

# MARYLAND VAWA FORENSIC COMPLIANCE GUIDELINES

Endorsed by:



MARYLAND ATTORNEY GENERAL  
Douglas F. Gansler

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## Background

The 2005 reauthorization of the Violence Against Women Act (VAWA) contains new requirements effecting the provision of sexual assault forensic exams. All States must be able to certify that they are in compliance with the new statutory requirements within VAWA or they could jeopardize State eligibility for VAWA STOP funding<sup>1</sup>.

*“Nothing in this section shall be construed to permit a State, Indian tribal government, or territorial government **to require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursement for charges incurred on account of such an exam, or both.**”*

**42 USCA S. 3796gg-4 (d) (1)**

Although the VAWA 2005 reauthorization mandates that States certify that they meet the forensic requirements, it does not articulate to States the method of compliance. As a result, the Governor’s Office of Crime Control and Prevention (GOCCP) in close partnership with the Maryland Coalition Against Sexual Assault (MCASA) convened a statewide workgroup and hosted a series of stakeholder meetings comprised of law enforcement professionals, prosecutors, victim advocates and forensic nurse examiners<sup>2</sup> in order to develop statewide recommendations regarding the local jurisdictional implementation of VAWA compliance forensic exam policies and protocols in Maryland. Compliance is not difficult and this guide has been developed to walk stakeholders through the process thereby ensuring our collective success.

Agencies represented in the statewide workgroup included:

- The Governor’s Office of Crime Control and Prevention
- The Maryland Chiefs of Police Association
- The Maryland Coalition Against Sexual Assault
- The Maryland Police and Correctional Training Commission
- The Maryland State’s Attorney Association
- The Maryland Sheriffs’ Association
- The Office of the Attorney General

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<sup>1</sup> Currently Maryland receives a little over 2 million dollars annually to support law enforcement, prosecution, court, and victim services related to violence against women.

<sup>2</sup> MCASA as a statewide coalition represents victim advocate and forensic nurse constituencies.

Maryland must be compliant with the above mandate by **January 5, 2009**. This required certification of compliance applies to the entire state – not just VAWA STOP fund grantees.

## **Recommended Model Policy**

The following is a suggested framework for a sexual assault response protocol compliant with the 2005 reauthorization of the Violence Against Women Act (VAWA). It is recommended that local Sexual Assault Response Teams (SARTs) examine their current protocols, the guidelines below, and sample protocols from VAWA compliant states (included in the resource section of this guide) to develop their own approach to compliance. Jurisdictions that do not have active SARTs are encouraged to develop or reestablish a local sexual assault response team as this forum is the best way to ensure a multidisciplinary, victim-centered approach to forensic compliance. (For more information on how SARTs function or how your jurisdiction could establish a SART, contact the Maryland Coalition Against Sexual Assault (MCASA)<sup>3</sup>.

### **I. Presenting Options**

A. When a patient presents at a Sexual Assault Forensic Exam (SAFE) hospital<sup>4</sup> as a victim of a sex crime, an advocate or designated hospital staff member<sup>5</sup> shall present the victim with the following options:

- Report to police and receive a forensic exam;
- Receive a forensic exam as an anonymous report; or
- Receive medical treatment only

B. If victim selects the anonymous report option the victim/patient shall be fully informed of the following:

1. The benefits (e.g., time to weigh options before participating in the criminal justice system) and drawbacks (e.g., challenges for investigation and prosecution) of anonymous reporting<sup>6</sup>;
2. The length of time for which evidence will be stored; and
3. If the victim decides to report, who to contact and how.

C. The advocate or designated hospital staff member shall have the victim/patient sign a written consent form that outlines that all options have been presented to them including the benefits and drawbacks of the anonymous collection of forensic evidence. One copy should be given to the victim and one

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<sup>3</sup> [www.mcasa.org](http://www.mcasa.org); 1517 Ritchie Hwy., Suite 207, Arnold, MD 21012; 410-974-4507

<sup>4</sup> SAFE hospital: any hospital that offers a specific Sexual Assault Forensic Exam program. A statewide list of SAFE programs can be found at <http://www.mcasa.org/C/2/a/C2a.htm>

<sup>5</sup> Each local jurisdiction shall designate a hospital staff member (e.g., forensic nurse, triage nurse, call nurse, hospital social worker, etc.) to present victims with options upon presentation to the hospital.

<sup>6</sup> See FAQs on page 12 for an expanded discussion of benefits and drawbacks.

copy retained by the SAFE program. Note: If an additional copy is included with the SAFE kit, it should be sealed inside the evidence envelope to protect the identity of the victim until and unless s/he decides to report.

## **II. Conducting the Forensic Exam**

- A. It is recommended that all Sexual Assault Forensic Exams be conducted in accordance with the U.S. Department of Justice National Protocol for Sexual Assault Medical Forensic Examinations regardless of a patient/victim's decision to immediately report the crime to law enforcement.
- B. For forensic exams linked with a traditional report that includes immediate involvement with law enforcement, existing protocols shall be followed.
- C. For forensic exams linked with an anonymous report, the hospital shall collect forensic evidence and maintain records in a manner that protects the identity of the victim.
1. A tracking system to link the patient's identity, patient/medical record number and the SAFE kit should the patient/victim decide to report to law enforcement at a later date shall be established
  2. The name of the victim/patient shall not be recorded on the outside of the SAFE kit.
- D. The Forensic Nurse Examiner (FNE), advocate or other designated hospital staff member, shall provide the following information to the patient/victim:
1. The anonymous report SAFE kit tracking number
  2. Date of the exam
  3. Name and contact information of law enforcement agency holding the evidence
  4. Name and contact information of the SAFE program where the kit was collected
  5. Name and contact information of local rape crisis and recovery center
  6. Length of time evidence will be stored without a traditional report to law enforcement
  7. Information regarding how to proceed should victim decide to report offence to law enforcement

## **III. Storage and Transportation of Anonymous SAFE kits and Other Evidence**

- A. After a sexual assault forensic exam has been completed, the FNE shall contact the designated law enforcement agency or specific unit within that

agency to notify police that an anonymous SAFE kit is ready to be picked up for storage.

B. SAFE hospitals shall maintain chain of custody in accordance with other evidentiary procedures until SAFE kit and other evidence are turned over to the designated law enforcement agency.

C. Should the SAFE kit not be able to be immediately retrieved by law enforcement, the SAFE hospital shall maintain the kit and other evidence temporarily in a secure, locked storage area. Hospitals, SAFE programs, emergency departments or other medical facilities shall not hold completed SAFE kits and other evidence for long-term storage.

D. Law enforcement shall provide a receipt for any evidence collected which shall indicate the date, time and manner of pick-up.

E. Law Enforcement shall pick-up, transport and store SAFE kits and other evidence according to departmental procedures.

1. A tracking system to link the SAFE kit and the police case number should the patient/victim decide to report to law enforcement at a later date shall be established.
2. Methods such as anonymous report, citizen contact, suspicious incident, etc. can be utilized to generate a case number.

F. One law enforcement agency within the jurisdiction served by the SAFE hospital shall be the primary responder and responsible for long-term storage of the evidence. Evidence in anonymous SAFE cases shall be stored for a minimum of 90 days; as a best practice store evidence for one year or longer.

#### **IV. Disposition of Evidence in Anonymous Report Cases**

A. Prior to the end of the evidence holding period, a designated agency (e.g. SAFE program or rape recovery program) may contact the victim – only if victim gave permission at the time of the SAFE exam – to remind the victim of her/his option to report before evidence is destroyed.

B. If no further action is taken by victim after the evidence holding period has expired and/or the kit is not connected to another open case<sup>7</sup>, the law enforcement agency shall address the final disposition of the evidence according to standard departmental procedures.

