NORTH DAKOTA SEXUAL ASSAULT PROTOCOL

OFFICE OF THE ATTORNEY GENERAL
NICHOLAS J. SPAETH

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Adopted from the Sexual Assault Protocol as developed by the United States Department of Justice, in conjunction with the Office of the Illinois Attorney General

Edited and revised by Anna M. Frissell

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TABLE OF CONTENTS

FOREWORD

This Protocol and the Sexual Assault Evidence Collection Kit are the work products of a number of multidisciplinary professionals who met over a shared concern of the sexual assault examination and evidence collection process. The goal of this group was to develop materials to encourage uniform procedures to reduce the trauma of victims of sexual assault and enhance the quality and quantity of evidence to facilitate prosecution of the crime.

While this state shares wide diversity in training, education, facilities, and cultures, it is the hope of the committee that the Protocol and kit will encourage each community to prepare a response, through a team of people prepared to take action, when a sexual assault victim comes forth. Local resources and needs must be considered and juxtaposed to provide a process that will be responsive to each community. The Protocol and kit will serve as your guide to the development of local resources in response to those needs.

The committee anticipates the need to evaluate the progress we have achieved through the use of the Protocol and kits. Therefore, the development of the Protocol and the evidence collection kit is an ongoing process. We anticipate the need for continuing revisions as local professionals find new and better approaches to satisfying the needs of the victim and the task of evidence collection.

INTRODUCTION

Reports of sexual assaults against adults have continued to increase throughout the past decade, although no one knows for certain how many actual assaults take place each year. One reason for this uncertainty is that some victims choose not to report the assault because of embarrassment, fear, or trauma as a result of the assault. Another reason for not reporting is that many sexual assault victims lack faith in the follow-up treatment, investigative and prosecutorial systems.

Additionally, there is a wide jurisdictional variance in legal definitions of what constitutes sexual assault. For example, many communities only submit statistics concerning cases of forced penetration of a female by a male -- the traditional but very narrow definition of "rape". Others report all types of deviant sexual behavior, including the use of foreign objects and anal or oral copulation.

Reports of child sexual assault also have increased dramatically in the past few years, although these reports remain even more difficult to document on a national level than adult reports. This is due largely to the lack of a uniform record keeping system within individual states, as well as a failure on the part of law enforcement and child protection agencies to submit available statistics to one central location.

A factor more important than uniform reporting is the extremely low rate of reporting of child sexual assault. Many child sexual assaults are committed by someone known to and/or trusted by the child. Children often do not report this type of abuse immediately. Some children may not report the abuse for months or even years, if at all. The reasons for this are extremely complex. Many children are too young to understand that certain kinds of physical contact by adults or older children are inappropriate. Others may realize that something is wrong but are unable to articulate their feelings, or are dependent upon the abuser for care. When children do report the abuse to a third party, their account may be interpreted or dismissed as fantasy or even as a lie. Further complicating the situation is the fact that threats, however subtle, may be made, which discourage reporting by children. Children can be led to believe that something terrible will happen to them or to their families if anyone finds out, or that in some way they themselves are responsible for the abuse.

Traditionally, the successful prosecution of both adult and child sexual assault cases has been a difficult task. Evidence from the offender and the crime scene often may be found on the body and clothing of the victim. Since the victim is often the only witness to the crime, the collection of physical evidence as well as the documentation of medical trauma may be necessary either to substantiate an allegation or to help strengthen a case for court. When immediate medical attention is received, the chances increase that some type of physical evidence will be found. Conversely, the chance of finding physical evidence decreases in direct proportion to the length of time which elapses between the assault and the examination.

By necessity, much of the responsibility for the job of collecting physical evidence in sexual assault cases has fallen to physicians and nurses in hospital emergency rooms and pediatric units. The role of medical personnel in this process is often the key to successful prosecution and can help to promote early victim recovery.

Although the role of law enforcement and other victim support personnel is of equal importance to the role of medical professionals, the primary purpose of the Protocol is to promote a uniform evidence collection method that will assist hospitals to:

1. Minimize the physical and psychological trauma to the victim of a sex crime;

2. Maximize the probability of collecting and preserving the physical evidence for potential use in the legal system; and,

3. Address important issues of current controversy surrounding the collection of medical and physical evidence.

HISTORY OF THE PROTOCOL

The North Dakota Sexual Assault Protocol and the Sexual Assault Evidence Collection Kit were developed by a multidisciplinary task force of representatives from law enforcement, the medical community, rape crisis organizations, the North Dakota Hospital Association, the Attorney General's office, the Department of Human Services, and the Department of Health and Consolidated Laboratories. The task force was formed in response to concerns voiced by various individuals, agencies, and facilities throughout the state. These concerns focused on the lack of uniform procedures to be used when responding to a report of a sexual assault.

The multidisciplinary task force received input not only from members of the task force but from eight public hearings held throughout the state. The comments and concerns that reached the task force reinforced the decision to develop the Protocol and Sexual Assault Evidence Collection Kit.

Coincidentally the task force learned that the U.S. Department of Justice, Office of Victim Programs, in conjunction with the Office of the Illinois Attorney General, had committed resources to authoring a Protocol. The U.S. Department of Justice's Protocol was to be offered for the consideration of the individual states for adoption in whole or in part.

The task force decided to adopt the U.S. Department of Justice's Protocol as the framework for the North Dakota Sexual Assault Protocol with additions and changes to accommodate the needs of the professionals and facilities within North Dakota.

As the North Dakota Protocol was being developed the task force was also developing the Sexual Assault Evidence Collection Kit. Under the guidance of Aaron Rash, Forensic Division of the Department of Health and Consolidated Laboratories, the task force determined what procedures should be called for in the North Dakota Sexual Assault Evidence Collection Kit. Although the Protocol and evidence collection kit were developed to be inter-dependent every effort was made to allow the use of one without the other, if necessary.

The much borrowed from U.S. Department of Justice's Protocol was developed by a National Advisory Committee formed to assist project staff in examining specific issues of long-standing concern. Committee members represented the medical, legal, law enforcement, victim advocacy and forensic science communities, and

had extensive experience and expertise in working with sexually assaulted adults and children.

Each National Committee member was asked to complete in-depth questionnaires designed to elicit up-to-date procedures involved in the collection and processing of physical evidence. Also, members were asked to attend two working conference sessions in Chicago, Illinois to discuss the content of the questionnaire, as well as to consider ancillary victim service issues.

When considering what types of evidence specimen to collect and the manner in which to collect them, the National Committee as well as the North Dakota task force took great care to make recommendations based upon the physical and emotional needs of the sexual assault victim, reasonably balanced with the basic requirements of the legal system.

In addition to the development of the Protocol, a slide/cassette training presentation was produced by the U.S. Department of Justice detailing the proper method of collecting and preserving physical evidence for analysis by the forensic examiner. The training presentation as edited for use in North Dakota is intended to be an adjunct to the written Protocol, and should be viewed subsequent to reading the Protocol. The training presentation is available through the North Dakota Attorney General's office, State Capitol, Bismarck, North Dakota.

ORGANIZATION OF THE PROTOCOL

The North Dakota Sexual Assault Protocol was developed to assist a wide variety of professionals to coordinate their efforts when responding to a sexual assault. The main focus of the Protocol is to facilitate the collection of evidence by the medical professional. However, the Protocol takes the approach that a sexual assault is a medical emergency demanding coordinated efforts by the response team. The response team is made up of medical professionals, law enforcement and support personnel or advocates. Each type of professional is an essential member of the response team and their individual roles are highlighted in the Protocol.

The Protocol is to be used in conjunction with the Sexual Assault Evidence Collection Kit. However, if there is not an evidence collection kit available, the Protocol will assist the physician in the methods and types of evidence collection. As the primary concern of the response team is meeting the medical needs of the victim, there should be no hesitation in accomplishing diagnosis and treatment procedures in lieu of evidence collection should that necessity arise. Evidence collection procedures do not substitute for a medical examination.

The Protocol is a narrative guide to the collection of evidence. Although the Protocol's foremost concern is the immediate and long-range medical treatment of the victim and the proper collection, storage and handling of evidence, several corollary issues are also addressed.

These issues include a brief discussion of victims with special needs, such as the elderly, disabled, or male victim. Section III of the Protocol addresses the special needs of children who are victims of sexual assault. Section IV, Sexually Transmitted Diseases, is a reminder of the sexually transmitted diseases that victims may become exposed to and medical facilities must anticipate.

The collection of evidence is an ongoing process. Throughout the investigatory process new evidentiary concerns may arise. The majority of the evidence collection procedures which are the subject of the Protocol and are called for in the Sexual Assault Evidence Collection Kit must be accomplished within 72 hours of a sexual assault.

If the sexual assault occurred several days months or even years before the victim is first seen by the response team than there is no evidentiary reason to use the Sexual Assault Evidence

Collection Kit. However, there may be evidence collection procedures discussed in the Protocol which can still be conducted and may be of evidentiary value. For instance, the victim may not have washed the clothing he/she was wearing during the assault and that clothing may be collected and analyzed for debris, dried blood, remnants of bodily secretions or other cross-transfer evidence. Likewise, the use of a colposcope may support the victim's account of what occurred by aiding in the detection of lacerations, scarring or other trauma. The members of the response team should consult with the victim to determine when the assault(s) occurred if there is any "time" question.

The appendices to the Protocol act as a quick reference to the written material included in the evidence collection kit. (Appendix A-1 to A-8.) The appendices also include the relevant statutes of the North Dakota Century Code. (Appendices A-9 to A-20.)

SECTION I. GENERAL CONSIDERATIONS

1.1 Definition of Sexual Assault

For the purpose of this Protocol, the term "sexual assault" will be used to refer to all sex crimes perpetrated against adults and children, with the term being defined in a broad context as follows:

> Any act of sexual contact or intimacy performed upon one person by another, and without mutual consent, or with an inability of the victim to give consent due to age, mental or physical incapacity. (See N.D.C.C. § 12.1-20-02 for the precise definition of "deviate sexual act", "object", "sexual act", and "sexual contact", see also N.D.C.C. ch. 12.1-20, Sex Offenses. See Appendices A-9 through A-13.)

1.2 Sensitivity to the Needs of Victims

While some sexual assault victims suffer severe physical injuries, contract a sexually transmitted or other communicable disease, or become pregnant as a result of the attack, many others do not. In each situation, however, victims will experience varying degrees of psychological trauma. The effects of this type of trauma may be more difficult to recognize than physical trauma.

An individual's perceptions of how sexual assault victims should look, dress or act and the way those perceptions are conveyed can have a major effect upon the victim's recovery process in the weeks and months following the crime. Each person has his or her own method of coping with sudden stress. When severely traumatized, victims can appear to be calm, indifferent, submissive, jocular, angry, or even uncooperative and hostile toward those who are trying to help. However, all of these responses are within the normal range of anticipated reactions.

An inappropriate response by the helping professional (either medical, law enforcement or a support person) to information concerning the circumstances surrounding the assault or a misinterpretation of a victim's reaction to the assault may lead to further traumatization and hinder the interview or evidence collection process.

Hospitals and law enforcement should seek the assistance of reliable community consultants to help develop procedures and counseling resources which will reflect the special needs of the victim of a sexual assault.

For example, in certain cultures, the loss of virginity is an issue of paramount importance, and one which may render the victim unacceptable for an honorable marriage. In other cultures the loss of virginity may not be as great an issue as that of the assault itself. Also, religious doctrines may prohibit a female

from being disrobed in the presence of a male who is not her husband, or forbid a genital examination by a male physician. Such practices are considered a further violation. Therefore, if at all possible, a female physician should be made available for victims who request them.

1.3 The Elderly Victim

In general, the elderly are physically more fragile than the young. Consequently, injuries from an assault are more likely to be life-threatening to the older victim. In addition to possible pelvic injury and sexually transmitted diseases, the older victim may be more at risk for other tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often renders the elderly victim unable to make his or her needs known, which may result in an unnecessarily prolonged period before reporting or an error in treatment. It is also not unusual for hospital and law enforcement personnel to mistake this confusion and distress for senility. The recovery process for elderly victims also tends to be far more lengthy than for younger victims.

As with most other victims, the elderly victim experiences extreme humiliation, shock, disbelief, and denial. However, the full emotional impact of the assault may not be felt until after initial contact with physicians, police, legal and advocacy groups, or later, when the victim is alone. It is at this time that older victims must deal with having been violated and possibly diseased, and when they become more acutely aware of their physical vulnerability and mortality.

Fear, anger or depression can be especially severe in older victims who many times are isolated, have no confidant and live on meager incomes. Medical and social follow-up services must be made easily accessible to older victims, or they may not be willing or able to seek or receive assistance.

Without encouragement and assistance in locating services, most older victims may be reluctant to proceed with the prosecution of their offenders.

1.4 The Disabled Victim

Criminal and sexual acts committed against the disabled (physically, mentally, or communicatively) often are unreported and seldom are successfully prosecuted.

Offenders often are family members, caretakers, or friends who repeat their abuse because their victims are not able to report the crimes against them.

Professionals are faced with a number of difficult problems in providing quality care for such victims, whose disabilities may range from minimal to severe. The difficulty of providing adequate responses to the sexual assault victim are compounded when the victim is disabled. Some have limited mobility, cognitive defects which impair perceptual abilities, impaired and/or reduced mental capacity to comprehend questions, or limited language or communicative skills to tell what happened. They may be confused or frightened, unsure of what has occurred, or they may not understand that they have been exploited and are victims of a crime.

These victims and their families should be given the highest priority and attention in the emergency room. Additional time should be allotted for evaluation, medical examination and the collection of evidence.

The physically disabled victim may be more vulnerable to a brutalizing assault and may need special assistance to assume the positions necessary for a complete examination and collection of evidence. Improvisation from normal procedures may be indicated in some instances in order to adequately examine these victims.

In sexual assault cases involving the communicatively disabled victim, the use of anatomically-correct dolls has proved to be a successful method of communication.

Also, under section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and police departments) that directly receives federal assistance or indirectly benefits from such assistance, must be prepared to offer a full variety of communication options in order to ensure that hearing-impaired persons are provided effective health care services. This variety of options, which must be provided at no cost to the victim, also includes an arrangement to provide interpreters who can accurately and fluently communicate information in sign language.

Finally, referrals to specialized support services and reports to law enforcement agencies are particularly necessary for the developmentally and physically disabled who may need protection, physical assistance or transportation for follow-up treatment and counseling.

1.5 The Male Victim

It is believed that the number of male victims of sexual assault who report the crime or seek medical care or counseling represents only a very small percentage of those actually victimized. It is likely that most adult males do not seek medical care unless they also have been seriously injured. Male child victims are now being seen at hospitals in increasing numbers, in large measure as a direct result of public education and more stringent child abuse reporting laws throughout the nation.

Although there has been significant progress in educating the public toward an understanding of the concept of sexual assault of both sexes as an act of violence, there still remains a great reluctance on the part of most male victims to report a sexual assault. Present social and cultural values, with the added stigma of implied loss of masculinity or fear of being categorized as homosexual, can make the trauma of the reporting experience by the male victim at least equal to that of the female victim.

The male victim may have serious problems concerning his inability to resist the assault or confusion about the nature of his role as victim/participant because of a possible involuntary physiological response to the assault, such as stimulation to ejaculation.

It is just as important for males, as it is for females, to be reassured that they were victims of a violent crime which was not their fault, and that other sexually assaulted males survive to function normally in every way.

Referrals to therapists or advocacy groups with expertise in the area of sexual assault of males are vital to assist in the recovery process.

SECTION II ADULT PROTOCOL

Many of the forensic issues apply equally to adult and child victims of sexual assault, and are discussed in the following sections. However, the particular issues regarding the interviewing, medical examination and evidence collection needs of children are in Section III of this report.

2.1 Treatment Facilities

It is advantageous for all victims of sexual assault to seek both medical treatment and evidence collection from a hospital facility. Adults should be treated in an emergency room and children should be treated in a hospital pediatrics unit, if available.

Physicians who work primarily in private office-based facilities usually do not have evidence collection kits on hand, and may not be as familiar as hospital-based physicians with the specific medical and evidence collection procedures relevant to sexual assault victims. Additionally, many private medical offices are not open on a 24-hour basis, and may not have equipment available to make the necessary cultures. Local facilities may not allow immediate transportation of a victim to a hospital with evidence collection kits on hand. Although a hospital is preferable, the lack of such a facility should not impede treatment of the victim or evidence collection.

Hospitals that provide sexual assault treatment should have a 24-hour emergency room facility with staff trained in sexual assault examinations. The ideal situation would also include the on-call availability of a specially trained obstetrician/ gynecologist for consultation, the services of a local sexual assault victim advocate, and contingency plans for cases requiring photographs and bite mark impressions. (See Photographs, Section 2.9.11 and Bite Marks, Section 2.9.5.) Many of these services may not be available in your area. If they are not available, treat the victim with compassion and make the best of your local resources.

While many jurisdictions have some type of hospital reimbursement plan for sexual assault victims, including the cost of collecting evidence and the collection kit used, victims receiving treatment in private facilities very often will have to be charged. In many cases the Crime Victims Reparation Program will compensate victims for the cost of medical treatment and related expenses. For more information on the Crime Victims Reparation Program call (701) 224-4150 or 1-800-445-2322.

Compilation of a local treatment facility list will provide an excellent opportunity for hospital, law enforcement and support personnel to meet and discuss transportation issues and other mutual concerns involving treatment and follow-up policy. Local

law enforcement offices, hospital personnel or support personnel should consider setting up such a joint committee.

2.1.1 Transfer

If a victim of sexual assault arrives at a hospital that is not equipped to provide a sexual assault examination, arrangements should be made to transfer the victim to the nearest designated treatment facility. However, if there are acute medical or psychological injuries that must be treated immediately, this should be done at the initial receiving facility and a copy of all records, including any X-rays taken, should be transported with the victim to the designated treatment hospital.

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community. The list of designated hospitals should then be provided to all local law enforcement agencies and victim advocacy organizations. This should be accomplished locally and lists disseminated to local personnel.

Developing this list will greatly reduce the amount of confusion and additional trauma incurred by those victims who are initially taken or referred to a non-treatment facility, as well as reduce the loss of valuable evidence.

