A National Protocol for Sexual Assault Medical Forensic Examinations

Adults/Adolescents

Third Edition

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Foreword

Sexual violence continues to plague our nation and can have devastating and lasting impacts on people's lives. All members of society are vulnerable to this crime, regardless of race, ethnicity, age, gender, sexual orientation, ability, faith, sexual history, or socio-economic status. When sexual assault does occur, patients deserve competent and compassionate medical forensic care. This third edition of the *National Protocol for Sexual Assault Medical Forensic Examinations* provides detailed guidelines for clinicians and ancillary professionals, including criminal justice practitioners and victim advocates, in responding to the immediate needs of patients who have experienced sexual assault. We know that effective collection of evidence is of paramount importance to successfully prosecute sex offenders, but also to preserve patients' options when they are not sure if they want to engage with the criminal justice system at the time of the medical forensic examination. Just as critical is performing sexual assault medical forensic examinations in a sensitive, dignified, and patient-centered manner. For individuals who experience this horrendous crime, having a positive experience with the health care and criminal justice systems can contribute greatly to their overall healing.

As we have learned in the years since the enactment of the Violence Against Women Act in 1994, coordinated community efforts are the best way to stop interpersonal violence, hold offenders accountable for their crimes, and promote victim healing and recovery. That is why this protocol was designed as a guide for practitioners who respond to victims of sexual assault, including clinicians, law enforcement officers, prosecutors, interpreters, advocates, victims' lawyers, and others. Combining an evidence-based, trauma-informed medical forensic response with collaboration among service providers will greatly enhance our ability to treat and support victims as well as identify and prosecute individuals who have sexually abused or assaulted. We hope that this protocol lays the foundation for these efforts.

Since the first edition of this protocol was released in 2004, the evidence base supporting medical forensic examinations has improved. This third edition of the protocol has the same emphasis and values as the original but has been updated to reflect current technology, science, and standards of practice. It has also been updated to include additional information reflecting changes consistent with the subsequent reauthorizations of the Violence Against Women Act, the most recent of which was in 2022.

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Goals of the National Protocol for Sexual Assault Medical Forensic Examinations

Sexual assault is a crime of violence against a person's body and will. Offenders use physical and/or psychological aggression or coercion to victimize, in the process often threatening a person's sense of privacy, safety, agency, and well-being. Sexual assault can result in physical trauma and significant mental anguish and suffering. Sexual violence is most often also a part of a pattern of systemic oppression.[1] A victim may be reluctant, however, to report the assault to law enforcement and to seek medical attention for a variety of reasons. For example, they[2] may blame themselves for the sexual assault and feel embarrassed. They may fear their assailant or worry about whether they will be believed. They may not have their own transportation or access to public transportation. They may have limited English proficiency or fear that reporting the assault may jeopardize their immigration status.[3] They may lack health insurance and believe it would be too costly to get the medical care they need. They may not be aware that as a victim of a crime, they are not responsible for the costs of most services related to medical forensic examinations. Their budget may not allow them to pay out-of-pocket expenses and then await reimbursements. They may lack trust in law enforcement or healthcare systems based on prior trauma or because of historical or intergenerational trauma. If they do have access to services, they may perceive the medical forensic examination as yet another violation because of its comprehensive nature in the immediate aftermath of the assault. Rather than seek assistance, a person who has experienced sexual assault may simply want to go somewhere safe, clean up, and try to forget the assault ever happened. It is our hope that this protocol will help jurisdictions in their efforts to respond to people who have experienced sexual assault in the most competent, compassionate, and understanding manner possible.

This protocol was developed with the input of national, local, and Tribal experts throughout the country, including law enforcement representatives, prosecutors, victims' attorneys, advocates, medical personnel, forensic scientists, survivors, and others. We hope that this protocol will be useful in helping jurisdictions develop and refine responses that are sensitive to patients[4] who have experienced sexual assault and that promote offender accountability. Specifically, the protocol has the following goals:

- Supplement, but not supersede, the many excellent protocols that have been developed by states, Tribes, and local jurisdictions, as well as those created at the national level. We hope that this protocol will be a useful tool for jurisdictions wishing to develop new protocols or revise their existing ones. **It is intended as a guideline for suggested practices rather than a list of requirements.** In many places, the protocol refers to "jurisdictional policies" because there may be multiple valid ways to handle a particular issue, and which one is best

[1] See Pennsylvania Coalition Against Rape. (2017). Racism & Sexual Violence (last visited July 8, 2024).

[2] The terms "they" and "their" are used as singular-reference, gender-neutral pronouns throughout this protocol.

[3] For more information about working with immigrant victims, see the National Sexual Violence Resource Center, Sexual Assault Response Team Toolkit, ("SART Toolkit"), Section 6.12. Immigrant Victims of Sexual Assault (last visited July 8, 2024).

[4] The term "patients" refers to individuals who have experienced sexual assault and is generally used by health care professionals and is therefore the preferred term used in this protocol. However, the term "victims" may also be used, depending on which responders are primarily being discussed.

should be determined by the jurisdiction after consideration of local laws, policies, practices, and needs.

- Provide guidance to jurisdictions on responding to adult and adolescent patients. Adolescents are distinguished in the protocol from prepubertal children who require a pediatric exam. **Pediatric exams are not addressed in this document. This protocol focuses on the examination of the post-pubertal patient.** Jurisdictions vary in the age at which they consider individuals to be minors. Child sexual abuse statutes, mandatory reporting policies for sexual abuse and assault of minors, instances when minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded also vary among jurisdictions. **If the adolescent patient is deemed a minor under the law, follow the relevant laws regarding patient consent, mandatory reporting, and patient confidentiality.**

- Support the use of coordinated community responses to sexual violence, such as Sexual Assault Response Teams (SARTs) or Sexual Assault Response and Resource Teams (SARRTs). Although this document is directed primarily toward clinicians and medical forensic examiner programs, it also provides guidance to other key responders, such as advocates, prosecutors, and law enforcement representatives. This type of coordinated community response is supported by the Violence Against Women Act (VAWA) and subsequent reauthorizations. Such a response can help afford patients access to comprehensive and immediate care, minimize the trauma patients may experience, and promote the use of community resources. It can also facilitate the criminal investigation and prosecution, increasing the likelihood of holding offenders accountable and preventing further sexual assaults.

- Address the needs of patients while supporting the criminal justice system response. This protocol focuses on stabilizing, treating, and educating patients about the services available to victims and their legal rights (including protection orders, immigration relief, language access and health care offered by federally qualified health centers), connecting patients with experienced legal and social services providers, and engaging patients as essential partners in the criminal investigation. Thus, this protocol includes information about concepts such as "anonymous reporting," which may give patients needed time to decide if and when they are ready to engage in the criminal justice process. An anonymous report may also provide law enforcement agencies with potentially useful information about sex crime patterns in their jurisdictions.[5] The objective is to promote better and more patient-centered[6] sample collection for the sexual assault evidence collection kit, and in the process, gather admissible evidence that will lead to increased offender accountability.

- Promote high-quality, sensitive, and supportive medical forensic examinations for all consenting patients, regardless of jurisdiction and geographical location. The protocol offers recommendations to help nationally standardize the quality of care for patients who have

[5] States that receive certain VAWA funds are responsible for ensuring that the costs associated with performing a medical forensic examination are paid and ensuring that all patients who have experienced sexual assault (including incarcerated and detained patients) are provided the opportunity to have a medical forensic examination conducted, regardless of whether they choose to participate in the criminal justice system (34 U.S.C. § 10449(a); 28 C.F.R. § 90.13).

[6] See the section on "Patient-Centered Care" for an explanation of this term.

experienced sexual assault. It is based on the latest scientific evidence and standards of practice. It emphasizes the importance of targeted medical care that is responsive to both the acute and long-term healthcare needs of patients who have experienced sexual assault. It also promotes timely sample collection for the sexual assault evidence collection kit that is accurately and methodically gathered, so that high-quality evidence is available should the case move forward in the criminal justice system.

This protocol primarily discusses the clinician's role in conducting the medical forensic examination, but also addresses the roles of the following responders: advocates, law enforcement representatives, forensic scientists, prosecutors and legal services attorneys. Each of these professions has a distinct and complementary role in responding to sexual assault. Rather than dictate who is responsible for every component of the response, the protocol is designed to help communities consider what each procedure involves and any related issues. With this information, each community can make decisions for its jurisdiction about the specific tasks of each responder during the exam process and the coordination needed among responders. The following is a general description of the responsibilities with which each responder may assist:[7]

- **Clinicians** assess patients for acute medical needs and provide stabilization, treatment, and/or consultation. Clinicians, in the context of the medical forensic examination, may be registered nurses, advanced practice nurses, physician assistants or physicians, depending on factors such as local protocols, support for specialized clinical programs, and available education. Ideally, sexual assault medical forensic examiners perform the medical forensic examination, gather information for the medical forensic history, collect and document samples for the sexual assault evidence collection kit, and document pertinent physical findings from patients. They offer information, treatment, and referrals for sexually transmitted infections (STIs),[8] including HIV, and other nonacute medical concerns; assess pregnancy risk and discuss treatment options with the patient, including reproductive health services; and testify in court if needed. They provide sensitive and emotionally supportive services, while also coordinating with advocates to ensure patients are offered crisis intervention, support, and advocacy before, during, and after the exam process. They also encourage the use of victim services and discuss legal options. They may follow up with patients for medical and forensic purposes. Other health care personnel who may be involved include, but are not limited to, emergency medical technicians, staff at hospital emergency departments, gynecologists, surgeons, primary care physicians, health care interpreters, medical directors,[9] and/or local, Tribal, campus, or military health services

[7] There are instances where a defendant may be prosecuted concurrently in two or more jurisdictions. For example, crimes such as sexual assault that are committed within Tribal communities may be prosecuted concurrently by the federal government or the Tribe. Similarly, there may be sexual assaults that violate both state and federal statutes. In such situations, there will likely be different victim advocates, prosecutors, and court personnel assigned to each case. There may also be different law enforcement officers involved in the investigation. Coordination of services in multi-jurisdictional investigations and prosecutions is critical to the success of the criminal cases and the health and well-being of the patient.

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

[9] The role of the Medical Director may vary from program to program, but they can provide support for quality assurance/quality improvement/peer review efforts, participate in continuing education, assist in policy and protocol development, and provide operational support as needed. See also, Ferrell, J., Henin Award, S., & Markowitz, J. (2009). Sustainability 101: Fostering Collaboration between SANE Program Coordinators and Medical Directors. *National Sexual Violence Resource Center*. https://www.nsvrc.org/sites/default/files/Publications_SANE_Collaboration-Medical-Directors_0.pdf.

personnel. Many communities refer to their sexual assault medical forensic examiners by more specific acronyms based upon the discipline of practitioners and/or specialized education and clinical experiences (e.g., sexual assault nurse examiner [SANE]).[10]

- **Advocates** should be involved in initial victim contact when possible (via hotline, text or web-based platforms, or face-to-face meetings). Advocates, also referred to as victim advocates or sexual assault advocates can offer victims advocacy, support, crisis intervention, information, culturally appropriate resources, and referrals before, during, and after the exam process. They can help with safety planning, assist individuals with limited English proficiency in advocating for language assistance and requesting that a qualified interpreter be made available,[11] and they can help ensure that victims have transportation to and from the exam site. They often provide comprehensive, longer-term services designed to aid victims in addressing any needs related to the assault, including but not limited to counseling and legal (civil, criminal, and administrative) and medical systems advocacy, to include hospital accompaniment.[12] Some advocacy organizations may be able to offer support for basic needs, such as food, clothing, and housing support. A number of agencies, broadly referred to as victim service providers, may offer some or all of the services described above, including community-based sexual assault victim advocacy programs, criminal justice system victim-witness offices, patient advocate programs at health care facilities, campus or military victim service programs, Tribal social services, adult protective services, and others. Where they exist, community-based sexual assault victim advocacy programs are typically best positioned to provide these specific services. Community-based advocacy programs may use paid and/or volunteer advocates to provide services up to 24 hours a day, every day of the year. It is important to note that information victims share with government-based service providers usually becomes part of the criminal justice record, while community-based advocates typically can provide some level of confidential communication for victims. In addition, community-based advocates commonly receive education specific to the medical forensic examination process and sexual assault issues in general. They support victims regardless of whether the victims engage with the criminal justice system.

- **Law enforcement representatives** (e.g., 911 dispatchers, patrol officers, officers who process crime scene evidence, detectives, and investigators) respond to initial complaints, work to enhance victims' safety, arrange for victims' transportation to and from the exam site as needed, interview victims, collect evidence from the scene, coordinate collection and delivery of evidence to designated labs or law enforcement facilities, interview suspects and

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[10] The sexual assault medical forensic examiner may not be the first clinician involved in the examination process depending on the location of the examination and organizational policy. For patients presenting to hospital-based exam sites, they may initially be seen by emergency department personnel (physicians, physicians' assistants, or nurse practitioners) who will perform a medical screening examination to identify whether the patient has any emergency medical conditions that need to be addressed prior to completion of the medical forensic exam.

[11] All entities receiving federal financial assistance (including hospitals and law enforcement agencies) are obligated to provide language assistance for the services they are providing. It should not be left up to the advocates to provide interpreters for other professional in the response process (Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq.).[12] Some faith-affiliated victims of abuse may also want to involve the hospital chaplain or the support of a faith or Tribal leader.

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witnesses, and conduct other investigative activities (such as requesting crime lab analyses, reviewing medical and lab reports, preparing and executing search and arrest warrants, writing reports, and working with and/or presenting cases to prosecutors). Law enforcement representatives can be at the local, state, territory, Tribal, and federal levels. Some agencies may have staff with specialized education and experience who may be dedicated to investigating sexual assault cases and/or may be part of a special unit for investigating sexual assaults. In this protocol, personnel from law enforcement agencies are referred to as "law enforcement officers" or "law enforcement representatives," unless more specificity is required.

Forensic scientists are responsible for analyzing evidence in sexual assault cases and providing results of the analysis to investigators and/or prosecutors. They also may testify at trial regarding the results of their analysis. The evidence they analyze typically includes DNA and other biological evidence, toxicology samples, latent prints, and trace evidence. Some forensic scientists specialize in the analysis of specific types of evidence. In this protocol, forensic scientists working in crime laboratories are often referred to as "crime lab/laboratory personnel" and "crime lab/laboratory scientists." Forensic scientists analyzing drug and alcohol samples are also referred to as "toxicologists**."**

- **Prosecutors** determine if there is sufficient evidence to file charges and, if so, prosecute the case. They should be available to consult with first responders and they follow-up with investigators as needed. Depending on the jurisdiction and individual practice, prosecutors may be more active early in the investigation, sometimes responding to the exam site so that they can become familiar with the case, meet the victim, and help guide the investigation. Prosecutors must also adhere to the governing victims' rights statutes in their jurisdictions. Different types of prosecution offices exist at the local, Tribal, state, territory, and federal level (e.g., Tribal prosecutor's office, county prosecutor's office, district attorney's office, state attorney's office, United States Attorney's office, and military judicial branches). Some offices may have personnel with specialized education and experience in sexual assault prosecutions, who may be dedicated to prosecuting sexual assault cases and/or may be part of a special unit for prosecuting sexual assaults. In this protocol, attorneys from prosecution offices will be referred to as "prosecutors" unless more specificity is required.

- **Victims' Rights or Legal Services Attorneys** are civil attorneys who represent victims and use the law and the courts to address concerns that affect immediate and long-term well-being of victims. They typically represent victims in civil legal matters, e.g., civil protective order hearings, but in limited instances, may represent victims' interests in the criminal justice system.[13] Because civil attorneys represent the individual victim, where the prosecutor represents the government, civil attorneys and prosecutors play different roles. Victims are not required to seek civil representation for a case to proceed through the criminal justice system; however, civil attorneys can make victims aware of other legal options separate from criminal prosecution. This includes legal issues related to criminal privacy rights, safety, divorce and custody, immigration, education, housing, employment, and finances. In the U.S. Armed Forces, certain victims of sex-related offenses under the Uniform Code of Military Justice are

[13] For example, a civil attorney may apply for immigration relief, apply for crime victim compensation, or move to quash third-party subpoenas, related to the criminal case.

entitled to free legal counsel for representation, legal consultation, and assistance known as the Special Victims' Counsel Program.[14]

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

[14] See 10 U.S.C. § 1044e.

Introduction

Sexual assault is a prevalent crime that can have devastating and long-term impacts on individuals across the lifespan. In addition to emotional trauma, an assault can result in a range of health-related issues, such as acute and chronic mental health issues and substance misuse, physical injuries, pregnancy, and sexually transmitted infections (STIs). It is essential that communities provide victim-centered, trauma-informed assistance to victims in the immediate aftermath of an assault. Communities must also work to hold offenders accountable for their actions and stop them from committing further sexual violence. Elements of an effective initial response typically include:

- Providing prompt medical screening examinations and treatment, including stabilization and/or referrals for medical care that extend beyond what is offered by the standard medical forensic examination, such as evaluation for strangulation injury or head trauma
- Physical examination, documentation of findings, and collection of samples for medical evaluation, the evidence collection kit, and toxicological testing (if the patient consents).
- Responding to, documenting, and investigating the sexual assault, which may lead to the filing of charges against and prosecution of offenders.
- Support, crisis counseling, information, and referrals for victims, as well as advocacy to ensure that victims receive appropriate assistance.
- Support and information for victims' families and friends.

This protocol focuses on elements of immediate response that are the responsibility of clinicians, i.e., medical forensic care for patients who have experienced sexual assault, including the collection of samples for the sexual assault evidence collection kit. It seeks to assist clinicians in validating and addressing patients' health concerns, minimizing patient trauma, promoting healing, and maximizing the collection and preservation of samples from patients for the evidence collection kit that may then be used in the legal system. (A sexual assault medical forensic examination, as described in this document, addresses both the medical and evidentiary needs of the patient following sexual assault.)

This protocol also addresses the role of advocates, law enforcement representatives, prosecutors, forensic scientists, and other responders to sexual assault in our communities. For various reasons (such as fear, stigma, lack of information, lack of access, or mental trauma), many victims of sexual assault choose not to seek medical care or have samples collected for the evidence collection kit. However, coordination among professionals involved in the immediate response may be instrumental in reversing this trend. The use of 24/7 crisis lines may be instrumental in developing and/or assisting with the process of multidisciplinary collaboration while addressing the patient's immediate needs. Multidisciplinary collaboration can improve the likelihood that victims engage with responders and then seek medical forensic care, which can result in the timely gathering of samples for the sexual assault evidence collection kit. Overall, such collaboration helps ensure that victims are informed of their options for assistance, in a trauma-informed and victim-centered manner. Additionally, multidisciplinary coordination can enhance medical forensic care for patients who present after sexual assault.[15]

[15] For example, when first responders work with victims collaboratively, they are more likely to be directed to facilities that can provide medical forensic examinations, decreasing wait times or unnecessary transfers from facility to facility, and ensuring time-sensitive sample collection and medication administration (such as for pregnancy and HIV prophylaxis).

Background

The U.S. Department of Justice, Office on Violence Against Women (OVW) first developed this national protocol under the direction of the Attorney General pursuant to the Violence Against Women Act of 2000.[16] In so doing, OVW reviewed existing protocols and consulted with national, state, local, and Tribal experts on sexual assault from rape crisis centers, state and Tribal sexual assault and domestic violence coalitions and programs, and programs for criminal justice, forensic nursing, forensic science, emergency medicine, law, social services, and sex crimes in underserved communities.[17]

This is the third edition of the protocol. For this revision, OVW again solicited input from subject matter experts representing the relevant disciplines, such as forensic nurses, physicians, prosecutors, law enforcement, advocates, forensic scientists, and civil attorneys, as well as the National Institute of Justice. Multiple focus groups, each with a diverse group of experts, were convened to solicit input regarding updates on current technology, science, and appropriate terminology over the course of a nine-month period. Many of the revisions from the previous editions of the protocol are based on recommendations made by the consulted experts. Some of the recommendations are based on empirical research.

This national protocol recommends, rather than mandates, methods for conducting the medical forensic examination.[18] It serves as an informational guide to communities as they develop or revise their own protocols.[19] In no way does it invalidate previously established state specific and jurisdictional protocols, policies, or practices.

About This Document

Organization. This protocol is organized into several broad sections: A) overarching issues, B) operational issues, and C) the examination process. Each section builds on information presented in previous sections and includes components of the examination to be addressed, issues to be considered, and related recommendations. Although an effort has been made to avoid repetition of information throughout the document, there are instances where data are repeated for clarity or emphasis. Within the appendices, there is discussion of the customization of protocols by jurisdictions.

Protocol foundation. This protocol is based on a belief that it is possible, with a patient's consent, to simultaneously address their immediate health needs and the future needs of advancing community safety and accountability through the criminal justice system.

Key principles underlying patient response include:

- Recognition of patient health, safety, and well-being as paramount goals of response.
- Recognition that patients know far more about themselves and their needs than responders.
- Respect for patients' right to make their own choices.

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[16] See Section 1405 of the Violence Against Women Act of 2000, Public Law 106-386.

[17] Id.

[18] The protocol has no regulatory purpose and is not intended to, nor does it provide legal advice.

[19] See Appendix A on customizing protocols for ways that jurisdictions can use this protocol when they are developing/revising their own protocols.

- Recognition that providing patients with information about their options during the examination process, possible outcomes of choosing one option over another, and available resources can help them make more informed decisions.
- Recognition that all patients, regardless of backgrounds and circumstances and whether they choose to report the crime, have the right to receive a comprehensive, quality medical forensic examination and to be treated with respect, dignity, and compassion.
- Respect for patients' right to confidentiality.
- Recognition of the importance of patients' feedback to improving the examination process.

This protocol recognizes that most sexual assaults are committed by assailants known to patients.[20] Historically, sexual assault committed by nonstrangers was not taken seriously and interventions were less than adequate. It is imperative that responders acknowledge that sexual assaults committed by persons known to patients are as grave a crime as those committed by strangers. Responders should be aware that patients' reactions to an assault are affected by a multitude of factors. One of them is the prior relationship between the patient and the assailant. Responders should also understand that many variables may affect the relevance of certain types of evidence to a particular case, including whether an assault was committed by a stranger, whether a known offender claims sexual contact did not occur, or whether a known offender claims the patient consented to the sexual contact.[21]

Use of Terms

In addition to the definitions of the various responders previously listed, and the terms explained throughout the protocol to clarify the context in which they are used, common terms are also listed here alphabetically:[22]

Adolescent: Adolescents are distinguished in the protocol from prepubertal children who require a pediatric examination. This document focuses on the examination of the post-pubertal patient.[23] Adolescence is considered any patient who has begun puberty, although clinicians must consider on a case-by-case basis the patient's developmental level and sexual maturation when deciding

[20] Farahi, Narges, and McEachern, Morgan. "Sexual assault of women." American family physician 103.3 (2021): 168-176 ("Fifty to 80% of sexual assaults are committed by a person known to the survivor.") (internal citations omitted).

[21] For example, evidence, such as DNA, that leads to the identification of the offender in a stranger-committed sexual assault, is often critical for an investigation to continue. In cases in which the patient knows the offender, such evidence is less critical to establish identification, but may be evidence to corroborate the victim's account, particularly if the offender denies sexual contact. In cases where the offender claims that the sexual contact was consensual, while DNA evidence is still corroborative, evidence and documentation related to whether force or coercion was used against patients is often more important. Because clinicians will likely not know at the time of the exam whether the offender will claim that the sexual contact was consensual or did not occur or whether a defense will change by the time of trial, clinicians should collect and document all potentially relevant evidence with the patent's consent.

[22] These definitions may vary among protocols developed by states, territories, Tribes, and local communities.

[23] Adolescence is considered by the National Protocol for Child Sexual Abuse Medical Forensic Examinations to be an individual who is Tanner Stage 3 (referring to the stage of sexual maturation) or above who has reproductive capability. Youth who are Tanner 3 and even 4 may require case by case decision making, depending on their developmental level and sexual maturation stage. For more information, see the National Protocol for Child Sexual Abuse Medical Forensic Examinations, including Appendix 1 (page 207) for Tanner Stages.

whether this protocol applies. Jurisdictions vary in the age at which they consider individuals to be minors, at what age a minor may consent to their own health care (including contraception, terminating a pregnancy, medical forensic examinations, and/or emergency care), the legal definition of "child abuse," and mandatory reporting requirements. Responders should know their jurisdiction's laws and policies regarding these issues, screening procedures for determining whether a pediatric examination is needed (particularly in the case of younger adolescents), and local protocols for response to prepubertal patients. Medical forensic examination facilities must follow jurisdictional laws regarding parental/guardian consent including any exceptions.

Coordinating councils: This term refers to multidisciplinary groups that typically work at the state, territory, or regional level to coordinate systems responses to sexual assault. They tend not to be involved in direct response, but rather endeavor to improve overall services, interventions, and prevention efforts. They may be a subcommittee of an entity that more generally promotes a coordinated response to violence in the community.

Coordinated community response (CCR): This term refers to immediate and longer-term local response to sexual assault that is coordinated among involved responders. The premise of the CCR is that while each responder provides services and/or interventions according to agency-specific policies, there should be collaboration among all responders from other agencies and disciplines to achieve a more cohesive response in service to the needs of the community. Of vital importance is that each agency understands the roles of their partner agencies. The desired result is a collective response to sexual assault that is appropriate, streamlined, and as comprehensive as possible. Coordinated community response to sexual assault is a concept that developed out of a need to reduce the historically fragmented approach to these cases and its negative impact on victim well-being, offender accountability, and prevention of future assault. These community responses may be known as sexual assault response teams or sexual assault response and resource teams (SARTs or SARRTs).[24]

Culture: Sociologists discuss culture as languages, customs, beliefs, rules, arts, knowledge and collective identities and memories developed by members of all social groups that makes their social environments meaningful. This concept of culture and the personal values that the patient holds, shaped by their upbringing, gender identity, sexual orientation, religion, community, and culture influences their decisions about health and healthcare, and should be considered in care provision and treatment decisions to be truly patient-centered.[25]

Disability: A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). There are many types of disabilities, such as those that affect a person's vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships. People with disabilities are a diverse group of people with a wide range of needs. Two people with the same type of disability can be affected in very different

[24] Some SARTs or other CCR efforts may be statutorily mandated. Such laws may delineate when a SART should convene and who must participate. See, e.g., Or. Rev. Stat. Ann. § 147.401 (West) (requiring the SART "to meet least quarterly at a time appointed by the district attorney of the county; and listed those who should attend).

[25] See the U.S. Department of Justice, Office on Violence Against Women. (May 2023). National Protocol for Intimate Partner Violence Medical Forensic Examinations ("IPV Protocol") at page 20.

ways. Some disabilities may not be visible or readily apparent, such as patients who have intellectual or developmental disabilities.[26]

Examination site/facility: Emergency health care facilities, such as those in hospitals, traditionally have been the setting for provision of medical forensic services to patients who have experienced sexual assault. However, nonemergency health care programs, such as hospital-based or community-based examiner programs, community clinics, mobile health clinics, Tribal health clinics, local health departments, military hospitals or clinics, and college and university health centers, may also offer full or partial sexual assault medical forensic services. Sexual assault medical forensic examiners also may conduct examinations at additional health care and non-health care sites. The facility conducting the examinations may be referred to in this protocol as the "examination site," in recognition that not all sites performing the examination are health care facilities. Medical forensic examiners providing care at examination sites are broadly referred to in this document as clinicians.

First responder: A first responder(s) responds in the immediate aftermath of a sexual assault disclosure. Each responder typically must follow agency-specific policies for responding to victims and often work in collaboration with other first responders as part of a coordinated community response. Those who traditionally have been responsible for immediate response to adult and adolescent sexual assaults include victim advocates, 911 dispatchers, law enforcement representatives, and sexual assault medical forensic examiners. A wide range of other responders also may be involved, such as emergency medical technicians, public safety officials, service providers for victims of intimate partner violence, protective service workers, prosecutors and victim/witness staff, emergency department staff, mental health and substance use providers, social service workers, corrections, detention, and probation staff, religious and spiritual counselors/advisors/leaders, school personnel, employers, qualified interpreters, and providers from organizations that address needs of specific populations (e.g., persons with disabilities, racial and ethnic minority groups, elderly individuals, poor and low-income individuals, people experiencing homelessness, and youth who have runaway and adolescents in foster care).[27] Families and friends of victims also can play an important role in the initial response because victims may first disclose the assault to them, ask for their help in seeking professional assistance, and want their ongoing support. However, they are not considered first responders in this document, because they are not responding to these disclosures in an official capacity.

Intimate partner violence: The term intimate partner violence (IPV) encompasses physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse. IPV occurs across all genders and sexual orientations and does not require a sexual relationship. It includes coercive control, i.e. strategic patterns of behavior an abuser may use to gain power and control by eroding their partner's autonomy and sense of self. This may occur through a variety of actions such as threats, intimidation, disparaging remarks, isolation from loved ones, reproductive coercion, financial control, use of technology to monitor or spy, nonconsensual distribution of intimate images, and other activities which may or may not be illegal but can affect the health and well-being of patients served every day in clinical practices.[28] Response to sexual assault occurring within an IPV context requires understanding the overlapping dynamics of sexual assault and intimate partner

[26] See Centers for Disease Control and Prevention. Disability and Health Overview (last visited June 25, 2024).

[27] Patients who have experienced sexual assault can present anywhere in the healthcare system. Therefore, most healthcare providers have the potential to be a first responder at some point in their career.

[28] See above, IPV Protocol at page 7.

violence, the complex needs of victims, the potential dangerousness of offenders, the resources available for victims, and adherence to jurisdictional policies on response to intimate partner violence. Intimate partner violence is often used interchangeably with the terms domestic violence and dating violence.

Language assistance services (LAS): Language assistance services are oral or written services that substitute the English language with the primary language spoken, read, or understood by the person receiving the services, so that person can meaningfully access the underlying service being offered. This might also include providing a live or video relay American Sign Language (ASL) interpreter for a Deaf[29] or hard of hearing person who use ASL.

Limited English Proficiency (LEP): LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English. Under Title VI of the Civil Rights Act of 1964, all entities that receive any federal financial assistance (including hospitals, law enforcement agencies, courts, and victim service providers) are required to take reasonable steps to provide meaningful access to their programs and activities by people who are limited in their English proficiency because of their national origin. This generally involves providing language assistance, which should be provided at no cost to the individual seeking services.[30]

Patient-centered: Patient-centered refers to "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."[31] The term, "patient-centered approach," as used in this protocol recognizes that patients who have experienced sexual assault are central participants in the medical forensic examination process, and they deserve timely, compassionate, respectful, and appropriate care. They have the right to be fully informed in order to make their own decisions about participation in all components of the examination process.

Sexual assault: In broad terms, sexual assault is sexual contact without consent or when an individual lacks the capacity to consent. This definition includes, but is not limited to, a wide range of behaviors classified by state, territory, federal, military, and Tribal law as rape, sexual assault, sexual abuse, sexual misconduct, and sexual battery. Responders should refer to applicable statutes for legal definitions in their jurisdictions. In the public health and violence prevention arenas, sexual violence is often used as the more encompassing term, which refers to "sexual activity when consent is not obtained or freely given."[32]

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[29] In 2023, OVW awarded funds to the organization, Activating Change, to establish a new virtual "for Deaf, by Deaf" victim services program, the Deaf Service Line. The estimate to launch the service line is Spring 2025, although it will start with limited hours. The services offered will include crisis intervention, support groups, counseling, and advocacy. All services will be provided by individuals who are Deaf, or who are part of the Deaf community.

[30] See Title VI of the Civil Rights of 1964, 42 U.S.C. § 2000d et seq.; see also 28 C.F.R. § 42, subpt. C; see also Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41455 (June 18, 2002); see also 28 C.F.R. §§ 115.16, .116, .216, .316 (If the victim is in confinement, the confining agency shall take reasonable steps to ensure meaningful access to its programs and services by individuals who are LEP, at no cost to the person in confinement.); see also National Standards To Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106 (June 20, 2012).

[31] See Institute of Medicine (U.S.) Committee on Quality of Health Care in America. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century at page 6. *National Academies Press*.

[32] See Centers for Disease Control and Prevention. (2024). About Sexual Violence (last visited July 8, 2024).

Sexual assault medical forensic examination: The sexual assault medical forensic examination is an examination conducted by a clinician on a patient who has experienced sexual assault. Ideally the clinician has specialized education and clinical experience in their medical evaluation and collection of samples for the sexual assault evidence collection kit. The examination includes obtaining the medical forensic history; a comprehensive examination; coordinating treatment of injuries; documentation of the complete examination; and collection of samples for the sexual assault evidence collection kit; information, treatment, and referrals for STIs, pregnancy prevention, suicidal ideation, alcohol and substance abuse, and other nonacute medical concerns; and follow-up as needed to provide additional healing, treatment, or collection of evidence. Some communities may refer to the exam as a SAFE examination (sexual assault forensic examination).

Sexual assault response team (SART): The sexual assault response team is a group of specially trained members of health care, law enforcement, prosecution, and advocacy that work together to provide health care and advocacy services to victims of sexual assault, while investigating sexual assault cases for the purpose of criminal prosecution.[33] The team typically includes health care personnel, law enforcement representatives, victim advocates, prosecutors (usually available on-call to consult with first responders, although some may be more actively involved at this stage), civil legal services attorneys, and forensic lab personnel (typically available to consult with examiners, law enforcement, or prosecutors, but not actively involved at this stage). However, SART components vary by community. Some communities expand on the concept of the SART and have a sexual assault response and resource team (SARRT). This type of coordinated team response involves a wider array of agencies and disciplines in their collaborative effort. A **SARRT** will thus involve all of the first responders who are typically included in a **SART,** but it may also include professionals who coordinate services for victims beyond the immediate response (e.g., representatives from mental health, public health, substance disorder treatment, and other social services). Many of these response teams meet monthly and often engage in systems review to ensure that optimal victim-centered services are being provided in their communities. *For simplicity, this protocol will use the acronym SART to refer to both types of multidisciplinary response teams, understanding that individual jurisdictions can determine which model is most appropriate for their needs.*

Suspected individuals: In this document, the suspected individual is typically referred to as an assailant or offender. When litigation is discussed, they may be referred to as a defendant. When talking more broadly about the impact of the criminal justice system, the term "offender accountability" is used.

Victim: A victim is someone who has been sexually assaulted. In this document, a victim may be any gender or sexual orientation. Because this document addresses a multidisciplinary response, the term victim is not used in a strictly criminal justice context. The use of victim simply acknowledges that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them feel safe, recover, and seek justice. Survivor is rarely used in this protocol, since it commonly refers to someone who is going through or has gone through the recovery process,[34] and the protocol addresses the immediate aftermath of sexual violence.

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[33] See U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime. SANE Program Development and Operation Guide, Glossary of Key Terms (last visited July 8, 2024).

[34] See Sexual Assault Kit Initiative ("SAKITTA"). Victim or Survivor: Terminology from Investigation Through Prosecution (last visited July 8, 2024); see also, Rape, Abuse & Incest National Network ("RAINN"). Key Terms and Phrases (last visited July 8, 2024).

However, people may identify as either a victim or survivor, or move between the two terms. It is up to the individual to decide how best to define themselves in the aftermath of sexual violence.

For the purposes of the protocol, the term "patient" primarily is used since the focus is on medical forensic examinations, and within this context, it is the appropriate terminology for clinicians.

Vulnerable adults: Vulnerable is used in this document to refer to adults who do not have the physical or mental capacity to independently provide for their daily needs. However, some states also include the elderly within the definition of vulnerable adults per statute, regardless of impairment or capacity. Exam sites should have internal policies based on jurisdictional statutes governing consent for treatment for and sample collection from this patient population.

A.Overarching Issues

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

1. Coordinated Team Approach
2. Patient-Centered, Trauma-Informed Care
3. Informed Consent
4. Confidentiality
5. Reporting to Law Enforcement
6. Payment for the Examination Under VAWA

1. Coordinated Team Approach

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

- Understand that the purpose of the examination is to address patients' health care needs and collect samples for the sexual assault evidence collection kit that can be used by the criminal justice system should the case move forward.
- Identify key responders and their roles.
- Develop quality assurance/improvement measures to ensure effective response during the examination process.

Communities should ensure that every victim disclosing sexual assault has access to medical, legal, and advocacy services. A collaborative response among disciplines can ensure that when patients undergo the medical forensic examination, they will have access to immediate comprehensive care, but also, through victim advocacy, access to the appropriate resources they need to help minimize trauma they may be experiencing, and knowledge of community services in the aftermath of the examination. Such a response can also enhance public safety by facilitating investigation and prosecution, increasing the potential for offenders to be held accountable for their behavior and further sexual assaults prevented. Raising public awareness about the existence and benefits of a coordinated response to sexual assault may lead more victims to disclose the assault and seek the help they need.

Responders should understand how historical trauma may contribute to patients' reactions and needs when working with historically marginalized populations. Adequate self-education by responders, combined with education by individuals from within these populations, can prepare responders to be sensitive to the historical context in which victimization occurs and to avoid assumptions about patients' cultural practices. Tribal jurisdictions may have their own sexual assault response protocol in place that addresses the Tribe's unique needs and incorporates its cultural traditions, practices, and language.

Understand that the purpose of the examination is to address patients' health care needs and collect samples for the sexual assault evidence collection kit that can be used by the criminal justice system should the case move forward. The medical forensic examination, when completed in its entirety, addresses the following components:

- Prompt patient examination.
- Support, crisis intervention, and advocacy.
- Medical forensic history gathering.
- Comprehensive assessment.
- Documentation of examination findings.
- Evaluation and treatment of injuries and other identified acute healthcare issues.
- Addressing and planning for the safety of the patient.
- Proper collection, handling, and preservation of samples for the sexual assault evidence collection kit and other potential evidence such as clothing items.
- Information, treatment, and referrals for STIs and pregnancy.
- Follow-up care related to the medical forensic examination, and for other identified medical and emotional needs as indicated.
- Language assistance services for limited English proficient (LEP), Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.

As a routine part of their post-examination process, clinicians may be called upon to:

- Interpret and analyze examination findings.
- Present findings and provide factual and/or expert opinion.

Coordination among involved disciplines is strongly recommended to simultaneously address the needs of both patients and the justice system. Ensuring that patients' needs are met from both advocacy and medical perspectives, may help them feel more comfortable and willing to engage with the criminal justice process.[35]

Identify key responders and their roles. Two types of teams are recommended to facilitate a coordinated community response to sexual assault: a sexual assault response team (SART) or a communitywide coordinating group (often called a "council"). A SART is useful to coordinate immediate interventions and services, including victim support, medical forensic care, and the initial criminal investigation.[36] A council can help promote efforts to improve a comprehensive response to sexual violence, including prevention education and outreach,[37] training, legal representation, technical assistance, improvement of victim services, protocol development, public policy advocacy, dissemination of materials, and evaluation of the effectiveness of these efforts.[38] A council may also oversee activities of a SART. Military bases, school campuses, and Tribes may develop councils or SARTs of their own to allow for a more specialized response tailored to the needs of their populations. Councils may encourage consistent responses across a state, territory, Tribal land, or region.

American Indian and Alaska Native Tribes may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault. Responders should be familiar with procedures for coordinating services and interventions for patients from these communities and should work with community groups to develop plans for providing examinations to members of Tribes. These plans should address evidence preservation and provide examination payment and reimbursement information. Responders within Tribal

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[35] See Campbell, R., Patterson, D., & Fehler-Cabral, G. (2010). Using Ecological Theory to Evaluate the Effectiveness of an Indigenous Community Intervention: A Study of Sexual Assault Nurse Examiner (SANE) Programs. *American Journal of Community Psychology, 46* at pages 263-276.; see also, Campbell, R., Patterson, D., & Bybee, D. (2012). Prosecution of adult sexual assault cases: A longitudinal analysis of the impact of a sexual assault nurse examiner program. *Violence Against Women, 18*(2) at pages 223-244.

[36] Sexual assault medical forensic examiners must be mindful of their role on the SART: while they collaborate with other disciplines to help achieve a patient-centered, trauma-informed response, their role requires them to be objective healthcare professionals, and not an arm of the investigation, nor victim advocates. That role clarity benefits patients in the examination room, and should they choose to engage with the criminal justice system, in the courtroom, as well.

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

[38] See American College of Emergency Physicians. (2nd Edition 2013). Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient at page 16.

communities should share resources and information to enable them to develop their own protocols and programs that address the community's unique needs.