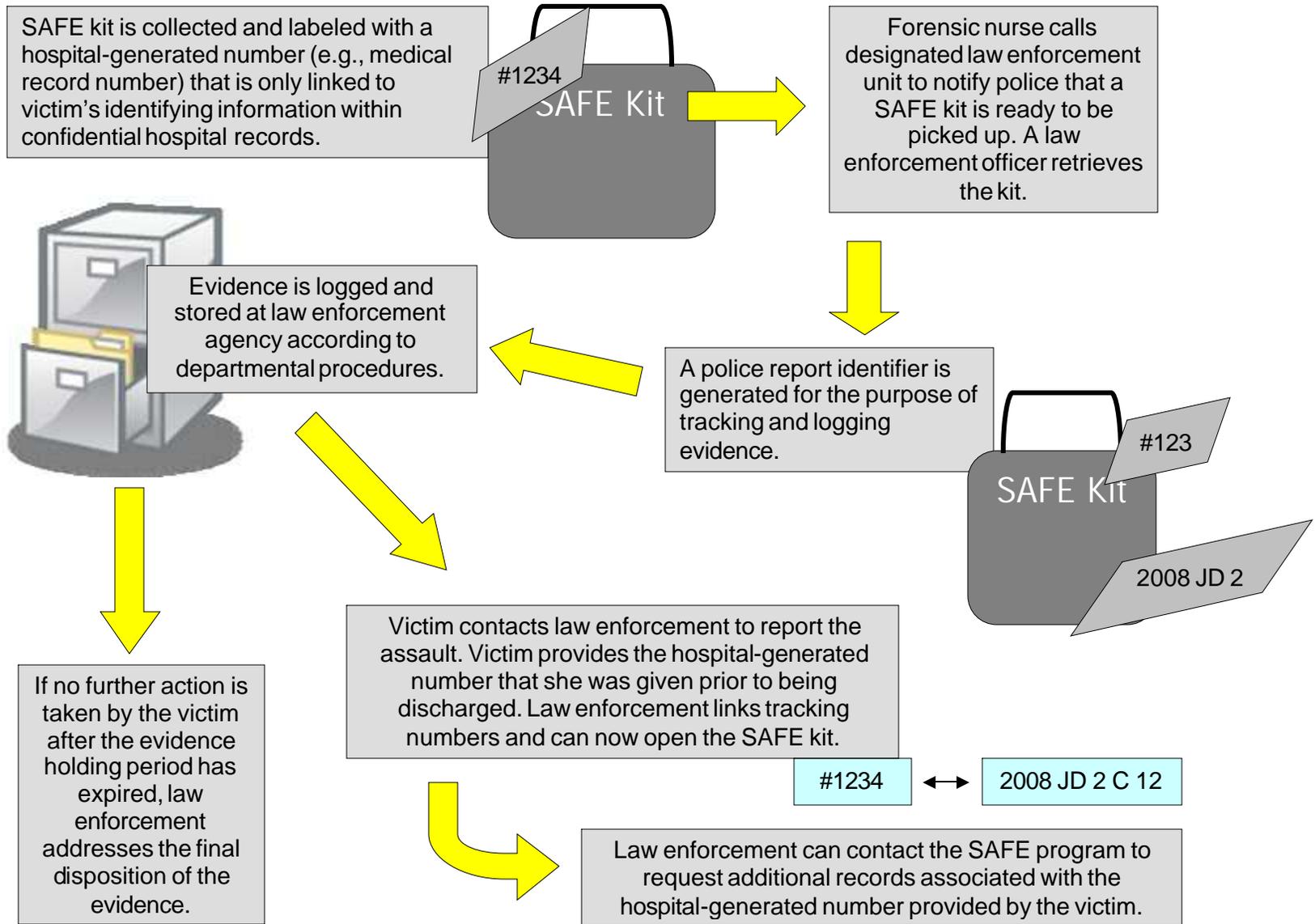
C. Should a victim contact police to file a traditional report prior to the end of the evidence holding period, the evidence may be reclassified as a rape, sexual

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<sup>7</sup> Criteria of kit being connected to another open case only applies to those jurisdictions that opted to process the DNA in all SAFE kits regardless of a victim's decision to immediately report the crime to law enforcement.

assault, etc. and an investigation shall begin according to standard departmental procedures.

# Flowchart



## **Special Considerations for Sexual Assault response Team (SART) Members**

It is recommended that the local SART in each Maryland jurisdiction use these guidelines as the basis for their own local policies and procedures for providing forensic exams to sexual assault victims who chose not to immediately involve law enforcement. It will require all responders and agencies working collaboratively to carry out the exams and preserve the evidence in the most effective way balancing the goals of justice, community safety and victim support.

If the local jurisdiction does not already have a SART, implementing policies and procedures to provide forensic exams for all victims whether or not they immediately report to law enforcement is an important reason to establish a SART. A SART is a multidisciplinary team that works collaboratively to provide specialized services for victims of rape and sexual assault, while encouraging victim participation in the criminal justice system and improving safety for the general public. At a minimum the SART should include the Sexual Assault Forensic Examiner (SAFE) or medical care provider, a rape crisis advocate, a law enforcement officer, and a prosecutor. Other members may include domestic violence victim advocates, state crime laboratory personnel, clergy, and social services staff<sup>8</sup>.

As local jurisdictions in Maryland work towards compliance with VAWA 2005, each first responder – SAFE programs, rape crisis centers, and law enforcement agencies – should consider how their role will change under new policies and procedures.

For more information on the SART concept, how your jurisdiction could establish a SART, or assistance in implementing a forensic compliant protocol, contact the Maryland Coalition Against Sexual Assault (MCASA)<sup>9</sup>.

### **FORENSIC NURSE**

Local jurisdictions must decide who will be responsible for presenting options to the sexual assault victim/patient. In some jurisdictions, this may be the advocate while in others it may be the forensic nurse or other hospital employee. The forensic nurse should work closely with the SART to ensure a seamless process for moving the victim from initial presentation at the hospital through the forensic exam, regardless of who discusses options with the victim. Some questions for the forensic nurse to consider:

- With the availability of anonymous reporting, SAFE programs are advised to expect a 10 to 30 percent increase in the number of SAFE exams they will be performing. How will the program respond to this increase? If the

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<sup>8</sup> Ledray, Linda E. (1999) "Sexual Assault: Clinical Issues: Date rape drug alert." Journal of Emergency Nursing. Volume 17, Number 1, pp. 1-2

<sup>9</sup> www.mcasa.org; 1517 Ritchie Hwy., Suite 207, Arnold, MD 21012; 410-974-4507

SAFE program is experiencing a shortage of forensic nurses, what recruitment and retention strategies will be used to ensure that an adequate number of forensic nurses are available?

- What new documents (e.g., consent forms, waivers) will the SAFE program need to incorporate into its paperwork? How can other SART members contribute to the process of developing these documents? Which other hospital staff must review these documents before they can be used?
- Will the hospital's process for dispatching the forensic nurse change under new policies and procedures? If so, how?
- How will anonymous kits be identified and tracked by the hospital? For example, will the hospital label the kit with a medical record number that law enforcement can then associate with a property held number?
- How will the FNE notify law enforcement that an anonymous SAFE kit is ready to be picked up? The SAFE Coordinator should find out who the appropriate point of contact is at the law enforcement agency.
- What are the training implications for hospital staff outside the SAFE program? SAFE Coordinators may consider providing training for all ER staff on the anonymous reporting option and its impact on policies and procedures.
- Since victims may present to non-SAFE hospitals, how will the SAFE program in conjunction with the SART reach out to non-SAFE hospitals to apprise them of the new changes?

#### **ADVOCATES AND RAPE CRISIS CENTER STAFF**

- How will the new forensic compliance requirements impact the SART response protocol? Will the advocate now be called in earlier in the SART response process? Will the advocate be responsible for presenting the options to the sexual assault victim/patient?
- Training curricula for staff and volunteers will need to be updated to reflect the anonymous reporting option. Regardless of whether or not the advocate is the person designated to present options to the victim, advocates (both hospital and hotline) should be familiar with anonymous reporting, including the benefits and drawbacks to choosing this option.
- If the rape crisis center plans to contact victims who have anonymously reported to check in and let the victim know that the evidence holding period is going to expire, how will this be done? Will this process be any different from the standard way in which advocates follow up with victims after a SAFE exam?
- The new forensic compliance requirements may demand that other professionals outside of the SART will need training on the new response

system. For example, the rape crisis center may add information regarding anonymous reporting to their community presentations or collaborate with the SAFE program to provide training for ER staff. How will standard education and training programs change as a result of increased options for victim/survivors?

## **LAW ENFORCEMENT**

- How long will law enforcement hold evidence from anonymously reported sexual assaults? Throughout the nation, the average holding time is about one year.
- How should the forensic nurse notify law enforcement that an anonymous SAFE kit is ready to be picked up? What will be the process for retrieving these kits?
- What is the most efficient way to track anonymous SAFE kits? Will anonymous SAFE kits be given a unique police identifier that can be linked up with a hospital generated number? If so, what will that number be?
- If and when the victim decides to report, who at the law enforcement agency should s/he contact?
- When the evidence holding period expires, what will be done with the evidence contained in anonymous SAFE kits?
- What are some implications for police training that come with the new forensic compliance requirements? How will the department address these new training needs?
- Does the law enforcement agency expect the forensic nurse to collect any information about the assault above and beyond what is documented in the medical forensic history? Some SARTs have created a brief form to collect anonymous demographic information (e.g., time and location of assault) that may substitute for a police report, while other SARTs agree that completing this type of report is outside the scope of practice for the forensic nurse.
- Are there multiple law enforcement agencies within your jurisdiction that investigate sexual assault? If so, how will these agencies work together to ensure that anonymously reported sexual assaults are handled in a consistent manner? It is recommended that in jurisdictions where there are multiple law enforcement agencies, that there be one designated agency to respond to all anonymously reported sexual assaults.

