Recommended Guidelines

Sexual Assault Emergency Medical Evaluation
Washington State

Adult and Adolescent
2017

The following is a guideline for conducting the medical-legal examination and collecting forensic evidence for adult and adolescent patients of all genders when there is a report or concern of sexual assault.

Summary of critical changes from 2010 Guidelines:

- We have added more detailed information on providing informed care to unique populations.
- While CDC recommends STI testing on all sexual assault patients, the WA State Guidelines Committee decided that DOJ protocol of treating prophylactically for adults and previously sexually active adolescents still makes the most sense.
- Cefixime is no longer acceptable prophylaxis for gonorrhea. The only acceptable treatment is Ceftriaxone 250 mg 1M OR Azithromycin 2gm for PCN allergic patients.
- We have included considerations that must be discussed with patients prior to STI testing.
- CVC will now pay for the full 30 days of HIV PEP.
- New addenda include: Sample Discharge Form, Sample Trafficking Documentation Form, Sexual Identity Terms, and Strangulation.

These guidelines are not intended to include all the medical evaluations and tests which may be necessary for care for an individual patient. Likewise, not all the steps outlined here will be appropriate for every patient. The TriTech Sexual Assault Evidence Kit Re-WA 3 is designed to work with these guidelines and meets the requirements of the Washington State Patrol Crime Lab.

These guidelines were developed by a committee which included representatives from medical specialists, sexual assault nurse examiners, attorneys, forensic scientists, and law enforcement in Washington State. Development was sponsored by Harborview Center for Sexual Assault and Traumatic Stress, with support from the Office of Crime Victims Advocacy .

Table of Contents

General

Coordinated Response

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.

Victim-Centered Care

The medical exam is done for the benefit of the patient

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

Social/Psychological

- Respond to the patient's immediate emotional needs and concerns, assess safety and assist with intervention, provide information about typical reactions and coping strategies, explain the reporting process and Crime Victims Compensation
- Develop culturally responsive care and be aware of issues commonly faced by victims from specific populations.
- Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.

Medical

- The competent adult patient may decline any aspect of the exam or evidence collection.
- Identify and treat injuries, assess risk of pregnancy and sexually transmitted disease, document the history and medical findings, and provide prophylactic medication when indicated
- Give sexual assault patients priority as emergency cases.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.
- Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible.
- Address physical comfort needs of patients prior to discharge. The medical forensic exam is done by the healthcare provider for the benefit of the patient

Forensic and legal

- Collect forensic evidence, preserve evidence integrity and maintain chain of custody, transfer to law enforcement with appropriate consent.

- Provide the necessary means to ensure patient privacy.
- The patient has a right to have a friend, relative or advocate present at the medical center or clinic (RCW 70.125.060)

Refer/report

- Refer for follow-up medical care, advocacy, and counseling.
- Assist with law enforcement report as requested by patient. In cases of minors or vulnerable adults, report to authorities as required by law (RCW 20.44.030)

Triage

Telephone Triage

Referral to a hospital is not always needed

When a patient calls before arrival for examination, determine if the assault occurred within the examination time frame.

- If within 120 hours medical forensic exam is appropriate
- If more than 5 days have passed since the assault, emergency exam is not needed. Refer to community resources for care and/or offer assistance in reporting to law enforcement
- An exception would be if the patient has been non-ambulatory, forensic evidence may be collected up to 2 weeks after the assault.
- This time frame is extended for patients who have been non-ambulatory or have been abducted

Discuss with caller what to expect.

Advise patient:

- Do not bathe before exam
- Bring in clothes worn at time of assault, and bring in change of clothing
- The exam and wait time may be several hours
- Bring a support person (family, friend) if possible

Evaluation for injury and co-existing conditions

Patients with significant injury should be medically evaluated before or after the medical/ forensic exam. This includes patients who have:

Treat life threatening injuries first

- possible fractures
- blunt injury to abdomen
- altered mental status
- facial injury
- active bleeding
- loss of consciousness
- strangulation
- psychiatric emergencies

Pregnant patients, especially if over 20 weeks gestation need assessment for fetal health.

Safety for the patient and medical provider always comes first and may require modification of procedures (e.g., private room may not be safe).

If apparent psychiatric illness complicates assessment of report of sexual assault, both psychiatric assessment and medical forensic exam often will be necessary. Proceed according to patient needs and tolerance

Limited English Proficiency

A medical interpreter should be accessed for limited English proficiency patients.

- Family members are not appropriate interpreters in this situation. Professional phone interpreters are acceptable
- Patients may be embarrassed to ask for an interpreter, so always assess if an interpreter is needed, even if patient states initially they do not need one.

Consent for care

Regular Consent

The forensic exam is not a medical emergency. All patients are required to give consent for care. Forensic consent includes:

- Patient providing informed consent for the collection of evidence and understanding the risks and benefits of consent or refusal of forensic collection
- Informing the patient specifically regarding urine or blood specimens for toxicology, which will identify drugs the patient may have been given or has taken
- Photography of injuries, general and body

When the patient is unable to consent

Attempts should be made to obtain consent

Due to a transitory condition (e.g. Intoxication)

- The sexual assault exam should be delayed until the patient is capable of meaningful consent. This judgment should be made by the health care provider
- Clinical assessment is more useful than laboratory numbers of alcohol level

Due to a longer term condition (e.g. intubation) or if evidence will be lost (e.g. going to surgery)

Evidence must be dried and stored in a manner that will preserve chain of evidence and integrity until authorization for release is obtained

- The health care provider determines whether in his/her opinion evidence collection is in the patient's best interest or in the interest of public health and safety

- **With this assessment, it is legally permissible to collect forensic evidence,** including clothing, hair, urine, and swabs from skin and orifices
- **The evidence should be stored** until specific consent from patient or legally authorized surrogate decision-maker is obtained.
- If the legally authorized surrogate decision-maker cannot be located in a timely manner:
    - The health care provider can determine if evidence collection is in the patient's best interest (by allowing the option of investigation for sexual assault)
    - With this assessment, it is legally permissible to collect forensic evidence, including clothing, hair, swabs from skin and orifices
    - However, the evidence cannot be transferred to police without authorization With this assessment, it is legally permissible to collect forensic evidence, including clothing, hair, swabs from skin and orifices

Refusal of care

A competent adult patient may choose to decline all or part of the examination and evidence collection. For example, he or she may consent to the physical exam but not forensic collection, or may decline skin swabs while consenting to other exam procedures

The adult patient has the right to decline a forensic exam

- The patient should be informed of the consequences of declining evidence collection procedures, specifically that this may impede criminal prosecution
- The clinician is not obliged to complete an exam or forensic collection if in his or her medical opinion this could cause physical or psychological harm to the patient

Minors

Consent for care

In general the parent or legal guardian must consent for care for patients under 18 years of age. If a child is brought in for care by someone other than the parent or legal guardian, the parent or guardian should be contacted to give consent for care.

- In Washington State, minors may consent to their own care for reproductive health issues - sexually transmitted diseases at age 14 and birth control at any age (RCW 70.24.110 and State v. Koome.84.wn.2d901 (1975). The sexual assault exam is not considered a minor right in Washington.
- A minor may also sign for his or her own care under the Mature Minor Rule (considering age, intelligence, maturity, training, experience, economic independence, conduct as an adult, and freedom from control of parents)
- The patient must be able to give informed consent, that is, understand the risks and benefits of the medical treatment and treatment alternatives
- If a minor signs for her own care, document patient's maturity, independence, decision making capacity, understanding of treatment, and plans for safety

- See Minor Health Care Rights in Washington
- Providers should follow their institution's policy on minor rights.

Mandatory Reporting

A crime against a minor must be reported to authorities

Health care workers and other mandated reporters must report when they have reasonable cause to believe that a child (person under 18 years of age) has experienced sexual abuse, assault, or sexual exploitation by any person, including non-caregivers.

- Mandatory reporting applies when there is a reasonable suspicion that a minor is a victim of a crime, even when the minor has signed for care. HIPAA privacy regulations are over-ridden by child protection requirements
- The report must be made to law enforcement or Child Protective Services at the first opportunity, in no case longer than 48 hours.