2.2 Initial Role of Law Enforcement

2.2.1 Responding Officer

Most adult victims of sexual assault will be experiencing their first contact with a law enforcement officer.

The primary responsibility of this responding officer is to ensure the immediate safety and security of the victim and to obtain some basic information about the assault in order to apprehend the assailant.

Basic information that the responding officer should provide the sexual assault victim includes:

1. The importance of seeking an immediate medical examination. Injuries can go unnoticed or appear at a later time. It is vital that the responding officer explain the importance of seeking an immediate hospital examination.

2. The importance of not inadvertently destroying potentially valuable physical evidence prior to the hospital examination. This would include washing/showering, brushing/using a mouthwash, and douching.

3. The importance of not inadvertently destroying potentially valuable evidence which may be present on

clothing worn during the assault as well as on bedding or other materials from the crime scene.

The officer should request that a change of clothes be brought along to the hospital in the event clothing is collected for evidentiary purposes. The victim should never have to leave the hospital in a hospital gown.

Although intimate details of the sexual assault itself are not needed at this point in the investigation, a preliminary interview with the victim is necessary so that the responding officer can relay information that may be vital to the apprehension of the assailant. The preliminary interview should include the following questions:

1. The extent of the injuries, if any, to the victim;

2. A brief description of what happened;

3. Where the assault took place;

4. The identity or description of the assailant(s), if known;

5. Where the assailant(s) lives and/or works, if known;

6. The direction in which the assailant(s) left and by what means; and

7. Whether or not a weapon was involved.

At the hospital, the responding officer should provide the hospital staff with any available information about the assault that may assist in the examination and evidence collection procedures.

While the victim is being treated at the hospital, the responding officer should wait in the prescribed waiting area. In most jurisdictions, local police policies call for the officer who accompanies the victim to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is completed before making arrangements to conduct the more in-depth interview with the victim.

2.3 Intake by Medical Professionals

The treatment of victims of sexual assault should be considered a medical emergency. Although many victims may not have visible signs of physical injury, they will, at the very least, be suffering from some type of emotional trauma.

A private location within the hospital should be utilized, if at all possible, for the preliminary consultation with the victim.

This could be a room adjacent to the emergency department or a private office located nearby.

In order to prevent others from hearing the conversation, it is recommended that this same type of privacy be provided for the follow-up law enforcement interview at the conclusion of the examination.

Over the past several years, many hospitals have developed "code" plans, such as "Code R" or "SA" which they use when referring to sexual assault cases. This eliminates the needless embarrassment to victims and/or their families of being identified in the public emergency or examining room setting as the "rape" or "sexual assault" victim.

Other methods can be devised to avoid inappropriate references to sexual assault cases, and hospitals are encouraged to develop their own sensitive code plans to ensure privacy.

2.3.1 Reporting

North Dakota has mandated reporting laws for violent crimes, including sexual assault. These laws specify that local law enforcement authorities shall be routinely notified by hospital personnel as soon as is practicable. (See N.D.C.C. § 43-17-41, Appendix A-18.)

Victims of sexual assault should be encouraged to report and/or cooperate in the police investigation toward the goal of prosecution of an offender. Victims should be assured that their cooperation in providing physical evidence is not an irrevocable decision to support prosecution.

2.4 Support Personnel

Whenever possible, one person should be assigned to stay with the victim throughout the entire emergency department visit.

Some hospitals are fortunate enough to have in-house staff who are specially trained to treat victim trauma, and who can provide crisis intervention for sexual assault victims and their families. Some of these staff members also are qualified to provide follow-up counseling to victims on a short or long-term basis.

Primarily as a result of the dedication of women involved in the issue of sexual assault, increasing numbers of communities throughout the state now have resources for follow-up counseling, and many hospitals have entered into working agreements with victim advocate organizations. (See Appendix A-8.) These organizations may provide immediate crisis intervention to victims who have arrived at the hospital seeking treatment, as well as follow-up counseling and referrals. In some instances, they also are able to provide support for the victim throughout the entire criminal justice process.

2.4.1 Role of the Support Person

The importance of having a support person available to sexual assault victims cannot be overemphasized, whether that support person is a member of the hospital staff or a member of a community victim advocacy organization. It is important to remember that consent to have a support person present must be given by the victim. Also, at any time throughout the treatment and evidence collection process, the victim should be able to refuse further interaction with the designated support person and/or request that the support person leave.

Well-trained support persons can provide the crisis intervention necessary when victims first enter the hospital for treatment. They can assist hospital emergency room staff in explaining the necessity of medical and evidence collection procedures. They can counsel family members or friends of the victim who may be at the hospital. A support person can also help provide counseling referrals and other information, such as the existence and availability of victim compensation programs or other types of assistance, emphasize the importance of follow-up testing for possible venereal disease or other medical problems, and answer additional questions victims may have following their medical and evidence collection examinations.

Your community may not have specialized support personnel available to respond to sexual assaults. If this is the case victims should be encouraged to contact the nearest agency for necessary follow-up assistance. (See Appendix A-8.)

2.5 Victim Consent to Evidence Collection (See Appendix A-3)

Obtaining a victim's written consent prior to conducting a medical examination or administering treatment is standard hospital practice. With the advent of evidence collection requirements and crisis intervention services, sexual assault victims are expected to make a decision about consent to these procedures as well.

Informed consent should be a continuing process that involves more than obtaining a signature on a form. When under stress, many victims may not understand or remember the reason for or significance of unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained as thoroughly as possible, so that the victim can understand what the attending physician and nurse are doing and why.

Although much of the examination and evidence collection process can be explained by the hospital support person, law enforcement, or a victim advocate, this function is ultimately the responsibility of hospital personnel.

When written consent is obtained, it should not be interpreted as a "blank check" for performing tests or pursuing questions. If a

victim expresses resistance or noncooperation, the physician should immediately discontinue that portion of the process and consider going back to it at a later time in the examination if the victim then agrees.

In either event, the victim should have the right to refuse one or more tests or to refuse to answer any question. Having a sense of control is an important part of the healing process for victims, especially at the early stages of examination and initial interviewing.

Hospitals should follow their usual procedures for obtaining consent in extraordinary cases, e.g., for severely injured or incoherent victims.

2.6 The Evidentiary and Medical Examination

2.6.1 General Information

A physical examination should be performed in all cases of sexual assault, regardless of the length of time that may have elapsed between the time of the assault and the examination.

Some victims may ignore symptoms that would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness that will later develop into bruises but which are not apparent at the time of initial examination.

If it is determined that the assault took place more than 72 hours prior to the examination, the use of an evidence collection kit is generally not necessary. It is unlikely that trace evidence would still be present on the victim. However, evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises or lacerations), photographs and bite mark impressions (if appropriate), and statements about the assault made by the victim.

If the assault occurred within the 72 hours prior to the examination, an evidence collection kit should be used.

When a forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times. This coordination of medical and forensic procedures is crucial to the successful examination of sexual assault victims.

For example, in order to minimize victim trauma, blood drawn for medical purposes (testing for syphilis) should be done at the same time as blood drawn for evidence collection purposes. Also, when evidence specimen are collected from the oral, vaginal, or rectal orifices, cultures for sexually transmitted disease should be taken immediately following these collection procedures.

2.6.2 Presence of Personnel

The only people who should be with the victim in the examining room are the examining physician, attending nurse and, with the consent of the victim, a trained support person. Although every effort should be made to limit the number of people in attendance during the examination, there may be instances when a victim requests the presence of a close friend or family member. If at all possible, these requests should be honored.

There is no medical or legal reason for a law enforcement representative, male or female, to observe the medical examination and evidence collection process. Maintaining the chain of custody during the examination should be the sole function of the attending medical personnel, and one which requires no outside assistance.

The least traumatic and least time consuming method of collecting physical evidence from sexual assault victims is to integrate those procedures into the medical examination. By virtue of the examination, the rectum and vagina/penis of the victim must be revealed for proper medical assessment and evidence collection.

Subjecting victims to the observation of law enforcement personnel during these procedures, as well as having the law enforcement representative privy to the private communications between the victim and the hospital examining/support team, is an extremely offensive and unnecessary practice.

2.6.3 Medical Report Form for Sexual Assault Examination (Not included in the Sexual Assault Evidence Collection Kit, but for medical records.)

Throughout the evaluation and medical examination, the attending physician should explain to the victim why questions are being asked, why certain medical and evidentiary tests may need to be performed and what treatment, if any, may be necessary.

1. Vital signs and other initial information, such as the date and time of both the examination and the assault, should be recorded.

2. A brief description of the medical details of the assault should be recorded. This description should include any oral, rectal, or vaginal penetration, whether the assailant penetrated the victim with finger(s) or foreign object(s), whether any oral contact occurred, and whether ejaculation occurred (if known).

   The victim's account of what happened should be recorded accurately, briefly, and in the victim's own words as much as possible.

3. Information regarding the physical location of the assault should be recorded (car, rug, grass, alley). This information will assist the physician with an indication of where to look for evidence and what evidence to collect such as hair, fibers, and other trace material.

4. Significant medical history of the victim should be recorded. This would include any allergies, current medication, acute or chronic illness, surgery and any post-assault symptoms such as bleeding, pain, loss of consciousness, nausea, vomiting or diarrhea.

5. Gynecological history information including menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy), and contraceptive history should be evaluated and recorded.

   If a victim is at risk of pregnancy, a urine pregnancy test should be done to establish a baseline for possible preexisting pregnancy. (The urine sample can also be examined for Trichomonas.)

6. During the general physical examination, record all details of trauma, such as bruises, abrasions, lacerations, bite marks, blood or other secretions, with particular attention paid to the genital and rectal areas of both male and female victims.

   Common sites and types of injury, even if not yet visible, include the breasts, the upper portion of the inner thighs, grab or restraining marks on the arms, wrists, or legs, and injuries or soreness to the scalp area, back or buttocks as a result of being thrown against an object or onto the ground.

Information concerning sexually transmitted diseases is contained in Section IV of this report. However, it is recommended that if penicillin is to be given as prophylaxis, it should not be delayed until the very end of the victim's hospital examination. Because some victims may be allergic to penicillin but unaware of their allergy, it is recommended that this treatment, if provided, be administered in time to allow for at least 30 minutes of victim observation.

2.7 Evidence Collection Documentation

(Refer to Appendix A-1 and A-2 for the instructions which are included in the Sexual Assault Evidence Collection Kit.)

If the sexual assault has occurred within the last 72 hours always use a Sexual Assault Evidence Collection Kit paying close

attention to the following procedures. If a Sexual Assault Evidence Collection Kit is not available, the following procedures should nevertheless be considered.

2.7.1 Packaging and Refrigeration

In order to prevent the loss of hair, fibers, or other trace evidence, clothing and other evidence items must be sealed in paper or cardboard containers.

If the containers are plastic, moisture remaining in the evidence items will be sealed in, making it possible for bacteria to quickly destroy any unstable biological fluid evidence. Unlike plastic, paper "breathes", and allows moisture to escape.

The evidence collection kit must be refrigerated at all times after the evidence has been collected. The kit should not be frozen. The hospital or law enforcement must maintain this refrigeration until delivery to the crime laboratory.

2.7.2 Chain of Custody (Preserving the Integrity of Evidence)

The custody of any evidence collection kit and the specimen it contains must be accounted for from the moment of collection until the moment it is introduced in court as evidence. This is imperative in order to maintain the legally necessary "chain of custody".

It is advisable to keep the number of people who handle evidence to a minimum so it will be easier to determine and present evidence about "chain of custody". It is important that the names of those involved in the medical examination and collection and handling of evidence be legible on the evidence specimen and that enough information is recorded to locate them in the event their testimony is needed (label evidence items with your initials, the date, source of specimen, name of the attending physician, and name of the victim).

"Chain of custody" need not be something to worry about if the above simple practices are implemented. Its importance cannot be overemphasized because without being able to establish the "chain of custody", evidence cannot be introduced in court. But with proper handling and information recording there will not be a problem.

2.8 Spermatozoa and Semen

Historically, medical and law enforcement personnel have placed great emphasis on whether or not spermatozoa were present in or on the body or clothing of a sexual assault victim. If spermatozoa were found during the physical examination, this was often thought to be the most important indication that a sexual assault occurred. When no spermatozoa were found, a shadow of doubt was sometimes cast upon the victim's allegation of sexual assault,

contributing to the misconception that the absence of spermatozoa meant that no sexual assault occurred.

In order to understand the importance of both spermatozoa and semen and the role they can play in the forensic analysis of sexual assault evidence, the following brief explanation is offered for review:

Semen is composed of cells and fluid, known as spermatozoa and seminal plasma, respectively.

The finding of spermatozoa is useful for two reasons:

1. When present, it is positive indication that ejaculation occurred and that semen is present.

2. When spermatozoa are motile (alive), it can be an indicator of the length of time since ejaculation.

The survival time of spermatozoa in the vaginal, oral and rectal orifices following ejaculation varies considerably in scientific studies. However, there is fairly wide consensus that they may remain for up to 72 hours or longer in the vagina (persisting longer in the cervical mucosa), and up to several hours or more in the rectal cavity, particularly if the victim has not defecated since the assault.

Seminal plasma also is useful for two purposes:

1. In the absence of spermatozoa, seminal plasma components (p30 and acid phosphatase) can be used to identify semen.

   p30 is a prostatic antigen known to exist in the semen of humans and its presence is regarded as a conclusive indication of semen. Acid phosphatase is present in high levels in seminal samples but is considered only a presumptive test for the presence of semen because it also appears in samples that are not seminal in origin, such as vaginal fluid.

2. Most of the genetic markers detected in semen and which are used to identify the possible donor, are located in seminal plasma.

Inasmuch as seminal plasma is produced in the ejaculates of all males, vasectomized or not, the forensic examiner is especially interested in the presence of seminal plasma. It is primarily the seminal plasma, not the spermatozoa, that gives evidence of the ABO blood type of secretors and the genetic markers of the donor of the specimen.

In the past few years, there has been a dramatic increase in the number of vasectomies, as well as evidence that many sexual

assault offenders are sexually dysfunctional and do not ejaculate during the assault. Additionally, offenders may use a condom, have a low sperm count (frequent with heavy drug or alcohol use), ejaculate somewhere other than in an orifice or on the victim's clothes or body, or fail to ejaculate if the assault is interrupted. Therefore, a lack of spermatozoa is not conclusive evidence that no assault occurred. It only means that spermatozoa may have been destroyed after being deposited or that it may never have been present.

Furthermore, the absence of semen means only that either no ejaculation occurred, for the reasons described above, or that various other factors contributed to the absence of detectable amounts of semen in the specimen. For example, there could have been a significant time delay between the assault and the collection of specimen, penetration of the victim could have been made by an object other than the penis, the victim could have inadvertently cleaned or washed away the semen, or the specimen could have been collected improperly.

Although the finding of semen, with or without the presence of spermatozoa, may corroborate the fact that a sexual act did take place and make a stronger case for the prosecution, its presence is not an absolute necessity for the successful prosecution of a sexual assault case.

2.8.1 Presence of Sperm and Sperm Motility - Wet Mount and Permanent Smears

Wet mount slides are generally made immediately after specimens are collected, by combining a drop of the specimen from a swab with a drop of nutrient medium on the slide. The appropriate medical professional then examines the slide right away to determine whether sperm is present, and if so, whether motile, non-motile or both. Motile sperm indicates a very recent ejaculation; it may be present for as short a time as 30 minutes and seldom beyond 6 to 8 hours. Several factors affect motility and/or presence of sperm. These factors include body temperature, amount of ejaculation, vaginal pH, presence of contraceptives, post-assault hygiene and whether the offender has had a vasectomy.

Permanent smears (dry mount slides) should be made from the samples obtained. These can be stained to help visualize sperm, kept indefinitely and examined by both medical and forensic personnel. Non-motile sperm may be seen on these slides where no sperm were seen on the wet mount. Non-motile sperm may be seen in vaginal or rectal secretions up to 12 to 20 hours following ejaculation - rarely might be found 48 to 72 hours later. Both wet amount and permanent smears must be labeled and retained as evidence.

2.8.2 Analysis of Specimen - Specimen Collection

Unlike the clinical laboratories in most hospitals, forensic laboratories generally have more sophisticated equipment, specialized training and ultra-sensitive techniques which enable them to detect even minute traces of semen and spermatozoa. They are also able to conduct a genetic marker analysis of semen which the majority of hospital technicians are not equipped to perform.

Likewise, certain tests can only be run immediately after evidence collection at the medical facility. (See Presence of Sperm and Sperm Motility, Section 2.8.1 and see Testing for Sexually Transmitted Diseases, Section 4.1.) The results of these hospital run tests should be shared with forensic personnel for further evidentiary analysis.

It is not uncommon for the tests run at the forensic laboratory to contradict those run at the medical facility. For instance, because of the enhanced detection ability of the forensic laboratory traces of semen may be found despite negative test results from the hospital. Unfortunately, the forensic analysis must then be explained in court by forensic personnel and the apparent contradiction cleared.

To minimize the chance of these types of contradictions occurring, all medical and forensic specimen collected during the sexual assault examination must be kept separate both in terms of collection and processing. Those required only for medical purposes should be kept and processed at the examining hospital, and those required strictly for forensic analysis should be transferred with the Sexual Assault Evidence Collection Kit to the forensic laboratory for interpretation.

2.8.3 Use of Wood's Lamp

A Wood's Lamp is a long wave ultraviolet light that can be used to scan clothing or the body for evidence of dried or moist secretions, stains or injury. Semen usually exhibits a green or blue fluorescence under this light but may not fluorescence when fresh. Clothing made of fluorescent synthetic material or washed in light optical density detergent may show seminal stained areas as absent or diminished fluorescence. If observations such as these have been made, diagrams should be used to record the location and extent of stains and/or injury.

If secretions are found on the hair, the matted hair can be cut and placed in a paper bindle. Thinner stains can be collected with the use of swabs moistened in distilled water which are then air dried and packaged in an envelope or tube. Secretions that are still moist can be collected with dry swabs to avoid dilution, air dried and packaged in the same way. (See Dried Fluid, Section 2.9.4.)