## **PROSECUTION**

The new forensic compliance requirements under VAWA 2005 will directly impact the roles of first responders to sexual assault, typically including the forensic

nurse, the advocate, and law enforcement. Prosecutors are rarely involved in the initial process of moving a victim from presentation at the hospital through the SAFE exam. However, prosecutors can provide valuable input into the process of becoming compliant, as they can identify evidentiary issues that may arise under the new policies and procedures. It is recommended that prosecutors work closely with their SART to ensure that the anonymous report storage and tracking systems developed will stand up in court. Once compliant protocols are operational, prosecutors may be best positioned to audit the entire process from start to finish – working to oversee quality control measures.

## Maryland Frequently Asked Questions

### 1. What is the value of forensic compliance to the criminal justice system?

Rape and sexual assault remain the most under-reported crimes in our nation<sup>10</sup>, with only 36% of rapes being reported to police<sup>11</sup>. Forensic compliance encourages reporting by allowing traumatized victims to have the time they need to decide how they want to proceed while simultaneously preserving critical forensic evidence. Universal victim access to a forensic exam will provide law enforcement with more information regarding the prevalence of sex crimes as well as patterns of crime that otherwise would never be known. For those jurisdictions that choose to process all SAFE kits, anonymous cases could also provide a cold hit. In all anonymous report cases, victims receive care and resources that they may not otherwise receive.

### 2. What are the drawbacks to forensic compliance?

Victims who chose to get a forensic exam without immediately reporting to police may have the possibility of successful prosecution of their case severely compromised. Without immediate police involvement, the crime scene may be lost, corroborating witness statements may be missed, other people may become the victim of the same perpetrator, and the victim's credibility may be increasingly questioned. However, as limited as an anonymous report may be, the theory is that limited information is better than no report at all.

### 3. How will VAWA 2005 impact the volume of SAFE kits collected?

There is very little data available to indicate the effect that VAWA compliance will have on the number of SAFE kits collected. Furthermore, the few studies of this issue have been isolated to unique populations—specifically military and college campuses—so the results may not be able to be generalized to the public. However, local SARTs should expect and prepare for as little as a 10 percent increase and as much as 30 percent increase in the number of SAFE kits collected.

### 4. How should evidence be transported, tracked, and stored?

VAWA does not specify how evidence should be transported, tracked, and stored. Different states and jurisdictions have various ways of handling evidence from anonymously reported cases. ***However, it is recommended that law***

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<sup>10</sup> CDC Injury Center. Sexual Violence: Fact Sheet (2007), citing data from the National Violence Against Women Survey and National Crime Victimization Survey.

<sup>11</sup> U.S. Department of Justice, Bureau of Justice Statistics. (2002) Forcible Rape. Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000. Washington, D.C.: U.S. Department of Justice. 2002.

**enforcement transport and store anonymous kits. Hospitals are NOT recommended for long-term storage.**

In some places, the hospital assigns a SAFE kit identification number, which is linked only to the patient/medical record. When the kit is picked up by law enforcement, a police tracking number may also be assigned for evidence storage purposes. If and when the victim reports, the police tracking number, kit ID number, and patient/medical record number are linked and law enforcement may open the kit and access the victim's files.

Some jurisdictions in Maryland are planning to issue an evidence tracking number—a police report number generated for the sole purpose of tracking and logging evidence (i.e. jane doe report, citizen contact, suspicious incident)—to attach to anonymously reported kits. If and when the victim reports, evidence will be reclassified as a rape, sexual assault, etc.

Local SARTs should collaboratively develop a process for tracking and storing anonymous SAFE kits.

#### **5. How long should evidence in anonymous cases be stored?**

VAWA does not specify how long evidence should be stored. **However, jurisdictions in Maryland are advised to hold evidence for no less than 90 days.** Across the nation, the average storage time is about one year. It is recommended that victims be given an ample amount of time to begin their recovery and weigh their options, yet some jurisdictions struggle with limited storage space for evidence. Therefore, local law enforcement must determine an appropriate length of time for evidence storage. It is recommended that this decision be made collaboratively with the SART.

When a victim elects for anonymous reporting, s/he should be told how long s/he has to report and to whom s/he should report, if s/he decides to do so. Furthermore, victims should be informed of the benefits (e.g., time to weigh options before participating in the criminal justice system) and drawbacks (e.g., challenges for investigation and prosecution) of anonymous reporting.

Local law enforcement agencies should determine what is done with evidence after the evidence holding period is over.

#### **6. Should the victim's clothes still be collected as part of the SAFE exam for an anonymous report?**

Yes. The SAFE kit should not be conducted any differently for an anonymously reported sexual assault. Medical forensic history should be taken at the beginning of the exam, and any clothing that may contain forensic evidence should be collected.

In designating storage space for anonymous kits, the local law enforcement agency should bear in mind that anonymous kits may also include the victim's clothing.

### **7. What additional information should the forensic nurse collect from the victims in anonymous report cases?**

VAWA does not require that the forensic nurse collect additional information about the assault outside of that information that is gathered for the forensic medical history.

However, in some jurisdictions, the forensic nurse may complete a short anonymous report to serve as a substitute for a police report. This report may include some demographic information about the victim, the perpetrator, and the assault (e.g., general location of assault, description of the perpetrator, and description of the victim).

Local SARTs should work together to determine if this component should be included in their anonymous reporting protocols. Alternatively, some SARTs have concluded that completing this type of report is outside the scope of practice for the forensic nurse. An effective SART approach will ensure that such a report, if collected, is used in a victim-friendly manner and is valuable to law enforcement.

### **8. Can law enforcement process evidence from anonymously reported sexual assaults/Jane Doe kits?**

Compliance with VAWA 2005 hinges on a victim's access to forensic evidence collection, meaning that law enforcement can no longer be the gatekeeper of the SAFE exam and victims cannot be required to cooperate with law enforcement in order to receive a SAFE exam. The question of whether or not to process evidence from anonymously reported cases is not related to compliance with VAWA 2005.

Jurisdictions may decide for themselves whether or not they want to process anonymous kits. However, processing evidence without the knowledge or consent of the victim raises a number of concerns. Therefore, it is recommended that jurisdictions that desire to process anonymous SAFE kits should make that protocol explicitly clear in the initial release form that the victim signs at the hospital when consenting to a forensic exam. Furthermore it should be made explicitly clear that if a victim wishes to be notified by law enforcement should a cold hit be made from the DNA evidence in the kit, that they will lose their anonymity. Those jurisdictions in which evidence is backlogged should consider whether it is practical to process anonymous SAFE kits.

**9. Will local jurisdictions report to the state the number of anonymous SAFE kits collected? Will these cases be reflected in UCR?**

There is currently no statewide mechanism for tracking the number of anonymous SAFE kits collected. However, SAFE programs and law enforcement agencies are encouraged to keep track of how many anonymous sexual assault reports are made. ***Law enforcement agencies are not required to include anonymously reported sexual assaults kits in their statistics that are given to UCR.***

**10. Who should inform the victim of her/his options? How should the anonymous reporting option be presented to the victim?**

Compliant states and local jurisdictions have various processes by which the victim is informed of her/his options. Most commonly, either the forensic nurse or the advocate discusses options with the victim.

In many cases, anonymous or delayed reporting is presented only when the victim has already declined to report to police, or if she has opted for medical treatment only. Since many victims may have already made up their mind to report at the time of the SAFE exam, presenting a third and more complicated option prematurely may only serve to confuse the victim.

Victims should be fully informed of the terms of anonymous reporting, including the potential benefits and drawbacks. In some states, victims sign both a consent form to permit collection of forensic evidence and a waiver to acknowledge their decision to delay reporting to police.

**11. Does the role of the advocate change when the victim is reporting anonymously?**

Not necessarily. The advocate should still be dispatched as early as possible in the process, and the responsibilities of the advocate before, during, and after the SAFE exam should continue to be carried out according to best practices.

The advocate may be the ideal responder for discussing reporting options with the victim, as triage nurses or other medical personnel may not be specially trained to work with sexual assault victims and have very limited time to spend with patients.

If SART members decide that an advocate should present options to the victim, the SART should work collaboratively to ensure that advocates are trained on each element of the SART response. This will enable advocates to provide victims with complete and accurate information on each reporting option.

**12. Should the victim be contacted before the end of the evidence holding period?**

Unless law enforcement intends to store the evidence forever, it is advisable to notify the victim before the evidence holding period expires. The SAFE program or rape recovery program may consider following up with victims by telephone shortly before the evidence holding period expires.