- See CPS Reporting, or call 1-800-562-5624
- Sharing information: Upon receiving a report, DSHS and law enforcement shall have access to all relevant records of the child in the possession of mandated reporters and their employees (RCW 26.44.030)
- Sexual abuse includes consensual sexual contact when there is a specific age difference:

Age of victim	Age of offender
Less than 12	24 months or more months older
12 or 13 years	36 months or more older
14 or 15 years	48 months or more older

Confidentiality

It is not possible to guarantee confidentiality from the parents or legal guardians. In the event of a sexual assault, parents **will** become aware of the investigation.

- Mandatory reporting for minors still applies and confidentiality cannot be promised. The patient should be clearly informed of the limitations of confidentiality and that a police report will be made.
- Healthcare provider should offer to assist the patient in informing the parent or guardian about the assault event
- If the patient feels it would be unsafe to tell the parent or guardian, then Child Protective Services should be contacted to assess safety and provide consent for care.

Vulnerable adults

When there is suspicion of sexual abuse or assault of a vulnerable adult, a report must be made immediately to law enforcement and to the appropriate agency.

A vulnerable adult has a specific legal definition in Washington State. "Vulnerable adult" (RCW 74.34.020) includes a person who is:

(a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(b) Found incapacitated under chapter 11.88 RCW; or

(c) Who has a developmental disability as defined under RCW 71A.10.020; or

(d) Admitted to any facility; or

(e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or

(f) Receiving services from an individual provider.

Mandatory Reporting

For residents of long-term care facilities, including nursing homes, boarding homes, or adult family homes:

- Mandatory report must be made to law enforcement to assure victim safety (Mandatory Reporting for Vulnerable Adults).
- A report must be also be made to the Department of Social and Health Services Complaint Resolution Unit 1-800-562-6078

For vulnerable adults who reside in their own or family home or a place other than a residential care facility:

- A report must be made to law enforcement and to Adult Protective Services
- Specific county contacts can be found on the ALTSA webpage.

Note: The medical history is not a forensic interview. The medical provider should not obtain forensic details such as description of the assailant, exact location of the assault, etc. This information should be obtained by police investigators outside presence of SANE to preserve medical hearsay rule – see State v. Hurtado.

Forensic and Medical History

Obtain and document information regarding the assault event in order to provide appropriate medical care and evidence collection. Provide privacy for the initial interview and use specific language when asking questions. It is also very useful to use a structured form or question list.

Document:

- Person who accompanied patient and relationship to patient
- Source of information (patient, police, or accompanying person)
- Police report if filed: police department and case number
- Current symptoms: pain, bleeding, respiratory distress, nausea, anxiety

- Time and place of assault
- Hours since assault
- Brief narrative history of assault

Document the following in patient's own words, in quotes, for salient statements:

Assailant(s)

Number of assailants and sexual assailants

Relationship to victim (this is relevant to issue of STI and continued risk)

- Risk factors of assailant regarding Hepatitis B, syphilis, and HIV, if known:
- Is assailant known or suspected to be HIV positive
- Is assailant a man who has had sex with men

Memory of event

If patient does not recall part or all of the event

If patient had impaired consciousness due to sleep, substances, or mental status

Nature of force used

Restraint, threat, weapon, victim unable to resist, hit, strangled, kicked

Perceived life threat

If history of attempted strangulation (choking) is obtained, follow **Strangulation addenda**.

Specific information regarding sexual contact:

Sites of contact and sites of penetration (oral, vaginal, anal)

Contact or penetration by what: hand, mouth, penis, foreign object

Sites where saliva might be deposited

Sites where semen might be deposited

If condom was used

Post assault activity – if patient:

Showered, bathed

Douched, rinsed mouth, urinated, or defecated

Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to medical exam

Drug use

Known drug or alcohol ingestion by victim (how much and when)

Suspected surreptitious drug administration

Review of Systems

- Active medical problems
- Current medications
- Ob-gyn history
- Use of contraception –

  - If oral contraceptives, how long taken and if any pills missed in cycle. Depoprovera (date of last injection). Contraceptive patch, date of last patch change
- Date of last menstrual period
- Time since last consensual intercourse – if within 10 days, specify number of days ago, or no prior intercourse ever
- History of hepatitis B vaccine or illness
- Last tetanus immunization
- Allergies to medications
- Review of systems, with attention to trauma related symptoms: pain, limitation of motion, nausea or vomiting, loss of consciousness, skin symptoms, bleeding, dysuria, rectal discomfort
- Psychiatric history, including developmental delays, dementia, prior trauma, etc.

Medical exam

General

Each patient should have a complete head to toe exam, with attention to signs of trauma. The medical exam may be conducted before or at the same time as evidence collection.

The order of exam and evidence collection can vary. It is usually best to begin with less sensitive areas (hands, face). Injury signs (bruises, abrasions, lacerations) should be noted in writing as well as photo-documented. Charting would not be considered complete without a documented Traumagram (bodygram).

Evidence collection principles

Offer clear explanations or the reasons for each procedure and offer patient some control over the exam process

The instructions below are for collecting evidence from a victim. For collecting evidence from a suspect, go to Suspect Evidence Guidelines.

The patient may decline any aspect of the exam or evidence collection. Because a patient may not recall or may be embarrassed to report all aspects of the assault, the exam should be complete and evidence collection from all orifices (mouth, vagina, rectum) is routine.

Exception: If oral assault only is reported, genital-anal exam may be omitted.

General Exam

Skin: Examine for tenderness, bruises, abrasions, lacerations and bite marks. Injury documentation should include description of type, size, color, pattern and associated pain. As much as possible, each injury should be individually documented.

HEENT: (Head, Ears, Eyes, Nose, Throat)

Head: Palpate scalp for tenderness or swelling, assess for loss of hair and sponginess

Ears: Asses for blood in canals, bruising on pinna or behind ear

Eyes: Asses for conjunctival hemorrhage and petechiae, including assessment of sclera and inner eye lids, periorbital petechiae and bruising. In cases involving intoxication or drugging asses pupil size and reactivity. Document reports of vision changes as related to injuries

Nose: Document any injuries including noted fractures.

Throat/Mouth: Examine soft and hard palate for petechia or exudate. Assess inner lips and tongue for bruising, lacerations, bites or torn frenulum. Note broken or loose teeth.

Neck: Examine for bruises, suction injuries or ligature marks. Asses ROM and tenderness. Note if voice is hoarse.

Chest: Auscultate lung sounds, examine for tenderness, bruises or bite marks.

Heart: Auscultate heart sounds

Abdomen: Palpate for tenderness and masses. Auscultate for bowel tones.

Extremities: Note bruises, ligature marks, abrasions, pattern injuries. Evaluate for pain, tenderness, ROM of arms and legs and any obvious deformities

Neuro/Mental: Assess orientation to person, place and time.

Genital Exam

Female: Generally performed in dorsal lithotomy position but should be modified for patient with limited mobility. During genital exam, assess inner thighs for bruises, abrasions, pattern injuries. Injuries should be documented using the clock and avoiding use of Left or Right as location identifiers.

Vulva: (include clitoral hood, clitoris, labia majora, labia minora) Assess for bruises, lacerations abrasions, redness, swelling and tenderness.

Posterior fourchette/fossa: Assess for lacerations, abrasions, contusions. Consider application of Toluidine Blue** for better evaluation of possible injuries. Use only after forensic swabs have been collected. Procedure

Hymen: Assess all edges of the hymen for tears, bruises or abrasions. Document if tears are full hymenal transection (meaning to the base of the hymen) or partial transection and if there is any bleeding present.

Vagina: Examination of the cervix and vagina is not always necessary as trauma/injuries to these structures are uncommon. Speculum is recommended only in specific circumstances and contra-indicated in premenarchal adolescents.**

If assessing vagina and cervix, document abrasions, lacerations or bruising to vaginal wall, floor and endocervix. Clearly document source of any bleeding, being clear to distinguish menstrual blood at cervical os from injury.

Perineum: Document abrasions or lacerations to perineal area.

Anus: Document perianal abrasions, lacerations, bruising, loss of anal folds. Separate anal folds to visualize lacerations. Digital exam is not indicated except if concern for foreign body retention. Anoscopy ** is indicated if there is anal bleeding by history or exam.

A Bimanual exam is generally not indicated unless concern for vaginal injury or PID.

Male: Typically performed with patient lying on back or side on the exam table.

During genital exam, assess inner thighs for bruises, abrasions and/or pattern injuries.

Documentation of the male perineal and anal exam should be done using the clock but the clock is typically not used to describe injuries to the scrotum or penis. Location should be described as anterior, posterior or lateral and/or glans, corona, foreskin.