Team efforts are enhanced when SART members reflect the communities being served. At a minimum, members should strive to understand the needs and concerns of specific underserved populations living in the area served. SARTs should reach out to agencies that serve these populations to participate in SARTs where possible so that team members can more effectively collaborate. This includes promoting partnerships among Tribal and relevant federal and state agencies to better coordinate responses and resources, learn from past mistakes, and strive towards a shared vision of aiding and empowering patients. Likewise, to improve care of incarcerated and detained victims of sexual assault, communities should create partnerships between local SARTs and area correctional facilities.[39]

Organizations with an interest in or a responsibility for victims of sexual assault should be considered for membership in coordinating councils.[40] They may include:

- Community-based victim advocacy organizations.
- Healthcare professionals (including medical forensic service providers, emergency medicine clinicians, public health professionals and others who may regularly provide first contact or follow-up with patients, such as clinicians who serve migrant farmworkers or immigrant patient populations, and clinicians caring for patients who are unhoused).
- Prosecutors and civil attorneys who advocate for victims' rights and address other legal issues collateral to the criminal justice process.
- Survivors.
- Forensic laboratory personnel (including forensic biologists and toxicologists).
- Judicial personnel.
- Detention, corrections, and probation staff.
- Educators (K-12, college/university) and college and university staff (e.g., residence life, Title IX).
- Mental health and substance use disorder treatment providers.
- Sex offender treatment professionals.
- Local policy makers.
- Faith-based, community, or spiritual leaders.
- Tribes and Tribal agencies.
- Organizations that work with people who are Deaf and hard of hearing.
- Organizations that work with elders and Adult Protective Services.
- Organizations that specifically work with people with disabilities.
- Organizations that represent culturally and linguisticallyspecific populations in the community.
- Military organizations.
- Other professionals or agencies as identified by the council.[41]

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[39] See Hastings, A., Subramanian, R., & Littel, K. (2015). Partnering with Community Sexual Assault Response Teams A Guide for Local Community Confinement and Juvenile Detention Facilities. *Vera Institute of Justice.*

[40] See above, IPV Protocol at page 30.

[41] List adapted from above, Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient at page 16.

Attempting to involve all agencies and individuals listed above is an enormous task and could prove to be a barrier to council formation and initial council efforts. Therefore, communities should make their own decisions about which stakeholders are critical to initial efforts and form a core membership, and then identify other agencies and individuals to participate as they are able to join.[42]

Develop quality assurance/improvement measures to ensure effective response during the examination process.[43] Involved agencies should have mechanisms to ensure that the quality of discipline-specific response and coordinated response is optimal. This may include training, ongoing education, supervision, periodic performance evaluations, and peer reviews (e.g., medical forensic reports), as well as feedback from victims and involved professionals and collection and analysis of data from the exam process (as discussed below). Review of both active and resolved cases may provide opportunities to improve the performance of individual team members and the team as a whole, although team members should be mindful of any confidentiality obligations in case discussions. In addition to federal privacy laws protecting some types of information, funders may also have confidentiality obligations that limit or prohibit disclosure of certain information.[44] Patient information should not be shared unless permission is expressly granted, in writing, for disclosure to each individual entity.

Obtain feedback on victim impact, the examination process, and criminal justice outcomes. All involved responders can benefit from victims' feedback about whether they felt the response to the crime was adequate and if anything could have been done to improve response or better address their needs. It can be useful to talk with victims about the examination process, including the location of the examination, and explore how the process might be changed to better minimize trauma; however, soliciting that information should not be done at the time of the examination itself. Victim feedback can be obtained in several ways: by requesting completion of an evaluation form (not immediately after the examination), conducting a follow-up (anonymous) online or text survey, or inviting participation in focus group discussions. It is important to solicit feedback from diverse populations in the community (e.g., persons with disabilities, racial and ethnic groups, elderly individuals, poor and low-income individuals, people experiencing homelessness, youth who have runaway and adolescents in foster care). Ask patients prior to medical discharge if they will allow such subsequent contacts, whether it is safe to contact them, and the best method of contacting them without compromising their privacy. Clinicians and other responders should ensure they ask patients for a safe manner to contact them, particularly in situations involving sexual assault by intimate partners, gang rape, or other potentially dangerous situations. Advocates can help design a victim feedback system that is sensitive, does not harm victims, and has mechanisms to quickly link victims with appropriate victim services if needed. Families and friends of victims may also be able to provide useful feedback, with victim consent.

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[42] For additional resources about the development and operation of a multidisciplinary response, see above, SART Toolkit; see also, above, SANE Program Development and Operation Guide, Multidisciplinary Response and the Community.

[43] Quality assurance ("QA") is a reactive process that measures compliance against certain necessary standards, typically focusing on individuals. Quality improvement ("QI") is a proactive continuous improvement process focused on processes and systems. See above, SANE Program Development and Operation Guide, Quality Assurance and Quality Improvement.

[44] See Victim Rights Law Center. (2016). CCR Toolkit: A Privacy Toolkit for Coordinate Community Response Teams (last visited July 8, 2024).

Feedback from and facilitating dialogue among the first responders (law enforcement, advocates, medical personnel) to the sexual assault and the clinician who conducted the examination are also critical. Periodic evaluation of the examination process by clinicians, medical directors/clinical program directors, and feedback from SART members can help ensure that victims' needs are addressed, problems are resolved, current practice standards are maintained and improved upon, appropriate technologies are employed, and training needs are identified. As part of the feedback loop, clinicians can benefit from engaging with other disciplines to discuss how their role and their work with patients impacts patients, individual cases, and the systems' response as a whole.

SARTs can serve several purposes and improve responses to sexual assault in several respects. Data collection may provide a way to measure outcomes in several categories:[45]

- Multidisciplinary outcomes: To improve and maintain SART sustainability and ability to make changes throughout the system response. Data to collect includes victim satisfaction, changes in policies or resources, number of cases referred to community-based services, team member attitudes and beliefs, knowledge and understanding.
- Advocacy outcomes: To enhance the quality of a person's experience of seeking help after a sexual assault. Data to collect includes victim satisfaction, number of victim referrals, outreach and service to diverse populations, dissemination of information for victims, education for victims, access to other resources and service providers, language accessibility and use of qualified interpreters as appropriate.
- Medical outcomes: To provide quality comprehensive medical care to patients who have been sexually assaulted. Data to collect includes patient satisfaction (e.g., medical care, exam process, options, patient agency), number of medical forensic examinations, number and types of kits collected (e.g., anonymous vs reporting), number and types of services provided, data on quality of evidence collected by medical forensic examiners, number of clinicians subpoenaed to testify, language accessibility and use of qualified interpreters as appropriate.
- Law enforcement outcomes: To facilitate reporting and investigation of sexual assault. Data to collect includes victim satisfaction, number of exam kits submitted to and processed by crime labs, data on quality of evidence collected by law enforcement, number (percentage) of cases assigned for investigation, number (percentage) of cases submitted to prosecutors for review, language accessibility and use of qualified interpreters as appropriate.
- Prosecution outcomes: To increase offender accountability and victim participation. Data to collect includes victim satisfaction, number of charges, number (percentage) of case filings, number (percentage) of trials, pleas, sentences, numbers (percentages) of dispositions, trial results, timeliness of response, language accessibility and use of interpreters as appropriate.[46]

SARTs can also collect basic victim demographic data (age, race, socioeconomic status, gender, primary language of the victim, and other desired information) to better understand who they serve.

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[45] The following list is adapted from above, SART Toolkit at Section 4.2. Operations, Meeting Logistics.

[46] See Long, J., Powers, P., Spainhower, H., & Newman, J. (2022). Seeking Justice Through Sexual Violence Prosecutions. *Strategies: The Prosecutors' Newsletter on Violence Against Women*, 19 (discussing how conviction rates do not adequately measure whether a prosecutor's office is successful in handling cases involving sexual violence).

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

2. Patient-Centered, Trauma-Informed Care

Recommendations at a glance for clinicians and other responders to facilitate patient-centered care during the exam process:

- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy and on-site safety.
- Adapt the examination process as needed to address the unique needs and circumstances of each patient based on the history the patient provides.
- Develop culturally and linguistically responsive care and be aware of issues commonly faced by patients from specific populations, including immigrant, racial and ethnic minorities, LGBTQI+, elder patients, and patients with disabilities.
- Recognize the importance of offering victim advocacy immediately, assuming the patient does not already have a victim advocate available.
- Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., faith-based, community, or spiritual counselor/advisor/healer) present during the examination unless considered harmful by the clinician, e.g., if the person is a suspected offender or abuser.
- Strive to limit the number of persons (beyond the patient, examiner, advocate, personal support person, and any necessary interpreters) in the exam room during the exam.
- Accommodate patients' requests for responders of a specific gender throughout the examination as much as possible.
- Prior to starting the examination and conducting each component, explain to patients what is entailed and its purpose.
- Assess and respect patients' priorities.
- Integrate medical and sample collection procedures where possible to increase examination efficiency.
- Work with the patient to identify and address their safety concerns during and after the examination.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.
- Address physical comfort needs of patients prior to discharge including hygiene products and clean clothing to replace any collected as part of the evidence collection kit and/or damaged from the assault.

Patient-centered care means providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. Trauma-informed care is a framework that involves understanding, recognizing, and responding to the effects of all types of trauma and seeks to employ practices that contribute to positive outcomes for patients, staff, and systems. It emphasizes physical, psychological, and emotional safety; trustworthiness and transparency; collaboration and mutuality; empowerment; and cultural sensitivity and responsiveness.[47] These are the foundational underpinnings of the medical forensic

[47] See above, IPV Protocol at pages 17, 20.

examination. This section outlines the ways in which the process can be as patient-centered and trauma-informed as possible.

Give sexual assault patients priority as emergency cases. This includes a prompt medical screening examination. Recognize that any time patients spend waiting to be examined may cause undue trauma and loss of evidence. Individuals disclosing a recent sexual assault should be quickly transported to the examination site, promptly evaluated, treated for serious injuries, and offered a medical forensic examination. (For more discussion on this topic, see *C.2. Triage and Intake.*) Ensure there is a plan if the clinician conducting the medical forensic examination is not available right away. For example, determine if there a quiet, private place the patient can wait or a phone available in a private space so the patient can talk to an advocate or a friend or family member while waiting. Jurisdictions should consider policies and training for facility staff and administration regarding what to do while patients are waiting. This is particularly important in rural and remote areas where there may not be access to a trained medical forensic examiner, and alternatives for conducting the examination need to be considered.[48]

Provide the necessary means to ensure patient privacy and on-site safety. Allow patients private spaces for triage and waiting to maximize confidentiality and avoid any potential embarrassment of being identified in a public setting as a victim of sexual assault.[49] Unless it is absolutely unavoidable, do not complete medical forensic examinations in spaces only separated from other exam spaces by a curtain or permeable partition, as patients may have concerns about safety as well as concerns that others may overhear portions of their examination. Ensure that an on-call advocate is called at the time the patient is triaged for onsite support, crisis intervention, and advocacy. It may be useful to give patients the option of speaking with an advocate via a 24-hour crisis hotline (if accessible) until an advocate arrives. Examination site personnel should provide patients with access to a phone to contact family members and/or support persons as desired. Discuss law enforcement reporting options early with patients, if the police are not already involved, so that if patients know they want to report the assault, law enforcement can be contacted as early as possible to decrease wait times. For those programs that also conduct suspect/offender examinations, ensure they are not occurring in the same facility at the same time as the patient's examination.

Prior to beginning the medical forensic examination, clinicians should explain the scope of confidentiality, including any mandatory reporting requirements that may be triggered during the examination process and during communication with advocates. If a patient is identified as having limited English proficiency (LEP), they must be provided a qualified interpreter at no charge, so they are able to understand, consent to, and meaningfully participate in the medical forensic examination process.[50] (For information on this topic, see *A.4. Confidentiality*.)

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[48] For organizations and agencies that do not have regular access to a trained medical-forensic examiner, the International Association of Forensic Nurses has a free two-hour course for all clinicians, Caring for the Sexually Assaulted Patient When There is No SANE in Sight ("No SANE in Sight"), that provides basic information on caring for the patient presenting after sexual assault.

[49] If the facility in which the patient presents does not have direct and timely access to medical forensic services, encourage programs to initiate a "warm handoff" protocol in which resources at the receiving facility are ensured, notified, and arranged prior to the patient leaving the transferring facility to minimize patient wait times and unnecessary clinical interactions.

[50] See Title VI of the Civil Rights of 1964, 42 U.S.C. § 2000d et seq.; see also 28 C.F.R. § 42, subpt. C; see also Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41455 (June 18, 2002).

Adapt the examination process as needed to address the unique needs and circumstances of each patient based on the history the patient provides and how the patient presents. Patients' experiences during their assault and the examination process, as well as their post-assault needs, may be affected by multiple factors, including:

- Age.
- Sex designated at birth and gender, including transgender and non-binary.
- Physical health history and current status.
- Mental health history and current status.
- Substance use history and current status.
- Disability.
- Language access needs for patients that have limited English proficiency, Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.
- Ethnic and cultural beliefs and practices.
- Faith-based and spiritual beliefs and practices.
- Economic status.
- Housing status, including homelessness and housing instability.
- Being an immigrant or refugee.
- Sexual orientation.
- Military status.
- History of previous victimization.
- Past or current experience with the criminal justice system (including currently incarcerated or involuntarily confined) and associated agencies (e.g., child protective services).
- Involvement of drugs and/or alcohol in the assault.
- Prior or current relationship with the suspect, if any.
- The relationship of the patient to the assailant (i.e. if the assailant held a position of authority over the patient).
- Whether the assault was part of a broader continuum of violence and/or oppression (e.g., intimate partner and family violence, gang violence, hate crimes, war crimes, commercial sexual exploitation, sex and/or labor trafficking).
- Where the assault occurred.
- Whether the patient sustained physical injuries from the assault and the severity of those injuries.
- Whether photographs or recordings should be taken as a part of the assault.
- Number of assailants.
- Collateral misconduct by the patient at the time of the assault (e.g., voluntary use of illegal drugs or underage alcohol use) or outstanding criminal charges.
- Other activities by the patient prior to the assault that traditionally generate victim blaming or self-blaming (e.g., drinking alcohol prior to the assault or agreeing to go to the assailant's home).
- Capacity to cope with trauma and the level of support available from families and friends.
- The importance they place on the needs of their extended families and friends in the aftermath of the assault.
- Whether they have dependents who require care during the examination, were witness to the assault, or who may be affected by decisions patients make during the examination process.
- Community/cultural attitudes about sexual assault, its victims, and assailants.
- The patient's or their community's personal or historic relationship with law enforcement.
- Frequency of sexual assault and other violence in the community and historical responsiveness of the justice system, health care systems, and community service agencies.

The level of trauma experienced by patients can also influence their initial reactions to an assault and to post-assault needs. While some may suffer physical injuries, contract an STI, or become pregnant as a result of an assault, many others do not. Fears of these concerns may not end with discharge from the medical forensic examination facility and may compound the trauma born from the assault. The experience of psychological trauma will be unique to each patient and may be more difficult to recognize than physical trauma. There is no one way patients express trauma, and patients may employ coping behaviors that are outwardly expressed in a variety of ways that confound those expecting a specific clinical picture of trauma: as laughing or joking with friends, hostile or uncooperative towards those attempting to provide assistance, or uncommunicative and flat even after consenting to participate in the examination and investigative process. Clinicians should ensure they do not make credibility determinations or assessments about needed support or follow-up care based on myths or misconceptions about patient behaviors.

In addition, patients' fears and concerns can affect their initial reactions to the assault, their post-assault needs, and decisions before, during, and after the examination process. They may not want anyone to know about the assault or may be afraid that family members and friends will reject or blame them. They may fear bringing shame to their families or be concerned that family members will seek revenge against the assailant. They may fear perceived or real consequences of reporting to law enforcement. They may be concerned about how their cultural background could affect the way they are treated by responders. They may wonder if the assailant will harm or harass them or their loved ones if they tell anyone about the assault, and for some patients, including incarcerated and detained patients or military members, retaliation may be a significant fear. They may worry about losing their home, children, ability to remain in the United States, job, and other sources of income as a result of disclosure, particularly if an intimate partner assaulted them.[51] They may be concerned about costs related to the examination and subsequent care of injuries.

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

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

Develop culturally and linguistically responsive care and be aware of issues commonly faced by patients from specific populations, including immigrant, LGBTQI+, and elder patients. Develop culturally competent and sensitive care by building awareness about and sensitivity to the ways that culture can impact a person's experience in the immediate aftermath of

[51] For example, minors may fear being removed from their homes if offenders live with them. Persons living in residential settings, such as group homes or nursing facilities may fear being removed from their homes if they report an assault that occurred in that setting. People with disabilities who have been assaulted by a caregiver may fear losing their ability to live independently if they report.

sexual assault and across their lifespan. Be aware and responsive to the ways in which different identities (e.g., race, ethnicity, national origin, gender, religion, ability/disability, language [limited English proficiency], immigration status, socioeconomic status, sexual orientation, gender identity or expression, age) may influence a person's experience during the examination process as well. Patients are complex and cannot be reduced to a single experience or identity. It is incumbent upon the clinician to see how the totality of a patient's experiences and identities shapes their understanding of the world and how they navigate it.[52] Education for clinicians on issues facing a specific population may serve to enhance care, services, and interventions provided during the examination process. Clinicians should identify different populations that exist in their practice and determine what information they should have readily available to help them serve patients from these populations, including languages spoken and how to access the qualified interpreters needed. Building understanding of the perspectives of a specific population may help increase the likelihood that the actions and demeanor of clinicians will mitigate patient trauma. However, do not assume that patients will hold certain beliefs or have certain needs and concerns merely because they belong to a specific population, as no single group is a monolith.

Develop policies and procedures. Involved agencies and SARTs should develop policies and procedures to meet the needs of specific patient populations (e.g., to obtain necessary interpreter services and translated documents for limited English proficient (LEP) patients, qualified interpreters for patients who are Deaf and hearing impaired and individuals with sensory or communication disabilities, and legal referrals for immigrant patients when necessary). When creating these policies and procedures, consider what barriers exist for patients from different populations to receiving a high-quality examination and what can be done to address these barriers. Also, consider what equipment and supplies might be needed to assist persons from specific populations (e.g., a hydraulic lift exam table for patients who have a physical disability or non-gendered body maps for transgender and gender diverse patients).

Partner with those who work with specific populations that may be typically marginalized, such as LGBTQI+ individuals, people with disabilities and specific cultural, racial, and ethnic minorities. Involved responders should seek expertise from and collaborate with organizations and leaders that primarily serve specific populations if they are not already members of the SART. Not only may they be willing to provide information and training on working with patients from the population they serve, but they also may be a resource before, during, and after the examination process. Individuals from these organizations should be trained on the dynamics of sexual victimization, know about procedures for getting help for patients, and work with the multidisciplinary response team to clarify their roles and procedures for response.

Recognize the importance of offering victim advocacy immediately, assuming the patient does not already have a victim advocate available. In many jurisdictions, community-based sexual assault victim advocacy programs and other victim service programs offer a range of services before, during, and after the examination process (see below for a description of typical services). Ideally, advocates should begin interacting with patients (in the patient's primary language) prior to the examination, as soon after disclosure of the assault as possible. This is true even in cases where the examination will be offered via telehealth.[53] Patients who come to examination sites in the immediate aftermath of an assault are typically coping with trauma, anticipating the examination, and

[52] See above, IPV Protocol at page 18.

[53] Patients undergoing sexual assault medical forensic exams via telehealth also need access to victim advocates. For more information on the role of the advocate in these circumstances see IAFN's FAQs on the Role of Victim Advocates in Tele-Sexual Assault Forensic Exams.

considering the implications of reporting. Most responders with whom patients come into contact are focused on objective tasks. Law enforcement officials gather information and collect crime scene evidence to facilitate the investigation. Clinicians assess medical needs, offer treatment, and collect samples from patients for the evidence collection kit. Victims must make many related decisions that may seem overwhelming. Advocates can offer a tangible and personal connection to a long-term source of support and advocacy.[54] Community-based advocates, in particular, have the sole purpose of supporting victims' needs and wishes. Typically, communications with community-based advocates are confidential because many jurisdictions have victim-advocate privilege that shields communications from disclosure. Conversely, systems-based advocates, such as those who work for law enforcement agencies or prosecutors' offices, are bound by the prosecutors' discovery obligations, and therefore cannot serve as a confidential resource for victims.[55] Similarly, statements to clinicians become part of the medical forensic record and may be subject to a subpoena for documents or a subpoena for testimony by the clinician and therefore subject to disclosure during the criminal discovery process. Relevant information regarding privacy and confidentiality should be provided to the patient.

Because advocates support patients during the examination process, clinicians can more easily focus on the components of the medical forensic examination, allowing patients to generally have better experiences.[56] In addition to victim advocates, civil attorneys also may be able to help victims assess legal needs and options regarding their privacy, safety, immigration, housing, education, employment, financial, and other legal needs post-assault. In addition to providing immediate crisis management and support, the role of the advocate during the medical forensic examination may include: [57]

- Normalizing feelings of fear and stress associated with health care and the examination process in particular.
- Accompanying the patient through every step of the medical forensic examination (advocates may be present with the patient's consent from the initial point of contact through the examination itself to the discharge and follow-up appointments).
- Discussing privacy and confidentiality with patients and clarifying communication methods and preferences.
- Providing or arranging transportation if requested.
- Making connections and referrals between different services and working with the patient to identify the most appropriate resources for ongoing support.

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[54] To prepare community-based advocated to competently provide sexual assault victim services, they are typically trained and receive supervision according to the policies of the sexual assault advocacy agency where they are affiliated. In addition, community-based advocated must abide by any jurisdiction-specific requirements for confidentiality or privilege. System-based advocates may be required to have specific credentials based on system and jurisdictional policies and laws.

[55] See Sexual Assault Kit Initiative ("SAKITTA"). Advocacy Meets Prosecution: The Benefits of a Strong Partnership (last visited July 10, 2024).

[56] See Campbell, R., Greeson, M. R., & Fehler-Cabral, G. (2013). With care and compassion: adolescent sexual assault victims' experiences in Sexual Assault Nurse Examiner programs. *Journal of Forensic Nursing*, *9*(2), at pages 68–75.; see also, Campbell R. (2008). The psychological impact of rape victims. *The American psychologist*, *63*(8), at pages 702–717.; see also, Campbell R. (2006). Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence Against Women*, *12*(1), at pages 30–45.

[57] The following list was drawn in part from the Sexual Assault Demonstration Initiative (2020). Foundations of Advocacy Training Manual, at page 274.

- Providing information about the patient's needs to the clinicians (and others who may be in contact with the patient during the examination process) and supporting patients in voicing their concerns to relevant responders.
- Informing patients of their rights as a victim of sexual assault and a crime victim, including the right to medical care without sample collection or reporting to law enforcement and participating in the criminal justice process.
- Serving as a resource and follow-up point of contact for any future inquiries or service referrals.
- Helping patients' families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support patients may need from them.
- Assisting patients in planning for their safety and well-being.

It is the medical forensic examiner program's responsibility to secure assistance from qualified interpreters to ensure language access for all patients. Clinicians' agencies must set up formal agreements with qualified interpreters and with language lines that provide interpreters in languages that are less common in the community. These arrangements may include contracts with qualified interpreters who also work with or for victim advocacy agencies.[58] Clinicians should not rely on advocates to provide interpretation services (even if they are native speakers) or find qualified interpreters on the clinicians' behalf unless a formal arrangement is in place for such services.

Post-exam, advocates can continue to advocate for patients' rights and wishes; offer patients ongoing support, counseling,[59] information, and referrals for community services; assist with applications for victim compensation programs;[60] and encourage patients to obtain follow-up testing and treatment and take medications as directed. They can also accompany patients to follow-up appointments, including those for related medical care, legal assistance, and criminal and civil justice-related interviews and proceedings. (Note that the advocate could be compelled to testify about what the victim said at these appointments, if the advocate's presence is legally deemed waiver of a privilege or the if underlying conversation is not protected, which is the case with law enforcement interviews.) They can work closely with the responders involved to ensure that post-exam services and interventions are coordinated in a complementary manner and are appropriately based on patients' needs and wishes.

Contact the victim service/advocacy program immediately. As soon as a sexual assault patient identifies themselves, facilities should call the victim service/advocacy program and ask for an

[58] The Joint Commission, which accredits thousands of healthcare organizations in the U.S., requires provision of qualified interpreter services; see Limited English Proficiency website (last visited July 15, 2024); see also Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient, (August 2003), 68 Fed. Reg. 47311.

[59] Many advocacy agencies offer ongoing support and advocacy to victims. Some also provide professional mental health counseling, but many refer victims to community or private agencies.

[60] For more information on crime victim's compensation, see the U.S. Department of Justice, Office for Victims of Crime webpage on Victim Compensation and Assistance in Your State (last visited July 10, 2024).[61] Community-based sexual assault victim advocates should be used where possible. If not available, victim service providers based in the examination facility, criminal justice system, social services, or other agencies may be able to provide some advocacy services, if trained to provide those services. Patients should be aware that government-based service providers typically cannot offer confidential communication.

advocate to be sent to the examination site (unless an advocate has already been called).[61] Facilities should not wait for the medical forensic examiner to arrive before contacting the victim advocacy program. Prior to introducing the advocate to a patient, examination facility personnel should explain briefly, in the patient's primary language, the victim services offered and ask whether the patient wishes to speak with the onsite advocate. Note that some jurisdictions require that patients be asked whether they want to talk with an advocate before the advocate is contacted. Others, however, affirmatively require the facility call a victim advocate.[62] When doing so, facilities should not disclose the victim's identity to further protect the patient's confidentiality.[63] If possible, the patient should be allowed to meet with the advocate in a private place prior to the examination. If that is not feasible, the advocate should have time alone with the patient prior to discharge when would not interfere with the medical forensic examination. Ideally, the patient should be assisted by the same advocate during the entire examination process.[64]

Patients who are undocumented immigrants may be reluctant to discuss or report the victimization. It is inappropriate to ask patients about information, such as legal status or sexual or gender identity that is unrelated to the assault. It is, however, appropriate to ensure that all patients are provided with information regarding immigration relief for crime victims including U and T visas, VAWA immigration relief, and Special Immigrant Juvenile Status.[65]

When possible, contact organizations who have advocates with experience working with culturally specific populations.

Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., faith-based, community, or spiritual counselor/advisor/healer) present during the examination, unless their presence would impede or harm the process.[66] Clinicians should get explicit consent from patients to allow support persons in the medical forensic

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[61] Community-based sexual assault victim advocates should be used where possible. If not available, victim service providers based in the examination facility, criminal justice system, social services, or other agencies may be able to provide some advocacy services, if trained to provide those services. Patients should be aware that government-based service providers typically cannot offer confidential communication.

[62] See, e.g., Or. Rev. Stat. Ann. § 147.404 (West) (requiring "the provider of the medical assessment or, if applicable, a law enforcement officer [to] contact a victim advocate and make reasonable efforts to ensure that the victim advocate is present and available at the medical facility in which the medical assessment occurs.").

[63] This may be relevant in small communities where patients may know some or all advocates (e.g., a small, close-knit community that speaks an uncommon dialect). Some patients may feel comfortable being supported by an advocate known to them while others may not. Patients concerned about anonymity should be provided with as many options as possible. For example, they may prefer to speak with an on-call advocate on the phone prior to making their decision about whether they want an advocate present during the examination. Another option may be for the local advocacy program to partner with an advocacy program in a neighboring jurisdiction, so they can provide a backup advocate when needed.

[64] Continuity of advocates can be challenging when response by law enforcement or the clinician is delayed, the examination process is lengthy, or travel to the examination site is considerable, particularly when volunteers may not be able to remain after the end of their on-call shift.

[65] See Department of Homeland Security. Interactive Infographic U.S. Immigration Benefits for Noncitizen Crime Victims (English), November 2021, and the Blue Campaign Gender-Based Violence Pamphlets and Flyers; see also, SART Toolkit at Section 6.2. Cultural Responsiveness.

[66] For example, in cases involving adolescents or vulnerable adults, caretakers should not be allowed in the exam room if they are suspected of committing the assault or of being otherwise abusive to the patient.

examination; this should be done without that individual present (if the individual is anyone other than a trained victim advocate),[67] and the clinician should clarify if there are any aspects of the process for which the patient does not want the support person to be present (e.g., during the taking of a patient's medical forensic history). Patients' requests in this regard should be respected (e.g., adolescents may not want their parents present). Regardless of who is present, appropriately drape patients and position additional persons to protect privacy and modesty. It is also important to inform patients of confidentiality considerations regarding the presence of support persons during the medical forensic history. (For a discussion of this topic, see *C.4. The Medical Forensic History*.)

Strive to limit the number of persons (beyond the patient, examiner, advocate, personal support person, and any necessary interpreters) in the exam room during the examination. The primary reason is to protect patients' privacy, but also because exam rooms often cannot accommodate more than a few individuals. Chaperones should be used according to institutional policy. The chaperone may be an advocate or another clinician. In circumstances where the clinician and the patient are different genders, a chaperone of the patient's gender may create a more trauma-informed experience for the patient, although this should not be assumed. Consent should be sought before inviting the chaperone into the room.[68]

Law enforcement representatives should not be present during the examination. When additional clinicians are needed for consultation (e.g., a surgeon), the patient's permission should be sought prior to their admittance. In cases in which clinicians are supervising a medical forensic examiner-in-training, the patient's consent should be obtained prior to the student's admittance to examine patients or observe the examination. It is inappropriate to ask patients to allow a group of non-licensed medical or nursing students to view the examination.

Accommodate patients' requests for responders of a specific gender throughout the examination as much as possible. For a variety of reasons, patients may to prefer to work with a law enforcement officer, clinician, or advocate of a particular gender.

Prior to starting the examination and conducting each procedure, explain to patients in their primary language what is entailed and its purpose and obtain their consent to proceed. In addition, it is important to explain the examination process and the purpose of the examination more generally (e.g., how the examination documentation and samples collected may be used outside of the healthcare system). A clear explanation is particularly important for individuals who may not previously have had a speculum examination or medical care involving any type of genital examination, or who have difficulty understanding what has happened and why they are being offered a medical forensic examination. Remember that some examination procedures may be uncomfortable or even painful to patients, considering the nature of the trauma they have

[67] There is always concern that the person intended to provide support may be problematic, even if they are not the assailant. Spouses or parents may pressure the patient into allowing them to stay, but it is important to ensure the patient is comfortable enough to disclose information needed for comprehensive care. From a safety perspective, it is important that the additional person in the room does not weaponize information from the examination against the patient at a later time. From a legal perspective, anyone in the room becomes a witness to the examination and may have to later testify if subpoenaed to do so.

[68] Other countries that have standardized the use of chaperones as a part of the medical forensic exam, such as Australia, also give patients the option of having the chaperone present outside the door or behind a curtain where the chaperone is available within hearing distance but is not physically present for the exam. See, e.g., The Royal College of Pathologists of Australasia. (September 2021). Guideline: The Presence of Chaperones during Intimate Forensic Medical Examinations. In this way, patients can call for them if they need them, but they do not have to have the additional person in the room with them during the exam.

experienced. By taking the time to explain procedures and their options, patients may be able to make more informed choices, feel more in control of what's occurring, and make decisions that meet their needs. After providing the necessary information, seek patients' consent to proceed with all examination components. (For a more detailed discussion on seeking informed consent of patients, see *A.3. Informed Consent*.)

Address and respect patients' priorities. Although medical care and sample collection for the sexual assault evidence collection kit are offered to all patients during the examination process, clinicians should provide patients with information about all of their options and assess and respect their priorities. Clinicians cannot anticipate and should not assume to know what patients will prioritize as components of their care and the safety and discharge process. (For a more detailed discussion on safety and discharge planning, see *C.10. Discharge and Follow-up.*)

Integrate medical and sample collection procedures where possible to increase examination efficiency. Medical care and sample collection procedures should be integrated to maximize efficiency and minimize trauma to patients. For example, if needed, draw blood for medical and sample collection purposes at the same time. Consider how the examination can be structured so that it is seamless to simultaneously assess the patient and gather the requisite samples for the evidence collection kit. Keep in mind that some assessments can be done while samples are being collected.

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

Provide information that is easy for patients to understand, in the patient's primary language, and that can be reviewed at their convenience.[69] Information should be tailored to patients' communication skill level/modality and language. This includes providing qualified interpreter services and the required translation of key documents into languages other than English for patients who have limited English proficiency (LEP).[70] Developing material in alternative formats may be useful, such as information that is recorded, in Braille, in large print, in various languages, or uses pictures and simple language. Online information to which a patient could be directed might be useful as a way to reduce the amount of information patients have to bring home with them, in

[69] Many local sexual assault advocacy programs, Tribal sexual assault and domestic violence coalitions, and state sexual assault coalitions offer such publications. However, any involved agency, SART, or coordinating council could also develop such literature.

[70] See Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency: 67 Fed. Reg. 52762 (August 30, 2000).

situations where it might be unsafe for patients to have the information with them, or as a supplement in the case of lost or damaged information. Any patient information that includes the following topics may be helpful:

- The crime itself (e.g., facts about sexual assault and related criminal statutes).
- Common reactions to experiencing sexual assault (stressing that it is never the patient's fault), and signs and symptoms of traumatic responses.
- Relevant time frames with regard to reporting and other statutory timelines.
- Victims' rights.
- Victim support and advocacy services.
- Civil, criminal, and administrative legal services.
- Treatment and support to address mental health conditions.
- Treatment and support to address substance use disorders.
- Resources for the patient's significant others and loved ones.
- The examination—what happened and how the information may be used by entities outside the healthcare setting.
- Medical discharge and follow-up instructions.
- Planning for the patient's safety and well-being.
- Examination payment and reimbursement information.
- Steps and options in the criminal justice process.
- Procedures for patients to access their medical records.
- Procedures for tracking the sexual assault evidence collection kit (if applicable), any toxicological samples that were sent for testing to forensic laboratories, and any applicable law enforcement reports.

Address physical comfort needs of patients prior to discharge, including hygiene products, and clean clothing to replace any collected as part of the evidence collection kit and/or damaged from the assault. For example, provide them with the opportunity to privately bathe (offering shower facilities if possible);[71] brush their teeth; change clothes (clean and ideally new replacement clothing should be available); eat and drink; charge their phone; and make needed phone calls, texts, or emails. They may also require assistance in coordinating transportation from the examination site to their home or another location.

[71] Ideally, the examination room should have an attached bathroom with a shower.

3. Informed Consent

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

- Seek the informed consent of patients as appropriate throughout the examination process.
- Make sure policies exist to guide the process of seeking informed consent from populations where obtaining consent may be challenging, such as patients who are cognitively impaired, incapacitated, or other circumstances as identified by the clinical staff.

Seek the informed consent of patients as appropriate throughout the examination process.[72] The process of seeking informed consent is a discussion between patient and clinician that results in the patient authorizing or declining an intervention.[73] There are two aspects of the consent process that must be addressed—one that attends to the medical evaluation and treatment and the other to the sample collection for the sexual assault evidence collection kit. Patients should understand the full nature of their consent to each component of the examination, what the procedure entails, possible side effects, limits of confidentiality, and potential impact. Patients should also understand at the outset that care is not predicated upon cooperating with law enforcement or having samples collected for the sexual assault evidence collection kit. The only way patients can make informed decisions about whether to consent to any aspect of the medical forensic examination is by presenting them with all relevant information in a language they understand. Obtaining informed consent for the medical forensic examination is a flexible and ongoing process; the patient may decline any portion of the examination. Additionally, the patient should clearly understand their ability to withdraw consent at any point during the process.[74] The informed consent process includes making patients aware of the impact of declining a procedure, that it may increase their risk of health consequences from the assault, limit the completeness of the samples collected for the evidence collection kit, and, ultimately, any criminal investigation and/or prosecution. Patients should be asked for verbal consent throughout the medical forensic examination, even after providing written consent, so that it is clear they may withdraw consent at any time.

Verbal and written information given to patients to facilitate the consent process should be complete, clear, and concise. This information, along with consent forms, should be tailored to

[72] As discussed in earlier sections, patients who are limited English proficient (LEP) must be provided trained qualified interpreters by the healthcare facility at no cost to the patient. Patients must be able to understand the examination process, make informed choices about if and how they wish to proceed with the medical forensic examination, provide informed consent to the examination, participate in the examination, and partner in the discharge process. If the examination cannot be conducted in the patient's primary language, a qualified interpreter is necessary.

[73] See The Joint Commission, Division of Health Care Improvement. (2016). Informed consent: More than getting a signature. *Quick Safety, 21* at page 1.

[74] See above, IPV Protocol at page 40.

the communication skill level/modality and language of patients.[75] Clinicians should be aware of verbal and nonverbal cues from patients and adjust their methods of seeking consent to meet patients' needs. Encourage patients to ask questions and to inform clinicians if they need a break or information repeated or do not want a particular part of the examination process done. Make sure all signatures and dates needed are obtained on written consent forms and document consent or declinations as appropriate (either on the medical record or forensic report forms). There are patients who may see the sexual assault as both a personal violation and also stigmatizing (e.g., some male patients, patients from certain cultures), and may have particular concerns about confidentiality. Clinicians may need to spend additional time helping patients understand the scope and breadth of confidentiality and privacy limitations to allow for a more trauma-informed consent process.

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

Clinicians and other responders must refrain from any judgment or coercive practice in seeking patients' consent. It is contrary to ethical and professional practices to influence their decisions. Patients' reasons for declining any or all aspects of the medical forensic examination may be predicated on a variety of previous experiences or concerns. For example, transgender and gender diverse patients have typically been subject to others' curiosity, prejudice, and violence (including from healthcare providers) and may be reluctant to report the crime or consent to the examination for fear of being exposed to inappropriate questions or abuse. Informed consent includes advising patients that they can receive medical treatment, including for STIs, without having the medical forensic exam. Informed consent also means advising patients that they do not have to make a report to law enforcement to receive a forensic exam. The ways in which healthcare and law enforcement systems have historically interacted with certain communities, including Tribal and immigrant communities, can also influence the levels of comfort patients may have with the idea of the medical forensic examination and reporting sexual violence.

Seek consent for all aspects of the medical forensic examination in the patient's primary language. Follow facility policy for seeking patients' consent for medical evaluation and treatment and all sample collection. Clinicians should also obtain authorization for disclosure of information to outside entities. Any written consent and authorization forms developed for the purpose of the examination may need to be reviewed and approved by facility administration.

Documentation of patient consents and authorization become part of the medical record. Informed consent and authorization are typically needed for the following:

- General medical assessment and treatment.
- Pregnancy testing and emergency contraception if desired.
- Testing (if applicable) and prophylaxis for STIs.
- Human Immunodeficiency Virus (HIV) prophylaxis.

[75] See Anver, B., Orloff, L., Kolic, J., & Fitzpatrick, M. (April 14, 2016). Translation Requirements for Vital Documents, Intake and Notice of LEP Assistance for DOJ and HHS Grantees Serving Immigrant Crime Victims.

- Photographs, including genital and non-genital images.
- Permission to contact the patient for follow-up.
- Release of medical information.
- Notification to law enforcement or other authorities (depends upon mandatory reporting requirements if applicable).
- Sample collection and release of the sexual assault evidence collection kit and other evidence collected (e.g., clothing).
- Toxicology screening and release of samples if there is a separate kit for drug/alcohol facilitated sexual assault testing.
- Release of information to SART members, and partnering service providers, if applicable.
- If information will be used for other purposes, such as education.

Patients should be informed that data without patient identity may be collected from the report for health and forensic purposes by health authorities or other qualified persons with a valid educational or scientific interest for demographic and/or epidemiologic studies. If photos are to be used for future educational purposes, specific consent is required from the patient.

What is the Difference Between Consent and Authorization?[76]

Consent is the process of getting permission from a patient prior to providing care. Consent is based on the legal and ethical idea that an individual is entitled to control what happens to their body. The legal obligation of consent is created by both state and federal laws. Consent laws can exist as independent statutes or the expectation that patients are entitled to consent can be incorporated into both nurse and medical practice acts.

Authorization is a concept created under the Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164) of the Health Insurance Portability and Accountability Act (Pub. L. 104-191.). The purpose of the Privacy Rule is to protect patient information from disclosure. The rule clearly states that for protected health information to be shared with entities or individuals who are not health care providers, a patient must provide written authorization. Details of what is required in an authorization are described in the rule (45 C.F.R. §164.508(b)(1)). Unless there are other legal exceptions, written authorization is required to release the medical forensic examination record to law enforcement, crime labs, prosecutors and any entities who are not health care providers.