The SART is the ideal forum for determining a process for following up and reminding the victim of her/his options.

**13. Does the VAWA 2005 forensic certification requirement pertain to men and children?**

This statute does apply to men and to teens ages 13 and up. No adolescent or adult sexual assault patient—male or female—shall be required to participate in the criminal justice system or cooperate with police in order to receive a forensic medical exam.

While VAWA is specifically focused on violence against women, the anti-discrimination provision of the Omnibus Crime Control and Safe Streets Act of 1968 prohibits STOP-funded programs from barring any person from receiving grant-funded services on the basis of that person's sex.

VAWA does not currently define "youth" or "teen." However, the Department of Justice (DOJ) has been interpreting "teen" to be an individual who is between 13 to 17 years of age. Furthermore, since a patient is medically treated as an adult at age 13, it is implied that the new forensic certification requirement applies to patient-victims ages 13 and up.

**14. Doesn't anonymous reporting conflict with Maryland's mandatory reporting laws for child sexual abuse?**

No. All types of State mandatory reports to law enforcement and/or government agencies such as Child Protective Services or Adult Protective Services supersede the federal law. However, Maryland law very specifically defines child "sexual abuse" as "any act that involves sexual molestation or exploitation of a child by a parent or other person who has had permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member<sup>12</sup>. If a perpetrator does not have the "care and custody" relationship with the victim, then it does not meet the criteria of a mandated report and that minor victim should still be able to receive an anonymous exam should they so choose. Anyone that does not fall into a mandated report category should have the option for an anonymous forensic exam. For a more detailed discussion, see *Overview of Maryland Law Regarding Mandatory Reporting of Sexual*

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<sup>12</sup> Fam.L.Art §5-701(u)(1); see also, § 5-701(b).

*Assault/Abuse: A Guide for Medical Professionals* included in the resource section of this guide.

**15. Will SAFE kits from victims who anonymously report be reimbursed?**

Yes. The Maryland Department of Health and Mental Hygiene (DHMH) is currently revising the Code of Maryland Regulations (COMAR) to comply with VAWA 2005 requirements. Instead of exclusively accepting a police report number as a requirement for reimbursing the SAFE kit, DHMH will begin accepting an alternative identification number.

## Resources

### Helpful Links

#### ***Maryland State STOP Grant Administrating Agency***

Governor's Office of Crime Control and Prevention  
300 East Joppa Road, Suite 1105  
Baltimore, Maryland 21286  
[www.goccp.org](http://www.goccp.org)

Kristen Mahoney, Executive Director  
[Kmahoney@goccp-state-md.org](mailto:Kmahoney@goccp-state-md.org)  
410-821-2828

Justice Schisler, STOP VAWA Program Manager  
[Justice@goccp-state-md.org](mailto:Justice@goccp-state-md.org)  
410-821-2850

#### ***Maryland State Sexual Assault Coalition***

Maryland Coalition Against Sexual Assault (MCASA)  
Jennifer Pollitt Hill, Executive Director  
1517 Gov. Ritchie Highway, Suite 207  
Arnold, Maryland 21012  
[jphill@mcasa.org](mailto:jphill@mcasa.org)  
410-974-4507  
[www.mcasa.org](http://www.mcasa.org)

#### ***Office on Violence Against Women***

##### ***Frequently Asked Questions: Anonymous Reporting and Forensic Examinations***

<http://www.ovw.usdoj.gov/docs/faq-arfe052308.pdf>

##### ***Violence Against Women Act (VAWA) 2005 Reauthorization Forensic Compliance Mandates - Brief Overview***

[http://www.mcasa.org/pdfs/VAWA\\_Fact\\_sheet.doc](http://www.mcasa.org/pdfs/VAWA_Fact_sheet.doc)



## Overview of Maryland Law Regarding Mandatory Reporting of Sexual Assault/Abuse

### *A Guide for Medical Professionals*

#### ***INTRODUCTION***

The Maryland Coalition Against Sexual Assault is the statewide coalition of the State's rape crisis centers, law enforcement, mental health and health care providers, attorneys, educators, survivors of sexual violence and other concerned individuals. MCASA provides, among other things, education and technical assistance to health care providers, including forensic nurse examiners, also called sexual assault nurse examiners (SANEs) or sexual assault forensic examiners (SAFEs). This document addresses the laws regarding mandatory reporting requirements for forensic nurse examiners working with victims of sexual assault and sexual abuse.

Maryland has no general requirement for citizens (including health care providers) to report all sexual assaults or sexual abuse of adults. However, "sexual abuse" of children and certain categories of adults must be reported. This memorandum discusses when sexual abuse must be reported to law enforcement and the Department of Social Services. As always, MCASA member agencies and others should consult with their own attorneys regarding individual cases.

#### **BRIEF SUMMARY**

##### **A. Adult Victims of Sexual Assault**

- 1) Are health care providers, including forensic nurse examiners, ***required/mandated*** to report rape or other sexual offenses to law enforcement or other government agencies when the victim is an adult?

**NO**, with several important exceptions.

Sexual assaults committed against any of the following individuals are ***required*** to be reported (legal citations are listed in footnotes):

- a) Adults who fall under the legal definition of "vulnerable adult," meaning an adult who lacks the capacity to care for her or his daily

needs, [for instance, persons with serious mental retardation or dementia];<sup>13</sup>

- b) Adults with mental illness who by reason of their mental or physical condition are unable to authorize disclosure and have no legal guardian or legal representative to authorize disclosure for them or who are under guardianship of the State;<sup>14</sup>
- c) Adults who are developmentally disabled;<sup>15</sup>
- d) Residents of nursing homes and similar institutions (including some small private homes where unrelated adults are cared for);<sup>16</sup> and/or
- e) Residents of homes for emotionally disturbed children or adolescents.<sup>17</sup>
- f) Injuries caused in certain ways also must be reported. These are generally unrelated to sexual offenses, but could occur simultaneously with a sexual assault. They are (in all counties): gunshot wounds;<sup>18</sup> certain burn injuries; and injury by moving vessel [boat].<sup>19</sup> Additionally, injuries by automobile or lethal weapon, or by the individual in charge of the treating hospital, must be reported if they occurred in certain counties.<sup>20</sup> The counties<sup>21</sup> are:
  - Allegany
  - Anne Arundel
  - Charles
  - Kent
  - Montgomery
  - Prince George's
  - Somerset
  - Talbot
  - Wicomico

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<sup>13</sup> Family Law Art. §14-302(a)-(d)

<sup>14</sup> Health-Gen. §4-307(k)(ii)(1) regarding recipient of information and other requirements, see also Cts. & Judicial §5-609. Disclosure under this section is to the state protection and advocacy program, Maryland Disability Law Center, telephone 410-727-6352.

<sup>15</sup> Health-Gen. §7-1005(b)

<sup>16</sup> Health-Gen. §19-347(b)

<sup>17</sup> COMAR 10.07.04.05

<sup>18</sup> Health Gen. §20-703

<sup>19</sup> Health-Gen. 20-702

<sup>20</sup> Health-Gen. §20-701

<sup>21</sup> Please note that the list of counties required to report injuries caused in certain ways such as gunshot wounds; certain burn injuries; and injury by moving vessel [boat] have recently expanded.

g) Sexual abuse of minors is discussed in detail below.

- 2) Are health care providers, including forensic nurse examiners, ***permitted/allowed*** to report rape or other sexual offenses to law enforcement or other government agencies when the victim is an adult, has not given permission to report, and does not fall under one of the exceptions listed above?

**NO**, confidentiality must be maintained.

### **B. Child Victims of Sexual Assault or Abuse**

- 1) Are health care providers, including forensic nurse examiners, ***required/mandated*** to report rape, other sexual offenses or sexual exploitation when the victim is a child and the ***perpetrator is a family member or other caretaker***?

**YES.** When the perpetrator is a family member or other caretaker, the rape, other sexual offenses, or sexual exploitation falls under the legal definition of child sexual abuse that must be reported. The State law defines child “sexual abuse” as “any act that involves sexual molestation or exploitation of a child by a parent or other person who has had permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member.”<sup>22</sup>

- 2) Are health care providers, including forensic nurse examiners, ***required/mandated*** to report rape or other sexual offenses when the victim is a child and the ***perpetrator is NOT a family member or other caretaker***?

**NO.** If the perpetrator is **NOT** a family member or other caretaker, then reporting is **NOT** required.

- 3) Are health care providers, including forensic nurse examiners, ***permitted/allowed*** to report rape or other sexual offenses when the victim is a child and the ***perpetrator is NOT a family member or other caretaker*** and informed consent ***has not*** been obtained?

**NO**, but they may report with informed consent.

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<sup>22</sup> Fam.L.Art §5-701(u)(1); see also, § 5-701(b).

