b. Who may Receive a Restricted Report. Sexual Assault Response Coordinators (SARCs) can receive restricted reports of sexual assaults. Victim Advocate (VA) selected by the SARC may receive restricted reports after being appointed to serve as the advocate for that victim.

c. Who May Make a Restricted Report. Restricted reporting is available to military personnel and their dependents 18 years and older of the Armed Forces and the Coast Guard when attached to the Department of Defense. Military personnel include members on active duty and members of the Reserve component (Reserve and National Guard) provided they are performing federal duty (active duty training or inactive duty training and members of the National Guard in Federal (Title 10) status). Members of the Reserve Component not performing Federal duty are not eligible.
Retired member of any component and Air Force civilian employees are not eligible.

RESPONSIBILITIES:

a. McConnell Air Force Base agrees to the following:

1) When responding to victims of sexual assault the SARC and Health Care Providers (HCP)s from the 22nd Medical Group shall refer the victim to Via Christi Hospitals Wichita, Inc.'s Harry Street Campus Emergency Room for medical evaluation and treatment. Emergency Room staff will be advised if the victim is a qualified military or family member who has

been sexually assaulted and has requested a restricted report. Forensic Nursing Services Program (FNS) will be notified as appropriate.

2) When contacted by Via Christi Hospitals Wichita, Inc.'s FNS that a military member is seeking care for a sexual assault, the SARC or VA will respond rapidly to advise the victim of his/her reporting options.
3) The SANE will contact the SARC to obtain a RR case number in accordance with Air Force Policy.
4) The SARC will assign a VA to the victim.
5) The victim's name will not be reported, except when required under the restricted reporting program
6) Military Criminal Investigative Organizations (AFOSI, ACID, NCIS) will not be notified unless requested by the victim.
7) The SARC or VA will be available to assist in returning the victim home or to a safe place.
8) The SANE will conduct the Sexual Assault Forensic Examination (SAFE) kit.
9) The SARC or VA will verify that the correct restricted report case number was designated on the documentation forms, the SAFE kit, and any other sealed containers holding evidence.
10) FNS office staff will notify AFOSI to assume custody of the SAFE kit, documents and other evidence for storage under established chain of custody procedures.

b. Via Christi Hospitals Wichita, Inc.'s Forensic Nursing Services agrees to the following

1) When Via Christi Hospitals Wichita, Inc.'s FNS receives a sexual assault referral of a qualified military or family member from McConnell Air Force Base they shall provide medical care and, if requested by the victim, a SAFE kit.
2) When a qualified military or family member independently comes to Via Christi Hospitals Wichita, Inc. and requests medical care for a sexual assault, FNS will contact the McConnell AFB SARC or VA who will present to explain restricted and unrestricted reporting options available to the victim.
3) The FNS SANE will fully explain the SAFE process and obtain the victim's written consent prior to interviewing the patient or commencing with the evaluation.
4) FNS staff will not contact civilian or military criminal investigative authority's unless required by law or requested by the victim to do so.
5) The victim's name will be used on the primary documentation, but will not be used in any identifying information on the exterior of the kit. A restricted report case number will be used to track the documentation, and will be reported to the SARC.
6) The SANE will verify the correct restricted reporting case number was designated on the documentation forms, the SAFE kit, and other sealed containers holding evidence.
7) The FNS office staff will transfer custody of the SAFE kit, documents and other evidence to AFOSI for storage under established chain of custody procedures.

EFFECTIVE ADMINISTRATION AND EXECUTION OF THIS MOU:

a. This MOU becomes effective upon the date of signature by both parties and shall remain in effect until one party cancels or is replaced by a new agreement. This MOU should be reviewed annually and shall remain in full force and effective until specifically abrogated by one of the parties to this agreement with thirty (30) days notice to the other party. Any modification or cancellation of this agreement must be agreed upon by both parties and made in writing.

b. Effective execution of this agreement can be achieved only through continuing communication and dialogue between the parties. It is the intent of this MOU that channels of communication will be used to resolve questions, misunderstandings or complaints that may arise that are not specifically addressed in this MOU.

c. Personnel from McConnell Air Force Base and Via Christi Hospitals Wichita, Inc.'s Forensic Nursing Services Program shall meet, as necessary and appropriate, to share information regarding individual cases after having received signed "Release of Information" forms from the victims and to generally discuss and review quality of services provided to victims.

[redacted] _____ 8/10/13

[redacted] **Colonel, USAF** — **Date**

Commander, 22nd Air Refueling Wing

[redacted] 8/16/13

[redacted] **Program Coordinator** — **Date**

Forensic Nursing Services Program

Via Christi Hospitals Inc.

[redacted] _____ 8/16/13

Date

Director Emergency Services

Via Christi Hospitals Inc.

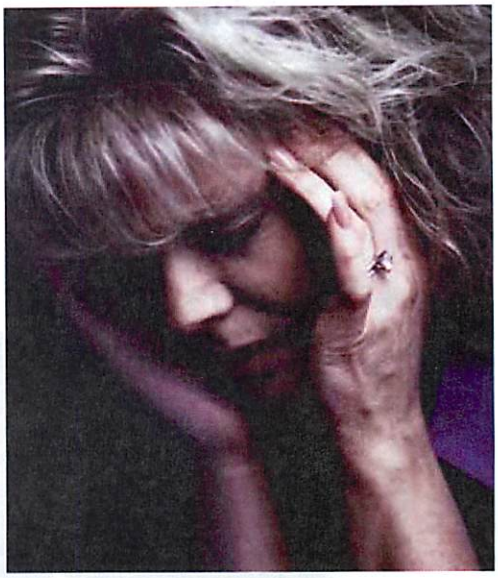
AF.Q.72

APRIL 2013

A National Protocol for Sexual Assault Medical Forensic Examinations

Adults/Adolescents

Second Edition



DNA INITIATIVE

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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

301434

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.

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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.[1] 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.[2] 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

[1] 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.
[2] 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/hprr/sexual%20assult/adultprotocol2011.ashx.

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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.[3] The objective is to promote better and more victim-centered[4] 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:[5]

- **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

[3] 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.
[4] Please see the section on "Victim-Centered Care" beginning on page 29 for more explanation of this term.
[5] 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.

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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),[6] 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.

[6] STIs are also commonly known as sexually transmitted diseases (STDs).

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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'[7] 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[8] 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.

[7] 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.
[8] 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.

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- 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

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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),[9] 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.[10] 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.[11] (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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[9] 42 U.S.C. § 3796gg-4.
[10] 28 C.F.R. § 90.14(a).
[11] 42 U.S.C. 3796gg-4(d).

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- 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

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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.

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- 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.

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- 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.

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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.

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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).[12] 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.[13]

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.[14] 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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[12] STI are also commonly known as sexually transmitted diseases (STDs).

[13] 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.

[14] 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/.

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nursing, forensic science, emergency-medicine, law, social services, and sex crimes in underserved communities.[15]

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,[16] 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.[17] 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.[18] It serves as an informational guide to communities as they develop or revise their own protocols.[19] 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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[15] Such consultation was required under Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386.

[16] 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.

[17] 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.

[18] 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.)

[19] 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.

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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.[20]

Use of Terms

Many terms are explained throughout the protocol to clarify the context in which they are used.[21] 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.

[20] 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.

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

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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.[22] 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 of 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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[22] 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).

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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.[23] 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.[24] 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

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

[24] Drawn from the Power and Control Wheel developed by the Domestic Violence Intervention Project of Minnesota.

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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.[25]

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

[25] Drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, Overview, p. 7.

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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,[26] 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

[26] 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.

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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.

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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

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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.[27]

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,

[27] 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.

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including prevention education and outreach,[28] training and technical assistance, improvement of victim services, protocol development, public policy advocacy, dissemination of materials, and evaluation of the effectiveness of these efforts.[29] 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):[30]

- **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

[28] 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.

[29] American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

[30] Bulleted section partially adapted from Pennsylvania's *SART Guidelines*, 2002, created by the Pennsylvania Coalition Against Rape.

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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.[31]

- **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.[32] For example, members might include[33] 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;[34] 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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[31] 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.

[32] American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, p. 19.

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

[34] 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.

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identify which agencies and individuals would be useful to have at the table at some point but are not essential to getting started.[35]

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

[35] 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.*

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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: [36]

- 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.

[36] 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-SARTReportJuly2005.pdf.

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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.[37] 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.

[37] The chapter was partially built on information from the *North Carolina Protocol for Assisting Sexual Assault Victims*, 2000.

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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.[38]

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

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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.[39] They may be concerned about costs related to the exam and subsequent care of injuries.[40]

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

[39] 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.
[40] Paragraph partially adapted from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2002, p. 2.

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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.[41] 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.[42]
- 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.[43]

—Victims with limited English proficiency[44]

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[41] 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.

[42] 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) .

[43] 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.

[44] 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 (PDF); Joint

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- Be patient and understanding toward victims' language skills and barriers, which may worsen with the crisis of sexual assault.[45]
- 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,[46] are LEP or who may prefer to communicate in a non-English language. Use qualified interpreters when possible and not victims' families or friends.[47] Take the victim's country of origin, acculturation level, and dialect into account when responding or arranging interpretation.[48] 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[49] 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.[50]
- 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.

[45] 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.

[46] 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.

[47] 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.

[48] 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.)

[49] Professional interpreters are expected to be familiar with confidentiality requirements and cultural issues.

[50] 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.

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repeatedly by the same offender.[51] 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).[52]
- 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.[53] 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.[54] 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

[51] 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.
[52] Examples of service animals include guide dogs and hearing-assistance dogs, and therapy dogs.
[53] Note that individuals may have their own assistive devices, but words needed to communicate may have to be programmed.
[54] Drawn from A. Conrad, *SANE/SAFE Organizing Manual*, 1998, p. 7, developed for the New York State Coalition Against Sexual Assault.

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experience was like for them.[55] 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[56]

- 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.[57]

—Adolescent victims[58]

- 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.[59] 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.[60]

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[55] Drawn from L. Ledray, *SANE Development and Operation Guide*, 2000, pp. 82–85. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.
[56] Drawn partially from L. Ledray, *SANE Development* and *Operation Guide*, 2000, p. 79. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.
[57] 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.
[58] 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.
[59] For example, the size of the speculum used with adolescent female victims and exam positions of victims may vary.
[60] Drawn partially from L. Ledray, *SANE Development* and *Operation Guide*, 2000, p. 7. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.

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- 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).[61]
- 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.[62]
- 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.[63]
- 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.[64]
- 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

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[61] Drawn partially from L. Ledray, *SANE Development* and *Operation Guide*, 2000, p. 98. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.

[62] Ibid.

[63] 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.)

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

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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.[65] 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[66]

- The military offers victims the option of restricted reporting or unrestricted reporting.[67] 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

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[65] Drawn partially from L. Ledray, *SANE Development* and *Operation Guide*, 2000, pp. 82-85. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.

[66] 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.

[67] For more information on reporting in the military, please see http://www.sapr.mil/.

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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

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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[68] 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.[69] When community-based advocates support victims, examiners can more easily maintain an objective stance.[70] 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: [71]

- 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

[68] 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.
[69] K. Littel, *SANE Programs: Improving the Community Response to Sexual Assault Victims*, 2001, p. 6.
[70] 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.
[71] 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).

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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[72] and support to help cope with the trauma of the assault[73] 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,[74] information, and referrals for community services; assist with applications for victim compensation programs;[75] 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).[76] 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.[77] 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.[78]

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[72] 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.

[73] 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.

[74] 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.

[75] For more information on crime victim's compensation, please see http://www.ovc.gov/publications/factshts/compandassist/welcome.html.

[76] 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.

[77] 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.

[78] 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.

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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.[79]

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.[80] An exception would be if responders consider the request to be potentially harmful to the patient or the exam process.[81] 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

[79] 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_nilc_table_10.pdf.

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

[81] 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.

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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.[82] 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.[83] 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[84]), 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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[82] 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.
[83] 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.
[84] It would be useful for the exam room to have an attached bathroom with a shower.

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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.[85] 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

[85] 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.

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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.[86] 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

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

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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.[87]

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.

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

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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.[68] 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.

[68] 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.)