Responders should coordinate efforts to seek patients' consent for sharing information among team members. On a systems level, SARTs (or involved responders if a SART does not exist) can identify all areas where consent is needed to share information during the initial response and subsequent encounters. They can make sure appropriate written consent forms are developed as well as procedures for requesting verbal and written consent. They should determine which responder has the knowledge needed to provide patients with information about each part of the response and consider from whom patients might feel the most comfortable receiving this information. For

[76] See U.S. Department of Health and Human Services, Office for Civil Rights. (December 28, 2022). FAQ: What is the difference between consent and authorization under the HIPAA Privacy Rule?

example, while each responder may provide discipline-specific information to patients, advocates may provide a broad overview of the response. Checklists that clarify discipline-specific roles in obtaining consent may be useful.[77]

Make sure policies exist to guide the process of seeking informed consent from populations where obtaining consent may be challenging, such as patients who are cognitively impaired, incapacitated, or other circumstances as identified by the clinical staff.[78] Certain conditions or circumstances may raise questions about a patient's ability to consent to the medical forensic examination, including the presence of an intellectual or cognitive disability, mental health conditions, and intoxication. However, these do not automatically negate a patient's ability to consent. With intellectual or cognitive disabilities, providing appropriate accommodations can enhance understanding. A patient's ability to consent must be evaluated on an individual basis, considering the following:

- Can the patient communicate the choice to have the medical forensic examination?
  - Ensure interpretation, if needed.
  - Provide the patient with clear choices and respect the choices made, providing the opportunity for the patient to control the process throughout the medical forensic examination.
- Is the patient able to understand what they are agreeing to in consenting to the medical forensic examination, including all available options?
  - Provide clear information about the health impacts of sexual violence.
  - Encourage the patient's questions and offer opportunities for the patient to ask questions throughout the encounter.
  - Use methods like a teach-back strategy to assess the patient's understanding.
- Is the patient able to appreciate the consequences of participating in the medical forensic examination, including verbalizing decisions around sample collection for the evidence collection kit and involvement of law enforcement?
  - Ask the patient about their greatest health concerns at this time, as well as any concerns about involving law enforcement, the criminal justice process, immigration-related matters, or safety in general.
- Is the patient able to participate in decisions about their care and the available choices, including all risks and benefits?
  - Provide treatment options as choices, reviewing the various risks and benefits of opting or declining as they arise.
  - Ask the patient about their preferences and respect their choices without judgment or pressure.

If the patient is too intoxicated to consent to the medical forensic examination, based on the clinician's application of the above criteria, the clinician may monitor the patient until they are able to participate in the medical forensic examination. It is important to note that no specific blood alcohol level is recommended at which an individual is considered able to consent. Therefore, a blood alcohol concentration is not necessarily helpful in determining capacity, particularly for patients who may have

[77] For resources on patient consent, record keeping, and other areas related to maintaining patient privacy, see above, SART Toolkit at Section 3.5. Confidentiality.

[78] See above, IPV Protocol at pages 40-41.

chronic alcohol use disorder. Programs should consider beforehand what the ethical and appropriate procedure is for patients who may be too intoxicated to render informed consent.

If a patient is unconscious or otherwise unable to consent, the clinician should follow their facility's protocol for obtaining consent and consult with the organization's risk management or legal counsel, where available. This may include obtaining third-party consent. Laws vary from state to state, but obtaining third-party consent may require assigning a family member to be the patient's guardian. However, in doing so clinicians must consider privacy concerns; patients may not want to involve other family members, it may be difficult to identify other family members, or there may be concerns about the possibility of a family member as the assailant. In such cases, a third-party guardian ad litem unrelated to the patient may be a suitable option.

In the case of adolescent patients, the clinician should follow the law in their jurisdiction governing consent and access to care. State statutes differ regarding whether minors can consent to healthcare, including undergoing all or part of sexual assault medical forensic examinations, whether the results of those examinations can be kept confidential from a minors' parent or legal guardian, and when clinicians are mandated to report.[79] For instance, a state statute may allow minors to receive reproductive healthcare, but not other aspects of an examination without parental or guardian consent. In some jurisdictions, a minor may consent to the examination but may not keep the results private from a parent or legal guardian. In still others, an adolescent may be fully legally empowered to make their own health care decisions. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian cannot be contacted and time constraints exist on the evidentiary needs of the patient. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge.[80]

A patient's parent or guardian may learn about the exam on billing or insurance statements. Clinicians must therefore explain billing procedures to minor patients if, for example, their parents may get a bill from the medical facility for medical treatment provided or an explanation of benefits from their insurance provider.

When assessing vulnerable adults' ability to consent, clinicians should likewise follow examination facility policy and the laws governing their jurisdiction. Clinicians should be aware that guardians could be offenders and if a patient is unable to communicate consent, alternate means for consent may need to be obtained. Because patients who are unable to communicate consent may also be unable to testify or tell law enforcement about the crime, medical evidence may be seen as that much more crucial. Medical practitioners must nonetheless obtain consent from either the patient or a third-party, regardless of how "important" the evidence collection process may be. When patients lack capacity and are unable to consent and cooperate with the exam, they should not be

[79] See, e.g., Okla. Stat. Ann. tit. 63, § 2602 (West) ("Any minor who is the victim of sexual assault [can consent]; provided, however, that such self-consent only applies to a forensic medical examination by a qualified licensed health care professional."); Mo. Ann. Stat. § 595.220 (West) ("A minor may consent to examination under this section. Such consent is not subject to disaffirmance because of minority, and consent of parent or guardian of the minor is not required for such examination. The appropriate medical provider making the examination shall give written notice to the parent or guardian of a minor that such an examination has taken place.")

[80] For information regarding jurisdiction-specific laws governing minor victims, see the Victim Rights Law Center's Minors' Privacy Toolkit by searching for "minors," or send an email to TA@victimrights.org.

forcibly examined or subjected to procedures that are not necessary for their own health and safety.[81]

In situations where legal consent is obtained through a third party, the patient must still be willing to participate (i.e., the patient must assent). That is, clinicians should not force a patient to undergo an exam if it is clear that they do not want to participate. For example, clinicians should not examine an adolescent if they do not want the exam, even if their parents want an examination done.

[81] See Miles, L. W., Knox, E., Downing, N., & Valentine, J. L. (2022). Ability to consent to a sexual assault medical forensic examination in adult patients with serious mental illness. *Journal of Forensic and Legal Medicine*, 85, 102285. (Discussing concerns and providing recommendations for conducting SAMFEs in adult patients with mental illness, and explaining that in "instances where a patient has the capacity and is cooperative, the decision to undergo, postpone, or decline a SAMFE ought to be ultimately made by the patient, rather than on their behalf by the provider, SANE or forensic examiner.").

4. Confidentiality

Recommendations at a glance for jurisdictions to maintain confidentiality:

- Be sure jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared.
- Increase the understanding of relevant confidentiality issues.
- Explain relevant information about confidentiality to patients.
- Consider the impact of the federal privacy laws regarding health information on patients who have experienced sexual assault.
- Strive to resolve intrajurisdictional conflicts that disrupt or prevent a patient- (victim-) centered approach within the jurisdiction.

Be sure jurisdictional policies address the scope and limitations of confidentiality as it relates to the examination process and with whom information can be legally and ethically shared. The confidentiality of records (as well as forensic evidence and photographic images) is intricately linked to the scope of patients' consent. Members of a SART or other collaborating responders should inform victims of the scope of confidentiality of their communication and be cautious not to exceed the limits of the consent they receive. For example, systems-based advocates, law enforcement officers, and prosecutors should explain that they cannot offer victims any confidentiality whereas community-based advocates should detail the privacy, confidentiality, and privilege protections that apply in their jurisdiction to protect victim/advocate communications.

Increase the understanding of relevant confidentiality issues. Clinicians and advocates should be aware of applicable laws surrounding confidentiality and privilege available to patients.[82] The presence or absence of a privilege may depend on who is present during any one discussion with a patient. Note-taking will likely not affect whether privilege exists. However, notes, just like the testimony of an advocate or clinician, may be subject to disclosure via legal process. It is best to seek advice from legal counsel with regard to confidentiality and privilege issues. Responders should be aware that victims in the military who choose restricted reports can confidentially speak with a sexual assault victim advocate, a sexual assault response coordinator, military chaplain, healthcare personnel, and special victims' counsels/victims' legal counsel.[83]

[82] See the section on "informed consent" for a discussion of confidentiality of adolescent patients.

[83] It is important to note that while this process exists for sexual assault medical forensic examinations, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits protected health information (PHI) of Armed Forces personnel to be disclosed under special circumstances. "Commonly referred to as the Military Command Exception, covered entities such as military treatment facilities may disclose the PHI of Armed Forces personnel to Command authorities for authorized activities. These activities include fitness for duty determinations, fitness to perform a particular assignment, or other activities necessary for the military mission. PHI disclosed to military command authorities, while no longer subject to HIPAA, remains protected under the Privacy Act of 1974" (https://www.health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Military-Command-Exception).

Explain relevant information about confidentiality to patients. Involved responders should proactively explain the following to patients:

- The limits of confidentiality regarding their communications, as noted above.
- Absent a court order, patients' medical records will remain confidential.
- If the assault is reported to law enforcement, health care professionals then provide the information and evidence they have collected to law enforcement pursuant to a signed patient authorization or pursuant to subpoena or other court order.[84]
- If the patient chooses to get an examination, but not to report to law enforcement, the evidence collection kit is typically held in a secure setting for a period of time as determined by applicable law or policy. At that point, unless the patient reports the assault to law enforcement, the evidence collection kit may be destroyed.[85]
- Information that patients share with law enforcement representatives, prosecutors, justice system-based advocates, and adult/child protective services will likely become part of the criminal justice record. If charges are filed against the offender, such information will likely have to be provided to defense counsel representing the offender, pursuant to the prosecutor's discovery obligations.[86]
- Each case potentially involves individuals from different agencies responding to the patient that may have their own confidentiality policies (e.g., school counselors and mental health providers).
- Court documents and proceedings are generally matters of public record, with the exception of certain excluded materials (e.g., some statutes prohibit victim contact information from appearing on public court documents such as names, social security number, date of birth). Many prosecutors seek protective orders, among other methods of preventing unnecessary disclosure in open court of evidence affecting a victim's dignity and privacy, unless disclosure is necessary for legitimate evidentiary purposes, discovery obligations, or compliance with court rules or rulings.
- Military members, as part of a process called "restricted reporting," can confidentially report sexual assault to specified officials in order to receive medical care, counseling, victim advocacy, and legal services without requiring command notification or triggering the investigatory process. However, disclosure of the sexual assault to anyone other than the

[84] Depending on the laws and policies of any given jurisdiction and whether there is an ongoing criminal investigation, patients may be permitted to access copies of police reports. However, like any other healthcare document, patients are entitled to access their own medical-forensic examination records through the agency or organization that completed the exam.

[85] See, e.g., 18 U.S.C. § 3772 (Sexual Assault Survivors' Bill of Rights) and state law analogues that provide for how long an evidence collection kit will be preserved before destruction and notice entitled to survivors before destruction.

[86] For more information about the criminal discovery process, see the U.S. Department of Justice, Office of the United States Attorneys: Justice 101, Steps in the Federal Criminal Process, Discovery (discussing the prosecutors' statutory and constitutional obligation to provide the defendant copies of certain materials and evidence).

specified professional enumerated in the restricted reporting confidentiality provisions can result in unrestricting a report, meaning an official investigation and command notification will take place. Victims may file restricted reports even if they disclosed the sexual assault to their commander or to personnel in their chain of command.[87]

Consider the impact of federal privacy laws regarding health information on patients.[88] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and its implementing regulations (found at 45 CFR Part 160 and Subparts A and E of Part 164), established national standards for the protection of certain individually identifiable health information created or held by health plans, certain health care providers, and health clearinghouses.[89] Unless a patient provides a written consent to release information, HIPAA limits access to protected health information with certain exceptions, including compliance with mandatory reporting laws and compliance with subpoenas and other court orders, particularly when there is an ongoing criminal investigation. Other federal laws have since built upon HIPAA's protections. The Health Information Technology for Economic and Clinical Health Act (HITECH) expanded HIPAA to address electronic transmission of health information and specifically defined business associates who could receive electronic protected health information and the requirements for maintaining confidentiality (U.S. Department of Health & Human Services, 2017). The 21st Century Cures Act, was enacted to promote information sharing and ensure healthcare providers may use technology to both exchange health information with patients and allow patients to access their health information, based on what is already available to patients under HIPAA.[90] If the medical forensic record is accessible under the existing system as a default, organizations can work with their electronic health record vendors to establish processes for keeping specific portions private, in accordance with Cures Act guidelines.[91]

For some patients, instead of HIPAA, the Family Educational Rights and Privacy Act (FERPA) may apply. FERPA is a federal law that specifically protects the privacy of student educational records. Generally, this statute will apply to clinicians providing services on college or university campuses that receive any funds from the U.S. Department of Education. FERPA recognizes inherent privacy for medical records (known as treatment records within the act). What is considered a treatment record, however, is defined narrowly.[92] Clinicians and advocates should seek legal guidance to best

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[87] For more information on restricting reporting in the military, see the United States Department of Defense Sexual Assault Prevention and Response Office's website (last visited July 13, 2024).

[88] See above, IPV Protocol at pages 43-44.

[89] Many states laws are broader than HIPAA and therefore, clinicians should refer to their state laws for guidance. For more information about the HIPAA Privacy Rule generally, including the conditions under which other disclosures are permitted, see the U.S. Department of Health and Human Service website. (last visited July 13, 2024.)

[90] The rule in its entirety can be found in the Federal Register. (last visited July 13, 2024).

[91] For more information about the eight information blocking exceptions, including their objectives and key conditions, see the Office of the National Coordinator for Health Information Technology. (last visited July 13, 2024.)

[92] See 20 U.S.C. § 1232g (a)(4)(B) (Family educational and privacy rights, defining what "education records" do not include) ("Records on a student who is eighteen years of age or older, or is attending an institution of postsecondary education, which are made or maintained by a physician, psychiatrist, psychologist, or other

understand how FERPA impacts their clinical services and how to develop policies to protect patients' confidentiality. They should further know how best to educate student-patients on the scope of their confidentiality protections under FERPA. Generally, once a report of the examination is provided to law enforcement, prosecutors, **or the patient**, FERPA protections may be removed, making information available to certain parties, including school officials with legitimate educational interest and the patient's parents.[93]

With respect to victim advocacy organizations, the HIPAA Privacy Rule permits hospitals and other health care professionals to alert a victim advocacy organization to the presence of a patient who has experienced sexual assault at the hospital without giving any identifying information about the patient. Further, once the advocate is at the hospital, if the patient is informed in advance and agrees or does not object, or the hospital reasonably infers from the circumstances that the patient does not object to an advocate's presence, then the Privacy Rule permits hospital staff to introduce the advocate to the patient and share information pertinent to the advocate's involvement in the patient's care.[94]

In addition to the aforementioned federal laws that impact privacy, agencies that receive funding under the Violence Against Women Act (VAWA) to provide victim services must also comply with VAWA's confidentiality provisions.[95] There are also provisions substantially similar to VAWA for victim service providers who are funded by the Victims of Crime Act (VOCA)[96] or the Family Violence Prevention Services Act (FVPSA).[97] Generally, these provisions require that a victim's personally identifying information or individual information may not be released without a victim's written, time-limited authorization or a court or statutory mandate. This applies whether the information is

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recognized professional or paraprofessional acting in his professional or paraprofessional capacity, or assisting in that capacity, and which are made, maintained, or used only in connection with the provision of treatment to the student, and are not available to anyone other than persons providing such treatment, except that such records can be personally reviewed by a physician or other appropriate professional of the student's choice.").

[93] See the rules related to FERPA and HIPAA, including an overview of each and where they may intersect, in the Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records (December 2019).

[94] See SART Toolkit Section 3.5 | National Sexual Violence Resource Center (NSVRC). (last visited July 26, 2024.)

[95] See 34 U.S.C. § 12291(b)(2) (Nondisclosure of private or confidential information) ("In order to ensure the safety of adult, youth, and child victims of domestic violence, dating violence, sexual assault, or stalking, and their families, grantees and subgrantees under this subchapter shall protect the confidentiality and privacy of persons receiving services."). For more information, see 28 C.F.R. § 90.4(b) and OVW's Frequently Asked Questions on the VAWA Confidentiality Provision

[96] See 28 C.F.R. § 94.115.

[97] The U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF), Office of Family Violence Prevention and Services (OFVPS) administers the Family Violence Prevention and Services Act (FVPSA) program. FVPSA primarily funds shelters and services for survivors and their children of domestic/ intimate partner violence (including dating violence), and funds domestic violence coalitions in all states and territories, as well as specialized national resource and training centers (Family Violence Prevention and Services, 42 U.S.C. § 10401; the American Rescue Plan Act of 2021 §§ 2204-2205, Public Law 117-2, 135 stat. 4, 34-35.)

being sought by federal, state, Tribal, or territorial grant programs. It also applies to disclosures from victim services divisions or components of an organization, agency, or government to the leadership of the organization, agency, or government, unless there is "an extraordinary and rare circumstance."[98] Routine monitoring, supervision, and audits do not qualify as extraordinary and rare circumstances.[99] For example, victim assistance programs that receive funding under VOCA are limited by the type of information that state administering agencies (SAAs) and sub-recipients of VOCA funds may disclose and/or share with one another. Given these restrictions, a VOCA-funded medical forensic examination provider cannot provide an SSA with unrestricted access to copies of patients' examination records (including information that directly or indirectly identifies the patient; details of their victimization; medical and mental health information; and visual depictions of their bodies) for the purposes of an audit. Campus-based advocates may also have confidentiality obligations under Title IX or other federal provisions.

Strive to resolve intrajurisdictional conflicts that disrupt or prevent a patient- (victim-) centered approach within the jurisdiction. Maintaining confidentiality is often difficult where most people know one another or in close-knit or insular communities, e.g., school campuses and Tribal, military, religious, or immigrant communities. Because word can travel quickly in these environments, special precautions must be taken to preserve confidentiality. Every effort should be made to avoid conflicts of interest (e.g., the investigator is related or a friend of the suspect or the clinician, or the advocate or interpreter is an acquaintance of the patient). Patients should be given as many options as possible to avoid these conflicts of interest, including assigning a different investigator or clinician or being examined at an alternate site, if possible. Clinicians should strive to identify and prevent these possible sources of privacy breaches before they occur.

[98] See 28 C.F.R. § 90.4(b)(2)(iii).

[99] See 28 C.F.R. § 90.4(b)(2)(iii).

5. Reporting to Law Enforcement

Recommendations at a glance for jurisdictions and individuals responding to the patient who has experienced sexual assault to facilitate patient-centered, trauma-informed reporting practices:

- Except where the law mandates reporting, it is the patient's decision to report a sexual assault to law enforcement.
- Inform patients about reporting options and any potential consequences.
- Promote a patient-centered, trauma-informed reporting process.

Many patients who undergo medical forensic examinations may choose to report the assault to law enforcement. Reporting may lead to a criminal investigation, additional evidence collection from the crime scene(s) and prosecution, if there is sufficient evidence to do so, all of which may result in offender accountability. Given the danger that sex offenders pose to the community, reporting can serve as a first step to stop them from reoffending. Service providers should discuss all reporting options with victims and the risks and benefits of each, including the fact that delayed reporting may be detrimental to the prosecution of an offender. Patients need to know that even if they are not ready to report at the time of the examination, the best way to preserve all available options is to have the examination performed and the evidence collected. Such information should be provided in the patient's primary language.

Some victims are unable to decide about whether they want to report or be involved in the criminal justice system. Pressuring victims to report may discourage their future involvement. Yet, they can benefit from support and advocacy, treatment, and information that focuses on their health and well-being. With that in mind, victims should be encouraged to undergo a medical forensic examination because there may be healthcare concerns that are time sensitive (including HIV prophylaxis and pregnancy prevention), there may be physical injuries that heal quickly and therefore cannot be later documented, and there may evidence on their bodies that will be lost as time passes. Victims who are treated with compassion and appropriate medical forensic care are more likely to participate with law enforcement and prosecution in the future.[100]

Except where the law mandates reporting, it is the patients' decision to report a sexual assault to law enforcement. In some jurisdictions, clinicians are mandated by law to report some or all forms of sexual assault, regardless of patients' wishes.[101] In jurisdictions without mandated

[100] See Campbell, R., Bybee, D., Townsend, S. M., Shaw, J., Karim, N., & Markowitz, J. (2014). The impact of sexual assault nurse examiner programs on criminal justice case outcomes: A multisite replication study. *Violence Against Women, 20*(5), at pages 607-625; Campbell, R., Patterson, D., & Bybee, D. (2012). Prosecution of adult sexual assault cases: A longitudinal analysis of the impact of a sexual assault nurse examiner program. *Violence Against Women, 18*(2), at pages223-244.

[101] Some jurisdictions mandate reporting for some or all violent crimes, where there are stab wounds, gunshot wounds, evidence of strangulation, or other serious bodily injury irrespective of whether a sexual assault occurred. See, e.g., Alaska Stat. Ann. § 08.64.369 (Health care professionals to report certain injuries). Other jurisdictions mandate reporting of sexual assault, regardless of use of violence. See, e.g., Cal. Penal Code § 13823.11(a) ("The minimum standards for the examination and treatment of victims of sexual assault or attempted sexual assault . . . and the collection and preservation of evidence therefrom, include: Law enforcement authorities shall be notified.") For a state-by-state summary compilation of mandatory reporting

reporting, clinicians should not report to law enforcement without the consent of patients. All involved health care providers should be aware of the reporting requirements in the jurisdiction in which they work, including whether there is mandated reporting for cases involving vulnerable adults and minors.

Health care personnel should inform patients as soon as possible if they are mandated to report, what triggers a mandatory report, that a report is being made, and the contents of the report. Clinicians should limit the contents of the report to only the information required by law and explain that to the patient. Patients should understand that even if health care personnel make a mandatory report, the patient is not obligated to talk with law enforcement. Mandatory reporting by health care personnel should not impact patient confidentiality.

States are required, as a condition of eligibility for STOP Violence Against Women Formula Grant funds, to arrange for patients to receive examinations free of charge regardless of the level of their participation in the criminal justice process.[102] Financial barriers should not deter victims from undergoing examinations because the evidence obtained during an examination may be invaluable to an investigation and prosecution, whether the patient reports immediately or chooses to do so later in time, which often occurs.[103] Patients also have the right to receive medical care for assault-related injuries and concerns, regardless of their decision to report and/or consent to sample collection for the sexual assault evidence collection kit.

Jurisdictions need to consider the logistics of storing sexual assault evidence collection kits and other evidence in cases when patients opt not to participate in the criminal justice process. Many jurisdictions do not retain kits in perpetuity where there has been no report to law enforcement.[104] For more information on this topic, see *B.6. Evidence Integrity.*

Under VAWA 2005 and subsequent VAWA reauthorizations, as a condition of STOP Formula Grant funding, states must also certify that law enforcement officers, prosecutors, and other government officials do not ask or require victims of sex offenses to submit to polygraph exams or other truth telling devices as a condition for proceeding with the investigation or prosecution of the offense.[105]

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requirements, see National District Attorneys' Association Reporting Requirements Related to Rape of Competent Adult Victims (2016). (Last visited July 15, 2024). Health care personnel should be aware that these reporting laws may conflict with military policy allowing for "restricted reporting."

[102] See 34 U.S.C. 10449(a)-(d); 28 CFR 90.13; States not required to bear the cost of all medical care but are only required to pay for the aspects of the examination that part of the "forensic medical examination" defined as "an examination provided to a victim of sexual assault by medical personnel to gather evidence of a sexual assault in a manner suitable for use in a court of law. (1) The examination should include at a minimum: (i) Gathering information from the patient for the forensic medical history; (ii) Head-to-toe examination of the patient; (iii) Documentation of biological and physical findings; and (iv) Collection of physical evidence from the patient. (2) Any costs associated with the [above items], such as equipment or supplies, are considered part of the 'forensic medical examination.'" 28 C.F.R. § 90.2(c).

[103] This is also true for patients who are detained or incarcerated, see PREA Standard 115.21(c)(Evidence protocol and forensic medical examinations).

[104] See, e.g., 18 U.S.C. § 3772(a)(2)(A) (Sexual assault survivor has the right to "have a sexual assault evidence collection kit or its probative contents preserved, without charge, for the duration of the maximum applicable statute of limitations or 20 years, whichever is shorter.")

[105] See 34 U.S.C. § 10451 (Polygraph testing prohibition).

Inform patients about reporting options and any potential consequences. Prior to making a decision about reporting, clinicians, advocates, or other responders familiar with the reporting process in the relevant jurisdiction should inform patients of the following:

- All available reporting options.
- The process of reporting to law enforcement and the information that will typically be requested from the patient.
- Whether health care personnel are mandated by law to report the assault and to whom.
- The purposes of the examination and how the medical forensic examination documentation may be used during investigation and prosecution.
- The possibility that delays in reporting, especially extended ones, may result in loss of evidence and may negatively affect the ability of the criminal justice system to investigate and prosecute a case.[106]
- Practices regarding arresting and prosecuting sexual assault victims for unrelated criminal charges.
- Policies related to payment for the examination, sample collection, medical care, and whether a victim reports to law enforcement a report is made.
- Policies on collecting/retaining and destruction of the sexual assault evidence collection kit and other evidence when there is no report to law enforcement.

For many communities, the decision about whether to report is not simply about weighing obvious risks and benefits. Historical trauma, cultural norms, or collective experiences may contribute to a patient's reluctance or fear in reporting. Patients may be reluctant to report the crime for a variety of reasons, including fear of not being believed, fear of getting in trouble, and fear of losing their independence. For many communities of color, particularly Black and Brown communities, fear of overzealous law enforcement response rooted in racial discrimination, and contextualized by historical and present-day police violence, abuse, and discriminatory policing may contribute to a reluctance to report.[107] There is also underreporting among people with disabilities. [108] In the most recent survey of transgender and gender diverse individuals in the U.S., nearly two-thirds of respondents reported they would be "very uncomfortable" or "somewhat uncomfortable" asking for help from the police when needed because of their gender identity or expression.[109]

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

[107] See Holliday, C. N., Kahn, G., Thorpe, R. J., Jr, Shah, R., Hameeduddin, Z., & Decker, M. R. (2020). Racial/Ethnic Disparities in Police Reporting for Partner Violence in the National Crime Victimization Survey and Survivor-Led Interpretation. *Journal of racial and ethnic health disparities*, *7*(3), 468480; see also Decker, M. R., Holliday, C. N., Hameeduddin, Z., Shah, R., Miller, J., Dantzler, J., & Goodmark, L. (2019). "You Do Not Think of Me as a Human Being": Race and Gender Inequities Intersect to Discourage Police Reporting of Violence against Women. *Journal of urban health: 96*, at pages 772–783.

[108] See the 2021 U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Crimes Against Persons with Disabilities 2009-2019 Statistical Table, showing 19% of rapes or sexual assaults against persons with disabilities were reported to police, lower than the percentage for victims without disabilities (36%).

[109] See James, S.E., Herman, J.L., Durso, L.E., & Heng-Lehtinen, R. (2024). Early Insights: A Report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality. (last visited July 15, 2024).

Many jurisdictions have implemented alternatives to standard reporting procedures.[110] "Alternative reporting options" is an umbrella term for different approaches to achieving the goals of VAWA forensic compliance and meeting the demand for trauma informed and victim-centered responses. These approaches reduce barriers for victims and increase access to the criminal justice system and other community services. For example, many law enforcement agencies, in processes sometimes known as "blind reporting" or "Jane Doe reporting" permit victims to report without identifying themselves (or the offender). These approaches may have no formal name and may not be documented in any official protocol, policy, or procedure, but instead may just be done in practice. For example, although a victim reports a sexual assault to an investigator, because the victim does not want to identify themself, that investigator may not investigate or may take limited investigative steps.

The goal of alternative reporting includes:

- Creating a *process* of disclosure and reporting, rather than requiring victims to report everything within a specified time limit.
- Increasing the number of meaningful options for victims to access services and support, as well as reporting.
- Allowing victims to convert from an alternative report to a standard report.
- Maintaining victim participation in the process, by creating a climate where victims feel safe and supported enough to not only report but also to continue working with the system through potential prosecution or other resolution that holds the offender accountable.[111]

Promote a patient-centered, trauma-informed reporting process. Some approaches for communities to consider:

- Provide victims with a process for information sharing, including case progression, kit tracking (if available), and relevant dates.
- Explore the myriad reasons why victims may not want to report and how the actions or attitudes of agencies may perpetuate these fears.
- Help agencies understand how to address reluctance and fears (e.g., immigrant victims who fear deportation and immigration enforcement may benefit from being immediately connected with legal services providers with expertise on immigration). Information about their legal rights under VAWA's immigration protections, the U and T visa for victims of covered crimes, and SIJS programs should be provided to victims in their primary language.[112]

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[110] See Lonsway, K.A., Archambault, J., & Huhtanen, H. (2022). Opening Doors: Alternative Reporting Options for Sexual Assault Victims. *End Violence Against Women International*, pages 24, 91 (discussing alternatives to reporting).

[111] See the U.S. Department of Justice Framework for Prosecutors to Strengthen Our National Response to Sexual Assault and Domestic Violence Involving Adult Victims (May 2024) ("Prosecutor Guide") (providing a blueprint for building provable cases in a trauma-informed manner that treats victims with humanity and ensures due process for defendants).

[112] See, e.g., multilingual resources developed by the National Immigrant Women's Advocacy Project, U.S. Department of Homeland Security – Interactive Infographic U.S. Immigration Benefits for Noncitizen Crime Victims (English)(November 2021); DHS Immigration Options for Victims of Crimes

- Encourage the development of community-based programs to support victims.
- Evaluate local trends regarding reporting and victims' involvement in the criminal justice system. Based on feedback, develop and implement a plan to improve multidisciplinary response to sexual assault, including implementation of alternate reporting methods.
- Incorporate topics into first responder education such as cultural humility, use of qualified interpreters and equitable communication, and collaborating with disability service providers to increase reporting access and enhance reporting experiences of populations who historically have been disenfranchised by the process.
- Encourage reporting of criminal justice statistics that accurately reflect the full range of sexual assaults that are reported in a jurisdiction.
- Expand community collaboration to include culturally and population-specific organizations who can work with the local coordinating council and SARTs to provide support to patients as soon as possible. Patients from groups that have been historically marginalized may find greater comfort and care in the process when they have access to organizations and resources that primarily serve LGBTQI+ individuals, faith or spiritual communities, communities of color, immigrant communities, and other populations that live and work within the jurisdiction.
- In institutional settings such as correctional facilities, detention centers, nursing homes and assisted living programs, inpatient treatment centers, and group homes, ensure that victims can report assaults to outside agencies and are offered protection from retaliation for reporting.
- Ensure that victims who opt not to participate in the criminal justice process have access to the same comprehensive medical forensic examination as those who do.
- Encourage the development of a coordinating council and/or SART to facilitate a more coordinated, victim-centered, comprehensive community response to sexual violence, including organizations that are representative of all members of the community, not just the dominant culture.
- Support the formation of specialized medical forensic examiner programs, investigative and prosecution units, and sexual assault victim advocacy programs to handle these cases. Specialization can potentially increase the knowledge base and commitment of those responding to sexual assault patients or victims, increase adherence to jurisdictional protocols for immediate response to sexual assault, encourage a patient- or victim-centered response, and positively advertise services offered.
- Ensure patients are offered access to victim advocacy immediately during the reporting process or allow them to have their chosen support person available to them as much as possible during the reporting process.
- After steps have been taken to identify and remove barriers to reporting sexual assaults, educate the public about how to report, what happens once a report is filed, and advocacy services available for victims of sexual assault. Build upon already existing public awareness efforts of local advocacy programs.
- Recognize that there are multiple ways for victims to seek justice. For example, American Indian and Alaska Native patients may choose to seek justice through

https://niwaplibrary.wcl.american.edu/pubs/imm-options-victims-of-crimes; and Gender-Based Violence Pamphlets and Flyers.

[113] See 34 U.S.C. § 10441(a); For more information on the STOP Formula Grant Program and medical forensic examination payment requirement, see OVW STOP Frequently Asked Questions (updated Oct. 2017). (last visited July 15, 2024).

criminal justice interventions, use of more traditional practices of the Tribe related to holding perpetrators accountable, and/or other victim-identified strategies.

6. Payment for the Examination Under VAWA

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

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

Understand the VAWA provisions related to medical forensic examination payment. VAWA and subsequent legislation authorizes all states, Territories, and the District of Columbia to receive funds under the STOP (Services, Training, Officers, and Prosecutors) Violence Against Women Formula Grant Program (STOP Program).[113] The program enhances the capacity of local communities to develop and strengthen effective law enforcement and prosecution strategies to combat violent crimes against women and to develop and strengthen victim services in cases involving violent crimes against women.

As a condition for receiving funding under the STOP Program, states and territories must annually certify that they are in compliance with the requirements of VAWA, including that the state "incurs the full out-of-pocket cost of forensic medical exams" for patients."[114] "Full out-of-pocket cost" means "any expense that may be charged to a victim in connection with a medical forensic examination for the purpose of gathering evidence of a sexual assault."[115] Examples of such expenses may include the full cost of the examination or a fee established by the facility conducting the examination, or a copayment or deductible in jurisdictions that require patients to submit the charges to insurance.

[113] See 34 U.S.C. § 10441(a); For more information on the STOP Formula Grant Program and medical forensic examination payment requirement, see OVW STOP Frequently Asked Questions (updated Oct. 2017). (last visited July 15, 2024).

[114] See 34 U.S.C. § 10449(b) (Rape exam payments); For patients who are American Indian and Alaska Native, the costs of the examination will be borne by either the state-designated payment source or in some cases the federal government. Under 34 U.S.C. § 20141(c)(7), a federal investigating agency that conducts a sexual assault investigation shall pay for the cost of a medical forensic examination "which an investigating officer determines was necessary or useful for evidentiary purposes." However, in most cases where the patient does not choose to report the assault to law enforcement or to participate with the criminal justice process, a state that receives STOP funds will still be responsible for payment because at that stage there will be no federal investigation. The state's responsibility for payment applies regardless of whether the crime occurred in Indian Country or within the special maritime and territorial jurisdiction of the United States. If a patient is referred out of an IHS facility for care, and if the patient is eligible to receive Purchased/Referred Care support, then the cost is covered, as a payor of last resort (Indian Health Manual - Part 2, Chapter 3: https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/). Although Tribes are not directly eligible for STOP Formula Grants, they are eligible for subgrants from the states, as well as other Office on Violence Against Women grant programs that can address sexual assault. Sexual assault *and* domestic violence medical forensic examinations for U.S. military service members are provided at no cost within military treatment facilities and covered by Tricare when provided by a Civilian Health Care Facility (https://manuals.health.mil/pages/DisplayManual.aspx?SeriesId=TRT5).

[115] See 28 C.F.R. § 90.13(b).

Often, medical services that are not related to evidence gathering will not be covered by this requirement.[116]

If one part of a state or territory, such as a county or city, requires patients to incur these costs, then the state or territory will be ineligible for STOP Program funds. In addition, states and territories must also certify that they do not require victims to participate with the criminal justice process in order to be provided with an exam.[117] Some victims are unable to make a decision about whether they want to report to law enforcement in the immediate aftermath of the assault. Recognizing their health and well-being is a priority, with certain treatment options having shorter windows for efficacy (e.g., emergency contraception, HIV prophylaxis), clinicians should encourage patients to consent to a complete medical forensic examination as soon as possible, and then take time to decide about reporting the crime.

States and territories are permitted to use STOP Program funds to pay for the examinations if they meet two conditions. First, the examination must be performed by a "trained examiner for victims of sexual assault." [118] Second, the state must not *require* patients to seek reimbursement from their insurance carriers.[119] Medical forensic examinations are also allowable under VOCA "to the extent that other funding sources such as state appropriations are insufficient."[120]

Notify patients of examination facility and jurisdictional policies regarding payment for medical care and the medical forensic examination. Clinicians must be aware of governing policy and laws regarding payment so that they can accurately inform patients.[121] Many jurisdictions will not pay for medical care provided as part of the medical forensic examination, such as the costs of treatment for injuries or treatment for STIs, or they may require patients to apply separately for crime victim compensation to be reimbursed for such expenses. Responders can help patients apply for crime victims' compensation (if available) or arrange a payment plan with the examination

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[116] See 28 C.F.R. § 90.2(c), defining "forensic medical examination" as "an examination provided to a victim of sexual assault by medical personnel to gather evidence of a sexual assault in a manner suitable for use in a court of law. (1) The examination should include at a minimum: (i) gathering information from the patient for the forensic medical history; (ii) Head-to-toe examination of the patient; (iii) Documentation of biological and physical findings; and (iv) Collection of evidence from the patient. (2) Any costs associated with the items listed in paragraph (c)(1) …such as equipment and supplies, are considered part of the 'forensic medical examination.' (3) The inclusion of additional procedures (e.g., testing for sexually transmitted diseases) may be determined by the State… in accordance with its current laws, policies, and procedures."

[117] See 34 U.S.C. § 10441(d).

[118] See 34 U.S.C. § 10449(c).

[119] Id.

[120] See 28 C.F.R. § 94.119(g) (When using these funds, "[m]edical forensic examiners are encouraged to follow relevant guidelines or protocols issued by the state or local jurisdiction. Subrecipients are encouraged to provide appropriate crisis counseling and/or other types of victim services that are offered to the patient in conjunction with the examination. Subrecipients are also encouraged to use specially trained clinicians such as Sexual Assault Nurse Examiners.")

[121] See the SAFEta Exam Payment Technical Assistance Project supported the U.S. Department of Justice, Office on Violence Against Women for information and assistance regarding all aspects of payment for medical forensic examinations.

facility.[122] When patients are billed by the examination facility for costs that they must bear, facilities should incorporate procedures to protect patient privacy into the billing process.

All personnel who are actively involved in the medical forensic examination billing process, including those who regularly submit for reimbursement, should be properly trained and educated regarding coding and billing practices, as determined by the facility or by local laws or policies.

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

B.Operational Issues

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

The following chapters are included:

1. Sexual Assault Medical Forensic Examiners

2. Facilities

3. Equipment and Supplies

4. Sexual Assault Evidence Collection Kit

5. Timing Considerations for Collecting Evidence

6. Evidence Integrity

1. Sexual Assault Medical Forensic Examiners

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

- Encourage the development of specific knowledge, skills, and patient-centered and trauma-informed approaches in clinicians who perform medical forensic examinations.
- Encourage advanced education and supervised clinical practice of clinicians who perform medical forensic examinations, as well as certification for all clinicians who are eligible to obtain it.
- Provide access to experts who can participate in sexual assault medical forensic examiner training and continuing education, precepting, mentoring, clinical case review, photography review, and quality assurance/improvement processes.

It is critical that clinicians are committed to providing trauma-informed, compassionate and competent health care, collecting samples for the sexual assault evidence collection kit in a thorough and appropriate manner, and testifying in court if needed. Their commitment should be grounded in an understanding that sexual assault is a serious crime that can have profound acute and long-term consequences for those victimized. Clinicians should recognize the role of advanced education and clinical experience in building competency to perform the examination.

A growing trend across the United States is the use of sexual assault nurse examiners (SANEs) to conduct the examination. SANEs are registered nurses who receive specialized education and fulfill clinical requirements to perform these examinations. Some nurses have been certified as SANEs–Adult and Adolescent (SANE–A) through the International Association of Forensic Nurses (IAFN).[123] Others are specially educated and fulfill clinical requirements as forensic nurse examiners (FNEs), enabling them to provide medical forensic care for patients presenting following a variety of crimes. Additionally, some nurses may have obtained other clinical credentials specific to medical forensic patient care, including but not limited to advanced forensic nursing-board certified (AFN-BC) and advanced forensic nursing-certificate (AFN-C).[124] The terms "sexual assault medical forensic

[123] Eligibility criteria for IAFN SANE Adult/Adolescent certification includes: Current, unrestricted licensure as a registered nurse (RN) or advanced practice nurse (APRN); a minimum of 2 years of practice as an R.N. in the U.S. or as a first-level general nurse in the country of licensure; successful completion of an adult/adolescent SANE education program that includes a minimum of 40 continuing education contact hours of classroom instruction; completion of a SANE clinical preceptorship; and Accrual of 300 hours of SANE-related practice within the past 3 years (at least 200 with the intended exam population).See *IAFN SANE Certification Exam Eligibility* (listing what constitutes SANE-related practice for eligible hours.)

[124] The Advanced Forensic Nursing Certification (AFN-BC) credential is available, for renewal only, through the American Nurses Credentialing Center (ANCC). The AFN-BC is for nurses with experience in caring for patients with acute and chronic concerns related to being the victim of violence. For more information, see the American Nurses Credentialing Center. The Advanced Forensic Nurse – Certified (AFN-C) is a licensed RN who practices in the forensic nursing specialty, practices the core competencies, and has obtained experience required for Advanced Forensic Nurse certification. For more information, see FNCB Certifications.

examiner" (SAMFE),[125] "sexual assault forensic examiner" (SAFE),[126] and "sexual assault examiner" (SAE) are often used more broadly to denote a health care provider (e.g., a physician, physician assistant, nurse, or nurse practitioner) who has been specially educated and completed clinical requirements to perform this examination.

