

Revised February 2011

Ohio Protocol For Sexual Assault Foresnic and Medical Examination

Office of Healthy Ohio
Bureau of Health Promotion and Risk Reduction

Sexual Assault and Domestic Violence Prevention Program



Ohio Attorney General's Office
Bureau of Criminal Identification
and Investigation



Ohio Alliance to
End Sexual Violence



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Ohio Department of Health
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Ohio Protocol for Sexual Assault Forensic and Medical Examination

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Copies of all or part of this protocol can be mailed as an unbound copy upon request. Samples of forms and patient handouts can be adapted to include agency or community specific information. Contact staff listed above to receive Microsoft Word documents by e-mail or computer disk that will allow you to create the necessary documents. Copies of the protocol can be downloaded from the internet:

<http://www.odh.ohio.gov/odhPrograms/hpr/sadv/sadvprev1.aspx>

The Ohio Department of Health (ODH) is in the process of formalizing a permanent review committee to provide on-going revisions to the protocol, assist with implementation of the protocol, identify training needs and evaluate the effectiveness of the protocol. ODH is interested in learning what information in the protocol is useful and what additional information you would like to include in future revisions. Your feedback is an important and an essential part of making this protocol an effective tool. Your feedback will be provided to the review committee. Please submit your feedback to: BHPRR@odh.ohio.gov. Please put "Protocol for Sexual Assault" in the subject line.

Acknowledgements

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This revised protocol results from a review of the National Protocol for Sexual Assault Medical and Forensic Examination and best practices from other states and a number of experts throughout Ohio. ODH is grateful to all of these individuals who gave a considerable amount of guidance, time and effort in working to produce this Protocol. We believe this Protocol will enhance the ability of Ohio health care practitioners, along with the entire sexual assault response team to treat and support all survivors with a standard of care that is compassionate and consistent.

Individuals serving on the review committees for previous editions of the protocol are available upon request to ODH.

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Protocol For The Treatment Of Adult and Older Adolescent Sexual Assault Patients

Definitions

Sexual assault: For the purposes of this protocol, “sexual assault” encompasses a wide range of criminalized sexual conduct, including rape and sexual battery. Division (A) of the Ohio Revised Code (O.R.C.) section 2907.01 defines “sexual conduct” as “vaginal intercourse between a male and female; anal intercourse, fellatio and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening or another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.” This protocol doesn’t attempt to address the legalities of sexual assault; instead, sets forth the manner in which a health care provider is to approach the examination of an alleged sexual assault victim/patient while maintaining the dignity of the victim/patient and the integrity of the process. A list of ORC citations relevant to sexual assault can be found in Appendix 16 and at <http://codes.ohio.gov>.

The completed **Sexual Assault Evidence Collection Kit** is considered biological evidence, defined by the O.R.C. 2933.82(A) (1) (a) (i), and must be turned over to the law enforcement agency with jurisdiction where the crime occurred. Beginning in 2010, Ohio law specifies retention times for biological evidence. O.R.C. 2933.82(B). The best practice for all hospitals is to establish within the community Sexual Assault Response Team (SART) protocol an agreement with the county prosecutor and local law enforcement agencies regarding the storage and disposition of kits. A contingency plan for the handling of anonymous kits, and kits whose proper jurisdiction is unknown or is outside of the county should also be included in the SART protocol.

The following protocol was developed by the Ohio Department of Health in conjunction with: Ohio Attorney General’s Office, Bureau of Criminal Identification and Investigation, Ohio Chapter of the American College of Emergency Physicians, Ohio Chapter of the International Association of Forensic Nurses, Ohio Committee on Child Abuse and Neglect of the American Academy of Pediatrics, Ohio Chapter and other identified experts. The protocol is issued under the authority of the **Ohio Public Health Council**, which is charged by the Ohio General Assembly to establish procedures for gathering evidence related to sexual assault. O.R.C. 2907.29.

Policy

This protocol has been developed from the recommendations of Ohio experts based on best practices and the National Protocol for Sexual Assault and Medical Forensic Examinations. It is intended to be used by health care providers to ensure comprehensive care of sexual assault patients. Priority medical/forensic care is to be provided to the sexual assault patient with sensitivity, culturally appropriate and respectful manner regardless of when the sexual assault occurred. The type of care received will start her/him on the process of becoming a survivor.

If the examination occurs within 96 hours (four full days) after an attack, evidence should always be collected. There are cases in which evidence should be collected beyond 96 hours. Examples include cases where the victim/patient has been unconscious or sedentary, where the sexual assault is due to a cognitive disability and victim/patients are unable to give an accurate timeline or where an exam may corroborate chronic injury or excessive force related to the sexual assault. Clear documentation, specific to the case, as to the need for an examination beyond 96 hours must be made to justify the exam on the SAFE reimbursement request form.

Ohio has chosen to align with the National Protocol for Sexual Assault and Medical Forensic Examinations by recommending health care providers [physician, nurse practitioner or Sexual Assault Nurse Examiner (SANE)], with specialized education, training and experience in the evaluation and treatment of the sexual assault patients, complete the examination and provide treatment for this patient population.

Overarching Issues

1. Coordinated Team Approach

Ohio communities should ensure that all victims/patients have access to medical services, law enforcement, prosecutor and advocacy services. Use of a coordinated, multi-disciplinary approach in conducting the medical forensic examination can enable victims to gain access to comprehensive immediate care, help minimize trauma they may be experiencing and encourage the use of community resources. Such a response enhances public safety by facilitating investigation and prosecution; thereby, increasing the likelihood that offenders will be held accountable for their behavior and future sexual assault will be prevented. Raising public awareness about the existence and benefits of a coordinated, multi-disciplinary response to sexual assault may lead more victims/patients to disclose the assaults and seek the help they need for healing.

The Ohio Sexual Assault Task Force (OSATF) created a model community response protocol that is a template designed to define the different roles for the key responders making up the sexual assault community response team. Each community is unique and it is critical that each component be adapted by their local responding service providers.



In addition to establishing a local response protocol, communities are encouraged to implement a sexual assault response team (SART) to ensure a coordinated approach to this issue. Please refer to **Appendix 1 Model for Community SART Protocol** and **Appendix 2 Ohio SART Training Information**. The community protocol should clearly outline the abilities and responsibilities of each team member and their limitations in order to foster a cohesive and consistent team approach. Cross-training of all SART members is strongly encouraged. Understanding the importance and role of each member prior to the patient's arrival improves the overall response to the patient's needs. The community protocol should also address how disagreements between SART members are resolved to minimize the impact on the victim/patient.

In communities with both rape crisis based and prosecutor/law enforcement based victim advocates, it is best practice that the rape crisis center advocate respond at the hospital and make appropriate referrals to the prosecutor or law enforcement advocate if/when the victim/patient/survivor is engaged with the legal system. Guidelines on how the two organizations work together should be clearly written within the community response protocol.

2. Victim Centered Care

It is critical to respond to individuals disclosing sexual assault in a timely, culturally appropriate, sensitive and respectful manner. Every action should be taken by medical services, law enforcement, prosecutor and advocacy services during the exam helps facilitate the victim/patient's (hereinafter known as "patient") care and healing and/or the investigation (if the patient chooses to report to law enforcement).

Sexual assault patients should be viewed as "priority emergency cases" and be provided the necessary means to ensure patient privacy. The patient should be given priority for a room assignment in a private area. The medical or nursing examiner should recognize that every minute the patient spends waiting for a forensic medical exam there may be a loss of evidence and undue trauma.

As with all traumas, each individual has her/his way of coping in accordance to her/his cultural beliefs, values and norms. Sexual assault is certainly no different, and in the aftermath of an assault a patient may present exhibiting a wide range of emotions. Some patients may appear calm, indifferent, submissive, angry, uncooperative or even hostile to those trying to help. They may also giggle or laugh at seemingly inappropriate times. Because everyone reacts differently following a sexual assault, a victim should be allowed to express their emotions in a non-judgmental and supportive environment. It is vital that all first responders understand that there isn't any "right" or "wrong" way for a victim to respond following an assault. A patient's emotional reaction should in no way influence the quality of care given. How a patient presents emotionally at the hospital is in no way indicative of the degree of seriousness of the assault, nor should it be taken as evidence that an assault did or did not occur.

While reactions to a sexual assault may vary significantly for each individual, there are certain common feelings and fears that many patients face including:

- ✘ Fear of not being believed
- ✘ Fear of being blamed for the assault
- ✘ Fear that the offender may return and/or retaliate
- ✘ Fear of loss of support by primary caregiver or personal care attendant if either is the perpetrator
- ✘ Fear of unknown medical and/or criminal justice processes
- ✘ Fear of friends and family finding out
- ✘ Fear of being labeled a 'victim'
- ✘ Feelings of shame and/or embarrassment
- ✘ Feelings of guilt
- ✘ Feeling suspicious and/or hyper-vigilant
- ✘ Feeling unsafe or scared
- ✘ Feeling a loss of control

It is the duty and obligation of the responding medical, law enforcement, prosecutor and advocacy services (i.e., SART team members) to address these concerns in a way that is appropriate and respectful to the needs of the patient.