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- 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[89] (although prosecutors may request the court to shield certain information from the defense, such as history of prior pregnancies, abortions, and STIs).[90]
- 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[91] 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.

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[89] 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.)

[90] 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.)

[91] 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.

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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).

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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.[92] 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[93]

[92] 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.

[93] 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

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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.[94]
- 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.[95]
- 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.

[94] 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.

[95] 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.

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In response to VAWA 2005, many jurisdictions have implemented alternatives to standard reporting procedures.[96] 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).[97] 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.[98] 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.[99] 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.[100]
- 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

[96] 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.

[97] 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.)

[98] 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.)

[99] 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).

[100] 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_nilc_table_10.pdf.

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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.[101]
- 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.[102]
- 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.[103]
- 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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[101] 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.

[102] 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

[103] 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.

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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.[104] 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.[105]

Each of these entities certifies each year that it is in compliance with the requirements of VAWA.[106] 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.[107]

States are permitted to use STOP Program funds to pay for the exams if they meet two conditions.[108] 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."[109] 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

[104] 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.
[105] 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.
[106] 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.
[107] 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.
[108] 42 U.S.C. 3796gg-4(c).
[109] 28 C.F.R. § 90.14(a).

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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.[110] For example, responders can help them apply for crime victims' compensation (if available) or arrange a payment plan with the exam facility.[111] 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.

[110] 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/factshts/compandassist/welcome.html.

[111] Exam facilities are sometimes willing to waive some related medical care costs that are not covered by government entities.

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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

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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).[112] 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.[113]

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.[114] 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.

[112] 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.)

[113] 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.

[114] 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..

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- 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.[115]
- 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[116]) 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.[117]
- 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.

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[115] 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 800–321–0SHA. 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.

[116] 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.

[117] 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.

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- 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,[118] 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.

[118] Examples of institutional settings include prisons, jails, immigration detention centers, juvenile detention centers, nursing homes, assisted living and rehabilitation programs, and inpatient treatment centers.

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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.[119] 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)[120] 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.[121] 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.[122]

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.[123] 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.

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[119] 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.

[120] 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).

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

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

[123] 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.

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- 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,[124] 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.[125] 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[126] or nonprofit sexual assault victim services programs.[127] 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.[128]

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:[129]

- 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.

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[124] 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.

[125] Drawn from L. Ledray, *SANE Development and Operation Guide*, 2000, pp.35–36.

[126] 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.

[127] For more information on the President's Family Justice Center Initiative, see http://www.ovw.usdoj.gov.

[128] 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.

[129] Adapted from Pennsylvania's *SART Guidelines*, 2002, p.21.

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- 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.[130] 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.[131]

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[130] 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.
[131] Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.

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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.

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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: [132]

- 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.[133]
- 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.[134] 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.[135]
- 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

[132] 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.

[133] 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.

[134] 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.

[135] 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.

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

- An anoscope may be used in cases involving potential anorectal penetration or anal/rectal trauma.[138] 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.[139] In these cases, an optically staining microscope is used to highlight cellular material and facilitate the search for sperm.[140] (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.[141] 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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[136] Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 37.

[137] 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.

[138] 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.

[139] 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.

[140] 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.

[141] 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.

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- Apply for grant or foundation funding for equipment where eligible.[142]
- 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.

[142] 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.

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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.[143]

- 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:[144]
  - 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,[145] and swabs of suspected semen, saliva, and/or areas highlighted by alternate light sources.[146]
  - Hair if required in the jurisdiction.[147]
  - Vaginal/cervical swabs.
  - Penile swabs.
  - Anal/perianal swabs.
  - Oral swabs.
  - Body swabs.[148]

[143] 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.

[144] 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").

[145] 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 patent to that risk.

[146] 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.

[147] 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.

[148] 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.

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- 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.[149] A designated agency in the jurisdiction should be responsible for oversight of kit development and distribution.[150] It should:

- Ensure that facilities that conduct sexual assault medical forensic exams are involved in kit development and supplied with kits.[151]
- 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.)

[149] 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.

[150] 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.

[151] 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.

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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.[152] 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.[153] 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.

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[152] Paragraph drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 29.

[153] 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 Medi cine, 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.

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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.[154] 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.

[154] 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.

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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,[155] 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.[156] 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.[157] Urine should be refrigerated or frozen when stored.[158] 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

[155] Dry evidence unless indicated otherwise (e.g., freezing).
[156] 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.
[157] 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.
[158] 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.

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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.[159] 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.

[159] Adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 34.

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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

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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.[160] 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.

[160] 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.

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- 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.[161]
- 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.[162] Victims with disabilities may have equipment (e.g., wheelchairs and other assistive devices) and/or service animals that also need to be transported.[163] 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.

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[161] 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.
[162] Many jurisdictions have designated exam sites. For more information on this topic, see *B.2. Facilities.*
[163] In addition, evidence may be found on assistive devices and/or service animals.

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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.

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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.[164] (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.[165]

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[164] 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.

[165] 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

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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[166] for victims who are LEP.[167]

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.

[166] 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).

[167] 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.

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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.[168] (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.[169]

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,

[168] 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.

[169] 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.

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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.

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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.[170]

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.[171] 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.[172]

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.

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[170] 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.

[171] Some repetition of questions is likely to occur during the exam process.

[172] 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.

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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.[173] These individuals could be subpoenaed as witnesses in their case.[174] 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.[175]

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.[176]

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.[177] However, the following information should be sought routinely from patients:[178]

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

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[173] 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.

[174] 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.

[175] 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.

[176] 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.
Paragraph partially drawn from N. Baladerian, *Skills for Interviewing Adult Abuse Victims Who Have Developmental Disabilities*, p. 1.

[177] 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.

[178] 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.

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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.[179]
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:[180]

    - 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

[179] 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.
[180] 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.[181]

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.

[181] 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.

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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.[182] 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.[183] 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).[184] 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.[185]

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.

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[182] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.
[183] Avoid requiring that patients go to another site (e.g., the law enforcement agency) to have initial photographs taken.
[184] 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.
[185] 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.

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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.[186] 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.[187] 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

[186] 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.
[187] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 56.

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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.[188]

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.

[188] 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.

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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.[189] 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.[190] (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.[191] 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.[192] 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

[189] 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.
[190] Drawn from L. Drawn partially from L. Ledray, SANE Development and Operation Guide, 2000, p. 79. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf, *SANE Development and Operation Guide*, 1998, p. 63.
[191] U.S. Department of Justice, Bureau of Justice Statistics, *Female Victims of Violence*, http://www.bjs.gov/content/pub/pdf/fvv.pdf
[192] J. Archambault and D.K. Faugno, Overcoming a Consent Defense to Sexual Assault, *Journal of Emergency Nursing*, 27:204–208, April 2001.

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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.[193] 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.[194] 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.[195] 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.[196]

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.[197] 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.[198] 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[199] 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.

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[193] L. Ledray, *SANE Development* and *Operation Guide*, 2000, p. 63. http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.

[194] 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.

[195] 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.)

[196] 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.

[197] 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.

[198] An exception is that a forensic lab may input frequency information related to the DNA profiles in its statistical database. Victims' identity remains anonymous.

[199] Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.

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Understand the implications of the presence or absence of seminal evidence.[200] 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.[201] 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.[202] 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.[203] 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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[200] 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.
[201] In the absence of sperm, certain seminal fluid components may be used to identify semen.
[202] If assailants who had a vasectomy ejaculated, their seminal fluid would not contain sperm.
[203] 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*.

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Anogenital examination.[204] During the female genital exam,[205] 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, clitorial hood and surrounding area, perurethral tissue/urethral meatus, hymen,[206] fossa navicularis, and posterior fourchette. The use of a colposcope during the external genital exam enhances viewing microscopic trauma and may provide photographic documentation.[207]

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.[208] 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.[209]

Collect evidence to submit to the crime lab for analysis, according to jurisdictional policy.[210] The following evidence from patients, along with completed documentation forms, typically is submitted to the crime lab designated by the jurisdiction.[211] Jurisdictions may require collection of additional or different

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[204] 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.

[205] 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.)

[206] 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.)

[207] 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).

[208] 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.)

[209] 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.

[210] 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.

[211] 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

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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.[212] 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).[213] When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged.[214] 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.[215] 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.

[212] 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.

[213] 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.

[214] 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.)

[215] 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.

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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.[216]
- 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,[217] and initial the seal.

Collect debris.[218]

- 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.[219] 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.

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[216] Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.
[217] 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.)
[218] 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.
[219] Some jurisdictions routinely collect fingernail samples and photograph fingernail damage that may have been related to the assault.

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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.[220] Follow jurisdictional policy for collection of hair reference samples.[221] 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.[222] 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.[223] 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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[220] See footnote under hair combing regarding patients with limited mobility.

[221] 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.

[222] Note that a patient may believe hair is sacred and thus may be reluctant or decline to have hair evidence collected.

[223] 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.

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- 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[224]

- 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[225]

- 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.[226] 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.[227] Because sperm motility decreases quickly with time and removal from the vagina/cervix,[228] wet-mount evaluation during the exam can provide the only opportunity to see sperm motility.[229] The presence of motile sperm may help narrow the timeframe that the crime could have occurred.

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[224] One jurisdiction also collects a lip/lip area swab and smear and an oral rinse if there was oral contact.

[225] 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.)

[226] 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.

[227] 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.

[228] 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).

[229] 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.

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In most jurisdictions, however, the crime lab is responsible for all analysis of evidence[230] and examiners do not do the wet-mount evaluation for sperm.[231] 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 quakuty 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.[232] 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).[233]
- 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[234]

- 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[235]

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[230] A possible exception may be toxicology analysis.

[231] 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).

[232] 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.)

[233] 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.

[234] See the next footnote for patients with spinal cord injury and/or history of autonomic dysreflexia.

[235] 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

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- Collect swabs from the anal cavity.[236] 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.[237]
- 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.)

[236] 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.

[237] Several state protocols indicate dry blood collection is an acceptable method to obtain known DNA samples.

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is typically specified by the designated crime lab.[238] If tubes are included in the evidence collection kit, check expiration dates and replace if expired.[239] 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.

[238] The *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 52.
[239] Drawn from Connecticut's Video Training Program, Part 1, *The Examination: Sexual Assault Evidence Collection*, 1998.

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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.[240]

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.[241] 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.[242] 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

[240] 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.
[241] 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.
[242] 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.

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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.[243]

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.[244] 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:[245]

- 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, psysiologic 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).[246]

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:[247]

- The purposes of toxicology testing and the scope of confidentiality of results.[248]
- 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[249] 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.[250]

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[243] 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.

[244] 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.

[245] Bullets drawn from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.

[246] 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.)

[247] List adapted partially from Connecticut's *Interim Sexual Assault Toxicology Screen Protocol*, 2002.

[248] 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.

[249] 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.

[250] 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.

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- 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).[251]
- 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.[252]
- 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).[253] Urine allows for a longer window of detection of drugs commonly used in these cases than does blood.[254] The sooner a urine specimen is obtained after the assault, the greater the chances of detecting substances that are quickly eliminated from the body.[255]

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[256] 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[257]) according to jurisdictional policy. A blood sample taken within this time period may pinpoint the time when drugs were ingested.[258] 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

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[251] 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.
[252] 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.
[253] American Prosecutors Research Institute, Violence Against Women Program, 1999, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, Chapter 2, p. 1.
[254] M. LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults, *Forensic Science Communications*, 1999, p. 3.
[255] Ibid.
[256] Ibid.
[257] Ibid.
[258] American Prosecutors Research Institute, Violence Against Women Program, 1999, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*, Chapter 2, p. 2.

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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.[259] 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 qualities).[260] 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.[261] 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.[262]

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[259] M. LeBeau, Toxicological Investigations of Drug-Facilitated Sexual Assaults, *Forensic Science Communications*, 1999, p. 3.
[260] American Prosecutors Research Institute, Violence Against Women Program, 1999, Video supplement, *The Prosecution of Rohypnol and GHB Related Sexual Assaults*.
[261] 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.
[262] These guidelines are available at http://www.soft-tox.org.

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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.[263]

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.[264] 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.[265] 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.[266] Their presence does not necessarily indicate acquisition during the assault, since these infections exist among some sexually active women.[267] 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.*)

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[263] 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.