2.9 Sexual Assault Evidence Collection Kit (Evidence Collection Procedures)

2.9.1 Sexual Assault Report Form For Forensic Laboratory (See Appendix A-4)

Note: If there are indications that oral contact occurred during the sexual assault, Section 2.9.8 - Saliva Specimen, and Section 2.9.7 - Oral Swabs, should be done at this time to allow the victim to wash his/her mouth. The victim should not have anything to drink, eat or smoke for a minimum of 15 minutes prior to saliva collection.

The hospital may consider including a copy of the Medical Report Form in the evidence collection kit.

Although it is helpful to the Forensic Laboratory to receive certain written information with the evidence collection kit, it is recognized that by their nature, hospital medical report forms may contain some confidential information which is not required for the forensic examination.

Examples of confidential information not relevant to the forensic evaluation of evidence, include the following:

1. Information concerning gynecological history, such as miscarriages, abortions, past or current pregnancy, hysterectomy and tubal ligation.

2. Information on the victim's emotional status, drug allergies, or past medical problems, such as cancer.

Therefore, in the interest of protecting and maintaining victim confidentiality, a separate form is recommended solely for the purpose of providing information required for forensic analysis of evidence. (See Appendix A-4.)

2.9.2 Information Collected (See Appendix A-4)

The following information should be obtained by medical personnel and included with the evidence sent to the Forensic Science Division of the Department of Health and Consolidated Laboratories. Use the form entitled "Sexual Assault Report Form for Forensic Laboratory" if a Sexual Assault Evidence Collection Kit is available:

1. Date and time of collection/date and time of assault.

   It is essential to know the period of time that has elapsed between the assault and the collection of evidence. The presence or absence of semen may correspond with the interval following the assault.

2. Sex and number of offenders.

Forensic serologists seek evidence of cross-transfer of trace materials from the victim, assailant(s) and scene of the crime. These trace materials include foreign hair and the deposit of secretions from the assailant(s) on the victim.

The gender of the assailant may determine the type of foreign secretions that might be found on the victim's body and clothing. Therefore, the serologist should be informed whether to search for foreign semen or vaginal secretions, and to focus the analysis on the relevant stains.

3. Action of victim since assault.

The quality of evidence is critically affected both physically and chemically by actions taken by the victim, and by the passage of time.

For example, the length of time that elapsed between the assault and the collection of evidence, as well as self-cleansing efforts of the victim, can affect the rate of drainage of semen from the vagina or rectum. Trace evidence such as foreign hair, fibers, plant material or other microscopic debris deposited on the victim by the assailant or transferred to the victim at the crime scene also can be lost.

It is important for the analyst to know which activities were performed prior to the examination, including bathing, urination, brushing of teeth, and changing of clothes, any of which could help explain the absence of secretions or other foreign materials. For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina.

Failure to explain the circumstances under which semen could have been destroyed might jeopardize criminal prosecution if apparent contradictions are not accounted for in court.

4. Contraceptive/Menstruation information.

Certain contraceptive preparations can interfere with accurate interpretation of the preliminary chemical test frequently used by forensic laboratories in the analysis of potential seminal stains. In addition, contraception foams or creams can destroy spermatozoa.

Lubricants of any kind, including oil or grease, are trace evidence and may be compared with potential

sources left at the crime scene or recovered from the body of the assailant.

Knowing whether or not a condom was used also can be helpful in explaining the absence of semen.

Tampons and sanitary napkins can absorb all of the assailant's semen, as well as any menstrual blood present. Additionally, the presence of blood on the vaginal swab could either be from trauma or as a result of menstruation.

5. History of assault.

An accurate but brief description of the assault is crucial to the proper collection, detection, and analysis of physical evidence. This includes the discovery of oral, rectal, and vaginal penetration of the victim, oral contact by the offender, ejaculation (if known by victim) and penetration digitally or with foreign object(s).

Analytical findings of the forensic laboratory which corroborate the victim's account will support the victim's testimony in court.

6. Physical examination details.

In the search for cross-transfer of trace evidence, it is essential to know the location and extent of the injuries sustained by the victim. For instance, is blood from the victim's injuries likely to be found on the body or clothing of the assailant or at the crime scene? If the victim did not bleed at all, is all of the blood located on his/her clothing from the assailant?

Sometimes saliva and semen stains are more easily visualized under ultraviolet light. The use of a hand held UV lamp (Wood's Lamp) will assist in locating the presence of such stains on the body of the victim during the medical examination. (See Wood's Lamp, Section 2.8.3.)

If the victim is bitten, there is a potential that saliva was deposited on the victim's body or clothing. However, in order to effectively search the clothing for saliva stains, the crime laboratory must know precisely where the bite occurred.

7. Date of Last Voluntary Coitus

When analyzing semen specimen in sex-related crimes, forensic analysts sometimes find genetic markers that

are inconsistent with a mixture from only the victim and the defendant. A mixture of semen from a defendant and the victim's previous sexual partner could lead to blood grouping results which, if unexplained, could conflict with the victim's own account of the assault.

The Sexual Assault Evidence Collection Kit requests that physicians ask victims if they engaged in voluntary sexual intercourse within 72 hours prior to the assault. If so, law enforcement and state forensic laboratory personnel will than be alerted and consideration will be given to the fact when analyzing the evidence. (See Appendix A-4.)

Very often, when the date of last voluntary coitus is asked during the physical examination, the identity of the sexual partner is also solicited as a matter of record. Knowing who the prior sexual contact was is significant only to the extent that saliva and blood samples from the individual involved can be made available for comparison. Unless there is a conflict in specimen, this person's identify is not relevant either to the medical examination or for the initial findings of the forensic laboratory. Consequently, the identity of a voluntary partner should not be sought at the initial examination.

8. Communicable diseases of risk to forensic science personnel.

Forensic science personnel are concerned about the possibility of contracting a communicable disease from physical evidence and clothing submitted for analysis. Communicable diseases of risk to laboratory analysts include but are not limited to chlamydia, syphilis, gonorrhea, hepatitis, tuberculosis, herpes, and AIDS.

For example, serology tests necessitate that a considerable number of cuttings be made from cloth and other items. Accidental lacerations received while working with contaminated evidence can be quite dangerous. Syphilis, hepatitis and AIDS are of special concern to analysts because they can be transmitted through a puncture wound or open sore. Also, contaminated blood can sometimes splatter on laboratory personnel due to pressure release when the test tubes are opened. Information regarding the presence of parasites, especially the presence of crab lice (in pubic hair), head lice and body lice, is also important to laboratory personnel and should be noted.

Unless a sexually transmitted disease is discovered or suspected at the time of the initial examination, discovery by testing for sexually transmitted or other

communicable diseases would not be made in time for such information to be included initially in the kit.

Health care facilities are encouraged to develop policies for the management of exposure for health care employees and to contact the Forensic Science Division of the Department of Health and Consolidated Laboratories, Bismarck, North Dakota, as to the proper procedures for evidence transportation and collection which minimizes exposure problems. Blood screening tests and immunization of high-risk medical personnel and forensic personnel should be considered as routine policy.

2.9.3 Clothing Evidence
(See Appendix A-1, Step 3)

Clothing frequently contains the most important evidence in a case of sexual assault.

The reasons for this are twofold:

1. Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hair and fibers, as well as debris from the crime scene.

   While foreign matter can be washed off or worn off the body of the victim, the same substances often can be found intact on clothing for a considerable length of time following the assault.

2. Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the victim with trace evidence collected from the suspect and/or the crime scene.

The most common items of clothing collected from victims and submitted to the Forensic Science Division of the Department of Health and Consolidated Laboratories for analysis are underwear, hosiery, blouses, shirts, and slacks. There also are instances when coats and even shoes must be collected.

Traditionally, it has been difficult for victims of crime to recover personal property, especially items of clothing which were collected for evidentiary purposes. The inability to have clothing returned, even after the case is concluded, can be extremely frustrating and costly.

It is recommended, therefore, that prior to the full examination, great care be taken by the attending physician or nurse to determine if the victim is wearing the same clothing he or she wore during or immediately following the assault. If so, the clothing

should be examined for any apparent foreign material, stains, or damage.

If the victim is not wearing the same clothing involved in the assault, the attending physician or nurse should inquire as to the location of the original clothing, such as at the victim's home or at the laundry for cleaning. This information should then be given to the investigating officer so that he or she can make arrangements to retrieve the clothing before any potential evidence is destroyed.

When the determination has been made that items may contain possible evidence related to the assault, with victim consent, those items should be collected.

In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions.

For example, if semen in the female victim's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear contradictory to the victim's own testimony in court of exactly what events occurred in the assault.

Therefore, each garment should be placed separately in its own bag to prevent cross-contamination from occurring.

2.9.3(1) Clothing Collection Procedure
(Use paper bags only)

To minimize loss of evidence, the victim should disrobe over a white cloth or sheet of paper. If victims cannot undress on their own, and due to their condition it is necessary to cut off items of clothing, be sure <u>not to cut</u> through existing rips, tears, or stains.

Any foreign materials found should be collected and put into a small paper envelope, properly labeled and sealed with cellophane tape. If the victim consents, the clothing should then be collected and packaged in accordance with the following procedures:

1. After air drying items, such as underpants, hosiery, slips or bras, they should be put into small paper bags. Remember, infant diapers may also be valuable as evidence because they may contain semen or pubic hair. Items such as slacks, dresses or blouses, should be put into larger paper bags.

2. Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags.

It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain, so that the stains are not in contact with the bag or other parts of the clothing.

3. If, after air drying as much as possible, moisture is still present in the clothing and might leak through the paper bag during transportation to the forensic laboratory, the labeled and sealed clothing bags should be placed inside a larger plastic bag and the top of the plastic bag left open. In these instances, affix a label to the outside of the plastic bag, alerting the forensic laboratory that wet evidence is present inside the plastic bag. This will enable the laboratory personnel to remove the evidence and avoid loss of evidence due to putrefaction.

2.9.4 Dried Fluid

Semen and blood are the most common secretions deposited on the victim by the assailant. There also are other secretions, such as saliva, which can be analyzed by laboratory personnel to aid in the identification of the perpetrator.

It is important that the medical team examine the victim's body for evidence of foreign matter, and that a swab be taken and a smear made for each separate secretion. (See Wood's Lamp, Section 2.8.3.)

If secretions, such as dried blood or seminal fluid, are observed on parts of the victim's body during the examination, the material should be collected by taking a smear and a swab. A different swab and smear should be used for every secretion collected from each location on the body. These supplies are not provided for in the evidence collection kit. Please use available hospital supplies and include in evidence collection kit, labeled and returned to forensic laboratory.

2.9.4(1) Dried Fluid Collection Procedure

Dried secretions are collected by moistening the swab slightly with distilled water and swabbing the indicated area. After the smear is taken and the slide prepared, the slide should be returned to a mailer and allowed to dry, then the mailer is labeled and sealed with tape.

If no cardboard tube is available, the cotton swab should be placed in an envelope or paper bag, which is then labeled and sealed. The examiner must be sure to indicate on the label the location of the secretion on the victim's body.

2.9.5 Bite Mark Evidence

Bite marks may be found on victims as a result of a sexual assault or other violent crimes and should not be overlooked as important evidence. Bite mark impressions can be compared with the teeth of a suspect and can sometimes become as important, for identification purposes, as fingerprint evidence.

The collection of saliva and the taking of a photograph of the affected area are the minimum procedures that should be followed in cases where a bite mark is present. Saliva, like semen, demonstrates blood group factors characteristic of their donor. Therefore, the collection of saliva from the bite mark should be made prior to the cleansing or dressing of any wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva.

It is important that photographs of bite marks be taken properly. It is recommended that a representative of the local law enforcement agency be contacted when this hospital procedure is developed, to provide the proper instructions on how to take photographs of bite mark evidence if hospital personnel are to take the photographs.

In many bite mark cases it is also vital to have a three-dimensional cast made. Whenever possible, a dentist or a forensic odontologist should be called to examine the bite mark, make the cast and further document findings.

Hospitals either should contact the Forensic Science Division of the Department of Health and Consolidated Laboratories for a listing of qualified forensic odontologists who can assist in this process, or the American Board of Forensic Odontology, Inc., which can furnish a list of their members.

2.9.5(1) Bite Mark Collection Procedure

In cases where a bite mark is present, the minimum procedures that should be followed are the collection of saliva and the taking of a photograph of the affected area.

Saliva is collected from the bite mark area by moistening a swab with distilled water and gently swabbing the affected area, following the same procedure as instructed for other dried fluids.

To demonstrate the size of the bite mark, a ruler should be placed adjacent to but not covering the bite mark, and then photographed. These supplies are not provided for in the evidence collection kit. Please note the presence of bite marks on the body diagrams before returning the evidence collection kit to the Forensic Laboratory.

2.9.6 Hair as Evidence
(See Appendices A-1 and A-2, Steps 5, 6, 9, and 10)

For the past several years, there has been much controversy surrounding the collection of head and pubic hair from sexual assault victims. Many forensic scientists and prosecutors believe that obtaining these standards (pulled hair with roots) at the time of a victim's initial hospital examination can provide vital evidence in the prosecution of sexual assault cases.

Hair occurs in three growth states: anagen (actively growing), catagen (resting stage), and telogen (ready to be shed). There are subtle morphological differences that can be detected by a trained microscopist as the growth stages progress.

During an assault, the hair most likely to be transferred from suspect to victim or victim to suspect tends to be telogen. Other hair transferred during an assault is pulled out by friction or other means of forcible removal. Most of this hair tends to be anagen or catagen.

Known hair samples from the head and pubic regions of the body usually are obtained by using the following technique:

> The samples are taken separately by combing and pulling out the hair. This technique results in obtaining telogen hair, as well as actively growing hair which will exhibit roots. These roots can be used as an integral part of a forensic comparison of questioned and known hair. This procedure generally is regarded as the best alternative for forensic comparisons.
>
> Samples taken by cutting the hair on the head or in the pubic area are generally agreed by forensic analysts to be the worst alternative for comparative purposes and should be avoided. Although hair which has been cut quite close to the skin sometimes can provide comparative value on an extremely limited basis, it lacks essential features found by analyzing at or near the root of the hair. Furthermore, those submitted as "locks" or "tufts" of hair are considered virtually worthless for comparison purposes.

2.9.6(1) Pulling and Combing Pubic and Head Hair at Initial Examination
(See Appendix A-1, Step 5 and Step 6)

The proper collection of representative hair standards from the sexual assault victim is the only way to ensure that hair standards will be usable for comparison with evidence hair which may be recovered from the crime scene, suspect's clothes, or victim's own body or clothing.

Since the most advantageous time to recover physical evidence is as soon as possible after the crime has occurred, and the initial

examination of the victim is the first major opportunity for such recovery, it is best to collect hair standards at that time.

Routine cosmetic changes may occur between the time of the initial examination and the weeks or months that follow. Hair alterations may include cutting, bleaching by the sun, chemical bleaching, dyeing, frosting, straightening, the use of permanents, and the appearance or disappearance of lice or other parasites. Collecting hair standards at the time of initial examination is undeniably the best method to avoid encountering cosmetic changes.

2.9.6(2) Procedures for Collection of Combed Pubic and Head Hair (See Appendix A-1, Step 5 and Step 9)

The top, back, front and sides of the victim's head hair should be combed over a piece of paper to collect all loose hair and fibers.

The combings and the comb are to be placed in an envelope marked "head hair combings"; the labeling information should be completed and the envelope sealed with tape.

A second comb should be used to collect any loose hair or fibers from the pubic area, over a piece of paper or paper towel to collect the hair. Victims may prefer to do the combing themselves to reduce embarrassment and increase their sense of control.

The pubic hair combings and the comb are placed in a second envelope marked "pubic hair combings". After the labeling information is completed the envelope should be sealed with tape.

Combings should be done vigorously and thoroughly to lessen the chance that valuable evidence may be missed. Therefore, it is important that the combs used for the head and pubic hair be of a good quality so that the teeth will not break off when combing through thick or curly hair.

Where there is evidence of semen or other matter or material on pubic or head hair, it may be collected in the same manner as other dried fluids. The swab should then be placed in a small paper envelope and labeled "possible secretion sample from head hair". Although this specimen also can be collected by cutting off the matter or material, it is important to obtain the victim's permission prior to cutting any significant amount of hair.

2.9.6(3) Pulled Standards of Pubic and Head Hair (See Appendix A-1 and A-2, Step 6 and Step 10)

A standard sample of at least fifteen head hair should be collected, consisting of a minimum of three strands of hair pulled from each of the following areas: back, top, front, left side, right side. To minimize victim discomfort, the attending physician or nurse can pull the hair, 2 (two) strands at a time,

using the thumb and forefinger. Forceps and hemostats should not be used.

The pulled head hair is to be placed into an envelope, and the envelope should be labeled and sealed with tape.

A standard sample of (10) ten to (15) fifteen strands of pubic hair should be collected from various areas of the pubic region. The hair should be plucked 2 or 3 strands at a time with thumb and forefinger or, if the victim wishes, he/she can perform this procedure. Forceps and hemostats should not be used.

The absence of pubic hair should be noted. The pulled hair should be placed in an envelope which is labeled and sealed with tape.

2.9.7 Swabs and Smears
(See Appendix A-1, Step 7 and Step 8)

2.9.7(1) General Information

The purpose of making smears is to allow the forensic analyst to test microscopically for the presence of spermatozoa. If no spermatozoa are present, the analyst will then proceed to use the swab(s) to identify the seminal plasma components to confirm the presence of semen.

The number of tests that forensic laboratories can perform is limited by the quantity of semen or other fluids collected; therefore, two swabs should be used when collecting specimen from body orifices.

Depending upon the type of sexual assault, semen may be detected in the mouth, vagina and rectum. However, embarrassment, trauma, or a lack of understanding of the nature of the assault may cause a victim to be vague or mistaken about the type of sexual contact that actually occurred. For these reasons, and because there also can be leakage of semen from the vagina or penis into the anus, even without rectal penetration, it is recommended that the victim be encouraged to allow all three orifices to be examined and specimen collected from them.

In cases where a victim insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), it is important for the victim to be able to refuse these additional tests. This "right of refusal" also will serve to reinforce a primary therapeutic principle -- that of returning control to the victim.

When taking swabs, the examiner should take special care not to contaminate the individual collection with secretions or matter from other areas, such as vaginal to rectal or penile to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

If victims must use bathroom facilities prior to the collection of these specimen, they should be cautioned that semen or other evidence may be present in their pubic, genital and rectal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.