All communities should strive to ensure that victims of a recent sexual assault have access to specially educated and clinically prepared clinicians to perform the medical forensic examination. Programs should recognize the value of attracting and maintaining individuals from a variety of clinical backgrounds who are dedicated to being permanent additions to the team, identifying registered nurses from a wide array of specialties, and including advanced practice nurses, physician assistants, and physicians in recruitment efforts. As much as possible, clinicians should be permanent rather than on temporary assignment in a jurisdiction. It can be challenging for clinicians who are temporary (e.g., working locum tenens at an Indian Health Service facility or completing an assignment as a travel nurse) to understand needs of victims from the community or to be familiar with jurisdictional policies and procedures and governing laws. If they move to another job assignment, arranging for them to testify in court can be complicated.[127]

Encourage the development of specific knowledge, skills, and patient-centered and trauma-informed approaches in clinicians who perform medical forensic examinations. Conducting a sexual assault medical forensic examination is a complex and time-consuming procedure. It is useful for clinicians to have specific knowledge and skills that can guide them as they perform these examinations. For example, it is beneficial for them to know the following:

- The dynamics of sexual violence.
- Victim responses to sexual violence.
- Effective interaction and collaboration with multidisciplinary team members.
- Requirements for accurately, objectively, and concisely obtaining medical forensic information associated with a sexual assault.
- Assessment and identification of physical findings in the patient, including potential mechanisms of injury following a sexual assault.
- Use of a patient-centered approach to obtaining and preserving the biologic and trace specimens from the patient who has experienced sexual assault.
- Accurate and objective documentation through the use of medical forensic photography.
- Assessment of sexually transmitted infection (STI) exposure, including HIV exposure risks, testing, and prophylaxis.
- Assessment for the risk of pregnancy following a sexual assault and providing emergency contraception for pregnancy as appropriate.
- Accurate, objective, and concise documentation of findings and evidentiary specimens associated with a sexual assault.

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[125] SAMFE is the preferred terminology within the Department of Defense (DoD), because it covers the wide variety of clinicians who respond to patients who have experienced sexual assault. Within DoD, SAMFEs are not limited to nurses.

[126] The use of SAFE as an acronym can be confusing because the sexual assault evidence collection kit is also sometimes referred to as the SAFE kit (sexual assault forensic examination kit) in some jurisdictions.

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

- Development, prioritization, and facilitation of appropriate discharge and follow-up care based on their individual needs, age, developmental level, health status, cultural values, and geographic differences.[128]

It is critical for medical forensic examiners to be able to:

- Provide culturally responsive care to all patients.
- Explain examination options to the patient in a developmentally appropriate manner, in their primary language.
- Recognize and initiate mandatory reporting where applicable.
- Assess patient capacity to consent.
- Provide a trauma-informed, comprehensive medical forensic examination to patients of all genders.
- Understand mandatory reporting requirements and the limitations of confidentiality.
- Recognize the critical elements to include in the medical forensic history, including review of systems.
- Understand the impact of issues such as trauma and substance use/abuse on the patient's ability to recall and sequence details.
- Use information from the history to establish the plan of care.
- Identify, collect, and preserve samples for the sexual assault evidence collection kit.
- Employ appropriate physical assessment techniques specific to the care of the patient who presents after sexual assault.
- Position patients for the examination to allow optimal visualization of anogenital structures, including those patients who have mobility restrictions.
- Integrate the collection of specimens into the physical assessment process based on the history, if available, and the assessment findings.
- Perform detailed anogenital examinations, employing a variety of techniques to assist with assessment.
- Identify extragenital and anogenital injury.
- Provide written and photographic documentation of the medical forensic examination.
- Assess, evaluate, and offer prophylaxis for STIs including HIV.
- Assess, evaluate, and provide emergency contraception for pregnancy.
- Package all samples for the sexual assault evidence collection kit and any other evidence collected and maintain chain of custody.
- Participate in continuing education for maintenance of competency, certification (where applicable), and knowledge updates.[129]

Encourage advanced education and supervised clinical practice of clinicians who perform medical forensic exams, as well as certification for all clinicians who are eligible to obtain it. Such a standard must speak to specific education and supervision needs of involved disciplines. For example, medical forensic examiners who are registered nurses may require medical supervision and backup, in addition to completing necessary training and clinical requirements.

[128] Adapted from the IAFN. (2018). Sexual Assault Nurse Examiner (SANE) Education Guidelines.(Last visited July 17, 2024.)

[129] Adapted from the U.S. Department of Justice, Office on Violence Against Women. National Training Standards for Sexual Assault Medical Forensic Examinations, Second Edition (2018).

When designing classroom education for clinicians, the coursework must include a multidisciplinary response. Educators from advocacy, law enforcement, prosecution, judiciary, and crime laboratories should support primary clinical educators.

Consideration must be given to systematically securing, supervising, and retaining clinicians who provide care in low-income, rural, or remote areas, as well as those who staff clinics in institutional settings,[130] military treatment facilities, college health centers, LGBTQI+, Tribal health facilities, migrant farm worker clinics, clinics serving immigrant communities, and other areas needing increased victim outreach. Clinicians need to know how to respond, in a trauma-informed manner, to various populations within their community. To do so, education may require additional content on cultural competency and cultural humility to assist clinicians with effectively communicating when there are barriers or cultural differences. Clinicians should be trained on their institutions' procedures for securing language assistance (including interpreters) and reasonable accommodations. Standardized curricula on sexual assault exams in medical school, nursing and nurse practitioner programs, and physician assistant programs are also recommended.[131] In addition, other health care personnel, such as emergency medicine technicians and paramedics, who may come into contact with patients prior to the medical forensic examination, need information on procedures for obtaining immediate patient assistance and caring for patients prior to their arrival at the examination site.

National certification (SANE-A) exists for registered and advanced practice nurses through the International Association of Forensic Nurses.[132] It is not required to practice as a sexual assault nurse examiner. There is no equivalent certification for physicians or physician assistants. Some states also have their own certification process through either their State Board of Nursing or Attorney General's Office (optional or mandatory) for registered nurses to complete in order to practice in that state. Additionally, some nurses may have obtained other clinical credentials specific to medical forensic patient care, including but not limited to AFN-BC, AFN-C, and the GFN-C.[133]

Provide access to experts who can participate in sexual assault medical forensic examiner training and continuing education, precepting, mentoring, clinical case review, photography review, and quality assurance/improvement processes. Access to such experts can help increase examiner competence and the consistency of high-quality forensic examinations. Telemedicine may help provide this expertise, especially to rural and underserved areas.

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[130] Institutional settings include correctional facilities, immigration detention centers, juvenile detention centers, nursing homes, assisted living and rehabilitation programs, and inpatient treatment centers.

[131] Even if clinicians are not able to attend a 40-hour sexual assault medical forensic examiner course, other specialty education courses exist that are geared toward a variety of clinicians, including above, No SANE in Sight, and the more detailed Sexual Assault Medical Forensic Examiner Virtual Practicum, a collaborative project led by End Violence Against Women International.

[132] See the International Association of Forensic Nurses Certification Central (last visited July 15, 2024).

[133] The Advanced Forensic Nursing certification (AFN-BC) is no longer available, but those who have the credential can maintain it through the American Nurses Credentialing Center. A different Advanced Forensic Nursing (AFN-C) and Generalist Forensic Nursing certification credential can be obtained through the Academy of Forensic Nurses.

2. Facilities

Recommendations at a glance to build the capacity of health care facilities to respond to the medical forensic needs of patients who have experienced sexual assault:

- Recognize the obligation of examination facilities to serve patients in a culturally and linguistically appropriate manner.
- Ensure that examinations are conducted at sites served by clinicians with advanced education in sexual assault care and clinical experience with this patient population.
- Explore possibilities for optimal site locations. Communities may wish to consider developing basic requirements for designated examination sites.
- If a transfer from one health care facility to a designated medical forensic examination site is necessary, develop a protocol that ensures patients are medically stabilized, their wait times are minimized, and care is taken to prioritize patient needs while minimizing potential evidence destruction or degradation.

Recognize the obligation of examination facilities to serve patients in a culturally and linguistically appropriate manner. Programs that respond to patients who have been sexually assaulted have an obligation to treat the whole patient, and not simply act as evidence collectors in a healthcare setting. This requires the ability to obtain full consent, assess and treat patients of all genders who may present to the program. Culture, and the values patients hold, must be considered in order to be truly patient-centered. For instance, different cultures may place particular meaning in the provision of samples like hair, blood, and nails. Clinicians need to understand why a patient may be reluctant to provide samples and should be respectful in collecting a minimum amount when necessary.

Likewise, it is the responsibility of every exam facility to ensure equitable communication for patients who are Deaf, hard of hearing, have limited English proficiency, or do not speak English as their primary language,[134] have cognitive disabilities, have language developmental challenges, or are visually impaired. Medical forensic examiner programs can take the following steps to ensure this is accomplished:[135]

- **Develop written policies**: Develop written policies for providing care to patients with communication needs (e.g., Deaf, hard of hearing, limited English proficiency), specifying how and when to deploy language and communication assistance.
- **Establish relationships**: Establish relationships with local organizations that have experience working with diverse communities, including culturally specific communities, to better understand the needs and challenges of their communities. These organizations could serve as a resource for identifying language services, including interpreters and translators, or helping to assess the competency of the facility's self-identified bilingual employees. Facilities should compensate local organizations for such services.
- **Provide training**: Ensure that all staff are trained on how to assess when language services are needed, how to provide those services, and how to work with interpreters across different types of platforms and a variety of assistive aides and devices. Provide or arrange for sexual assault-specific training to medical interpreters. This should include addressing potential

[134] This includes American Indians and Alaska Natives who may speak English as a second language.

[135] See above, IPV Protocol at pages 22-25.

cultural biases that could create inaccuracies in the language services or discomfort for the patient seeking care.[136]

- **Budget for services:** Include language assistance, including staff training, in the budget, so that equitable communication is built into clinical service provision and staff sees its value reflected in the program's funding priorities.
- **Use qualified language and communication assistance:** Formal, trained interpreters (preferably medical interpreters with additional training on IPV/sexual assault, if possible) are ideal; friends or family members should never be used as interpreters.[137]
  - Using bilingual staff as interpreters is not best practice. This should be considered only in the absence of other options or in the case of a clearly articulated patient preference.[138] If staff members are to be used, they must be competent to interpret with more complex medical and legal terminology that may arise as part of the patient encounter. If they serve in that capacity, they cannot serve in any other capacity (e.g., advocate or healthcare provider). All efforts should be made to avoid using staff as interpreters whenever possible.
  - The provision of qualified interpreters is consistent with requirements of the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act, and Section 504 of the Rehabilitation Act.[139]
- **Do not make assumptions**: For a patient who is Deaf or hard of hearing, do not assume that the patient's preferred method of communicating is American Sign Language (ASL). Patients may lip-read, use ASL or another signlanguage, be able to communicate in writing, need an assistive aide or device, or require another type of accommodation. The facility's policies and procedures should address how the facility will assess the patient's communication needs, accommodate patients' preferences for communication, and arrange the appropriate assistance for the individual.[140]
- **Brief the interpreter**: Brief the interpreter prior to the patient encounter to ensure they are informed of the nature of the content. Even if they are familiar with medical interpretation, the subject matter and terminology covered in the sexual assault medical forensic examination may still be a departure from typical content. Include a discussion of confidentiality and ways to provide the patient with an option to decline the specific interpreter if they are not comfortable with them (for example, if the patient is from a small community and knows the interpreter).
- **Plan for the interpreter's professional introduction**: The interpreter will provide introductory information for both the patient and clinician about the process. Regardless of how interpretation is being conducted, the clinician should ensure that their communication

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[136] Staff training should include education on cultural competency and cultural humility to assist the clinician with effectively communicating when there are barriers or cultural differences from their own (e.g., direct eye contact being seen as disrespectful).

[137] This may be an opportunity to collaborate and provide additional education to ensure that qualified interpreters have necessary and relevant information to be prepared to interpret during medical forensic examinations.

[138] Some patients may not trust clinicians or interpreters based on previous experiences of their own, of their family, or others within their community. It may feel safer for these patients to have a family member communicate through the bilingual staff. Consistent use of appropriately trained qualified interpreters should assist in breaking down this barrier to trust with patients.

[139] See above, Limited English Proficiency website; Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, (August 2003), 68 Fed. Reg. 47311, 47323, Appendix A.

[140] According to the World Federation of the Deaf, more than 300 sign languages are used throughout the world. If the patient uses a sign language other than ASL, the specific type should be documented.

continues to be with the patient, even if the interpreted responses are coming through a third party. That means directing questions to the patient, making eye contact with the patient as answers are being provided, and continuing to actively listen, watching for nonverbal cues, and other important responses that are a critical component of the patient assessment.

- **Use teach-back strategies**: Use a teach-back strategy to confirm the patient's understanding of critical points, rather than only asking if they have questions or relying upon non-verbal responses, such as head nods. This strategy helps to clarify and reinforces important information.

Individual states may have specific requirements for hospitals in responding to patients who have experienced sexual assault; facilities should ensure they are in compliance with any applicable statutes.[141] Facilities should also familiarize themselves with the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to turn away patients with emergency medical conditions.[142]

Ensure that examinations are conducted at sites served by clinicians with advanced education in sexual assault care and clinical experience with this patient population. Some jurisdictions designate specific facilities as examination locations because they employ or have ready access to specially educated and clinically prepared medical forensic examiners, as well as the necessary space, equipment, supplies, and policies to facilitate the examination process. Jurisdictions may rely on medical forensic examiner programs to serve multiple examination sites within a specific area.[143] Communities can benefit from designated examination facilities and medical forensic examiner programs that use specially educated and clinically prepared clinicians to conduct the examination because they:

- Increase the quality of care for patients and attention to their needs.
- Increase the likelihood of an examination consistent with current evidence-based guidelines and standards of care.
- Enhance a multidisciplinary approach.
- Encourage quality control (e.g., through use of competent and dedicated clinicians, established procedures for sample collection, and quality assurance/quality improvement/peer review practices).[144]

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[141] For example, Texas has specific requirements related to information provided to patients who have experienced sexual assault and mandatory training on sexual assault for all nurses who work in emergency departments. See the Texas Health and Human services website. Illinois requires all attending physicians, physician assistants, advanced practice nurses and registered nurses who are not educated as sexual assault medical forensic examiners to have a minimum of two hours of sexual assault training. It also requires having "qualified medical providers" to initiate treatment within 90 minutes to a patient who has experienced sexual assault presenting in the emergency department, and the use of photodocumentation as a component of the examination, maintained as part of the electronic medical record (Illinois Public Act 100-0775 and100-1087).

[142] 42 U.S.C. § 1395dd. Visit EMTALA.com, for more information. (last visited July 16, 2024).

[143] A clinical program may be based in one health care facility and in addition to providing services at that facility, also may contract with other examination sites to provide services as requested. Such a program may also be independent, with administrative offices only, and solely contract with examination sites to provide clinical services.

[144] For more information, see above, SANE Program Development and Operation Guide, Maintaining a Quality Program.

Explore possibilities for optimal site locations. Communities may wish to consider developing basic requirements for designated examination sites. Some factors to consider when identifying medical forensic examination sites include:

- Physical safety for patients and staff.
- Privacy of the examination space and waiting areas.[145]
- Accessibility for patients: Can patients easily get there using public transportation? Is the program well-publicized and easy to find for self-referring patients?
- Capacity to accommodate patients with disabilities.[146]
- Availability of clinicians with specific medical forensic education and clinical experience (on-site or on-call within a specified response period).
- Access to medications: This includes emergency contraception and HIV prophylaxis which have very specific time restrictions for administration.
- On-site availability of and collaboration with emergency medical services if needed or transfer agreements with local hospitals for community-based programs.

Examination sites that provide examinations for military installations are encouraged to draft Memoranda of Understanding to address such issues as confidentiality and storage of sexual assault evidence collection kits and enhance collaboration between civilian and military components.

Decisions about site location should reflect the needs of patients (e.g., for accessible care close to their home and local referrals), what is most efficient for the multidisciplinary response team, and the need to maintain the neutrality and objectivity of sexual assault medical forensic examiners (e.g., if the site location is at a rape crisis center, the clinician may be viewed as more of an advocate, even though the role is still a healthcare one; if it's housed within the police department, the clinician may be seen as an arm of law enforcement). Designated facilities may be in hospitals, health clinics, mobile health units, or other alternative sites, including family justice centers[147] or nonprofit sexual assault victim services programs. The majority of medical forensic examinations are conducted in hospital emergency departments. This location typically offers some level of security, is open 24 hours a day, and provides access to a wide array of medical and support services. Clinical staff often have the experience and expertise to perform the examination and collaborate with appropriate disciplines. Some jurisdictions have or are developing specialized hospital or community-based examiner

[145] Ideally, patients also will have access to bathrooms and shower facilities attached to the exam space, but this may not be possible in all circumstances. Whenever possible, these spaces should be made available for medical forensic examinations, in order to minimize patient contact with others, and increase feelings of safety and privacy.

[146] Title II and Title III of the Americans with Disabilities Act explain requirements for facilities in accommodating persons with disabilities (which may vary depending on the type of facility). Title II prohibits discrimination against persons with disabilities in all programs, activities, and services of public entities. Title III requires places of public accommodation to make reasonable modification in their policies, practices, and procedures in order to accommodate individuals with disabilities. See ADA.gov for related information and resources.

[147] For more information on the President's Family Justice Center Initiative, see the U.S. Department of Justice, Office on Violence Against Women website (last visited July 16, 2024).

programs.[148] Increasingly, communities also are exploring the use of telehealth to address gaps in sexual assault medical forensic examination services.[149]

Clinicians that are not working within a regional program or a larger hospital system with multiple examination sites may benefit from networking with clinicians in other facilities or areas for support for peer review of medical forensic documentation, quality assurance/improvement, and information sharing (e.g., continuing education, practice updates, and referrals for patients).

Some basic requirements for designated examination sites may include**:**[150]

- Providing a quiet, safe and private room where the entire patient assessment will not be interrupted by the outside environment. The exam room should be able to accommodate patients with a variety of different sensory and mobility concerns. If the examination site will be a separate area outside of an emergency department, create a trauma-informed space with visible entrances/exits, soothing décor, and comfortable spaces for waiting.
- Maintaining current protocols regarding the care of patients reporting sexual assault, and for the collection and storage of the sexual assault evidence collection kit.
- Promoting clinician opportunities for continuing education.
- Ensuring and monitoring for quality, conduct ongoing review and oversight of services provided through the quality assurance program for quality improvement purposes.
- Routinely use the designated sexual assault evidence collection kit, if the patient consents to have samples collected. Use the designated drug facilitated sexual assault or toxicology kit, where appropriate.
- Ensuring that emergency contraception is provided to the patient upon request without delay, unless the patient is already pregnant or the treatment is otherwise medically contraindicated.
- Ensuring that STI prophylaxis is provided to the patient unless declined or otherwise medically contraindicated.
- Maintain a supply of and provide an initial supply to patients, as medically indicated, of prophylaxis for HIV.
- Providing each patient with an appropriate and safe discharge, including medical transfer as necessary, and necessary and appropriate follow-up care/referrals.
- Designating a program coordinator to exercise administrative and clinical oversight for the program.
- Providing clinicians on-site or on-call available to the patient within 60 minutes of arriving at the hospital, except under exigent circumstances.
- Providing a location for locked, secure storage of sexual assault evidence collection kits in the event they cannot be collected by law enforcement immediately or must be stored by the facility.
- Adhering to proper coding and billing practices for sexual assault cases, as determined by the facility and informed by jurisdictional policy.

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[148] For a review of the different types of models, including their advantages and disadvantages, see above, SANE Program Development and Operation Guide, Program Models

[149] For more information on the use of telehealth, see Walsh, W. A., Meunier-Sham, J., & Re, C. (2019). Using Telehealth for Sexual Assault Forensic Examinations: A Process Evaluation of a National Pilot Project. *Journal of Forensic Nursing, 15*(3), at pages 152–162; see also, IAFN's technical assistance site on TeleSAFE (last visited July 16, 2024).

[150] Adapted from the New York State Department of Health's Sexual Assault Forensic Examiner (SAFE) Program's SAFE-designated hospitals (last visited July 16, 2024).

Designated examination sites should be publicized to all local hospitals, law enforcement agencies, emergency medical services, sexual assault victim advocacy programs, legal services, population-specific providers, and protective services. Promoting community public awareness about these sites is also important given that victims may first disclose an assault to family members, friends, teachers, faith, community, or spiritual leaders, employers, coworkers, and others. In addition, success will depend on interagency cooperation in explaining facility options to victims and transporting them to designated medical forensic examination sites (with their permission). Law enforcement representatives and advocates may need guidance on how to recommend an examination location to victims without mandating that they go to a specific site.

If a transfer from one health care facility to a designated medical forensic examination site is necessary, develop a protocol that ensures patients are medically stabilized, their wait times are minimized and care is taken to prioritize patient needs while minimizing potential evidence destruction or degradation.[151] If a sexual assault patient arrives at a facility that is not equipped to provide a sexual assault medical forensic examination, a medical screening examination should be completed in accordance with the Emergency Medical Treatment and Labor Act (EMTALA),[152] and then arrangements should be made to transfer the patient to the nearest examination facility, with their consent. Protocols should minimize time delays and loss of evidence, and continue to prioritize the patient's needs, comfort, and well-being. Cost and reliability of transport should be evaluated and discussed if transfer is required, as some patients may need support or assistance to access an alternate medical forensic examination site. If acute medical or psychological concerns exist that must be treated immediately, this should be done at the initial receiving facility. Additionally, keep in mind in cases where a report is necessary (e.g., minors, endangered adults) the initial facility has the same duty to report as if they had provided the full scope of care, even when the patient is planning to transfer. A copy of all records, including any imaging, should be transported with the patient to the designated examination facility to facilitate the continuum of care.

Some patients may be hesitant to transfer to another facility. Advantages and disadvantages of available options should be explained, including any costs the patient may incur. To accommodate circumstances in which transfer is not possible or is declined, providing emergency department personnel with basic training in sexual assault medical forensic care must be a priority.[153]

If transfer is needed to provide the medical forensic exam, the initial facility should provide for STI prophylaxis, emergency contraception and HIV prophylaxis, as medically necessary, if the patient consents. Time is of the essence in the administration of both HIV prophylaxis and emergency contraception, and patients should not have to wait for transfer to receive these medications.

Ideally patients should be directed to a fully staffed examination facility first to minimize stress and confusion for patients and eliminate unnecessary delays in care resulting from transfer. This should also reduce the need for the patient to disclose to multiple providers, reduce the potential loss of evidence, and ideally increase engagement with the examination process given the lengthiness of the encounter. SART members should be aware of area examination facilities and direct patients for care as appropriate. Information about locations of examination facilities should also be available to the public.

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[151] The following section is adapted from Indiana Guidelines. (2019). Guidelines for the Medical Forensic Examination of Adolescent and Adult Sexual Assault Patients at page 21.

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

[153] See above, No SANE in Sight.

In some circumstances, community-based programs may need to transfer patients to emergency departments for further care following the sexual assault medical forensic examination, as in cases where a patient has been strangled and requires additional evaluation. Community-based programs may also begin a medical forensic examination, but have a patient require transfer to the emergency department because the patient decompensates during the examination. Programs should consider transfer agreements with area emergency departments and outline specific circumstances in which patients will be transferred or referred. Circumstances should include issues related to injury (e.g., strangulation, penetrating trauma) and concomitant impacts on health status (e.g., suicidality, exacerbations or identification of serious health issues). Policies should reflect any limitations of access to diagnostic adjuncts, such as labs and imaging, based on an understanding of the potential for a broad range of injury among patients who experience sexual assault.[154]

[154] Adapted from above, IPV Protocol at page 59.

3. Equipment and Supplies

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

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

Clinicians should know how to use all equipment and supplies (including medications) properly during the medical forensic examination. It is important that clinicians maintain currency with the latest research on the use of equipment and supplies used in the sexual assault medical forensic examination.

Consider what equipment and supplies are necessary to conduct a thorough medical forensic examination. Plan to have the following equipment and supplies readily available for the examination, according to jurisdictional policies: [155]

- A copy of the most current examination protocol used by the jurisdiction.
- Standard exam room equipment and supplies for a physical assessment, including genital examination. This includes specula in multiple sizes, light source, and water-soluble non-spermicidal lubricant or saline during the vaginal and/or rectal examination. This is an acceptable practice and promotes patient comfort.[156] Additionally, mobility issues and positioning and stabilizing aids for patients with physical disabilities should be considered in arranging and stocking the exam room.[157]
- Personal care supplies for patients. Suggested items: clean and ideally new replacement clothing, toiletries, food and drink, and other items that can allow patients to leave the facility feeling some sense of normalcy or comfort, such as makeup or gender-affirming binding tape for transgender and gender diverse patients who may not have these items with them. It is also important during the exam process to help patients obtain items they request related to their spiritual healing.[158] It may be useful for facilities to have items on

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

[156] See U.S. Department of Justice, National Institute of Justice. (2016). National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 19.

[157] For example, it would be ideal to have an exam table with a hydraulic lift for patients with mobility impairments. If this exam table is not available, clinicians must be aware of how to assist patients with physical disabilities onto standard exam tables. However, exam tables are only one area that must be considered for patients with disabilities. Consider also clear pathways of travel to and around the exam room; clear floor and turning spaces inside the exam room and bathroom; shower facilities that can accommodate patients who use wheelchairs and other mobility devices; and accommodations like lighting on dimmers, weighted blankets, and headphones for patients with sensory needs. See 28 CFR Part 35, Nondiscrimination on the Basis of Disability; Accessibility of Medical Diagnostic Equipment of State and Local Government Entities.

[158] Along with these items, patients may want the opportunity to speak with a trusted religious or spiritual leader, such as a medicine man/woman, rabbi, priest, or imam, before, during, or after the exam.

hand that are commonly requested in that jurisdiction (e.g., things that are used for local Tribal traditional healing practices) and policies for their use in the facility.[159]

- Sexual assault evidence collection kits and related supplies. (See *B.4. Sexual Assault Evidence Collection Kit* for information on minimum kit contents.) Related supplies might include tweezers, tape, nail clippers and scrapers, scissors, collection paper, saline solution or distilled water, extra swabs, sterile containers, envelopes, paper bags, and pens/pencils. Specimen collection containers for toxicology testing may not be within the kit, so they may need to be provided separately.
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. With any drying method or device used, ensure minimal contamination of evidence, and maintain the chain of custody. The kit's design may also aid in the drying process (most swab packaging materials allow for drying to continue if they are packaged while still damp). If a drying box is used, it should not contain a fan.[160]
- A camera and related supplies for photo documentation during initial and follow-up examinations. Related supplies might include digital media, batteries and/or charger, a flash, a color bar, foot pedal, and a scale for size reference. (Also see *C.5. Photography*.)
- Testing and treatment supplies needed to evaluate and care for patients (follow exam facility policies). Also, testing supplies may be needed that are not included in the sexual assault evidence collection kit.
- An alternate light source (ALS) can aid in examining patients' bodies, hair, and clothing. ALS may fluoresce both biological (e.g., semen) and non-biological substances (e.g., lubricants, oils). Emerging research also provides evidence that ALS *may* be useful in detecting and documenting potential injury,[161] although at this time there is no consensus for using it for this purpose. While the examination can be done without a light source, it is a relatively inexpensive piece of equipment that is commonly used during examinations. (Also see *C.6. Exam and Sample Collection Procedures*.)
- An anoscope may be used in cases involving potential anorectal penetration or anal/rectal trauma. This instrument may be used to assist in visualizing anorectal injury, obtaining reliable rectal swabs (if there is a concern about contamination), and identifying and collecting trace evidence. The clinician needs to weigh the clinical utility of anoscopy against any potential

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[159] Involved responders/facilities should be aware of local traditional healing practices and support patients if they wish to use such practices at some point before, during, or after the examination. Many Native people may observe traditional spiritual or healing practices, which vary by Tribe.

[160] Swab dryers with fans should not be used as the blowing fan can transfer DNA from one swab to another. Drying boxes can still provide a protected environment in which to dry swabs, but they should be used without the fan.

[161] See Scafide, K. N., Downing, N. R., Kutahyalioglu, N. S., Sheridan, D. J., Langlois, N. E., & Hayat, M. J. (2022). Predicting alternate light absorption in areas of trauma based on degree of skin pigmentation: Not all wavelengths are equal. *Forensic science international*, *339*, 111410; see also, Scafide, K. N., Downing, N. R., Kutahyalioglu, N. S., Sebeh, Y., Sheridan, D. J., & Hayat, M. J. (2021). Quantifying the Degree of Bruise Visibility Observed Under White Light and an Alternate Light Source. *Journal of Forensic Nursing*, *17*(1), at pages 24–33; see also, Scafide, K. N., Sheridan, D. J., Downing, N. R., & Hayat, M. J. (2020). Detection of Inflicted Bruises by Alternate Light: Results of a Randomized Controlled Trial. *Journal of Forensic Sciences*, *65*(4), at pages 1191–1198. Additionally, practice guidelines for the use of an alternate light source to assess for physical trauma are now available from Scafide, K., Ekroos, R. (2023). Alternative light assessment of skin trauma (AtLAST). Guidelines for clinical application There is no consensus by the field for the adoption of these guidelines at this time, so clinicians should continue to evaluate the research as it emerges. See also Green, W. and Fineman, G. (2023). Alternate Light Sources (ALS) and Bruising from Strangulation: Beliefs and Controversies.

discomfort and retraumatization. Specific consent to anoscopy is necessary when conducting this examination, and patients should understand the benefits and disadvantages, medically and from a sample collection and injury identification perspective, when making their decision. (Also see *C.6. Exam and Evidence Collection Procedures*.)

- Toluidine blue dye. In some jurisdictions, the dye is used to assist in highlighting observed genital and perianal injuries. (Also see *C.6. Exam and Evidence Collection Procedures*.)
- Foley catheters. Particularly in adolescent patients, the foley catheter can be useful in visualizing hymenal tissue, using equipment readily available in the majority of healthcare facilities. (Also see *C.6. Exam and Evidence Collection Procedures*).
- Written materials for patients. (For details on this topic, see *A.2. Patient-Centered, Trauma-Informed Care*.)

In addition:

- A colposcope with photographic capability may be used. Innovations in photographic technology coupled with the significantly higher costs of colposcopes have resulted in many facilities using digital cameras to provide the magnification and photo documentation that was once only achievable with colposcopes. However, some clinicians still prefer the binocular visualization achievable with the colposcope or were already using colposcopes and continue to maintain that practice. (Also see *C.6. Exam and Sample Collection Procedures*.)

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

Note that some jurisdictions, particularly those in rural and remote areas, are beginning to use advanced technology (equipment and methods) such as telehealth consultation, to support clinicians conducting examinations. Using this type of technology, clinicians can eliminate the barriers of geography and consult with offsite medical experts. Equipment needed to facilitate use of telehealth may include, but is not limited to, computers with webcams, software programs, and a reliable internet connection.[162] Jurisdictions that use such technology must consider ways to protect patient confidentiality.

Address cost barriers to obtaining necessary equipment and supplies. Equipment and supplies can have a significant impact on the quality of the medical forensic examination and the patient's experience. However, the costs of equipment and training on equipment use can be prohibitive for some jurisdictions and medical forensic examiner programs. Some ideas to address cost barriers:

- Seek used or donated equipment or alternative, less-expensive equipment where it exists.
- Apply for grant or foundation funding for equipment where eligible.[163]

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[162] Keep in mind that telehealth practices in sexual assault medical forensic examinations are still being developed—further research and evaluation is needed to address issues related to logistics of use, patients' consent, confidentiality, and impact; legal implications; affordability; and accessibility.

[163] Funding under the STOP Violence Against Women Formula Grant Program and the Grants to Indian Tribal Governments Program may be used to cover costs of some equipment. For more information, see the U.S. Department of Justice, Office on Violence Against Women website.

- Ask for help from community groups in raising funds for one-time equipment or ongoing supply costs.
- Consider sharing costs and equipment with other departments in an exam facility or among other near-by local health care facilities.
- Consider the benefits of a mobile medical forensic examiner program where costs of equipment, clinician education and clinical preparation, and on-call costs may be shared by multiple examination sites.

4. Sexual Assault Evidence Collection Kit

Recommendations at a glance when developing/customizing kits:

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

Use kits that meet or exceed minimum guidelines for contents. Many jurisdictions have developed their own sexual assault evidence collection kits or have purchased premade kits through commercial vendors. Kits may vary from one another in types or numbers of samples collected, collection techniques,[164] materials used for collection, and terms used to describe categories of evidence. Despite variations, however, it is critical that every kit meets or exceeds the following minimum guidelines for contents.[165]

- A kit container. This container should have a label with blanks for identifying information and documenting the chain of custody. Most items gathered during evidence collection are placed into the container after being dried, packaged, labeled, and sealed according to jurisdictional policy. Bags are typically provided for bulkier items that will not fit in the container (e.g., clothing). Some jurisdictions provide large paper bags to hold the container and additional evidence bags.
- An instruction sheet or checklist that guides clinicians in collecting the samples and any additional evidence, as well as maintaining the chain of custody.
- Forms that facilitate sample collection and analysis, including patients' consent for collection and release of the sexual assault evidence collection kit and information to the law enforcement agency; the medical forensic history; and body maps documenting injury and other findings.
- Materials for collecting and preserving the following evidence, according to jurisdictional policy:[166]

    - Patients' clothing and underwear.
    - Foreign materials on patient's body, including blood, dried secretions, fibers, loose hairs, vegetation, soil/debris, fingernail scrapings and/or cuttings, matted hair cuttings, material dislodged from mouth.[167]
    - Swabs of suspected semen, saliva, and/or areas highlighted by alternate light sources and swab boxes.[168]

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[164] For collection technique best practices, please refer to above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at pages 20-21.

[165] See, generally, the *Sexual Assault Evidence Collection Kit, VEC200A*, by Sirchie; the Texas Evidence Collection Protocol; the Colorado Sexual Assault Evidence Collection Protocol; the Oregon Attorney General's Sexual Assault Task Force – Medical Forensic Committee Triage & Medical Guidelines for Sexual Assault Evaluation; and above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach.

[166] Some samples that historically have been collected are no longer recommended. For a complete list, see above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 23.

[167] Flossing for evidence is not recommended secondary to concerns about infection risk. See Id.

[168] Debris and swabs for areas that fluoresce under ALS may be organized together in many kits—they are listed separately here for ease of understanding.

- Hair if required in the jurisdiction (may include a separate envelope for pubic hair).[169]
- Vaginal/cervical swabs and swab boxes.
- Vaginal vestibule (including labia minora, clitoris, hymen, fossa navicularis, and posterior fourchette) swabs and swab boxes.
- Mons pubis/labia majora swabs and swab boxes.
- Penile/scrotum swabs and swab boxes.
- Anal/perianal swabs and swab boxes.
- Oral swabs and swab boxes.
- Other body swabs, to use for obtaining samples such as touch DNA and bite mark swabs as determined by the patient's history or presentation.[170]
- Known standard sample: either blood, saliva sample, or buccal swab for DNA analysis and comparison.

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

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

Even though photographs are a form of evidence, they are not part of the sexual assault evidence collection kit and should never be packaged in the kit. (For specifics on photographs see C.5 Photography)

Blood and urine collection containers for toxicological testing in suspected alcohol- and drug-facilitated sexual assaults are often provided in separate kits.[171] They should contain the following:

- one 30- to 100-mL urine collection container.
- one 10- mL gray-stopper blood collection tubes containing sodium fluoride (1 -2%) and potassium oxalate (0.2%) in each.
- chain of custody form.[172]

(For specifics on patient care in suspected and known alcohol and drug facilitated sexual assault cases, see C.7 Alcohol and Drug Facilitated Sexual Assault.)

[169] Some jurisdictions collect pubic and head hair combings, while others collect only pubic combings. Some also collect pubic and/or head hair reference samples. Materials should be included in the kit to collect and preserve hair evidence required by jurisdictional policy. Jurisdictions should evaluate the necessity of routinely collecting hair samples based on data related to how often such evidence is useful or used in the jurisdiction.

[170] Material may be present on body surfaces from contact with blood or body fluids. The number of swabs available in each kit vary by jurisdiction. Examination facilities should have extra swabs on hand in case they need to collect from additional sites on the body, along with self-sealing blank envelopes for packaging.

[171] Commercial toxicology kits can be purchased through vendors if the jurisdiction does not have them available through local or state crime laboratories.

Work to standardize sexual assault evidence collection kits within a jurisdiction and across a state or territory, or for federal cases.[173] A designated agency in the jurisdiction should be responsible for oversight of kit development and distribution.[174] It should:

- Ensure that facilities that conduct sexual assault medical forensic examinations are involved in kit development and supplied with kits.
- Work with relevant agencies (e.g., crime labs, law enforcement agencies, examination facilities and sexual assault medical forensic examiner programs, advocacy programs, and prosecutors' offices) to keep abreast of related changes in technology, scientific advances, and standards of practice.
- Review periodically (e.g., every 2 to 3 years) kit efficiency and usefulness.
- Make adjustments to the kit as necessary.
- Establish mechanisms to ensure that kits at examination facilities are kept up to date (e.g., if a new sample collection procedure is added, facilities need to know what additional supplies should be readily available).
- If not yet implemented, consider instituting a kit tracking system to track the status and location of sexual assault evidence collection kits and other evidence collected, allow all parties involved in the handling of kits and other evidence to update and track the status and location of the evidence, and allow patients to anonymously or confidentially track or receive updates on the status of their kits.[175]

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

[173] See above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 14 (recommending the establishment of minimum standards for a national sexual assault kit, to include uniform packaging, a unique identifier, discreet labeling to protect patient privacy, identification for type of kit (victim or suspect), standardization of documentation, and standardization of wording and labeling on sample envelopes and collection items such as swabs and envelopes).

[174] It is important to consider costs to the state/territory/Tribe/federal agencies and local community, and ability of local communities to cover those costs. In some states, one state agency (e.g., the crime laboratory) assumes the costs. In others, the costs are passed on to local criminal justice agencies.

[175] See above, 18 U.S.C. § 3772 (Sexual Assault Survivors' Bill of Rights) (requiring sexual assault patients be informed of the status and location of a sexual assault evidence collection kit; and upon written request, receive written notification from the appropriate official with custody not later than 60 days before the date of the intended destruction or disposal of their sexual assault evidence collection kit or be granted further preservation of the kit or its probative contents).

5. Timing Considerations for Collecting Evidence

Recommendations at a glance for clinicians and other individuals responding to patients to optimize evidence collection:

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

Understand the importance of gathering information for the medical forensic history, examining patients, and documenting examination findings, separate from collecting evidence. Clinicians should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether samples are collected for the sexual assault evidence collection kit or not. The medical forensic history and subsequent examination helps determine the samples that may need to be collected in addition to the specific care the patient needs. This information is integral to the crime lab personnel who analyze the evidence collection kits, as it guides testing. In addition, the information documented can be invaluable to an investigation and prosecution if the patient chooses to report. (See C.3 Medical Forensic Documentation for more detailed information on documentation.)

Examine patients promptly to identify medical needs and concerns and minimize loss of potential evidence. Forensic DNA evidence deteriorates with time. Therefore, it is imperative that samples be collected as soon as possible. Samples should be collected regardless of the patient's post-assault activities (e.g., showering, urinating, douching, swimming, sexual activity, eating, or drinking). Sexual assault samples should be collected from any consenting patient seeking care as soon as possible and up to five (5) days or longer post-assault.[176] Toxicology samples should be collected within 120 hours (if collecting urine, which is preferred); within 24 hours if collecting blood.[177] Prompt examination also helps to quickly identify patients' medical needs and concerns and allows for the administration of medications that have specific time constraints, such as emergency contraception and HIV prophylaxis.

Some patients may have existing medications they need to take, and or may wish to eat or drink before starting the lengthy examination. Therefore, clinicians may choose to collect certain samples out of order (e.g., oral samples), in order to allow patients the ability to have a snack or maintain their medication schedule. Health and comfort of patients should be prioritized over a rigid exam order.

[176] Adapted from above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 17.

[177] See Society of Forensic Toxicologists. Fact Sheet: Drug Facilitated Sexual Assault.

Advancing DNA technologies also continue to extend time limits.[178] Such breakthroughs demonstrate the importance of collecting all possible evidence and consulting with local crime labs when there are questions about when and if to collect samples outside of recommended timeframes.