Scrotum: Assess all surfaces of the scrotum for bruising, abrasions, tenderness or swelling. Careful assessment of the posterior surfaces of the scrotum is important so that dependent bruising is not missed.

Penis: Document whether patient is circumcised.

Assess the foreskin, glans, corona and anterior, posterior, and lateral aspects of the penile shaft for bruises, abrasions, lacerations, tenderness or swelling.

Anus: Document perianal abrasions, lacerations, bruising, loss of anal folds. Separate anal folds to visualize lacerations. Digital exam is not indicated except if concern for foreign body retention. Anoscopy ** is indicated if there is anal bleeding by history or exam.

Medical Exam and Evidence Collection Steps

Specific instructions for evidence collection are printed on each envelope of the Washington State Evidence Kit (Tri-Tech USA).

Step	Indication	Directions
Toxicology	Forensic urine should be collected with patient's permission in all cases Collect when patients report any drug or alcohol use Collect when patients report concern for surreptitious drugging or drug facilitated sexual assault Testing is done at the Washington State Toxicology laboratory Hospital toxicology should be done for medical care only. Results of hospital toxicology are not used for evidentiary purposes.	Urine for forensic toxicology (routine) 30 ml urine only Collect urine in standard specimen cup, then transfer urine to state toxicology leakproof plastic cup or 2 red top tubes. Place in biohazard bag with one paper towel. Label cup and bag Package according to WA State Evidence Packaging Guidelines. Blood for forensic toxicology If concern for drug facilitated assault, and <24 hours since event Collect blood in 2 grey top tubes Maintain at room temperature or refrigerate until transfer. Do NOT freeze glass tubes. **Do NOT package urine or blood in kit**. Grey top blood tubes should be rubber banded to the top of kit for transfer to law enforcement. DO NOT PLACE BLOOD TUBES IN THE EVIDENCE KIT. DO NOT FREEZE

		BLOOD TUBES. Urine sample should be refrigerated or frozen. If that is not an option, urine may be maintained a room temperature for up to 3 hours. DO NOT PLACE URINE SAMPLE IN THE EVIDENCE KIT. Transfer to law enforcement within three hours. ***Urine specimen cups and grey top tubes can be obtained from the toxicology laboratory by emailing* toxlab@wsp.wa.gov
Trace Debris	Collect if assault occurred outside victim's own home, especially if assault occurred outdoors. Collect if patient has not bathed or changed clothes. Purpose is to collect forensic evidence that ties the victim to the scene of the assault.	Place clean bed sheet (or paper sheet) on floor Place paper from "Trace Debris" envelope on top Have patient undress while standing on paper Fold paper to retain debris Place in envelope, seal, sign and date over tape Have patient dress in examination gown

Clothing	Collect clothing worn at time of the assault. Use discretion when considering taking clothing as evidence. Clothing that is ripped, torn or stained would be important to collect. Pants worn without underwear either at assault or immediately after assault would also be important. Outer clothing or clothing not likely to have come into contact with the suspect or scene is not as important to collect. Purpose is to link the victim to the suspect, scene or both.	Place each article of clothing in a separate brown paper bag. Place "outer clothing" label on outside of bag. Package according to the evidence packaging guidelines. Bags should only be sealed with clear packing tape. Indicate on outside of bag number ___ of ___ bags collected as well as what item is inside the bag (i.e. jeans, shirt, etc) Label bags containing wet clothing "wet" on outside and freeze or transfer to law enforcement within 3 hours.
Underwear	Collect in all cases. Purpose is to collect potential suspect DNA from surface of underwear. If patient brings underwear worn at time of assault, those should be collected as clothing. Underwear worn at time of exam should be collected in underwear envelope	Place in the "underwear" envelope from the evidence kit. Package according the evidence packaging guidelines. Seal, label, place in the Evidence Kit **Note:** Do not attempt to dry wet underpants or incontinence pads. Either transfer to law enforcement within 3 hours, or place in open plastic container (basin) or open plastic bag. Place in double paper bag, seal. Label "WET" and refrigerate or freeze until transfer
Mouth	Collect in all cases Purpose is to obtain suspect DNA from the oral area.	Use 4 cotton swabs total. Do not moisten Using 2 swabs at a time, swab around gingival border, at margins of teeth, buccal and lingual surfaces

		Repeat with remaining 2 swabs Dry for one hour Place in swab boxes marked "oral" and package according to packaging guidelines.
Hands	Collect in all cases Purpose is to obtain suspect DNA that may be under fingernails If patient was forced to touch the genitals of the offender, a separate skin swab of the hand surfaces should be obtained (see skin swab section below).	Use 4 swabs total - 2 swabs for each hand Moistened 1 swab with distilled water, swab all 5 fingertips on one hand, concentrating on area under nails Repeat with 1 dry swab on same hand Repeat process on other hand Dry swabs for one hour • Both swabs from one hand may be packaged in same box. Label box as "R hand" or "L hand". Package according to the evidence packaging guidelines.
Reference DNA	Collect in all cases Purpose it to obtain a sample of victim DNA for reference.	Use either lancet from kit, or blood from a peripheral blood draw. May obtain at the same time in as other labs Place blood on designated filter (FTA) paper, fill at least 1 circle. **NOTE: DO NOT TOUCH FILTER PAPER WITH UNGLOVED HANDS**
Debris on Skin	Collect if patient presents with visible debris on skin or in hair Particularly important if assault occurred outdoors. Purpose is to connect the victim to the crime scene	Use cotton swabs provided in the kit Unfold the paper sheet found in the debris on skin envelope and ideally place on a flat surface Using either a swab moistened with distilled water or the wooden end of the swab, remove debris and place on paper sheet. Refold paper sheet to retain debris and place in "debris on skin" envelope. If debris adheres to the swab, dry for one hour and place swab in a swab box marked "debris on skin" On back of "debris on skin" envelope, note location on body where debris was collected on the anatomical drawing.

		Package according to the evidence packaging guidelines.
Skin Swabs	Collect if patient reports possible semen, saliva or lubricant deposits on the body from the assault. Collect even if patient has bathed or showered Particularly important are any bite mark or suctions ecchymosis areas. Consider skin swabs for touch DNA on any area of the body where there may have been forceful grabbing or manual strangulation. These can be collected if the patient has NOT bathed or showered. Purpose is to collect suspect DNA from the victim's body	Use 2 swabs total for each site, one wet one dry Moisten 1 swab with 1 drop of distilled water Swab area of suspected foreign secretions in outwardly expanding circular motion Repeat with second, dry swab Repeat 2 swab wet/dry technique for each suspect area Number each collection site (i.e. Skin Site #1) Indicate suspected type of evidence (i.e. semen, saliva, lubricant or touch DNA) on swab box as well as on the bodygram on the back of the envelope. Allow swabs to dry for one hour Both swabs for each site can be placed in one swab box. Package according to evidence packaging guidelines.

Pubic Hair Combing	Omit if shaved or absent pubic hair Omit if bathed or showered Purpose is to collect suspect hair that may have been deposited in victim pubic hair	With patient in dorsal lithotomy position, place paper sheet from "pubic hair combing" envelope under patient's buttocks Using comb supplied in "pubic hair combing" envelope, comb downward through patient's pubic hair to collect any loose hairs onto paper sheet Fold paper sheet to retain both evidence hairs and comb used Return paper sheet to "pubic hair combing" envelope If matted pubic hair is noted, use clean scissors to clip matted area out and place in paper sheet and fold to retain. It is not necessary to retain scissors used for clipping. Package per evidence packaging guidelines
Female Genital Swabs		
Perineal Vulvar	Collect on all patients reporting contact to vagina, perineum or anus Collect even if patient has bathed or showered Purpose is to collect suspect DNA form deposits of semen or saliva	Use 4 cotton swabs total Moisten 2 swabs with 1 drop of distilled water on each Using both swabs simultaneously, thoroughly swab external genital folds and perineum Repeat with 2 dry swabs Dry for one hour Place 2 swabs per box in swab boxes marked "perineal vulvar" Package per evidence packaging guidelines
Vaginal	Collect when patient reports contact to vagina, perineum or anus Collect even if patient has bathed or showered A speculum exam is recommended only in specific circumstances and contra-indicated in pre-menarchal adolescents	Use 4 cotton swabs total **If NOT using a speculum**: Using 2 swabs at a time, insert in posterior direction approx 4", and swab posterior vaginal pool Repeat process with 2 more swabs. It is not necessary to moisten swabs but they may be moistened for patient comfort. **If using a speculum:** Use only water to lubricate prior to evidence