[264] Drawn partially from Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 92.

[265] 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.)

[266] 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).

[267] 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)

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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.[268] 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.[269] (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.[270]

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.[271] 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.[272] 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.[273] 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).

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[268] Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91.
[269] 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).
[270] Nonphysician examiners providing STI prophylaxis typically must operate within the boundaries of a protocol and have access to medical supervision, consultation, and review.
[271] Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91. This section was drawn from this document.
[272] This paragraph is drawn from Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 91.
[273] 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.)

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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[274] from a sexual assault appears to be low,[275] it is typically of grave concern for sexual assault patients.

Provide information and referrals.[276] Examiners should talk with patients about their concerns regarding the possibility of contracting HIV.[277] 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.[278]

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.[279]

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.[280] Confidential and anonymous testing is recommended.

Assess the need to offer HIV postexposure prophylaxis.[281] In certain circumstances, the likelihood of HIV transmission may be reduced by postexposure therapy for HIV with antiretroviral agents. Postexposure

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[274] 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.)

[275] 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.)

[276] 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/ or by calling the CDC's HIV/AIDS Information Hotline (see below footnote).

[277] 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.

[278] This paragraph is drawn from Sexually Transmitted Diseases Treatment Guidelines, 2010, p. 92.

[279] L. Ledray, *SANE Development and Operations Guide*, 2000, p. 74.

[280] Drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 126.

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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.[282] 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.[283]

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:[284]

- 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.[285]

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[286] 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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[281] 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).

[282] 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.)

[283] Paragraph drawn from the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Abused Patient*, 1999, p. 125.

[284] Bullets drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 93.

[285] 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.)

[286] See 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).

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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 [287] 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.[288] 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).[289] 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.[290] 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

[287] Bureau of Justice Statistics Bulletin, 9/2005 NCJ 214644.
[288] L. Ledray, *SANE Development and Operation Guide*, 2000, p. 75.
[289] Preexisting pregnancy may raise patient privacy issues. If the case is prosecuted, the prosecutor should work to address concerns such as this one.
[290] 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/.

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is to offer hormone therapy (emergency contraception pills or EC).[291] 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.[292] 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,[293] a synthetic hormone,[294] be used.[295] This option is recommended for its higher efficacy rate and ease of dosing, and the fewest number of side effects, particularly nausea and vomiting.[296] 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.[297] 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 levonorgestral are just as effective and better tolerated by the patient.[298]

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 antinausea medications, with a list of pharmacies that stock the medication.[299]

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.[300]

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[291] 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.
[292] CA Protocol
[293] 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.
[294] FDA website: http://www.fda.gov/cder/drug/infopage/planB/planBQandA.htm.
[295] 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.
[296] 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
[297] http://www.planbonestep.com/plan-b-prescribers/index.aspx
[298] 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 levonorgestral 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.
[299] 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.*
[300] This hotline and website are operated by the Office of Population Research at Princeton University and by the Association for Reproductive Health Professionals.

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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.[301] 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:[302]

- 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.[303]

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[301] 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.
[302] Bullets drawn partially from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 98.
[303] 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.

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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.[304] 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

[304] Drawn from M. Nosek and C. Howland, *Abuse and Women with Disabilities*, 1998, p. 3.

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progresses.[305] 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.[306] 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.*)

[305] 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.
[306] 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.

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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,[307] 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:[308]

- Provide them with information about courtroom proceeding basics (e.g., criminal justice process and terms, who typically is present,[309] 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).[310]

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[307] 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.)

[308] 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.

[309] 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.

[310] 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.

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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.[311]

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.[312] 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.[313]
- 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.[314]
- 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.[315]

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."

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[311] 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.
[312] Section partially adapted from Arkansas's *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examination*, 2001, pp. L1–3.
[313] 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.
[314] 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.
[315] 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.

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- 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.[316] 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,[317] desired outcomes, and how the effectiveness of the action will be evaluated. The plan can be revisited periodically to assess progress and evaluate outcomes.

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[316] Section drawn from K. Littel, M. Malefyt, 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.

[317] 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.ovw.usdoj.gov/.

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Create a protocol. To promote an effective protocol development process, consider the following:[318]

- 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.[319] 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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[318] 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.
[319] 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.

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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.

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Appendix B. Creation of Sexual Assault Response and Resource Teams

Create a SART/SARRT to facilitate coordination among involved disciplines.[320] 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[321] 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, [322] without using victims' names or other identifying information.[323] 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

[320] 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.

[321] "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.

[322] 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.

[323] 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' identify 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' identify.

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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.

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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*[324] and *Davis* v. *Washington*[325] 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.[326]

[324] 541 U.S. 36, 124 S.Ct. 1354, 158 L.Ed.2d 177 (2004).
[325] 126 S. Ct. 2266 (2006).
[326] *Giles* v. *California*, 128 S. Ct. 2678 (2008).

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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 glassl 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.

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DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 6310.11A CH-1
BUMED-M3
18 Sep 2013

BUMED INSTRUCTION 6310.11A CHANGE TRANSMITTAL 1

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: SEXUAL ASSAULT PREVENTION AND RESPONSE MEDICAL-FORENSIC PROGRAM

Encl: (1) Revised enclosures (6) through (8)

1. Purpose. To update paragraph 2e(1) by removing subparagraph 2e(1)(f) of enclosure (6), update paragraph 4 of enclosure (7), and update paragraphs 3 and 4 of enclosure (8) of the basic instruction. Added new form.

2. Action. Remove enclosures (6) through (8) from the basic instruction. Replace with enclosure (1) of this change transmittal.

3. Form. New form NAVMED 6310/7 (Rev. 08-2013) is available on the BUMED Web site at: http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx

4. Retain. For record purposes, keep this change transmittal in front of the basic instruction.

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http://www.med.navy.mil/directives/Pages/default.aspx

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 6310.11A
BUMED-M3
2 May 2013

BUMED INSTRUCTION 6310.11A

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: SEXUAL ASSAULT PREVENTION AND RESPONSE MEDICAL-FORENSIC PROGRAM

Ref: (a) through (t) see enclosure (1)

Encl: (1) through (12) see enclosure (2)

1. Purpose. To provide guidance for timely, readily accessible quality care, and medical-forensic evaluation of the sexual assault victim per references (a) through (t). Enclosure (1) is a list of references. Enclosure (2) is a list of enclosures. Enclosure (3) is a list of acronyms. Enclosure (4) is a list of terms and definitions used in this instruction. Enclosure (5) is a list of reference links. This instruction exclusively addresses the Bureau of Medicine and Surgery's (BUMED's) medical-forensic requirements in support of sexual assault victims per reference (b). Administrative guidance on the execution of the Department of Defense Sexual Assault Prevention and Response Program (SAPR) for Navy Medicine activities will be released via separate BUMED instruction.

2. Cancellation. BUMEDINST 6310.11.

3. Background. References (a) through (q) establish policy, responsibility, and guidance for shore and operational platforms in caring for victims of sexual assault. The comprehensive victim-centered management of sexual assault victims requires addressing physical and psychological trauma, appropriate coordination of care, and collection of medical forensic evidence.

4. Policy. Navy Medicine personnel will adhere to policies and procedures established in enclosures (6) through (12) when caring for victims of sexual assault. This will include the requirement to provide Sexual Assault Forensic Examinations 24/7 at all Navy medical treatment facilities or through an established memorandum of agreement with a local civilian treatment facility.

5. Applicability and Scope. This instruction applies to:

a. All Ships and Stations having medical department personnel.

b. Active duty members, reserve personnel who are sexually assaulted when performing active service, inactive duty training, and military dependents 18 years and older who are eligible for treatment in the Military Health System (MHS) in the continental United States and outside of the continental United States (OCONUS).

c. Department of Defense (DoD) civilians, their family members, and DoD contractors who are eligible for medical treatment in the MHS at military installations OCONUS.

6. Action. Navy Medicine region commanders and medical treatment facility (MTF) commanders, commanding officers, and officers-in-charge must ensure this instruction is implemented and strictly followed. Enclosure (6) provides a list of responsibilities.

7. Training. References (m) and (n) establish a requirement for Sexual Assault Medical Forensic Examiner training. All health care providers performing the Sexual Assault Medical Forensic Examination will complete initial training via DVD per enclosure (8). This training is designed for physicians, advanced practice nurses, physician assistants, registered nurses, and independent duty corpsmen to increase capability to conduct medical forensic examinations and provide guidance necessary to care for sexual assault victims. It is designed to be exportable to all platforms, and to remain sustainable over time.

8. Kits. DoD contracts with the Tri-Tech company for the purchase of forensic evidence collection kits. Per reference (q), these DoD approved kits can be ordered in cases of 5 or 15, via item stock number RE-0DOD (FS). The contact number for Tri-Tech is 1-800-438-7884.

9. Records. Records created as a result of this instruction, regardless of media and format, shall be managed per reference (r).

10. Reports. The reports required in this instruction are exempt from report control per reference (j), part IV, paragraph 7n.

11. Forms

a. DD Form 2910 (Nov 2008), Victim Reporting Preference Statement, is available on the DoD Forms Management Program website at:
http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2910.pdf

b. DD Form 2911 (Sep 2011), Forensic Medical Report: Sexual Assault Examination, is available on the DoD Forms Management Program website at:
http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2911.pdf

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c. NAVMED 6310/5 (03-2009), Department of the Navy (DON), Sexual Assault Restricted Reporting Evidence Submission Chain of Custody is available electronically at: http://www.med.navy.mil/directives/ExForms/NAVMED%206310-5.pdf

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REFERENCES

(a) DoD Directive 6495.01 of January 23, 2012
(b) DoDINST 6495.02 of March 28, 2013
(c) SECNAVINST 1752.4A
(d) OPNAVINST 1752.1B
(e) OPNAVINST 1752.2B
(f) MCO 1752.5A
(g) SECNAVINST 1752.3B
(h) DoD 6025.18-R June 24, 2003
(i) OPNAVINST 5800.7A
(j) SECNAV M-5214.1
(k) NAVADMIN 195/12
(l) OPNAVINST F3100.6J
(m) Department of Justice September 2004 National Protocol for Sexual Assault Medical Forensic Examinations for Adults/Adolescents
(n) Department of Justice June 2006 National Training Standards for Sexual Assault Medical Forensic Examiners
(o) Section 1079, Title 10, United States Code
(p) Sections 101 (d)(3), 113, 504, 4331, chapter 47, and chapter 80 of Title 10, United States Code
(q) BUMED Memo 6000 Ser M3B2/AT244686 of 20 Jul 12
(r) SECNAV M-5210.1 of January 2012
(s) 45 CFR parts 160 and 164
(t) DoD Directive 6025.18 of December 2, 2009

ENCLOSURES

(1) References
(2) Enclosures
(3) Acronyms
(4) Terms and Definitions
(5) Additional Resources
(6) Navy Medicine Sexual Assault Prevention and Response Guidance
(7) Documentation and Coding of Medical Forensic Examinations
(8) Training Guidance and Competency Assessment
(9) Evidence Handling for Restricted and Unrestricted Report of Sexual Assault
(10) Guidance on Forensic Photography
(11) Sample Sexual Assault Medical Care and Forensic Examination Procedures Checklist for Health Care Providers
(12) Sample Memorandum of Understanding

ACRONYMS

AFMES	Armed Forces Medical Examiner System
BAC	Blood Alcohol Content
BUMED	Bureau of Medicine and Surgery
CBC	Complete Blood Count
CFR	Code of Federal Regulations
CHCS	Composite Health Care System
CMP	Complete Metabolic Panel
CO	Commanding Officer
CONUS	Continental United States
DoD	Department of Defense
DoJ	Department of Justice
DON	Department of the Navy
DNA	Deoxyribonucleic acid
EMD	Emergency Medical Department
ETOH	Ethanol
FFSC	Fleet and Family Support Center
GCC	Gonorrhea and Chlamydia Collection
HCG	Human Chorionic Gonadotropin
HEPBSAB	Hepatitis B Serum Antibody
HEPBSAG	Hepatitis B Serum Antigen
HEP C AB	Hepatitis C Antibody
HIV	Human Immunodeficiency Virus
HIPAA	Health Insurance Portability and Accountability Act
IDC	Independent Duty Corpsman
LOD	Line of Duty
MCCS	Marine Corps Community Services
MCIO	Military Criminal Investigative Organizations
MHS	Military Health System
MOU	Memorandum of Understanding
MTF	Medical Treatment Facility
NCIS	Naval Criminal Investigative Services
NMETC	Navy Medicine Education and Training Command
NMPDC	Navy Medicine Professional Development Center
OCONUS	Outside the Continental United States
OIC	Officer in Charge
PMO	Provost Marshall Officer
RPR	Rapid Plasma Reagent
RRCN	Restricted Report Case Number
SACMG	Sexual Assault Case Management Group
SAFE	Sexual Assault Forensic Examination/Examiner
SARC	Sexual Assault Response Coordinator

SAPR	Sexual Assault Prevention and Response
SJA	Staff Judge Advocate
VA	Victim Advocate

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TERMS AND DEFINITIONS

1. Consent. Words or overt acts indicating a freely given agreement to the sexual conduct at issue by a competent person. An expression of lack of consent through words or conduct means there is no consent. Lack of verbal or physical resistance or submission resulting from the use of force, threat of force, or placing another person in fear does not constitute consent. A current or previous dating relationship by itself, or the manner of dress of the person involved with the accused in the sexual conduct at issue, shall not constitute consent.