See [Appendix 3 for Ohio Crime Victim's Rights Handout and link to Picking up the Pieces document handed out by law enforcement.](#)

3. Sexual Abuse/Hospital Advocate/Support Person/Interpretative Services

In all instances the hospital or medical facility (hereinafter known as "hospital"), responding health care provider or SART coordinator shall immediately call a trained advocate from the local rape crisis center or victim/witness services to the hospital to meet with the patient. It is the responsibility of the hospital to identify the appropriate local advocacy center. If the hospital/clinic does not have local resources then staff should call in the hospital's social work personnel to work with the patient. The patient may also designate a friend, family member, someone from a place of worship or someone from her/his community as a designated support person.

The advocate/support person (hereinafter known as "support person") should be introduced to the patient. The support person will explain their role and the benefits of having additional support during the exam. The patient should be allowed to choose whether or not to speak with the support person. Having the support person present at



the hospital allows the patient more access to the resources and support offered by the local crisis center. Confidential patient record information should not be shared with the support person unless it is done so by the patient, thus avoiding any medical records confidentiality issues. Also, at any time throughout the treatment and evidence collection process, the patient should be asked if they would like to decline further interaction with the advocate/support person and/or request that person to leave.

There is no Ohio law that prohibits a patient from having a support person present during the medical/forensic examination or during the law enforcement interview. The hospital must request an interpreter be present, with prior notification to the patient to ensure communication access during medical services, law enforcement, prosecutor and advocacy services in the emergency department. The patient has the right to not utilize any sign language or foreign language interpreter and place a new request for an alternate interpreter due to genuine concerns in their translating ability or conflict of interest. Honor the patient's request by making necessary arrangements to contact the interpreting agency to secure another interpreter. It may take up to an hour before another interpreter arrives at the emergency department. The patient has a right at all times to determine who she/he would like present, including the interpreter during all stages of the medical and law enforcement interviewing process.

NOTE: If there is an indication that the assault took place in the context of a domestic violence situation and the suspected perpetrator is present, every effort should be made to assess and examine the patient without the suspected perpetrator in the room. The suspected perpetrator could be a primary caregiver (family and friends) or personal care attendant who provides daily living care services to people with disabilities, or adults in their senior years.

Rape crisis center's hospital advocates are specially trained to provide patients with free, confidential, non-judgmental, emotional support, information and resources so the patient can make informed decisions about their care and their reporting options following the exam. In accordance with the ODH Rape Prevention Program Standards, all advocates should complete 20 hours of initial sexual assault training, and have five additional hours of preparation via role-plays, observation of experienced advocates, and provision of medical advocacy while being supervised. The advocate must be familiar with the dynamics of sexual assault and relevant community resources, as well as how medical services, law enforcement, prosecutor and social services respond to patients of sexual assault. The advocate should receive training in the policies and procedures of the local hospital and a tour of their emergency department. All medical advocates should be supervised and evaluated by a coordinator at the local rape crisis center. **(See Appendix 1 Model for Community SART Protocol).**

Interpretative Services:

For communication access, either the hospital or SART coordinator should immediately request a sign language or foreign language interpreter if the patient utilizes American Sign Language or any other native language from her/his country of origin. The health care professional should respectfully inform the patient that a request has been made for interpretative services. It is important to directly inquire of any need for adaptive technology for patients with sensory, cognitive, developmental, and mental disability to ensure barrier-free access to medical services, law enforcement, prosecutor and advocacy services in the emergency department in compliance with the American Disabilities Act.

Patients Decline of Support Person or Interpretative Services:

If the patient chooses not to have a support person, the health personnel and law enforcement should repeat the offer to call a support person and/or interpreter periodically throughout the medical examination and law enforcement interviewing process.

The patient has a right to decline usage of a professional interpreter during medical services, law enforcement, prosecutor and advocacy services in the emergency department. To ensure communication access, confer with the patient as to the best communication method. Family or friends should not be used to provide interpretative services. Only a certified interpreter with extensive training and certification from a college and professional body can adequately facilitate communication between the patient and multi-disciplinary team in the hospital.

4. Minor Patient

Consent:

The minor patient does not need to have the written consent of a parent or legal guardian before proceeding with the examination. O.R.C. 2907.29. It is recommended that any patient age 15 and younger should be treated according to the Pediatric Sexual Abuse Protocol and in a pediatric facility. According to O.R.C. 2907.29, parents or guardian must be notified in writing after the exam. See **Appendix 4 Sample Notification Letter for Hospitals/Facilities** to send after examining a minor what parental consent.

In cases where the reported perpetrator is not the parent or guardian, it is recommended that the minor be encouraged to notify their parent or guardian at the time of the hospital/facility visit, if appropriate. Best practice is for medical personnel to advise the minor patient of the requirement to send the treatment notification letter to a parent or legal guardian and the approximate date when it will be mailed.

In cases where the alleged perpetrator is also the parent or guardian who will receive the notification, the county Department of Job and Family Services (JFS), law enforcement agency involved, and the minor child should all be advised of the nature of the notification letter and the approximate date when it will be mailed. Coordination with the county's JFS and Children Service Program must be done to insure the safety of the minor.

In cases of child sexual abuse, safety issues need to be considered before notifying the parent or guardian. Especially, if, in the opinion of medical personnel, such notification is likely to endanger or cause harm to the minor. When a minor is examined at the request of the county JFS, it shall be the responsibility and discretion of that department, to notify the parents/guardians who are the alleged perpetrators, while taking into account safety issues. Although the ORC and ODH adult sexual assault protocol state a minor's parent or guardian must be notified after a sexual assault/abuse examination, staff should follow directions given by local law enforcement and child protective services in cases where the suspected abuser is a parent or guardian.

The hospital is obligated under Ohio law (O.R.C. 2151.421) to report alleged or suspected sexual abuse of a minor whether or not the patient or their family chooses to speak with law enforcement. It is considered best practice that medical personnel **must** inform the minor patient they are legally mandated to report to law enforcement and/or JFS. **NOTE:** An adult may remain anonymous, but the sexual assault must be reported to law enforcement.

Personal health information concerning the sexual abuse and/or identity of the sexual assault patient shall not be given to the media or any other person(s) seeking information without the written consent of the patient or legal guardian.

Distinct Usage of the Adult Protocol:

This protocol can be used with a patient aged 16 and over with no cognitive disabilities. For the minor patient age 16 and 17 years old without cognitive disabilities, the health care professional will evaluate patient history to determine if the assault occurred more than 96 hours prior to the exam. If the assault occurred more than 96 hours, then the adult protocol cannot be used and the genital exams must be performed by an approved physician, advance practice nurse or registered nurse who is an expert in child sexual abuse. (**Appendix 5 Criteria for Ohio SAFE Program — Competency Requirements for Physicians conducting Child Sexual Abuse Evaluations**).

Parents or legal guardians accompanying the minor patients have a right to choose either pediatric or adult facility for exam or treatment.



It is recommended that patients under 21 years of age with cognitive disabilities be seen at a pediatric facility. However, parents or legal guardians accompanying the patients have a right to choose either pediatric or adult facility for exam or treatment.

Unwilling Minor:

If an unwilling minor is presented for a sexual assault exam by a parent or guardian, the exam should not be conducted unless the minor agrees to: submit to the exam without necessity of restraints or sedation; and after discussion with the health care provider who will be conducting the exam. If the parent or guardian presents a court order for a forceful examination, consult your hospital/facility legal counsel.

5. Reporting to Law Enforcement

Many sexual assault patients who come to hospital or other exam sites for a sexual assault examination choose to report to law enforcement. Reporting provides the criminal justice system with the opportunity to offer immediate protection for the victim, collect evidence from all crime scenes, investigate the case, arrest a suspected offender and prosecute if there is sufficient evidence. All patients 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. Additionally, patients need to know law enforcement cannot mandate or request they take a polygraph, voice stress analyzer, or other truth telling test as a precursor to taking a report and conducting a thorough investigation. O.R.C. 2907.10.

Regardless of the adult patient's decision to report, it is the responsibility of medical personnel to inform the patient that law enforcement must be notified that a sexual assault has been reported to the hospital in accordance to the O.R.C. This should be done after the patient has been deemed medically stable. The law, O.R.C. 2921.22(A) and (B), does not require that the adult patient's name be given, but states that any person knowing that a felony has been or is being committed shall report it to law enforcement authorities.

6. Anonymous Reporting Procedure

Medical personnel and/or hospital support person should inform the adult patient of her/his right to decide whether or not to speak to law enforcement personnel. If the patient decides not to report the sexual assault, the hospital/facility may simply provide the date and general location of the assault to the law enforcement agency having jurisdiction without giving the patient's name, address or other identifying information.