	Purpose is to obtain suspect DNA from the vaginal vault	collection Collect two swabs together from the posterior vaginal pool Collect two swabs, one at a time from the endocervix Dry all swabs for one hour Package in swab boxes, two swabs per box indicating site of collection on outside of box (i.e. vaginal or endocervix) Package according to evidence packaging guidelines

Male Genital Swabs

Scrotal/Perineal	Collect on all patients reporting contact with assailant's saliva or other body fluids Collect even if pat has bathed or showered Purpose is to obtain potential suspect DNA from scrotum and/or perineum	Collect 4 swabs total from scrotal/perineal area Moisten 2 swabs with distilled water. Using both swabs simultaneously, thoroughly swab anterior and posterior surfaces of scrotum and perineum. Repeat with 2 dry swabs. Dry for one hour. Place 2 swabs per box in swab boxes marked "scrotal/perineal" Package per evidence packaging guidelines.
Penile	Collect on all patients reporting contact with assailant's saliva or other body secretions Collect even if patient has bathed or showered. Purpose is to obtain potential suspect DNA from patient's penile area	Collect a total of 4 swabs. Lightly moisten 2 swabs with 1 drop of distilled water on each. Swab penile shaft: anterior, posterior, lateral, glans, penis and under foreskin with moistened swabs. Repeat with 2 dry swabs. Allow swabs to dry for one hour. Place dried swabs, 2 per box, in swab boxes marked "penis." Package according to evidence packaging guidelines.

Anal	Collect on all patients reporting contact to vagina, perineum or anus Collect even is patient has bathed or showered Purpose is to obtain potential suspect DNA from either outside or inside the anus	Collect a total of 4 swabs from anal area Moisten 2 swabs with distilled water one at a time swab along the peri-anal folds Moisten 2 swabs with distilled water and slowly insert 1 swab into the anus, just beyond the sphincter (appox 1.5 cm or the length of the cotton tip) Repeat with second moistened swab Dry for one hour Place in swab boxes labled "external anal" or "anal folds" and "internal anal" or "anal" Package according to evidence packaging guidelines

Evidence packaging, storage, and transfer

Evidence Packaging

Specifics of evidence packaging may be obtained from "Sexual Assault Evidence Packaging Handbook" for Washington State.

- Clothing worn at the time of the assault should be placed in separate paper bags, taped closed, and labeled.
- Underpants should be placed in paper bag in kit
- Wet clothing should be dried or transferred to law enforcement within 3 hours
- For specific evidence collection order and techniques see Medical Exam

Forensic Evidence Storage and Transfer

Forensic specimens are not processed within the hospital, but stored separately and transferred to law enforcement. Evidence may later be tested by the Washington State Patrol Crime Lab though not all evidence is necessarily processed.

Chain of custody of evidence

One staff member must be responsible for maintaining chain of evidence. That staff member at all times:

- Maintains continuous physical possession of specimens and items of evidence, or
- Designates another staff member to maintain possession of evidence, or
- Locks specimens in closed area (room, cabinet, refrigerator or freezer)

All evidence should be thoroughly dried before packaging. If small items cannot be dried (e.g., tampons, condoms) continence pads, menstrual pads, or clothing):

1. Place in urine specimen cup
2. Place in locked freezer or refrigerator if available OR
3. Transfer to law enforcement within 3 hours

If larger wet items are collected (incontinence pads, menstrual pads, clothing

1. Package in paper (may line bottom of the bag with plastic)
2. Transfer to police within 3 hours, or freeze until transfer.
3. Mark the outside of these packages "WET"
4. **Document** transfer in hospital records.

Drying Swabs

Be sure to maintain chain of custody while drying. A swab moistened with 3 drops of water will take 1 hour to dry in a standard drying box. Swabs left outside of a box will take a similar time to dry.

- Swabs may be locked in room, cabinet or drying box to dry
- Do not use heat or fan to dry swabs
- If plexiglass drying box is used:
- Place swabs from only one patient at a time in drying box
- Use plastic "Crash cart" lock to close box or lock box in a cabinet or room
- When drying is complete, place used plastic lock into evidence kit to demonstrate chain of custody of evidence
- Clean drying box between uses with 20% bleach or hospital approved disinfectant

Medical photography

If visible injuries are present, hand drawing as well as photography is highly recommended for documentation. A standard protocol should be in place for taking photos, storage, and transfer.

Photography with digital or video camera

- Each camera type has advantages and limitations.
    - Video should have no sound recording unless all parties are aware of and consent
- Careful documentation with drawing or writing is mandatory even when photographs are obtained
- Each institution should take appropriate steps to maintain the privacy and dignity of the patient in photos
- Always document name of photographer and date of photos. This may be done by documentation in the chart, in a photo log, or by writing the photographer name and date on the patient identification label which is then photographed.

Technique

Staff must be trained in specific camera and photography techniques.

- If date function is used, verify that date is correct
- Check flash function: photos may be better either with or without flash
- First photo is of patient identification label
- One photo should include patient face
- Photograph each injury site 3 times
    1. At least 3 feet away, to show the injury in context
    2. Close up
    3. Close up with a measuring device (ruler, coin, or ABFO rule)

Body photos

Photos of body injury may be more significant than genital injury in sexual assault cases

- Drape patient appropriately, photos may be shown in open court
- Hospital personnel may either take the photos or assist law enforcement in obtaining photos

Bite Marks

Bite marks should be photographed, but police should be notified for police photographer to obtain technically optimal photos. Use of a measuring device and good technique (camera perpendicular to plane of skin) is particularly important

Colposcopy

Magnified photos of the genital or anal area can document injury.

- Use photo or video-colposcope, or camera with macro function
- Measuring device is not needed in these photos
- If blood or debris is present, photograph first, then clean area and photograph again
- If toluidine blue is used, photograph before and after dye application (see page ?)

Photo storage and release

Storage

- Photos are part of the medical record
- Photos may be stored outside of the medical records department (just as x-ray films are stored in the radiology department)
- Follow medical records retention rules regarding disposal of photographs

Release

- Follow HIPPA compliance policies for release of all records including photos
- Photos may be released to law enforcement with proper

Provide formal tracking of copies, release dates, and person responsible for releasing and receiving photos.

authorization EXCEPT colposcopy photos or genital/anal photos. Because of the extremely confidential nature of colposcopy photos, these are released only in response to a subpoena and then are released directly to the medical expert who will review the photos.

Lab tests

Pregnancy test

Obtain on all females ages 10 to 55 years of age, except if history of hysterectomy

STI Tests

STI tests are not generally useful for forensic purposes; positive tests usually indicate pre-existing infection.

- Patient assent for these tests should be obtained. Inform patient that these tests are related to health issues, and not forensic tests
- Many centers provide routine post exposure STI prophylaxis and do not routinely test before treatment
- Vulnerable adults and young adolescents are an exception: in these cases, if there has been no prior consensual activity STI tests may be legally important.
- Non-culture nuclear amplification tests (NAATs) for gonorrhea and chlamydia are acceptable in most cases
- Conventional culture tests for gonorrhea and chlamydia are necessary for testing of pharynx or rectum
- A positive non-culture test should be verified by another method before treatment
- RPR (syphilis) test is not routinely recommended, but may be done in follow-up

HIV Testing

- Baseline HIV testing may be performed up to 2 weeks after assault, and may be performed at follow-up visit.
- If HIV prophylaxis will be given, baseline HIV serology is recommended
- Patient must exhibit understanding that the acute test will not reflect acquisition of HIV from the assault, but relates to possible exposure 2 months or more prior
- Arrangements must be made to inform patient of results

Medical Treatment

Emergency Contraception

Discuss and provide emergency contraception when:

Emergency contraception will reduce the chances of pregnancy when taken up to 5 days of unprotected intercourse

- Assault occurred within prior 5 days and
- Patient is at risk for pregnancy and
- Patient feels any pregnancy conceived in the last five days would be undesirable to continue and
- Pregnancy test is negative

By Washington State law every hospital providing emergency care for sexual assault victims must:

- Provide information about emergency contraception
- Inform each victim of her option to be provided with this medication, and
- If not medically contraindicated provide emergency contraception immediately
- It is not legally permissible to provide a written prescription only
- See RCW 70.41.350 and WAC 246.320.286
- See **Post Assault Medications**