2. Covered Communication. Oral, written, or electronic communications of personally identifiable information concerning a sexual assault victim or alleged assailant provided by the victim to the sexual assault response coordinator (SARC), victim advocate (VA), or health care personnel.

3. First Responders. Includes law enforcement, base security, the SARC, the VA, health care personnel, military criminal investigative organizations, judge advocates, and chaplains.

4. Health Care Personnel. Persons who assist or administratively support health care providers (e.g., administrative personnel assigned to a Military Treatment Facility (MTF)). For the purposes of this instruction, the term health care personnel also include all health care providers.

5. Health Care Providers. Those personnel who are employed or assigned as healthcare professionals, or are credentialed to provide healthcare services, at a military medical or military dental treatment facility, or who provide such care at a deployed location or in an official capacity. This also includes military personnel, Department of Defense (DoD) civilian employees, and DoD contractors who provide health care at an occupational health clinic for DoD civilian employees or DoD contract personnel. Health care providers may include, but are not limited to, licensed physicians, advanced practice nurses, physician assistants, registered nurses, and independent duty corpsmen (IDC).

6. Other Sex-Related Offenses. All other sexual acts or acts in violation of the Uniform Code of Military Justice (e.g., indecent acts with another and/or adultery).

7. Restricted Reporting. Restricted reporting is a process by which a sexual assault victim may report or disclose to specified officials that he or she is the victim of a sexual assault. Under these circumstances, the victim's report and any details provided to the SARC, VA, or health care providers will not be reported to law enforcement unless the victim consents or an established exception applies. The restricted reporting option is available to those sexual assault victims who are Service members. For more information on restricted reporting see references (d), (e), (g) and (l). Health care personnel may only receive a restricted report if it is within their duties and responsibilities as a health care professional in caring for patients. Health care personnel or health care providers who are not providing patient care may not receive a restricted report. Reference (e), enclosure (4), covers military dependent sexual assault victims who are

assaulted by a spouse or intimate partner. Restricted reporting may not be an option if the sexual assault occurs outside of the military installation or a civilian authority and will vary by State, territory, overseas local agreements, and/or in an area of civilian authority or jurisdiction. References (a) and (d) will provide further guidance.

8. Sexual Assault. Sexual assault is intentional sexual contact, characterized by use of force, threats, intimidation, abuse of authority, or when the victim does not or cannot consent. Sexual assault includes rape, forcible sodomy (oral or anal sex), and other unwanted sexual contact that is aggravated, abusive, or wrongful (to include unwanted and inappropriate sexual contact), or attempts to commit these acts.

9. Sexual Assault Case Management Group (SACMG). The purpose of the SACMG is to review all pending and newly reported unrestricted sexual assault cases, improve the reporting process, facilitate victim updates, and discuss process improvements to ensure quality services are available to victims. The SARC will chair the installation/regional SACMG.

10. Sexual Assault Medical Forensic Examination. A medical and forensic examination used to address patient's health care needs, document findings, collect evidence and refer them for other medical treatment or behavioral health services.

11. Sexual Assault Medical Forensic Examiner. A healthcare provider, physician, licensed independent practitioners, registered nurse and in the operational environment independent duty corpsmen, who have had training to care for sexual assault patients, document findings, collect forensic evidence, and refer them for other medical treatment or behavioral health services.

12. Sexual Assault Response Coordinators (SARC). Military personnel or DoD civilian employees who serve as the central point of contact at an installation or geographic area with responsibility for ensuring that appropriate and responsive care is properly coordinated and provided to victims of sexual assault.

13. Unrestricted Reporting. A process by which the sexual assault victim discloses that he or she has been the victim of a sexual assault without requesting confidentiality or restricted reporting. Under this circumstance, the victim's report and any details provided to any health care personnel, SARC, VA, command authorities, or other persons are reportable to law enforcement and may be used to initiate the official investigative process. Once notified, the victim's command is required to report the incident to Naval Criminal Investigative Service, who may refer the incident to local civilian law enforcement per reference (d). If a victim unintentionally makes an unrestricted report of sexual assault, nothing in DoD policy requires that victim to participate in any criminal investigation.

14. Victim Advocates (VA). Military personnel, DoD civilian employees, DoD contractors, or volunteers who facilitate care for victims of sexual assault, and who, on behalf of the sexual assault victim, provide liaison assistance with other organizations and agencies on victim care

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matters, and report directly to the SARC when performing victim advocacy duties. As appropriate and using DD Form 2910, Victim Reporting Preference Statement, the VA must provide a thorough explanation to the victim of each of the reporting options available to him or her, including the exceptions and/or limitations on use applicable to each. The VA helps the victim navigate the process to get needed care and services, but the VA is not a therapist or an investigator.

15. Sexual Assault Medical Program Manager. Health care provider assigned to oversee the Sexual Assault Medical Forensic Examiner Program. This position coordinates with the Sexual Assault Prevention and Response (SAPR) Administrative Program Manager for tracking, reporting and monitoring of the SAPR program. At the Navy Medicine Regions and at the MTFs one person may hold the medical and administrative responsibility.

16. Sexual Assault Administrative Program Manager. This position has oversight of the BUMED administrative function of the SAPR program, tracking, reporting and monitoring and works closely with the Sexual Assault Medical Program Manager.

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ADDITIONAL RESOURCES

1. DoD Service Sexual Assault Links

   a. DoD Sexual Assault Prevention and Response Program – http://www.sapr.mil/

   b. DoN Sexual Assault and Response Program Office – http://www.donsapro.navy.mil

   c. BUMED Office of Women's Health – https://www.med.navy.mil/bumed/womenshealth/Pages/default.aspx

   d. U.S. Marine Corps Sexual Assault Prevention and Response Office (SAPRO) – http://www.usmc-mccs.org/sapro/index.cfm; POC – http://www.usmc-mccs.org/sapro/pocs.cfm; Resources - http://www.usmc-mccs.org/sapro/resources.cfm

   e. Army Sexual Assault Prevention and Response Program – http://www.sexualassault.army.mil/

   f. Navy Sexual Assault Victim Intervention – http://www.cnrsw.navy.mil/FSC/savi.asp

   g. DoD Sexual Assault Forensic Examiner Helpline – www.safehelpline.org

2. Other DoD/Government Related Links

   a. Defense Task Force on Sexual Harassment and Violence at the Military Service Academies –http://www.dtic.mil/dtfs

   b. Defense Task Force on Domestic Violence – http://www.defenselink.mil/releases/release.aspx?releaseid=2851

   c. Defense Department Advisory Committee on Women in the Services (DACOWITS) – http://dacowits.defense.gov

   d. Center for Women Veterans (Department of Veterans Affairs) – http://www1.va.gov/womenvet

   e. Military OneSource – http://www.militaryonesource.com

   f. DoD Victim and Witness Assistance Council (VWAC) – http://www.defenselink.mil/vwac

   g. Under Secretary of Defense for Personnel and Readiness – http://www.dod.mil/prhome

   h. U.S. Department of Defense (Defense Link) – http://www.defenselink.mil

i. Washington Headquarters Services, Executive Services Directorate, Directives and Records Division, DoD Issuances, and Office of the Secretary of Defense (OSD) Administrative Instructions – http://www.dtic.mil/whs/directives/

j. Department of Defense Equal Opportunity – http://www.defenselink.mil/prhome/eo.html

3. Public Web Sites

a. National Sexual Violence Resource Center (NSVRC) – http://www.nsvrc.org

b. Violence Against Women Online Resources – http://www.vaw.umn.edu

c. Department of Justice (DoJ) Office for Victims of Crime – http://www.ojp.usdoj.gov/ovc

d. National Online Resource Center on Violence against Women – www.vaw.umn.edu

e. MedLine PubMED (medical literature search) – http://www.nlm.nih.gov/medlineplus

f. The International Association of Forensic Nurses – http://www.iafn.org/

g. National Criminal Justice Resources Services – http://virlib.ncjrs.org/vict.asp?category=50&subcategory=114 – DoJ search engine

h. The National Women's Health Information Center – http://www.womenshealth.gov/

i. Department of Justice (DoJ) Office on Violence against Women – http://www.ovw.usdoj.gov

j. Rape, Abuse and Incest National Network (RAINN) – http://rainn.org

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NAVY MEDICINE SEXUAL ASSAULT PREVENTION AND RESPONSE MEDICAL-FORENSIC PROGRAM GUIDANCE

1. Background

a. The Department of Defense (DoD) does not tolerate sexual assault and has implemented a comprehensive program that reinforces a culture of prevention, response, and accountability for the safety, dignity, and well-being of all members of the Armed Forces. The DoD restricted reporting policy encourages victims to seek the medical support that is available to them without fear of reprisal or stigma. Navy Medicine fully supports the DoD policy on Sexual Assault Prevention and Response (SAPR). BUMED supports this instruction by providing implementation guidance for medical-forensic response to victims of sexual assault. Administrative guidance on the execution of the DoD SAPR Program will be released via separate BUMED instruction. Information about DoD SAPR is available at: http://www.sapr.mil/.

b. This SAPR instruction provides Navy Medicine personnel with guidance in providing victim-sensitive, comprehensive-care for adult victims of sexual assault.

c. Navy leaders will exhibit top-down leadership engagement by promoting a consistent message that sexual assault is unacceptable and that medical personnel know their roles and responsibilities for caring for sexual assault victims.

2. Responsibilities

a. Chief, Bureau of Medicine and Surgery (BUMED) is responsible for appointing a BUMED Sexual Assault Medical Program Manager to:

(1) Provide proactive oversight of the Sexual Assault Medical Forensic Examiner Program.

(2) Work in collaboration with the Sexual Assault Administrative Program Manager.

(3) Coordinate with BUMED Education and Training (BUMED-M7) and Navy Medicine Education and Training Command (NMETC) to ensure training requirements and plans are standardized and tracking mechanisms are established and implemented via the appropriate Navy Medicine Region.

(4) Collaborate with Commander, Navy Installations Command Sexual Assault Response Coordinators (SARC) and the BUMED Sexual Assault Administrative Program Manager to collect data and prepare the Annual Report to Congress.

(5) Prepare the BUMED annual report to Health Affairs on Sexual Assault Forensic Examinations (SAFE) capability and number of trained examiners.

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(6) Collaborate with Navy Medicine Regions to monitor and track Memorandum(s) of Understanding with civilian health care facilities.

(7) Collaborate with operational forces medical liaisons, to include Fleet Forces Surgeon, Pacific Fleet Surgeon, and the Medical Officer of the Marine Corps to ensure operational platforms have the capability to provide medical-forensic examinations to support victims of sexual assault.

b. Commanders, Navy Medicine Regions shall:

(1) Appoint a Regional Sexual Assault Medical Program Manager to assume responsibility for and ensure that the DoD standard of care of sexual assault victims is met at the medical treatment facility (MTF) and clinics under the regional purview. Medical management shall be trauma-informed, victim-centered, gender-sensitive, compassionate, and non-judgmental. The Regional Sexual Assault Medical Program Manager can be a physician, registered nurse, or other licensed independent practitioner.