A pencil should be used when labeling frosted-end slides to lessen the chance that the labeling information will become smudged. It is suggested that pencils be of the "golf" variety as they contain hard lead and are pre-sharpened, eliminating the need for hospital staff to worry about pencil sharpening during the examination.

2.9.7(2) Vaginal Swabs and Smears
(See Appendix A-1, Step 7)

When collecting the vaginal specimen, it is important not to aspirate the vaginal orifice or to dilute the secretions in any way.

2.9.7(3) Vaginal Swabs and Smears Collection Procedure

The vaginal smears are prepared by using two cotton swabs together and swabbing the vaginal orifice.

The examiner must be sure that the frosted end slides are properly labeled and include the word "vaginal" to indicate the origin of the specimen. After the glass slides have been placed back into the mailer, they should be air dried before sealing. The slides should not be fixed or stained.

After the label specifying "vaginal smear" has been affixed to the mailer, the mailer should then be sealed all around with tape.

The vaginal cotton swabs are then allowed to air dry before being placed in a second cardboard tube. They should be labeled and sealed as was done for the oral swabs. Immediately following this procedure, the pelvic examination should be performed and medical cultures taken.

2.9.7(4) Penile Swabs
(If Sexual Assault Evidence Collection Kit is available use the envelope labeled Vaginal Smear/Swab. See Appendix A-1, Step 7.)

For the male adult and child victim, the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice; and feces or lubricants might be found if rectal penetrations occurred.

The proper method of collecting the penile swab evidence is to slightly moisten two cotton swabs with distilled water and thoroughly swab the external surface of the penile shaft and

glans. All outer areas of the penis and scrotum where contact is suspected should be swabbed.

These swabs are not, however, for use in the medical diagnosis of a sexually transmitted disease; therefore, they should not be used to swab inside the penile opening at this time.

When the penile swabs are air dried, they are placed in a cardboard tube. A white label is completed, affixed to the tube without covering the air hole, and the tube flaps are sealed with tape.

It is at this time that swabs should be made for detection of possible sexually transmitted disease.

2.9.7(5) Oral Swabs and Smear
(See Appendix A-1, Step 8)

The oral smear can be as important as the vaginal or rectal smears. The purpose of this test is to recover seminal fluid from recesses in the oral cavity where traces of semen could survive. This test should be done first, so that the victim can rinse out his or her mouth as soon as possible. Such a practice will reduce a significant source of unnecessary victim distress.

2.9.7(6) Oral Swabs and Smear Collection Procedure
(only if oral assault has occurred)

The oral smear is prepared by using two cotton swabs together and swabbing the mouth. Attention should be paid to those areas of the mouth, such as between the upper and lower lip and gum, where seminal material might remain for the longest amount of time.

The kit does not provide a slide for the oral/rectal smear. The hospital is asked to provide one if an oral/rectal assault occurred.

The material from the swabs should be gently rubbed onto a glass slide which has been labeled in pencil and contains the word "oral" to indicate the source of specimen. After the slide has been placed in a cardboard mailer, it should be allowed to air dry before sealing. The slide should not be fixed or stained.

When the oral swabs have air dried, they should be inserted into a cardboard tube.

The end flaps are to be sealed with cellophane tape, but care must be taken not to cover the air hole on the tube with the tape.

A white label should then be completed and affixed to the cardboard tube.

2.9.7(7) Rectal Swabs and Smear (only if rectal assault occurred)
(See Appendix A-1, Step 8)

The kit does not provide a slide for the rectal smear. The hospital is asked to provide one if a rectal assault occurred.

The rectal smear is prepared by using two cotton swabs at the same time and swabbing the rectum. To minimize discomfort for the victim, these swabs should be moistened slightly with distilled water.

After preparing the slide, it should be placed in a cardboard mailer, allowed to air dry, then affixed with a label and sealed.

After the anal swabs have air dried, they should be placed in a third cardboard tube, and the tube sealed and labeled in the same manner as the oral, vaginal and penile swabs. At this time, any additional examinations or tests involving the rectum should be conducted.

2.9.8 Saliva Specimen
(See Appendix A-2, Step 11)

Although ABO factors are found in everyone's blood, approximately 75-80% of the population also demonstrate ABO factors in their body secretions (semen, saliva, vaginal secretions, etc.). Such persons are called ABO secretors. The remaining 20-25% are called non-secretors, because they lack ABO factors in their secretions.

In the ABO analysis of secretion mixtures, such as semen and vaginal secretions, the ABO type of the victim must be identified in order to evaluate properly the blood type of the other contributor. A dried sample of known saliva and the known liquid blood sample are used to determine the ABO secretor status of the victim.

Filter paper discs should be used for the collection of the saliva sample. Unlike gauze pads, filter paper air dries quickly. Also, the loose weave structure of some gauze pads tend to disperse the saliva, making it more difficult to analyze.

2.9.8(1) Saliva Specimen Collection Procedure

It is important that this specimen not be contaminated by outside elements. Therefore, the victim should not smoke or have anything to eat or drink for at least 15 minutes prior to this procedure. But remember, if there has been oral contact during the sexual assault the victim may wish to wash out her/his mouth. Please perform this procedure as soon as possible for the victim's comfort.

The examiner should collect a saliva sample by using a filter paper disc which is already packaged in a small, presealed

envelope. The victim should manually place the disc in his/her mouth, saturating it with saliva. Labeling information on the envelope is then to be completed.

Victims should be reminded not to chew the disc; moistening it for a few seconds usually is sufficient. Victims should also be instructed to remove the disc with their own fingers. The disc must not be removed by anyone other than the victim unless a hemostat is used, because the slightest contamination from another person's secretions may be detected by the forensic analyst.

When dry, the disc is to be completely inserted back into the envelope and the envelope sealed with tape.

2.9.9 Whole Blood Specimen
(See Appendix A-2, Step 12)

In some cases of sexual assault, blood will be found on the offender, the offender's clothes and/or at the crime scene. There also may be blood found on the victim or the victim's clothing.

The purpose of collecting whole blood is to determine the blood group of the victim. Blood groups are defined as inherited factors which appear in blood and certain body fluids, also known as genetic markers.

The ABO blood group is the most common blood group to the general population and divides the population into four types: A, B, O and AB.

Blood tubes either contain an anticoagulant or no anticoagulant. Tubes without an anticoagulant, such as the red top tube, result in clot formation of the cells which must then be physically separated from the clot in order to perform ABO typing and other blood group determinations. However, this tube is preferred by some analysts who feel that anticoagulants have a negative effect on additional blood group factors.

Other analysts prefer the use of anticoagulants, such as those contained in the yellow top (ACD) tube or purple top (EDTA) tube, because the red blood cells used for typing remain separated and do not coagulate. The Sexual Assault Evidence Collection Kit contains a yellow top tube.

In view of the additional medical requirement to collect blood to test for sexually transmitted disease (see Section IV) it is recommended that only one tube be used for evidence collection purposes.

Finally, it is important to know that if whole blood is not collected, then it is not necessary to take either the dried blood or saliva sample. The reason for this is as follows:

Whole blood is the most reliable standard for determining the ABO blood group of the victim. The saliva sample alone may not always reveal which ABO types are present in their secretions (such as subtypes of Group A). Therefore, it is necessary to have both the whole blood and the saliva standard for the most accurate determination of which ABO factors are secreted by an individual.

2.9.9(1) Whole Blood Collection Procedure

For adults, 7 milliliters of blood should be collected in either a red or yellow top blood tube. In order to minimize victim discomfort, blood needed for the VDRL should also be collected at this time. A white label is then affixed to the blood tube.

It is important that collected whole blood samples be refrigerated but not frozen. Any additional blood or other specimen collected to determine possible sexually transmitted disease are to remain at the hospital for processing.

2.9.9(2) Dried Blood Specimen

Analysis of dried blood is a more lengthy and less informative procedure than that used for fresh blood. The purpose of obtaining a dried blood sample is to provide a "backup" or "fail safe" method which assures that the victim's ABO type can be salvaged in the event an evidence kit is mishandled.

For example, the liquid blood could putrefy (spoil from lack of refrigeration), hemolyze (cell rupture as a result of freezing), or the blood tube could break during transportation. The dried blood procedure is not intended to replace the collection of whole blood, but to act as an adjunct to its collection. This procedure is not provided for in the Sexual Assault Evidence Collection Kit but is encouraged and may be used at the discretion of medical professionals and law enforcement.

2.9.9(3) Dried Blood Collection Procedure

The examiner should place several drops of blood directly from a syringe onto a filter paper disc. After the disc has air dried it should be placed back into an envelope, and the envelope sealed with tape, labeled, and placed into the Sexual Assault Evidence Collection Kit.

2.9.10 Fingernail Scrapings and Clippings
(See Appendix A-2, Step 13)

During the course of a physical crime, the victim will be in contact with the environment as well as the assailant. Trace materials, such as skin, blood, hair, soil and fibers (from upholstery, carpeting, blankets, etc.), can collect under the fingernails of the victim.

The victim may also break a fingernail during the sexual assault. If the victim did break a fingernail during the sexual assault, then the remaining fingernail can prove to be of evidentiary value. For instance, the broken portion of the fingernail may be found at the crime scene and matched to the later obtained clipping.

Remember that the purpose of collecting fingernail scrapings and clippings is that this evidence is potentially useful for cross-transfer or identification. But also remember that the collection of this evidence, particularly the clippings, is highly intrusive to the victim.

2.9.10(1) Fingernail Scrapings and Clippings Collection Procedure

It should be determined from a victim whether or not he/she scratched the assailant's face, body, or clothing. If so, or if fibers or other materials are observed under the victim's fingernails, the nails should be scraped, one hand at a time, using an orange stick. If a fingernail(s) is determined to have been broken during the assault that fingernail(s) should be clipped as close to the skin as is comfortable. This is a function that victims may want to perform themselves, and they should be encouraged to do so.

It is important that scrapings and clippings be made for each hand over a separate piece of paper. Scrapings should be placed in one envelope and clippings in another. The paper should then be folded and placed in small, individual envelopes.

The examiner should complete the labeling information for each envelope making certain to differentiate between "left" and "right" hand on the labels. The flaps are then sealed with tape.

2.9.11 Medical Examination Documentation

2.9.11(1) Body Diagrams/Photographs
(See Appendices A-5 and A-6)

Photographs of sexual assault victims should not be taken on a routine basis. Rather, drawings of the human figure should be used showing the location and size of the injury, as well as a written description of the trauma. The Sexual Assault Evidence Collection Kit includes drawings of adult male and female figures. These adult figures should be adopted for use when a child is the victim.

Photographs of extremely brutal injuries and of bite marks can prove beneficial in court. However, many times injuries such as bruises, will become apparent only after several days. There is no guarantee that developed photographs will show the actual severity of the injury. Once taken, photographs can be subpoenaed into evidence and may hurt the case if actual injuries appear minimal or cannot be seen. Therefore, any photographs that are

taken should be limited to those instances where there is an opportunity to proceed clear pictorial evidence of injury, such as bruises or lacerations. Also, if photographs are taken, they should be done only with the specific consent of the victim.

Photographs should not be taken of the genital areas, unless the victim specifically requests this procedure, because of added trauma to the victim during the examination, as well as embarrassment in court. Again, drawings accompanied by accurate written descriptions can be as effective in court as photographs.

Finally, it is vital that all photographs be taken by a competent photographer, preferably of the same sex as the victim, and that a ruler and color chart be used to indicate the size and nature of each injury.

2.10 Terminology

Findings from the physical examination should be documented as completely as possible on the medical record. While some sexual assault prosecutions do not require the presence or testimony of the attending physician or nurse, there will still be times it is necessary. If testimony is needed, a thoroughly completed and legible medical record and accompanying body diagram will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical and evidentiary examination, the attending physician must be careful not to include any subjective opinions or conclusions as to whether or not a crime occurred.

The indiscriminate use of the term "rape" or "sexual assault" on a medical document is a conclusion that may prejudice future legal proceedings. Instead, the diagnosis on the chart should be stated as "sexual assault examination", plus any pertinent medical findings.

Also, an important distinction must be made between information gathered for the purpose of providing medical treatment, and that which is gathered for the follow-up investigation and potential prosecution.

Hospital personnel should not be expected to further expand their role to act as that of "investigator". They should not ask for details beyond those necessary to perform the medical and evidence collection tasks; it is the responsibility of the law enforcement officer who is the follow-up investigator to ask the more detailed questions.

2.11 Toxicology Blood/Urine Screen

Blood/urine screens for the purpose of determining toxicology should only be done in the following situations in cases of sexual assault:

1. If the victim or accompanying person (such as a family member, friend or police officer), states that the victim was drugged by the assailant(s); and/or

2. If, in the opinion of the attending physician, the victim's medical condition appears to warrant toxicology screening for optimal victim care.

Great care should be exercised to ensure that toxicology screens do not become routine for victims of sexual assault.

2.12 Steps Prior to Release of Evidence to the Forensic Laboratory

When all evidence specimen have been collected, they should be placed back into the Sexual Assault Evidence Collection Kit, making certain that everything is properly labeled and sealed. Any unused kit components or medical specimen collected for non-evidentiary purposes should not be included in the Kit.

The original copy of the Sexual Assault Report Form for Forensic Laboratory (see Appendix A-4) is to be included in the completed kit and a second copy may be retained for the hospital records.

All required information should then be filled out on the top of the box just prior to sealing the kit with red or orange evidence tape at the indicated area. The completed kit and clothing bags should be kept together and stored in a safe area. Paper bags are to be placed next to but not inside the completed kit.

2.13 Transportation of Evidence

Under no circumstances should victims be allowed to handle evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer physical evidence from hospitals to forensic laboratories for analysis and this must be done immediately (within a reasonable time). Remember, evidence (excluding clothing and crime scene) must remain refrigerated.

Not only is it embarrassing and offensive for victims to transport evidence collection kits but the evidence could be lost or inadvertently destroyed by being improperly stored or handled. (See Chain of Custody, Section 2.7.2 and Packaging and Refrigeration, Section 2.7.1.)

Such a procedure could prompt defense allegations of evidence tampering, switching, altering or improper preservation. For example, if the seal on the kit were to be accidentally broken, a burden would then be placed upon the victim and/or family members to prove that evidence contained in the kit had not intentionally been altered or contaminated.

2.14 Release of Evidence (See Appendix A-3)

It is the preferred practice that evidence collection items not be released from a hospital without the written authorization and consent of the informed adult victim (age 18 or older) or an authorized third party acting on the victim's behalf if the victim is unable to understand or execute the release.

An "Authorization for Release of Information and Evidence to Law Enforcement Agency" form should be completed, making certain that all items being transferred are checked off (see Appendix A-3).

In addition to obtaining the signature of the victim or authorized third party on this form, signatures must be obtained from the hospital staff person turning over the evidence, as well as the law enforcement representative who picks up the evidence.

One copy of the release form should be kept at the hospital, if possible, and the other original given to the law enforcement representative. This representative should also print and sign his or her name on the cover of the collection kit and bags of clothing and fill in the time of transfer.

2.15 Non-Authorization of Release

Although the vast majority of sexual assault victims consent to have their evidence collection specimen released to law enforcement subsequent to the medical examination and evidence collection process, there may be instances when a victim will not authorize this release. The victim should be informed that release of evidence is not a commitment to prosecute. If, for any reasons, consent is not initially received, the Sexual Assault Evidence Collection Kit will still be returned to the Forensic Laboratory. The forensic personnel will analyze and store the evidence pending later word as to prosecution. If evidence was collected without the aid of a Sexual Assault Evidence Collection Kit this evidence should also be returned immediately to the Forensic Science Division of the Department of Health and Consolidated Laboratories.

Hospital or law enforcement personnel should not react negatively to a victim's initial decision not to release evidence. Although the lack of authorization on the date of collection may be questioned in court, such reluctance can be explained easily and is not considered by prosecutors to be a serious problem.

If the release forms are not signed by the victim or an appropriate representative, a note should be included in the evidence collection kit. This note is to inform the Forensic Science Laboratory of the lack of release. If the victim later signs the form, law enforcement or medical professionals obtaining the signature should notify the Forensic Laboratory.

2.16 Follow-up

2.16.1 Victim Information Form (See Appendix A-7)

The discussion of follow-up services for both medical and counseling purposes is an important aspect of treating the sexual assault victim.

Before the victim leaves the hospital, a "Victim Information Form" should be completed. The type and dosage of any medication prescribed or administered should be recorded on the first portion of this form.

Victims should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted disease, and urinary tract or other infections within four to six weeks after the initial hospital visit. Many hospitals report that the majority of sexual assault victims initially treated at their facility do not return for these follow-up tests.

Denial of the assault or of the need for follow-up testing, especially if no unusual symptoms are experienced, are two reasons for a failure to return. Another reason is inadequate information provided by many hospitals concerning the necessity for follow-up treatment.

Therefore, it is vital that both written and verbal information be provided, including the location of a public health clinic or a referral to a private physician for medical follow-up if the victim does not wish to return to the treating hospital. Victim advocates can be helpful in explaining the need for a return visit and what kinds of tests should be performed.

The second portion of the "Victim Information Form" should be used for the recording of follow-up counseling information. An appointment should be recommended or scheduled with a trained hospital counselor, or a referral made to a victim advocate, social worker or psychologist in the community who is known to provide quality service.

While encouragement should be given to seek follow-up counseling, the victim's decision to do so must be voluntary. For many reasons, some victims may be reluctant to talk with a counselor; however, they are more likely to participate if counseling has been coordinated with the examination process.

The original copy of the "Victim Information Form" should be given to the victim and a second copy may be retained for the hospital's records.

2.16.2 Follow-up Contact

Any further contact with sexual assault victims must be carried out in a very discreet manner. Concern should be shown about victims receiving mail or telephone calls at home or work which might breach confidentiality or cause embarrassment.

Victims should be asked, prior to leaving the hospital, whether or not they can be contacted about follow-up services, and if so, at what address and/or phone number.

2.16.3 Brochures

(See Appendix A-8 for agencies with brochures)

Many victim advocacy agencies and individual hospitals have developed informational brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to victims some of the common problems they may encounter, such as disturbances in sleeping or eating patterns, flashbacks of the attack, and post traumatic stress syndrome. Brochures also can provide reassurance to the victim that sexual assault victims are not responsible for the assault.