Make decisions about whether to collect samples for the sexual assault evidence collection kit and what samples to collect on a case-by-case basis, guided by knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected. Clinicians and law enforcement representatives should be aware of the standard timeframes for medical forensic examinations in their jurisdictions. However, timeframes are offered only as a benchmark for consideration and should not be used as the basis to deny medical forensic care to any patient who has experience sexual assault.[179] It is important to remember that sample collection beyond the cutoff point is conceivable and may be warranted in particular cases, and patients likely will need medical attention regardless of the feasibility of obtaining viable samples for the evidence collection kit. When there is a question as to whether the patient will benefit from sample collection, SART members who are making the referral should consult with the clinical staff to determine if they should send the patient, since there also may be healthcare needs to be considered. Even in the absence of sample collection outside the allocated timeframe, the sexual assault medical forensic examiner program may still be the appropriate referral for the patient. SARTs should be clear on the scope of the sexual assault medical forensic examiner programs with whom they work, including whether they provide healthcare for patients outside the designated timeframe, phone consultation for patients to make non-acute healthcare referrals to other clinicians, and/or follow-up care.

Clinicians providing the medical forensic examination should avoid basing decisions about whether to collect samples for the sexual assault evidence collection kit on how they think patients' characteristics or circumstances will affect the investigation and prosecution. For example, the fact that a patient was intoxicated should in no way influence the decision of the clinician to collect samples or document the medical forensic examination objectively and fully.

Responders, clinicians, and law enforcement representatives should seek education and resources to aid them in making well-informed decisions about evidence collection. Law enforcement representatives require training and resources to allow them to make informed decisions about whether to collect evidence and what to collect in each case. They also need local policies and instructions that encourage them to make informed decisions on a case-by-case basis, rather than applying a limiting general standard to all. First responders also need instructions on collecting a urine sample if there is a suspicion of alcohol- or drug-facilitated sexual assault and victims cannot wait to urinate until their arrival at the exam site. Clinicians completing the medical forensic examination should be trained on approaching the decision-making process in a patient-centered and trauma-informed way and balancing the patient's healthcare needs with their desire for sample collection.

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[178] See Mayntz-Press, K. A., Sims, L. M., Hall, A., & Ballantyne, J. (2008). Y-STR Profiling in Extended Interval (> or = 3 days) Postcoital Cervicovaginal Samples. *Journal of Forensic Sciences*, *53*(2), at pages 342–348; see also, Ballantyne, J. (2013). DNA Profiling of the Semen Donor in Extended Interval Post-Coital Samples. Final report submitted to the National Institute of Justice.; see also, Hanson, E., & Ballantyne, J. (2014). A Y-short tandem repeat specific DNA enhancement strategy to aid the analysis of late reported (≥ 6 days) sexual assault cases. *Medicine, Science, and the Law*, *54*(4), at pages 209–218; see also, Sween, K. R., Quarino, L. A., & Kishbaugh, J. M. (2015). Detection of Male DNA in the Vaginal Cavity After Digital Penetration Using Y-Chromosome Short Tandem Repeats. *Journal of Forensic Nursing*, *11*(1), at pages 33-40.

[179] See above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 18.

Communities can benefit from both discipline-specific and interdisciplinary training to ensure all responders are current in their knowledge and consistent with national standards of practice.

6. Evidence Integrity

Recommendations at a glance to maintain evidence integrity:

- Follow jurisdictional policies for drying, packaging, labeling, and sealing samples collected for the sexual assault evidence collection kit and any additional evidence collected, such as clothing.
- Ensure transfer policies maximize evidence preservation.
- Ensure storage policies maximize evidence preservation.
- Follow jurisdictional policies for documentation, tracking, storage, and transfer of evidence.

Follow jurisdictional policies for drying,[180] packaging, labeling, and sealing samples collected for the sexual assault evidence collection kit and any additional evidence collected, such as clothing. Clinicians should be educated regarding these policies. It is critical to air-dry wet samples and other evidence at room temperature in a clean environment and quick manner that prevents contamination whenever possible. A drying box without a fan or other device may be used to facilitate the drying process.[181] Jurisdictions should have policies for handling evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, sanitary napkins, tissues, diaphragms, and condoms), as well as for liquid evidence such as urine and drawn blood samples. When packaging dry evidence, use paper containers rather than plastic, because plastic containers retain moisture and promote degradation of biological evidence. Following proper drying and packaging procedures is vital to prevent the growth of mold and bacteria that can destroy an evidentiary sample.

Documentation is a critical component of the sample collection process. Follow jurisdictional policies for documenting the medical forensic examination, including the packaging, labeling, and sealing of the sexual assault evidence collection kit and other evidence. Properly recording and preserving this information is essential for admissibility during a trial, should the case move forward through the criminal justice system.

Make sure transfer policies maximize evidence preservation. Minimize transit time between collection of evidence and storage of kits whenever possible. To avoid potential degradation of evidence, it is important to transport kits containing liquid samples and other wet evidence in a timely fashion. Only a law enforcement official or duly authorized agent should transfer evidence from the exam site to the appropriate crime laboratory or other designated storage site (e.g., a law enforcement property facility). Jurisdictional procedures for evidence management and distribution must be in place and followed. Those involved in evidence management and distribution should be educated on the specifics of these procedures and their responsibilities.[182]

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[180] Dry evidence unless indicated otherwise (e.g., refrigerating).

[181] As referenced in *B.3. Equipment and Supplies*, swab dryers with fans should not be used as the blowing fan can transfer DNA from one swab to another. Drying boxes can still provide a protected environment in which to dry swabs, but they should be used without the fan.

[182] See above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 39 ("If the evidence cannot be physically retrieved by law enforcement from the health care agency within three days from the date of collection, a shipping method should be employed with a tracking system that includes the location with dates, times, and signatures necessary to preserve the chain of custody. Packaging should be completed with attention to preservation of the type of evidence. Frozen evidence should be packed with dry ice and dry

Make sure storage policies maximize evidence preservation. Secure storage sites should be designated, and storage requirements should be consistent across a jurisdiction. Storage requirements depend on what types of specimens are being collected and on jurisdictional policy. Dry evidence should be kept in a locked cabinet until it can be retrieved by law enforcement personnel. It should not be refrigerated and will not be useful to do so. However, liquids, such as blood and urine, must be refrigerated; they should be stored in a locked refrigerator to which only a limited number of authorized people have access.[183] If there are questions about how to store a particular sample or piece of evidence, consult local policies or crime lab personnel for clarification. Those involved in storing biological evidence should be knowledgeable regarding optimal storage conditions as well as the hazards for handling and storing evidence. Evidence should be retained for as long as possible, as storage space permits.

Make sure jurisdictional policies are in place to address evidence storage in cases where patients are undecided about reporting. Finding adequate storage space for these kits is a challenge for many facilities and agencies (e.g., community-based or hospital medical forensic examiner programs generally lack the capacity for secure long- term storage of kits at their facilities). Except where required by statute, exam facilities should not be the final storage site for sexual assault evidence collection kits and other evidence such as clothes obtained as part of the medical forensic examination. Local responders, particularly clinicians, law enforcement representatives, and crime lab staff, should discuss and address these and related challenges and develop procedures that allow for the secure storage of these kits without revealing a patient's identity. Storing the kits as long as necessary is the ideal (e.g., until the patient decides whether to report or until the jurisdiction's statute of limitations for retaining evidence expires). However, due to lack of storage space, kits in some jurisdictions are stored for a limited time (e.g., 1, 5, or 10 years) and then destroyed if no report is made. Recent revelations about untested sexual assault evidence collection kits and concerns about kit testing backlogs have altered approaches for many jurisdictions, from tracking evidence to storage of kits to the ways in which victims are notified. Many jurisdictions now have statutes that outline the length of time for which evidence kits must be held; they also describe the processes by which victims must be contacted prior to any evidence being destroyed so there is additional opportunity for participation in the criminal justice system.[184]

Follow jurisdictional policies for documentation, tracking, storage, and transfer of evidence. Clinicians must maintain custody of all samples from time of collection through drying, packaging, and storing, according to jurisdictional requirements, or must transfer it to the custody of a duly authorized agent for transport to a storage site. Chain of custody is critical in establishing authentication and relevance for purposes of admissibility of the evidence in court. A properly documented chain of custody identifies all persons who have had custody of the evidence and tracks the location of that evidence in chronological order from collection to destruction. The collection of

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evidence should be packaged in temperature-controlled environments that preserve the integrity of the sample and diminish degradation. The sender should follow appropriate guidance for mailing biological substances, regardless of whether wet or dry evidence.")

[183] See U.S. Department of Commerce, National Institute of Standards and Technology. (2013). The Biological Evidence Preservation Handbook: Best Practices for Evidence Handlers, Technical Working Group on Biological Evidence Preservation at page 34.

[184] For more information on best practices related to kit storage, tracking and testing, see the Sexual Assault Kit Initiative ("SAKITTA"); see also, above, 18 U.S.C. § 3772 (Sexual Assault Survivors' Bill of Rights).

samples for the SAK often establishes the first link in the chain of custody.[185] Patients, advocates, family members, and other support persons should not handle the evidence. Documentation of the chain-of- custody information is vital to ensuring that there has been no loss or alteration of evidence prior to trial.

Educate all those involved in handling, transferring, and storing evidence regarding the specifics of maintaining the chain of custody. If the patient is transferred between facilities, staff at both facilities should be careful to complete this documentation.

Jurisdictions should consider implementing a process for tracking the sexual assault evidence collection kits if one does not exist already:[186]

- Chain of custody.
- Date/time/identity of individual who collected evidence.
- Any person(s) in possession of the evidence at scene and during transport.
- Date/time/identity of person who submitted the evidence.
- Date/time/identity of property/evidence custodian who accepted/received the evidence.
- Date/time/identity of any person to whom the evidence was released and from whom it was returned.
- Unique item identification.
- Description of item.
- Unique number identifier (e.g., unique and scan-capable barcode).
- Evidence items created from analysis or separated from the original evidence item should be documented to show the linkage between it and the original evidence.
- Location of item in property/evidence storage room or other external location(s)
- Location (e.g., shelf number or bin) where evidence is stored.
- Date/time/identity of person who stored the evidence.
- System should have the means to identify items or evidence that has not been returned according to agency policy.

Once law enforcement has possession of the sexual assault evidence collection kit, it should be submitted to the crime lab within seven business days from the time of collection or as required by statute. For detailed recommendations about transfer and storage of kits, see the *National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach*.

[185] See above, National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 33.

[186] Id. at page 34.

C. The Examination Process

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

The following chapters are included:

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

1. Initial Contact

Recommendations at a glance to facilitate initial contact with victims:[187]

- Build consensus among involved agencies regarding procedures for a trauma-informed, victim-centered coordinated initial response when a recent sexual assault is disclosed or reported.
- Recognize essential elements of initial response and create/update protocols to standardize the response.
- Educate clinicians and other responders on local protocols.

Build consensus among involved agencies regarding procedures for a trauma-informed, victim-centered coordinated initial response when a recent sexual assault is disclosed or reported. First responders (e.g., 911 dispatchers, law enforcement representatives, emergency medical services (EMS) technicians, hospital emergency department staff, sexual assault examiners, and advocates) need to be educated about and follow these procedures. Responders also need discipline-specific procedures (e.g., EMS procedures should include evidence preservation when caring for acute injuries and treating victims with sensitivity).

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

Recognize essential elements of initial response and create/update protocols to standardize the response. Some victims may initially present at an exam site on their own. But many victims may initially contact 911, law enforcement, or an advocacy agency for help.

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

- Assess victims' needs for immediate care for potentially life-threatening or serious injuries. Administer necessary first aid and request/obtain emergency medical assistance according to jurisdictional policy.
- Address safety needs of victims and others at the scene (e.g., offenders may be present), calling for assistance/backup if needed.

[187] Initial contact may look different on military installations, college and university campuses, in detention facilities, assisted living facilities, and in some remote areas of the country where access to services may be measured in days rather than hours. In these circumstances, it is imperative that the local response has clearly defined protocols for what the initial contact will consist of, a timeframe for the process, who will be involved, and how victim services will be deployed. Issues such as mandatory reporting, which might be triggered because of the location of the assault (e.g., some campuses) or who has been told (e.g., military), will need to be clear among all responders, so that victims understand their rights and can make informed choices.

- Assess the age, abilities, communication modality, and health condition of victims and tailor the response as appropriate (e.g., a qualified interpreter, assistive devices, support person for the person with a disability, or disability service provider may be needed).
- Respond to requests for victim assistance as quickly as possible.[188] Understand that victims need immediate assistance for many reasons: they may not be safe, may be physically injured, and/or are experiencing trauma. Be aware that time delays in response can increase trauma and cause loss of evidence.
- Even if injuries do not appear serious, or there are no visible injuries, encourage patients, in a trauma-informed manner, to have a medical forensic examination and address related health concerns.[189] Explain the purpose and benefits of the medical forensic examination, keeping in mind the amount of information that victims want or are capable of processing at this time varies.
- Inform victims about exam facility options (if options exist) and seek their consent to transport them to the facility of their choice (if options exist) for treatment and/or medical forensic evaluation.[190]
- Encourage victims' interaction with advocates as soon as possible after disclosure of the assault, even if victims choose not to undergo the medical forensic examination or receive any medical intervention. In some jurisdictions, advocates may be dispatched directly to the scene to provide victim support and advocacy, if appropriate. Jurisdictions should follow local procedures for activating an advocate.
- Ask victims if there is a particular support person, such as a friend or family member, they would like contacted. Consider that clergy or other faith-based individuals or spiritual leaders may be the support person of choice for victims.
- Employ interpreter and translation services as appropriate for victims who are not proficient in English or who may prefer to communicate in a non-English language.
- Take measures to preserve crime scene evidence and evidence on the clothing of victims.

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

[189] For information on conducting trauma-informed investigations, see resources accompanying the Justice Department's Prosecutor Guide and resources compiled by the International Association of Chiefs of Police (IACP).

[190] Inform victims of the approximate amount of time it will take to travel to the facility and how long they will be at the exam site. This information can help them prepare for what to expect and make needed arrangements (e.g., childcare, getting time off from work or school, or informing family members). In some areas, it may take considerable time to get to the exam site (i.e., several hours). Involved agencies in these areas may want to consider the feasibility of having a specially trained examiner located in their community. Ideally, options should be geared toward facilities that have medical forensic examiners available, so that they are not subjected to the possibility of a transfer to a secondary exam site once they arrive.

- Document victims' demeanor and statements related to the assault, according to jurisdictional policy. Victims' statements to law enforcement are generally inadmissible during trial except in narrowly prescribed circumstances.[191] However, victims' statements made to medical personnel, such as paramedics and emergency medical technicians (EMTs), as well as those made to clinicians during the medical forensic examination, may be admissible during trial and can be used to corroborate their testimony.[192]
- Explain to victims their reporting options based on jurisdictional availability.[193] Keep in mind that the amount of information desired will vary per individual.
- Responding law enforcement officials should seek basic information from victims about the assault in order to apprehend suspects and facilitate crime scene preservation in a timely manner.
- Develop and publicize protocols precluding detention or other immigration enforcement against victims who come forward to report a sexual assault.

If victims agree to a medical forensic examination or, at a minimum, seek basic emergency medical treatment:

- Discuss ways they can maximize retention of evidence that may be sampled during the medical forensic examination, such as refraining from urinating or eating and drinking, if they are able to do so. Some victims may be physically unable to do so, and victims should not be retraumatized or made ill for the sake of evidence preservation.
- Explain to victims in their primary language that clothing may be taken as evidence, particularly if they haven't changed since the assault. They may wish to bring or have someone bring a clean change of clothes to the exam facility. If applicable, let victims know that replacement clothing will be available at the exam site. If they changed clothes since the assault, the clothing worn during and immediately after the assault will be needed. Follow law enforcement procedures for retrieving clothing or other items from a crime scene so that evidence is not inadvertently destroyed or contaminated.
- In suspected cases of alcohol- or drug-facilitated assault, victims' first available urine sample should be sought if they cannot wait to urinate until arrival at the exam site. (For information on procedures, see *C.7. Alcohol and Drug-Facilitated Sexual Assault*.) Victims might have been drugged without their knowledge. If they or their families, friends, or responders suspect alcohol- or drug-facilitated assault, a urine sample should be requested from the victim.

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[191] See Fed. R. Evid. 802 (The Rule Against Hearsay).

[192] See Fed. R. of Evid. 803(4) (Statement Made for Medical Diagnosis or Treatment.); see also the Justice Department's Prosecutor Guide at page 15 (discussing exceptions to the rule against hearsay and when victims' statements may be admissible).

[193] While reporting options used to be binary, with victims choosing to report or not, many jurisdictions have opted for more nuanced approaches to the process. To review the ways in which some communities approach reporting, including sample protocols, see above, Opening Doors: Alternative Reporting Options for Sexual Assault Victims.

- Transport or arrange transportation for victims to the exam site that has the most appropriate medical forensic examination capability.[194] Victims with disabilities may have equipment (e.g., wheelchairs and other assistive devices) and/or service animals that also need to be transported.[195] The victim's mobility device or service animal should be transported with them.
- Follow jurisdictional policy on alerting medical forensic exam facilities about the pending arrival of patients.
- Do not take suspects to the same exam facility as victims at the same time, if possible. If doing so cannot be avoided, take care to ensure that the victim and suspect do not have contact at the facility.

Advocate response. If victims have initial contact with advocates, this contact typically occurs through a phone hotline call, text or web chat, or a face-to-face meeting. Advocates should follow agency-specific and jurisdictional policy for first response. Advocates should support victims in seeking care for possible injuries or in their desires for a medical forensic examination, provide information about their options (e.g., health care, advocacy and counseling, interpretation and translation, exam site options, and reporting options), and offer referrals.

In general, advocates can help victims identify and consider how to address their myriad needs and concerns, as well as identify individuals who might support them in dealing with the aftermath of the assault. They can activate the SART (if one exists) with victims' permission. Alternately, advocates can offer to help victims arrange transportation to the medical forensic exam site, obtain nonemergency medical care, and obtain assistance from law enforcement. They can also accompany them through the medical forensic examination.

Regardless of which agencies are first responders, the responders should always be sensitive to the victim's needs and level of trauma. It is common for victims of sexual violence to have showered, eaten, laundered clothing or bedding, or taken other self-protective actions that may impact the retrieval of evidence prior to engaging any service providers. Responders should recognize that all victims should still be offered the full array of victim services available in the community, including advocacy and a medical forensic examination, since these services are not predicated on the availability or identification of DNA evidence.

Educate clinicians and other responders on local protocols. All sexual assault responders should be educated on local protocols to ensure a consistent response and optimal collaboration. If there is a functioning SART within the community, consider cross-training to better educate all responders on respective protocols. Even in the absence of a functioning SART, multidisciplinary, or interdisciplinary training efforts on respective protocols will help foster collaboration and encourage maintaining and updating protocols.

[194] Many jurisdictions have designated exam sites. For more information on this topic, see *B.2. Facilities.*

[195] In addition, evidence may be found on assistive devices and/or service animals.

2.Triage and Intake

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

- Identify patients who have experienced sexual assault as priority patients.
- Complete prompt trauma-informed medical assessment, including evaluation and treatment of acute injuries, trauma care and any safety needs of the patient over sample collection for the sexual assault evidence collection kit.
- Alert medical forensic examiners of the presence of a patient in order to minimize patient wait times.
- Contact victim advocates so they can offer services to patients, if not already done.
- Assess and respond to safety concerns upon arrival of patients at the exam site, such as threats to patients or staff.
- Assess patients' needs for immediate mental health intervention prior to the medical forensic examination, following facility policy.

Identify patients who have experienced sexual assault as priority patients.[196] Consider identifying sexual assault patients as a higher Emergency Severity Index (ESI) triage level based solely on the amount of time and resources that may be required to treat them. This should be included in triage provider's protocols and training. Use a private location within the exam facility for patient intakes, as well as for a waiting area for patients' family members and friends and law enforcement interviews. (Also see *A.2. Patient-Centered, Trauma-Informed Care*.)

Complete prompt trauma-informed medical assessment, including evaluation and treatment of acute injuries, trauma care, and any safety needs of the patient over sample collection for the sexual assault evidence collection kit. In addition to promoting physical health, sensitive and timely medical care can help reduce the likelihood of acute psychological trauma and its aftereffects, support patients' coping skills, and set the tone for patients' resumption of normal functioning. Mandatory reporting requirements should be reviewed with the patient as soon as possible so they are able to choose the best course of action for themselves.

Acute medical needs take precedence over sample collection and other evidentiary needs. If alcohol- or drug-facilitated sexual assault is suspected, and patients need to urinate prior to the arrival of examiners, ensure that the urine sample is collected properly while maintaining the chain of custody.

The clinician completing the medical forensic examination should be involved in all aspects of the care of the patient who has experienced sexual assault. As soon as possible after the initial triage, management, and stabilization of acute medical problems and before treating non-acute injuries, the

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

medical forensic examination can be conducted (with patients' permission). In circumstances in which patients are seriously injured or impaired, clinicians must be prepared to work alongside other health care providers who are stabilizing and treating them for other issues. In such cases, clinicians may need to perform examinations in settings such as a health care facility's emergency department, an operating room, a recovery room, or an intensive care unit. Pregnant patients should be treated according to the institution's trauma pregnancy protocol if they initially present to the emergency department; in a clinic or other community setting, protocols should be in place detailing when the patient needs to be referred or transferred to the emergency department for further evaluation.[197]

Alert medical forensic examiners of the presence of a patient in order to minimize patient wait times. The medical forensic examiner program will identify acceptable timeframes to conduct a medical forensic examination after a patient's arrival and medical evaluation, management, and stabilization. If clinicians are not based at the site or need to be dispatched, the facility should contact them immediately after identifying a patient that has experienced sexual assault.[198] Clinicians are often required to arrive at the exam site within a certain period of time (e.g., 30-45 minutes) after being dispatched.

Some patients may be apprehensive about interacting with clinicians from ethnic and racial backgrounds different from their own. They may fear or distrust clinicians or assume they will be met with insensitive comments or unfair treatment. They may benefit from clinicians of the same background or at least clinicians who understand their culture. Conversely, in smaller ethnic and racial communities, patients may be more likely to know the clinicians and doubt their ability to maintain confidentiality.

Contact victim advocates so they can offer services to patients, if not already done*.* (For a discussion of this topic, see *A.2. Patient-Centered, Trauma-Informed Care*.) This should occur as soon as the patient arrives. The medical forensic examiner does not need to arrive before the advocate is contacted.

Assess and respond to safety concerns of victims upon arrival at the exam site, such as threats to patients or staff. The facility should have policies and procedures to assess such safety concerns at the exam site and to respond to such threats or dangerous situations. (For a discussion

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[197] Ideally, a pregnant patient should have access to concurrent care, where the obstetrics provider, emergency medical personnel, and the sexual assault medical forensic examiner all work together to provide patient care. Often after a traumatic event, the obstetrics provider recommends prolonged fetal monitoring, which can take a minimum of four hours. Performing the medical forensic examination while the patient is being monitored significantly lessens the time a patient has to complete the tasks facing them. The model of concurrent care offers an increase in patient satisfaction and alleviates anxiety the medical forensic examiner may have when caring for the patient presenting with bleeding or suspected gynecological pain while pregnant. While waiting on the obstetrics provider, the complete medical forensic documentation, photography, injury documentation, completion of the external examination, and any swabs of the external genitalia per protocol may be performed. Once the OB provider is present and it is deemed safe to complete the internal assessment, swabs may be collected from the vaginal vault if the patient consents.

[198] It is possible that clinicians could also be dispatched by first responders at the crime scene or by health care staff after being alerted that a sexual assault patient will be arriving at their facility. Although activating clinicians as early as possible seems like it would benefit these patients, such a procedure can potentially cause confusion. For example, after activating an examiner to go to a particular exam facility, there may be significant delays in getting the patient to the site or changes enroute to the facility. Patients may also change their minds about care or evidence collection/

of this topic, see *A.2. Patient-Centered, Trauma-Informed Care.)* Communicating any information may require a qualified interpreter[199] for patients who are LEP.[200]

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

Gender Affirming Care.[201] Many transgender and gender diverse patients have had negative and even violent experiences with the healthcare system. [202] Clinicians should be cognizant of best practices in providing services to transgender and gender diverse patients including using the correct gender identification, avoiding unnecessary, invasive questions unrelated to the sexual assault medical forensic examination, and ensuring equal access to care.[203]

- Intake forms, billing forms, and other documents that ask about gender or sex should be accurate and beyond the binary. Ensure questions appropriately distinguish between sexual orientation (the gender(s) someone is attracted to), gender identity (a person's internal sense of self as being male, female, both, neither, or another gender), and their sex assigned at birth (male, female, or intersex).

- Clinicians should clarify what name the patient uses versus what name may be listed on official documents (e.g., What may be used on insurance card, driver's license, or other legal documents). The name may not be the same, and the patient should be consulted as to whether they are comfortable having their medical forensic record reflect the name they use or the name on their official documents.

- If the patient opts to have the name on the medical forensic documentation reflect the name on their official documents, the clinician should still refer to the patient by the name and pronoun used during the medical encounter. For safety or other reasons, a patient may not want to request a change.

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

[200] See, above, discussion of Title VI and limited English proficiency.

[201] See above, IPV Protocol at pages 28-29.

[202] See above, Early Insights: A Report of the 2022 U.S. Transgender Survey (Discussing a U.S. transgender survey, in which of those who saw a health care provider within the last 12 months, nearly one-half (48%) reported having at least one negative experience because they were transgender, such as being refused health care, being misgendered, having a provider use harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them).

[203] Best practices should adhere to Section 1557 of the Patient Protection and Affordable Care Act's definitions for discriminatory care and Section 504 of the Rehabilitation Act of 1973.

- A transgender or gender diverse patient may be accompanied by someone who does not know their identity or history. In these cases, ask the patient privately how they would like you to refer to them in that person's presence.[204]

- Relatedly, any member of the LGBTQI+ community may not be publicly out, and that information should be treated as protected health information subject to all confidentiality and privacy rules.

[204] Adapted from FORGE SAFE protocol Trans Specific Annotation, page 1 (providing an annotated list and explanation of references to transgender survivors in the second edition of this protocol) (last visited July 15, 2024).

3. Medical Forensic Documentation

Recommendations at a glance for completing needed documentation:

- Ensure completion of all appropriate documentation.
- Educate clinicians on proper documentation.
- Ensure the accuracy and objectivity of medical forensic documentation.
- Ensure the appropriate storage of medical forensic records.

Ensure completion of all appropriate documentation. Clinicians are responsible for documenting the details of the entire medical forensic examination encounter, including the full assessment, all treatment provided, and all data collected for the sexual assault evidence collection kit, according to jurisdictional policy. The information needed for the sexual assault evidence collection kit usually includes patient consent forms related to the sample collection, the history of the assault, and information pertaining to the sample collection that will assist the crime lab in material identification for analysis.[205] (The medical forensic history and medical forensic examination are discussed in more depth in later chapters in this section.) The only medical issues documented in the information required by the crime lab are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings. If the case is reported, the criminal justice system will use the medical forensic record, along with collected samples, photographs, patient statements and other witness statements, as a basis for investigation and possible prosecution. If clinicians are required to testify in court, they will use the medical forensic documentation to prepare for testimony and refresh their recollection of the patient encounter.

The overall medical forensic documentation completed by the medical forensic examiners follows a standard approach of addressing acute complaints; gathering a medical forensic history; describing and photographing physical findings, laboratory and imaging findings, consultation reports (if done) and sample collection procedures; documenting treatment (and response to treatment) and follow-up recommendations and referrals. The complete medical forensic record of the sexual assault visit may be maintained separately from the patient's medical record to limit disclosure of unrelated information and to preserve confidentiality, or it may be stored with an additional layer of protection within the patient's existing medical record, which may be available with many electronic medical record systems.[206] The break-the-glass emergency protocol ensures that only a limited number of individuals have access to the protected information, and an audit trail is generated. Regardless of how the facility chooses to store the record, it should be stored at the exam site. The exam site should have clear policies about who is allowed access to these records.[207]

[205] Documentation of examination findings also should include patients' demeanor and statements related to the assault not already recorded on the medical forensic history, such as information about source of injury, if known to the patient.

[206] For recommendations about what to look for in electronic medical record management systems see the National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 29.

[207] Mechanisms to restrict access to records related to the examination are particularly important in small communities where exam site employees may be acquaintances, friends, and family members of patients or offenders.

Jurisdictions vary in the forms used for the examination documentation, with some facilities using a single medical forensic record created by or for their facility, and others using a combination of facility and state- generated forms.[208] Regardless of the approach, clinicians should understand that at the point that a patient discloses an acute sexual assault, the entire encounter is both medical *and* forensic by virtue of the patient's complaint of sexual assault. Medical forensic examiners cannot concern themselves solely with what they believe to be the forensic parts of the examination, since they are wholly intertwined. Health status, medical history, and other medical issues can impact the assessment, care, and discharge of every patient who presents after sexual assault. Moreover, should a sexual assault case move forward in the criminal justice system, the entire medical record from the patient's encounter on that date will be subpoenaed, not just the "forensic" parts.[209] For these reasons, facilities should treat the entire encounter as a single healthcare encounter to the extent governing law allows.

Educate clinicians on proper documentation. It is vital that the examination documentation be thorough, precise, and accurate. Clinicians must receive education on the importance of proper documentation and on completing documentation that is appropriate to the role of medical forensic examiner. As previously discussed, medical forensic documentation must include documentation of the complete patient encounter, including the medical forensic history, narrative descriptions of findings, corresponding body maps, a clear delineation of the samples collected, medications administered, and a discharge plan. Informed consent and authorization for release should be clearly documented to include consent for treatment, collection of samples, and, if appropriate, photography, and release of information and collected samples/other evidence.

Audio and video recording of patient medical forensic examinations, including medical forensic histories should not occur. Recording the medical forensic examination is not patient-centered or trauma-informed (the patient may not fully understand what they are consenting to or the implications of such a recording existing). The impact on patient privacy is significant, with recordings necessarily becoming available to entities not bound by the same privacy and confidentiality laws as clinicians. Furthermore, suggesting the use of a recording device to a patient who has experienced trauma has the potential to risk not just clinician-patient rapport building with the patient who is hesitant to engage with the medical forensic examination, but the entire encounter. It is also inappropriate to have the patient complete any portion of the documentation themselves.

Ensure the accuracy and objectivity of medical forensic reports. The most effective way to ensure accuracy, objectivity and consistency of medical forensic documentation is through a quality assurance, quality improvement, or peer review process. Clinicians should devise an appropriate quality or peer review process tailored to their needs; this may occur in-house, or for programs that are low volume, may be part of an expanded effort with other programs at the regional or state level to take advantage of larger patient volumes seen by the combined medical forensic examiner sites. Consider having a clinical director or clinical program supervisor at the exam site systematically review documentation related to the examination. Medical directors may also participate in documentation review. (In some jurisdictions, documentation review may be shared by other members of the team, as well.) These reviews can serve to increase the overall quality of the clinical program by ensuring that documentation is completed according to policy, using identifiable

[208] For patients seen by military treatment facilities, there are combination of forms used by the facility as well as the Department of Defense form DD 2911, the standard form completed for all sexual assault evidence collection kits.

[209] See, above, discussion about Discovery.

benchmarks, assessing staff training needs, considering adjustments needed to documentation, and anticipating program needs based on trends. The clinical director or clinical program supervisor (along with the medical director) can also be involved in broader multidisciplinary quality assurance efforts related to the examination process.

In many circumstances, quality assurance documents are protected under state quality assurance and peer review privilege statutes as well as under federal law.[210] However, not every state has laws to protect all quality assurance or peer review, and circumstances exist when this privilege may no longer apply. Clinicians should therefore consult legal counsel and risk management to ensure that the process at issue is protected.[211]

Ensure the appropriate storage of medical forensic records.[212] Regardless of location, clear protocols are necessary for how to store and maintain medical forensic records (including photographs, if taken as a part of the examination process). There is no single standardized federal record retention schedule to which clinicians and organizations must adhere. The *National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach* provides sample record retention requirements. [213] Sexual assault medical forensic record retention policies should be created in concert with statutes of limitation and the general needs of the criminal justice system rather than the traditional time frames of medical record retention.

Organizations should work with professionals within departments such as compliance, legal, risk management, and health information management to identify how and what information will be released to both patients and their proxies. This recommendation applies whether the program uses an electronic medical record or maintains paper records.

[210] 42 U.S.C. §§ 299b-21 to 299b-26 (Patient Safety and Quality Improvement Act).

[211] See above, IPV Protocol at pages 61-62.

[212] Id. at pages 67-68.

[213] See the National Institute of Justice National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 30.

4. The Medical Forensic History

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

- Allow advocates to provide support and advocacy during the history, if desired by patients.
- Consider patients' needs prior to and during history taking.
- Obtain information that will guide patient care and sample collection.

A medical forensic history is one of the initial components of the examination process. This history, obtained by asking patients detailed questions related to their health history and the history of the chief complaint, i.e., the sexual assault, is intended to guide the examination, which can include sample collection and crime lab analysis of findings if a sexual assault evidence collection kit is being collected.

Gathering information from patients often takes place soon after the assault, so it is imperative that this, as with all aspects of the medical forensic examination, be conducted in a trauma informed manner.[214] Discussing the assault can feel traumatic, and a patient's emotional and physical condition may make communication challenging, particularly if clinicians are expecting a concise, linear recitation of information. Clinicians should be careful not to conduct an investigative interview when obtaining a medical forensic history. At the time of such information gathering, patients may not want to speak with law enforcement or be ready to go into the extensive details needed for investigative purposes. Patients may withhold information from law enforcement or not want to talk with them about certain issues (e.g., their menstrual cycle or types of penetration). They might feel more comfortable talking to clinicians in private about a variety of topics needed for comprehensive patient care.[215] Attending to a patient's comfort, safety, and support needs can assist in creating an optimal process for information gathering.

Allow advocates to provide support and advocacy during the history, if desired by patients. The presence of an advocate may help patients feel more comfortable disclosing information and answering questions. Advocates may also assist patients in voicing their concerns about questions being asked and clarifying their needs during this time. Advocates should be clear about their role, however, and not answer questions asked of patients or otherwise influence their statements.

Advocates should be activated at the time a patient presents or is identified as having experienced sexual assault. They can introduce themselves to the patient and allow the patient to determine for themselves whether they would like to have advocacy services during and/or after the medical forensic examination. There is no breach of patient confidentiality by simply having the advocate meet the patient in the absence of identifying information. Once the patient has consented to advocacy services, patient information can be disclosed.

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[214] The Sexual Assault Medical Forensic Examination Virtual Practicum is an interactive training for clinicians to improve their skills in trauma-informed medical forensic history taking, as well as all other aspects of the medical forensic examination:

[215] For more information about keeping the medical forensic history taking separate from law enforcement interviews, see Sexual Assault Kit Initiative. (2018). *Medical history and law enforcement interviews: Separate and collaborative.* NCJ Number 252602. (Last visited July 15, 2024).

Patients should be informed about the type of advocate responding and understand the different types of confidentiality and privilege that exists among victim advocates. Community-based advocates serve only victims, and the information shared by victims is confidential. Furthermore, many jurisdictions provide statutory victim advocate privilege that shields any communications from disclosure. However, in jurisdictions that have physician/patient privilege, but not a victim advocate privilege, the advocate could be required to testify about what the victim told them. Systems-based advocates, such as those who work for police departments or prosecutors' offices, are bound by the prosecutors' discovery obligations, and therefore cannot serve as a confidential resource for victims.[216]

Presence of family members, friends, and other personal support persons. The presence of personal support persons can create potential challenges, of which patients should be aware prior to having them present for any aspect of the examination process. Some support persons can knowingly or unwittingly influence responses or decisions patients may make during the medical forensic examination, which can have subsequent impacts on either care or, should the case move forward, on the criminal justice process, including the patient's trial testimony.[217] These individuals also could be subpoenaed as witnesses.[218] If, after receiving this information, patients choose to have personal support persons present during the history, these individuals should be advised not to actively participate in the process. For example, they should not answer questions for patients, comment on patients' answers, interrupt patients, or make facial expressions in response to patients' answers.[219] The presence of personal support individuals does not mean that advocates should not also be offered.

For patients with disabilities, who are sexually assaulted at higher rates than the nondisabled population, caretakers, family members, or friends may be responsible for the sexual assault.[220] The same is true for elderly patients.[221] In such cases, offenders may bring patients to the exam site. Policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel. However, clinicians must respect patients' wishes regarding who they want to have present during the examination. There should not be

[216] Adapted from above, IPV Protocol at page 71 (footnote).

[217] Support persons may be accused of influencing decisions or even responses to questions that the patient is asked. Ideally, these individuals should not be present when clinicians give patients this information or when patients make the decision whether they want the support person present.

[218] Patients should also be informed that the presence of these individuals during the medical forensic history could potentially vitiate any privilege that advocates may have with the patient. As a result, these individuals become witnesses to what the patients says or does and may be subpoenaed to testify. Likewise, when there is no privilege, advocates may be called to testify about interactions between patients and family members or friends. Victims should be informed of this before disclosing non- medically relevant information.

[219] Requests to have family, friends, and other personal support persons present during the medical forensic history should be allowed unless it is considered potentially harmful to the examination process. For example, in cases involving adolescents, parents or guardians should not be allowed in the exam room if they are suspected of committing the assault or of being abusive to patients.

[220] See Ledingham, E., Wright, G. W., & Mitra, M. (2022). *Sexual Violence Against Women With Disabilities: Experiences With Force and Lifetime Risk. American journal of preventive medicine*, *62*(6), at pages 895–902; see also, Mailhot Amborski, A., Bussières, E. L., Vaillancourt-Morel, M. P., & Joyal, C. C. (2022). Sexual Violence Against Persons With Disabilities: A Meta-Analysis. *Trauma, violence & abuse*, 23(4), at pages1330–1343.

[221] See Fileborn B. (2017). Sexual Assault and Justice for Older Women: A Critical Review of the Literature. *Trauma, violence & abuse, 18*(5), at pages 496–507.

blanket policies that exclude anyone accompanying a patient with disabilities simply because it is easier than screening for abuse. Additionally, though these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of patients during the examination process. As always, if a patient with a disability requires a reasonable accommodation to receive services, the facility should provide it.

Consider patients' needs prior to and during history taking. Pressing issues (e.g., for treatment of serious injuries, immediate crisis intervention and support, language access needs, and childcare during the examination process) should be addressed before commencing with history taking. Clinicians should be mindful of patients' capacity to answer questions during a lengthy history taking process, and take breaks as needed.

The exam facility should have procedures in place and clinicians should be educated to accommodate patients' communication capacity and preferred mode of communicating. This is particularly important for patients with communication-related disabilities and patients with limited English proficiency. If interpreters are necessary, they should be present prior to the history taking process, and there should be space for them in the exam room and other rooms where information is gathered. If it is unclear what language the patient speaks, the use of "I Speak Statements Card" can be a simple way to identify the language in which interpretation is required.[222] Patients with communication-related disabilities may wish to use assistive communication devices to facilitate communication. Communication aids (such as picture boards customized to the language and concepts of the sexual assault medical forensic examination and associated issues, alphabet boards, white boards, and pens/paper) are tools that could be valuable in enhancing communication for patients with communication disabilities.[223]

It is important that clinicians be aware of and responsive to verbal and nonverbal cues from patients. Clinicians should not expect patients to react in a particular manner as they recall experiences during the assault. Some patients with disabilities may want to talk about their perceptions of the role that disability might have played in making them vulnerable to an assault. Some patients may make similar observations about the role that race, gender, sexual orientation, or other characteristics or perceived vulnerabilities may have played. Clinicians should document what patients tell them. Clinicians should not expect the medical forensic history-taking process to be a linear and focused fact-finding process, as trauma victims often do not recount their assaults in a linear manner.[224] Clinicians should take care not to push patients to give a linear account. In addition, patients may mention previous instances of victimization. Clinicians should not push patients to recount anything in particular but should also allow the patient to talk about such events and should document the prior victimizations. Advocates can be particularly helpful to patients who are dealing with the emotions that arise as they begin to discuss what occurred.

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[222] See the U.S. Department of Agriculture's I Speak Statements Card, a resource that helps "identify the primary language of non-English speakers by using a short phrase in each of the 49 languages that an applicant can check to indicate the language they speak."

[223] See Baylor, C., Burns, M., McDonough, K., Mach, H., & Yorkston, K. (2019). Teaching Medical Students Skills for Effective Communication With Patients Who Have Communication Disorders. *American Journal of Speech-Language Pathology*, *28*(1), 155–164.