- 4) Are health care providers, including forensic nurse examiners, **required/mandated** to report statutory rape?

**NO.** If the perpetrator is **NOT** a family member or other caretaker, then the crime does not fall under the mandatory reporting law.

- 5) Are health care providers, including forensic nurse examiners, **permitted/allowed** to report statutory rape if informed consent **has not** been obtained?

**NO.** Confidentiality must be maintained.

- 6) Are health care providers, including forensic nurse examiners, **permitted/allowed** to notify parents, guardians or caretakers of minor patients if informed consent from the minor **has not** been obtained?

**YES.** Health care providers, including forensic nurse examiners, are **allowed** to notify parents, guardians or caretakers, but are **not required** to notify them.<sup>23</sup>

## **IN-DEPTH DISCUSSION**

This section repeats the information above with more detailed discussion and legal authorities.

### **A. Adult Victims of Sexual Assault**

In 1989, the Maryland Attorney General examined the question of whether health care professionals may report that an adult patient had been raped or sexually assaulted over the patient's objections. Based on both law and ethics, the Attorney General issued an opinion that they may **NOT**.<sup>24</sup> There were however, several exceptions to this general principle. Certain statutes require health care professionals to breach confidentiality and report abuse, including sexual assault.<sup>25</sup>

Sexual assaults committed against any of the following individuals are **required** to be reported:

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<sup>23</sup> Medical personnel may NOT, however, notify parents, guardians or caretakers regarding a minor's abortion.

<sup>24</sup> 74 Op.Att'y Gen. 128 (1989).

<sup>25</sup> The term "sexual assault" is used generically to refer to all sex crimes, including rape, sexual offenses, etc.

- a) Adults who fall under the legal definition of “vulnerable adult,” meaning an adult who lacks the capacity to care for her or his daily needs, [for instance, persons with serious mental retardation or dementia];<sup>26</sup>
- b) Adults with mental illness who by reason of their mental or physical condition are unable to authorize disclosure and have no legal guardian or legal representative to authorize disclosure for them or who are under guardianship of the State;<sup>27</sup>
- c) Adults who are developmentally disabled;<sup>28</sup>
- d) Residents of nursing homes and similar institutions (including some small private homes where unrelated adults are cared for);<sup>29</sup> and/or
- e) Residents of homes for emotionally disturbed children or adolescents.<sup>30</sup>
- f) Injuries caused in certain ways also must be reported. These are generally unrelated to sexual offenses, but could occur simultaneously with a sexual assault. They are (in all counties): gunshot wounds;<sup>31</sup> certain burn injuries; and injury by moving vessel [boat].<sup>32</sup> Additionally, injuries by automobile or lethal weapon, or by the individual in charge of the treating hospital, must be reported if they occurred in certain counties.<sup>33</sup> The counties<sup>34</sup> are:
  - Allegeny
  - Anne Arundel
  - Charles
  - Kent
  - Montgomery
  - Prince George’s
  - Somerset
  - Talbot
  - Wicomico

<sup>26</sup> Family Law Art. §14-302(a)-(d)

<sup>27</sup> Health-Gen. §4-307(k)(ii)(1) regarding recipient of information and other requirements, see also Cts. & Judicial §5-609. Disclosure under this section is to the state protection and advocacy program, Maryland Disability Law Center, 410-727-6352.

<sup>28</sup> Health-Gen. §7-1005(b)

<sup>29</sup> Health-Gen. §19-347(b)

<sup>30</sup> COMAR 10.07.04.05

<sup>31</sup> Health Gen. §20-703

<sup>32</sup> Health-Gen. 20-702

<sup>33</sup> Health-Gen. §20-701

<sup>34</sup> Please note that the list of counties required to report injuries caused in certain ways such as gunshot wounds; certain burn injuries; and injury by moving vessel [boat] have recently expanded.

If an adult is sexually assaulted and does not fall under one of these exceptions, a health care provider **MAY NOT** breach confidentiality and report the assault without the patient's informed consent.

### ***Confidentiality & Privilege***

Communications between health care providers and their adult patients are generally *confidential*. The source of this principle is found in state and federal law and professional ethics. In Maryland, communications with certain health-care professionals are also *privileged*. This includes communications between patients/clients and psychiatrists and psychologists,<sup>35</sup> psychiatric-mental health nursing specialists,<sup>36</sup> and licensed social workers.<sup>37</sup> *Privilege* relates to whether a professional may testify about communications with a patient or client. *Confidentiality* prevents health care providers from sharing information out of court and is conceptually separate from privilege. However, the Court of Special Appeals has found that if a communication is legally privileged, it also must be held confidential and could only be revealed with the patient's permission.<sup>38</sup>

Maryland does not create a privilege for other professions. For example, there is no general privilege between doctors and patients<sup>39</sup>. However, doctors, nurses, and other health professionals work under ethical codes that prohibit disclosure of confidential health information, *see, e.g.*, the American Medical Association's Principles of Medical Ethics, "A physician shall respect the rights of patients, colleagues and of other health professionals and shall safeguard patient confidences and privacy within the constraints of the law;" American Nurses Association Code of Ethics, "The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature."

Complicating matters further, there are separate rules regarding medical *records*. A patient's medical records must be kept confidential and may not be disclosed unless otherwise provided in the law or at the patient's direction.<sup>40</sup> Some sexual assault evidence collection kits are not considered records. Regulations provide that if the Maryland State Police sexual assault kit is used to collect items of evidence, the evidence shall be submitted (and thereby disclosed) to the State Police Crime Laboratory.<sup>41</sup> Providers should consult with their own attorneys if a victim wishes to consent to the collection of evidence, but not to its submission to law enforcement.

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<sup>35</sup> Cts. & Jud. §9-109

<sup>36</sup> Cts. & Jud. §9-109.1

<sup>37</sup> Cts. & Jud. §9-121

<sup>38</sup> *Shaw v. Glickman*, 45 Md. App. 718, cert. denied 288 Md. 742 (1980)

<sup>39</sup> *Butler-Tulio v. Scroggins*, 139 Md. App. 122 (2001)

<sup>40</sup> Health-General §4-302(a)

<sup>41</sup> COMAR 10.12.02.03

### ***Confidentiality and HIPAA***

A recent federal law, the Health Insurance Portability Accountability Act<sup>42</sup> (HIPAA), has strengthened privacy protections for patients' health information. HIPAA applies only to "covered entities," namely health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a transaction covered

by what is known as the "Privacy Rule."<sup>43</sup> A full description of HIPAA and the Privacy Rule is beyond the scope of this memorandum. However, forensic nurse examiners typically work in hospitals and clinics. These types of health care providers would generally qualify as covered entities under the Privacy Rule, and MCASA may wish to provide education regarding HIPAA's privacy protections as applied to victims of sexual assault.

Under HIPAA, providers still must breach confidentiality and report sexual abuse where required by statute (see exceptions to confidentiality as listed (a)-(f) above), however, other breaches of confidentiality are ***prohibited unless the patient permits the disclosure***. Penalties for knowing disclosure of a patient's personally identifiable health information without permission are up to a \$50,000 fine, up to one year imprisonment, or both; if the offense is committed under false pretenses, the penalties increase to up to a \$100,000 fine, up to 5 years in prison, or both; and if the offense is committed with the intent to sell, transfer or use the information for commercial gain, personal gain, or malicious harm, the penalties are up to \$250,000 fine, up to 10 years in prison, or both.<sup>44</sup>

The U.S. Department of Health and Human Services (HHS) has provided further guidance regarding HIPAA's Privacy Rule and disclosure to law enforcement. Sexual assault was not specifically addressed, but domestic violence was. HHS noted that "under most circumstances, the Privacy Rule requires covered entities to obtain permission from persons who have been the victim of domestic violence or abuse before disclosing information about them to law enforcement."<sup>45</sup> Again, health care providers must obtain an adult victim's permission to disclose unless the circumstances fall under one of the statutory exceptions listed above (a)-(f).

There has been significant confusion regarding reporting domestic violence under HIPAA. HIPAA allows states with mandatory reporting of domestic violence to continue to mandate reporting. Maryland ***does NOT*** mandate reporting of domestic violence and HIPAA ***does NOT*** change this. Therefore, for example, when a wife presents at hospital and reports that she has been raped or otherwise assaulted by her husband, HIPAA ***does NOT*** require reporting. In Maryland, HIPAA requires the patient's permission before

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<sup>42</sup> P.L. 104-191, August 21, 1996

<sup>43</sup> For text of Privacy Rule, see <http://www.hhs.gov/ocr/hipaa/privrulet.txt>

<sup>44</sup> HIPAA, P.L. 104-191, §1177

<sup>45</sup> See, <http://www.hhs.gov/ocr/hipaa>, Questions and Answers, Answer ID 349, Disclosures for Law Enforcement Purposes.

disclosure may occur. Again, this may be an area for MCASA to provide education to hospitals and other health care providers covered by HIPAA.