(2) Coordinate with the regional SAFE point of contact (or program manager) to coordinate DoD and Navy sexual assault medical-forensic policy.

(3) Ensure availability of sexual assault medical response capability 24/7. All Navy medical facilities will ensure availability to complete SAFEs during hours of operation. If a facility is unable to perform a SAFE based on personnel manning, hours of operation, or facility design, Deputy Chief, Medical Operations (BUMED-M3) must be notified of location and a plan to manage patients who may present to their location. No ambulatory clinic is expected to open for business for the sole purpose of completing a SAFE.

(4) Develop a Regional Plan of Execution and timeline for implementation. The Regional Sexual Assault Medical Program Manager will identify sites that will or will not conduct a SAFE. If a site is identified as not being able to complete a SAFE, justification must be given to BUMED-M3 and a plan articulated to meet the capability should a victim of sexual assault present. The roll out plan should prioritize the hospital sites as first to be trained and when hospitals are complete move into the ambulatory sites. The time line for implementation is completion by the end of Fiscal Year 2013 with quarterly progress reports to the BUMED Chief of Staff via the BUMED Sexual Assault Medical Program Manager.

(5) Ensure that each MTF commander, commanding officer (CO), and officer in charge (OIC) adheres to the policy and remains committed to ongoing training.

(6) Assist the MTF Sexual Assault Medical Program Manager in establishing and sustaining a sexual assault program that will ensure DoD initial and refresher training standards are met for health care personnel, and personnel trained to provide medical-forensic examinations. All sites will identify physicians, registered nurses, and other licensed

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independent practitioners who will be trained to complete a SAFE. Independent duty corpsman (IDC) training will be provided if they are assigned to an operational platform. IDCs assigned to MTFs may not be required to complete training to perform the SAFE, depending on MTF requirements. The Command Program Manager will determine level of training needed.

(7) Ensure that training for health care providers performing sexual assault medical-forensic examinations is completed per enclosure (8) and entered into Fleet Training Management and Planning System under CIN: MED-SAFE.

(8) Collaborate with NMETC to facilitate standardized initial and refresher training for MTF providers. See enclosure (8) for training guidance. Establish a training process that includes competency testing, tracking, and reporting for registered nurses and independent duty corpsmen. Collaborate with operational commands to provide training and competency testing for their medical personnel.

(9) Prepare the annual report to BUMED on SAFE capability and number of trained examiners.

c. The MTF commanders, COs, and OICs shall:

(1) Appoint an MTF Sexual Assault Medical Program Manager to coordinate DoD and Navy sexual assault medical-forensic policy at the MTF and satellite clinics as appropriate, and will ensure the DoD standard of care for sexual assault victims is victim-centered, gender-sensitive, compassionate, and non-judgmental. The MTF Sexual Assault Medical Program Manager can be a physician, registered nurse, or other licensed independent practitioner. The MTF CO or designee and the Sexual Assault Medical Program Manager will establish a plan for Sexual Assault Medical Forensic Examination capability in their facility. The MTF Sexual Assault Medical Program Manager will:

(a) Coordinate with the Regional Sexual Assault Medical Program Manager to execute a plan for 24/7 availability of sexual assault medical and forensic capability at hospital sites and availability in the clinic setting during hours of operation. See paragraph 4b of this enclosure for guidance on restricted reporting. See enclosure (9) for guidance on evidence handling in cases of restricted reporting and unrestricted reporting, respectively.

(b) If an MTF is unable to provide sexual assault medical-forensic capability, a Memorandum of Understanding with a civilian medical facility capable of performing medical-forensic examinations must be executed. However, if such an agreement is not obtainable then the facility must be able to articulate a plan to cover medical-forensic capability.

(c) Work in collaboration with the Regional Sexual Assault Medical Program Manager and Regional Sexual Assault Administrative Program Manager to develop and monitor

implementation of a SAFE and Command SAPR program. Standardized tracking, reporting, and monitoring will be implemented and monitored via the Navy Medicine Region and reported to BUMED quarterly.

(d) Ensure that all medical forensic examiners are familiar with NAVMED 6310/5, Department of the Navy Sexual Assault Restricted Reporting Evidence Submission Chain of Custody, and their role in handling and mailing forensic evidence in the case of a restricted report. The Sexual Assault Medical Program Manager will communicate the process to mail evidence kits during working hours and after hours via appropriate procedures to maintain the chain of custody. For cases that occur after hours, on weekends, or on holidays, the medical forensic examiners will take the completed SAFE kit, the NAVMED 6310/5, chain of custody form, and other associated evidence, and lock these items in a secured environment until it can be mailed or personally turned over to law enforcement. See enclosure (9) for guidance on evidence handling in cases of restricted reporting and unrestricted reporting, respectively.

(2) Ensure tracking, monitoring, and reporting of training consistent with DoD requirements are met for general health care personnel and medical forensic examiners per reference (b).

(3) Attend the installation Sexual Assault Case Management Group (SACMG) meeting and ensure appropriate representation per enclosure (9) of reference (b).

(4) Ensure that members of the Reserve Component are able to access medical treatment and counseling for injuries and illness incurred from a sexual assault while in a status where the member is eligible to make a restricted report. For further information see enclosure (3) of reference (b).

(a) Line of duty (LOD) determinations for Reserve Component personnel may be made to law enforcement or command, without the victim being identified solely for the purpose of enabling the victim to access medical care and psychological counseling, and without identifying injuries from sexual assault as the cause. For LOD purposes, the victim's SARC may provide documentation that substantiates the victim's duty status as well as the filing of the restricted report to the designated official.

(b) If medical or mental health care is required beyond initial treatment and follow-up for Reserve Component personnel, a credentialed medical or mental health provider must recommend a continued treatment plan to support recovery and healing post assault.

(5) Consult with the local Staff Judge Advocate (SJA) prior to initiation of any official investigation per reference (k).

(6) Prepare the annual report to appropriate Navy Medicine Region on SAFE capability and number of trained examiners.

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d. Health care personnel (defined in Terms and Definitions, enclosure (4)) will:

(1) Complete initial and refresher training on sexual assault response policies for DoD and DON as well as DoD confidentiality policy, victim advocacy resources, medical treatment resources, sexual assault victim interview, and a basic overview of the medical-forensic examination.

(2) Be familiar with this SAPR medical-forensic instruction and understand the difference between restricted and unrestricted reporting options. See enclosure (9) for guidance on evidence handling in cases of restricted reporting and unrestricted reporting, respectively.

e. Health care providers performing the Sexual Assault Medical Forensic Examination will:

(1) Be defined as:

(a) Physicians practicing in the Military Health System (MHS) or operational environment to include undersea medical officers and flight surgeons.

(b) Advanced practice registered nurses practicing in the MHS or operational environment.

(c) Physician assistants practicing in the MHS or operational environment.

(d) Registered nurses practicing in the MHS or operational environment who have completed the Sexual Assault Medical Forensic Examination training program. Program managers at the MTFs will monitor and track competency training.

(e) IDCs and Military Sealift Command Medical Service Officers (MSOs) (Contingency Situations Only): In contingency situations, such as, but not limited to deployments to remote areas, combatant operations, Navy ships, Military Sealift ships submarines, or wing deployments, certified IDCs/MSOs may perform SAFEs upon completion of training.

(2) Be considered fully trained in SAFE after having completed training in enclosure (8).

(3) Complete initial and annual refresher training on pertinent policies; sexual assault victim medical forensic history taking; sexual assault examination process to include evidence collection kit, chain of custody, and documentation; prevention of pregnancy, emergency contraception, Human Immunodeficiency Virus testing/prophylaxis, and sexually transmitted infection treatment; trauma to include types of injury(s), photography of injury(s), behavioral health, and counseling needs; consulting and referral process; appropriate health care follow-up; medical record management; guidelines for reporting sexual assault; and an overview of the legal process. Training will be tracked by Regional and MTF Program Managers.

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(4) Will work with the designated SARC and Victim Advocate per enclosure (1).

3. Training. See enclosure (8) for training guidance and competencies.

4. Confidentiality

a. Health Insurance Portability and Accountability Act (HIPAA). Individuals within the DoD/MHS will adhere to reference (h), DoD Health Information Privacy Regulation of January 2003, section 3.4. Individuals outside the DoD Military Health System will enter into a Business Associate Agreement as defined in enclosure (12) and per references (h), (s), and (t).

b. For reporting options to include restricted reporting see references (d), (e), (g), and (l).

5. SAFE for Suspects

a. Suspect forensic examinations are conducted by the same procedure as the victim examinations. Health care providers performing the SAFE will use the approved DoD SAFE kit and DD Form 2911 to document and direct the forensic examination and evidence collection.

b. Suspect examinations will be conducted, under the authority of Naval Criminal Investigation Services (NCIS), either with the suspect's consent, a search warrant, or command authorization to search obtained by NCIS or other law enforcement agency, or exigent circumstances as determined by law enforcement. Suspects must be given their Article 31b rights prior to a forensic examination. This should have been completed by a SJA, investigating officer, NCIS agent, or other law enforcement agent prior to the suspect arriving at the MTF.

c. The health care provider can only collect the evidence as described by the search warrant, or command authorization to search, scope of consent, or as deemed allowable by exigent circumstances. The SJA will be notified before the health care provider conducts the examination. Restraint of the suspect for the examination is authorized and will be done unless the commander, CO, or OIC within his or her discretion disapproves or there is a reasonable threat of harm to either the suspect or provider.

d. The individual health care provider may refuse to conduct the exam for moral or ethical reasons. In the event that a provider does refuse to perform the exam, the commander, CO, or OIC must ensure that the exam is completed in a timely manner.

e. The health care provider will not ask the suspect any questions beyond the medical and social history questions in the DD Form 2911.

f. Billing should be coded as V71.5. If issues arise, commands will work with local NCIS and law enforcement regarding billing.

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DOCUMENTATION AND CODING OF MEDICAL FORENSIC EXAMINATIONS

1. Medical forensic examiners are responsible for documenting forensic details of the examination on DD Form 2911. This form guides the examination and methodical documentation of evidence, putting together a picture of what happened in an objective and scientific way. The DD Form 2911 shall be placed in the envelope and taped to the sealed kit.

2. The only medical issues documented in this report are findings that potentially relate to the assault or pre-existing medical factors that could influence interpretation of findings.

3. If the reporting is unrestricted, the criminal justice system will use the DD Form 2911, along with collected evidence, and victim/witness statements as a basis for investigation and possible prosecution. Section T of the DD Form 2911 will be completed in order to transfer collected evidence to law enforcement. Law enforcement will confirm receipt of all collected evidence by signing Section U of the DD Form 2911. Photographs taken will be maintained as a part of the medical forensic patient record. For deployed forces, photographs are turned over with the kit and chart, and chain of custody is documented in section T of the DD Form 2911.

4. If maintaining for any period of time, medical forensic examination records, including photographs, will be maintained separately from the outpatient treatment record to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The medical forensic examination records will be maintained by the medical treatment facility (MTF) in a secure location. There will be clear policies regarding personnel allowed access to these records according to the Health Insurance Portability and Accountability Act requirements. Only law enforcement and MTF personnel as designated by the above mentioned policies will be permitted access to these records.

5. The medical forensic examiner and other health care providers will document the encounter(s) as "sensitive" in Armed Forces Health Longitudinal Technology Application (AHLTA) or other clinical informatics data repository to protect and promote the welfare of the patient. Paper records, if any, will be treated as "sensitive" and maintained in a locked file. Electronic records will be stored in an encrypted file with limited access.

6. Coding is guided by the International Classification of Diseases. Document cases appropriately with the following codes:

   a. 995.83 for Adult Sexual Abuse

   b. V71.5 Observation Following Adult Sexual Assault

   c. V15.41 Personal History of Sexual Assault

7. Health care providers shall verify the victim's reporting choice during each visit related to the sexual assault and ensure documentation in the victim's medical record. Records pertaining to restricted reporting shall be appropriately marked to reflect their status as covered communications.

TRAINING GUIDANCE AND COMPETENCY ASSESSMENT

1. Background. Commander, Navy Medicine Education and Training Command (NMETC) will identify or develop a standardized curriculum and training plan to include a standardized approach for competency acquisition across Navy Medicine.