Brochures should also contain information about local or state resources such as victim compensation programs and availability of counseling services. If at all possible, arrangements should be made to provide a copy of such publications to sexual assault victims and their families when they leave the hospital.

2.17 Procedure Prior to Hospital Discharge

Many victims would like to wash up after the examination and evidence collection process and arrangements should be made by the hospital or law enforcement to provide the basics required, such as mouth rinse, soap and a towel.

If garments are collected for evidence purposes and no additional clothing was brought to the hospital, arrangements should be made to ensure that no victim has to leave the hospital in an examining gown.

This is an issue which hospitals and law enforcement can address by developing a community plan with local law enforcement agencies and victim assistance organizations. In those instances where police officers transport victims from their homes to the hospital, officers should be instructed to advise victims to bring an additional set of clothing with them in the event any garments are collected.

Some victims may wish to have a family member or friend contacted to provide substitute clothing. When the victim does not have personal clothing available necessary items could be supplied by hospital volunteer organizations and/or local victim assistance agencies.

2.18 Law Enforcement Investigative Interview

Many police departments, especially within metropolitan areas, have investigators or detectives whose duties include sexual assault investigations. These officers do not answer the initial call but rather enter the case after the responding officer has written his/her report.

Upon arrival at the hospital, the investigator should talk with the responding officer and/or attending hospital staff to obtain information about the assault and the condition of the victim.

In most cases, the investigator will conduct the follow-up interview after the victim already has been interviewed by the responding officer and the hospital staff. Therefore, it is very important that the need for this third interview be explained to the victim, especially the reason why more detailed questions must be asked.

Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information that the investigator must have in order to get an accurate picture of the circumstances surrounding the assault and to prepare a report for the prosecutor.

General guidelines for this interview include the following:

1. The interview should be conducted after the medical examination and evidence collection procedure have been completed.

   In some cases, it may be necessary to delay this interview for several hours or longer. Often, delays at hospitals are caused by the length of time necessary for the medical examination and determination by emergency room staff as to the victim's "readiness" for such an interview. The follow-up investigator must understand the role of hospital staff and the functions and priorities of the emergency room in coping with these delays.

2. If the follow-up interview is conducted at the hospital, it must be held in a private setting and one which is free from outside interruptions. If a suitable arrangement cannot be made, the investigator should schedule the interview at a later time and place, e.g., the police station or the victim's home.

3. With the consent of the victim, it is appropriate that a support person who was present during the medical and evidence collection examination also be present during this interview.

4. The interviewer should be sympathetic and understanding of the victim's trauma, while at the same time effective in collecting all necessary information about the assault.

5. The interviewer should establish him/herself as an ally of the victim, and try to cushion the victim from pressures by family, friends, and other workers as well as from possible threats made by the attacker.

6. The victim should be allowed to tell his/her story without interruption by the interviewer. This will also afford the victim an opportunity to vent pent-up feelings in describing the assault. A special note should be made to record anything the attacker might have said in order to help establish the modus operandi or crime pattern.

7. The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear.

Transportation should be arranged when the victim is ready to leave the hospital. In some cases, this will be provided by a family member, friend or victim advocate who may have been called to the hospital for support. In other cases, transportation can be provided by the local police department as a community service.

SECTION III CHILD PROTOCOL

Often a sexual assault with a child victim is referred to as "sexual abuse". However, for the purposes of this Protocol, it will be referred to as "sexual assault" and defined as set out in Section 1.1.

3.1 Intra and Extra-Familial Child Sexual Assault

The sexual assault of children falls into three major categories:

1. Sexual assault of a child by a stranger, many times involving kidnaping and/or the use of a weapon. These assaults usually occur on a random basis, are more likely to result in severe physical injuries of the child, and account for a growing number of sex-related deaths of children.

2. Sexual assault of a child through the use of pornographic materials and exploitation. Many of those involved are "run away" or "throw away" children who are dependent upon the exploiters for physical survival, and in some cases, even affection.

3. Sexual assault of a child by a family member or other person known to the child and whom the child trusts to some degree.

The offender in intra-familial child sexual assaults is related to the child victim through blood, marriage, adoption, or common living arrangement, and generally involves the following relationships:

1. The offender is legally related and a member of the child victim's immediate family (natural or adoptive parent, sibling).

2. The offender is a member of the child victim's extended family (e.g., grandparent, aunt/uncle, cousin).

3. The offender is not legally related but is seen by the child as part of the immediate family because the offender lives or has daily contact with the family (step parent, guardian/foster parent, male or female friend of parent).

The offender in extra-familial child sexual assault is not considered a part of the child's family. However, this person usually has an opportunity for frequent contact with the child and/or represents an authority figure which the child may believe to be synonymous with trustworthiness. These relationships include, but are not limited to the following:

Neighbor, day care/school employee, clergy, scout leader, friend of family, baby sitter.

Many children have been sexually assaulted in some way over a period of years. Long-term sexual activity is common in intra and extra-familial situations beginning when the child was three or four years of age or younger, and continuing well into adolescence or until the child leaves home.

Until recently, there has been little opportunity for many young children to learn outside the home what constitutes appropriate and inappropriate physical contact with an adult or older child. Secrecy associated with the sexual activity, or threats of personal harm to the child or to the child's family, may cause the child to sense that something is wrong. However, unless children are educated about proper and improper touching and the importance of telling someone when inappropriate behavior occurs, many children do not understand that they should report the incident(s).

The situation is made even more complicated when the offender is someone whom the child loves and/or trusts, such as a parent or other close family member.

Many times intra- and extra-familial sexual assault begins as fondling or gentle touching, and only escalates to manual penetration or full intercourse after an extended period of time. The offender is usually viewed as an authority who "must know what is best" which often allows the offender to convince the child that the sexual contacts are normal.

Some children become adolescents before realizing, through normal discussions with other teenagers about family life and events, that the sexual contact they have experienced is wrong and does not usually occur in other households. By this time, however, the child may have assumed a great amount of guilt about the sexual activities and may be even more reluctant to reveal the situation to a family member or any adult.

When an attempt is made to talk to someone about the sexual activity many children are unable to communicate what is happening. Even when the child is quite verbal, the listener may dismiss the account as "make believe" or accuse the child of lying. When no action is taken to protect the child from further abuse, the child may decline to initiate the subject again.

Because of the inability of most children to secure medical treatment on their own, the majority of sexually assaulted children do not receive immediate medical attention. When medical attention is received, it is usually at the request of a third party.

This request is frequently made by a parent who notices unusual genital soreness, discharge or urinary problems, by a teacher who

sees a sudden change in the child's behavior, by a relative who suspects physical abuse, or by a physician who discovers gonorrhea from a vaginal, urethral or throat culture.

3.2 Statute of Limitation

In North Dakota there are certain provisions of the law which grant different treatment to the period of time within which the prosecution of a sexual assault with a child victim may be commenced. (See Appendix A-17.)

The determination of whether action will be commenced within the appropriate period of time is one which is made by law enforcement and the criminal justice system. However, an awareness of the above cited statutes of limitations will provide the responding team of professionals with a better understanding of the time parameters.

3.3 Treatment Facility

Ideally, each hospital designated to treat adult victims of sexual assault will also have a multi-disciplinary team, available on an on-call basis, for the evaluation and examination of child sexual assault cases.

This team ideally should consist of a pediatrician for the physical examination, and a social worker and/or nurse to provide victim support and to provide coordination with the law enforcement and child protection agencies. An obstetrician/gynecologist should also be available on an on-call basis to provide consultation and follow-up when necessary. Each team member must be trained in the management and psychodynamics of the child sexual assault victimization

In the absence of those resources, the minimum requirements should be a readily available physician and nurse, both of whom are trained in the medical and psychodynamic aspects of a child victim of sexual assault.

3.3.1 Intake

Children are often brought to the hospital by a police officer and/or parents who are seeking examination and treatment.

When the child is accompanied by an officer, the officer should be directed immediately to the emergency/pediatric department so that a brief history of the assault can be provided to the attending medical staff.

If the child's parent or guardian also is present, he or she should then be asked if there is any additional information about the event that should be shared with the physician. In cases involving young children, the parent/guardian also should be asked to provide the physician with the child's medical history.

Since children many times will tell health professionals things they may not tell in the presence of parents or other adults, adolescents and older children should be encouraged to provide much of their own medical history, as appropriate. This interview should be conducted in a private area, and information regarding sexual history (of both males and females), menstrual history and use of birth control should be recorded.

The child's parents/guardians should be informed about and prepared for the physical examination by the nurse or the physician. They should also be told that specific lab tests will be done, the purpose of each test, and when the results will be available.

3.3.2 Reporting

Every case of known or suspected child sexual assault must:

(1) be reported to the appropriate child protection services and/or law enforcement agency;

(2) be considered a medical emergency; and,

(3) be seen without delay only after other acute cases, such as trauma or ingestions. (See N.D.C.C. ch. 50-25.1, Appendices A-19 and A-20. Also see N.D.C.C. § 43-17-41, Appendix A-18.)

3.4 Support Personnel

Under no circumstances should the child be left alone during their time at the hospital. Arrangements must be made to provide a support person who can establish a good rapport with the child.

As with adults, an important first step in intervention is to help children regain a sense of control over their bodies. For adolescents, this may be aided by allowing them a choice of the support person to be present during the physical examination. This support person could be a trained hospital social worker or nurse, a trained victim advocate, or a family member.

A support person of the same sex as the child can be quite reassuring and, in fact, may be required by many institutions for staff protection.

3.5 Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from parents/guardians of all children under the age of 18. Any child victim may personally consent to emergency care, and any child victim age fourteen or older may personally consent to receive examination, care, or treatment for venereal disease. (See N.D.C.C. § 14-10-17 and N.D.C.C. § 14-10-17.1, Appendix A-14.)

Fortunately, there are few situations when the parent/guardian will refuse to consent to these procedures. However, if consent cannot be obtained from the parent or guardian of the child, and if the child is in danger from his or her surroundings and requires immediate attention, appropriate authorities, such as a social service agency, should be notified immediately. In the case of parental refusal, children may be taken into protective custody by either law enforcement or a child protective service agency - a representative of the custodial agency can then sign an appropriate consent form as temporary guardian of the child.

This will allow the medical staff to provide diagnosis and treatment, the child protective and law enforcement agencies to investigate the assault, and at least on a short-term basis, protection of the child from further abuse.

In such cases, procedures established by policy or by law should be carefully followed in each jurisdiction.

3.6 Child Interviews

Many sexually assaulted children who are brought to a hospital for examination and treatment have not yet been interviewed by law enforcement or child protective service workers. Therefore, it is likely that the examining physician will be the first person to interview the child about the event(s).

It is the goal of the attending physician to get only that information necessary to complete the medical examination and for the collection of evidence. The law enforcement representative in conjunction with support personnel (preferably a child protection services worker) has the responsibility of investigating the allegations of suspected child sexual assault or neglect. It is important for all responding professionals to be aware of their role in order to minimize the trauma to the child of multiple interviews.

3.6.1 General Information

Interviewing children about an assault of any kind, physical or sexual, is not an easy task. It can often be difficult to get the child to talk or to understand what the child says. Many professionals are not really comfortable with children and may be unaware of techniques for establishing rapport with children.

When children are asked about their sexual activities with adults or other children, many times their inability or reluctance to answer these types of questions is due to embarrassment, shyness, a fear of being thought of as a "tattletale" or disloyal, or simply due to a lack of understanding of the question itself.

With children interviewers must be aware of the long-term ramification of their questions to a much greater degree than with adults. While the immediate goal is to elicit the clearest

possible information from the child, the interviewer should be aware of his/her own feelings about a child sexual assault and not communicate any attitudes which might create or increase the child's trauma. This is especially important in cases of sexual activity involving a family member where, in the child's mind, the action may have been viewed as one of affection.

Prior to the interview, it is important to determine what reactions the child has been exposed to following the disclosure of the sexual activity. For instance, the medical professional should try to ascertain if the child's family has been supportive, panicked, ambivalent, disbelieving, angry or blaming.

Also, parents and others who have regular contact with the child should be questioned, whenever possible, about any behavioral changes they have observed.

Indicators of a child sexual assault perpetrated by a family member or other trusted individual, however, are not always concrete. Therefore, hospital staff should be alert for signals from the parent/guardian which may indicate sexual activity, including but not limited to the following:

1. The child staying inside the house more frequently;

2. The child not wanting to go to school;

3. The child crying without provocation;

4. The child bathing excessively; and/or

5. A sudden onset of bed wetting.

An assessment of the child's emotional state is a vital part of the interview process. This is an age-dependent interpretation such as how the child relates, his or his body posture, and the language used.

It is also important to assess the child's verbal skills level and to use terms that are understandable to the child. This assessment can many times be accomplished by asking topical questions about family, school, television and everyday events. After a degree of rapport has been established, the child can then be asked to describe what happened.

The interviewer should be supportive and sensitive through tone of voice, body expression, and the maintenance of eye contact. The interviewer should also sit at eye level with the child so that the child is not intimidated and so that the interviewer is perceived as genuinely interested.

The child must be allowed to tell about the incident(s) with as few interruptions as possible and to use his/her own words in describing what happened.

It is absolutely vital that the child be believed at all times, especially in cases of disputed accounts by adults. The child's account should be taken at face value. Avoid making value judgments and expressions of shock or surprise.

It must be made very clear to the child, as often as needed throughout the interview, that the child was not at fault for what happened and that medical staff are there to help and protect him/her.

Statements made by the child should be recorded accurately. The child should not be led in such a manner that he or she answers questions to "please" the interviewer.

Younger children often have problems with times and dates. In order to establish a time frame in which the abuse occurred, it can help to discuss favorite events or activities. These could include asking about television shows, a vacation or trip to see a relative, going to the zoo, or a birthday.

Younger children also have a short span of attention. Therefore, the interviewer should avoid long and open-ended questions and provide short rest periods at appropriate intervals during the interview. For example, "Tell me about the assault?" would be an open-ended question. Instead, it would be better to use a series of short questions calling for direct response such as, "Did someone touch you in a way that made you uncomfortable?"

The use of interview aids is extremely helpful. Drawings, pictures and anatomically-correct dolls are particularly effective.

It may be necessary for the interviewer to follow-up the child's description with clarifying questions in order to learn exactly what happened. For instance, in situations where penetration did not occur but where there was other sexual contact, the child may not at first differentiate between oral and manual stimulation.

It is important that medical personnel be aware that multiple interviews can be very traumatic for child victims. It is anticipated that the information they need to obtain will be gathered during this initial medical examination.

3.7 Medical History Interview

An experienced professional medical staff person should conduct a preliminary medical history interview of the child.

The purpose of this interview is to obtain the information necessary to conduct a proper medical examination and possible collection of physical evidence. A more thorough, detailed investigative history will be obtained by law enforcement and child protective agency personnel at a later time.

The interview should be held in a private room adjacent to the emergency or pediatrics department and must be free from interruptions.

The interviewer must explain his/her need to know what happened and what procedures will be done. He/she should also use simple terms, including the child's vocabulary for body parts, acts, and people.

3.7.1 Presence of Personnel

As few persons as possible should be present during the medical interview/evaluation or examination/evidence collection process. Attending personnel should consist of the examining physician, an authorized support person and/or nurse.

3.7.2 Presence of Parent/Guardian

In all cases of a known or a suspected child sexual assault, the medical person in charge must decide whether or not the presence of a parent or guardian during the evaluation or medical examination is desirable.

Many times it is not preferable to have a family member present during the medical history interview or physical examination of the child, in order to minimize confusion and additional trauma to the child, and for the purpose of obtaining information that might otherwise be censored.

Some parents may be so emotionally distraught or disbelieving upon hearing the child's narrative that their presence has a negative impact upon the child and the interview/examination process. When these situations occur, the parent/guardian should be taken to a private area and provided with support and comfort.

However, if the child expresses a need for support from a parent/guardian, and that parent/guardian is not the suspected offender, their presence may be appropriate if they are supportive to the child.

<u>Under no circumstances, however, should the interview/evaluation be held in the presence of a parent/guardian who is the suspect offender.</u>

3.8 <u>Medical/Evidentiary Examination</u>

The medical examination should consist of a general physical examination, a genital examination, and where appropriate, the collection of physical evidence.

3.8.1 Steps Prior to the Examination

All equipment, containers, and other materials necessary for the examination and evidence collection procedures should already be in the room prior to the child's entry.

Basic equipment should include the following:

1. Routine examination equipment;
2. Appropriate lab slips and cultures;
3. Blood collection equipment;
4. Speculum for adolescent females;
5. Wood's Lamp (Ultraviolet illuminator) (see Section 2.8.3);
6. Sexual Assault Evidence Collection Kit (if appropriate); and
7. All medical and evidence collection paperwork.
8. Use of Colposcope (see Section 3.8.5)

In preparation for the examination, the child should be completely undressed (except for underwear), and be wearing an examination gown. Help with this process can be provided by the attending nurse, support person and/or parent guardian (if present).

1. Throughout the examination, great care must be taken to minimize additional trauma to the child. For instance, many children have never before been in a hospital environment. Factors such as the presence of unfamiliar equipment (most of which can be quite "scary" in appearance), and the necessity of darkening the examining room in order to conduct the Wood's Lamp procedure properly, can be extremely disconcerting and frightening to a child.

   Therefore, all examination procedures must be explained to the child prior to being performed.

2. It is important for the examiner to be aware that children interpret statements literally. For example, avoid making statements such as "I'm doing cultures to see if there are bugs in there!" Children may think this means they are dirty or have something "alive" inside them.

3. The examiner should reinforce the idea that the child is not "damaged goods", or irrevocably marked in some obvious way.

4. The child should not be restrained in order to do the examination and/or to gather evidence. If the child is visibly upset, the physician should determine what measures are to be taken to reduce his/her anxiety.

   Some cases may require the use of sedation; however, it is recommended that general anesthesia not be administered except in the most extreme cases, such as in a life-threatening situation or when the removal of a foreign object would cause undue pain and trauma to the child. Careful explanation of any sedation or anesthetic should be provided to both the family and to the child.

3.8.2 Evidence Collection

Regardless of when the assault might have occurred, valuable evidence can still be obtained through a medical examination and interview of the child. Therefore it is vital that such an examination still be performed and that all paperwork be completed, whether or not evidence specimen are collected.