## **B. Child Victims of Sexual Assault**

As discussed above, confidentiality is the general rule for health care providers working with victims of sexual assault. When the victim is a minor, however, there are complicated rules governing when confidentiality must be breached and the assault or abuse must be reported to law enforcement and the Department of Social Services.

### ***Mandated Reporter Law***

Health practitioners, including forensic nurse examiners, are ***required/mandated*** to report rape or other sexual offenses when the victim is a child and the ***perpetrator is a family member or other caretaker***. The Maryland Family Law Article requires each health practitioner [including a nurse], police officer, educator or human services worker, acting in a professional capacity, to report abuse or neglect of a child. This is generally referred to as the “mandated reporter” law.<sup>46</sup>

Nurses and other professionals covered under the mandated reporter law must orally report abuse to the local department of social services (DSS) or to the appropriate law enforcement agency if they have “reason to believe” the abuse occurred. Nurses who are acting as a staff member of certain institutions<sup>47</sup> must also report the abuse to the head of the agency. In addition to the oral report, the nurse or other professional must send a written report to DSS within 48 hours, with a copy to the local State’s Attorney.<sup>48</sup>

The types of child sexual abuse triggering the mandated reporting law are defined in several related sections of the Family Law Article. As an initial matter, a child is a person under 18 years old<sup>49</sup> and “sexual abuse of a child” must be reported “whether physical injuries are sustained or not.”<sup>50</sup> Sexual abuse is defined by Family Law as “any act that involves sexual molestation or exploitation of a child by a parent or other person who has had permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member.”<sup>51</sup> Also per this statute, sexual abuse includes incest, rape, sexual offenses in any degree, sodomy, and unnatural or perverted sexual practices.<sup>52</sup> Each of these crimes are defined by statute themselves. However, the language “sexual molestation or exploitation” suggests that “sexual abuse” also includes a broader set of sexual acts. Exploitation would include, for instance, using a child in

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<sup>46</sup> Fam.L.Art. § 5-704; Maryland also imposes a general reporting requirement on all persons to report suspected child abuse. Fam.L.Art. § 5-705

<sup>47</sup> These institutions are a hospital, public health agency, child care institution, juvenile detention center, school, or similar institution.

<sup>48</sup> Fam.L.Art. §5-704(b)

<sup>49</sup> Fam.L.Art. §5-701(d)

<sup>50</sup> Fam.L.Art. §5-701(b)(2)

<sup>51</sup> Fam.L.Art §5-701(u)(1)

<sup>52</sup> Fam.L.Art §5-701(u)(2)

pornography. Again, however, the acts must have been committed by a family member or other caretaker to trigger mandatory reporting.

Reportable child sexual abuse *does not* include abuse by someone other than “a parent or other person who has had permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member.” This does not mean reporting is forbidden, but it does mean *informed consent is required* before a report can be made.<sup>53</sup>

If a parent is acting as the personal representative of a minor child (for instance, when a mother brings her daughter to the hospital because of suspected child sexual abuse by a stranger), then the parent may consent to reporting to the police. However, there are three situations where a parent *would not* have the authority to consent to reporting:

- a. When the minor is the one who consents to care and the consent of the parent is not required under Maryland law (see further discussion, below);
- b. When the minor obtains care at the direction of a court or a person appointed by the court; and/or
- c. When the parent has agreed that the minor and health care provider may have a confidential relationship.

Regarding the first exception (i.e. when the minor has the authority to consent to treatment), the provisions of Maryland’s Minor Consent Act,<sup>54</sup> permit minors to consent to treatment for a variety of health issues, including venereal disease, pregnancy, contraception, rape and sexual offenses.<sup>55</sup> Minors receiving treatment pursuant to these laws would have to give permission themselves in order for a health care provider to report a sexual assault *if the perpetrator was NOT* “a parent or other person who has had permanent or temporary care or custody or responsibility for supervision of a child, or by any household or family member.” If the perpetrator *did* fall under that category (i.e., the

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<sup>53</sup> Informed consent is an established concept in medical ethics and requires that patients be provided with information about the risks and benefits of actions proposed by health care providers and information about alternatives to those actions. Patients must then be permitted to make their own choices about which actions to pursue. See, e.g., T. Beauchamp and J. Childress, “The Principle of Autonomy,” in Principles of Biomedical Ethics 63 (1979); generally, Medical Ethics: A Clinical Textbook and Reference for the Health Care Professions, (N. Abrams and M.D. Buckner, eds., 1983). Case law in Maryland has discussed the concept of informed consent for medical procedures as including a patient’s willing uncoerced acceptance [consent] after adequate disclosure of the nature of the intervention, its risks and benefits, as well as disclosure of alternatives with their risks and benefits. *Bankert by Bankert v. U.S.*, 937 F.Supp. 1169 (D.Md. 1996); see also, *Sard v. Hardy*, 281 Md. 432 (1977). See text, above, regarding when minors have the right to make their own choices.

<sup>54</sup> Health-General, §20-102

<sup>55</sup> A minor is a person under 18 years of age; there is no other age limit contained in the Minor Consent Act. Another law, Health-General §20-104, also allows minors age 16 and older to consent to treatment for mental or emotional disorders by a physician, psychologist, or clinic.

parent or other caretaker was the perpetrator), sexual abuse **must be** reported - even if the victim objects.

### ***Parental Notification***

The Minor Consent Act permits, but **does not require**, attending physicians, psychologists, and, upon their direction, their staff, to inform parents, step-parents, guardians, and custodians of information about treatment needed or consented to by the minor. (There is an exception: information about a minor's abortion may NOT be disclosed when the minor is legally permitted to consent to the procedure herself.)<sup>56</sup> HIPAA does not change this. Confidential information about a minor may still be disclosed to these caretakers, even over the minor's objections. **Disclosure is not required**, however. If disclosure to the parent/guardian is made, the parent/guardian may choose to report the crime – parents/guardians are not required to maintain confidentiality.

HIPAA also permits health care providers to refuse to treat a parent as a child's "personal representative" (i.e. the person who may receive information and consent on behalf of the minor)

if the provider reasonably believes that this could endanger the child. Providers confronted with this situation should consult with their attorney.

### ***Statutory Rape***

"Statutory Rape" is not a term used in Maryland's criminal law, but is a generic term for prohibitions on certain sexual acts based on a person's age. Maryland's criminal law has age-based sexual crimes; they are found in sections of the second degree rape law and second, third and fourth degree sexual offenses.<sup>57</sup> Each of these offenses include prohibition of certain sexual conduct with persons under age 16 even if the minor consented. The available penalties and what is prohibited vary with the age of both parties and the acts themselves.<sup>58</sup>

In any event, these "statutory" provisions are part of Maryland's criminal law and separate from the legal definition of "child sexual abuse" triggering mandatory reporting. A "statutory rape" or other age-based sexual offense, by itself, **does not** trigger the

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<sup>56</sup> Health-General, § 20-103

<sup>57</sup> It is a second degree rape or sexual offense to have sexual intercourse or commit a sexual act (oral or anal sex, or vaginal or anal penetration with an object) with a person under 14 if the person committing the act is at least 4 years older than the victim, Criminal Law Article §3-304, 3-305; a person is guilty of a sexual offense in the 3<sup>rd</sup> degree if the person engages in vaginal intercourse or a sexual act (oral or anal sex, or vaginal or anal penetration with an object) with another person who is 14 or 15 years old when the perpetrator is at least 21 years old, Criminal Law Article §3-307; 4<sup>th</sup> degree sexual offense involves vaginal intercourse between a 14 or 15 year old and a perpetrator who is four or more years older or a sexual act with a 14 or 15 year old, not covered by 3<sup>rd</sup> degree sexual offenses (generally this applies to 18-20 year old perpetrators), Criminal Law Article §3-308.

<sup>58</sup> *Id.* (see previous footnote).

mandatory reporting law. Instead, mandated reporters must look to the Family Law Article provisions discussed above, *i.e.*, was the offense committed by a parent or family member.<sup>59</sup> If so, it must be reported; if not, confidentiality must be maintained.

Prior to the passage of HIPAA, some professionals advised that all potential “statutory rape” cases should be reported to law enforcement. It was suggested that a nurse or other health care professional need not ask a patient the age and relationship of a perpetrator, and that it should be left to the State’s Attorneys’ offices to determine the age and relationship of the people involved. Without commenting on this position, this type of reporting now appears to be prohibited under HIPAA. HIPAA permits disclosure *only* where state law affirmatively requires it. Health care providers risk violating this law if they fail to inquire about the relationship between a minor and the person she or he is sexually involved with, and then uses this lack of information as the justification for breaching confidentiality and reporting. Penalties for violating HIPAA include fines and imprisonment and are discussed in more detail above.