The best time for the individual to make the decision to report to law enforcement may not be immediately after the assault. The final decision to report can be deferred, but

the evidence collection, generally speaking, cannot. Recognizing the dual importance of being sensitive to the needs of the patient and the timely collection and preservation of evidence, the anonymous reporting procedure was developed. Patients may maintain their anonymity from law enforcement until such time as they decide to report the crime.

The evidence is collected in accordance with the *Ohio Department of Health Protocol for The Treatment of Adult Sexual Assault Patients* (Fifth Edition, 2011), except that the identity of the patient is not documented on any specimens or paperwork provided in the Sexual Assault Evidence Collection Kit. The following unique identification number is created and used in place of the patient's name on all specimens and paperwork: patient's birth date plus the last four digits of the medical record. (e.g., May 23, 1963 and the last 4 numbers of the medical record 1234 – 052319631234). Hospitals and facilities may create their own system.

The anonymous kit is considered biological evidence (defined by O.R.C. 2933.82 [A]) and is to be kept in locked storage and turned over to the law enforcement agency with jurisdiction where the crime occurred. (See definitions, *Sexual Assault Evidence Collection Kit*, page 1). Beginning in 2010, Ohio law specifies a retention time for biological evidence, although anonymous kits are not specifically addressed. The best practice is for the hospital to establish an agreement with the county prosecutor and local law enforcement for handling anonymous kits that is part of the local community protocol. A contingency plan for handling anonymous kits whose proper jurisdiction is unknown or is outside of the county should be included in the local protocol.

The anonymous patient ultimately **chooses whether or not to report** the crime to law enforcement. The patient is provided information about this option both verbally and in writing before the consent for an anonymous kit collection can occur.

The anonymous patient will have received upon hospital discharge the kit's unique identification number recorded on the consent form to be stored with the medical record. This will be recorded on the after care information handouts. **Appendix 6**. The patient will then provide their unique identification number to law enforcement so the evidence may then be associated with the reporting victim. At this time, an investigation of the crime, including the examination of the evidence, may commence. Additionally, the anonymous patient is informed about the retention time established in the agreement with the county prosecutor and local law enforcement and found in the local community protocol.

An Anonymous Kit cannot be completed by anyone under the age of 18.

As part of developing a community sexual assault response protocol, the SART must include this as one of their procedure. Each community may expand the number of days a collected kit will be stored (e.g., ninety days, twenty years), but it cannot be less than sixty days.

Operational Issues

This protocol is to be used by health care providers to ensure comprehensive care of adult sexual assault patients across the state of Ohio. The findings in the exam and collected evidence provide information to help reconstruct the details about the events in question in an objective and scientific manner. A timely, effectively performed medical forensic examination can potentially validate and address the patients' concern regarding a sexual assault while minimizing the trauma. At the same time, it can increase the likelihood that evidence collected will aid in criminal case investigations, resulting in sex offenders being held accountable and ensuring effective justice for all Ohioans.

Priority medical/forensic treatment and provision of care to the adult sexual assault patients should always be given regardless of when the sexual assault occurred. If it is within 96 hours (four full days) after an attack, evidence should always be collected on an adult. Research and evidence analysis indicates that some evidence may be available beyond 96 hours after the assault. Decisions about whether to collect evidence should be made on a case-by-case basis, guided by the knowledge that outside time limits vary due to factors such as the location of the evidence and type of sample collected. Cases in which evidence should be collected beyond 96 hours occur where an exam may corroborate chronic injury, excessive force or significant trauma. The examiner must provide written justification for evidence collected beyond 96 hours in order to receive payment for the examination through the SAFE program.

1. Facilities

The Joint Commission requires emergency and ambulatory care facilities to have established policies for identifying and assessing possible patients of rape and other sexual molestation. It also requires staff to be trained on these policies. As part of the assessments process, JCAHO requires facilities to define their responsibilities related to collection and preservation of evidentiary materials. Sexual assault examiner programs are helping many health care facilities to carry out these requirements. Facilities should also familiarize themselves with the Federal Emergency Treatment and Active Labor Act (EMTALA), which requires hospitals to provide a medical screening examination to anyone who comes into the emergency department to determine whether an emergency condition exists. Facilities should also be familiar with the O.R.C. sections 2907.27 - 2907.30, 2921.22 and 2151.421 Medical Assistance to Victims of Sexual Assault.

Factors the site and community SART should address in their local protocol:

- ✘ Safety and security for patient and staff.
- ✘ Physical and psychological comfort of patients.
- ✘ Capacity with adaptive technology and appropriate medical equipment (such as height and width of examining table for individuals with mobility disabilities) to ensure barrier free access for patients with disabilities.
- ✘ Availability of examiners with advanced education and clinical experience.
- ✘ Access to pharmacy for medications.
- ✘ Access to medical support services for care of injuries.
- ✘ Access to lab services.
- ✘ Access to equipment and supplies needed to complete the exam (e.g., sexual assault evidence collection kit, new replacement clothing, digital camera).
- ✘ Access to community, state and national resources to address aftercare, including emotional and psychological needs.
- ✘ Ability to maintain confidentiality amongst staff members and the SART members who are directly involved with the evidence collection, investigation and medical care of the victim. The facility should maintain a “no information” policy when dealing with the members of the media.
- ✘ Ability to maintain “chain of custody” of evidence which includes a locked storage area if police are not immediately available to pick up the evidence.
- ✘ Use of written community protocol outlining (i.e., SART) a coordinated multi-discipline response to the survivor that includes law enforcement, rape crisis advocates, prosecution and other community organizations.
- ✘ Use of a written agreement as part of the community protocol with the county prosecutor and local law enforcement agencies regarding the storage and disposition of both sexual assault evidence collection kits that are labeled with the survivor’s name or with an anonymous identification code.
- ✘ Ability to implement quality improvement measures to identify, evaluate, resolve and monitor actual and potential problems in the multi-disciplinary response to the patient, exam process, investigation and prosecution outcomes. **(See Appendix 7 for Sample Quality Assurance Tools).**

2. Protocol Coordinator

Effective January 1, 2012, each facility must designate at least one licensed medical professional who is a full time employee (e.g., Emergency Department Director, Head nurse, SANE Nurse). This person has training on the Ohio Protocol for Sexual Assault Forensic and Medical Examinations (Third Edition) to assume responsibility for:

- ✘ Acting as an official representative and facility liaison in communicating and working collaboratively with the Ohio Attorney General's Office, ODH and other local and state community organizations (e.g., local Rape Crisis or Domestic Violence Shelter, Ohio Alliance to End Sexual Violence).
- ✘ Acting as an official representative and facility liaison with the Ohio Attorney General's Office for filling out and responding to questions regarding the SAFE reimbursement form.
- ✘ Acting as an official representative who is familiar with all submitted sexual assault cases.
- ✘ Monitoring facility services to improve the quality of patient care and to assure that the services used to conduct the Ohio Protocol for Sexual Assault Forensic and Medical Examinations are provided in a safe and efficient manner. (See Appendix 7 for sample Quality Assurance Tools).
- ✘ Maintaining quantitative and qualitative case review of staff conducting the sexual assault and medical examinations that includes patient and local SART feedback.
- ✘ Assuring that staff conducting the sexual assault and medical examinations are trained on the protocol and are keeping within federal and state laws, rules, regulations, policies and procedures.
- ✘ Ensuring law enforcement has received the Sexual Assault Evidence Collection Kit.

3. Training

It is critical that health care providers conducting the sexual assault medical forensic exam are committed to providing compassionate and quality health care, collecting evidence in a thorough and appropriate manner and testifying in court, if needed. Their commitment should be grounded both in an understanding that sexual assault is a serious crime that can have a profound, negative effect on those victimized and in recognition of the role of advanced education and clinical experience in building competency to perform the exam. ODH recognizes that the sexual assault medical forensic examinations are complex and time-consuming procedure and recommends that health care providers, ideally SANEs, performing the exam have specific knowledge and skills that can guide them through these exams. **Appendix 8 identifies the National Protocol for Sexual Assault Medical Forensic Examination: Adult/Adolescents recommended examples of specific knowledge skills and attitudes that are beneficial for health care conducting the exam.**

A SANE is defined as an RN with specialized training that meets the International Association of Forensic Nursing (IAFN) standards for adult/adolescent patients and, if appropriate, pediatric patients. A SANE provides comprehensive care to sexual assault survivors, demonstrates competency in conducting a forensic exam to include evaluation for evidence collection, has the expertise to provide effective courtroom testimony and shows compassion and sensitivity to survivors of sexual assault.

4. Equipment and Supplies

The health care examiner should have knowledge necessary to properly use all equipment and supplies required during the exam including medication. Additionally, it is important that the examiner and the responders involved in sexual assault cases stay abreast of the latest research on the use of equipment and supplies.