If it was determined during the medical history interview that the last sexual contact took place more than 72 hours prior to the hospital visit, the percentage of cases where transfer of trace evidence will still be present on the child's body or clothing will be significantly low. This will be most common in situations involving long-term sexual activity. Therefore, a careful evaluation of each case must be made to decide which, if any, evidence collection procedures should be implemented.

If it was established that the last sexual contact took place within the prior 72 hours or if the time frame could not be determined, then evidence procedures should be implemented according to the instructions given for adults, but with the following modifications:

With young children, the amount of blood collected for forensic purposes should be limited to only 3 milliliters.

If it is determined that simultaneous use of two rectal swabs is not desirable, swabs should be used one at a time.

For the young female child and the adolescent female who is too traumatized to have a full pelvic examination, evidence specimen can be obtained by gently swabbing the exterior vaginal areas, using a moist swab or pipette.

It is recommended that hair standards not be taken from children at the time of the initial examination.

Only under the most extreme circumstances, and only after it has been determined that hair evidence is crucial to the successful prosecution of the offender, should a child's head hair be pulled.

It is further recommended that under no circumstances are pubic hair to be pulled from children.

3.8.3 Medical Examination

An immediate assessment of the child's status must be made to determine the presence of any significant vaginal, rectal, penile or other major trauma/sites of bleeding. If present, their control/stabilization must be the priority.

The more common medical indicators of a sexual assault are:

1. Presence of sexually transmitted disease;

2. Unexplained vaginal bleeding, discharge, or trauma;

3. Inappropriate sexual behavior for age;

4. Suspicious stains or blood in the underwear;

5. Lesions, bruising or swelling of the genital area not consistent with history;

6. Pain in the anal or genital area; and/or

7. Unexplained pain or soreness in the abdominal area.

The presence of genital and/or other types of physical injuries or abnormalities can serve as corroborative evidence and should be carefully recorded in the medical record. The location of these injuries should be recorded on drawings of the female and male body. (See Appendices A-5 and A-6.) Any specific explanations given by the child for the injury should also be included in the medical record, using the child's exact words if possible.

The medical examination of a sexually assaulted child may, in many cases, be negative. Nonetheless, the lack of any specific injury/finding in no way detracts from the likelihood that the assault occurred. A lack of physical findings may be due to many factors, such as the degree of force used, the type of activity perpetrated upon the child and the diagnostic skill of the examiner.

Prior to the full examination, a Wood's Lamp should be passed over the child. Whenever seminal fluid is present, it may florescence a characteristic light blue color. If present, specimen from these areas should be taken for submission to the forensic laboratory. The physician should:

1. Note the presence of any bruises, abrasions, lacerations, burns or other dermatologic lesions and record them.

2. Make an attempt to estimate the age of the injury; i.e., noting the color of a hematoma and the degree of healing or an abrasion.

3. Record any fractures, loose or absent teeth, grab marks, suction or bite marks, all of which are helpful in providing further confirmation of victimization.

3.8.4 Examination of the Anal, Perianal, and Perineal Area

The attending physician must decide on a case-by-case basis the extent to which rectal examinations should be performed with both female and male children during the initial examination.

Recent anal trauma may manifest itself by perianal erythema, edema or contusions, skin tags and spasm of the anal sphincter. An examination of the sphincter tone for spasm or laxity is important, and any findings should be noted.

If an anal tear or bleeding is present, an anoscopy should be performed.

Although "gaping" of the anus can be the result of certain chronic medical conditions, such as constipation, it can also be an indicator of chronic sexual activity involving the rectum.

3.8.5 Use of Colposcope

The colposcope is a binocular optical instrument used increasingly by physicians to assist in the medical examination of children who have allegedly been sexually assaulted. It utilizes a light source, provides five (5) to thirty (30) power magnification and may be equipped with a camera which allows photographs to be taken. Gynecologists have long used colposcopes for the detection of cervical cancer.

If a colposcope is available at your medical facility it can be of help when detecting lacerations, scarring or other trauma of the vaginal or anal area not easily discerned with the naked eyed. It does not touch or penetrate the child. The physician must be trained in colposcopy and experienced in the diagnosis of sexual assault to use the equipment effectively.

3.9 Genitalia

It often is helpful at the beginning of the genital examination to estimate the level of sexual maturation of male and female children by Tanner Staging.

3.9.1 Female Genital Examination

The attending physician must also decide on a case-by-case basis the extent to which vaginal examinations should be performed.

For the young female child, a complete gynecological exam is not recommended unless there is evidence or reasonable suspicion of genital trauma. However, a careful visual inspection should still be made.

In all cases where a pelvic examination is conducted, a small speculum should always be used. For victim comfort, the speculum can be moistened with warm water, but no lubricants of any kind should be used.

1. With the young child present on the mother/caretaker's lap (if appropriate), or supine on the examining table, the vaginal and perineal areas are inspected. The presence of erythema, hematomas, excoriations, abrasions, old scars, bleeding, discharge and odors as well as the overall appearance of the introitus and the interlabial spread should be recorded.

2. The urethral meatus should be examined for any signs of trauma or abnormal dilation.

3. An attempt to visualize the hymen is usually successful in prepubescent girls.

    a. The hymen most often is medically thin circular membrane originating from the edges of the vaginal entrance. Most frequently there is a central opening or openings.

    b. There are anatomical variations in both the size and types of openings ranging from unusually small and/or imperforate to completely absent.

    c. Hymenal damage can occur from causes other than intercourse or manipulation, such as athletic activities or falls. Conversely, the presence of the untraumatized hymen does not preclude ejaculation through an intact hymen.

    d. Inspection should also be directed at any discharge (seminal or purulent), as well as odors, evidence of a foreign body, tears, skin tags and tenderness.

3.9.2 Male Genital Examination

Both the glans and the scrotal area are targets of trauma in acute sexual assault.

Evidence of erythema, bruises, suction marks, excoriations, burns, or lacerations of the glans and frenulum should be recorded. The presence of testicular or prostatic tenderness or discharge from the urethra are important signs and may reflect trauma or infection.

3.10 Non-Authorization to Release Evidence

Although there have been instances where a parent or guardian has refused to authorize the release of evidence to law enforcement in child sexual assault cases, the actual incidence of this has been very low.

If this does happen, the examining physician may be able to assert authority and sign for the release. If the local child protective service or law enforcement agency are not already involved in the case, they should be contacted for assistance by hospital personnel. Each individual hospital should ascertain policy in their particular legal jurisdiction.

3.11 Follow-Up

3.11.1 Victim Information Form (See Appendix A-7)

A "Victim Information Form" should be filled out, providing the same information as is given to the adult victim. The victim's parent or guardian should sign the form at the bottom, and be given the original copy.

The provisions of psychological or counseling services for children and their parents or guardian is just as important as for adults. If this service is not available through the hospital, a referral should be made to an appropriate agency or individual with approved credentials and training in the field of child sexual assault.

It is extremely important that children return for a follow-up visit within one week to reevaluate any genital or other injuries, and to perform follow-up cultures, if necessary.

This visit will also provide the examining team an opportunity to assess how well the child and/or family are handling the stress and whether or not counseling has been received or is necessary.

3.12 Law Enforcement Interview

Depending upon the circumstances surrounding the case, some child victims will be interviewed by law enforcement and/or child protective service representatives at a location away from the hospital, such as the child's home, school or an agency facility.

It is the responsibility of the investigating officer to ascertain the most supportive environment for the child during the follow-up enforcement interview. However, space adjacent to the emergency room or pediatrics unit of the examining hospital should always be provided for those situations where the interview must be held immediately after the medical examination. Privacy is, of course, crucial to the success of this interview.

The goal of the social worker or investigator's interview with the child victim to determine whether the assault was committed by a stranger, family member or other trusted adult, is twofold:

1. To avoid further trauma to the child and offer protection to the child; and

2. To obtain accurate information needed for case investigation.

Ideally, the law enforcement interview would include the presence of a child protective services social worker, so that the trauma of multiple interviews is curtailed. It can also be helpful to have a support person present who has established a good rapport with the child during the medical examination/interview. This type of "joint response team" effort has proven effective in many areas of the country. To avoid confusion, however, it is important that only one person be the primary interviewer.

In all cases, the people present during the interview must be there for a specific purpose and must be psychologically supportive to the child.

3.13 Presence of Parent/Guardian

Although some children are more relaxed and informative without a parent/guardian present, others, particularly very young children, may not be willing to cooperative in an interview without such support. Also, parents or relatives may be the only adults to whom the child will talk. When this happens, questions can be directed to the child through these family members, but only after initial efforts of the interviewer to talk directly with the child are unsuccessful.

If a parent/guardian is present, the purpose of the interview should be explained in a straight-forward manner, and cooperation should be elicited to reassure the child that it is "safe" to talk with the interviewer.

The parent/guardian should also be told that any facial expressions of shock, disbelief or disapproval, or any verbal or physical signals to the child could impede the investigation.

As with the medical history interview, if it is suspected that the parent/guardian is the perpetrator, then under no circumstances should the interview of the child be held in his/her presence.

The support personnel/law enforcement officer should conduct the interview using the general guidelines previously discussed, with one important addition. (See Law Enforcement Investigative Interview, Section 2.18.) It is preferable that the officer be dressed in civilian clothing and not have handcuffs or weapons visible to the child. If wearing civilian clothes is not feasible, great care should be taken to minimize the amount of

paraphernalia carried during the interview so that it does not further intimidate or traumatize the child.

When the interview is concluded, it is important for the interviewer to thank the child for his or her cooperation, and with older children, to give them a telephone number where the interviewer can be reached if they have any further problems or questions.

SECTION IV SEXUALLY TRANSMITTED DISEASES (STD)

4.1 Testing for Sexually Transmitted Diseases

During the medical examination, doctors should be mindful of the possibility that the sexual assault of an adult or child may lead the victim to contract a sexually transmitted disease. Appropriate specimens should be taken at the initial examination to culture or otherwise detect viral, bacterial or other agents which could cause disease. These samples should be taken whether there appears to have been a recent assault or not, since sexually transmitted diseases may persist and sometimes not even manifest themselves until sometime after infection. Physicians should keep in mind that victims may be reluctant to reveal the full extent of the sexual assault and thus may not report oral, anal or vaginal contact or penetration right away.

The attending medical personnel will conduct the tests. Analysis of the tests will be the responsibility of the medical facility although the main purpose of these tests is to provide complete victim care a corollary purpose is evidentiary.

When the victim is a child, the presence of a sexually transmitted disease is a strong indication of sexual activity, and the presence of certain STDs might in some way link the offender to the crime. Although many infections, including venereal warts, gonorrhea and herpes genitalia, can be transmitted to an infant at birth by an infected mother, all children beyond the first few months of infancy should be considered as having been sexually assaulted if an STD is present. Therefore, all cases of sexually transmitted disease in children should be reported to the appropriate law enforcement and child protective services agency. Further, reports of sexually transmitted disease should be made to appropriate local health officers. (See N.D.C.C. ch. 23-07, Appendices A-15 and A-16.)

Although every effort should be made to ascertain whether or not the assailant is infected, few suspects are apprehended by the time the victim receives initial hospital examination and testing. Therefore, some adult victims will request immediate treatment as a precautionary measure and request contraindicated, prophylaxis be given at this time.

It could be helpful to the prosecution to have information on the presence or absence of STDs at the time of initial examination so an informed decision could be made as to whether to order additional tests of both the victim and the offender at some future date. If tests are initially negative, but at the follow-up examination the results are positive, the presumption is that the disease was contracted by the assailant.

Traditionally, tests for sexually transmitted disease in sexual assault victims have focused on screening tests for syphilis and gonorrhea. There are many types of sexually transmitted diseases.

The following represents a brief overview of those most likely to be seen in the sexually assaulted victim.

As the attending medical facility will be obtaining and analyzing this type of specimen and there must be a consideration for the chain of custody if it is to be of later evidentiary value. Remember a few simple rules.

1. Whenever any evidence is obtained, it is important to label, preserve and store it properly.

2. Watch how samples are packaged, sealed, and labeled, specifying dates, the doctor's and the victim's identity, and the area of the body from which sample was taken.

3. Minimize the number of persons who handle the sample and have each person who handles the sample initial it.

4. Note how and when samples are transferred from medical personnel to law enforcement and have law enforcement also affix initials to label.

4.2 Chlamydia

In the past few years, the incidence of Chlamydia trachomatis has escalated dramatically within the general population and has become the most prevalent cause of sexually transmitted disease in the United States.

Chlamydial organisms are unusual in that they are completely dependent upon their host cell for energy and therefore are only able to survive outside of their host environment for the briefest period of time. Transmission of organism, except in the newborn who can acquire chlamydial conjunctivitis and/or pneumonitis during passage through the birth canal, is almost always through sexual contact.

In adults chlamydial infections may be asymptomatic but more frequently are manifested in a wide variety of symptoms ranging from nonspecific urethritis to PID, orchitis, epididymitis, perihepatitis and proctitis.

In children, the exact incidence of this problem is unclear but infection with this organism has been shown to be significantly more frequent then was previously recognized. Moreover, children appear to be asymptomatically infected more often than adults especially when the infection is oral or rectal.

In the past, hospitals were reluctant to routinely test for chlamydia because the method for detection was expensive and time consuming. Recently, inexpensive fluorescent antibody tests have become available and are adequate for screening although not as sensitive as chlamydial cultures.

When symptomatic, common clinical manifestations in females, other than those in pelvic inflammatory disease, are vaginal irritation, itching and discharge. In males, a whitish urethral discharge, with and without painful urination, is a most common clinical picture.

Unlike many other STDs, tests are available to detect circulating antibodies to chlamydia. The presence of these specific antibodies can provide corroborating evidence of a chlamydial infection.

Due to the prevalence and severity of the infection, it is recommended that this test be included in the examination process for sexually transmitted disease.

4.3 Gonococcal Infection

Gonococcal infection is caused by Neisseria gonorrhea. Although newborns may acquire gonococcal infections during passage through the birth canal, older children and adults almost always become infected with this organism through sexual contact. Clinical symptoms are myriad and include, but are not limited to, newborn conjunctivitis, pelvic inflammatory disease, orchitis epididymitis, urethritis, perihepatitis, proctitis, pharyngitis, vaginitis and disseminated gonococcaemia.

The diagnosis of gonorrhea in a male can tentatively be made with a gram stain. However, a definitive diagnosis of gonorrhea is dependent in both males and females on a positive culture using Thayer Martin media and a differential sugar fermentation test.

Asymptomatic infections are not uncommon and should be treated. It is as important to recognize that chlamydial infections commonly occur in conjunction with gonorrheal infections.

4.4 Syphilis

Syphilis is caused by Treponema pallidum and is transmitted by sexual contact except in cases of congenital syphilis and in those individuals infected by blood products or contaminated needles. Clinical signs and symptoms are dependent upon any of the four stages that are manifested in the victim: primary, secondary, latent or tertiary. The diagnosis of syphilis, especially in the tertiary and latent stages, requires a high level of suspicion. Most hospitals utilize serologic tests (either an RPR or VDRL) for the initial screening of victims suspected to have syphilis.

4.5 Genital Herpes Simplex Virus Infection (HVS)

Genital herpes is the result of an infection with HSV type 1 or 2. This infection can be either symptomatic or asymptomatic and can reflect a primary, latent or recurrent process. Over 90% of genital herpes infections are due to type 2 with the remaining 10% due to type 1.

Symptoms may be limited to several localized and painful vesicles or can be systemic and associated with fever, malaise, and swollen lymph nodes, in addition to the local herpetic vesicles.

Transmission of the virus occurs during both its active and latent phases. The diagnosis of genital herpes is usually obvious from the clinical picture but immunofluoresent and serologic tests, as well as cultures, can be used to confirm the diagnosis. It is important to recognize that the presence of HSV-2 is almost always acquired through sexual contact and that HSV-1, when present in the genital area, should also arouse a suspicion of sexual activity.

4.6 Trichomonas Vaginalis

Trichomonads are protozoons which can infect the genitourinary tract of both males and females. The presence of these organisms, except in newborns who can become infected during passage through the birth canal, should be considered as indicators of sexual activity.

These organisms are easily identified by microscopically examining a fresh sample of urine or vaginal/urethral discharge. Trichomonads are approximately the size of white blood cells and are easily recognized by their unusual means of motility.

Symptoms of Trichomonas are usually localized to the site of the infection and consist of pruritus, pain on urination, urethral discharge in males, and vaginal and/or urethral discharge in females.

4.7 Genital and Anal Warts (Condyloma acuminatum)

These warts are due to infection with human papilloma virus (HPV), and except for newborns who can become infected during passage through the birth canal, transmission is almost always through sexual contact.

Condyloma acuminatum may occur as single or multiple lesions and are most often located on the glans areas of the penis or in the female on the labia, vagina and/or cervix. They can also be found in the anal canal and occasionally in the mouth, on the lips or on the breast nipples.

Condyloma usually appear as polyp like with irregular bright red surfaces. They produce few acute clinical manifestations other than obstruction (blockage of the urethra or the cervical outlet). The chronic presence of these lesions has been associated with malignant transformation. A diagnosis is usually made from the clinical appearance and location, but a tissue biopsy may occasionally be needed to differentiate these from other warts.

Autoinnoculation has been identified rarely and should be a diagnosis of exclusion.

4.8 Nonspecific Vaginitis

This is probably the most common form of vaginal infection in post pubescent sexually active females and represents the complex interaction of several organisms.

Gardnerells vaginalis is the organism most frequently identified in women with nonspecific vaginitis and it is often accompanied by anaerobes, Mycoplasma hominis and Ureaplasma Urealyticum.

Infections may be either asymptomatic or associated with local vaginal/urethral discharge, pruritus and burning on urination. The vaginal discharge is usually whitish gray and is striking because of its "fish like odor", especially when hydrogen peroxide is added to it.

4.9 AIDS (Acquired Immune Deficiency Syndrome)

AIDS is an infectious disease. It is contagious but it cannot be spread in the same manner as a common cold. Rather, it is contagious in the same way that sexually transmitted diseases are contagious. AIDS can also be spread through the sharing of intravenous drug needles and syringes used for injecting illicit drugs.