[224] See, e.g., Justice Department's Prosecutor Guide at page 13 ("[T]rauma does not affect accuracy, but trauma and stress can affect a victim's ability to recall memories and provide a linear account. As a result, a victim may sound scattered and fragmented, which may be unintentionally exacerbated by the way an interview is conducted.) (internal citations omitted).

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

Obtain information that will guide patient care and sample collection. The specific questions that clinicians ask patients for the medical forensic history vary among jurisdictions, as do forms used to record the history.[225] However, the following information should be sought routinely from patients:

- Date and time of the sexual assault(s): It is essential to know the period of time that has elapsed between the assault and the medical forensic examination, since there are a variety of aspects within the examination that are time-limited or time sensitive, including some medication administration (e.g., HIV prophylaxis, emergency contraception), and types of sample collection (e.g., blood vs urine for toxicology screening). Interpretation of both the physical examination findings and sample analysis also may be influenced by the time interval since the assault.
- Pertinent patient medical history: Medical history provides context for what clinicians may see during the examination, and it also allows clinicians to formulate care decisions. The interpretation of physical findings may be affected by medical data related to menstruation, recent anogenital injuries, surgeries, or diagnostic procedures, recent procedures that may alter the appearance of the patient's genitalia, and other pertinent medical conditions, such as clotting disorders. And, the patient's general care may be affected by information to include allergies, medications, acute and chronic health conditions, pregnancy history (if applicable), and immunization status.
- Recent consensual sexual activity: The sensitivity of DNA analysis makes it important to gather information about recent consensual intercourse, whether it was anal, vaginal, and/or oral, and whether a condom was used. If anogenital injury is assessed, it is important to recognize the possible sources of those injuries, which may include consensual partners if recent contact has occurred. A trace amount of semen or other bodily fluid may be identified that is not connected with the reported assault. Once identified, it may need to be associated with a consensual partner, and then used for elimination purposes to aid in interpreting evidence.[226]
- Post-assault activities of patients: The quantity and quality of evidence collected from a patient's body can be affected by patients' actions and the passage of time. It is critical to know what, if anything the patient did prior to the examination (including, but not limited to urination, defecation, wiping or bathing of genitals or the body, and removal/insertion of a tampon).
- Offender information (if known): Information about the gender and number of suspected offenders may be helpful to investigators and forensic scientists, particularly as it relates to the types and amount of foreign materials that might be found on patients' bodies and clothing. Offender information gathered during this history should be limited to that which will guide the exam and sample collection. *Law enforcement will ask detailed questions*

[225] See, e.g. Minnesota Coalition Against Sexual Assault's Standardized Sexual Assault Exam Report (last visited July 16, 2024); California Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination (CAL OES 2-923) (last visited July 16, 2024); see also above, IPV Protocol; Washington State Recommended Guidelines for Sexual Assault Emergency Medical Evaluation, Adult and Adolescent (2017) (last visited July 16, 2024).

[226] Consistent with governing law, during the course of a criminal investigation, law enforcement may seek to obtain an elimination DNA sample in the form of a buccal swab from consensual partners.

about offenders when they interview victims. It is not appropriate for clinicians to ask unless there is a clinical rationale to do so.

- Location of the assault(s): Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) is useful in aiding sample collection and analysis by the crime lab.
- Detection of alcohol- or drug-facilitated sexual assault: It is critical to collect information such as whether there was memory loss, lapse of consciousness, or vomiting; whether the patient was given food or drink by the suspect (if the patient knows); or whether the patient voluntarily ingested drugs or alcohol. Collecting toxicology samples within 120 hours of the suspected ingestion is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy and with the patient's specific consent.
- Description of the sexual assault(s) and assault-related patient history, including other mechanisms of injury: An accurate but brief description is crucial to guiding the examination and sample collection, if applicable. Although the clinician's questions will vary depending on the type of assault, a patient's description should include any:
  - Penetration of genitalia (e.g., vulva, hymen, and/or vagina of patient if applicable), however slight, including what was used for penetration (e.g., finger, penis, or other object).
  - Penetration of the anal opening, however slight.
  - Oral contact with genitals (of patient by suspect(s) or of suspects by patient).
  - Other contact with genitals (of patient by suspect(s) or of suspects by patient).
  - Oral contact with the anus (of patient by suspect(s) or of suspects by patient).
  - Nongenital act(s) (e.g., licking, kissing, suction injury, strangulation, and biting).
  - Other act(s) including use of objects for penetration and/or to injure, degrade, or humiliate the patient in any way; use of restraints; or taking of images or video by the offender(s).
  - If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other).
  - Use of contraception or lubricants.[227]

These questions require specific and sometimes detailed answers. Some may be especially difficult for patients to answer. Clinicians should explain that these questions are asked during every sexual assault medical forensic examination. They should also explain why each question is being asked. Clinicians should tell patients that if they do not know the answer to a question, "I don't know" is an acceptable response and that they should not guess if they are unsure.

Patients should also be asked about other mechanisms of injury used during the assault(s): use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, scratching, holding, pinching, biting, strangulation, burns (thermal and/or chemical), threat(s) of harm, and involuntary ingestion of alcohol/drugs. In addition, knowing whether offenders may have been injured during

[227] Certain contraceptive preparations can interfere with accurate interpretation of preliminary chemical tests frequently used in the analysis of potential seminal stains. However, the use of a small amount of water-based lubricant as a component of the exam is acceptable practice and promotes patient comfort. Contraceptive foams, creams, or sponges can destroy sperm. Lubricants of any kind are trace evidence and may be compared with potential sources left at the crime scene or recovered from bodies of suspects so if they were introduced as a component of the assault they should documented; the type of lubricant used as part of the exam process should also then be documented in the medical forensic record. Knowing whether a condom was used also may be useful in explaining the absence of semen, so if this information is known it should be included in the medical forensic history.

the assault may be useful when recovering evidence from patients (e.g., blood or skin under fingernails) or from suspects (e.g., bruising, fingernail marks, or bite marks).

Clinicians should ask about and document the location of extragenital injury, tenderness, pain and/or bleeding, and anogenital injury, pain, and/or bleeding, which can direct medical care, and sample collection. A thorough review of systems, which can provide context for appropriate healthcare decisions is appropriate as part of the medical forensic history taking process.

For patients who have undergone gender-affirming surgeries, it can be helpful to complete an anatomical inventory (also called an organ inventory) as part of the medical forensic history, to ensure an efficient and complete examination and discharge planning process and to avoid any assumptions about what type of care may or may not be needed. Sample language for raising the issue in a way that is both trauma-informed and sensitive to patients' concerns about potential negative experiences with healthcare providers includes, "*In order to provide you with the best clinical care, it is important for me to know if you have certain body parts. Is it okay if we talk through a list of body parts, and you can let me know whether you have these? If you use different words for parts of your body, please let me know*."[228] See Appendix B for an example of an anatomical inventory. Additionally, some electronic health records already include an integrated anatomical inventory.

Other acts of abuse that accompany sexual assault may have an enormous impact on patients and may be relevant to establish how the offender committed the sexual assault. This includes spiritual abuse,[229] use of intimate images (either through forced viewing of pornography, by making the patient be the subject of such images, or threatening the dissemination of such images), withholding access to necessary medication, breaking or withholding access to mobility or communication aids, and threats or actual acts of outing for members of the LGBTQI+ community. These should also be documented in the medical forensic record if relevant.

Population-Specific Considerations:

- Patients may not report or discuss the assault because the stigma associated with it is overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage is devastating and may render patients unacceptable for an honorable marriage. Even discussing an assault or sexual terms may be linked with intense embarrassment and shame in some cultures.
- It may be uncomfortable for patients from some cultures to speak about the assault with members of a different gender. Some patients, including some elderly patients may have difficulty describing or may not have language for the acts or for parts of their anatomy.[230]

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[228] See, e.g. Grasso, C., Goldhammer, H., Thompson, J., & Keuroghlian, A. S. (2021). Optimizing gender-affirming medical care through anatomical inventories, clinical decision support, and population health management in electronic health record systems. *Journal of the American Medical Informatics Association*, *28*(11), at pages 2531–2535.

[229] See, e.g., Tomalin, E. (2023). Spiritual Abuse and Gender-Based Violence. *Gender-Based Violence: A Comprehensive Guide* at pages 323-334; see also, Cham: Springer International Publishing; Awaad, R., & Riaz, T. (2020). Insights into the Psychological Sequelae of Spiritual Abuse. *Hurma Project Research Conference, Chicago, IL*.

[230] See Goldblatt, H., Band-Winterstein, T., Lev, S., & Harel, D. (2022). "Who Would Sexually Assault an 80-Year-Old Woman?": Barriers to Exploring and Exposing Sexual Assault Against Women in Late Life. *Journal of interpersonal violence*, *37*(5-6), at pages 2751–2775.

- Patients' language skills and barriers may worsen with the crisis of sexual assault. (See B.2 Facilities for more on working with qualified interpreters). When working with a qualified interpreter to complete the medical forensic examination, clinicians should ensure they are always speaking directly to the patient and not the interpreter.
- Some transgender and gender diverse individuals may have increased shame in or dissociation from their body. Some may use nonstandard labels for body parts, and others may be unable to discuss sex-related body parts at all. Clinicians should reflect the patient's language when possible and use alternative means of communication (such as anatomically correct dolls or paper and pen for the patient to write or draw) if necessary.

5. Photography

Recommendations at a glance to photograph evidence on patients:

- Consider the extent of medical forensic photography necessary.
- Consider the equipment needed while balancing issues of cost and clinician confidence and competence with technology.
- Consider patient comfort and privacy concerns when obtaining photographs.
- Explain medical forensic photography procedures to patients, obtaining separate consent for photography.
- Take initial and follow-up photographs as appropriate, according to jurisdictional policy.
- Consider how photographs will be stored, including who will have access at the point of storage, and how photos will be accessed when needed.

Consider the extent of medical forensic photography necessary. Taking photographs of patients is usually part of the medical forensic examination process; however, the extent of the photography will depend on examination findings, jurisdictional protocols, and patient consent. Photographs can supplement the medical forensic documentation and provide a mechanism for peer review after the fact.[231] As to the extent of photographs necessary, programs generally take two different approaches. Some routinely take photographs, with patients' consent, of both detected injuries and normal (seemingly uninjured) anatomy involved in the assault. Other programs limit photographs to remarkable findings. The specific choice should be supported by program policy and consistently applied. Both can be useful in the peer review process. Because photographs are two dimensional images depicting what was viewed during the examination, clinicians should be cautious about interpreting subtle and/or nonspecific findings (e.g., erythema or redness) that were not seen by the clinician on direct examination. Review of photographs cannot reliably diagnose injuries not seen by clinicians, but it can assist in improving the quality of future photo documentation, including problems with lighting, focus, clarity, and exam techniques.

Consider the equipment needed while balancing issues of cost and clinician confidence and competence with technology. It is appropriate for clinicians, and not law enforcement personnel, to take photographs, due to the highly personal nature of the photography involved and because photography is an accepted form of medical documentation. Any photographs taken by law enforcement should include only the head and extremities and should not document findings on the torso or genital region. Clinicians should not offer or agree to use law enforcement's cameras to capture any photos for them. Clinicians have specific privacy obligations to the patient that law enforcement do not.

Clinicians should be familiar with equipment operation and educated on using photography to document findings. Photographic equipment should be used that can clearly document findings.[232]

- Camera equipment costs can range from several hundred to tens of thousands of dollars. A clinician considering an equipment purchase for their team should consider issues, such as:
  - Location of the medical forensic examination: Is the program stationary or moving between multiple locations?

[231] See above, SANE Program Development and Operation Guide, Photo Documentation.

[232] See above, IPV Protocol at pages 92-93.

- Storage: Is there secure storage space? Is adequate space available for storing accessories or is space available only for storing one camera?
- Training: Will the organization invest in training clinicians in new technologies?
- Lighting: Does the exam space allow for manipulating lighting conditions? Does the exam space require additional lighting to adequately capture images?

- Point-and-shoot cameras that all team members can competently operate may be a better investment than more intricate Digital Single-Lens Reflex (DSLR) cameras that may intimidate or confound some users. In choosing cameras, 12 megapixels is the minimum number needed for photos that provide clarity with magnification.

Consider patient comfort and privacy concerns when obtaining photographs.[233] Clinicians should minimize patients' discomfort while they are being photographed and respect their need for modesty and privacy by draping them appropriately. If a full body image is required for identification, the patient should be clothed or appropriately gowned. If it is necessary that a patient be uncovered to document injury, the patient should be strategically draped to allow for maximum modesty. Clinicians should document any agreed upon approach to make the patient more comfortable. *There is never a scenario where a patient should be standing completely naked being photographed*.

For a patient with a disability, the clinician should work directly with the patient to determine their preference and ability to be positioned rather than the clinician making any assumptions. Clinicians should also work with the patient to identify and photograph damage to adaptive equipment if it is available during the medical forensic examination.

Patients who have been recorded or photographed as part of the sexual assault or previous abuse may be reluctant about or traumatized at the idea of photos. More broadly, patients may be unsure about the entire medical forensic examination process, nervous about the genital examination, or exhausted by the lengthy process. As a result, patients may want an advocate and/or a personal support person to be present during the photography portion of the exam.

Explain medical forensic photography procedures to patients, obtaining separate consent for photography. Photography is not a common aspect of most medical examinations and is unusual for anogenital examinations**.** Patients may be concerned about privacy and who will have access to the photos. A fully informed consent process that outlines all the information about photography is a necessary component of the medical forensic examination. Helping patients understand the purpose of photography, the extent to which photographs will be taken and procedures that will be used, potential uses of the photographs (particularly if the patient has given consent to release the images for purposes of an investigation), and the possible need to obtain additional photographs following the examination can help alleviate a patient's initial concerns. If it is safe to do so, clinicians should provide this information to patients as part of discharge instructions, so they have it to review later. (Also see *A.3. Informed Consent*.)

Take initial and follow-up photographs as appropriate, according to jurisdictional policy. The best photographs are clear and well-lit with consistently identifiable subject matter.[234]

[233] This section is adapted from above, IPV Protocol at page 96.

[234] Id. at page 92.

Patient identification. When obtaining identification images, clinicians should avoid any type of image which would make a patient feel as if they have committed a crime, such as taking photos that resemble a booking photo or mug shot. A profile view is never necessary. If a facial image is desired for identification, consider from mid-torso for patient comfort. Many programs have moved away from facial images for identification and now use images of the patient's label to create a reference photo, i.e., the medical record numbers, patient name and date of care is used to bookend the patient's photos, thus avoiding uncomfortable identification images altogether. If a facial image is desired for identifying injury, care should be taken to focus on the injury versus a full-facial photograph for identification. The photo series can then be linked to the medical forensic documentation.

Clear and accurate photographs.[235] The main goal of photography is to preserve (as closely as possible) and document the appearance of any findings assessed by the clinician at the time of the examination. For that to occur, the clinician must consider lighting and camera positioning to ensure accuracy, completeness, and minimal distortion. If the images do not accurately portray the injuries in question, they should be retaken. This is not only to provide adequate images for legal proceedings should they occur, but to ensure that subsequent treating clinicians are able to provide adequate follow up care (e.g., assess issues such as wound healing, identify whether a finding was injury or unrelated to the assault), and to provide accurate documentation for quality assurance/quality improvement/peer review purposes.

Scale. Clinicians should use a forensic scale or ruler for size reference in photographs. In addition to those photographs that identify patients and anatomical locations being photographed, clinicians should take at least two photographs of each area— one with and one without scale. Taking two photographs in this manner demonstrates that the scale was not concealing anything important. If photographing evidence such as a hair on the cervix, it should be photographed in place before moving it or collecting it. Clinicians must not alter or move evidence when photographing and should minimize background distraction while maintaining the focus of areas being photographed.

Orientation of photographs:[236]

1. Injury orientation (also known as medium-range) images of each remarkable finding, including cuts, bruises, lacerations, and abrasions: Injury orientation more accurately encapsulates the purpose of the image—to capture region or multiple regions of the body to orient the viewer to the location of the injury on the body.
2. Closeup images: Each wound should be photographed close-up, with and without a reference scale, ensuring that the scale does not obscure any aspect of the wound.

See Appendix C for a photograph log.

Photographing skin. If upon examination, the patient's body has traces of blood, skin, or hair, it should be photographed before samples are obtained and the patient cleaned up. Broken and missing nails should be treated in the same manner.

Photographing clothing. If the patient's clothing is torn or blood-stained from the assault, or there is visible debris or other unknown substances on it, the clothing should be photographed per jurisdictional policy, particularly if the patient declines having the clothing packaged as evidence.

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[235] Id. at page 93.

[236] See id. at page 94.

Bite mark evidence. Clinicians should swab and photograph bite marks, according to jurisdictional policy.[237]

Follow-up photographs. Photography should be repeated as new or different findings on patients' bodies are identified following the examination (e.g., bruising may appear days later). In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy and nonspecific findings like redness or swelling that could be confused with acute injuries. Patients should be informed how to access services for follow-up care including additional photographs (*see also C10, Discharge and Follow-Up*).

Consider how photographs will be stored, including who will have access at the point of storage, and how photos will be accessed when needed.[238] Photographs are part of the medical record. Originals should not be turned over to law enforcement. With a signed release from the patient, copies of the patient's body surface photos can be released for either 1) emergency concerns for restraining/orders of protection or 2) an immediate need for use as part of the criminal investigative process, but this should not occur automatically. Copies of the anogenital photos generally should not be provided to anyone except the patient without a subpoena or a signed release of information from the patient. The clinician should clearly explain to the patient that, once copies of the photos are released, they are no longer protected by HIPAA.

Organizations should establish policies and procedures related to digital imaging, including image security and authorization for access, image enhancement details, duplication and release, storage, and a secure image backup system. Digital images included in the medical record should be preserved in the original file format. If an image is to be enhanced, a new file should be created and details of the enhancement should be documented, leaving the original unchanged. Lawfully released photos should be encrypted.

[237] Bite wounds should be photographed and swabbed, though National Institute of Standards and Technology (NIST) issued a 2023 report, finding that a lack of support for key premises underpinning bite mark analysis.

[238] This section adapted from above, IPV Protocol at pages 96-97.

6. Examination and Sample Collection Procedures

Recommendations at a glance to facilitate the examination and sample collection:

- Recognize the medical forensic examination has a dual purpose—both attending to the healthcare needs of the patient and, for those that consent to it, providing sample collection for the sexual assault evidence collection kit.
- Strive to provide as comprehensive a medical forensic examination as possible, guided by the scope of the patient's consent, their medical forensic history, the examination findings, and their tolerance for the examination process.
- Modify the examination and sample collection to address the specific needs and concerns of patients.
- Prevent exposure to infectious materials and risk of contamination of samples collected for the sexual assault evidence collection kit.
- Explain examination and sample collection procedures to patients.
- Conduct the medical forensic examination and document the examination on the designated forms used by the facility or jurisdiction.
- Collect samples for the sexual assault evidence collection kit to submit to the crime lab for analysis, according to jurisdictional policy.
- Collect other evidence as appropriate.
- During the examination, keep samples that will be tested within the facility for medical purposes separate from samples collected for the sexual assault evidence collection kit or outside toxicology testing.

Prior to beginning the examination, if the patient has support persons present, the patient should be reassessed to ensure they are still comfortable having those individuals in the room with them.

Recognize the medical forensic examination has a dual purpose—both attending to the healthcare needs of the patient and, for those that consent to it, providing sample collection for the sexual assault evidence collection kit. During the examination, clinicians comprehensively examine patients and facilitate the collection of samples from their bodies and clothing. The findings documented in the examination and collected samples can provide information to help corroborate details about the assault. If other healthcare issues are identified during the medical forensic examination, clinicians should work with patients to ensure they have appropriate referrals as part of the discharge process (*see also C10, Discharge and Follow-Up*).

Strive to provide as comprehensive a medical forensic examination as possible, guided by the scope of the patient's consent, their medical forensic history, the examination findings, and their tolerance for the examination process. The medical forensic examination is not simply a series of tasks completed the same way with every patient. A patient-centered and trauma-informed approach necessitates that clinicians listen to and work with patients to tailor the examination to the specific needs of the individual patient, based on the patient's consent, the specific details of their assault history that guide what aspects of the examination and sample collection are recommended, the physical examination findings that dictate assessment and treatment plans, and the patient's particular tolerance for the examination process, as some patients may have a decreased tolerance to portions of the examination because of pain, exhaustion, anxiety, or simply a need to be finished with the examination. While the goal is a comprehensive medical forensic examination, patients should not be subjected to unnecessary aspects of the examination, just for the sake of

completing every step of the examination and sample collection. For example, a patient who reports they were only orally assaulted and reports no history of genital penetration, either attempted or completed, does not require a speculum examination and swabbing of the anogenital area simply because those are components of a complete medical forensic examination.

Modify the examination and sample collection to address the specific needs and concerns of patients. The medical forensic examination is meant to be modified to accommodate specific needs and concerns of patients to make it patient-centered and trauma-informed. Older patients or patients with physical disabilities may require examination modifications to allow for aspects of the examination like the genital assessment and sample collection while preserving their sense of comfort and safety. Clinicians need to assess the physical development of adolescent patients and take their age and development into consideration when determining appropriate methods of examination, including the genital assessment.

For patients with some degree of cognitive disability, intellectual disability, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke, accommodations may be useful to ease the exam process. This may include speaking in a clear and calm voice and asking very specific, concrete questions or providing specific, linear information when explaining what will happen during the exam process and the reason for each step. Many patients with cognitive disabilities (and patients who have sensory processing disorders, as well) can become easily distracted and have difficulty focusing. To reduce distractions, it can be helpful to conduct the exam in an area where there is less noise, and the lighting can be controlled on dimmers.

Patients' beliefs also might affect whether and how certain samples are collected. For example, patients from certain cultures or religious backgrounds may view hair or fingernails as sacred and therefore decline collection of hair and fingernail samples. Clinicians should ensure that they continuously get patient consent for all samples as they move through the collection process, even after the initial consent forms are signed. Patients may not be clear on the specifics of the sample collection process or may change their mind as the exam progresses.

For some patients, including some patients with disabilities, patients who may require interpreter services, elder patients, and medically complex patients, the medical forensic examination will take longer. This may be because it is necessary to make modifications to accommodate the use of assistive devices or to incorporate the interpreter into the examination process. Not having a preconceived expectation of how long the examination should take will ensure clinicians avoid rushing through the medical forensic examination, potentially providing patients with a lesser quality medical forensic examination.

Clinical rationales for modifications should be documented in the medical forensic record to assist future clinicians who may be caring for the patient or, should the patient choose to engage the criminal justice system, to clarify decision making for others who may review the record.

Prevent exposure to infectious materials and risk of contamination of samples collected for the sexual assault evidence collection kit. Clinicians should adhere to universal precautions when conducting the medical forensic examination, including sample collection, just as they would with any other type of healthcare encounter. [239]

[239] See Occupational Safety and Health Standards (OSHA). (2019). Bloodborne pathogens. (Standard No. 1910.1030).

Forensic evidence, which is usually small in volume, can be contaminated and diluted by foreign DNA. Every precaution should be taken by clinicians to reduce contamination of evidence. Gloves and masks should be worn while the examination is being completed and samples are being collected; gloves should be changed frequently throughout the medical forensic exam and sample collection, especially whenever cross-contamination could occur between the clinician and the patient, or when there is the possibility of transferring foreign biological material from one part of the patient's body to another, such as between body orifices. Examiners and other responders should seek guidance from their crime labs on procedures to prevent contamination.

Explain examination and sample collection procedures to patients. As part of the process of seeking informed consent from patients for the examination and sample collection, all components of the medical forensic examination and options should be explained in the patient's primary language. Clinicians may provide some basic information prior to starting the examination and additional information as the examination proceeds. For example, if specialized equipment is used, clinicians can explain to patients what the equipment is, how it will be used, for what purpose, and how long the procedure will take. Encourage patients to ask questions and to inform clinicians if they need a break. Patients should also be reminded that they can decline any portion of the exam or sample collection at any time, even if they previously consented to it. "Informed consent is a continuing process that involves more than obtaining a signature on a form. Therefore, all components of the exam should be explained thoroughly and as many times as necessary, so the patient can understand what the clinician is doing and why. Explanation of the examination and treatment process are solely the responsibility of the clinician."[240] (For more information on obtaining informed consent of patients, see *A.3. Informed Consent*.)

For some patients, including adolescents and patients with disabilities, they may never before have had a speculum or anoscopic examination. Some patients may have limited knowledge of reproductive health issues or anatomy and may require reviewing visual aids, such as diagrams or equipment to better understand the exam and sample collection moving forward.

Conduct the medical forensic examination and document the examination on the designated forms used by the facility or jurisdiction. In addition to instructions included in the sexual assault evidence collection kit, the medical forensic examination should be guided by the scope of informed consent and the medical forensic history. Information gathered from a review of systems can provide more useful information than general questions, such as asking if patients are injured anywhere, since patients may not even know the nature or extent of their injuries prior to the examination.

General physical examination. Attention to the ABCs of the potential trauma victim (airway, breathing/oxygenation and circulation) is the first priority, before beginning any aspect of sample collection. In keeping with trauma informed practices, it is recommended that as much of the exam that can be done with the patient clothed should be completed. Patients can then change into a gown for other parts of the exam (such as the chest and anogenital examinations).[241]

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[240] See State of New Hampshire Office of the Attorney General. (Ninth Edition 2018) .SEXUAL ASSAULT: An Acute Care Protocol for Medical/Forensic Evaluation, at page 20 (last visited July 16, 2024).

[241] See Peterson, P., & Riviello, R. (2nd Edition 2022). Male patient sexual assault examination. Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, *American College of Emergency Physicians,* at pages 51-54.

Clinicians should obtain the patient's vital signs, note the date and time of the medical forensic exam, physical appearance, general demeanor, behavior, and orientation, and condition of clothing on arrival. Clinicians should record all physical findings (which include observable or palpable tissue injuries; physiologic changes; and foreign materials such as grass, sand, stains, dried or moist secretions, or positive fluorescence) on body diagram forms contained in the medical forensic record. They should assess for redness, abrasions, bruises, swelling, lacerations, fractures, bites, burns, and other forms of physical trauma. Potential traumatic findings should be palpated to assess for tenderness and induration. Particularly in patients with darker skin, it may be difficult to identify some of these injuries through visual assessment alone. Clinicians may consider using an alternative light source (ALS), but despite some preliminary research, there is no consensus on using ALS to identify potential injury in patients with darker skin.[242] Other assessment techniques include palpation (pain, as well as temperature and texture, such as firmness or bogginess),[243] and depending on history, radiography, and lab work. Older patients may be more physically fragile than younger patients and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities. They too are likely to require enhanced assessment and evaluation tools to identify or rule out injury or co-occurring medical issues.

Genital examination.[244] The history of the patient will focus the clinician toward the areas that require closest examination. This may include genitals, inner thighs, and perineum, and will include any areas where the patient reported contact with the offender, as well as secondary points of trauma, such as areas of referred pain from a specific mechanism of injury. During the female genital examination, clinicians should examine the external genitalia and perineal area for injury, foreign materials, and other findings in the following areas: abdomen, thighs, perineum, labia majora, labia minora, clitoral hood and surrounding area, periurethral tissue/urethral meatus, hymen, fossa navicularis, and posterior fourchette. The use of a colposcope or a camera with magnification during the genital exam can enhance viewing subtle trauma and may provide photographic documentation.[245] In some jurisdictions, toluidine blue dye may be used to highlight trauma, either with or without the use of a colposcope.[246]

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[242] See Scafide, K. N., Downing, N. R., Kutahyalioglu, N. S., Sheridan, D. J., Langlois, N. E., & Hayat, M. J. (2022). Predicting alternate light absorption in areas of trauma based on degree of skin pigmentation: Not all wavelengths are equal. *Forensic science international*, *339*, 111410 (discussing using alternate light source (ALS) to identify bruising in patients with darker skin under specific circumstances.

[243] Steven, M., Struble, L., & Larson, J. L. (2015). Recognizing Pressure Injury in the Darkly Pigmented Skin Type. Medsurg nursing: official journal of the Academy of Medical-Surgical Nurses, 24(5), at pages 342–348.

[244] For patients with mobility impairment, clinicians should review their history at this stage. In patients with spinal cord injury (SCI), the level of injury and any history of autonomic dysreflexia must be noted and given special attention. Other considerations are histories of muscle spasm and triggers for both muscle spasm and autonomic dysreflexia. Clinicians should ask patients if they have ever had a speculum exam, what their experience was like, what the most comfortable position would be for the anogenital exam, and any history of autonomic dysreflexia with a speculum exam. Commonwealth of Massachusetts Sexual Assault Nurse Examiner Program, Protocol for Adult/Adolescent SANEs and Emergency Department Clinicians (2019) ("Massachusetts SANE Protocol"), Caring for Special Patient Populations at page 27. (last visited July 17, 2024).

[245] The use of a colposcope is a standard in many communities for magnified visualization and photodocumentation of anogenital structure detail. In communities that do not have colposcopes, clinicians can use digital cameras as an alternative to achieve magnification and capture images.

[246]"If both the anal and vaginal areas are to be examined, the dye should first be applied to the anal area to prevent cross-contamination. The dye should be applied with a cotton swab and excess dye can be removed by blotting the area with sterile gauze moistened with either a 1% acetic acid solution or lubricating jelly.

Following the external genital examination, examine the vagina and cervix for injury, foreign materials, and foreign bodies if the patient can tolerate a speculum.[247] Use a colposcope or camera with magnification if available and the patient consents to aid with assessment and documentation.

"For trans-masculine patients, testosterone may cause vaginal atrophy and decreased elasticity."[248] Transmen may be emotionally detached from or dysphoric about their vagina and may feel particularly "demasculinized" if vaginally penetrated. For some, lack of use in consensual sexual activity, as well as reduced elasticity of the tissue in general, may result in increased pain or tissue damage during the assault or exam. "A transwoman's surgically constructed vagina is generally created from the skin of her inverted penis and will be less elastic [and less deep] than a ciswoman's vagina. Because of these factors, there is an increased likelihood of tearing and other physical damage during an assault, raising the risk of STIs and HIV." Transwomen who have had vaginoplasty (the surgical creation of a vagina) may be very concerned about resulting injury.[249] Patients of any gender who are unable to tolerate a speculum should still be offered blind vaginal swabs for sample collection.

During the male genital examination, clinicians should examine the external and perineal area for injury, foreign materials, and other findings, including from the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Document whether patients are circumcised.

Anorectal examination. Clinicians should assess the anorectal region for gross injury, including tears, abrasions, bleeding, erythema, hematoma, discoloration, fissures, foreign bodies, engorgement, and friability, based on the patient's history and genital examination. Even in the absence of anal penetration, the perianal area should be assessed if a genital examination is also being completed (with patient consent). Anoscopy may be appropriate, per jurisdictional policy, particularly in the presence of positive clinical findings, such as anal bleeding or a history of foreign body penetration,

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Commercial, single use swabs are available which allow easy application and prevent cross-contamination. The dye should only be applied to epithelialized skin (labia, perineum, anal folds) and not to mucosal surfaces such as the hymen or vaginal wall. Once the excess dye is removed, raw or abraded tissue will stain blue, while intact epithelium will be easily wiped clean. Care should be taken to remove all excess as residual dye (such as can be found in skin crevices) may be misinterpreted as a traumatic injury. It should be noted that inflammatory or infectious lesions will also retain the dye, and care should be taken in differentiating traumatic versus non-traumatic lesions. The latter is often the case with diffuse and widespread uptake of dye. The patient should be informed that they may shed traces of dye into their clothes for a few days after the exam," above, Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient at page 68 (internal citations omitted).

[247] For patients who are pregnant, clinicians should consult with obstetrical providers prior to conducting any internal examinations.

[248] See above, FORGE SAFE protocol Trans Specific Annotation, at page 2.

[249] Id.; For more information on the medical forensic care of transgender patients, see Munson, M., Compassion, care, & creativity: Trans survivors and forensic exams FORGE (2020) (webinar, last visited July 16, 2024).

because it appears to improve injury detection and sample collection.[250] However, this must be weighed against the potential trauma and discomfort to the patient.

Patients who have experienced genital cutting should be offered a comprehensive medical forensic exam in the same manner as any other patient. Clinicians should not make assumptions about what the patient will want or is capable of tolerating but should talk with the patient about the scope of the exam and how the patient wants to proceed. Upon examination, clinicians should note external genital structures, including scarring and keloids, and assuming the patient consents to, and is able to tolerate a speculum exam, remarkable internal findings, such as cervical inflammation,.[251] Patients who are unable to tolerate a speculum should be offered blind vaginal swabs as an alternative for sample collection from the vaginal vault.

A trauma-informed examination does not include passing any type of judgment or providing any commentary on a patient's body. Whether it is a patient who has experienced genital cutting or a patient who has undergone gender affirming medical procedures, verbal remarks or body language that includes gasping, sighing, a sharp intake of breath, or widening eyes can be upsetting to a patient who may worry their clinician is making a judgment about or assessment of their body. Ensuring the entire medical team is nonjudgmental and aware of their own biases, expressions, and behaviors is critical for a successful medical forensic exam.

Documentation of findings. Clinicians should record findings on the appropriate medical forensic documentation forms, including body maps. Detailed descriptions of findings should be provided as required. During the examination, clinicians should collect samples as specified in the sexual assault evidence collection kit and photograph according to jurisdictional policy.

Collect samples for the sexual assault evidence collection kit to submit to the crime lab for analysis, according to jurisdictional policy. The following samples from patients, along with completed documentation forms, typically are submitted to crime labs for analysis. Jurisdictions may require collection of additional or different specimens. Trained clinicians should use the medical forensic history and the physical assessment of the patient to guide the sample collection process. Instructions supplied in the kit may be helpful as a guide for those who are not experienced in the process of sample collection. However, kit instructions should not be read in front of the patient, which could cause further emotional trauma in the aftermath of the assault. If any requested sample is not collected, clinicians should clarify on documentation forms.

Collect clothing evidence. Clothing frequently contains relevant evidence in sexual assault cases. It "provides a surface upon which traces of foreign materials, such as semen, saliva, blood, hairs, fibers, and debris from the crime scene, may be found. While foreign matter can be washed off or worn off the body, the same substances often can be found intact on clothing for a considerable length of time following an assault. Damaged or torn clothing may be significant, as damage may be

[250] See Ernst, A. A., Green, E., Ferguson, M. T., Weiss, S. J., & Green, W. M. (2000). The utility of anoscopy and colposcopy in the evaluation of male sexual assault victims. *Annals of emergency medicine*, *36*(5), at pages 432–437 (discussing a study that concluded that for "male sexual assault victims with anal penetration, anoscopy is significantly better for gathering evidence than is colposcopy.")

[251] See Muñoz, J. M., Beausang, J., Finley, E., & Wolf, S. (2020). Protocol for evaluating women with female genital mutilation seeking asylum. *International journal of legal medicine*, *134*(4), at pages 1495–1500. (providing guidance about the three primary parts of evaluation: the interview, exam, and report.)

evidence of force,"[252] and therefore, clinicians should not cut through any existing holes, rips, or stains on clothing. Prior to the full examination, the clinician needs to determine if the patient is wearing the same clothing they wore during or immediately following the assault. If so, the clothing should be collected so that it can be examined for any foreign material, stains, or damage. If the clinician detects damage to the clothing, they should identify whether the damage was related to the assault or present prior to the events in question. Evidence on patients' clothing can be compared with evidence collected from suspected offenders and crime scenes. Common items collected from patients include underwear, hosiery, blouses, shirts, and pants. Coats and shoes are collected less frequently because they are less likely to have evidentiary value and their loss may represent a significant financial burden for victims. Patients wearing binders or other gender affirming articles of clothing may not feel safe or comfortable parting with these items for evidentiary purposes, as they can be both costly to replace and contribute to a sense of dysphoria or increased trauma from the assault. Patients have the right to decline providing this aspect of evidence collection, as they do all other aspects during the medical forensic exam. When collecting clothing or considering collecting clothing, patients should know that items are likely to be destroyed or significantly altered during the evidence examination process. Alternatively, it may take an extended period of time to be returned to the patient.

Procedures for collecting clothing, underwear, and foreign material dislodged while undressing include the following:

- Place a clean hospital sheet on the floor as a barrier, and place collection paper over the sheet barrier. Be careful to prevent evidence transfer. Document all findings. Ask patients to disrobe, assisting them as requested and then draping them appropriately.[253] When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged.[254]
- Collect clothing pertinent to the assault. Clothing should be packaged separately from the sexual assault evidence collection kit and labeled, with each item in its own paper bag. Examination of clothing should only occur in a forensic laboratory. In addition to collecting underwear worn at the time of or immediately after the assault, collect underwear patients are wearing at the time of the examination or the garment closest to the patient's genitalia if they are not wearing underwear (if relevant to the case).
- Be sensitive about how much clothing is requested of patients as evidence. For example, request patients' coats or shoes only if it is determined that there may be evidence on them. The exam site can coordinate with advocacy programs to ensure that replacement clothing is available for patients in a range of sizes. This clothing is critical in some instances (e.g., a patient may own only the clothing that is being collected).
- If any items are wet, dry items according to jurisdictional policy, then package as noted above.

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[252] West Virginia Protocol for Responding to Victims of Sexual Assault, (Revised 2016- 6th Edition). *West Virgina Foundation for Rape Information & Services, Inc.*, at Chapter 5, page 9. (last visited July 16, 2024).

[253] If patients are concerned about disrobing in front of advocates and/or personal support persons, clinicians can hold up a sheet to shield patients, or have others leave the room while patients disrobe.

[254] For patients with mobility impairments, the collection paper should be placed on the exam table and left in place until the exam is completed. If patients prefer to disrobe in their wheelchairs, sheets can be tucked in around the wheelchair to catch debris. Wheelchairs should not go on collection paper, as debris from wheels may contaminate evidence. See above Massachusetts SANE Protocol at page 27

- Package the *collection paper* per kit instructions. The *barrier sheet* – which was placed under the collection paper should *not* submitted as evidence.
- Tape/seal bags closed; label, seal, and initial the seal. To seal the bags, use the evidence seals provided in the sexual assault evidence collection kit, evidence tape, or if none is available, patient labels.
- These steps may be modified if the patient has changed clothing and showered or bathed. For instance, a patient who presents several days after the sexual assault and has both changed clothing and showered may not need to undress over the collection paper. However, collecting their underwear may still be appropriate depending on the history of the assault.
- For patients who decline to provide clothing, such as underwear, where there are obvious or suspected secretions consistent with the description of the assault, swab and/or photograph the clothing.

Collect debris.

- Collect obvious debris on patients' bodies (e.g., dirt, leaves, fibers, and hair) on collection paper— package, label, seal, and initial the seal.[255]
- Swab the underside of the fingernails with a lightly moistened swab, unless the patient reports a history of scratching their assailant, which indicates that nail clippings might yield additional DNA. One swab should be used for each hand to concentrate the potential for DNA yield. Package and label swabs separately as right and left hand and/or right and left feet (per patient history). If clippings are being obtained, package and label separately as right and left hand and/or right and left foot. Use of tools to scrape underneath the fingernails should be avoided, as it is a potential source for injury and/or infection to the patient.[256]
- If collecting hand swabs, use one lightly moistened swab to concentrate any potential DNA recovery. Swab the entire palmar surface of each hand separately, and then package and label each envelope separately as left palm or right palm.

Collect foreign materials and swabs from the surface of the body. Clinicians should carefully inspect the body, including head, hair, and scalp, for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat, and saliva) and other foreign material. Use of an alternate light source can assist in identifying locations to sample. Clinicians should swab any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with use of the alternate light source, and any area for which patients relate a history or suspicion of bodily fluid transfer (e.g., licking, kissing, biting, splashed semen, or suction injury). Swabs should be collected from potentially high-yield areas (e.g., neck, breasts, or external genitalia) if the history is absent or incomplete.

Note: *To recover as much DNA foreign to the patient as possible during the evidence collection process, measures should be taken to concentrate the foreign material by using the fewest number of swabs necessary for the collection site. To ensure laboratory efficiency, if multiple swabs are used during the collection, they should be collected* ***concurrently*** *and, if not concurrently taken, it would be beneficial to note the order of the swabs collected.*

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[255] Debris-with evidentiary value may be found on adaptive or medical equipment, such as wheelchairs, scooters, canes, wheelchair pads, assistive communication devices, and catheters. Such debris collected or equipment swabbed with the consent of the patient and according to governing policy.

[256] Some jurisdictions routinely photograph fingernail damage that may have been related to the assault.

- Swab skin where there is known or suspicion for oral contact (such as bite marks), using two lightly moistened swabs, from each affected area, packaged per jurisdictional policy.
- For samples for touch DNA, use two lightly moistened swabs, from each affected area, packaged per jurisdictional policy.
- Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.
- According to jurisdictional policy, dry all specimens, package swabs, label, seal, and initial the seals.