Finally, it is useful to note that there would be serious detrimental effects for many minors if the law did require reporting of “statutory” offenses when the perpetrator is not a family or household member or “other person who has had permanent or temporary care or custody or responsibility for supervision of a child.”<sup>60</sup> If reporting is mandated, young women and men in sexual relationships with older persons would be discouraged from seeking counseling and reproductive health care. Additionally, this type of reporting would be unlikely to produce much benefit. These relationships are already prohibited by criminal law and, as discussed above, health care providers have the discretion to inform a minor’s parent or guardian regarding treatment. Balancing the risk of harm with potential benefits, violating minors’ confidential relationships with counselors and reproductive health care providers by extending the mandatory reporting law would do more harm than good. As a result, amendment of the law is not advised.

### ***Neglect***

In a limited number of cases, health care providers may be required to report a parent’s neglect if the parent fails to act appropriately in response to a sexual assault against a child. Health care providers, including forensic nurse examiners, are required to report child neglect to the Department of Social Services and, if acting as a staff member of certain institutions,<sup>61</sup> to the head of the institution.<sup>62</sup>

“Neglect” is defined as leaving a child unattended or “other failure to give proper care and attention to a child by a parent or other person who has had permanent or temporary

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<sup>59</sup> Fam.L.Art §5-701(u)(1)

<sup>60</sup> Fam.L.Art. §5-701(u)(1)

<sup>61</sup> These institutions are a hospital, public health agency, child care institution, juvenile detention center, school, or similar institution.

<sup>62</sup> Fam.L.Art. §5-704(a)(ii)

care or custody or responsibility for supervision of a child, under circumstances that indicate:

- (1) that the child's health or welfare is harmed or placed at substantial risk of harm; or
- (2) mental injury to the child or a substantial risk of mental injury.”<sup>63</sup>

Mental injury is “the observable, identifiable, and substantial impairment of a child's mental or psychological ability to function.”<sup>64</sup>

This is a high standard. Health professionals considering breaking confidentiality and reporting neglect because of a parent or caretaker's failure to respond to a child's sexual assault should discuss the facts with their own counsel.

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For more information regarding the contents of this memo, contact MCASA's Sexual Assault Legal Institute at 301-565-2277 or Toll-Free at 877-496-SALI.



Original – 7/2003  
Update – 9/2008

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<sup>63</sup> Fam.L.Art. §5-701(p)

<sup>64</sup> §5-701(o)

## Oregon Recommended Policy



Attorney General's  
Sexual Assault Task Force

### **HB 2154 Forensic Enhancement Bill OR Laws Chapters 789 SAVE Fund**

July 2007

#### **~Recommended Law Enforcement Policy~ For implementation of HB 2154**

*The Criminal Justice Committee of the Attorney General's Sexual Assault Task Force, comprised of law enforcement, prosecutors, an advocate, a survivor and representative s from the OSP Forensic Services Division and the Department of Public Safety Standards and Training, developed the following policy for law enforcement agencies to successfully comply with the passage of HB 2154.*

**HB 2154** was passed in order to eliminate the requirement for law enforcement authorization prior to collection of an Oregon State Police (OSP) Sexual Assault Forensic Evidence (SAFE) Kit and to protect the identity of victims who choose to have a SAFE Kit collected without making a report to law enforcement. Moreover, the passage of HB 2154 will put Oregon in compliance with Federal Violence Against Women funding requirements, thereby ensuring that Oregon continues to be eligible for monies granted to law enforcement agencies, prosecutors' offices, the courts and training programs.

#### **Law Enforcement Recommended Policy**

- I. Law enforcement agencies are responsible for maintaining chain of evidence for ALL SAFE Kits and associated evidence for victims of sexual assault collected by medical facilities.
- II. SAFE Kits should be retrieved within 2 hours of receiving a call from the medical facility.
- III. The law enforcement agency whose jurisdiction includes the medical facility where the SAFE Kit and other evidence were collected is the primary responder.
- IV. SAFE Kits, where the identity of the victim is unknown, will need to be assigned a case number and entered into evidence. Methods such as Jane Doe reporting, citizen contact, suspicious incident or sexual offense can be utilized for generating a case number.
- V. The SAFE Kit number should be used as a reference to ensure that victims who choose to report the assault are able to have their evidence readily retrieved using the numbers they were provided with by the medical facility.

Hardy Myers, Attorney General

93 Van Buren St. Eugene, Oregon 97402 Ph: (541) 284-TASK (8275) Fax: (541) 343-0316 Email: [taskforce@oregonsatf.org](mailto:taskforce@oregonsatf.org) Web: [www.oregonsatf.org](http://www.oregonsatf.org)

- VI. SAFE Kits and other evidence collected for victims whose identity is unknown should be maintained in the same manner as other SAFE Kits and evidence.
- a. SAFE Kits collected for victims whose identity is unknown should not be opened until or unless the victim reports the assault. Opening SAFE Kits will compromise the admissibility of evidence for the purpose of prosecution.
- VII. SAFE Kits where the identity of the victim is unknown must be kept by law enforcement for a period of at least six months (180 days).
- a. With the passage of HB 2153, the Statute of Limitations for Rape I and II, Sodomy I and II, Unlawful Sexual Penetration I and II and Sex Abuse I have been increased to 25 years when the DNA evidence of a suspect has been collected. Law enforcement agencies are therefore encouraged to maintain SAFE Kits and other evidence for 25 years.

SAFE Kits and other evidence are the property of the criminal justice system. Law enforcement is responsible for the retrieval and storage of ALL evidence, including SAFE Kits.

**HB 2154 - Forensic Enhancement Bill**  
**OR Laws Chapters 789 - SAVE Fund**

July 2007

**~Recommended Medical Facility Policy ~**  
For implementation of HB 2154

*The Medical Forensic Committee of the Attorney General's Sexual Assault Task Force, comprised of registered nurses, forensic specialists, Sexual Assault Nurse Examiners (SANEs), physicians, public health representatives and an advocate, developed the following policy for medical facilities to successfully comply with the passage of HB 2154.*

**HB 2154** was passed in order to eliminate the requirement for law enforcement authorization prior to collection of an Oregon State Police (OSP) Sexual Assault Forensic Evidence (SAFE) Kit and to protect the identity of victims who choose to have a SAFE Kit collected without making a report to law enforcement. Moreover, the passage of HB 2154 will put Oregon in compliance with Federal Violence Against Women funding requirements, thereby ensuring that Oregon continues to be eligible for monies granted to law enforcement agencies, prosecutors' offices, the courts and training programs.

**Medical Facility Recommended Policy**

- I. Medical facilities are required to offer victims of sexual assault a complete medical assessment (medical exam, SAFE Kit collection, STI prophylaxis and EC prophylaxis) to all victims who present within 84 hours post assault, regardless of whether they choose to report the assault to law enforcement. Law enforcement authorization for SAFE Kit collection is NOT required.
- II. Medical facilities shall collect SAFE Kits and maintain records in a manner that protects the identity of the victim.
  - a. The SAFE Kit number, located on the outside of the OSP SAFE Kit, shall be recorded in the medical/patient record.
  - b. The name of the victim shall NOT be recorded on the outside of the OSP SAFE Kit envelope.
  - c. Consent forms to be signed by the victim shall clearly specify whether the SAFE Kit and other evidence collected will be turned over to law enforcement for 'investigation purposes' or for 'storage only'.

- III. Medical facilities shall provide information to non-reporting victims that includes:
- a. The SAFE Kit Number
  - b. Date of the exam
  - c. Law enforcement agency who received the SAFE Kit and other evidence
  - d. Name and location of the medical facility where exam was conducted
  - e. Six month (or 180 day ) minimum storage of evidence by law enforcement
- IV. Medical facilities shall maintain chain of evidence until SAFE Kits and other evidence are turned over to the appropriate law enforcement agency.
- V. Medical facilities shall turn SAFE Kits and other evidence over to law enforcement in a manner that protects the identity of the victim.
- VI. All documentation turned over to law enforcement should be sealed in the SAFE Kit envelope to protect the identity of the victim.
- VII. The SAFE Kit number should be used as a reference to ensure that victims who choose to report the assault are able to have their evidence readily retrieved using the numbers they were provided by the medical facility.

SAFE Kits and other evidence are the property of the criminal justice system. Law enforcement is responsible for the retrieval and storage of ALL evidence, including SAFE Kits.