AIDS is not spread by common everyday contact, but often, by sexual contact through penis-vagina, penis-rectum, mouth-rectum, mouth-vagina, mouth-penis contact. Those practicing high risk behavior (multiple sexual partners, intravenous drug use, homosexual activity) and become infected with the AIDS virus are found mainly among the following groups: homosexual men, bisexual men and women, and male and female intravenous drug users. Heterosexual transmission is expected to account for an increasing proportion of those who become infected with the AIDS virus in the future. (The Surgeon Generals Report on Acquired Immune Deficiency Syndrome, U.S. Department of Health and Human Services, 1987).

If you have any questions as to the AIDS virus and testing, consult:

National AIDS Hotline
1-800-342-AIDS

OR

North Dakota State Department of Health and Consolidated Laboratories Division of Disease Control
1-800-472-2180
(701) 224-2378

4.10 Further Information as to Treatment Regimens

Due to continuing research and discussion of the most effective treatment of sexually transmitted diseases specific to sexual assault victims, treatment regimens have not been included in this Protocol. Instead, it is suggested that the reader consult the latest publication of the U.S. Department of Health and Human Services Centers for Disease Control, for their latest treatment recommendations: "Sexually Transmitted Diseases Treatment Guidelines" 1985.

APPENDICES

NORTH DAKOTA SEXUAL ASSAULT EVIDENCE COLLECTION KIT INSTRUCTIONS

(SEE PROTOCOL)

THIS KIT IS DESIGNED TO ASSIST THE EXAMINING PHYSICIAN AND NURSE IN THE COLLECTION OF EVIDENTIARY SPECIMENS FOR ANALYSIS BY THE CRIME LABORATORY SERVING YOUR LOCAL POLICE AGENCY. THE HOSPITAL IS NOT REQUESTED OR ENCOURAGED TO ANALYZE ANY OF THE SPECIMENS/ EVIDENCE COLLECTED IN THIS KIT. ANY SPECIMENS REQUIRED BY THE HOSPITAL ARE TO BE COLLECTED WITH HOSPITAL SUPPLIES.

☐ STEP 1 AUTHORIZATION FOR RELEASE OF INFORMATION AND EVIDENCE TO LAW ENFORCEMENT AGENCY FORM

Fill out all information requested on upper section form and have patient or parent/guardian sign and date where indicated. Retain pink copy for hospital records. Return white copy to the kit box.

☐ STEP 2 SEXUAL ASSAULT REPORT FORM FOR FORENSIC LABORATORY

Fill out all information requested on form and sign where indicated. Retain pink copy for hospital records, return white copy to kit bx.

☐ STEP 3 CLOTHING AND UNDERWEAR (1 small and 2 large bags provided)

Note:
A) If additional clothing bags are required, use new paper bags only.
B) Wet or damp clothing should be air dried before packaging.
C) If victim is not wearing the clothing worn at the time of the alleged assault, collect only the items that are in direct contact with victim's genital area.
D) If victim has changed clothing after assault, inform officer in charge so that the clothing worn at the time of the assault can be collected by the police.
E) Do not cut through any existing holes, rips or stains in victim's clothing.
F) Do not shake out victim's clothing or microscopic evidence will be lost.

Place white cloth or paper sheet on floor and instruct victim to stand in center of sheet. Have victim carefully disrobe over sheet and hand you each article of clothing as removed. Place each article in separate paper bag. Place victim's underwear in Underwear bag. Staple all bags shut and fill out all information requested on bag labels. Fold sheet in manner to retain any debris present and place in kit box.

☐ STEP 4 DEBRIS COLLECTION

Remove paper bindle from Debris Collection envelope. Unfold and place on flat surface. Collect any foreign material found on victim's body (leaves, fibers, hair, dried semen, etc.) and place in center of bindle. Refold in manner to retain debris, and return bindle to Debris Collection envelope. Note location from which sample was taken on anatomical drawings on envelope. Seal and fill out all information requested on envelope.

☐ STEP 5 PUBIC HAIR COMBINGS

Remove paper towel and comb provided in Pubic Hair Combings envelope. Place towel under victim's buttocks. Using comb provided, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall on paper towel. Fold towel in manner to retain both comb and any evidence present. Return to Pubic Hair Combings envelope. Seal and fill out all information on envelope.

☐ STEP 6 PULLED PUBIC HAIRS (See Protocol)

Note: Hair should be pulled with thumb and forefinger — DO NOT USE HEMOSTAT FOR PULLING HAIRS.

Remove paper bindle from Pulled Pubic Hairs envelope, unfold and place on flat surface. Pull, do not cut, 10 to 15 full-length pubic hairs from various locations and place in center of bindle. Refold in manner to retain hairs and return bindle to Pulled Pubic Hairs envelope. Seal and fill out all information requested on envelope.

☐ STEP 7 VAGINAL SWABS AND SMEARS (If within 5 days of assault)

Note: If victim is male, moisten the two swabs provided with distilled water and swab shaft and glans. Allow swabs to air dry and then place in swab box and mark box accordingly. Do not prepare smears.

Using both swabs simultaneously, carefully swab the vaginal walls and cervix. Using both swabs, prepare two smears. Allow both swabs (2) and smears (2) to air dry. Return smears to vaginal smears slide holder and place both swabs in swab box. Fill out information requested on containers, and return to envelope. Seal and fill out all information requested on envelope. Do not stain or chemically fix smears. Do not moisten swabs prior to sample collection.

☐ STEP 8 ORAL/RECTAL SWABS (only if oral/rectal assault has occurred)

Using two swabs, carefully swab the rectal canal. Allow the swabs to air dry and return to the swab box. Label box in place provided and return to envelope. Using two swabs, carefully swab the buccal area and gum line. Allow the swabs to air dry and return to the swab box. Label box in place provided and return to envelope.

☐ STEP 9 HEAD HAIR COMBINGS

Remove paper towel and comb provided in Head Hair Combings envelope. Place towel under victim's head. Using comb provided, comb head hair in downward strokes so that any loose hairs and/or debris will fall on paper towel. Fold towel in manner to retain both comb and any evidence present. Return to Head Hair Combings envelope. Seal and fill out all information on envelope.

☐ STEP 10 PULLED HEAD HAIRS

Note:	Hairs should be pulled with thumb and forefinger — DO NOT USE HEMOSTAT FOR PULLING HAIRS.

Remove paper bindle from Pulled Head Hairs envelope, unfold and place on flat surface. Pull, do not cut, a minimum of three full-length hairs from each of the following scalp locations: center, front, back, left side and right side. Place in center of the bindle and refold in manner to retain the hairs. Return to envelope, seal and fill out all information requested on envelope.

☐ STEP 11 KNOWN SALIVA SAMPLE

Note:	The victim should not have anything to drink, eat or smoke for a minimum of 15 minutes prior to saliva sample collection.

Remove filter paper disk from Saliva Sample envelope. Do not touch inner circle. Place folded paper in victim's mouth and instruct victim to thoroughly saturate inner circle with saliva. Allow sample to air dry. Return disk to Saliva Sample envelope, seal and fill out all information requested on envelope.

☐ STEP 12 KNOWN BLOOD SAMPLE

Note:	If expiration date of blood tube has expired, replace with same or red-stoppered tube — DO NOT USE BLOOD ALCOHOL TUBE.

Using blood collection tube provided, draw to maximum volume from victim and write victim's name on blood tube label.

☐ STEP 13 FINGERNAIL SCRAPINGS AND CLIPPINGS (left and right hand)

Note:	Collect fingernail clippings only if fingernail(s) were broken off during assault — USE STERILE SCISSORS OR CLIPPERS (not provided in kit).

Remove both paper bindles and fingernail scrapers from Fingernail Scrapings and Clippings envelope. Unfold one bindle and place on flat surface.

A) Left Hand: Hold each finger (as scraped) over bindle so that any debris present will fall onto bindle. After scraping all five fingers on left hand, place used scraper in center of bindle. Using scissors or fingernail clippers (not provided in kit), cut sample from each fingernail and let fall on paper bindle. Refold bindle to retain debris, scrapers, scrapings and clippings. Tape closed and write "L" on bindle.

B) Right hand: Follow same procedure used on left hand. Mark bindle with "R".

Return to envelope, seal and fill out information requested on envelope.

☐ STEP 14 PHYSICAL CONDITION OF VICTIM (Anatomical Drawings)
Using the appropriate anatomical drawing, indicate all signs of physical trauma — e.g., bruises, scratches, marks, discolorations (size and color) or bite marks on any part of the victim's body.

☐ STEP 15 PATIENT INFORMATION FORM
Fill out all information requested on form. Retain pink copy for hospital records and give patient or parent/guardian white copy.

FINAL INSTRUCTIONS

1) Make sure all information requested on all sample envelopes and forms have been filled out completely.
2) With the exception of sealed and labeled Clothing and Underwear bags, return all other evidence/envelopes, used or unused, to kit box along with all forms.
3) Initial and affix red police evidence seals where indicated on box top.
4) Fill out all information requested on kit box top under "For Hospital Personnel".
5) Hand sealed kit and sealed sacks to investigating officer and have officer fill out all information requested on the Receipt of Information section on the bottom half of Step 1 form (hospital copy).

NOTE: If officer is not present at this time, place sealed kit and sealed bags in secure and refrigerated area, and hold for pick up by investigating officer.

STEP 1 AUTHORIZATION FOR RELEASE OF INFORMATION AND EVIDENCE TO LAW ENFORCEMENT AGENCY

(Please print, type or use a patient information stamp)

Patient's Name: _____

Date of Birth: _____

Hospital Number: _____

I hereby authorize _____
(Name of Hospital)

to release the following information covering treatment given to me on _____ to _____
Month Day Year (Name of law enforcement agency)

	AUTHORIZED FOR RELEASE (Check those which apply)	NOT AUTHORIZED FOR RELEASE
1. One sealed evidence kit, including specimens collected and one copy of the Sexual Assault Forensic Laboratory Report Form	☐	☐
2. X-rays or copies of X-rays taken in connection with examination	☐	☐
3. Photographs	☐	☐
4. Clothing	☐	☐

Authorized for release (please list clothing or miscellaneous items)

Article	Description

Name of person authorizing release of information (please type or print): _____ Date _____
Last First Middle

Person authorizing release of information is (check one): ☐ Patient ☐ Patient's Parent ☐ Patient's Guardian ☐ Other (specify) _____

Signature of person authorizing release of information _____

RECEIPT OF INFORMATION

I certify that I have received the following items (check those which apply):

☐ One sealed evidence kit ☐ X-rays or copies of X-rays ☐ Photographs

☐ Sealed clothing bag(s) (if more than one sealed clothing bag, please note): _____

☐ Other _____

Signature of person receiving information and/or articles: _____ Date _____ Time _____

ID #/Shield #/Star #/Title _____ Precinct/Command/District _____

Person receiving article(s) is representative of _____

Name of person releasing articles: _____
Printed Name Signature

White copy: Return to kit box Pink copy: Retain for hospital records

STEP 2

SEXUAL ASSAULT REPORT FORM FOR FORENSIC LABORATORY

Name of Patient: _____ Age: _____ Sex: _____ Race: _____

Date of Collection: _____ Time of Collection: _____ (AM/PM)

Date of Assault: _____ Time of Assault: _____ Sex of Offender: _____

Suspect(s) (if known): _____

Race of Suspect(s) (if known): _____ Number of Offenders: _____

Prior to evidence collection, patient has: ___ Douched ___ Bathed ___ Urinated ___ Defecated ___ Had Food or Drink ___ Brushed Teeth/Used Mouthwash ___ Changed Clothes ___ Vomited ___ None of the Above

At time of Assault, was:

Contraceptive foam or spermacide present?	___ Yes	___ No	___ Don't Know
Lubricant used by offender?	___ Yes	___ No	___ Don't Know
Condom used by offender?	___ Yes	___ No	___ Don't Know
Tampon present?	___ Yes	___ No	___ Don't Know
Patient menustrating?	___ Yes	___ No	___ Don't Know

At time of exam, was tampon present? ___Yes ___ No Menstruation at time of exam? ___ Yes ___ No
Was patient bleeding from any wounds inflicted by offender? ___ Yes ___ No
Any consentual coitus in the previous 72 hours? ___ Yes ___ No ___ Don't know

---

History: (Pertinent details of assault: e.g., oral, anal, vaginal penetration; penetration manually or with other foreign object; oral contact by patient; ejaculation, if known by patient)_____

_____

_____

_____

_____

PHYSICAL EXAMINATION; (Include pertinent medical details of trauma, secretions on body and clothing, Wood's Lamp/black light examination, if available) _____

_____

COMMUNICABLE DISEASES OF RISK TO LAB PERSONNEL: (e.g., Hepatitis, TB, Herpes, HTLV/III, etc.) and/or presence of parasites (e.g., head lice, crab lice, body lice, mites, etc.)

_____

EVIDENCE ITEMS COLLECTED BUT NOT PART OF KIT

___ Clothing ___ Photographs ___ X-Rays ___ Other _____
(Please Specify)

_____ (# of bags)

Was authorization for Release of Information & Evidence Form Completed? ___ Yes ___ No

---

Nurse: _____ (signature) Physician: _____ (signature)

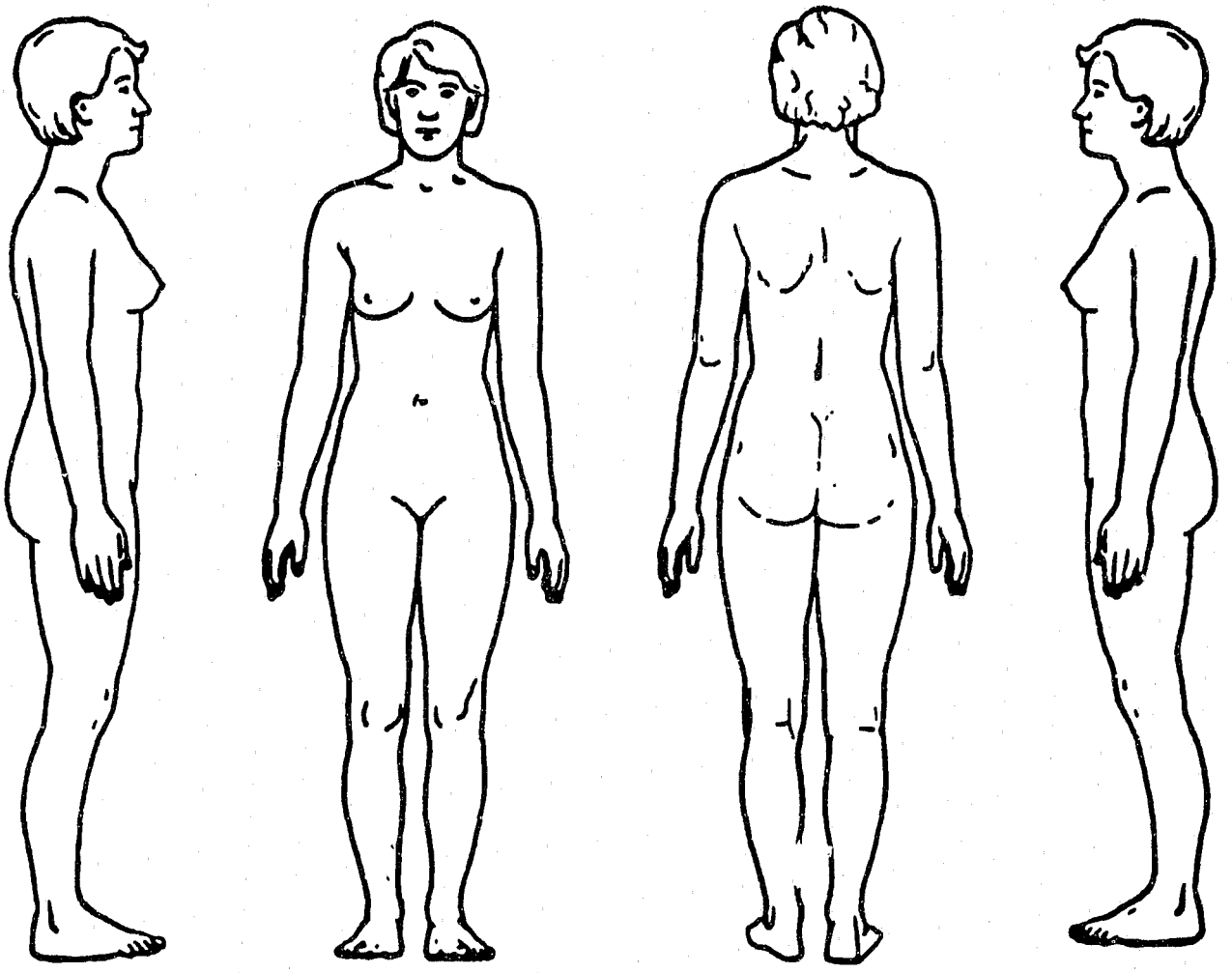
_____ (Printed Name) _____ (Printed Name)

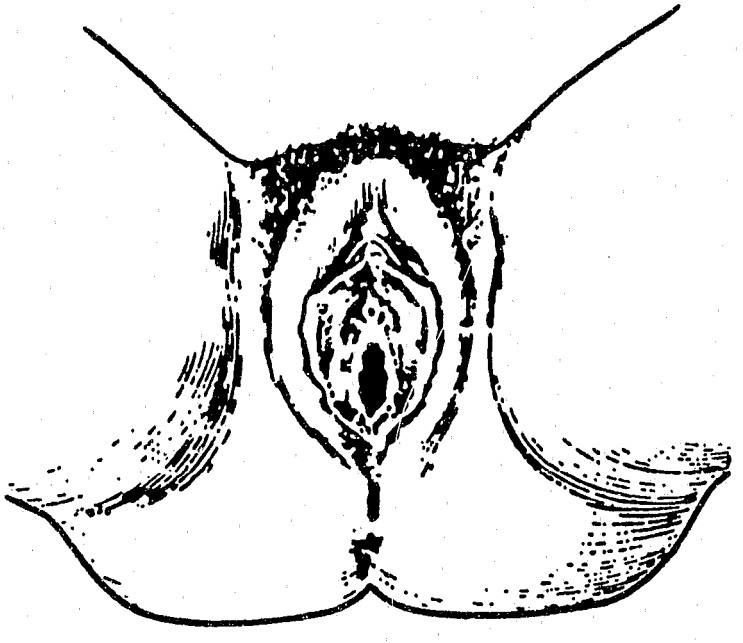
Name of Hospital _____ City _____ State _____