The following equipment and supplies should be readily available for the exam:

- ✘ A copy of the Ohio Protocol for Sexual Assault Forensic and Medical Examination.
- ✘ Standard exam room equipment and supplies for physical assessment and evidentiary pelvic exam. The needs for patients with disabilities must be taken into account to ensure barrier-free access to medical services. Related supplies might include tweezers, tape, nail clippers and scrapers, scissors, dental floss, collection paper, saline solution or distilled water, extra swabs, slides, containers, paper bags and pens/pencils.
- ✘ Comfort supplies for patient, even if minimal. Suggested items: clean and ideally new replacement clothing, toiletries, food, drink and access to a phone in as private a location as possible. It is also important during the exam process to help the patient obtain items they request related to their spiritual healing (e.g., Bible, Koran, a religious or spiritual leader) before, during or after the exam.
- ✘ ODH sexual assault evidence collection kit or other kit that meets the standards of the ODH sexual assault protocol and the specification of the ODH kit. (See Appendix Recommended Sexual Assault Kits).
- ✘ 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. The ODH kit's design also aids in the drying process.
- ✘ A camera and related supplies (using the most up-to-date technology possible) for forensic photography during the initial and follow-up examinations. Related supplies might include film, batteries, a flash and an inch scale or ruler for size reference. (See Protocol Section VI Evidence Integrity).

- ✂ Testing and treatment supplies needed to evaluate and care for the patient medically (follow exam facility policies). Also, testing supplies may be needed for forensic purposes that are not included in the evidence collection kit (e.g., supplies for toxicology).
- ✂ An alternate light source (using the most up-to-date technology possible) can aid in examining patients' bodies, hair and clothing. It is used to scan for evidence such as dried or moist secretions, fluorescent fibers not visible in ambient light and subtle injuries.
- ✂ A locked storage area if police are unavailable to pick up the evidence immediately (e.g., file cabinet). **Do not store kit or clothing in the refrigerator.**
- ✂ An anoscope may be used in cases involving anal/rectal trauma.
- ✂ A colposcope with photographic capability and/or other type of digital technology. Although injuries can be detected visually by examiners without a colposcope and/or digital technology, it is an important asset in the identification of microscopic trauma. Photographic equipment, both still and video can be attached for forensic documentation.

Protocol Procedure:

Section I: Intake and Triage

Upon arrival to the hospital, the sexual assault patient should be viewed as a priority patient and given immediate privacy in a designated area. This patient should be seen by hospital personnel within 15 minutes of arrival or as soon thereafter as possible. Hospital personnel should immediately implement the following protocol:

- ✘ Give priority for room assignment in a private area as well as a waiting area for family members, friends and law enforcement interviews.
- ✘ Elicit sufficient information to complete the hospital registration process quickly and in private, if possible.
- ✘ Respond to acute injury, trauma care and safety needs of the patient before collecting evidence.
- ✘ Instruct the patient to not use bathroom facilities, wash, change clothes, smoke, drink or eat until initially evaluated by a forensic examiner, unless necessary for treating acute medical needs. If use of the bathroom is necessary, the patient should be informed that evidence may be present in the genital and anal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.
- ✘ Collect urine specimens immediately if there is any indication of drug-facilitated sexual assault. (**See Appendix 9 DFSA Protocol**).
- ✘ Maintain hospital policy stipulating who will be notified immediately when a sexual assault patient presents in the emergency department. If there is no SANE program in place, then the hospital must designate a specialist with training in the sexual assault protocol to coordinate services to the patient. If there is a SANE program available in the community the patient should be given the option of going to that facility. (**Note:** if patient chooses to go to SANE facility a brief examination should occur ensuring that the patient has no emergent medical needs in order to ensure compliance with EMTALA regulations). ***This initial exam is not billable to the SAFE program.***
- ✘ Immediately call a hospital advocate from the local rape crisis center to come to the hospital and meet with the patient. If the hospital area does not have access to a local rape crisis program then someone from the hospital's social services shall be called to provide support. **See Overarching Issues, 2. Sexual Abuse/Hospital Advocate/Support Person page.**
- ✘ Assess and respond to safety concerns such as threats to patients and staff, upon the patient's arrival at the exam site.
- ✘ Assess patient's need for immediate medical or mental health intervention.
- ✘ Ensure that emotional support is also offered to the patient's family and/or friends who are present.

Section II: Informed Consent for Examination and Release of Evidence.

The protocol requires you to seek both verbal and written consent of the patient prior to conducting the medical evaluation, medical treatment and evidence collection, and releasing information and forensic evidence to the law enforcement agency. Informed consent should be an on-going educational process throughout the exam. Additionally, under Ohio law, (ORC 2907.29), all patients reporting a sexual assault must “be informed of available venereal disease, pregnancy, medical and psychiatric services.” The “Consent for Exam and Release of Evidence” form is provided in the Sexual Assault Evidence Collection Kit, and a copy can be found in **Appendix 10**.

To begin the informed consent process, medical personnel should provide the “Information You Should Know As A Survivor of Sexual Assault” handout from the ODH Sexual Assault Evidence Collection Kit to the patient. **See Appendix 6.**

Throughout the forensic exam, the procedures should be fully explained so the patient understands what is being done and why. The patient should be encouraged to ask questions and be informed of her/his right to withdraw consent at any point during the exam. If the patient expresses resistance to the procedure, the medical examiner should immediately discontinue that portion of the exam and consider going back if the patient agrees. If the patient is under guardianship and the guardian wants the exam to proceed but the individual expresses resistance to the procedure, consult your hospital/facility’s legal counsel.

Note: If the patient withdraws consent of any portion of the exam this should be documented fully on the forensic collection envelop label.

Hospitals should follow their usual procedures for obtaining consent for all tests and treatment necessary outside the forensic exam including extraordinary cases, e.g. for severely injured or incoherent patients.

Any personal health information concerning the sexual abuse and/or identity of the sexual assault patient shall not be given to the media or any other person(s) seeking information without the written consent of the patient or legal guardian.

Patients who do not want to file police report (must be 18 years or older)

If the patient declines consent for the evidence collection, even after being presented with the anonymous reporting option (see Overarching Issues, 6. Anonymous Reporting) they should be examined for injuries and other medical concerns such as possible pregnancy and exposure to HIV/AIDS and other sexually transmitted infections. This examination is the financial responsibility of the patient and they should be so informed. If the patient is uninsured and unable to pay for this treatment, a referral to an appropriate health facility or clinic should be made for follow-up care.

If, once all options have been explained, the patient declines to report the sexual assault to law enforcement, or to participate in future possible prosecution, this decision should be respected. The individual will benefit from making the decision and regaining a sense of control.

Anonymous Kit Consent (patients must be 18 and older)

If the patient requests an anonymous kit, she/he should be advised a de-identified kit with a unique identification number will be given to law enforcement where the crime has occurred. This kit will be locked in storage. Assure the patient that the kit will be completely de-identified and no photos will be turned over to law enforcement until permission is given by them.

The patient should be told she/he will be provided with the kit's unique identification number at the end of the evidence examination. Assure the patient that she/he ultimately decide to make a report to law enforcement. She/He will need to provide the law enforcement agency with this number so the evidence may then be associated with their case. Additionally, the patient should be informed about the retention time established in the agreement with the county prosecutor and local law enforcement and found in the local community protocol.

Section III: Patient Medical History/Assault/Abuse History Assessment (including domestic violence assessment)

1. Documentation

Healthcare professionals should write objective information only relating to treatment needs of the patient and not make judgments about "emotional state." In collecting patient demographic, any documentation on classification of disability, whether observed or self-reported, needs to be discussed and clarified with the patient in a respectful manner with appropriate usage of Persons First Language. The patient has the right to choose to self-disclose and reinforce preferred self-identification in regards to their intellectual, emotional, mental, and physical status.

Healthcare professionals should quote the patient using only the exact statements given. Do not paraphrase or clean up language. Do not make judgments or statements about whether or not the rape or sexual assault occurred. Use terms such as "reported" or "stated" rather than "alleged," "probable," or "possible." This is necessary to maintain neutrality of documentation. Remember 'rape' is a legal conclusion.

All written information must be legible and in ink. There should be documentation if a medical interpreter was used, including name of the interpreter and language used (e.g., American Sign Language, Spanish, Somali, Russian, etc. . .).

2. Special Considerations

Depending upon the type of sexual assault, semen may be present in the mouth, vagina/penis and anal area. However, embarrassment, trauma or a lack of understanding of the nature of the assault may cause a victim to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus, even without anal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them. In cases where a patient insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), a complete examination should still be requested of the patient. At a minimum, external anal swabs only need be collected during the genital exam. However, ultimately the patient may decline to have swabs collected.

This “right to decline” serves to reinforce a primary therapeutic principle — that of returning control to the patient who has been victimized. If the patient declines a step, this should be properly documented on the evidence collection envelope to ensure hospital compliance with the protocol and eligibility for reimbursement.

3. Patient Medical History

Obtain patient’s medical history. A sample medical history form for collecting this information is provided in **Appendix 11 Sample Forms**. Alternately, hospital triage forms which cover the following items may be used in its place.