Collect hair combings. The purpose of this procedure is to collect hair shed by offenders that may have been transferred to patients' hair. Hair combings may also reveal other foreign materials. It is important to examine head, facial, and pubic hair for secretions, foreign materials, and debris and collect as appropriate (see above for collection of debris and foreign materials). Clinicians should consult jurisdictional policy for collecting hair combings. Matted pubic hair may be clipped or swabbed with lightly moistened swabs. For patients without pubic hair, clinicians may collect samples from the mons pubis collected with two moistened swabs. If reference hair samples are collected, they should only be collected by cutting.

Collect oral and anogenital swabs. Patients' consent, the medical forensic history, and examination findings should guide collection of oral and anogenital specimens. In general, specimens should be collected only from orifices and areas surrounding the orifices that patients report to be involved in the assault. Keep in mind that some patients may be vague about the type(s) of sexual contact that occurred. If there is uncertainty about involved orifices (e.g., because patients have little memory of the assault, were unconscious or incoherent, or do not understand what occurred), collection from oral, vaginal, and anal orifices (with patients' consent) may be appropriate. When collecting these swabs:

- Take care not to contaminate the collection with secretions or materials from other areas, such as vaginal to anal or penile to anal.
- Follow jurisdictional policy for the timing and collection of swabs (and the number of swabs used to collect a sample) and for drying and packaging swabs.[257]
- Creation of slides and smears at the medical forensic exam site from oral and anogenital samples is unnecessary and should be eliminated, since the slides prepared during the medical forensic examination generally have more epithelial cells, bacteria, and other debris.
- Any presumptive or confirmatory testing for semen should be conducted in the forensic laboratory and not during the sample collection process.

Oral sample

- Use two dry swabs to swab/rub over the oral cavity (e.g., around teeth, cheeks, and gums).[258]
- Dentures and body jewelry from the mouth and lips of the patient can be removed and swabbed if they are not collected.
- Dry swabs.
- Package swabs, place in envelope, label, seal, and initial the seal.
- Dental floss is not recommended secondary to concerns about infection risk for patients.

[257] See above, the NIJ's National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach at page 18 for the recommended number of swabs, but this should not supersede local protocols.

[258] Some jurisdictions also collect perioral swabs if there was oral contact.

Vaginal vestibule (including labia minora, clitoris, hymen, fossa navicularis, and posterior fourchette)[259]

- Use two lightly moistened swabs, packaged together, unless the history indicates otherwise.
- Dry swabs.
- Package swabs, place in envelope, label, seal, and initial the seal.

Vaginal vault (including posterior fornix, cervix/ cervical os)

- Use two dry swabs, packaged together, unless the history indicates otherwise.
- Dry swabs.
- Package swabs, place in envelope, label (specifically indicating sampling site), seal, and initial the seal.

Penile and scrotal sample

- Use a total of two lightly moistened swabs from the shaft, glans (including under the foreskin and around the corona), and scrotum, unless the history indicates otherwise; be careful to avoid the urethra (which will yield the DNA of the patient).
- Dry swabs.
- Package swabs, place in envelope, label, seal, and initial the seals.

Anus/Perianus sample

- If there was no anal contact, but vaginal penetration occurred, swabbing is still recommended (with patient consent) as there may be leakage of semen in the perianal area. Use lightly moistened swabs, packaged together to swab the perianal area.
- For patients who report anal penetration, repositioning the patient may be necessary for optimal sample collection and assessment of the anus. "After fully explaining the procedure to the patient and obtaining their consent, keep the patient in either supine or place them in prone knee-chest position, and apply gentle bilateral pressure with the clinician's hands to the patient's buttocks. Allow enough time for anal dilation to occur. Swab the anal cavity [with two moistened] swabs."[260]
- Dry swabs
- Place in envelope, label, seal, and initial the seal.

Rectal sample[261],

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[259] Cleansing the area for catheterization and/or applying Lidocaine may dilute or contaminate the evidence. Therefore, when Lidocaine is applied to the perineal and anal areas to minimize the risk of autonomic dysreflexia, it should be done only after swabbing the external genitalia for evidence. If catheterization is required either for evidence collection or to empty the bladder for speculum examination, it should be done only after swabbing the external genitalia. See above, Massachusetts SANE Protocol, at page 28.(.

[260] Colorado Sexual Assault Evidence Collection Protocol, Fourth Edition (2022) at page 24 (last visited July 17, 2024).

[261] Note that for patients with spinal cord injury and/or history of autonomic dysreflexia, collection of anal/rectal samples is performed only with the highest level of awareness of risks and with observance of precautionary steps. Possible triggers for autonomic dysreflexia are anxiety, pelvic exam (a cold speculum or the pressure of manipulating a speculum or manipulation of the cervix and pressure on the uterus), rectal exam or swabbing, impacted bowel, urinary retention, a kinked catheter, a bladder infection, and deep skin lesion. Some symptoms are highly elevated blood pressure, nasal congestion, sudden onset of headache, flushing, sweating, shortness of breath, and muscle spasm. Precautions against a possible attack requires an empty bladder or leg bag for the

- Use two lightly moistened swabs, packaged together, if indicated per patient history (these should be collected separately from the anus/perianal swabs). Avoid contact with external skin surfaces.[262]
- Dry swabs.
- Package swabs, place in envelope, label, seal, and initial the seal.
- Any additional examinations or tests involving the anus should be conducted.

Known standards for DNA analysis and comparison. Samples collected during the exam may contain a mixture of secretions. For forensic analysts to interpret DNA profile results from these swabs, they must compare the results from the swabs to a known DNA profile of the patient. DNA reference samples are used for this purpose. Although clinicians should follow the policy governing their facility and crime lab, the recommended method of collection of a reference samples is via a buccal swab:

- Use two swabs to swab/rub over the inner aspect of each cheek.
- Collect the buccal swab as the patient's DNA standard *after* the evidentiary oral swab is obtained — rinse mouth after the oral swab is obtained (for evidentiary purposes) and before collection of the buccal swab (the reference standard).
- Air-dry the swab, package, place in envelope, label, seal, and initial the seal.

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Blood on Filter Paper

- If drawn blood is not being collected for medical or toxicological purposes, consider blood on filter paper because it is a less invasive method of blood collection and is easier to store.[263]
- Using an alcohol swab, wipe the tip of the patient's chosen finger.
- Using a sterile lancet, prick the finger.
- While holding the finger over the circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat procedure for any remaining circles as required by jurisdictional policy (it may not be necessary to fill all circles).
- Allow blood to air-dry according to jurisdictional policy. Fill out the patient's name on the first line. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.
- The clinician should be careful not to handle the card without freshly gloved hands and handle only from the bottom.

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exam; application of lidocaine gel to perineum and/or anal area before exam; examination performed in a semi-supine position; slow insertion and minimal manipulation of a warm speculum; constant monitoring of blood pressure and "checking in" with patients; having rapid acting anti-hypertensive medication on hand; and making health care staff aware of risks and on alert. Treatment for autonomic dysreflexia includes stopping the exam, bringing patients to sitting or semi-supine position, and involving emergency medical staff immediately who can administer a fast- acting anti-hypertensive medication. See Massachusetts SANE Protocol, Caring for Special Patient Populations at page 27. (last visited July 17, 2024). 40.)

[262] After the collection of vaginal samples, external secretions, and foreign materials have been collected, the perianal area should be cleaned thoroughly to avoid contaminating rectal swabs with vaginal drainage. An anoscope moistened with a water-soluble lubricant or lidocaine jelly may be used for this exam, but the use of lidocaine jelly should be documented. Samples should be obtained under direct visualization from above the tip of the anoscope. See State of California Governor's Office of Emergency Services Forensic Medical Report, Abbreviated Adult-Adolescent Sexual Assault Examination Instructions CAL OES 2-924, July 2019 at page 6 (last visited July 17, 2024). Clinicians should use discretion as to the use of the anoscope and weigh the potential discomfort to the patient against its potential benefits, particularly if there are no clinical indicators for its use, and it is only being done to collect samples.

[263] Several state protocols, including Illinois and North Dakota, use the dry blood collection as a method to obtain known DNA samples.

Drawn Blood

- If drawn blood is required, minimize patients' discomfort, and collect blood needed for the reference sample at the same time blood is collected for medical or toxicological purposes.
- Blood for the reference sample may be collected in lavender-top and/or yellow-top blood tubes. These colored tubes contain preservatives suitable for forensic blood typing. Clinicians should work with their local crime lab if they are unsure what tube to use. If tubes are included in the evidence collection kit, check expiration dates and replace if expired.[264] Mix according to jurisdictional policy.
- Write the patient's name, date and time of collection, and the collector's initials on the tube. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal. Be mindful of storage issues with drawn blood, since ideally it should be refrigerated if it is not being submitted to law enforcement immediately after packaging.

Collect other evidence as appropriate. Other evidence may be collected beyond what is needed for the sexual assault evidence collection kit. This could include toxicology samples or other samples based on the unique facts and circumstances of the case or the presentation of the patient.

- If a patient is menstruating, collect tampons, pads, or liners. Tampons can be placed in a sterile urine specimen collection container. Label the container with the name of the patient, date, time and clinician's initials. Punch three or four small (18-gauge needle) air holes through the cover of the container. Place the cover back on the specimen container and place it into a paper bag. Label the bag with the name of the patient, date, time and examiner's initials. Seal the paper bag with tape and keep it separate from the evidence collection kit. Do not attempt to secure the tampon and packaging in the evidence collection kit. Refrigerate the specimen if law enforcement is not collecting immediately. [265]
- Pads and liners can be air- dried as much as possible and then placed in a separate paper collection bag.
- If the patient is wearing a menstrual cup and it can be air-dried, treat it in the same way as a pad or liner and package accordingly. If it is saturated, package like a tampon.[266]
- Follow jurisdictional policy for handling and transporting other wet evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, diapers). Ensure that it is packaged in leak-proof containers and separated from other evidence when being transported. It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for its immediate analysis or further drying.
- Miscellaneous swabs may be collected, depending upon the area of contact noted in the medical forensic history.

Toxicology samples. Make the decision about whether to collect toxicology samples for forensic purposes, what to collect, and collection methods according to jurisdictional policy. Do not put toxicology samples in the sexual assault evidence collection kit, unless jurisdictional protocols

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[264] Kits with blood tubes have largely been discontinued because they expire and because most jurisdictions have moved to more patient-centered and trauma-informed buccal swabs or filter cards as reference standards. However, some commercial kits are still available with the blood tubes.

[265] See above, Colorado Sexual Assault Evidence Collection Protocol, at pages 24-25.

[266] Consult local crime lab if there are questions about the best way to handle and package the menstrual cup. See also Texas A&M University, School of Nursing, Center of Excellence in Forensic Nursing, & Texas Attorney General Sexual Assault Prevention and Crisis Services Program (2022). Texas evidence collection protocol at page 43.

require it. Identify which forensic labs the jurisdiction has selected to analyze these samples, choose a lab, and follow transfer policies. (See *C.7 Alcohol- and Drug-Facilitated Sexual Assault* for more information on collecting toxicology samples.)

If a patient cannot provide a history of the assault, the following samples are recommended for collection:

- Perioral area, lips, and oral cavity.
- Posterior fornix and cervix (in the post-pubertal female).
- Perianal folds, anus, and rectum.
- External anogenital structures (male or female).
- Neck.
- Breasts.
- Palms of hands.
- Fingernails.
- DNA reference samples.
- Areas that fluoresce under alternate light source (ALS).
- Debris or foreign materials.
- Toxicology (e.g., urine, blood if alcohol or drug facilitated sexual assault is suspected).

Self-collected kits. While the use of self-collected evidence kits (also known as DIY kits or MeToo kits) or self-sampling after sexual assault has been posited as a potential option in low-resource environments, such as developing countries, remote geographic locations, conflict affected regions, and displaced communities, they are not recommended when there is routine access to comprehensive medical forensic examinations in a healthcare setting for a number of reasons:

- They limit the opportunity for healthcare provision, particularly care that is time-sensitive, such as HIV prophylaxis.
- They limit potential injury documentation, since healthcare providers can provide more comprehensive examination, assessment, and documentation via gross visualization and specialty assessment techniques such as magnification, toluidine blue dye, anoscopy, and other methods of identifying and/or documenting injury.
- They limit the comprehensiveness of sample collection.
- Self-collection does not employ standardized protocols that ensure the integrity of the samples. It therefore may be difficult to ensure that there is no contamination, and it may present challenges to establish chain of custody during legal proceedings.
- They limit access to additional resources that can assist with healing, including healthcare referrals, advocacy, and other community-based services.[267]

During the examination, keep samples that will be tested within the facility for medical purposes separate from samples collected for the sexual assault evidence collection kit or outside toxicology testing. Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with patients' consent). It is not necessary to maintain the chain of custody on medical specimens—instead, clinicians should follow facility policy for documenting medical care and storing medical records. For example, programs may collect toxicology immediately upon a patient's arrival to rule out more serious medical issues. Those

[267] See Self-Collected Sexual Assault Kits: Assessing and Mitigating the Risks, Strategies in Brief, Aequitas (January 2022) (discusses the use of self-collected kits) (last visited July 17, 2024).

samples would be separate and distinct from any samples collected for forensic toxicology. Because the medical samples do not have the potential to be used in later legal proceedings, there is no need to preserve chain of custody and the samples would have a separate set of laboratory paperwork generated from their analysis. If both medical and forensic toxicology are collected for a patient, they should each be noted, including when the samples were drawn, and by whom.

7. Alcohol and Drug-Facilitated Sexual Assault

Recommendations at a glance to facilitate response in suspected alcohol- and drug-facilitated sexual assault:

- Promote training and develop jurisdictional policies.
- Plan response to voluntary use of drugs and/or alcohol by patients.
- Identify the circumstances in which toxicology testing may be indicated. Routine testing is not recommended.
- Explain toxicology testing procedures to patients and obtain specific consent.
- Collect toxicology samples as soon as possible after a relevant scenario is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.
- Identify toxicology laboratories and establish process for transporting samples for testing.
- Preserve toxicology samples and maintain the chain of custody.

Promote training and develop jurisdictional policies. It is essential that clinicians and other relevant health care personnel, 911 dispatchers, law enforcement representatives, emergency medical technicians, prosecutors, judges, and advocates receive training and information on alcohol- and drug-facilitated sexual assault. They need to be educated on the use of drugs and alcohol to facilitate sexual assault, screening for alcohol- or drug-facilitated assault, and how to handle situations in which an alcohol- or drug-facilitated sexual assault is suspected. Both agency-specific and multidisciplinary policies should be developed to guide immediate response to a suspected alcohol- or drug-facilitated sexual assault.[268]

First responders must recognize there are a wide variety of central nervous system (CNS) depressant drugs used to facilitate sexual assault, both prescription and over-the counter, including benzodiazepines, antidepressants, muscle relaxants, antihistamines, over-the-counter sleep aids, hallucinogens, and opioids.[269] However, alcohol remains the biggest factor, particularly in combination with other drugs.[270] It is critical to obtain samples as quickly as possible in order to have a chance of identifying many of these substances. All SART members should be aware that collection of toxicology samples is typically separate from the sexual assault evidence collection kit, and procedures for toxicology analysis may be different from that of other evidence analysis. Because some hospital facilities without specialty medical forensic examiner programs may not have established relationships with labs that are able to analyze forensic toxicology samples, communities should have a protocol for handling all samples, regardless of where patients present for the medical forensic examination.[271]

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[268] These policies should clarify that patients should not be responsible for costs related to toxicology testing. Testing done as part of forensic evidence collection is typically paid for by the involved government entity. See section above, "Understand the VAWA provisions related to medical forensic examination payment."

[269] See Society of Forensic Toxicologist, *Fact Sheet: Drug-Facilitated Sexual Assault* (last visited July 17, 2024.)

[270] Anderson, L. J., Flynn, A., & Pilgrim, J. L. (2017). A global epidemiological perspective on the toxicology of drug-facilitated sexual assault: A systematic review. *Journal of Forensic and Legal Medicine*, 47, 46–54.

[271] This may be especially true in jurisdictions that don't have government-run labs conducting toxicology testing, such as police labs, but rely on commercial labs for testing.

Ideally, the first available urine sample should be collected in suspected alcohol- or drug-facilitated sexual assault cases. Law enforcement agencies and emergency medical services should develop procedures and staff training for collection in cases where patients must urinate before arriving at the exam site. Advocates and other responders should provide patients with information on how to collect a sample if they cannot wait to urinate until they get to the site.

Plan response to voluntary use of drugs and/or alcohol by patients. Patients may have voluntarily used drugs and/or alcohol shortly prior to the assault.[272] It is important to document such use and whether it occurred before, during, and after the assault. Alcohol and drugs can mask or otherwise complicate certain healthcare issues, and it's critical that clinicians have as full of a picture as possible as to what the patient ingested. Voluntary drug and/or alcohol use should not diminish the perceived seriousness of the assault. Substance use coercion may be part of a greater power and control dynamic in the abusive relationship. Clinicians should not provide any lesser standard of care because a patient may have used drugs or alcohol as a component of the assault. Law enforcement officers and prosecutors should guard against declining cases in which patients voluntarily used illegal drugs or used alcohol (whether legal or illegal use). Patients should understand that information related to voluntary alcohol or drug use may be used to undermine their credibility in court, but also that in some instances it might be helpful in prosecuting a case by documenting their vulnerability (see the following section on explaining procedures).[273] Some jurisdictions have statutes protecting victims of sexual assault regarding drug and alcohol testing.[274]

SART members should have training on the use of alcohol and drugs as a method of coping with sexual assault and trauma. It is important to provide referrals and resources for victims who may reveal that they have a chemical dependency or are simply struggling to identify alternate ways to cope with their pain.

Identify the circumstances in which toxicology testing may be indicated (either for medical or forensic purposes). Routine testing is not recommended. However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:[275]

- If a patient's medical condition appears to warrant toxicology screening for optimal care (e.g., the patient presents with drowsiness, fatigue, light-headedness, dizziness, physiologic instability, memory loss, impaired motor skills, or severe intoxication).
- If a patient or accompanying person states the patient was or may have been drugged.
- Patient reports a lapse in memory that leaves a period of time unaccounted for with or without consumption of alcohol or other drugs prescription, recreational or otherwise.
- Patient reports regaining consciousness in a location and not knowing how they got there.

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[272] Health care personnel should adhere to facility policy regarding 1) asking patients about alcohol and drug use in the course of intake and treatment and 2) testing for alcohol and/or drugs if deemed medically necessary.

[273] For more information on prosecuting alcohol or drug-facilitated sexual assault and how to consider a victim's vulnerabilities in proving an allegation, see the Justice Department's Prosecutor Guide at pages 7-9, subsection titled, "Although the Victim's Account Is the Center of the Case, Focus on the Perpetrator's Conduct."

[274] See Cal. Pen. Code Section 13823.11, (Testing to determine if alcohol or other drugs were associated with an attempted or completed sexual assault as part of a medical forensic exam is not admissible against the victim in a civil or criminal proceeding and provides other immunity and confidentiality safeguards.). See also PL 116-283, Jan. 1, 2021, 134 Stat 3388 (looks past small violations of law by a military victim at the time of the assault, which might discourage the victim from reporting for fear of retribution.)

[275] List adapted in part from above, Colorado Sexual Assault Evidence Collection Protocol, at page 46.

Explain toxicology testing procedures to patients and obtain specific consent. Seek informed consent from patients to collect toxicology samples. Patients should understand the following before agreeing to toxicology testing (unless toxicology is emergently required for the treatment of the patient):

- The purposes of toxicology testing and the scope of confidentiality of results.[276]
- The ability to detect and identify drugs and alcohol depends on collection of urine and/or blood within a limited time following ingestion.
- There is no guarantee that testing will reveal that drugs were used to facilitate the assault.
- The scope of the testing, to include any drugs the patient may have taken voluntarily.
- Whether there is a local prosecution practice of charging sexual assault victims with a crime for illegal voluntary drug and/or alcohol use revealed through toxicology screening.[277]
- When and how they can obtain information on the results from toxicology testing.
- Who will pay for toxicology testing.
- If toxicology testing can proceed without a report to law enforcement.

Care should be taken when providing the above information to patients. In particular, they may need to hear repeatedly from clinicians that voluntary use of drugs and/or alcohol, if any, does not reduce the seriousness of the assault. Under no circumstances should the medical forensic examination and treatment be conditioned upon patient consent to toxicology testing.

Collect toxicology samples as soon as possible after a relevant scenario is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement. The length of time that drugs used for drug-facilitated assault remain in urine or blood depends on a number of variables (e.g., the type and amount of drug ingested, patients' body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated).[278] Urine allows for a longer window of detection of drugs commonly used in these cases than does blood.[279] The sooner a urine specimen is obtained after the assault, the greater the chances of detecting substances that are quickly eliminated from the body.[280]

Sample Collection:[281] The specimens of choice for toxicology in a suspected DFSA case are urine and blood.

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[276] This includes defense, prosecution and law enforcement potentially, so patients should be clear about who may see the results and how they may be used moving forward. Prosecutors can work to minimize the possibility that information about voluntary alcohol and/or drug use will be used against patients, particularly if patients are truthful from the start about their pre-assault drug/alcohol use and consent to testing, but who will eventually be able to access the results is a discussion clinicians need to have with patients.

[277] Clinicians should be careful not to make promises to patients regarding things not within their control, such as assuring patients they could never get in trouble for illegal drug use. Clinicians should only present patients with information they know to be true, such as presenting them with policies that exist.

[278] See LeBeau, M. A., & Montgomery, M. A. (2010). Challenges of Drug-Facilitated Sexual Assault. *Forensic science review*, *22*(1), 1–6.

[279] See Society of Forensic Toxicologist, Fact Sheet: Drug-Facilitated Sexual Assault. (Last visited July 17, 2024)

[280] See LeBeau, M. A., & Montgomery, M. A. (2010). Challenges of Drug-Facilitated Sexual Assault. *Forensic science review*, *22*(1), 1–6.

[281] See Society of Forensic Toxicologist, Fact Sheet: Drug-Facilitated Sexual Assault (last visited July 17, 2024)

- A urine sample should be collected from the patient if less than 120 hours have elapsed since the incident. If possible, one hundred (100) milliliters of urine should be collected in a specimen cup with the preservative sodium fluoride and stored refrigerated.
- Although most drugs will be undetectable in the blood more than 24 hours after ingestion, blood may prove useful in a DFSA case if collected less than 24 hours after the incident. At least 12 milliliters of blood should be obtained in a grey-top test tube containing the preservative sodium fluoride and the anticoagulant potassium oxalate. The blood should be stored refrigerated.
- Each biological specimen should be marked with the patient's name, date and time of collection and collector's initials.
- Specimens should be sealed with evidence tape and all relevant chain-of-custody protocols should be followed. Specimens should be submitted to a qualified forensic toxicology laboratory for analysis.

Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation, but clinicians should consult with their lab before sending it to ensure it is a sample they will analyze.[282] Collect and preserve according to jurisdictional policy.

Identify toxicology laboratories and establish process for transporting samples for testing. Exam facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small qualities).[283] Information about these labs (e.g., contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives investigating these cases, exam facilities, and medical forensic examiner programs.

If toxicology tests are needed purely for the medical evaluation of patients, the exam facility lab typically performs these tests. Lab results are recorded in patients' medical records, according to facility policy. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the exam facility lab and another for analysis by the identified forensic lab. Take samples at the same time to avoid more discomfort to patients than is necessary.

Exam facilities and law enforcement representatives should collaborate to create clear procedures for the transport of toxicology samples to the designated testing labs. Clinicians should not transport toxicology samples themselves.

Preserve toxicology samples and maintain the chain of custody. Clinicians should be aware of the toxicology lab's requirements on collection, packaging, labeling, storage, handling,

[282] LeBeau, M. A., (1999). Toxicological Investigations of Drug-Facilitated Sexual Assaults, *Forensic Science Communications*.

[283] See LeBeau, M. A., & Montgomery, M. A. (2010). Challenges of Drug-Facilitated Sexual Assault. *Forensic science review*, *22*(1), 1–6. See also Standard for the Analytical Scope and Sensitivity of Forensic Toxicological Testing of Urine in Drug-Facilitated Crime Investigations, ANSI/ASB Standard 121, First Edition 2021.

transportation, and delivery of specimens.[284] Policies should be in place for storage of these samples when patients are undecided about reporting or choose not to report. As with all samples, the chain of custody must be maintained.

Toxicology specimens require refrigeration beyond 24 hours. Freezing specimens is not necessary.

[284] Refrigerate toxicology samples according to jurisdictional policy. In general, drawn blood should be refrigerated when it is stored. Urine should be refrigerated or frozen when stored (Drawn from electronic communications with Dr. Marc LeBeau, Forensic Toxicologist, Federal Bureau of Investigations, March 2024).

8. STI Evaluation and Care

Recommendations at a glance to facilitate evaluation and treatment of STIs:

- Offer patients information in their primary language.
- Consider the need for STI testing on an individual basis based on the patient's history and examination.
- Provide prophylaxis against STIs as indicated per patient history, consistent with current CDC guidelines or in accordance with local public health indicators.
- Encourage follow-up STI exams, testing, immunizations, counseling, and treatment consistent with current CDC guidelines, local public health indicators, and the patient's individual health needs.
- Address concerns about HIV infection.

Contracting a sexually transmitted infection (STI), also commonly known as a sexually transmitted disease or STD, from assailants is typically a significant concern of sexual assault patients. Because of this concern, it should be addressed as part of the medical forensic examination. The Centers for Disease Control and Prevention's (CDC) Sexually Transmitted Infections Treatment Guidelines, Sexual Assault and Abuse and STIs – Adolescents and Adults (2021) are the best available guidelines, but they are primarily limited, "to the identification, prophylaxis, and treatment of STIs and conditions among adolescent and adult female" patients.[285] Male patients may still be assisted by these guidelines (as would presumably transgender and gender diverse patients, all of whom may present with different risk factors for STIs).

Offer patients information in their primary language.[286] Include information about the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until all STI treatment is completed), follow-up care, and referrals as needed.[287] Clinicians should refer patients for free and low-cost testing, counseling, and treatment options throughout various locations within the community. Clinicians should inform patients about the scope of confidentiality related to STI information in their medical records. Clinicians should orally provide as much information as the patient needs, e.g., some patients may be aware of risks and want treatment, while others may not be as knowledgeable of risks or their options).

Consider the need for STI testing on an individual basis based on the patient's history and examination. Testing at the time of the initial examination does not typically have forensic value if patients are sexually active and an STI could have been acquired prior to the assault but testing may be medically appropriate and should be considered on a case-by-case basis. Despite

[285] Centers for Disease Control and Prevention (CDC). (2021). Sexually Transmitted Infections Treatment Guidelines, Sexual Assault and Abuse and STIs – Adolescents and Adults ("CDC STI Treatment Guidelines").

[286] For patients who have limited English proficiency (LEP), clinicians should provide information about STIs in their primary language either via a translation or use of a qualified interpreter.

[287] See above, CDC STI Treatment Guidelines.

rape shield laws,[288] patients may be concerned that positive test results could be used against them during a trial against the offender (e.g., to suggest sexual promiscuity and that they are therefore lying about the sexual assault). This should not affect medical decision-making if STI testing and treatment are necessary. Transmission of an STI may also be a crime in certain jurisdictions. Therefore, STI testing may provide necessary evidence to prove that a crime was committed. For non-sexually active patients, a baseline negative test followed by an STI could be used as evidence, if the suspect also had an STI.

Trichomoniasis, bacterial vaginosis (BV), gonorrhea, and chlamydial infection are the most frequently diagnosed infections among women who are sexually assaulted.[289] Their presence does not necessarily indicate acquisition during the assault, since these infections exist among some patients who are sexually active. The medical forensic examination presents an opportunity to identify preexisting STIs, regardless of when they were acquired, and for clinicians to make recommendations for specific treatment. Some STIs, such as syphilis, have seen a resurgence in recent years, but are not among the infections for which patients are presumptively treated. Testing may be appropriate at the time of the medical forensic examination based on community infection rates.[290]

Seek the informed consent of patients for testing, if indicated, following CDC guidelines for testing methods. (For more information on this topic, see *A.3. Informed Consent*.)

Provide prophylaxis against STIs as indicated per patient history, consistent with current CDC guidelines or in accordance with local public health indicators. If patients accept prophylaxis at the time of the examination, testing is usually not indicated unless there are specific clinical indicators. Routine preventive therapy after a sexual assault is often recommended because follow-up with patients can be challenging.[291] It also may reduce the need for more expensive/extensive treatment if an STI is discovered later. Treatment should meet or exceed current CDC guidelines for STI preventive therapy for the geographic area. If clinicians are unsure about current concerns, such as medication resistance, reach out to local health department officials for guidance.[292] If patients decline prophylaxis at the time of the initial exam, clinicians should test as appropriate and arrange for a follow-up examination or refer the patient for testing at another agreed-

[288] See, e.g., Fed. R. Evid. 412 (prohibiting evidence of a victim's prior sexual behavior, absent certain exceptions).

[289]See above, CDC STI Treatment Guidelines. (Chlamydial and gonococcal infections in women are of particular concern due to the possibility of ascending infection. When searching for STIs in men who have been sexually assaulted, limited number of studies available demonstrate that chlamydia and gonorrhea appear to be most common types of STIs); see also van Rooijen, M. S., Schim van der Loeff, M. F., van Kempen, L., & de Vries, H. J. C. (2018). Sexually Transmitted Infection Positivity Rate and Treatment Uptake Among Female and Male Sexual Assault Victims Attending the Amsterdam STI Clinic Between 2005 and 2016. *Sexually transmitted diseases*, *45*(8), at pages 534–541; see also, Skjælaaen, K., Nesvold, H., Brekke, M., Sare, M., Landaas, E. T., Mdala, I., Olsen, A. O., & Vallersnes, O. M. (2022). Sexually transmitted infections among patients attending a sexual assault centre: a cohort study from Oslo, Norway. *BMJ open*, *12*(12), e064934.).

[290] Because the prevalence and incidence of STIs vary from community to community, creating relationships with local health departments can assist medical forensic examiner programs with better understanding rates in their own communities, allowing for clinical decision-making regarding testing, medication choices, and patient follow-up recommendations.

[291] See above, CDC STI Treatment Guidelines.

[292] Antibiotic prophylaxes are updated periodically and are usually tailored to specific regions (because, for example, one part of the country may be resistant to a certain antibiotic).

upon location/(follow-up care is recommended for all patients—see C.10 Discharge and Follow-Up).[293] Clinicians should document patients' decisions and rationales for declining prophylaxis in their medical records.

If patients' clinical presentation suggests a preexisting ascending STI, such as fever, abdominal or pelvic pain, and/or vaginal discharge, they should be evaluated and treated for the ascending infection. This treatment should be based on specific treatment options for sexually transmitted infections in the local community.

Prophylaxis for the following STIs, per CDC guidelines:

- Chlamydia
- Gonorrhea
- Trichomoniasis[294]
- Postexposure hepatitis B vaccination (without Hepatitis B immunoglobulin [HBIG]) if the hepatitis status of the assailant is unknown and the patient has not been previously vaccinated. If the assailant is known to be hepatitis B surface antigen (HBsAg) positive, unvaccinated patients should receive both hepatitis B vaccine and HBIG.
- Human papilloma virus (HPV) vaccination for patients aged 9–26 years who have not been vaccinated or are incompletely vaccinated.
- HIV post exposure prophylaxis (PEP) made on a case-by-case basis according to risk.[295]

Obtain informed consent from patients for treatment. (For information on this topic, see *A.3. Informed Consent*.) Patients should be aware of the benefits and toxicity associated with recommended regimens.

Encourage follow-up STI exams, testing, immunizations, counseling, and treatment consistent with current CDC guidelines, local public health indicators, and the patient's individual health needs.[296] Although patients may be reluctant to go for follow-up exams for STIs, such examinations may provide an opportunity to detect new infections acquired during or after the assault, complete hepatitis B and HPV immunizations, if indicated, and complete counseling and treatment for other STIs, if indicated. Examinations for STIs for patients should be repeated according to exam facility policy—the CDC recommends a follow-up appointment within 1 to 2 weeks of the

[293] Uninsured patients and immigrant patients can be referred for follow-up STI and other health care to federally qualified health centers; see HRSA Data Warehouse,.

[294] This typically applies to patients with vaginas; though on a case-by-case basis, patients with penises may be prophylaxed for trichomoniasis, such as if they are forced to penetrate their assailant vaginally, which would create a higher risk for transmission. The treatment regimen for prophylaxis is based on a randomized trial, which demonstrated that multidose metronidazole (500mg PO 2x/day for 7 days) reduced the proportion of women retesting positive at a 1-month test of cure visit by half, compared with women who received the 2g single dose. No published randomized trials are available that compare these doses among men. Workowski, K. A., Bachmann, L. H., Chan, P. A., Johnston, C. M., Muzny, C. A., Park, I., Reno, H., Zenilman, J. M., & Bolan, G. A. (2021). Sexually Transmitted Infections Treatment Guidelines, 2021.*Morbidity and mortality weekly report. Recommendations and reports*, *70*(4), at page 89.)

[295] See the algorithm and resources for assessing risk for HIV following sexual assault at above, CDC STI Treatment Guidelines

[296] This section adapted from id. See also Indian Health Service Sexually Transmitted Infections Strategic Initiative.

assault if the patient declined prophylaxis and initial tests were negative.[297] For patients who are treated during the initial visit, regardless of whether testing was performed, posttreatment testing should be conducted only if the patient reports symptoms. If initial test results were negative and infection in the assailant cannot be ruled out, serologic tests for syphilis can be repeated at 4–6 weeks and 3 months; HIV testing can be repeated at 6 weeks and at 3 months by using methods to identify acute HIV infection.

Follow-up communication with patients (particularly by clinicians and advocates) should include a reminder about follow-up examinations and STI-related testing, immunizations, and treatment as directed. Advocates and health care personnel may be able to assist patients in making follow-up appointments, obtaining transportation to and from appointments, and determining how to pay for expenses involved with follow-up testing and care. Some jurisdictions may cover follow-up treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more apt to seek follow-up treatment. Advocates may also be able to accompany patients to these follow-up appointments.

Address concerns about HIV infection. Although the risk of human immunodeficiency virus (HIV) infection from a sexual assault appears to be low,[298] it is typically of grave concern for sexual assault patients.

Provide information, treatment, and referrals.[299] Clinicians should talk with patients about their concerns regarding the possibility of contracting HIV.[300] Although a definitive statement of benefit cannot be made regarding PEP after sexual assault, the possibility of HIV exposure from the assault should be assessed at the time of the examination. The possible benefit of PEP in preventing HIV infection should also be discussed with the patient if the details of the assault pose an elevated risk for HIV exposure. These particular factors may include: the likelihood that the assailant has HIV, the time elapsed since the event, the exposure characteristics, and local epidemiology of HIV/AIDS. The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with their possible adverse side effects. Health care personnel must evaluate patients' risk of exposure to HIV and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of postexposure therapeutic agents should consult with a specialist in HIV treatment.[301]

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[297] It may be too early to identify infection acquired through the assault at the medical forensic exam, as there may be insufficient organism at the time of initial testing. See above, CDC STI Treatment Guidelines.)

[298] Although HIV-antibody seroconversion has been reported among individuals whose only known risk factor was sexual assault or sexual abuse, the risk for acquiring HIV infection through a single episode of sexual assault is likely low. The overall probability of HIV transmission during a single act of intercourse from a suspect known to be HIV-infected depends on many factors. In specific circumstances, the probability of transmission could be high. These factors may include the type of sexual intercourse (oral, vaginal, or anal), presence of oral, vaginal, or anal trauma (including bleeding), site of exposure to ejaculate, viral load in ejaculate, and presence of a STI or genital lesions in assailants or patients. See above, CDC STI Treatment Guidelines.

[299] A useful referral is the CDC's National Clinician's Post Exposure Prophylaxis Hotline: 888-448-4911. See also the CDC's HIV Infection: Detection, Counseling, and Referral Guidelines (2021).

[300] Some state statutes provide for mandatory HIV testing of suspected sex offenders upon arrest and/or conviction. Patients should be advised of the availability of such testing.

[301] Another resource for clinicians is the nPEP Toolkit from the AIDS Education and Training Center (2022), which has a step-by-step assessment and treatment reference guide.

If a patient decides to take PEP, clinical management should occur in conjunction with specialists as soon as possible and within 72 hours of the exposure. The sooner PEP is initiated after exposure, the higher the likelihood it will prevent HIV transmission if exposure occurred. The CDC recommends offering the patient a 3-7 day initial dose of PEP with a prescription for the remainder of the 28-day course, or if the initial dose is not available, a prescription for the full 28-days.[302] Part of the PEP informed consent process is a discussion of side effects and the importance of medication adherence and follow-up for labs and testing, including:

- The efficacy of postexposure prophylaxis for HIV in cases of sexual assault.
- The known side effects and toxicity of antiretroviral medications.
- The need for frequent dosing of medication and the follow-up care.
- The importance of compliance with the recommended therapy.
- The necessity for immediate initiation of treatment for maximum effectiveness.
- The estimated costs of the medication and monitoring.

See the CDC's Sexually Transmitted Infections Treatment Guidelines, Sexual Assault and Abuse and STIs for initial and follow-up lab and testing recommendations. Patients must be carefully monitored and provided follow-up by a health care provider or agency experienced in HIV issues. Patients should be alerted to symptoms of primary HIV infection (e.g., fever, fatigue, sore throat, lymphadenopathy, and rash) and seek care if these symptoms arise.

As with other STIs, clinicians should inform patients about HIV risks, symptoms and the importance of immediate examination if symptoms occur, testing and treatment options, and the need for abstinence or barrier use (condoms) during sexual intercourse until any treatment is completed. Patients who choose to take HIV prophylaxis require more medical follow-up than other patients. Clinicians should therefore provide referrals that increase patients' likelihood for successful completion of PEP, and they should work with patients to identify potential barriers to obtaining the full dose of medication, the necessary lab work, and follow-up care. Clinicians should collaborate with advocacy and other community agencies *(see C. 10 Discharge and Follow-up)* to identify resources and strategies for overcoming challenges that are identified.

Discuss testing options. Baseline HIV testing is not typically completed at the time of the medical forensic exam unless PEP is being initiated. However, if the patient's risk for HIV is high, and they decline PEP, they should be encouraged to establish their baseline HIV status within 72 hours after the assault and then test periodically as directed by clinicians. Even in cases where the patient's risk is deemed lower, some patients may still wish to be tested. Patients who present outside the PEP window also should be connected with community resources for testing and support.

Clinicians should ensure that referrals include information about whether the testing is free or fee-based, as well as confidential or anonymous.

[302] This paragraph is adapted from above, CDC STI Treatment Guidelines.

9. Pregnancy Risk Evaluation and Care

Recommendations at a glance to evaluate and treat pregnancy:

- Discuss the probability of pregnancy with any patient who could become pregnant from the assault.
- Administer a pregnancy test for all patients with the potential of becoming pregnant from the assault (with their consent).
- Discuss treatment options with patients in their primary language.
- Provide emergency contraception for any patient who wants it.

Becoming pregnant from a sexual assault is a significant worry for patients. Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Most programs offer emergency contraception if they are seen within 120 hours of the assault. Clinicians must be careful to provide patients with objective, evidence-based information and allow them to make the best decisions for themselves at the time of the medical forensic examination.

Discuss the probability of pregnancy with any patient who could become pregnant from the assault. The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent, similar to the risk of pregnancy from a one-time sexual encounter. Almost 2.9 million Americans have experienced rape-related pregnancy at some point in their lifetime.[303] A 2024 study identified that there have been nearly 65,000 patients who have become pregnant as a result of rape in states with abortion bans.[304] Determining the probability of conception also depends upon other variables, such as the use of contraceptives, regularity of the menstrual cycle, fertility of the patient and the offender, time in the cycle of exposure, and whether the offender ejaculated intravaginally. Clinicians should not assume that certain patients cannot get pregnant, unless they do not have the reproductive capability to do so. For example, a patient taking testosterone who no longer menstruates is at low risk for pregnancy, but that does not mean they could not get pregnant from a sexual assault. The same is true for an older patient who has not had a period for many months. Low risk is not the same as no risk and clinicians should not assure patients of something that could potentially occur.