2. Initial Training

a. All health care providers performing the Sexual Assault Medical Forensic Examination will complete the required training utilizing two DVDs. The first DVD, *Sexual Assault Forensics and Clinical Management: A Virtual Practicum*, is intended to meet the training needs of registered nurses, licensed independent practitioners, physicians, and Independent Duty Corpsman. This DVD covers:

(1) Patient interviewing and history gathering

(2) Medical Forensic Examination

(3) Evidence collection

(4) Survivor experiences

(5) Forensic evidence analysis

(6) Pre-trial preparation

(7) Court Testimony

b. The second DVD, *Sexual Assault Forensic Examinations in Navy Medicine*, will cover topics specific to Navy Medicine and provide links to guiding policy and Department of Justice National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents.

c. Physicians, Physician Assistants (PA), Advanced Practice Nurses, IDCs, MSOs, who are trained, credentialed/certified, and or/ privileged to perform pelvic and genitalia examinations will be considered fully-trained in SAFE after having completed the *Sexual Assault Forensics and Clinical Management: A Virtual Practicum* and *Sexual Assault Forensic Examinations in Navy Medicine* DVDs. Health care providers without pelvic or genitalia examination competency or privileges will only be considered fully SAFE trained after completing Navy Medical Sexual Assault Forensic Examination Competency Assessment (NAVMED 6310/7) annually and required DVD training.

3. Competency Assessments. Health care providers without pelvic or genitalia examination competency or privileging will be required to complete the standard Navy Medical Sexual

Assault Forensic Examination Competency Assessment (NAVMED 6310/7) to demonstrated minimum proficiency in completing a medical forensic examination. NAVMED 6310/7 can be found on the BUMED Web site at: http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx.

4. Annual Sustainment Training. The primary and secondary DVDs, *Sexual Assault Forensics and Clinical Management: A Virtual Practicum* and *Sexual Assault Forensic Examinations in Navy Medicine*, will be reviewed on an annual basis for all providers conducting Sexual Assault Forensic Examinations (SAFEs). Health care providers without pelvic or genitalia examination competency or privileging will complete the standard Navy Medical Sexual Assault Forensic Examination Competency Assessment (NAVMED 6310/7) annually, in addition to reviewing sustainment training requirements.

5. Training Compliance. Units shall document completion of both initial and sustainment training in individual Fleet Training Management Planning System training records. All entries will be noted under MED-SAFE. Individual commands will track providers' competencies.

6. Access to Training Resources. Navy Medicine Professional Development Center (NMPDC), a subordinate component of NMETC, will provide training resources. Contact the NMPDC Sexual Assault Forensic Examination Program Manager to request training materials.

7. Additional References. Additional information can be obtained from the Navy Knowledge Online NMPDC Staff Education and Training Sexual Assault Forensic Examination Training Community of Practice Web page.

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EVIDENCE HANDLING FOR RESTRICTED AND UNRESTRICTED REPORTS OF SEXUAL ASSAULT

1. Investigative Processes in Restricted Reports. Restricted reporting will not trigger the official investigative process, and any evidence collected will be documented in the appropriate manner to ensure the confidentiality of the victim's identity.

2. Procedure for Forensic Evidence Handling

a. The sexual assault response coordinator (SARC) or victim advocate (VA) will assign the alpha-numeric restricted report case number (RRCN) which will be marked on the kit. There shall be no victim identifying information on the package and it will be tracked using only the RRCN (maintained by the installation SARC).

b. Once the DD Form 2911 is completed, the Sexual Assault Medical Forensic Examiner will affix it to the outside of the kit in a manila envelope; the examiner will place any other written documentation inside the kit.

c. The examiner will place the wet prep report and any small items of clothing (i.e., underwear) into the Sexual Assault Forensic Examination kit. The remaining clothing will be placed in separate paper bags. All associated bags will finally be placed into one large paper bag that is properly sealed with evidence tape. The Sexual Assault Medical Forensic Examiner will then sign across the seal of the evidence tape and bag. If a forensic toxicology kit is not available, examiner is instructed to follow guidance from the DD Form 2911 in handling blood samples.

d. The examiner collecting the evidence shall initial the labels and write the date of the examination and the time the Sexual Assault Forensic Examination kit was sealed. The examiner will affix the "restricted evidence" seal (included in the kit) and write the RRCN number provided by the SARC on the kit. The examiner will affix a biohazard label to front of the box per Sexual Assault Forensic Examination kit instructions. The examiner will not write any identifying information on the Sexual Assault Forensic Examination kit.

e. The examiner will identify multiple Sexual Assault Forensic Examination kits as noted above and in a manner to ensure proper accountability (e.g., "1 of 2", "2 of 2").

f. The examiner must maintain the kit in his/her presence until all evidence is collected and the kit sealed.

g. The examiner shall complete NAVMED 6310/5 and attach to the sealed Sexual Assault Forensic Examination kit. An accurate and up-to-date chain of custody must be maintained at all times to ensure the integrity of the evidence. It is advised to eliminate unnecessary transfers and keep the chain of custody to a minimum.

h. For restricted reports the examiner will package, seal, and label the evidence container(s) with the RRCN and seal. The examiner will then place the container(s), the Sexual Assault Forensic Examination kit, and NAVMED 6310/5 into a larger mailing box. The examiner will mail the package via registered mail to the Naval Criminal Investigative Service (NCIS) holding facility at the address below within 48 hours. For deployment and/or isolated environments, the package shall be stored in a secure container while maintaining strict chain of custody until transportation becomes available.

Naval Criminal Investigative Service
Consolidated Evidence Facility
Restricted Reporting
9079 Hampton Blvd Suite 110
Norfolk, VA 23505-1098

i. For unrestricted Sexual Assault Medical Forensic Examination, the Sexual Assault Forensic Examination kit, toxicology kit, and other collected evidence will be turned over to Naval Criminal Investigative Services (NCIS) and/or the Provost Marshal Officer (PMO).

j. At no time should any evidence be left unattended or in a non-secure space.

3. Forensic Toxicology

a. Medical treatment facility (MTF) laboratories will not analyze forensic toxicology samples in unrestricted suspected drug-facilitated sexual assault cases. Forensic toxicology samples will be given to NCIS for separate mailing to Armed Forces Medical Examiner System (AFMES) Forensic Toxicology Division.

b. Medical forensic examiners shall recognize that certain drugs (i.e., alcohol, Rohypnol, and gamma hydroxyl butyrate, prescription, and over the counter) may be used to facilitate sexual assault and must understand the urgency of collecting toxicology samples (urine and blood) if a drug-facilitated sexual assault is suspected. Urine and blood samples shall be collected during the SAFE or as soon as possible. The Drug Facilitated Sexual Assault Evidence Toxicology Kit, Tri-tech stock number BU-DFRE, will be used. If the drug toxicology kit is not available, the medical forensic examiner shall follow DD2911 guidance in the collection and handling of toxicology samples.

c. If toxicology tests are needed purely for the medical evaluation and treatment of the patient, the MTF laboratory will perform these tests. These lab results will be recorded in the patient's medical record per MTF policy. If toxicology samples are needed for clinical and forensic purposes, the clinical sample will be collected for immediate evaluation by the MTF lab and the forensic sample will be collected with patient consent for analysis by AFMES.

GUIDANCE ON FORENSIC PHOTOGRAPHY

1. Background. Taking photographs of parts of the patient's anatomy involved in the assault can supplement the medical forensic and physical findings in sexual assault cases.

2. Procedural Guidance

a. The medical forensic examiner will obtain written patient consent for photography. To help reduce the chances of re-traumatizing the patient, explain the purpose of photography in evidence collection, the extent to which photographs will be taken and the potential uses of photography during investigation and prosecution, and the possible need to obtain additional photographs after the examination. The medical forensic examiner shall only use a government owned camera to take photographs during the exam.

b. Once the patient has consented, take identity photographs (face or ID card) at the beginning and end of the set of images for identification. Use adequate lighting whether the source is natural or flash.

c. Use a forensic scale for size references in photographs. Take at least 2 photographs of each area, one with and one without scale. Photograph evidence in place before moving or collecting it. Do not alter or move evidence while photographing and maintain the focus of the areas being photographed.

d. Take at least 2 photographs at 3 different orientations. Take long range photographs of patient and injury to denote regional body areas. Take medium-range photographs of each separate genital or non-genital injury, including cuts, bruises, swelling, lacerations, and abrasions. Photographs shall include easily identifiable anatomical landmarks. Take close up photographs of particular injuries, using the scale and show its relationship to another part of the body. Take at least 3 photographs of each wound. Document pattern injuries caused by an object.

e. 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 restraint or bondage marks 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.

f. Strict chain of custody for photographs must be maintained. Do not delete any photographs from the camera. All evidence (e.g., photographs, documents, clothing, etc.) should be turned over to either Naval Criminal Investigative Service (unrestricted reporting) or sent with the kit to the repository (restricted reporting).

SAMPLE SEXUAL ASSAULT MEDICAL CARE AND FORENSIC EXAMINATION PROCEDURES CHECKLIST FOR HEALTH CARE PROVIDERS

Response:

( ) The Sexual Assault Response Coordinator (SARC) has been notified.

( ) The Victim Advocate (VA) has been notified.

( ) Local law enforcement and/or Military Criminal Investigating Organizations (MCIO) have been notified (if applicable).

Reporting Type

The SARC or VA will explain each of the reporting options available to the victim. The victim's elected reporting option shall be documented on the DD Form 2910.

( ) Restricted Reporting

( ) The SARC has assigned the victim's case a restricted reporting number.

( ) MCIO was not informed of the sexual assault case.

( ) The victim's name was not reported to their chain of command.

( ) Unrestricted Reporting

( ) The respective local law enforcement and/or MCIO have been notified of sexual assault case.

Medical Care

( ) The sexual assault victim is triaged as emergent and evaluated for any emergent injuries and illnesses as soon as possible.

( ) The victim did not shower, have anything by mouth or void their bladder until after the exams are completed. Collect specimen at first void if possible. This will depend on the victim's history; realize that this may happen prior to arrival at the medical facility.

( ) Collect appropriate labs following Centers for Disease Control and Department of Justice guidelines which may include:

( ) CBC
( ) RPR
( ) HCG (urine and/or serum)
( ) HIV
( ) Gonorrhea/Chlamydia (GC) urine
( ) Hep B SAb
( ) Hep B Surface AG
( ) Hep C SAb
( ) Hep C Surface AG
( ) LFTs (if starting HIV prophylaxis)
( ) Toxicology (e.g., BAC ((as appropriate))

( ) Complete pregnancy and STD counseling and provide prophylaxis as appropriate.

( ) Provide follow-up testing guidelines with discharge instructions.

( ) Consider the option of recommending Sick in Quarters, administrative, or convalescent leave as indicated by the assessment of the victim by the provider.