1. Patient demographic and personal information.
2. Other individuals accompanying the patient.
3. Vital signs (as warranted).
4. Allergies.
5. Last tetanus.
6. Current medications.
7. Acute illnesses.
8. Past surgeries.
9. Last menstrual period.
10. Gravida.
11. Para.
12. Contraception used.
13. Approximate weight/height.
14. Family physician.
15. Gynecologist.
16. The names of medical health care providers performing the exam should be noted on the medical history form.

4. Patient Assault/Abuse History

The sexual assault history must be documented in duplicate on the form provided in the Sexual Assault Evidence Collection Kit. The original should be retained with the medical record. The copy goes to the forensic lab with the Sexual Assault Evidence Collection Kit. If any additional copies are needed they will need to be copied by the hospital.

See recommended form in Sexual Assault Evidence Collection Kit; a copy can be found in Appendix 10. *A medical form which covers the following items may be used in its place.*

1. Time, date and place of the assault.
2. Date and time of the exam.
3. Sex, number and relationship of assailant(s), if known.
4. Was the assailant injured or bleeding?
5. Type of penetration, if any.
6. Indicate places on the body that were kissed, bitten, licked, sucked or any other oral contact.
7. Did assailant use lubrication such as saliva on any part of the body?
8. Did the patient douche, change clothes, bathe, urinate, defecate, vomit, brush teeth, rinse mouth, etc. since the assault?
9. Was patient menstruating at time of assault? At time of exam?
10. Was a tampon present at time of assault? At time of exam?
11. Was a condom used?
12. Has there been consensual sexual activity within 96 hours?
13. Narrative history (as described by the patient):
 - ✘ The narrative history is documented in direct quotations from the patient. Use only objective data. Along with the verbal medical history, document the objective data that is observed such as poor eye contact, inability to hold attention, loud speech, crying, etc. Record the patient's description of the assault. Do not record your subjective observations.
 - ✘ Print or write legibly as this information is critical to the investigation.
 - ✘ Type of weapon used, if any.
14. Description and condition of clothing (e.g. torn, dirty, bloody, etc.)

5. Assessment of Intimate Partner Violence Screening

Intimate partner violence (IPV), (also known as domestic violence), is a significant, preventable public health problem that impacts at least 32 million Americans each year. IPV occurs when physical, sexual or emotional injuries are intentionally inflicted by a current or former partner. Forms of IPV include sexual assault, rape and stalking. IPV can impact heterosexual and same-sex couples; teens and adults. Previous studies indicate that as many as 50 percent of adult women screened in an emergency department setting had been patients of IPV and 38-46 percent of adolescents report abuse from an intimate partner.¹

The Partner Violence Screen², developed and validated for use in emergency departments, is an efficient screening tool for interpersonal violence. This tool, or a similar series of questions, may be used to determine if the patient or patient's family would benefit from resources to support patients of IPV.

Partner Violence Screen

1. Have you been hit, kicked, punched, choked or otherwise hurt by someone in the past year?
 Yes No
If so, by whom?
 Person in current relationship
 Person from previous relationship
 Someone else
2. Do you feel safe in your current relationship?
 Yes No Currently not in a relationship
3. Is there a partner from a previous relationship that is making you feel unsafe now?
 Yes No

It is important that your questions about IPV not put the patient at increased risk for harm. Therefore, questions should be asked privately, away from a potential abuser (partner, family member, friend, primary caregiver, or personal care attendant) or anyone who may reveal your patient's answers to an abuser. You must make resources regarding domestic violence shelters available to the patient. If the patient desires to return home in spite of IPV, provide information regarding a safety plan before discharge. Be respectful of patient's decision to return to the abusive situation. She/He is the only person who can determine their safety.

Resources:

National Domestic Violence Hotline: 800-799-SAFE (800-799-7233)
National Network to End Domestic Violence: 202-543-5566
Ohio Domestic Violence Network: 800-934-9840
ACTION OHIO Coalition for Battered Women: 888-622-9315

Written Information:

List of Ohio Domestic Violence Shelters:

<http://www.actionohio.org/dvshelter.htm>

Safety Plan:

http://www.ncadv.org/protectyourself/Safety_Plan130.htm

Teens Health: Abuse:

<http://www.teenshealth.org/teen>

Section IV: Evidence Integrity

Maintaining the chain of custody (or chain of evidence) is as important as collecting the proper evidence. The custody of the evidence in the collection kit, as well as any clothing or other collected items must be accounted for from the time it is initially collected until it is admitted into evidence at a trial. Complete documentation is also essential and must include the signature of everyone who has had possession of the evidence from the health care professional who collected it to the individual who brings the evidence into the courtroom.

- ✘ If this proper chain of custody is not maintained, the evidence may be inadmissible.
- ✘ Maintaining the chain of custody is critical to prevent any possibility of evidence tampering and deterring defense counsel from raising the issue of reasonable doubt on the basis of evidence integrity.
- ✘ Both signatures of the chain of evidence document are necessary for any transfer—one from the person releasing the evidence and the second from the person receiving it.

It is very important to follow the directions provided in the Sexual Assault Evidence Collection Kit and to maintain the chain of custody. Follow the Procedure for Evidence Collection **checklist (18 steps) found in Appendix 10 and the Detailed Instructions for the ODH Sexual Assault Evidence Collection Kit in Section V** which follows this section. These instructions are also included in the evidence collection kit.

- A. The medical examiner must adhere to all written and or accepted workplace protocols regarding the collection of sexual assault evidence collection and maintaining chain of custody.
- B. The medical examiner must complete and sign the forensic laboratory chain of custody collection form included in the sexual assault evidence collection kit.
- C. All evidence collected is the property of law enforcement. Once the evidence collection forms and kit have been completed, they should be handed over to law enforcement.

Community sexual assault protocols should specify procedures for handing over of evidence. This may include using Fed-Ex services and requiring a signature by the local law enforcement as receipt of delivery from the hospital.

See Appendix 1 for Model Community SART Protocol.

- D. If the police are unavailable to pick up the evidence, the medical examiner must place it in a locked storage area, preferably with signed access. **(Do not refrigerate kits).** When the police arrive, the examiner can sign for the stored evidence and personally hand it to law enforcement personnel.
- E. All photographs should be taken by a forensically trained medical staff or law enforcement photographer. If a law enforcement photographer is not available, photos should be taken by a trained forensic staff member or forensic nurse.

Close-up photos should be taken of the patient's face and trauma areas with a measuring device to document the size of the injury (cut, bruise, scratch, etc.). The photos should be identified (labeled) with the patient's name, hospital/facility number and date. It is recommended that genital photos be taken when indicated by trained forensic staff members or the forensic nurse.

The law enforcement photographer is responsible for documenting the patient's face and full body photographs. Forensically trained medical staff is responsible for photo documentation of any evident trauma including genital photographs.

Two sets of photos are recommended. Both sets remain with the medical records unless a law enforcement agency requests the trauma photos for their files. One set should be given to the law enforcement agency with a proper release form.

- F. The law enforcement agency may ask for additional tests and/or specimens. As with all tests, the patient's consent must be obtained if any such additional tests are performed or specimens taken.

Section V: Medical Considerations and Testing

Each patient should be assessed and treated as a unique individual. The following tests should be discussed and recommended based on the patient's needs. As with all patients, note all treatments given and any tests completed in the Patient Medical Record.

1. Suspected Drug Facilitated Rape/Toxicology Blood/Urine – See Appendix for Drug Facilitate Sexual Assault Protocol

- A. There are a number of ways in which the use of alcohol or drugs may contribute to an act of sexual assault. The substance most frequently involved in sexual assaults is alcohol, something the victim may consume voluntarily. Increasingly, cases have



been reported in which the perpetrator surreptitiously administers a drug to the victim, most often through adding it to a drink, in order to incapacitate her/him so that she/he is unable to prevent the assault. There are several dozen different drugs which are known to be used for this purpose.

- B. The medical personnel conducting the exam should assess the assault history to determine whether any indicators of drug impairment exist (see following list of symptoms). Ideally, the patient should not urinate until after the evidence has been collected. Since these drugs can metabolize very quickly, the timeliness of the specimen collection is important. The sooner a urine specimen is obtained after the assault, the greater chance of detecting drugs.
- C. If the patient presents with any of these symptoms please refer to **Appendix 9: Drug Facilitated Sexual Assault Protocol**:
 - 1. Confusion
 - 2. Decreased heart rate
 - 3. Dizziness
 - 4. Drowsiness
 - 5. Impaired judgment
 - 6. Impaired memory
 - 7. Lack of muscle control
 - 8. Loss of consciousness
 - 9. Nausea
 - 10. Reduced blood pressure
 - 11. Reduced inhibition

References:

Nora Fitzgerald and K. Jack Riley, Drug Facilitate Rape: Looking for the Missing Pieces, National Institute of Justice Journal, April 2000.

<http://www.ncjrs.gov/pdffiles1/jr000243c.pdf>

Marc LeBeau, et al, *Recommendations for Toxicological Investigations of Drug-facilitated Sexual Assaults*, Journal of Forensic Sciences, Volume 44, pages 227-230, 1999.