Administer a pregnancy test for all patients with the potential of becoming pregnant from the assault (with their consent). Clinicians need not administer a test if a patient is clearly pregnant. If a patient is pregnant, the pregnancy may affect what medications can be administered or prescribed during the course of or after the examination. Clinicians should follow policies of the medical facility for pregnancy testing. Most commercially available urine pregnancy tests are sensitive to about 50 milli-international units/ml and will detect pregnancy 8 to 9 days after conception, before a menstrual period is missed. Blood pregnancy tests will detect HCG at very low levels. If the pregnancy test is positive, emergency contraception (EC) is contraindicated and decisions about other medications (e.g., STI prophylaxis) must be made in consideration of the pregnancy. If the test is negative and the patient has had unprotected intercourse within the last 10

[303] Basile, K. C., Smith, S. G., Liu, Y., Kresnow, M. D., Fasula, A. M., Gilbert, L., & Chen, J. (2018). Rape-related pregnancy and association with reproductive coercion in the U.S. *American Journal of Preventive Medicine*, 55, at pages 770-776.

[304] Dickman, S. L., White, K., Himmelstein, D. U., Lupez, E., Schrier, E., & Woolhandler, S. (2024). Rape-Related Pregnancies in the 14 U.S. States With Total Abortion Bans. *JAMA internal medicine*, *184*(3), at pages 330–332.

days and would continue that pregnancy if conception has occurred, then the clinician should treat the patient as pregnant and not administer emergency contraception.

Discuss treatment options with patients in their primary language, including emergency contraception.[305] Clinicians should discuss treatment options with patients, including emergency contraception. An immediate option is to offer emergency contraception pills.[306] Another option in some jurisdictions is the Copper-T intrauterine device, which has distinct benefits (long-acting and extremely effective, particularly for patients where weight may be a concern) and drawbacks (cost, availability and discomfort in the insertion process).[307] Clinicians should discuss options with the patient and provide information regarding the timeframe for emergency contraception provision, so they can make an informed decision. Clinicians should inform the patient that emergency contraception will not prevent sexually transmitted infections. The conversation with the patient should include a thorough discussion, including mechanism of action for each treatment option, side effects, dosing, and follow-up. This information should also be provided in writing in the primary language of the patient, if possible.[308]

Provide emergency contraception for any patient who wants it. Providing emergency contraception is the standard of care for patients who present following sexual assault.[309] When a provider refuses to offer certain forms of contraception for moral or religious reasons, patients must receive treatment from a different clinician. Because emergency contraception is time-limited, simply giving patients information or a prescription to purchase the medication elsewhere should be considered the option of last resort. Medical forensic examination programs that have clinicians who oppose providing emergency contraception should proactively create policies to address alternate methods for ensuring patients can be treated.

Offer emergency contraception if the patient is at risk, according to facility policy.

Oral Contraceptive Pills

Emergency contraceptive pills are a hormonal method of preventing pregnancy that can be used after sexual assault. There are two distinct types available through most medical forensic examiner

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[305] For more information about sexual assault and pregnancy, visit the National Sexual Violence Resource Center.

[306] Upadhya, K. K., Breuner, C.C., Alderman, E.M., Grubb, L. K., Hornberger, L. L., Powers, M.E. & Wallace, S.B. (2019) AAP Policy Statement: Emergency Contraception). Some states require emergency departments to offer emergency contraception to patients presenting after sexual assault.

[307] While programs are beginning to explore the use of progestin-containing IUDs for emergency contraception, there does not appear to be sufficient evidence yet to recommend them: Ramanadhan, S., Goldstuck, N., Henderson, J. T., Che, Y., Cleland, K., Dodge, L. E., & Edelman, A. (2023). Progestin intrauterine devices versus copper intrauterine devices for emergency contraception. The Cochrane database of systematic reviews, 2(2), CD013744.

[308] For patients who have limited English proficiency (LEP), clinicians should provide information about STIs in their primary language either via a translation or use of a qualified interpreter.

[309] See *The Use of Emergency Contraception After Sexual Assault* position statement by the International Association of Forensic Nurses (2022) ("IAFN recommends that EC be immediately offered and available to all female (or trans-male) victims of sexual assault or abuse of reproductive age or stage who choose to use EC as a means of protection from unintended pregnancy."). See also the American College of Obstetrics and Gynecology *Practice Bulletin on Emergency Contraception* originally written in 2015 and reaffirmed in 2022): ("Reproductive-aged women who are victims of sexual assault always should be offered emergency contraception.")

programs.[310] The only contraindication for either is pregnancy, although neither will end a pregnancy that is already in progress. Both are considered a safe and easy treatment for patients with minimal side effects.

Progestin emergency contraception (Levonorgestrel or LNG):[311] a synthetic hormone that can be taken as a single dose (ideal: 1.5 mg single dose) or split dose (two 0.75 mg doses 12 hours apart). Levonorgestrel is *most* effective if used within 72 hours. Efficacy rates are between 81 — 90% reduced pregnancy risk, depending on when it is taken. There is some concern that patients with a BMI greater than 25 may have decreased efficacy, but the research is not conclusive and to date, the FDA has not recommended a change to the packaging. These can be obtained over the counter.[312] Side effects including spotting, breast tenderness, and nausea.

Ulipristal acetate (Ella):[313] Ulipristal is more effective than the progesterone contraceptive pills, with a 2.1% failure rate and can be taken up to 5 days post assault. Side effects are similar to the progestin only pills. Some research indicates that the efficacy diminishes for patients with BMIs greater than 35. As with the progestin emergency contraceptive pill, ulipristal appears to have a similar mechanism of action—effecting follicular development to delay or inhibit ovulation.[314]

Providing an anti-emetic, such as ondansetron, can help patients avoid nausea, one of the most common side effects, especially when taken in conjunction with the antibiotics for STI prophylaxis.

Intrauterine Device (IUD)
Copper-T IUD: The use of the Copper-T IUD reduces the risk of pregnancy by more than 99% when placed within 5 days of the assault. Unlike the emergency contraceptive pills, there are no weight restrictions for the IUD, and it contains no hormones. The IUD appears to work by interfering with fertilization by impeding the sperm from reaching the egg. There are misconceptions that IUDs are inappropriate for patients who have never given birth or that they increase the potential for ascending infection in patients that have experienced sexual assault, but neither of these are true.[315]

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[310] There is a 3rd type, known as the Yuzpe method, which is using combined oral contraceptives (one dose of 100 µg of ethinyl estradiol plus 0.50 mg of LNG, followed by a second dose of 100 µg of ethinyl estradiol plus 0.50 mg of LNG 12 hours later), but because that method has so many more side effects, and involves many more pills, it is rarely used in the U.S.

[311] Portions of this paragraph adapted from KFF Women's Health Policy: Emergency Contraception.

[312] See Guttmacher Institute for more information on age restrictions for over-the-counter purchases.

[313] Portions of this paragraph adapted from KFF Women's Health Policy: Emergency Contraception.

[314] Gemzell-Danielsson K. (2010). Mechanism of action of emergency contraception. Contraception, 82(5), 404–409; Brache, V., Cochon, L., Deniaud, M., & Croxatto, H. B. (2013). Ulipristal acetate prevents ovulation more effectively than levonorgestrel: analysis of pooled data from three randomized trials of emergency contraception regimens. *Contraception*, *88*(5), 611–618.

[315] Salcedo, J., Cleland, K., Bartz, D., & Thompson, I. (2023). Society of Family Planning Clinical Recommendation: Emergency contraception. *Contraception, 121,* 109958; Papic, M., Wang, N., Parisi, S. M., Baldauf, E., Updike, G., & Schwarz, E. B. (2015). Same-day intrauterine device placement is rarely complicated by pelvic infection. *Women's health issue: official publication of the Jacobs Institute of Women's Health*, *25*(1), 22–27; Sufrin, C. B., & Averbach, S. H. (2014). Testing for sexually transmitted infections at intrauterine device insertion: an evidence-based approach. *Clinical obstetrics and gynecology*, *57*(4), 682–693; Sufrin, C. B., Postlethwaite, D., Armstrong, M. A., Merchant, M., Wendt, J. M., & Steinauer, J. E. (2012). Neisseria gonorrhea and Chlamydia trachomatis screening at intrauterine device insertion and pelvic inflammatory disease. *Obstetrics and gynecology*, *120*(6), 1314–1321.

It can also be an excellent form of contraception for those interested in a long-acting contraceptive (it is effective for ten years). However, it does require a clinician with specialized training to place the IUD. Cost and pain management should be discussed with the patient.

Levonorgestrel (LNG) IUDs have been recommended as another option for emergency contraception, as they appear to work as well as the Copper-T IUD when placed within 5 days of the assault, although continued research about their efficacy compared to the Copper IUD is encouraged.[316]

Follow-up Care: The patient should be informed that following the use of emergency contraception, they may have a heavier or lighter menses than usual and the menses onset may not occur at the expected time. If no bleeding has occurred within three weeks, the patient should repeat a pregnancy test. The patient must be advised not to have unprotected intercourse until after the menses has occurred, or until the repeat pregnancy test is negative.

If the facility chooses not to provide EC on site, patients should be provided information on where to access emergency contraception, a prescription (if necessary), and antinausea medications. Clinicians should also provide patients with a list of stores or pharmacies that stock the medication. This does not apply for emergency departments in states that by statute must offer patients emergency contraception.[317]

If the facility is not willing to provide EC or write the needed prescriptions, it is recommended that the patient be given local referrals to medical facilities that can *immediately* assist with alternative treatment.

[316] Salcedo, J., Cleland, K., Bartz, D., & Thompson, I. (2023). Society of Family Planning Clinical Recommendation: Emergency contraception. *Contraception, 121,* 109958.

[317] For a complete list of emergency contraception access by state, see Emergency Contraception Policies.

10. Discharge and Follow-up

Recommendations at a glance to facilitate discharge planning and follow-up with patients:

- Provide patients with specific information about medical discharge and follow-up care.
- Coordinate between the different disciplines (advocates, law enforcement representatives, and other involved responders) to discuss a range of other issues with patients prior to discharge in order to decrease patient wait times. For confidentiality, it may be important for an advocate to meet with the patient in a private space, outside the presence of law enforcement or the clinician.

Clinicians have important tasks to accomplish prior to discharging patients. They should collaborate with advocates to ensure that patients leave the medical forensic examination with the necessary information without overwhelming or confusing them with conflicting or incomplete information.

Provide patients with specific information about medical discharge and follow-up care. Clinicians should address the following issues with patients prior to discharge:

Ensure patients' medical and mental health needs related to the assault have been addressed. Discuss with patients whether they have any other medical and/or mental health concerns related to or co-occurring with the assault.[318] If additional evaluation for injuries is required, clinicians should refer patients to the appropriate clinical site (e.g., hospital emergency department staff) for care or provide the appropriate community referrals prior to discharge. Ideally, a warm handoff will take place between the medical forensic examiner program and the receiving clinical site to ensure continuity of care and coordination of services.

Provide patients with oral and written medical discharge instructions (if it is safe to do so). Clinicians should include a summary of the examination (e.g., samples collected, tests conducted, medication prescribed or provided, and treatment received), medication doses to be taken, follow-up appointments needed or scheduled, and other referrals. The discharge form could also include contact information and hours of operation for local advocacy programs and victim service providers. Patients should also be given information about what to expect regarding any billing for services not considered part of the medical forensic examination. For patients who are limited English proficient (LEP), translations should be provided in the patient's primary language or through oral interpretation of written information following federal language access requirements.

Arrange follow-up appointments for patients. Follow-up may be indicated to document developing or healing injuries (for example, bruising) and complete resolution of healing. It may also be indicated to further evaluate nonspecific findings (such as redness, swelling, or almost any cervical finding) that may be difficult to establish as trauma rather than pathology or normal variant. (A jurisdictional policy describing the indications and procedures for follow-up for documentation purposes should be in place.) Appointments may also be needed to address co-occurring medical concerns. If appointments are not scheduled, at a minimum, patients should be clear about their referrals, including locations and how to establish appointments if sites are different from where the initial examination took place. Patients should not have to disclose the assault to receive follow-up medical

[318] Care should be taken to ensure that mental health and substance use disorder providers can appropriately and respectfully handle trauma patients, as well as patients from minority and/or stigmatized groups such as specific cultural groups or transgender individuals.

care, although information provided upon discharge may help patients avoid unnecessary testing and potentially repeat procedures depending on the type of follow-up care being sought. Clinicians should ensure that follow-up procedures are accessible and reasonable, and consider transportation challenges, childcare issues, and other potential barriers. Follow-up appointments may include:

- For patients with evidence of acute trauma: A short-term follow-up appointment to reexamine and document the development of visible findings and an exam 2 to 4 weeks later to document resolution of findings or healing of injuries.
- For patients who did not receive STI prophylaxis, examination for STIs can be repeated 1–2 weeks after the assault (patients who were treated only need follow-up testing if they are symptomatic). If there is a concern about exposure to syphilis and initial testing was negative, but infection in the offender cannot be ruled out, follow-up testing should be done 4-6 weeks after the initial testing. Patients concerned about HIV exposure should have repeat testing at 6 weeks and 3 months. (*see also C.8 STI Evaluation and Care)*[319]
- Primary healthcare providers or other nonacute care providers can provide longer term care as needed (e.g., administering doses of Hepatitis B and HPV vaccine; addressing concerns noted during speculum exam).

Discuss follow-up medical contact procedures. Clinician should discuss with patients whether they would like health care providers to provide a follow-up call or text and, if so, the best method and time for this contact (maintaining patients' privacy and safety). The main purposes of such contact to check on medical status, the patient's ability to obtain any additional medications they were not provided on site, and to remind patients about the necessity of completing all medications and obtaining follow-up testing and care. An optimal time for a first medical follow-up contact is 24 to 48 hours following discharge. Those who follow up with patients should be familiar with the initial encounter, confidentiality and safety issues, and the patient's potential medical needs.

Coordinate between the different disciplines (advocates, law enforcement representatives, and other involved responders) to discuss a range of other issues with patients prior to discharge in order to decrease patient wait times. For confidentiality, it may be important for an advocate to meet with the patient in a private space, outside the presence of law enforcement or the clinician. Clinicians should ensure that prior to the patient being discharged from their care, the patient has been provided clear information from each responder that is present at the medical forensic examination about next steps and contact information. Some of this information may overlap (such as safety planning). There may be a point at which the patient is simply overwhelmed by information and cannot receive anymore, so this cannot be the only time, and the only way in which this information is provided. If clinicians are the only responders at the medical forensic examination, they may need to provide patients with much of the information below.

After the examination is finished, address patients' continued physical comfort needs. (For a discussion of this topic, see *A.2. Patient-Centered, Trauma-Informed Care*.)

Help patients plan for their safety and well-being. Jurisdictional and exam site policies should be in place to facilitate this process. Clinicians should assist patients in developing a post examination plan that addresses their physical safety and emotional well-being. Clinicians should screen for domestic

[319] See above CDC STI Treatment Guidelines, at page 134.

and dating violence and other forms of abuse.[320] Clinicians should assist patients in considering things such as:

- Where are they going after being discharged? With whom? Will these individuals provide them with adequate support? Is there anyone else they would like to contact? (Provide information about available community resources for obtaining support and help in making the contact if possible.)
- Will their living arrangements expose them to the threat of continued violence or harassment? Is there a need/want for emergency shelter or alternative housing options? (Provide options and help obtain if possible.)
- Are they eligible for protection orders? (Provide information and help connect them with local resources to assist.)
- Is there a need for enhanced security measures? (Discuss options and help obtain if desired.)
- If they feel unsafe, what would make them feel safer? (Discuss options and help them develop a plan.)
- Are they eligible for crime victim compensation funds to help defray costs associated with their assault, including medical bills not covered as part of the sexual assault medical forensic examination? (Provide information about state crime victim compensation.[321])

Planning is not a one size fits all process but must take into account the needs and concerns of specific populations and circumstances. For example, if patients with physical disabilities require shelter, the shelter must be accessible and staff must be able to meet their needs, including personal assistance with activities of daily living or accommodating service animals.[322] If patients living in institutional settings have been assaulted by another resident, a staff person, or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that patients will come into contact with the offender again. The facility should also ensure access to services designed to promote their recovery. Safety planning should address additional options for safety if the institution fails to address the harm.

Clinicians should collaborate with local advocacy organizations for additional safety planning training to ensure they are aware of available resources and to enhance the capabilities of the responders within the healthcare facility who may interface with sexual assault patients in the absence of medical forensic examiners or when patients decline the medical forensic examination.

Explain follow-up contact procedures of all responders involved. Clinicians should coordinate follow-up contact of involved agencies as much as possible, keeping the number of responders who contact patients to a minimum. Clinicians should determine the best way to contact patients with limited English proficiency or who are members specific communities or institutions (e.g., schools, military bases, prisons, or residential programs may have their own procedures). Clinicians should consider offering options such as text messages and email (if safe) rather than phone calls, as many patients are more comfortable with certain modes of communication.

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[320] See also, above IPV Protocol.

[321] See the National Association of Crime Victim Compensation Boards website for a listing of state compensation programs.

[322] For more information on safety planning with patients who have disabilities, see the Metropolitan Organization to Counter Sexual Assault, Rose Brooks Center, & UMKC Institute for Human Development. *Safety planning for persons with disabilities*. Safety First Initiative.

Explain advocacy and counseling services. Sexual assault advocacy programs typically offer a host of services for victims and their loved ones, in addition to those provided during the exam process. (For more information on services, see *A.2.Patient—Centered, Trauma-Informed Care*.) Advocates can review their services and discuss counseling and other related options in the community. Some advocacy programs provide professional mental health counseling, but many refer patients to community or private agencies. Before being discharged, advocates, like clinicians, should obtain consent to follow-up, and determine optimal methods and times for the contacts.

During follow-up contacts, advocates can continue to work with patients to assess their safety; offer support and crisis counseling; review discharge instructions; answer their questions and provide additional referrals and information; and help coordinate other advocacy services and counseling based upon identified needs.

Explain the investigative process. If law enforcement is involved, clinicians should discuss the investigative and criminal justice process (to the extent the clinician is comfortable) and when they might expect to hear from law enforcement and who that person will be. If not already done, clinicians explain a victims' rights, discuss any safety concerns and provide assistance as warranted, and then recontact them as needed as their case progresses.[323] Clinicians should inform patients about other personnel who may become involved. Patients should receive contact information of involved law enforcement representatives and agencies and a case report number. They should feel free to call their investigator with any new relevant information, including if new signs of injuries appear, about offenders' compliance with protection orders or bond conditions, including whether offenders try to contact them, or if they have other related questions or concerns. They should understand if and when they might hear from prosecutors, and whether other individuals from the prosecutor's office may be in contact, such as investigators or victim witness professionals. (Patients should be aware that it is their decision whether to report their case and talk with law enforcement officials and prosecutors.)

If a sexual assault evidence collection kit has been collected and law enforcement is involved, the law enforcement representative may discuss with patients the results of DNA analysis or whether other victims of the same offender have been identified. Clinicians can ask patients if they want to be contacted by law enforcement in these situations and, if so, determine the best contact method.

Patients who have not made a report to law enforcement should be given information on what to do if they change their mind and how to contact law enforcement. They should also be given information on where the kit will be stored and how it will be tracked (for example if there is a tracking number, it should be provided). If the kit was collected anonymously and is being stored by law enforcement, they should be provided information on how they can identify themselves and their kit.[324]

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[323] Some patients may want information about the amount of time it takes for cases to move through the criminal justice system. If it's possible to provide a range of time typical of the jurisdiction, that may be helpful, but patients should be aware it is impossible to predict how long it could take for a case to work its way through the process. Some timeframes may be known, such as analyzing of kits, but others, such as when a case may be set for trial, may be much tougher to identify. Providing patients with a point person and contact information for case updates may be a more realistic way to help patients stay connected to progress made in their case without making promises that cannot be kept.

[324] In some jurisdictions, anonymous reporting is not possible, but there may be options for victims to get evidence collected without reporting to law enforcement. For example, in Michigan, patients have the option of having kits collected and held by the hospital or program that completed the medical-forensic exam. They have a

Provide information. Clinicians should offer patients clear and concise information, both orally and in writing.[325] Information should be tailored to patients' communication skill level/modality and language. (For more information on the types of information that patients might find useful, see *A.2. Patient-Centered, Trauma-Informed Care*.) What helps one patient deal with a traumatic situation like sexual assault may not be the same for another patient. Clinicians should help patients obtain culturally specific assistance and/or provide referrals where they exist.[326]

Population-Specific Considerations

- Patients should be provided information regarding immigration relief for crime victims, including the availability of U and T visas, VAWA self-petitions, and Special Immigrant Juvenile Status (SIJS) immigration relief.[327]
- An immigrant victim who is undocumented may not self-identify for fear of deportation. While it is not appropriate to ask a patient's immigration status, information about their rights should be offered in a non-judgmental manner to all patients and in coordination with a referral to a service provider who is an expert in working with immigrant victim populations in your community.
- Many male patients focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may help reduce their self-blame.
- Male patients may be less likely than other patients to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.[328]
- Older adults and patients with disabilities who have been sexually assaulted in care facilities often experience intense feelings of vulnerability in those facilities following sexual assault and may want to be relocated. Patients who rely upon others for care are likely to need the assistance of relatives, friends, and involved professionals to safely relocate or, if they are unable to relocate, to create safety plans.

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minimum of one year to decide if they want them turned over to law enforcement to make a report and have the kit analyzed. In circumstances such as this, patients should be discharged with clear instructions about how to have their kits released to law enforcement should they change their mind.

[325] Many local sexual assault advocacy programs and state coalitions offer publications that address victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council should develop such literature. For more information, see State and Territory Coalitions (last visited July 16, 2024).

[326] For example, some patients may benefit from and find comfort in talking about culturally specific models of healing (where they exist) and their application to recovery from sexual assault. To facilitate such a discussion, they may wish to speak with a religious or spiritual healer from their culture. For more resources, the National Sexual Violence Resource Center maintains a searchable directory of organizations, including culturally specific organizations. The National Organization for Sisters of Color Ending Sexual Assault (SCESA) also maintains a comprehensive list of national and local culturally specific sexual assault organizations. See also the Alliance of Tribal Coalitions to End Violence (ATCEV) for links to all Tribal coalitions.

[327] See Department of Homeland Security (DHS) – Interactive Infographic U.S. Immigration Benefits for Noncitizen Crime Victims (English) (November 2021) ; DHS Immigration Options for Victims of Crimes; DHS Gender Based Violence Brochure (English) (October 2022).

[328] See organizations such as 1in6 for more information.

- Encourage use of follow-up medical, legal, and nonlegal assistance. Older patients and patients with disabilities may be reluctant to seek these services or proceed with prosecution. If barriers to accessing services or ongoing health care exist, such as lack of transportation, work with local service providers to identify potential remedies.
- Be sensitive to a patient's cultural, religious, and/or spiritual beliefs and practices. The best practice is to ask, rather than assume, what they need to be safe, address their health concerns, be supported in inner healing, and feel a sense of justice.
- Ensure that all referrals given to transgender or gender diverse patients have been trained on or have significant experience with the special needs of transgender and gender diverse victims of sexual assault.

11. Examiner Court Appearances

Recommendations at a glance for jurisdictions to maximize the usefulness of examiner testimony:

- Encourage clinicians to learn about testifying.
- Encourage clinicians to request prosecutors to promptly notify them if they must testify.
- Encourage clinicians to prepare for their testimony with the counsel who has subpoenaed them.
- Consider implementing peer review of clinician testimony to provide feedback and improve effectiveness of future court appearances.

Clinicians should expect to testify in court as fact and/or expert witnesses and should therefore complete each medical forensic examination with the understanding that they may have to testify about it. For more information about the difference between fact and expert testimony and for specific guidance about preparing for testimony, clinicians should consult the *Testimony Toolkit* (2024), developed by the International Association of Forensic Nurses. It covers in-depth the topics listed below:

Encourage clinicians to learn about testifying. Topics should include:

- The role of the medical forensic examiner at trial.
- Courtroom basics (e.g., criminal justice process and terms, who typically is present,[329] and prosecution and defense strategies).
- Differences between fact witnesses and expert witnesses.
- Effectively and objectively testifying during direct and cross examination.

Clinicians should be trained by a variety of trainers from not only fellow healthcare professionals, but from prosecutors, members of the judiciary, and defense attorneys. Clinicians should also stay abreast of cutting-edge practices and related case law (e.g., rulings that impact the scope of issues they can testify on in court).[330]

Encourage clinicians to request that prosecutors promptly notify them if they must testify. Ideally, attorneys would inform clinicians well in advance if they are being called as witnesses. Clinical schedules are typically set weeks to months in advance, and it can cause significant challenges for not just medical forensic examiner programs, but other clinical departments in which the clinician may also be employed if there is not sufficient notice provided. However, trials often get unexpectedly delayed and rescheduled based on a variety of factors. By developing relationships with the prosecutors who routinely handle the clinicians' testimony, clinicians may be able to better plan their schedules. Although the clinician will formally receive a

[329] The following may be present in the courtroom in a criminal proceeding: the judge, prosecutor, defense attorney, jury, bailiff, clerk, court reporter, law enforcement investigator, victim, defendant, victim advocate, and interpreters, as necessary.

[330] In addition to educating clinicians, attorneys who handle cases involving medical examinations must know how to properly interpret and present information from those examinations during hearings or at trial. For training and technical assistance, AEquitas is available to assist and educate prosecutors and other professionals. Similarly, it is important to encourage judicial education on issues related to examiner testimony. The National Judicial Education Program (NJEP) offers a resource for judges, *Medical Forensic Sexual Assault Examinations: What Are They and What Can They Tell the Courts?*

subpoena, open communication with the attorneys is the best way for clinicians to know when they will be needed to testify.

Some organizations prefer that all subpoenas are routed through risk management or the legal department; others want them served directly to the medical forensic examiner program. Regardless, unexpected subpoenas can cause examiners a great deal of anxiety, so the goal should be as much notice as possible to allow for both preparation for testimony and adequate scheduling.

If clinicians and attorneys communicate regularly, attorneys may be able to minimize the amount of time examiners wait to testify, allowing them to return to their work as quickly as possible.

Encourage clinicians to prepare for their testimony with the counsel who has subpoenaed them.[331] Clinicians should be prepared for both direct examination and cross examination.

Although criminal justice records include the medical forensic report and accompanying photographs, clinicians must strictly comply with HIPAA rules and governing protocols related to the disclosure of patient information. Clinicians must not discuss a patient's case with colleagues, other attorneys, or any other third party unless authorized to do so by the patient or by legal process, such as a subpoena or other court order.

- It is critical that clinicians meet in advance with the attorney(s) calling them as witnesses, in order to prepare for testimony in individual cases. Not only should they review and discuss the initial examination of the patient, but also any subsequent contacts between the patient and the examiner.
- The clinician should know the following information in advance of trial:
  - Are they testifying as a fact witness or expert witness?
  - What are potential subjects and questions that will be asked during the testimony on direct examination?
  - Do they need to provide any records or photographs?
  - Will they be required to provide a written disclosure prior to trial?[332]
  - Will they be expected to listen to other testimony?
  - What is likely to be asked on cross-examination by the opposing attorney?
- Prior to testifying, clinicians should review records of the exam, including photographs. Because a clinician's testimony is not a test of their memory, clinicians will typically be permitted to look at their notes and a patient's medical record to refresh their recollection. However, a clinician should prepare to testify as though their notes may not be available.
- Clinicians should be prepared to educate the judge and the jurors. They should use terminology and descriptions that will help individuals with little to no medical or forensic background understand key concepts that are central to the testimony.

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[331] Section partially adapted from above, *SANE Testimony*. See also International Association of Forensic Nurses, Testimony Toolkit, (2024).

[332] In some jurisdictions, written expert witness disclosures are required by the court. For example, Federal Rule of Criminal Procedure 16(a)(1)(G)(iii) requires a written expert witness disclosure that must contain (1) a complete statement of all opinions that the government will elicit from the witness in its case-in-chief, or during its rebuttal; (2) the bases and reasons for them; (3) the witness's qualifications, including a list of all publications authored in the previous 10 years; and (4) a list of all other cases in which, during the previous 4 years, the witness has testified as an expert at trial or by deposition.

- Clinicians should keep in mind that anything they write about the case is potentially discoverable. This includes texts and emails to counsel.
- Clinicians should be prepared to discuss their educational background, clinical experience, and if relevant, prior experience as expert witnesses. They should create and maintain a curriculum vitae that outlines their professional accomplishments and be prepared to provide it to the counsel that subpoenaed them prior to trial.[333]
- It is impermissible to testify about whether a patient consented to the sexual contact or whether they believe the patient was raped or assaulted. However, if a clinician is qualified as an expert, they may be permitted to testify about whether the patient's presentation was consistent with their history. The clinician should clarify the scope of testimony prior to trial.
- If the attorney that subpoenaed the clinician believes clarification is needed, the attorney will ask additional questions to clarify.

During testimony, clinicians should consider the following:

- The purpose of clinician's testimony is to educate judges and juries.
- Business attire is generally appropriate for court appearances, but if there is a question about what to wear, clinicians should ask the attorney that subpoenaed them. Nothing the clinician wears should distract from their testimony.
- Clinicians should be sincere, polite, and objective. They should maintain eye contact with the jury and the lawyer questioning them and maintain the same demeanor throughout direct and cross examination.
- Clinicians should be confident in their knowledge and expertise because they know more about the particular medical forensic examination at issue than anyone in the courtroom. Being nervous is normal, even for clinicians who have testified repeatedly.
- Clinicians should listen to the questions carefully and allow time to compose answers before speaking. Answers should be concise and accurate, avoiding terms such as "I believe" or "I think", as well as the use of "always" and "never".
- If clinicians use medical jargon, they should provide a definition.
- Clinicians should answer only questions that are asked and not elaborate unless the attorney or judge asks for more information. It is appropriate to ask for clarification or to restate the question if needed.
- It is appropriate to answer, "I don't know," if that is the truthful response. If it is a matter of not remembering the answer, clinicians can ask to refer to records if their memories need refreshing.
- If the clinician realizes an error or omission occurred in testimony, they should acknowledge and correct it.
- Clinicians should be aware of the phrasing of questions during cross-examination that may be designed to place doubt on clinician testimony. For instance, if a compound question is asked, the answer to one part may be "yes" and to the other part may be "no." Clinicians should clarify as appropriate.
- If the questions include incorrect information, the erroneous information should be corrected. When disagreeing with the questioning attorney, clinician should do so without argument or interruption.
- Clinicians should be careful to provide consistent answers, especially if cross-examining attorneys ask the same question several times, using different wording.

[333] There are a variety of guides available online to assist clinicians with creating CVs. See Purdue University's *Writing the Curriculum Vitae* (last visited July 2, 2024).

Although it is most likely that clinicians will be called by the prosecution, they may also be called by the defense.[334] No matter who subpoenas them, clinicians are expected to give objective and truthful testimony.

Consider implementing peer review of clinician testimony to provide feedback and improve effectiveness of future court appearances. Like other aspects of clinical practice, testimony is a skill that cannot improve without review and feedback. Clinicians should ask more experienced peer to watch their testimony to provide feedback. Although attorneys can provide some limited feedback, other clinicians can do a more thorough job of reviewing the accuracy and thoroughness of the testimony, from use of terminology to description of injury to clarity of the state of the science. In the absence of having a clinician in the courtroom, clinicians can order transcripts of the testimony and use them as a review tool with a colleague or among team members to receive feedback and help teach less experienced clinicians about the testimony process.

[334] Medical forensic examiners may also serve as expert witnesses for the defense. There is no prohibition against this, and in fact, unless there is a conflict (such as another member of that clinician's team having conducted the medical-forensic examination), there are no ethical reasons for clinicians not to provide this service. In the interest of justice, both prosecution and defense should have access to evidence-based, medical-forensic professionals.

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Appendix A. Developing Customized Protocols: Considerations for Jurisdictions

Jurisdictions developing or updating their own medical forensic examination protocols are encouraged to consider the recommendations in this national protocol in their entirety and tailor them to fit local needs, challenges, statutes, and policies. Jurisdictions that have existing protocols can consider whether any of the protocol recommendations or the tasks below could serve to improve their immediate response to sexual assault or address gaps in services or interventions.

Form a protocol planning team. At a minimum, this team should include clinicians involved in the medical forensic examination process, as well as program facility administrators, law enforcement representatives, victim advocates, prosecutors, and forensic laboratory personnel. Organizations serving specific populations in the community should also be involved to ensure the protocol speaks to the needs of victims of diverse backgrounds. Team participants should have authority to make policy decisions on behalf of their agencies. Bringing together this type of team may present challenges, particularly in jurisdictions with multiple sexual assault victim advocacy programs, exam facilities, law enforcement agencies, prosecution offices, and court systems (or where several levels of government may be involved in investigation and prosecution of sexual assault cases). Although representation from all involved disciplines and agencies is the ideal, the absence of an agency's participation should not halt the planning process. Ensure that there is a communication loop in place that allows those who are unable to participate in person the opportunity to provide feedback in the protocol development process.

Assess needs.[335] Before initiating policy changes, it is important the planning team assesses the jurisdiction's current response to sexual assault, with a focus on the medical forensic examination process. Not only will this help build a more effective response, but it will also create a foundation for more sustainable medical forensic programming. Some information to gather:

- Determine where patients who have experienced sexual assault are currently going for medical forensic examinations. (Is it far away? Are they not being referred for examinations?)
- Seek input from clinicians involved in the exam process on current gaps, problems, and challenges.
- Evaluate the adequacy of existing policies pertaining to each aspect of immediate response.
- Compare statistics on sexual assault within the community as captured by represented agencies.
- Identify community demographics, including the various populations that make up the area.
- Review existing feedback from victims about their experiences and satisfaction with immediate response.
- Review systemic breakdowns that have occurred within the community when responding to sexual assault.
- Evaluate the capacity of each discipline to work collaboratively with other disciplines.
- Evaluate the ability of individual agencies and the community as a collective to effectively respond to victims from a wide range of backgrounds and diverse experiences.

[335] Adapted from above, SANE Program Development and Operation Guide, Readiness Assessment, and Rozzi, H. (2013). *Sexual assault and society*, see above, Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient.

- Evaluate the adequacy of related trainings and resource materials.
- Identify related jurisdictional statutes and evaluate their adequacy in supporting effective response.
- If there is a plan to create a formalized medical forensic examiner program as part of the policy change:
- Identify sources for funding medical forensic examinations and whether this may impact program structure, availability, and other needed clinical services, such as follow-up care.
- Clarify any backup plan that may be needed (such as taking patients to a different exam location) to cover gaps in scheduling, presence of more than one patient at a time, or other unforeseen issues.

Devise an action plan. The protocol planning team can take what it learns through the needs assessments and translate it into an action plan for improving the medical forensic examination process and creating a protocol. The plan should clearly identify what needs to happen, who is responsible for coordinating or carrying out each action, possible resources,[336] desired outcomes, and how the effectiveness of the action will be evaluated. The plan can be revisited periodically to assess progress and evaluate outcomes.

Create a protocol.[337] To create an effective medical forensic examination protocol, the following aspects are necessary:[338]

- Develop a mission and accompanying vision statement to guide the work, outline accountability, and provide focus for the team.
- Create a process to facilitate decision making on protocol development or revision.
- Formalize commitments by participating agencies to all aspects of developing and implementing the protocol through interagency agreements or memorandums of understanding.

The planning team should review the National Protocol to determine the appropriateness of national recommendations for the jurisdiction. It must consider what jurisdictional statutes and policies need to be discussed and how to address community-specific needs and challenges. Once a draft has been developed, it should be made available to relevant professionals, agencies, survivor groups, and organizations serving specific populations across the jurisdiction. Their feedback should be solicited and then incorporated into the draft to the extent possible. Once a final protocol is created, the team should consider pilot testing and revising it based on feedback from the tests. Then the protocol should be implemented based on recommendations of team members and others from whom input has been sought.

Distribute the protocol. The planning team should determine the most efficient method to disseminate the protocol to all professionals in the jurisdictions who are involved in the immediate

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[336] Funding under the STOP Violence Against Women Formula Grant Program may be used to cover costs related to protocol development and implementation. For more information, see https://www.justice.gov/ovw.

[337] For assistance with writing protocols, see the Sexual Violence Justice Institute (n.d.). *Sexual assault team protocol template: A new way of thinking about protocol development.* Sexual Violence Justice Institute, Minnesota Coalition Against Sexual Assault https://mncasa.org/wp-content/uploads/2022/06/Protocol-Template.pdf

[338] Bulleted section adapted from Sexual Violence Justice Institute (n.d.). *Safe Harbor Protocol team formation starter kit*. Sexual Violence Justice Institute, Minnesota Coalition Against Sexual Assault. https://mncasa.org/wp-content/uploads/2022/06/Safe-Harbor-Protocol-Team-Formation-Starter-Kit_A-Guide-for-New-Teams.pdf

response to sexual assault, and it should agree upon a specific distribution plan (e.g., web-based vs email distribution). Be mindful of any members who may have challenges with consistent internet access and plan for alternate methods of distribution, such as making copies available on portable drives or in print.

Build the capacity of agencies to implement the protocol.[339] A protocol's effectiveness depends on individual agencies having adequate resources (e.g., funding, personnel, multilanguage capacity, equipment, supervision, training, professional development opportunities, and community partnerships) to carry out their responsibilities and coordinate efforts with other involved responders. Agencies can assist one another in building individual and collective capacity to respond to sexual assault and participate in coordinated interventions. For example, together they can seek opportunities for technical assistance, training, and grants and share costs, personnel, equipment, expertise, and information. Also, each jurisdiction most likely will encounter a variety of barriers and difficulties in protocol implementation. Overcoming such problems requires a willingness on the part of involved agencies to individually and collaboratively understand the unique needs of victims in their community and to think creatively to identify solutions.

Promote training. Agency-specific and multidisciplinary trainings are crucial components of protocol implementation. Involved responders must be informed of any changes in how they carry out agency-specific responsibilities during the exam process and understand why these changes are needed. If they are being asked to coordinate their efforts formally with other agencies, they must understand their role in coordination, the benefits of a collaborative response, the challenges such an effort involves, and ways to overcome challenges.

Set up an evaluation system. How and what data hospitals and medical forensic examiner programs choose to keep may differ depending on a variety of factors, including the type of program and the scope of the services they provide. The planning team should work with the clinical programs in the jurisdiction to identify how they can obtain data from the programs (while maintaining victims' anonymity) to evaluate effectiveness of the system response and make improvements to the protocol as needed.

Revise the protocol periodically. Revisions may be based on feedback from responders and victims, evaluation recommendations, changes in laws, identification of new crime trends and prevention efforts, technology, research, and identification of new promising practices. The planning team should keep track of protocol areas needing improvement and meet periodically to discuss pertinent issues such as language to be used, how to resolve controversies, and, ultimately, to make needed change.

[339] Section drawn from K. Littel, M. Malefyt, and A. Walker, *Promising Practices: Improving the Criminal Justice System's Response to Violence Against Women*, 1998, page 241. https://www.ojp.gov/pdffiles1/pr/172217.pdf

Appendix B. Anatomical Inventory

Breasts

o Present
o Absent

- ☐ Chest reconstruction
- ☐ Bilateral mastectomy
- ☐ Unilateral mastectomy, R
- ☐ Unilateral mastectomy, L
- ☐ Breast augmentation/implants

Uterus

o Present
o Absent

- ☐ Hysterectomy-cervix removed
- ☐ Hysterectomy-cervix remains

Ovaries

o Present
o Absent

- ☐ Bilateral salpingo-oophorectomy
- ☐ Unilateral salpingo-oophorectomy, R
- ☐ Unilateral salpingo-oophorectomy, L

Vagina

o Present
o Absent

- ☐ Colpocleisis-closure of the vagina
- ☐ Vaginoplasty

Cervix

o Present
o Absent

Penis

o Present
o Absent

- ☐ Phalloplasty/penile implant
- ☐ Metoidioplasty
- ☐ Erectile device
- ☐ Penectomy

Testes

o Present
o Absent

- ☐ Testicular implant(s)
- ☐ Bilateral orchiectomy
- ☐ Unilateral orchiectomy, R
- ☐ Unilateral orchiectomy, L

Urethra

o Present
o Absent

- ☐ Urethral lengthening

Prostate

o Present
o Absent

- ☐ Prostatectomy

(adapted from Grasso et al., 2021)

This appendix is from the U.S. Department of Justice, Office on Violence Against Women, National Protocol for Intimate Partner Violence Medical Forensic Examinations (May 2023) https://www.justice.gov/d9/2023-12/IPVMFEProtocol.pdf

Appendix C. Sample Photograph Log

Patient Name: _____
Patient MRN:_____
DOB: _____ DOS:_____

Photo/JPEG #	Photograph Description (e.g., injury description, measurement)

This appendix is from the U.S. Department of Justice, Office on Violence Against Women, National Protocol for Intimate Partner Violence Medical Forensic Examinations (May 2023) https://www.justice.gov/d9/2023-12/IPVMFEProtocol.pdf

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