STI Post-Exposure Prophylaxis

- Single dose post-exposure prophylaxis is practical for prevention of gonorrhea, trichomonas, and chlamydia
- Metronidazole po 2 gm single dose is recommended to treat or prevent trichomonas
- Patient should be advised to not drink alcohol 24 hours before and 24 hours after taking metronidazole due to Antabuse-like effect
- An alternative is to not provide STI prophylaxis at the time of the acute visit, but to offer a 2 week follow-up with testing at that time.
- This strategy is preferred for patients for whom STI presence might be legally significant, this includes young women who have not been sexually active and vulnerable adults
- See **Post Assault Medications**

For patients requesting STI testing in lieu of post exposure prophylactic medications, prior to testing inform patients that:

- A positive test result is more likely to be the result of a prior sexual encounter and not the recent sexual assault
- Positive STI test results in Washington state require mandatory reporting to the local health department and/or the Washington State Infectious Disease Office
- Patients who test positive for Chlamydia, Gonorrhea, Syphyllis, Hepatitis B and HIV will be advised to notify recent sexual partners. Medical providers are require to ensure all sexual partners have been treated.
- Their regular consensual sexual partners may be made aware of the patient's STI test results because of reporting requirements.
- Despite rape shield laws, a positive test result could potentially be used against patients in the legal case.

HIV Post-Exposure Prophylaxis

Specific factors of the assailant (a man who has sex with men) and of the assault (anal assault, genital-anal tissue injury during the assault, multiple assailants) increase the risk of HIV transmission

- Discuss with the patient the risk of HIV, and medications available to decrease that risk
- Consider community incidence and prevalence prior to administering HIV PEP
- Medication must be taken for 28 days to be effective, and follow-up must be arranged
- See **Post Assault Prophylaxis**

Unique Populations[1]

Cultural Groups

Culture can influence beliefs about sexual assault, its victims, and offenders as well as healthcare practitioners. It can affect health care beliefs and practices related to the assault and medical treatment outcomes, and 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

- Some victims may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disrobe.
- 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.

Disabled

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.

- People with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault.
- Speak directly to victims with disabilities, even when interpreters, intermediaries, or guardians are present.

[1] This section is adapted from the U.S. Department of Justice's "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents, Second Addition," April 2013, 32-29.

- Recognize that individuals may have some degree of cognitive disability: mental retardation, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke.
- Assess a victim's level of ability and need for assistance during the exam process. Ask for permission before proceeding in an exam (or touch them, handle a mobility or communication device, or touch a service animal).
- 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. The perpetrator may also be their caregiver and the only person they rely on for daily living assistance.
- 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.
- 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. 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.

Incarcerated Victims

Sexual Assault medical providers should understand that prison culture is a very unique culture that is influenced by inmate characteristics, prison as a segregated society, as well as policies and practices of the prison itself. Prison culture is based on assumptions about a person's physical and mental weakness.

PREA

In 2003 congressed passed the Prison Rape Elimination Act (PREA) which is the first federal law that has been passed to deal with the sexual assault of prisoners. PREA has a number of provisions related to sexual assault care of those incarcerated including:

- The agency shall offer all victims of sexual assault access to forensic medical examinations, whether on site or at an outside facility
- Inmate/resident victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services as well as timely access to medications to prevent sexually transmitted infections and emergency contraception.
- Treatment shall be provided without cost to the victim and regardless of whether the offender is named or victim cooperates with an investigation
- Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) shall perform the exams where possible
- The facility shall provide victims with access to outside victim advocates for emotional support and shall attempt to make available a victim advocate from the local rape crisis center.

Victim Demographic

- Prisoners most likely to be victimized are those who are young, smaller in stature or less experienced in prison culture, physically or developmentally disabled prisoners and young inmates who identify as LGBTQ.
- Sexual assault experiences of male and female prisoners differ
    - Male inmates were most likely assaulted by other inmates, more likely to be threatened with harm, have greater use of physical force or have a weapon used in the assault. They are likely to have more physical injuries and to experience more sexual acts.
    - Women were as likely to be assaulted by other inmates as by prison staff.

Reporting

- Under-reporting is common due to poor handling of complaints, lack of criminal charging of offenders, fear of retaliation. Inmates who reported sexual violence were often subjected to more violence.
- When prison staff members are the assailants, victims are even less likely to report as they have no escape from the assailant. They often have even more to fear as the assailant who is a staff member has absolute power over the victims.

The Exam

- It is not appropriate to inquire about the reason for incarceration.
- Sexual assault examiners should provide culturally relevant trauma-informed care to all victims.
- Care should be taken to ensure the safety of the examiner. Prior to caring for incarcerated patients, examiners should create a memo of understanding and be aware of policies around presence of guards at exams, restraint of patients at exams, appropriate communication between examiners, patients and prison staff.

Male Victims

Men and adolescent boys can be victims of sexual assault by women or by men.

- Help male victims understand that male sexual assault is not uncommon and that the assault is 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 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.

Military

Sexual assault victims who are in the military or are family members of active duty military should be referred to the sexual assault advocacy services for their base or duty station to ensure comprehensive support.

The military offers victims the option of restricted reporting or unrestricted reporting. 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.

Multiple Victims

Victims may reside in group homes, assisted living, nursing homes, adult family homes, or be inpatient in hospitals. Reporting to Adult Protective Services (APS) is mandated for all vulnerable adults. Examination and evidence collection can be done even if outside of the standard time frame, as mobility and cognitive impairments may be present.

Appropriate triage and planning is essential to a patient-centered, coordinated response.

Considerations should include:

- Timing of exams
- Transportation to exams
- Location of exam (clinic vs ED)
- Collaboration/coordination between multiple healthcare facilities to provide exams for multiple victims
- Which patients actually need exams (anyone with possible exposure to offender should have an exam)
- Multiple examiners may be needed to prevent possible cross contamination of evidence

Exam/examiner considerations should include:

- Multiple victims needing exams at the same time
- Need for multidisciplinary collaboration (health care, social work, APS, facility staff)
- Availability of multiple facilities and multiple examiners to care for victims
- Availability of appropriate, private exam location/facility
- Ability to ensure no cross-contamination of evidence
- Discharge planning which may include possible need for relocation/change in housing
- Inclusion of support person for exam
- Access to medical records from home or facility
- Past medical history including records from facility
- Older and/or vulnerable adult victims may experience humiliation, shock, disbelief and denial. The full emotional impact of the assault may not be felt until the victim is alone, after initial contact with health care professionals, law enforcement, and legal advocates.

- Fear, anger or depression can be common responses in these victims. Fear of losing independence as a result of family members learning about the sexual assault can be a strong deterrent to reporting.
- Recognition by health care professionals that the offender may be a family member, friend or caregiver is important.

Native Americans

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.
- 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 mindful of historical trauma. Some victims may be slow to engage with non-natives.

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.

Be aware that caretakers may sexually assault older adults.

- 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.
- 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.
- 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.
- Do not mistake disabilities (such as hearing loss or aphasia) or acute stress reaction following assault for senility.
- 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.
- Some older victims may be reluctant to report the crime or seek treatment because they fear losing their independence.

Sex Trafficked/Commercial Sexually Exploitated Victims

Human trafficking is considered an especially egregious form of exploitation of vulnerable persons and an emerging health care priority. Victims of sex trafficking can come from all countries and walks of life, though the majority of victims are women and girls. See Trafficking Questionnaire and Charting for a sample charting aid.

- Key factors for sex trafficking include young age, history of abuse, poverty, lack of education, conflict with family of origin, lack of economic opportunity
- Traffickers may include females who are respected in communities, males who present as "boyfriends" or even family members.
- It is important for providers to recognize the varied experiences and reactions of victims and to demonstrate consistent, culturally aware trauma-informed care when working with sexually trafficked persons.
- Disclosures can be both emotionally difficulty and potentially dangerous for the victim. Victims may not disclose even in a supportive medical environment due to fear for safety, loyalty to trafficker, or lack of understanding of their situation.