Marc LeBeau, *Toxicological Investigations of Drug-Facilitated Sexual Assaults*, Forensic Science Communications, Volume 1 Number 1, April 1999.

<http://www.fbi.gov/hq/lab/fsc/backissu/april1999/lebeau.htm>

2. Sexually Transmitted Infections

Contracting Sexually Transmitted Infections (STIs) also referenced as Sexually Transmitted Diseases, from an assailant is a typical concern of sexual assault patients. The health care providers must offer and encourage prophylactic treatment at the time of the exam. It may reduce the need for more expensive/extensive treatment than if the STI is discovered at a later time.

When using the adult protocol, testing for STIs is not recommended. Medical personnel must offer all patients information about the risks of STIs including: gonorrhea, Chlamydia, trichomonas, syphilis, HIV and hepatitis with consideration on presenting information in a visual manner for full comprehension. The information should include: what to do if the symptoms occurs after the exam and referrals to free and low-cost testing, counseling and treatment within their community

When the patients is offered prophylactic treatment by the health care provider, the patient should be aware of the benefits and consequences of taking prophylactics against STIs and be able to make their own decisions about treatment. Prophylactic treatment should be based on current guidelines from the Centers for Disease Control and Prevention (CDC) online at <http://www.cdc.gov/std> or by calling 888-232-3228.

If the patient declines prophylactic treatment at the time of the initial exam, document the patient's decisions and rationales in their medical record.

Although the patient may be reluctant to go for follow-up exams for STIs, such exams are essential. 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. The CDC recommends a follow-up appointment within one to two weeks of the assault. In some communities the support personnel may be available to accompany patients to these follow-up appointments.

A. Hepatitis B virus (HBV) and Postexposure Prophylaxis

See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunization, prevaccination antibody screening, postexposure prophylaxis and special considerations. Centers for Disease Control and Prevention (CDC) online at <http://www.cdc.gov/std> or by calling 1-888-232-4636.

Medical personnel must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Support personnel should also be educated about the possibility of patients receiving prophylaxis HBV and encourage those who start the vaccine regimen to follow-up for required additional doses.

B. Risk for Acquiring HIV Infection

Medical personnel must discuss with the patient their concerns regarding the possibility of contracting HIV. As with other STIs, patients should be offered information about HIV risks, symptoms and the need for immediate examination if the symptoms arise. HIV/AIDS testing must be discussed including the difference between anonymous and confidential testing. Local referrals for testing and counseling should be provided. The statewide AIDS/HIV/STD hotline can provide a listing of local HIV/AIDS test sites. Their telephone number is 1-800-332-2437. More information about the hotline can be found in **Appendix 12**.

Given the special circumstances pertaining to HIV Post-Exposure Prophylaxis (PEP), further information and a suggested algorithm are included in **Appendix 12**.

Additional information is available from the CDC online at <http://www.cdc.gov/std> and the PEpline on-line at: http://www.nccc.ucsf.edu/Clinical_Resources/PEPGuidelines.html

C. Resources for HIV and Hepatitis B and C

National Perinatal HIV Consultation and Referral Hotline: 888-488-8765

National HIV Telephone Consultation Service: 800-933-3413

National Clinicians' Post-Exposure Prophylaxis Hotline for HIV and hepatitis B and C (PEpline) 888-488-4911

3. Emergency Contraceptives

In accordance with O.R.C. 2907.29, medical personnel **must** discuss and offer all legal options for possible pregnancy, including emergency contraception with all (female) patients of child-bearing age who have not had a hysterectomy or permanent sterilization. Information should be given to the victim about the risks as well as the medications that can be taken to help prevent pregnancy. This emergency contraception information must be provided as an important part of the treatment and healing process for the patient. Treatment is at the discretion of the authorized health care provider with the permission of the patient.

Emergency prophylactic treatment should be based on current medical practice, which is available online at <http://www.cdc.gov>. Emergency prophylactic treatment should be started within 72 hours for the best chance of working but can be started up to 120 hours (5 days) afterward and still be effective. Medical personnel should inform the patient that some medications may lessen the effectiveness of emergency contraception and determine if the patient is taking such medication.

If the patient wishes to receive emergency contraception, and the institution or physician is precluded from providing it, a referral **must** be provided to the patient and available within 72 hours after the assault occurred to another physician, health care institution or agency. Refer to **Appendix 13** for patient information regarding emergency contraceptive.

Section VI: Post Examination Information

Medical personnel have important tasks to accomplish prior to discharging the patient, as do hospital advocates/support person and law enforcement (if patient has requested involvement). The responding medical, legal, and advocacy services (i.e., SART team) should coordinate their activities as much as possible to reduce the repetition and avoid further overwhelming the patient. These activities should be part of the community sexual assault protocol.

1. Medical Personnel

Medical personnel, preferably the examiner should address issues related to medical discharge and follow-up care. The medical personnel should check all forms for completeness of information and signatures. Procedures for handling the paperwork should follow the policies of the protocol and medical facility.

- A. Make sure patients medical and mental health needs related to the assault have been addressed. Instruct the patient on the importance of medical follow-up. Give patient the telephone number of a local rape crisis center and/or counseling agency(ies) which can provide follow-up services related to the sexual assault.
- B. Let the patient know that neither she/he nor her/his insurance company should be billed for the evidence collection or the cost of any antibiotics administered as part of the examination. She/he may be billed for other associated medical care provided (i.e., emergency contraceptives, blood work, x-rays). Any of these costs, if not covered by insurance, may be covered by the Victims of Crime Compensation Program.
- C. Make a referral available to provide emergency contraception to patient within 72 hours after the assault occurred if the facility cannot provide this on site.
- D. Provide the patient with the completed "After Care Information for Sexual Assault Survivor" handout (patient discharge information) along with the "Common Reactions and Follow up Services for the Sexual Assault Survivor" handout. Note all referrals, treatment received and medication doses to be taken on the "After Care Information" handout. She/he should also be given a verbal explanation of the after care instructions and offered a final opportunity to explore any acute concerns prior to discharge. If the patient is admitted to the hospital, both pages are to remain with her/him. (See **Appendix 6 Patient Handouts**).

- E. Assist Anonymous Reporting patient with the procedure for reporting to law enforcement. Show the patient where their sexual assault collection number is located on the “Follow-up Services for the Sexual Assault Survivor” handout. Reinforce the retention expiration date for their kit. This date should also be placed on the “Follow-up Services for the Sexual Assault Survivor” handout.
- F. Assist the patient with follow-up medical and mental health appointments for the patient to document developing or healing injuries and complete resolution of healing. Appointments may also be needed to address on-going medical concerns. If appointments are not scheduled, at least indicate which appointments are needed on the “After-Care Information” form. Make it clear that patients do not have to disclose the assault to receive follow-up medical care. Follow-up appointments may include:
 - ✘ Locations for follow-up tests and treatment for syphilis, gonorrhea, chlamydia and hepatitis. Be sure the patient understands that no tests have been given and they need to arrange for follow-up testing.
 - ✘ Locations for anonymous HIV/AIDS testing in three and six months.
 - ✘ Contacting law enforcement or rape crisis center if additional bruises appear and new photographs and documentation must be done.
- G. Document that a safety plan has been developed for patient at discharge. Safety planning can be done with the hospital advocate or the hospital social worker.

2. Hospital Advocates/Support Person, Law Enforcement, Victim Witness Advocates and Other SART Representatives

Involved SART team members should come to agreement about who is responsible for the following steps. This should be written in the community protocol.

- A. Help patients plan for their safety and well-being. Assist the patients in considering things such as:
 - ✘ Where are they going after being discharged? With whom? Will these individuals provide them adequate support? Is there anyone else they would like to contact? (Provide information about available community resources and write down on the After Care Form. Help the patient make contact if needed).
 - ✘ Do they need transportation?
 - ✘ Will their living arrangements expose them to 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 patient with physical disabilities requires shelter, the shelter must be accessible and staff able to meet their needs. If there is a need for a personal care attendant to support daily living needs and activities at a shelter, its important involve the patient in the process of contacting a disability-related community resource to assist with this. The patient has a right in their choice that they feel safe with a personal care attendant while returning home or going to a shelter. If a patient was living in an institutional setting has been assaulted by another resident, staff person or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that the patient comes into contact with the assailant again.

- B. Explain advocacy and counseling services available within the community. Also explain that an advocate can be available throughout the exam, police interview and court process.
- C. Make the patient aware that it is their decision whether to report their case and talk with law enforcement officials and prosecutors.
- D. Explain the investigation process. (**See Appendix 14 for outline of criminal justice system**). If law enforcement is involved, inform the patient that investigators will request an interview with them. If not already done, explain the criminal justice process and victims rights. Law enforcement should provide a copy of the "Picking up the Pieces" handout to the patient. The law enforcement officer should write contact information on the "After Care Information" form. The patient should be encouraged to call their investigator with any new relevant information, if new signs of injuries appear, about suspect's compliance with protection orders or bond conditions, if suspect tries to contact them, or other related questions or concerns.
- E. Explain the community's protocol for handling anonymous kits. Information should include how long a collected kit will be stored with law enforcement and a mechanism for the patient to notify law enforcement to retrieve the kits for investigation.