Sexual Assault Forensic Examination (SAFE) and Photo Inventory

( ) PHOTOGRAPH:

( ) ID Card, CAC card, or hospital bracelet
( ) Face
( ) Full frontal, clothed
( ) Full back, clothed

( ) Hands, PHOTOGRAPH, then swab:

( ) PHOTOGRAPH L and R together
( ) Palms up
( ) Palms down

( ) L hand separate
( ) Palm up
( ) Palm down
( ) Fingernails

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( ) R hand separate
( ) Palm up
( ) Palm down
( ) Fingernails

( ) SWAB, scrape, or cuttings
( ) Fingernails, cuticles

( ) PHOTOGRAPH:

( ) Lower eyelids
( ) Internal oral, PHOTOGRAPH, then SWAB
( ) PHOTOGRAPH 3 frenulums
( ) Upper lip
( ) Lower lip
( ) Tongue to base of mouth
( ) Uvula/palate

( ) SWAB
( ) L and R mandibular pockets for evidence
( ) L and R cheek for reference DNA
( ) Consider "swish and spit" if history of oral penetration/ejaculation

( ) PHOTOGRAPH
( ) Neck
( ) Front
( ) L side
( ) R side
( ) Back, with hair up

( ) COLLECT shirt, camisole, bra
( ) INSPECT and PHOTOGRAPH
( ) Front, back
( ) Seams, panels, tags, straps
( ) Rips, tears, distortions, defects

( ) PHOTOGRAPH
  ( ) Upper body, unclothed
    ( ) Front
    ( ) Back
    ( ) Tattoos, distinguishing marks, injuries, findings

( ) COLLECT pants, shorts, undergarments
  ( ) INSPECT and PHOTOGRAPH
    ( ) Front, back
    ( ) Seams, panels, tags, straps
    ( ) Rips, tears, distortions, defects, stains

( ) PHOTOGRAPH
  ( ) Lower body, unclothed
    ( ) Front
    ( ) Back
    ( ) Tattoos, distinguishing marks, injuries, findings

( ) PHOTOGRAPH
  ( ) Genitals
    ( ) "Family photo": genitals, perineum, and anus together
      ( ) Comb pubic hair, if any or SWAB mons
      ( ) SWAB perineum

  ( ) INSPECT and PHOTOGRAPH anus, around the clock x 1.
    ( ) SWAB anus for evidence
      ( ) Apply and remove TBD
      ( ) REINSPECT and RE-PHOTOGRAPH anus, around the clock x 1

  ( ) INSPECT and PHOTOGRAPH external genitalia
    ( ) FEMALE: around the clock x 2
      ( ) Apply and remove TBD
      ( ) REINSPECT and RE-PHOTOGRAPH around the clock x 2
        ( ) INSPECT and PHOTOGRAPH internal genitalia (females only)
          ( ) Vaginal vault and cervix

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( ) SWAB
  ( ) Vaginal pool
  ( ) Cervix, for evidence
  ( ) Cervix, for GC/Chlamydia

( ) MALE
  ( ) INSPECT, PHOTOGRAPH, and SWAB
    ( ) Head of penis, coronal ridge, shaft of penis
    ( ) Base of penis and L scrotum
    ( ) Base of penis and R scrotum

- All clothing should be carefully inspected and photographed. Check seams, button holes, zippers, straps, and hooks for integrity. Check crotch areas for seepage of fluids or blood. Check for stains, dirt, debris, and distortions. Photograph all items taken for evidence. Ensure you use good descriptors of the clothing on the envelopes or bags. Photograph the tag, if present.

- All tattoos, piercings, and identifying marks should also be photographed.

- All evidentiary findings (fibers, hairs, foreign bodies, trace elements) should be photographed IN PLACE prior to collection.

- Remember: Even an absence of injury is a finding.

( ) The SAFE examiner has labeled and verified that the appropriate identification (restricted reporting number for restricted cases) has been documented on the appropriate forms and evidence.

( ) The SAFE examiner has packaged all evidence appropriately.

( ) Assure all medical and forensic documentation is completed.

( ) The SAFE examiner notified the appropriate law enforcement agency and/or MCIO (as indicated), to assume custody of the SAFE kit, documents, and evidence related to the examination for storage, under established chain of custody procedures for unrestricted cases. For restricted cases, mail the SAFE kit to the approved NCIS storage facility as described in enclosure (9).

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SEXUAL ASSAULT LABS

✓ Labs should be drawn within 60 min of triage

Ordering labs in CHCS			
Labs ordered under ED provider:		Labs ordered under Follow-up Provider: (see Step 5 of algorithm for names)	
Type into CHCS exactly what is written here:			
CBC	**Lavender top**	HEPBSAB	Plain Red
CMP	**Green top**	HEPBSAG	Plain Red
ETOH	**Grey top**	HEP C AB	Plain Red
HCG, qual, urine	Specimen Cup	RPR	T I G E R
		HIV antibody (source code = I, clinically indicated	R E D Y E L L O W
		GCC (endocervical) Reason for testing = screening	DNA probe

Urine: Dirty catch preferred. Split specimen into 2 cups.

1. Label, and send to lab for qualitative HCG (if patient is female).
2. Label, place in sealed plastic baggie, and lock in SANE cart, and do NOT order in CHCS.

Tubes to draw:

1 lavender	1 green	3 grey **	1 red	1 tiger	1 red/yellow

**Grey tops tubes:

1. Label 1 tube, and send to lab for BAC. If EMD provider does not feel test is necessary, they MUST document on the medical chart: "Patient is clinically sober based on my history, exam, and clinical observations and is able to provide informed consent. There is no indication to draw a BAC."
2. Label remaining 2 tubes, place in sealed plastic baggie, and place in locked location with urine specimen, and do NOT order in CHCS.

All remaining tubes/specimens/cultures will be sent to the lab for processing.

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SAMPLE MEMORANDUM OF UNDERSTANDING

BETWEEN
NAVY MEDICINE MEDICAL TREATMENT FACILITY
AND
CIVILIAN SEXUAL ASSAULT MEDICAL FORENSIC EXAMINER PROGRAM

1. General

a. Type of Action. This is a new agreement.

b. Participants and Types of Agreements. This memorandum of understanding (MOU) is entered into by and between Commanding Officer, Navy Medicine Medical Treatment Facility (MTF), City, and State, hereinafter referred to as "MTF," and Civilian Sexual Assault Medical Forensic Examiner Program, City, State. This MOU will address the basic relationship between the parties to this agreement.

c. Purpose. The purpose of this agreement is to establish guidelines for the medical forensic examination of adult victims of sexual assault who are eligible to receive treatment in MTFs. The facilities will coordinate the required procedures needed for the collection of evidence using the Sexual Assault Forensic Examination kit, reporting procedures for restricted reports and the handling, storage, and transportation of the kit using established chain of custody procedures from Civilian Sexual Assault Medical Forensic Examiner to the MTF and the Naval Criminal Investigative Service, Consolidated Evidence Facility, Norfolk, VA. As used herein, the term "Service member" refers to an active duty Service member, Military Service Academy cadet, or Midshipman or National Guard or Reserve Service member when performing active service and inactive duty training or a member of the Coast Guard or Coast Guard Reserve.

d. Background. Sexual assault has been underreported due to many victims' reluctance to inform their chain of command or activate law enforcement actions. Therefore, the option of restricted reporting has been instituted. The Department of Defense (DoD) policy states that all active duty Service members and Military dependents 18 years of age or older, who were victims of sexual assault involved by someone other than spouse or intimate partner, have the option to choose between unrestricted and restricted reporting.

(1) An unrestricted report affords the active duty victim of sexual assault an official investigation of their allegation in addition to medical care and follow-up counseling.

(2) Individuals who choose not to involve law enforcement or their command may opt for a restricted report. Restricted reports may be made to health care personnel, a sexual assault response coordinator (SARC), a victim advocate (VA), Fleet and Family Support Center counselors, and/or Chaplains. Restricted reporting allows the victim to receive medical care and follow-up counseling but will not trigger the investigative process or notify their command.

(3) Local facilities should be aware of state laws and local policies regarding payment and should consider the appropriateness of billing the costs for the examination to TRICARE. Section 1079(a) of Title 10 U.S. Code mandates coverage of examinations following a sexual assault to include the Sexual Assault Forensic Examination kit, which is a covered benefit for all TRICARE beneficiaries.

e. Authority. This agreement is supported by DoD Instruction 6495.02 of 23 Jun 2006 and Bureau of Medicine and Surgery (BUMED) Instruction 7050.1A.

2. Responsibilities

a. The MTF agrees to:

(1) Triage and provide any emergency treatment deemed necessary prior to releasing the patient to Civilian Sexual Assault Medical Forensic Examiner for a medical forensic examination and additional medical treatment.

(2) Inform and offer sexual assault victims who report the assault, restricted or unrestricted reports, the medical and forensic services offered by the Civilian Sexual Assault Medical Forensic Examination Program.

(3) Utilize the Civilian Sexual Assault Medical Forensic Examination Program and Facility.

(4) Ensure that the victim has an appropriate method of transportation to and from Civilian Sexual Assault Medical Forensic Examination.

(5) Provide the Civilian Sexual Assault Medical Forensic Examiner with the following:

(a) The current version of DD Form 2911 (Sep 2011), Forensic Medical Report: Sexual Assault Examination is used for documentation of the examination and evidence collected. An electronic version of this form can be found at: http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2911.pdf.

(b) NAVMED 6310/5 (03-2009), Department of the Navy Chain of Custody for maintaining chain of custody of forensic evidence, can be found at: http://www.med.navy.mil/directives/ExForms/NAVMED%206310-5.pdf

(c) The DoD Sexual Assault Forensic Evidence collection kit or civilian organization kit that matches Department of Justice protocol requirements. DoD Sexual Assault Forensic Examination kit ordering information can be found in this instruction.

(d) The current SARC contact.

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(e) The contact information for the Naval Criminal Investigative Service (NCIS) Consolidated Evidence Facility in Norfolk, VA and any special mailing procedures for mailing kits collected under the restricted reporting option.

(6) Utilize the Sexual Assault Program Manager to coordinate payment from TRICARE as necessary, as well as liaise with the MTF Sexual Assault Prevention and Response Program.

(7) Utilize the Sexual Assault Case Management Group to receive documentation from Civilian Sexual Assault Forensic Examination, if applicable, and coordinate and facilitate follow-up care.

b. The Civilian Sexual Assault Medical Forensic Examiner agrees to:

(1) Triage the patient and provide emergency treatment, as necessary, if the patient presents directly for care. Although sexual assault victims are not clinically categorized as emergent, victims of sexual assault shall be prioritized as emergent per U.S. Department of Justice (DoJ) National Protocol for Sexual Assault Medical Forensic Examinations for Adults and Adolescents.

(2) Contact the SARC and/or duty VA (if not already notified) upon the arrival of the Service member. Upon arrival of the SARC or VA, the victim will be informed of his or her rights and be given the option of restricted or unrestricted reporting. The victim will choose, in writing, whether he or she wants a restricted or unrestricted report.

(3) Provide appropriate trained personnel to conduct the medical forensic examinations for sexual assault victims.

(a) Persons rendering services pursuant to this MOU shall be at a minimum:

1. Physicians - Be licensed and maintain licensure as a physician of their respective state and possess training specific to the sexual assault medical forensic exam.

2. Registered Nurses - Be licensed and maintain licensure as a Registered Nurse by their respective State Board of Nursing and possess training and/or certification in the Sexual Assault Nurse Examination.

(b) Persons rendering these services must also provide care that meets the most current version of The National Protocol for Sexual Assault Medical Forensic Examinations from the DoJ.

(4) Provide the Service member a Sexual Assault Medical Forensic Examination and treatment for the prevention of sexually transmitted infections (including Human Immunodeficiency Virus) and pregnancy. The SARC or VA will remain with the victim if he or she chooses.

(5) Utilize DD Form 2911 Forensic Medical Report: Sexual Assault Examination, to document all findings of the Sexual Assault Medical Forensic Examination.

(6) Provide crisis intervention and emotional support as necessary, and information about victim preferences with respect to the exam, to include the right to refuse any or all medical and forensic services. Offer emergency contraception (Plan B) to the patient after appropriate medical counseling.

(7) If the victim chooses an unrestricted report, the Civilian Sexual Assault Medical Forensic Examiner will proceed with their standard protocol for sexual assault care. The SARC or VA will remain with the victim if he or she desires.

(8) If the victim's decision is a restricted report, the following actions will be taken:

(a) The SARC or VA will provide the Civilian Sexual Assault Medical Forensic Examiner with an alphanumeric restricted reporting case number (RRCN).

(b) The Civilian Sexual Assault Medical Forensic Examiner will conduct a medical forensic examination after informed consent is obtained. The examiner will place the wet prep report and any small items of clothing (i.e., underwear) into the Sexual Assault Forensic Examination kit. The remaining clothing will be placed into separate paper bags. All associated bags will finally be placed into one large bag that is properly sealed with evidence tape. The Sexual Assault Medical Forensic Examiner will then sign across the seal of the evidence tape and bag. If a forensic toxicology kit is not available, examiner is instructed to follow guidance from the DD Form 2911 in handling blood samples.

(c) The examiner must maintain the kit in his/her presence until all evidence is collected and the kit sealed.

(d) The medical forensic examiner shall place his or her initials, date the examination was completed, and time the box was sealed on the labels. The examiner will affix the "restricted evidence'" seal (included in the kit) and write the RRCN number provided by the SARC on the kit along with the name of the facility where the medical forensic examination was conducted.