Red flags for trafficking include:

- Recurrent STI's
- Multiple or frequent pregnancies
- Frequent or forced abortions
- Delayed presentation for medical care
- Companion who speaks for the patient and controls the encounter and refuses to leave
- Discrepancy between stated history and clinical presentation or pattern of injury
- Tattoos or other marks that may indicate "ownership" by another person

Trafficking of Children/Adolescents

- Presentation to health care with non-guardian or unrelated adults
- Access to material possessions outside their financial means
- Over-familiarity with sexual terms and practices
- Excessive number of sexual partners
- School truancy
- Fearful attachment to cell phone (as a monitoring/tracking device)

Providers should:

- Provide culturally sensitive, resilience-oriented trauma informed care to all patients
- Partner with advocates, social service providers and case managers to ensure all needs are met
- Educate self on dynamics of trafficking and resources within each community

Resources

Human Trafficking Guidebook on Identification, Assessment and Response in the Health Care Setting

Massachusetts Medical Society: Human Trafficking

Sexual minority patients (LGBTQ)

For a glossary of terms, see **Sexual Identity Terms.**

Things to note for sexual minority patients:

- 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.

Victims who are transgender or gender non-conforming:

- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Transgender victims may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the victim does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body parts at all.
- 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.
- 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.

Advocacy and support

Washington State has numerous advocacy programs

Many hospitals have a partnership with the local Community Sexual Assault Advocacy Program (CSAP). If this partnership is not in place, provide information regarding local Community Sexual Assault Advocacy Programs before discharge.

- This partnership may include calling an advocate before the patient arrives. The advocate can provide support and resources. In some communities, an advocate is available for the medical exam.
- If a medical advocate is available, it is preferable to call them as soon as the patient presents. As long as personal identifiers are not provided initially, it is not a HIPPA violation.
- The patient has the choice to have an advocate or support person present at the medical facility RCW 70.125.060. In the absence of an advocate, a social worker, sexual assault nurse examiner, or healthcare provider can stand in as a support person. The patient and provider together decide who will be present during the examination.

- Medical information cannot be shared without the patient's authorization (except for minors and vulnerable adults). With patient's written authorization, medical information can be shared with the CSAP for follow-up and advocacy.

Coordination with law enforcement and reporting requirements

The nonvulnerable adult patient may have difficulty deciding immediately whether he/she wants to make a police report. For vulnerable adults/persons less than 18 years of age, a police report is mandatory. The patient should be supported in his or her choice to report to police or to not report

- Procedures should be in place to allow evidence to be saved by the medical facility of by the police for a limited time (30 days is recommended) to allow this decision.
- The medical evaluation and exam may be done before or after a police report is made, or when a report will not be made.
- In general, the police officer or detective is not present in the room during the exam unless there are safety issues.

Authorization to release confidential health information

Protected health information includes:

- Information
- Medical records
- Photographs obtained by medical personnel
- Any evidence, including clothing and evidence kit obtained in the hospital

These are protected health information and are subject to HIPAA regulations

Information obtained by medical personnel cannot be shared with anyone, including law enforcement, without authorization from the patient or legally authorized decision maker. Children and vulnerable adults are exceptions.

This authorization may be by:

- The patient
- Legally authorized surrogate decision maker
- Court order or warrant

> **Note:** Genital photographs require a court order in order to be released.

Even if the patient is brought in by law enforcement, consent from patient or legally authorized surrogate decision maker must be obtained before releasing information to law enforcement.

Without this consent, only the following information can be released:

- Name
- Address

- Age
- Gender
- Type of injury of the patient

To disclose further information, another exception must apply such as children under age 18, vulnerable adults, or to minimize an imminent and serious threat to health or safety. If there are concerns about authorization for release, hospital risk management and legal counsel should be involved.

Discharge

- Review medication side effects
- Explain to patient:
    - Forensic swabs will not be tested at hospital. They are sent to the Washington State Crime Lab to be analyzed.
    - Tests that were obtained
    - Follow up for medical test results, if done
    - If police report has been made, forensic evidence will be transferred to police and a detective may be contacting the patient within several days.
    - If police report is not made, then evidence will be discarded within a specific time period. Every facility should have a process for anonymous kits. Provide the patient with this information.
- Provide written information regarding local sexual assault advocacy organizations and other crisis services. See Sexual Assault and Crisis Support Services
- Provide written discharge instructions. See Discharge Instructions sample
- Confirm plans for follow-up

Follow-up Medical Care

Follow-up medical visit by primary or specialized medical provider is recommended in 1-3 weeks after initial exam. This visit is typically not covered by CVC, unless it is done to complete the initial acute exam.

Review with patient:

- Acute exam findings
- Medical lab results, if any (crime lab results will not be available)
- Current physical symptoms
- Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks)
- Concerns for safety and legal issues
- Concerns regarding STIs and HIV
- Medical exam
- Individualize exam, depending on history and symptoms
- Check for resolution of injury
    - Evaluate any new symptoms
    - Refer for ongoing medical care, if needed

- Lab tests

Depending on risks and patient concerns:

- Pregnancy test
- Test for gonorrhea and chlamydia if single dose prophylaxis was not given at initial evaluation
- Syphilis test (RPR) 6 weeks after possible exposure
- Saline wet mount and KOH prep to evaluate vaginitis if symptoms present
- HIV testing : Baseline, 6 weeks, 12 weeks, and 24 weeks after exposure
- Hepatitis B vaccine. If series initiated at acute examination, continue to complete 3 vaccine series

Assess social support (family, friends)

Refer for follow-up medical care, counseling and advocacy

Billing

By law, the initial medical forensic exam for sexual assault for the purpose of gathering evidence for possible prosecution must be billed only to Washington State Crime Victims Compensation (CVC). The victim is not required to make a police report and does not need a "positive finding" of sexual assault for CVC to cover the initial exam.

Application

- A CVC application should be given to patient. **Do not** submit an application for the ED visit. This is already covered without an application.
- CVC prefers that the application be completed after further medical or counseling care is obtained.

Coverage and Billing

A patient does not have to complete the CVC paperwork for the initial exam

- Treatment, including antibiotics, emergency contraception, and 2 days of HEP B, tetanus vaccine, HIV prophylaxis, as well as all labs associated with the exam are covered by CVC.
- Assessment and treatment of injury (e.g . broken arm during the assault) is billed to the patient or their insurance. If patient applies to Crime Victims Compensation and claim is approved, CVC becomes the secondary payer.
- Billing requires the use of specific local codes and completion of a SAFE form. See CVC Information for Providers.

For further information, see Washington State Crime Victim's Compensation. Phone: 800-762-3716.

Addenda

Discharge instructions sample

INFORMATION FOR ADULTS AND TEENS

What happens next?

If you have made a police report, a detective will call you within several days. If evidence such as clothing and swabs was collected during the exam, and you have signed a release of information form, the evidence will then be transferred to the police.

Here are some helpful things that you can do:

- Take good care of yourself by paying attention to your basic needs for rest, food and exercise.
- Talk with a friend, family member, or someone you trust about what has happened.
- Be moderate in your use of alcohol and other non-prescription drugs.
- Talk with a counselor about your concerns and questions.
- Call our office if you have any questions or concerns

Can I talk to a counselor or advocate?

If you have signed an authorization, an advocate will call you within a few days. Or you can call

Agency: _____ Tel: _____

[Provide information about local agencies]

The following was done today as part of your exam:

☐ Tests for legal evidence.

If you have made a police report and signed a release, these tests are transferred to the police who will have it tested at the Washington State Patrol Crime Lab. It may take up to 6 months for testing to be completed.

The results of these tests are not normally available to you or the medical provider. Please contact the detective if you have questions regarding these tests.

If you have not decided to make a police report or you are not sure, we will keep the evidence and clothing for x amount of time. We will attempt to contact you before discarding the evidence.

☐ Lab tests to find out if you have any STD's (diseases you can get from sexual contact). There is a very low risk of HIV from sexual assault. If you have questions about this, please talk to the medical provider.

☐ Pregnancy test. Result: _____

☐ Digital photographs of injuries

If photos were taken of general body injuries (bruises, etc.) they will be provided to the police department if you have made a report. Photos of intimate areas are not normally provided to law enforcement.

The following medicines were prescribed

☐ **Plan B (levonorgestrol)** 1 package

This is to decrease the chance of getting pregnant**.**

You may have some bleeding like a menstrual period a few days after taking the medicine, or you may not. If you do not have your next period at the expected time, you should get a pregnancy test.

☐ **Azithromycin** 1 gm (4 tablets)

This medicine will treat Chlamydia if you have it or prevent it if you were exposed to it during the assault.

Take all 4 tablets at the same time. It often helps to take this with food.