Section VII: Sexual Assault Forensic Examination Program, Billing and Crime Victims Compensation Program

1. Sexual Assault Forensic Examination (SAFE) Program

The Ohio Revised Code 2907.28 (B) states that “no costs incurred by a hospital or emergency facility” for the collection of forensic evidence in sexual assault cases, “including the cost of any venereal diseases (known as Sexually Transmitted Infections) antibiotics administered as part of the examination,” “shall be billed or charged directly or indirectly to the victim or the victim’s insurer.” Physicians and other medical providers shall not seek reimbursement for services provided during a medical examination of a patient of sexual assault for the purpose of gathering physical evidence for a possible prosecution from the hospital or other facility where the exam was conducted and not bill the SAFE program or the patient of patient’s insurance.

The Attorney General’s SAFE Program will reimburse facilities for the cost incurred in conducting a medical examination of a victim of sexual assault for the purpose of gathering physical evidence for possible prosecution. For more information about the reimbursement program, contact the office of the Attorney General at 1-(800) 582-2877 or (614) 466-5610. (Also see **Appendix 15** for instructions for reimbursement for the SAFE Program.)

2. Ohio Crime Victims Compensation Program

The patient should be informed that they are responsible for the cost of other medical tests (not included in the sexual assault exam) or treatment needed as a result of the assault. If the patient is uninsured and unable to pay for this treatment, the hospital should provide as much immediate care as possible and make a referral to an appropriate health care facility or clinic follow up care. Expenses not covered by insurance may be costs eligible for reimbursement from the Ohio Crime Victims Compensation program. (See **Appendix 15** for more information about the compensation program).

In order to qualify for this program, the patient must meet necessary criteria and report the crime to law enforcement within 72 hours, or show a good reason for a delay. Explain to the patient that a community or prosecutor-based advocate can assist with the application for compensation. The Ohio Crime Victims Compensation program may cover costs for any part of such treatment not covered by insurance. Information about the Ohio Crime Victims Compensation program should be given to the patient prior to leaving the hospital. See **Appendix 6, After Care Information**, and **Appendix 16 ORC Section 2742.51 through 2743.72**.

Section VIII: Resources

1. National

National Domestic Violence Hotline 1- (800) 799-7299

<http://www.ndvh.org>

National Organization for Victim Assistance 1-(800) 879-6682

<http://www.trynova.org>

Nation Sexual Violence Resource Center 1-(877) 739-3895

<http://www.nsvrc.org>

National Victim's Resource Center 1-(800) 627-6872

<http://www.ncvc.org/ncvc/Main.aspx>

Rape, Abuse, & Incest National Network (RAINN) Hotline 1-(800) 656-4673

<http://www.rainn.org>

2. State of Ohio

Action Ohio: Coalition for Battered Women

(614) 825-0551

<http://www.actionohio.org>

The Justice League of Ohio

(614) 848-8500

<http://www.thejusticeleagueohio.org>

International Association for Forensic Nurses, Ohio Chapter

<http://www.ohiafn.org>

Ohio Alliance to End Sexual Violence

(614) 233-3301

Toll-Free: (888) 886-8388

<http://www.oaesv.org/contact.html>

Ohio Attorney General's Office

SAFE Program

(614) 995-5415

<http://www.ag.state.oh.us/victim/index.asp>

Ohio Department of Health

Sexual Assault and Domestic Violence Prevention Program

(614) 466-2144

<http://www.odh.ohio.gov/odhPrograms/hpr/sadv/sadv1.aspx>

Ohio Domestic Violence Network

1-(800) 934-9840

<http://www.odvn.org>

Other:

For local assistance, check your telephone directory. For local emergency assistance call 911 or the Sheriff's Office, the local Police Department or the Ohio State Highway Patrol in the area or 1-(877) 7PATROL(772-8765) for emergency services from the State Police.

Definitions Detailed Instructions

1. The following definitions apply to the evidence collection:
 - a. **Air dry** – Dry at room temperature. Do not use any heat. Keep away from direct sunlight.
 - b. **Sealing envelopes** – Do not lick the flaps of envelopes. If necessary, use a damp sponge or paper towel to moisten envelope flaps. Use patient identification stickers as a seal over each fastened envelope flap. Use paper envelopes only; never plastic.
 - c. **Slightly moisten** – Use just enough sterile saline or distilled water to facilitate collection of a dried external stain or prevent discomfort during the vaginal and rectal examination. Flooding the swabs decreases their absorbing power and should be avoided.
 - d. **Swabbing** – When swabbing a stain or body cavity, allow the swab to soak up as much as possible in order to maximize the recovery of evidence.
2. Step by step instructions follow (as they will appear in the kit instructions).

Detailed Instructions

(Recommended Order)

Ohio Department of Health Sexual Assault/Abuse Evidence Collection Kit

Please proceed in numerical order and complete all steps. The patient may not remember or may not be able to discuss certain aspects of the assault at the time of examination. Important evidence may be lost if all steps are not completed. However, it is also very important for the patient to resume control. Therefore, if the patient declines a step, write “patient declined” on the collection envelope and go on to the next step.

It is important to follow instructions and write legibly as these items may be used in court to prosecute a sexual offense. Remove strips to seal envelopes (**do not lick**).

✂ Please DO NOT use staples.

The **Assault History** form is required by the ODH Protocol. An institutional form of the same content may be substituted.

A sample Medical History form may be found in the protocol, **Appendix 12**. An institutional form of the same content may be substituted. **Do not place this in the kit.**

Step 1: Intake and Triage

The sexual assault survivor should immediately be placed in a private waiting area. The hospital advocate and the health care provider conducting the exam should be notified immediately. The survivor should be seen within 15 minutes of arrival. The survivor should not disrobe at this time. Clothing will be collected during the exam and evidence collection. The hospital advocate and the examiner should be notified immediately.

Step 2: Informed Consent for examination and release of evidence to police

Allow the patient or parent/guardian to read **Information You Should Know as a Survivor of Sexual Assault**. Explain to the patient what the sexual assault exam will entail. Explain to the patient that they can withdraw their consent at anytime.

Complete and have the patient or guardian sign the **Sexual Assault Exam Consent, Release of Evidence Consent, and Photography Consent** form.

Anonymous Kit Consent (patient must be 18 and older)

If the patient is unsure about reporting to law enforcement at this time, discuss the anonymous kit collection option. The patient should be advised a de-identified kit with a unique identification number will be given to law enforcement where the crime has occurred. This kit will be locked in storage. Assure the patient that the kit will be completely de-identified and no photos will be turned over to law enforcement until permission is given by them.

The patient should be told she/he will be provided with the kit's unique identification number at the end of the evidence examination. Assure the patient that she/he ultimately decide to make a report to law enforcement. She/He will need to provide the law enforcement agency with this number so the evidence may then be associated with the evidence. Additionally, the patient should be informed about the retention time established in the agreement with the county prosecutor and local law enforcement and found in the local community protocol.

See the Protocol Procedure, Section II Informed Consent

The release is not necessary for child abuse cases.

Step 3: Patient Medical history

Most providers use a standardized medical history form. A downloadable model from can be found on the ODH Website at <http://www.odh.ohio.gov/odhPrograms/hpr/sadv/sadvprev1.aspx> or in **Appendix 12**. Please DO NOT place the medical history form in the kit. This is for hospital records only.

Step 4: Abuse/Assault History Form

The ODH Protocol requires that a readable copy of this information be placed in the kit. Please write legibly.

This form is provided in the kit and is also found **in the protocol, Appendix 10**. Although discouraged, an institutional form may be substituted provided that it contains all of the same information and is readable.

Complete the first two pages of the **Assault History** form. In the **Patient Narrative** section, record the patient's description of the assault. Pay particular attention to information that will assist you in locating injuries and body fluid evidence such as semen, saliva and vaginal secretions. **Do not record** your subjective observations and opinions. Use quotation marks when recording the patient's own words. See protocol procedure section III, Patient Medical /Abuse/Assault History, 1.

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The rape crisis advocate/hospital support person, family member or other support person may remain in the room during the examination, if the patient so desires.

Step 5: DFSA Urine.

Consider collecting urine samples for toxicological screening for drug facilitated sexual assault if unexplained impairment or gaps in patient recall exist. **Refer to Appendix 9, Drug Facilitated Sexual Assault Protocol and Protocol Procedures, Section V Medical Considerations and Testing. Refer to the ODH Sexual Assault Protocol Section VII for testing instructions.**

Step 6: Cut Head Hair Standards ✂

Using clean scissors, cut a combined total of 10 – 15 hairs from various areas of the head. Cut NEXT to the skin. Place the head hairs in the envelope provided. Label and seal the envelope.