## **Florida Guidelines**

### **Guidelines for Forensic Examinations for Sexual Assault Victims Not Reporting to Law Enforcement**

#### **History:**

In 2007, the Florida legislature made several important changes to chapter 960, the victims' rights statute, to improve the treatment of victims of sexual battery. These changes were necessary in order to continue to receive federal grant funding for law enforcement programs, victim advocacy services, and enhanced prosecution through the reauthorized Violence Against Women Act (VAWA) 2005. In addition to several other provisions, VAWA 2005 required states to certify that victims of sexual battery are not required to report to law enforcement in order for victim compensation to pay for the forensic medical examination.

In order to address implementation issues, identify best practices, and support communities implementing the new statutory requirements, the Florida Council Against Sexual Violence convened a statewide workgroup comprised of prosecutors, law enforcement professionals, victim advocates, forensic examination and medical providers, and crime lab professionals.

#### **Recommendations:**

The workgroup developed these recommendations with the belief that communities ought to provide forensic exams to non-reporting victims within the same timeframe and to the same standards as those provided to victims who immediately report to law enforcement. These recommendations are also reflective of the following principles:

- All victims are entitled to voluntary, confidential services;
- All victims are entitled to advocacy; and
- All victims are entitled to complete information regarding their rights.

It is recommended that all hospitals and forensic exam facilities use the 2007 Florida Office of the Attorney General sexual assault protocols as a minimum standard for conducting the forensic exam. It is of particular importance for preserving DNA that the examiner ensures all swabs and other biological evidence are dried quickly and completely before being packaged and stored.

These recommended protocols do not displace or supersede any reporting, consent, or treatment requirements applicable to minor victims under Florida law; e.g., F.S. 39.201 (mandatory reporting of child abuse, abandonment, of neglect of a minor); F.S. 743.0645 (consent to medical treatment of minor); F.S. 394.4784 (consent to counseling for minor).

#### **Sexual Assault Response Teams (SARTs)**

It is recommended that the SART in each Florida county use these guidelines as the basis for their own local policies and procedures for providing forensic exams to sexual assault victims choosing not to immediately involve law enforcement. It will require all responders and agencies working collaboratively to carry out the exams and preserve the evidence in the most effective and victim-centered way.

If the county does not already have a SART, implementing policies and procedures to provide forensic exams for all victims whether or not they immediately report to law enforcement is an important reason to establish a SART. A SART is a multidisciplinary group made up, at a minimum, of representatives from local law enforcement agencies, the state attorney's office, the local certified rape crisis center, FDLE or the local crime lab, local colleges and universities and the medical facilities performing the forensic exams. Establishing a SART can help improve relationships and coordinate the community's response to all sexual assault victims.

There is no one way to organize a SART. Every team will have a different way of starting up and working together depending on the participating agencies and individual members and the available community resources. A team may start out informally to address one specific issue, such as providing forensic exams for non-reporting victims, and decide to formalize itself later with interagency agreements and system wide written protocols.

A first step in creating a SART is identifying one or more influential leaders to bring everyone together. The state attorney, sheriff, police chief, a judge, or another local elected official working collaboratively with the certified rape crisis program director is often an effective SART development partnership.

The goal of the initial meeting may be to discuss how the changes to Florida law regarding collecting forensic exams for non-reporting victims affect every agency. How can everyone work in collaboration to make this happen? Who will store the evidence? How will victim confidentiality be maintained until or unless she or he decides to file a police report? Who will track the kits and match them with victims? The meeting attendees can use the Guidelines to implement the changes and assign roles. Follow up meetings will help agencies determine how the new procedures are working and what needs more fine tuning.

Through the process of determining responsibilities and carrying out the Guidelines, the individuals will gain valuable experience working together in a team format to accomplish a goal. Members may find they better understand each agency's role and have built stronger professional relationships with one another. At this point the individual agencies may decide to formalize their team as a SART to address other concerns that have come to light as a result of this process and to generally improve the community response to victims of sexual assault.

The team could invite someone to who participates in an established SART in another part of the state to a meeting to talk about how their SART functions, and the benefits and challenges of serving on a SART.

A next step is to set goals for the SART. Solidifying goals will help keep the group going when things get more complex later on, bringing the focus back to what the team hoped to accomplish when it started. Another useful task is requesting that each agency bring current data on the number and types of sexual assault cases they see at their agencies. This will help the group determine baseline measures and track outcomes. Some SARTs decide the best way to carry out their duties consistently is to write a multidisciplinary sexual assault response protocol outlining how responders will interact with both reporting and non-reporting survivors, as well as with other members of the team.

Many teams find it valuable to ask each agency to sign an interagency agreement committing to participate regularly in SART meetings and to work towards accomplishing the team's goals. Each agency would pledge to send a representative with decision making authority to each meeting and to send the same person, for continuity purposes, as much as practicable. If the team decides to write a protocol, the interagency agreement would include that each agency will train all new and existing personnel on the new protocol and standards. SARTs then review the protocols yearly and make changes as necessary.

There are many successful SART development models for communities to use when creating multidisciplinary response teams to promote consistent, victim-centered responses and improve public safety. For technical assistance on establishing or enhancing a county's SART or for a SART Toolkit, contact the Florida Council Against Sexual Violence at 888-965-7273.

## **Guidelines**

### **I. Definitions**

- a. Forensic exam facility: an independent or free standing facility or program that performs forensic exams and is not operated by a hospital emergency room or emergency department
- b. Hospital: any licensed facility which provides emergency room services
- c. Secure storage area: a locked location with limited and recorded access
- d. Sexual assault forensic evidence (SAFE) kit: kit for collecting evidence from victim's body
- e. Toxicology kit: kit for collecting forensic samples of blood and urine
- f. Victim: a person seeking a forensic exam

### **II. Engaging Certified Rape Crisis Program Victim Advocate**

A. When a sexual assault victim arrives at a hospital or forensic exam facility requesting a forensic exam, the hospital or forensic exam facility shall immediately call the certified rape crisis program and other appropriate victim services.

### III. Tracking SAFE Kits and Toxicology Kits

A. If the victim chooses not to report the assault to law enforcement at the time of the exam:

- i. the hospital or forensic exam facility shall collect the SAFE kit and any toxicology kit and maintain records in a manner that protects the identity of the victim.
- ii. the hospital or forensic exam facility shall label the SAFE kit and any toxicology kit with the patient/medical record number.
- iii. the name of the victim shall not be recorded on the outside packaging of the SAFE kit or any toxicology kit.
- iv. the responding victim advocate shall record the patient's name and track the patient/medical record number.
- v. if the victim later chooses to file a report with law enforcement, the victim must sign a release authorizing the certified rape crisis program or hospital or forensic exam facility to make the patient/medical record number available to law enforcement to retrieve the kits and evidence from storage. The certified rape crisis program or hospital or forensic exam facility shall not release the patient/medical record number without the victim's consent.

B. The hospital or forensic exam facility shall provide information to the victim that includes:

- i. patient/medical record number
- ii. date of the exam
- iii. name of the law enforcement agency or forensic exam facility holding the SAFE kit, toxicology kit and any other evidence
- iv. name and contact information of the hospital or forensic exam facility where exam was conducted
- v. name and contact information of the local certified rape crisis program and other appropriate victim services
- vi. length of time evidence will be stored in the absence of a law enforcement report after which time the evidence may be destroyed
- vii. information regarding how the victim should proceed if she or he decides to report the offense

### IV. Storage and Transportation of Sexual Assault Forensic Evidence (SAFE) Kits and Other Evidence

A. The law enforcement agency or forensic exam facility storing the evidence shall:

- i. store SAFE kits and toxicology kits in a refrigerator in a secure storage area
- ii. store clothing in sealed evidence bags in a secured storage area at room temperature
- iii. as a minimum standard store evidence for 90 days; as a best practice store evidence for 15 months or longer

B. Guidelines for maintaining chain of custody and long-term storage of evidence at a law enforcement agency:

- i. One law enforcement agency within the designated area served by the hospital or forensic exam facility shall be responsible for long-term storage of the evidence.
- ii. The hospital or forensic exam facility shall contact law enforcement to collect the completed kits.
- iii. The hospital or forensic exam facility conducting the forensic exam shall maintain control of any kits until a representative from the law enforcement agency arrives to collect it.
- iv. Law enforcement shall provide a receipt for any evidence collected which shall indicate the date, time and manner of pick-up.
- v. The law enforcement agency shall directly transport the evidence to the secure evidence storage room, logging the date and time of its arrival.

C. Guidelines for maintaining chain of custody and long-term storage of evidence at a forensic exam facility:

- i. Upon finishing the exam the forensic exam facility shall immediately lock the evidence in the secure storage area.

D. Hospital emergency rooms and emergency departments shall not hold completed SAFE kits, toxicology kits, or other evidence for long-term storage.