☐ **Ceftriaxone** 250 mg

This medicine will treat Gonorrhea if you have it, or prevent it if you were exposed to it during the assault.

You can take this at the same time as the other pills, or at a different time.

☐ **Metronidazole** 2 gm

This medicine will treat or prevent Trichomonas.

It is important to NOT use alcohol for 24 hours before and after taking this medication

☐ **Hepatitis B vaccination # ___**

This vaccine helps protect you from a virus, which can cause severe liver problems. If this was your first vaccination, you must have a repeat dose in one month and again in six months. These can be obtained at _____

☐ **Other medications:** _____

If someone needs a copy of these medical records, they can call _____

Records will be released only with your authorization

If you are having any emergency problems related to the assault, call _____

Date: _____ Clinician: _____

Post-Assault Medications

Emergency contraception	Levonorgestrel 1.5 mg po x 1	Take medicine as soon as possible within 5 days after unprotected intercourse May be taken even if patient is using reliable birth control or has had a tubal ligation Confirm negative pregnancy test prior to giving medication
STI prophylaxis	Ceftriaxone 250mg IM x1 *PLUS* Azithromycin 1 gm po x 1 *PLUS* Metronidazole* 2 gm po x1 Hep B vaccine Tdap	For gonorrhea prophylaxis For Chlamydia prophylaxis Take with food to decrease GI side effects For trichomonas prophylaxis If patient not fully immunized Refer for completion of 3 dose series If more than 5 years since last Td, and open wound

* Metronidazole should not be taken within 24 hours after OR 24 hours before alcohol ingestion. Advise patients of antabuse-like reaction if combined with alcohol. Patient may choose to defer treatment

- For pregnant patients, consider providing no prophylactic antibiotics. In this case, gonorrhea and chlamydia tests should be obtained at follow-up visit in 2 weeks. If prophylaxis is strongly desired, cefixime and azithromycin are Class B drugs

For penicillin allergic patients

There is a 5-10% incidence of concurrent cephalosporin allergy.

If late onset, atypical, or undocumented allergy: use cefixime and azithromycin, as above

If history of anaphylaxis or immediate hives - consider either:

- Azithromycin 1 gm po (no cephalosporin) -This is appropriate in areas of low gonorrhea prevalence. Retest for GC in followup 2 weeks after assault OR
- Azithromycin 2 gm po at once (this will treat GC and Chlamydia, but is not generally recommended due to concern emerging resistance), may cause nausea

For updates, see newest CDC STI treatment guidelines

Sample Trafficked Victims Charting Aid

Gender of client: Female Male Other: _____

Age of client: _____ Date of birth: _____ Country of birth: _____

Number of years of schooling completed: _____

Client's preferred language: _____

Who all does client live with and relationship: _____

_____

1. Has anyone ever (check all that apply)
   - __ Withhold payment from you
   - __ Give your payment to someone else
   - __ Control the payment that you have been paid
   - __ None of the above

2. Have you ever worked (or done other activities) that were different from what you promised or told?
   __ No
   __ Yes → What were you promised or told that you would do?

   _____

   _____

   →What did you end up doing?

   _____

   _____

3. Did anyone where you lived or worked (or did other activities) ever make you feel scared or unsafe?
   __ No
   __ Yes → What made you feel scared or unsafe?

   _____

   _____

4. Did anyone where you lived or worked (or did other activities) ever hurt you or threatened to hurt you?
   __ No
   __ Yes →What did they do or say?

   _____

   _____ (pg. 1)

5. Were you ever injured or did you ever get sick in a place where you lived or worked (or did other activities)?
   __ No

__ Yes →Were you ever stopped from getting medical care? Y N
→What happened?

_____

_____

6. Have you ever felt you could not leave the place where you lived or worked (or did other activities)?
__ No
__Yes →Why couldn't you leave?

_____

_____

→What do you think would have happened if you did try to leave?

_____

_____

7. Did anyone where you lived or worked (or did other activities) tell you to lie about your age or what you did?
__ No
__Yes →Why did they tell you to lie?

_____

_____

8. Did anyone where you lived or worked (or did other activities) ever trick or pressure you into doing anything you did not want to do?
__ No
__ Yes →Examples?

_____

_____

9. Did anyone ever pressure you to touch someone or have any unwanted physical or sexual contact?
__ No
__ Yes →What happened?

_____

_____ (pg. 2)

10. Did anyone ever take a photo of you that you were uncomfortable with?
__ No
__ Yes →Who took the photo?

_____

→What did they want to do with the photo, if you know?

_____

_____

→Did you agree to this? Y N

11. Did you ever have sex for things of value (for example: money, housing, food, gifts, or favors)?
    __ No
    __ Yes →Were you pressured to do this? Y N
    →Were you under the age of 18 when this occurred? Y N

12. Did anyone take and keep your identification (for example: your passport or driver's license)?
    __ No
    __ Yes →Could you get them back if you wanted, explain?

_____

_____

13. Did anyone where you worked (or did other activities) ever take your money for things (for example: for transportation, food, or rent)?
    __ No
    __ Yes →Did you agree to this person taking your money? Y N
    →Describe:

_____

_____

Sample Trafficked Victims Charting Aid

	Partner 1	Partner 2	Partner 3
Male or Female			
Force			
Threat to harm			
Restrained			
Hit			
Kicked			
Choked/Strangled			
Pattern Injury			
Substance Use			
Voluntary (type/amount)			
Forced (type/amount)			
DFSA (Y/N)			
Type of Contact	**Check all that apply**		
Penis to: Vagina			
Anal			
Mouth			
Other			
Hand to: Vagina			
Anal			
Mouth			
Other			
Mouth to: Vagina			
Anal			
Mouth			
Other			
Condom Used (Y/N)			
Ejaculation and Location			

Sexual Identity Terms

These terms are to help you understand a little bit more about LGBTQ populations. They are not meant to be used in charting. They should be used with discretion considering potential bias.

Bisexual | A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree.

Cisgender | A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.

Gay | A person who is emotionally, romantically or sexually attracted to members of the same gender.

Gender dysphoria | Clinically significant distress caused when a person's assigned birth gender is not the same as the one with which they identify.

Gender expression | External appearance of one's gender identity, usually expressed through behavior, clothing, haircut or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine.

Gender-fluid | A person who does not identify with a single fixed gender.

Gender identity | One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Genderqueer | Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. They may see themselves as being both male and female, neither male nor female or as falling completely outside these categories.

Gender transition | The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing, using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions.

Lesbian | A woman who is emotionally, romantically or sexually attracted to other women.

Pansexual | Describes people who are capable of being attracted to multiple sexes or gender identities.

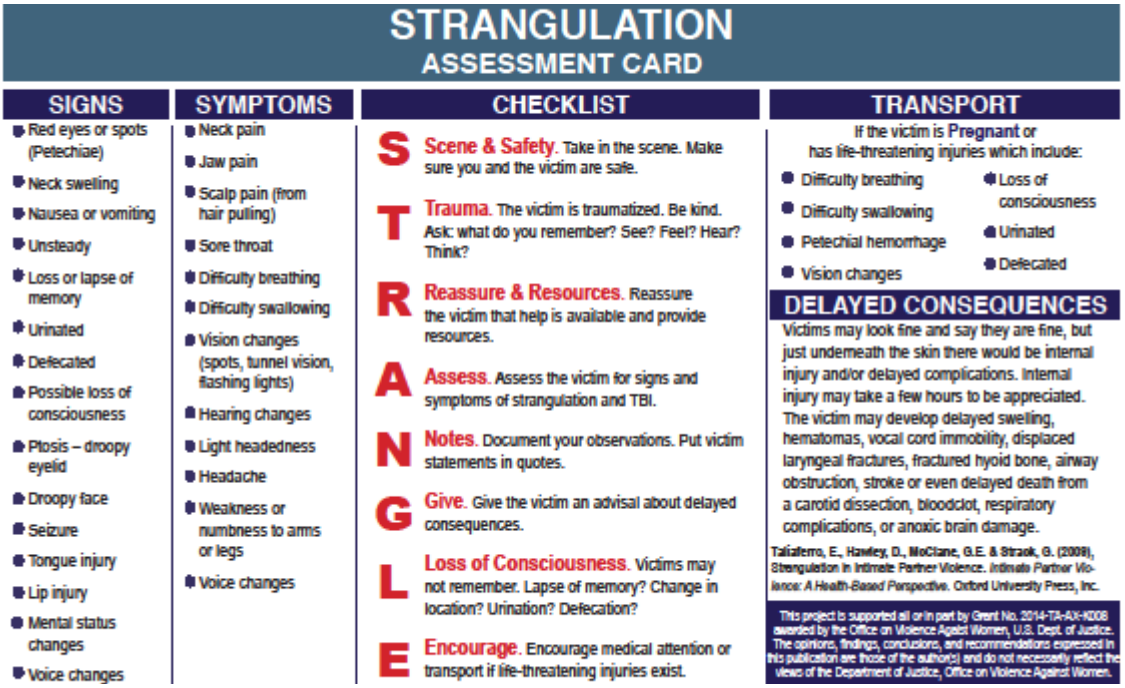
Queer | A term people often use to express fluid identities and orientations. Often used interchangeably with "LGBTQ."