Step 7: Oral Swabs and Smear

Collect four oral swabs **regardless of the assault history**. If necessary, slightly moisten the swabs with sterile water or saline. Rub two swabs back and forth between the left cheek and lower gum and as far back on the tongue as possible without triggering the gag reflex. Using two more swabs, repeat for the right side.

Use any one of the swabs to make the smear. Make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not discard the swab**. Do not use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four oral swabs in the boxes (2 swabs/box). Close the boxes and place in the envelope. Label and seal the envelope.

B. Children Only: Step 7A: Oral Culture for Gonorrhea

If indicated, culture the pharynx for gonorrhea.

- ✂ Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law.
- ✂ Do not use swabs with wooden applicators.
- ✂ Do not place cultures in the kit box—send to the hospital lab.

Step 8: DNA Reference Standard

Collect one oral swab. Rub between the cheek and UPPER gum line. Place in box and air dry. Close box and place in envelope. Label and seal envelope.

Step 9: Fingernail Scrapings, Swabbing and Cuttings

Scrape or swab under the patient's nails using the orange stick or swabs provided in the nail scrapings envelope. Moisten the swabs to collect dry material. Collect the scrapings or swabbings into the envelope. Be sure to dry the swabs before packaging. If a fingernail is broken, using clean nail clippers, clip off the broken end and place it into the envelope. Label and seal the envelope.

Step 10: Underwear Collection

The underwear **WORN TO THE EXAM must be placed in the kit**. If no underwear, collect intimate item worn next to the body such as tights or pantyhose. If pants worn next to the body, note that on this bag and place the empty bag in the kit. If a panty liner or pad is in place, leave it attached to the underwear. Collect the jeans or pants at Step 11.

If the patient is not wearing the clothing worn at the time of the assault, it is still necessary to collect the items that are in direct contact with the genital area (underpants/panty hose). Inform the law enforcement officer so that the clothing worn at the time of the assault can be retrieved from the patient's home.

Step 11: Clothing Collection (three bags)

Collect any bra or outer garments worn during or immediately after the assault, even if no damage or staining is apparent. As the patient disrobes, place one garment item in each bag.

- ✘ Do not shake out the garments, as evidence such as hairs and fibers may be lost.
- ✘ Do not cut through any existing holes, rips or stains in the patient's clothing.

Place your initials or other identifying mark on the clothing labels or on a piece of tape attached to the area where the clothing label is normally located. Label and seal the bags with the security seals provided.

- ✘ If any of the items are wet or damp, inform the law enforcement officer to ensure that the clothing can be properly air dried.

Step 12: Dried Stains

Collect potential semen or saliva stains by slightly moistening one or two swabs with sterile water or saline and swabbing the area.

- ✘ A Wood's lamp or other alternate light source may be helpful in examining the patient's body for dried semen stains.
- ✘ Saliva stains will not be visible under alternate light sources. Listen carefully to the patient's account of the incident to determine where saliva stains may be located and swab accordingly.
- ✘ If cunnilingus may have occurred, or if the perpetrator may have used his saliva as a lubricant, swab the external vaginal area in addition to collecting internal vaginal swabs.
- ✘ Collect each stain in a separate envelope.
- ✘ Ask if the assailant used his/her mouth anywhere on the patient or used his/her saliva as a lubricant. Swab these areas as above. Swab and photograph any bite marks.
- ✘ Label and seal envelope.

Step 13: Pubic Hair Combing or Collection of Stray Hairs found near Genital or Anus Area

With the patient standing, hold the envelope under the pubic area and use the comb provided to comb through the pubic hairs several times. Comb directly into the envelope. Place the comb into the envelope. If pubic hair not present, collect any stray hairs from the genital area. Label and seal the envelope. If the patient does not have pubic hairs, please note this on the envelope.

Step 14: Cut Pubic Hair Standards ✂

After completing Step 10 above, using clean scissors, **cut** a combined total of 10 – 15 hairs from various areas of the pubic region. Cut as close to the skin as possible. Place the pubic hairs in the envelope provided. Label and seal the envelope.

Step 15: Anal/Perianal Swabs and Smear

Collect four anal or perianal swabs **regardless of assault history**. See additional discussion in the protocol. If necessary, the swabs may be slightly moistened with sterile water or saline. If there is no evidence or report of anal penetration, it is acceptable to swab the perianal area rather than inserting the swabs.

Use any one of the swabs to make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not** discard the swab. **Do not** use fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four anal/perianal swabs in the boxes (2 swabs/box). Close the boxes and place in the envelope. Label and seal the envelope.

C. Children Only: Step 15A: Anal/Perianal Cultures

If indicated, culture the anus for gonorrhea and Chlamydia.

- ✂ Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law.
- ✂ Do not use swabs with wooden applicators.
- ✂ **Do not place cultures in the kit box**—send to the hospital lab.

Step 16: Vaginal/ Penile Swabs and Smear

For females: Collect four vaginal swabs **regardless of assault history**. Collect two swabs at a time, swabbing any pooled fluid and the cervical area.

Use any one of the swabs, make the smear by rolling the swab forward and back once in the center of the pre-labeled slide. **Do not** discard the swab. **Do not** use any fixative on the slide. Air dry the smear and place it in the slide mailer. Place the slide mailer in the envelope. Air dry all four vaginal or penile swabs in the boxes (2 swabs/box). Close the boxes and place in the envelope. Label and seal the envelope.

- ✂ If a tampon is present, air dry and place in a **Step 5** envelope. Label and seal the envelope.

- ✘ If cunnilingus may have occurred, or if the perpetrator may have used his saliva as a lubricant, swab the external vaginal area including labia minora in addition to collecting internal vaginal swabs. Place the external vaginal area swabs into a Step 12 (Dried Stains) envelope.

For males: Collect four penile swabs. Slightly moisten the swabs with sterile water or saline and swab the glans and shaft of the penis using two swabs at a time. Follow the instructions above for smears and packaging. **DO NOT INSERT SWABS INTO THE MALE URETHRA.**

For pre-pubertal females: Swab the external genitalia and labia minora with four slightly moistened swabs and make a smear as above.

- ✘ A speculum examination is almost never indicated on a prepubertal female and may add to the child's trauma. A speculum examination that is indicated for extensive injury should only be performed at a pediatric hospital under general anesthesia.

D. Children Only: Step 16A: Vaginal/Penile Cultures

If indicated, culture the vagina or urethra and Chlamydia.

- ✘ Non-culture tests, such as ELISA and DNA probes, may not be acceptable as evidence of infection in a court of law.
- ✘ Do not use swabs with wooden applicators.
- ✘ **Do not place cultures in the kit box**—send to the hospital lab.

Step 17: Document Injuries

Complete the third page of the **Assault History** form during your assessment. Take photos of the patient to assist recall and to document any physical injuries. Do not place photos in kit. Keep these photos with your records. Using the anatomical outlines provided, indicate all signs of physical trauma — e.g. bruises, scratches, marks, discolorations (size and color) or bite marks on any part of the patient's body.

The use of a Wood's Lamp or other alternate light source, colposcope or toluidine blue dye to help visualize stains and injuries is essential. The use of toluidine blue dye in sexual assault examination is helpful for the identification of microscopic injury and requires special training.

Step 18: Prophylaxis and Patient Information Packet

Give the handout packet to the patient. (See Appendix 6)

Refer to the ODH Sexual Assault Protocol for more information on follow up care.

For anonymous kit requests, make sure the patient receives their unique identification number and the retention time established by the local jurisdiction where the crime occurred.

Discuss STI and pregnancy prophylaxis with the patient as applicable. See Protocol Procedure, Section V, Medical Considerations and Testing, 2. Sexually Transmitted Infections and Emergency Contraceptives.

Step 19: Pack Up the Evidence Kit and Refrigerate DFSA Kit if Collected

1. Verify that all of the information requested on the collection envelopes and forms has been completed and that all of the envelopes are sealed.
2. Place the Assault History form into the kit. **Do not put the consent form inside the sexual assault examination evidence kit.**
3. Place all collection envelopes and the underwear bag (whether these items have been collected or not) into the kit. **Do not put the DFSA kit inside the sexual assault examination evidence kit.**
4. Using the seal provided, seal and initial the kit, and fill out all of the information requested on the box lid. This information is required.
5. Complete the top portion of the Chain of Custody forms (found at the bottom of the Step 2 Chain of Custody form and on the lid of the kit box). Hand the sealed kit and sealed paper bags to the law enforcement officer and have him/her complete the bottom portion of both Chain of Custody forms. One copy of the Chain of Custody form stays at the hospital in the medical record. One copy is given to the law enforcement officer.
6. If the evidence is not immediately released to law enforcement, the kit and clothing should be stored in a secure area according to the local protocol.
7. If the DFSA kit is not immediately released to law enforcement, the DFSA kit is stored in a secured refrigerator according to the local protocol.

This completes the evidence collection steps associated with the kit. See the Ohio Sexual Assault Protocol for the remaining steps. Be sure to complete and/or review with the patient the instructions for Section IV, Evidence Integrity, Section VI Post Examination Information, and Appendix 9, DFSA Protocol.