(e) The examiner will affix a biohazard label to the front of the kit in the designated area per Sexual Assault Forensic Examination kit instructions. The examiner will not write any identifying information on the Sexual Assault Forensic Examination kit.

(f) The examiner will identify multiple Sexual Assault Forensic Examination kits as noted above and in a manner to ensure proper accountability (e.g.,"1 of 2", "2 of 2")

(g) The sealed Sexual Assault Forensic Examination kit and any collected and packaged clothing marked with the RRCN will be documented on NAVMED 6310/5 and placed

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inside a larger box. The medical forensic examiner will complete DD Form 2911 and NAVMED 6310/5 and place both forms inside the larger box. The MTF will ensure both forms are available to the forensic examiner.

(h) After the evidence and written documentation has been placed in the box, place the red evidence label tape on the two designated sides of the box for secure closure of the kit. Using a black felt-tip pen, the medical forensic examiner will write the RRCN on the line that reads "Victim/Suspect Name" in lieu of the victim's name, along with the name of the facility where the medical forensic examination was conducted.

(i) Within 48 hours of the examination, the larger sealed box will be mailed by the Civilian Sexual Assault Medical Forensic Examiner to: NCIS, Consolidated Evidence Facility, Restricted Reporting, 9079 Hampton Blvd, Suite 110, Norfolk, VA 23505-1098. At no time is the SARC or the VA to take possession of the Sexual Assault Forensic Examination kit.

(9) The medical forensic examiner will provide a copy of the discharge and follow-up instructions to the patient. Following completion of services, the medical forensic examiner will notify the designated MTF Sexual Assault Program Manager to ensure MTF awareness and facilitate any needed follow-up appointments. Each case will also be reviewed by the Sexual Assault Case Management Group (SACMG) if this fails to occur.

(10) Billing for the visit will be processed through TRICARE without contacting the victim or victim's family for processing. The MTF has one processor for sexual assault bills to limit access to the confidential information. If any problems arise with respect to payment, the MTF will coordinate resolution via the TRICARE representative at the MTF. Section 1079(a) of Title 10 U.S. Code mandates coverage of examinations following a sexual assault to include the Sexual Assault Forensic Examination kit, a covered benefit for all TRICARE beneficiaries. TRICARE is the primary payer to all state Victims of Crime Compensation Programs, regardless of any language to the contrary in state laws or regulations. Medical forensic examinations performed under a civilian MOU agreement are to bill TRICARE directly.

3. Meetings. The parties agree to meet on a quarterly basis to discuss issues of mutual concern and to discuss provisions for mutual support of sexual assault care.

4. Health Insurance Portability and Accountability Act. Pursuant to 45 Code of Federal Regulations Parts 160 and 164, DoDINST 6025.18, Privacy of Individually Identifiable Health Information in DoD Health Care Programs, December 19, 2002, and DoD 6025.18-R, the parties agree to enter into a Business Associate Agreement, attached as Appendix A to this agreement.

5. Effective Period. This MOU is effective upon date of signatures for a period of 5 years. It may be continued without change during that period, but must be reviewed annually by all parties. This review will be documented.

6. Modification, Change, or Amendment. Any modifications, changes, or amendments to this MOU must be in writing, and are contingent upon BUMED Medical Operations (BUMED-M3) and MTF approval. Subsequent to BUMED's approval, the modification, change, or amendment must be signed by all parties.

7. Notice. All correspondence related to this MOU will be forwarded to the MTF for consolidation or corrective action.

8. Termination. The MOU may be cancelled at any time by mutual consent of the parties concerned. The MOU may also be terminated by either party upon giving 45 days written notice to the other party. In the case of mobilization or other emergency, the agreement may be terminated immediately upon written notice by the BUMED activity, and it will remain in force during mobilization or other emergency only within the BUMED activity's capabilities.

9. Concurrence. It is agreed that all parties to this MOU concur with the level of support and resource commitments that are documented herein.

_____	_____	_____
I. M. CAPTAIN CAPT, MC, USN Commanding Officer Military Treatment Facility City, State, Zip Code	I. R. COMMANDER CDR, MSC, USN Comptroller Military Treatment Facility City, State, Zip Code	I. M. CIVILIAN Civilian SAFE Program Civilian Hospital Medical Center Drive City, State, Zip Code
Date: _____	Date: _____	Date: _____

Annual Review:

CY ___:	_____ MTF Representative	_____ SAFE Program Representative
CY ___:	_____ MTF Representative	_____ SAFE Program Representative
CY ___:	_____ MTF Representative	_____ SAFE Program Representative
CY ___:	_____ MTF Representative	_____ SAFE Program Representative

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Appendix A
Department of Defense
Standard Clause for Business Associates

1. Introduction. Per DoD 6025.18-R "Department of Defense Health Information Privacy Regulation," January 24, 2003, the Business Associate meets the definition of Business Associate. Therefore, a Business Associate Agreement is required to comply with both the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations. This clause serves as that agreement whereby the Business Associate agrees to abide by all applicable HIPAA Privacy and Security requirements regarding health information as defined in this clause, and in DoD 6025.18-R and DoD 8580.02-R, as amended. Additional requirements will be addressed when implemented.

a. Definitions. As used in this clause generally refer to the Code of Federal Regulations (CFR) definition unless a more specific provision exists in DoD 6025.18-R or DoD 8580.02-R.

(1) HITECH Act shall mean the Health Information Technology for Economic and Clinical Health Act included in the American Recovery and Reinvestment Act of 2009.

(2) Individual has the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative per 45 CFR 164.502(g).

(3) Privacy Rule means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

(4) Protected Health Information has the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by the Business Associate from or on behalf of the Government pursuant to the Contract.

(5) Electronic Protected Health Information has the same meaning as the term "electronic protected health information" in 45 CFR 160.103.

(6) Required by Law has the same meaning as the term "required by law" in 45 CFR 164.103.

(7) Secretary means the Secretary of the Department of Health and Human Services or his/her designee.

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(8) Security Incident will have the same meaning as the term "security incident" in 45 CFR 164.304, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(9) Security Rule means the Health Insurance Reform: Security Standards at 45 CFR part 160, 162 and part 164, subpart C.

b. Terms used, but not otherwise defined, in this Clause shall have the same meaning as those terms in 45 CFR 160.103, 160.502, 164.103, 164.304, and 164.501.

c. The Business Associate shall not use or further disclose Protected Health Information other than as permitted or required by the Contract or as Required by Law.

d. The Business Associate shall use appropriate safeguards to maintain the privacy of the Protected Health Information and to prevent use or disclosure of the Protected Health Information other than as provided for by this Contract.

e. The HIPAA Security administrative, physical, and technical safeguards in 45 CFR 164.308, 164.310, and 164.312, and the requirements for policies and procedures and documentation in 45 CFR 164.316 shall apply to Business Associate. The additional requirements of Title XIII of the HITECH Act that relate to the security and that are made applicable with respect to covered entities shall also be applicable to Business Associate. The Business Associate agrees to use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits in the execution of this Contract.

f. The Business Associate shall, at their own expense, take action to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Clause. These mitigation actions will include as a minimum those listed in the TMA Breach Notification Standard Operating Procedure, which is available at: http://www.tricare.mil/tmaprivacy/breach.cfm.

g. The Business Associate shall report to the Government any security incident involving protected health information of which it becomes aware.

h. The Business Associate shall report to the Government any use or disclosure of the Protected Health Information not provided for by this Contract of which the Business Associate becomes aware.

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i. The Business Associate shall ensure that any agent, including a sub-Business Associate, to whom it provides Protected Health Information received from, or created or received by the Business Associate, on behalf of the Government, agrees to the same restrictions and conditions that apply through this Contract to the Business Associate with respect to such information.

j. The Business Associate shall ensure that any agent, including a sub-Business Associate, to whom it provides electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

k. The Business Associate shall provide access, at the request of the Government, and in the time and manner reasonably designated by the Government to Protected Health Information in a Designated Record Set, to the Government or, as directed by the Government, to an Individual in order to meet the requirements under 45 CFR 164.524.

l. The Business Associate shall make any amendment(s) to Protected Health Information in a Designated Record Set that the Government directs or agrees to pursuant to 45 CFR 164.526 at the request of the Government, and in the time and manner reasonably designated by the Government.

m. The Business Associate shall make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate, on behalf of the Government, available to the Government, or at the request of the Government to the Secretary, in a time and manner reasonably designated by the Government or the Secretary, for purposes of the Secretary determining the Government's compliance with the Privacy Rule.

n. The Business Associate shall document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Government to respond to a request by an Individual for an accounting of disclosures of Protected Health Information per 45 CFR 164.528.

o. The Business Associate shall provide to the Government or an Individual, in time and manner reasonably designated by the Government, information collected per this Clause of the Contract, to permit the Government to respond to a request by an Individual for an accounting of disclosures of Protected Health Information per 45 CFR 164.528.

2. General Use and Disclosure Provisions. Except as otherwise limited in this Clause, the Business Associate may use or disclose Protected Health Information on behalf of, or to provide services to, the Government for treatment, payment, or healthcare operations purposes, per the specific use and disclosure provisions below, if such use or disclosure of Protected Health

Information would not violate the HIPAA Privacy Rule, the HIPAA Security Rule, DoD 6025.18-R or DoD 8580.02-R if done by the Government. The additional requirements of Title XIII of the HITECH Act that relate to privacy and that are made applicable with respect to covered entities shall also be applicable to Business Associate.

3. Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Clause, the Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Clause, the Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Clause, the Business Associate may use Protected Health Information to provide Data Aggregation services to the Government as permitted by 45 CFR 164.504(e)(2)(i)(B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1).

4. Obligations of the Government. Provisions for the Government to Inform the Business Associate of Privacy Practices and Restrictions:

a. The Government shall provide the Business Associate with the notice of privacy practices that the Government produces per 45 CFR 164.520.

b. The Government shall provide the Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect the Business Associate's permitted or required uses and disclosures.

c. The Government shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Government has agreed to per 45 CFR 164.522.

5. Permissible Requests by the Government. The Government shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the HIPAA Privacy Rule, the HIPAA Security Rule, or any applicable Government regulations (including without limitation, DoD 6025.18-R and DoD 8580.02-R) if done by the Government, except for providing Data Aggregation services to the Government and for management and administrative activities of the Business Associate as otherwise permitted by this clause.

6. Termination

a. A breach by the Business Associate of this clause, may subject the Business Associate to termination under any applicable default or termination provision of this contract.

b. Effect of Termination

(1) If this contract has records management requirements, the records subject to the Clause shall be handled per the records management requirements. If this contract does not have records management requirements, the records shall be handled per paragraphs (2) and (3) below.

(2) If this contract does not have records management requirements, except as provided in paragraph (3) of this section, upon termination of this contract, for any reason, the Business Associate shall return or destroy all Protected Health Information received from the Government, or created or received by the Business Associate on behalf of the Government. This provision shall apply to Protected Health Information that agents of the Business Associate may come in contact. The Business Associate shall retain no copies of the Protected Health Information.

(3) If this contract does not have records management provisions and the Business Associate determines that returning or destroying the Protected Health Information is infeasible, the Business Associate shall provide to the Government notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Government and the Business Associate that return or destruction of Protected Health Information is infeasible, the Business Associate shall extend the protections of this contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such Protected Health Information.

7. Miscellaneous

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a. Regulatory References. A reference in this Clause to a section in DoD 6025.18-R, DoD 8580.02-R, Privacy Rule or Security Rule means the section currently in effect or as amended, and for which compliance is required.

b. Survival. The respective rights and obligations of Business Associate under the "Effect of Termination" provision of this Clause shall survive the termination of this Contract.

c. Interpretation. Any ambiguity in this Clause shall be resolved in favor of a meaning that permits the Government to comply with DoD 6025.18-R, DoD 8580.02-R, the HIPAA Privacy Rule or the HIPAA Security Rule.

_____	_____
I. M. CAPTAIN	I. M. CIVILIAN
CAPT, MC, USN	Executive Officer
Commanding Officer	Civilian SAFE Program
Military Treatment Facility	Civilian Hospital
City, State, Zip Code	City, State, Zip Code
Date: _____	Date: _____

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