Sexual orientation | An inherent or immutable enduring emotional, romantic or sexual attraction to other people.

Transgender | An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

Strangulation Addenda (Double-click images to open PDFs)

- **Assessment Card**



STRANGULATION
ASSESSMENT CARD

SIGNS
- Red eyes or spots (Petechiae)
- Neck swelling
- Nausea or vomiting
- Unsteady
- Loss or lapse of memory
- Urinated
- Defecated
- Possible loss of consciousness
- Ptosis – droopy eyelid
- Droopy face
- Seizure
- Tongue injury
- Lip injury
- Mental status changes
- Voice changes

SYMPTOMS
- Neck pain
- Jaw pain
- Scalp pain (from hair pulling)
- Sore throat
- Difficulty breathing
- Difficulty swallowing
- Vision changes (spots, tunnel vision, flashing lights)
- Hearing changes
- Light headedness
- Headache
- Weakness or numbness to arms or legs
- Voice changes

CHECKLIST

S Scene & Safety. Take in the scene. Make sure you and the victim are safe.

T Trauma. The victim is traumatized. Be kind. Ask: what do you remember? See? Feel? Hear? Think?

R Reassure & Resources. Reassure the victim that help is available and provide resources.

A Assess. Assess the victim for signs and symptoms of strangulation and TBI.

N Notes. Document your observations. Put victim statements in quotes.

G Give. Give the victim an advisal about delayed consequences.

L Loss of Consciousness. Victims may not remember. Lapse of memory? Change in location? Urination? Defecation?

E Encourage. Encourage medical attention or transport if life-threatening injuries exist.

TRANSPORT

If the victim is Pregnant or has life-threatening injuries which include:
- Difficulty breathing
- Difficulty swallowing
- Petechial hemorrhage
- Vision changes
- Loss of consciousness
- Urinated
- Defecated

DELAYED CONSEQUENCES

Victims may look fine and say they are fine, but just underneath the skin there would be internal injury and/or delayed complications. Internal injury may take a few hours to be appreciated. The victim may develop delayed swelling, hematomas, vocal cord immobility, displaced laryngeal fractures, fractured hyoid bone, airway obstruction, stroke or even delayed death from a carotid dissection, bloodclot, respiratory complications, or anoxic brain damage.

Taliaferro, E., Hawley, D., McClane, G.E. & Strack, G. (2008), Strangulation in Intimate Partner Violence. *Intimate Partner Violence: A Health-Based Perspective*. Oxford University Press, Inc.

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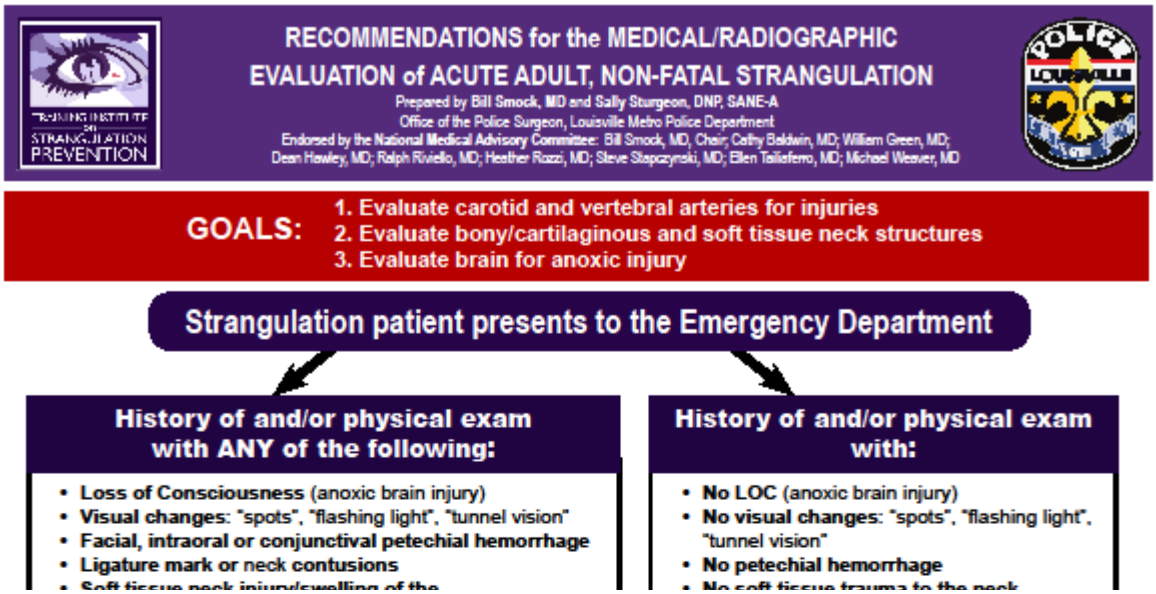
- **Recommendations for Evaluation**



RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

Prepared by Bill Smock, MD and Sally Sturgeon, DNP, SANE-A
Office of the Police Surgeon, Louisville Metro Police Department
Endorsed by the National Medical Advisory Committee: Bill Smock, MD, Chair; Cathy Baldwin, MD; William Green, MD; Dean Hawley, MD; Ralph Riviello, MD; Heather Rozzi, MD; Steve Stapczynski, MD; Ellen Taliaferro, MD; Michael Weaver, MD

GOALS:
1. Evaluate carotid and vertebral arteries for injuries
2. Evaluate bony/cartilaginous and soft tissue neck structures
3. Evaluate brain for anoxic injury

Strangulation patient presents to the Emergency Department

History of and/or physical exam with ANY of the following:
- **Loss of Consciousness** (anoxic brain injury)
- **Visual changes**: "spots", "flashing light", "tunnel vision"
- **Facial, intraoral or conjunctival petechial hemorrhage**
- **Ligature mark or** neck **contusions**
- **Soft tissue neck injury/swelling of the**

History of and/or physical exam with:
- **No LOC** (anoxic brain injury)
- **No visual changes**: "spots", "flashing light", "tunnel vision"
- **No petechial hemorrhage**
- **No soft tissue trauma to the neck**

Strangulation – Checklist

Strangulation Symptom Checklist:	**Details of the Strangulation:**	
☐ Breathing changes or difficulty ☐ Raspy or hoarse voice ☐ Cough ☐ Difficulty/pain when swallowing ☐ " Thick" feeling in throat ☐ Cognitive changes (memory loss/confusion/agitation/difficulty with word finding/restlessness ☐ Reported LOC or near LOC ☐ Loss of urine ☐ Loss of bowels ☐ Vision changes ☐ Thought were going to die ☐ Nausea and /or vomiting ☐ Scratches/red marks(jaw line, clavicles/neck/behind ears) ☐ Bruising(jaw line, clavicles/neck/behind ears) ☐ Bruising and swelling (lips/oral mucosa	☐ One hand ☐ Two hands (Right or Left) ☐ Forearm (Right or Left) ☐ Ligature ☐ Concurrent smothering/suffocation ☐ Duration of strangulation ☐ Was patient shaken by neck ☐ Was patient suspended by neck (lifted off ground)	
Noted Injuries:		
☐ Pt evaluated for strangulation by ED MD prior to SANE arrival ☐ Pt referred back to ED MD for strangulation evaluation		
☐ Strangulation discharge instructions reviewed with pt including: Stay with someone for 24 hours after strangulation event Return to ED for Difficulty breathing, increased trouble swallowing, swelling of neck or throat, increased hoarseness or voices changes, blurred vision, severe headaches, numbness of arms or legs.		
Examiner name (print)	**Examiner signature**	**Date**