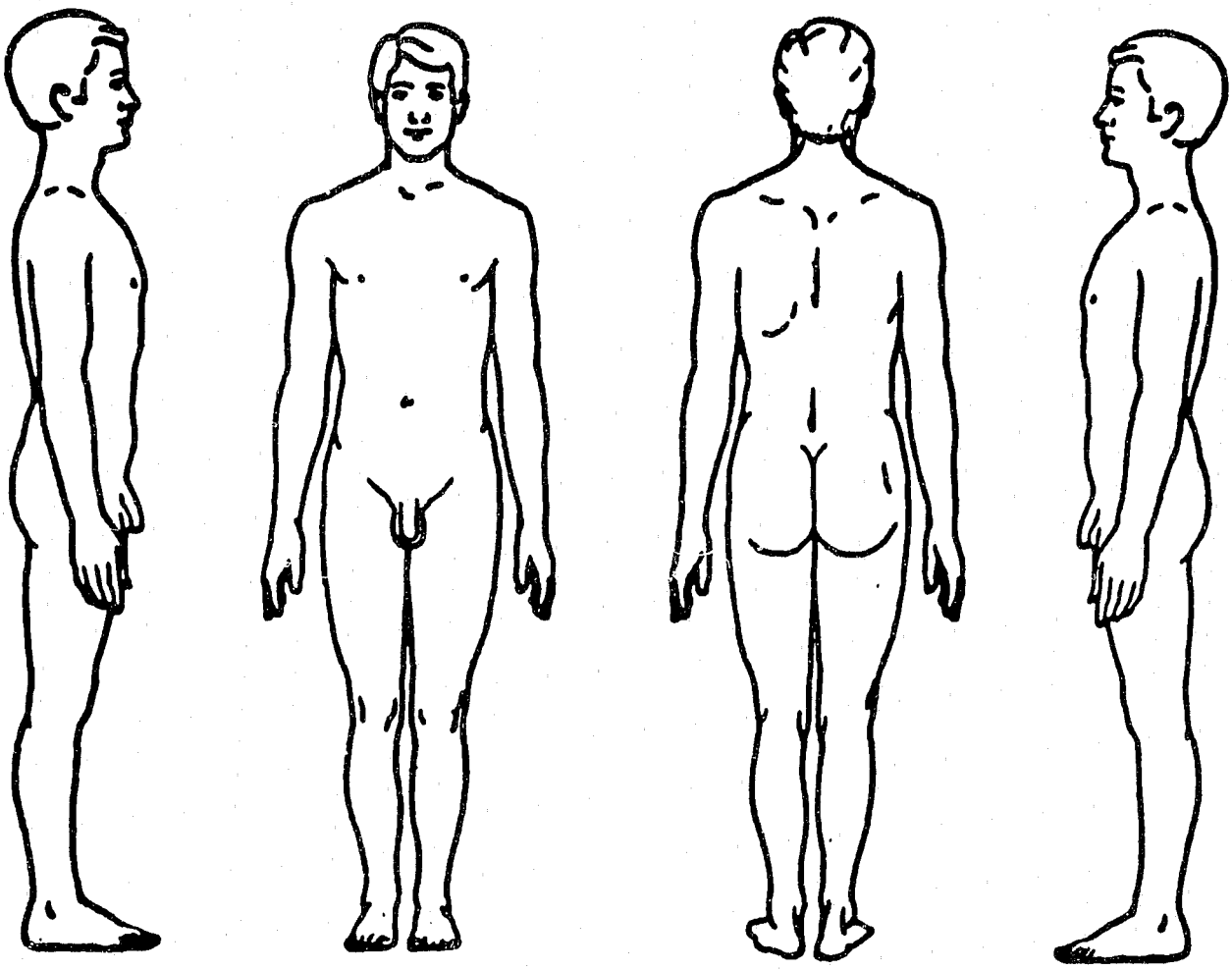
White copy: Return to kit box Pink copy: Retain for hospital records

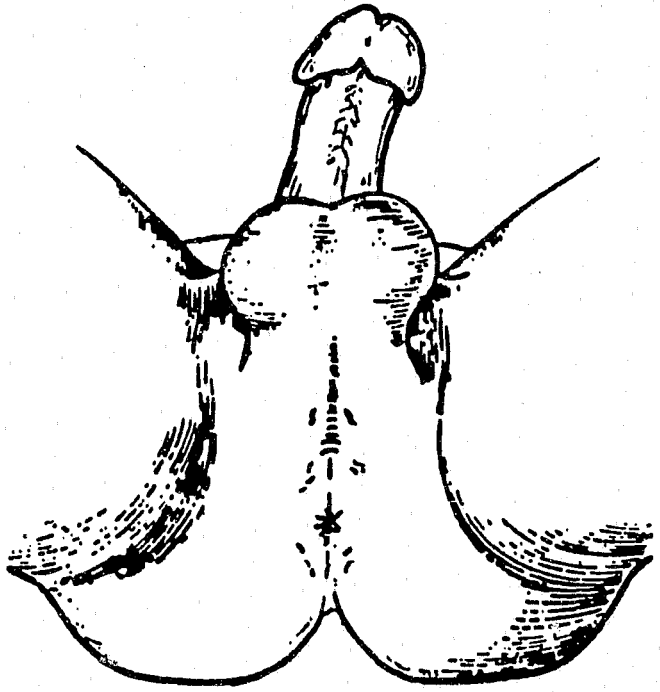
STEP 14

PHYSICAL CONDITION OF VICTIM









STEP 15

PATIENT INFORMATION FORM

(Please print, type or use a patient information stamp)

(Patient Stamp)

Patient Name: _____
Hospital Name: _____
Date of Examination: _____
Examining Physician: _____
Hospital Telephone No.: _____

With your consent, a number of specimens were collected from you to provide evidence in court should your attacker be caught and you decide to prosecute. Additional tests were conducted as follows:

1. A blood test for syphilis — Yes _____ No _____
2. Smear and culture for:
   - Gonorrhea — Yes _____ No _____
   - Chlamydia — Yes _____ No _____
3. Pregnancy test to determine pre-existing pregnancy only — Yes _____ No _____

☐ You were given an antibiotic to prevent gonorrhea. However, you must return 4 - 6 weeks* following this treatment for another test to be sure that you do not have syphilis. You need to return for this test and possible treatment the week of _____.

Name of Medication _____ Dosage _____

☐ You were not given treatment to prevent gonorrhea or any other venereal disease because _____

_____

If you wish counseling, referrals and/or follow-up testing and treatment for venereal disease from an agency other than this hospital, call one of the agencies listed below for assistance:

_____

_____

_____

☐ An appointment was made for you at this hospital for follow-up medical treatment on _____.
(Date)

☐ No appointment was made for follow-up treatment.

☐ An appointment was made for you at this hospital for follow-up counseling on _____.
(Date)

☐ I have received this Patient Information Form _____.
(Patient/Parent/Guardian Signature)

☐ I do not wish to receive this Form _____.
(Patient/Parent/Guardian Signature)

* Physician see STD Guideline

White copy: Give to patient or parent/guardian Pink copy: Retain for hospital records.

HOSPITAL PERSONNEL - Please Give This Sheet To The Victim/Patient

THE FOLLOWING IS A LIST OF PHONE NUMBERS WHERE YOU MAY REACH RAPE CRISIS PERSONNEL WHO WILL ASSIST YOU WITH COUNSELING AND VARIOUS OTHER SUPPORT SERVICES IN YOUR COMMUNITY.

Women's Action and Resource Center
Beulah
Phone: Office 873-2274
Crisis Line 748-2274

Bismarck-Mandan Rape Victim
Advocacy Program
Bismarck
Phone: Crisis Line 222-8782

Coalition Against Sexual Assault in N.D.
Statewide Coordinator
Bismarck
Referral: 1-800-472-2911

West Central Human Service Center
Bismarck
Phone: 255-3090

Lake Region Human Service Center
Devils Lake
Phone: 662-7581

Safe Alternatives for Abused Families
Devils Lake
Phone: Office 662-7378
Crisis Line 662-5050

Badlands Human Service Center
Dickinson
Phone: 227-2771

Domestic Violence and Rape Crisis Center
Dickinson
Phone: Office & Crisis Line 225-4506

Kedish House
Ellendale
Phone: Office 349-4729
Crisis Line 349-3611

Rape and Abuse Crisis Center
Fargo
Phone: Office & Crisis Line 293-7273

Southeast Human Service Center
Fargo
Phone: 237-4513

Domestic Violence Program of Walsh County
Grafton
Phone: Office 352-0647
Crisis Line 352-3059

Adult Abuse Community Services
Grand Forks
Phone: Office 746-0405
Crisis Line 746-8900

Northeast Human Service Center
Grand Forks
Phone: 746-9411

S.A.F.E. Shelter
Jamestown
Phone: Office & Crisis Line 251-2300

South Central Human Service Center
Jamestown
Phone: 252-2641

Domestic Violence Crisis Center
(Women's Action Program)
Minot
Phone: Office 852-2258
Crisis Line 857-2000

North Central Human Service Center
Minot
Phone: 852-1251

Abused Persons Outreach Center
Valley City
Phone: 845-0072

Northwest Human Service Center
Williston
Phone: 572-8126

12.1-20-01. General provisions. In sections 12.1-20-03 through 12.1-20-08:

1. When the criminality of conduct depends on a child's being below the age of fifteen, it is no defense that the actor did not know the child's age, or reasonably believed the child to be older than fourteen.
2. When criminality depends on the victim being a minor, it is an affirmative defense that the actor reasonably believed the victim to be an adult.

12.1-20-02. **Definitions.** In sections 12.1-20-03 through 12.1-20-12:

1. "Deviate sexual act" means any form of sexual contact with an animal, bird, or dead person.
2. "Object" means anything used in commission of a sexual act other than the person of the actor.
3. "Sexual act" means sexual contact between human beings consisting of contact between the penis and the vulva, the penis and the anus, the mouth and the penis, or the mouth and the vulva; or the use of an object which comes in contact with the victim's anus, vulva, or penis. For the purposes of this subsection, sexual contact between the penis and the vulva, or between the penis and the anus or an object and the anus, vulva, or penis of the victim, occurs upon penetration, however slight. Emission is not required.
4. "Sexual contact" means any touching of the sexual or other intimate parts of the person for the purpose of arousing or satisfying sexual or aggressive desires.

12.1-20-03. Gross sexual imposition.

1. A person who engages in a sexual act with another, or who causes another to engage in a sexual act, is guilty of an offense if:
   a. He compels the victim to submit by force or by threat of imminent death, serious bodily injury, or kidnapping, to be inflicted on any human being;
   b. He or someone with his knowledge has substantially impaired the victim's power to appraise or control his or her conduct by administering or employing without his or her knowledge intoxicants or other means with intent to prevent resistance;
   c. He knows that the victim is unaware that a sexual act is being committed upon him or her;
   d. The victim is less than fifteen years old; or
   e. He knows or has reasonable cause to believe that the other person suffers from a mental disease or defect which renders him or her incapable of understanding the nature of his or her conduct.
2. A person who engages in sexual contact with another, or who causes another to engage in sexual contact, is guilty of an offense if:
   a. The victim is less than fifteen years old; or
   b. He compels the victim to submit by force or by threat of imminent death, serious bodily injury, or kidnapping, to be inflicted on any human being.
3. An offense under this section is a class A felony if in the course of the offense the actor inflicts serious bodily injury upon the victim, or if his conduct violates subdivision a or d of subsection 1. Otherwise the offense is a class B felony.

2. A person who engages in sexual contact with another, or who causes another to engage in sexual contact, is guilty of an offense if:
   a. The victim is less than fifteen years old; or
   b. He compels the victim to submit by force or by threat of imminent death, serious bodily injury, or kidnapping, to be inflicted on any human being.
3. An offense under this section is a class A felony if in the course of the offense the actor inflicts serious bodily injury upon the victim, or if his conduct violates subdivision d of subsection 1, or if the victim is not a voluntary companion of the actor and has not previously permitted him sexual liberties. Otherwise the offense is a class B felony.

12.1-20-04. Sexual imposition.

1. A person who engages in a sexual act or sexual contact with another, or who causes another to engage in a sexual act or sexual contact, is guilty of an offense if the actor compels the other person to submit by any threat that would render a person of reasonable firmness incapable of resisting.
2. The offense is a class C felony unless the victim is a minor, fifteen years of age or older, in which case it is a class B felony.

12.1-20-05. Corruption or solicitation of minors.

1. An adult who engages in a sexual act with another person or who causes another person to engage in a sexual act, is guilty of a class A misdemeanor if the other person is a minor, fifteen years of age or older.
2. An adult who solicits a person under the age of fifteen years to engage in a sexual act or sexual contact is guilty of a class A misdemeanor.

12.1-20-06. Sexual abuse of wards. A person who engages in a sexual act with another person, or any person who causes another to engage in a sexual act is guilty of a class A misdemeanor if the other person is in official custody or detained in a hospital, prison, or other institution and the actor has supervisory or disciplinary authority over the other person.

12.1-20-06.1. Sexual exploitation by therapist — Definitions — Penalty. Any person who is or who holds oneself out to be a therapist and who intentionally has sexual contact, as defined in section 12.1-20-02, with a patient or client during any treatment, consultation, interview, or examination is guilty of a class C felony. Consent by the complainant is not a defense under this section. As used in this section, unless the context or subject matter otherwise requires:

1. "Psychotherapy" means the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction.
2. "Therapist" means a physician, psychologist, psychiatrist, social worker, nurse, chemical dependency counselor, member of the clergy, or other person, whether licensed or not by the state, who performs or purports to perform psychotherapy.

12.1-20-07. Sexual assault.

1. A person who knowingly has sexual contact with another, or who causes such other person to have sexual contact with him, is guilty of an offense if:
   a. He knows or has reasonable cause to believe that the contact is offensive to the other person;
   b. He knows or has reasonable cause to believe that the other person suffers from a mental disease or defect which renders him or her incapable of understanding the nature of his or her conduct;
   c. He or someone with his knowledge has substantially impaired the other person's power to appraise or control his or her conduct, by administering or employing without the other's knowledge intoxicants or other means for the purpose of preventing resistance;
   d. The other person is in official custody or detained in a hospital, prison, or other institution and the actor has supervisory or disciplinary authority over him or her;
   e. The other person is a minor, fifteen years of age or older, and the actor is his or her parent, guardian, or is otherwise responsible for general supervision of the other person's welfare; or
   f. The other person is a minor, fifteen years of age or older, and the actor is an adult.
2. The offense is a class A misdemeanor if the actor's conduct violates subdivision e or f of subsection 1, otherwise the offense is a class B misdemeanor.

12.1-20-08. Fornication. A person is guilty of a class A misdemeanor if he engages in a sexual act in a public place. A minor engaging in a sexual act is guilty of a class B misdemeanor.

12.1-20-09. Adultery.

1. A married person is guilty of a class A misdemeanor if he or she engages in a sexual act with another person, who is not his or her spouse.
2. No prosecution shall be instituted under this section except on the complaint of the spouse of the alleged offender, and the prosecution shall not be commenced later than one year from commission of the offense.

12.1-20-10. Unlawful cohabitation. A person is guilty of a class B misdemeanor if he or she lives openly and notoriously with a person of the opposite sex as a married couple without being married to the other person.

12.1-20-11. Incest. A person who intermarries, cohabits, or has sexual intercourse with another person related to him within a degree of consanguinity within which marriages are declared incestuous and void by section 14-03-03, knowing such other person to be within said degree of relationship, is guilty of a class C felony.

12.1-20-12. Deviate sexual act. A person who performs a deviate sexual act with the intent to arouse or gratify his sexual desire is guilty of a class A misdemeanor.

12.1-20-12.1. Indecent exposure. A person shall be guilty of a class B misdemeanor for:

1. Knowingly exposing one's penis, vulva, or anus in a public place with the intent to annoy or harass another person.
2. Masturbating in a public place.

12.1-20-13. Bigamy.

1. A person who marries another person, while married to another person, is guilty of a class C felony.
2. Subsection 1 does not extend to:
   a. A person whose spouse has been absent for five successive years and is believed by him or her to be dead.
   b. A person whose spouse has voluntarily absented himself and has continually remained without the United States for the space of five successive years.
   c. A person whose former marriage has been pronounced void, null, or dissolved by the judgment of a competent court.

12.1-20-14. Admissibility of evidence concerning reputation of complaining witness — Gross sexual imposition and sexual imposition.

1. In any prosecution for a violation of section 12.1-20-03 or 12.1-20-04, or for an attempt to commit an offense defined in either of those sections, opinion evidence, reputation evidence, and evidence of specific instances of the complaining witness' sexual conduct, or any of such evidence, is not admissible on behalf of the defendant to prove consent by the complaining witness. This subsection shall not be applicable to evidence of the complaining witness' sexual conduct with the defendant.
2. If the prosecuting attorney introduces evidence, including testimony of a witness, or the complaining witness gives testimony as a witness, and such evidence or testimony relates to the complaining witness' sexual conduct, the defendant may cross-examine the witness who gives such testimony and offer relevant evidence limited specifically to the rebuttal of such evidence introduced by the prosecuting attorney or given by the complaining witness.
3. This section shall not be construed to make inadmissible any evidence offered to attack the credibility of the complaining witness in the manner authorized by law, by rule of procedure, or by the court in the interests of justice in accordance with the procedure provided in section 12.1-20-15.
4. As used in sections 12.1-20-14 and 12.1-20-15, "complaining witness" means the alleged victim of the offense charged, the prosecution of which is the subject of the application of sections 12.1-20-14 and 12.1-20-15.

12.1-20-15. Credibility of complaining witness attacked — Procedure. In any prosecution for a violation of section 12.1-20-03 or 12.1-20-04, or for an attempt to commit an offense defined in either of those sections, if evidence of sexual conduct of the complaining witness is offered to attack the credibility of the complaining witness, the following procedure shall be followed:

1. A written motion shall be made by the defendant to the court and prosecuting attorney stating that the defense has an offer of proof of the relevancy of evidence of the sexual conduct of the complaining witness proposed to be presented and its relevancy in attacking the credibility of the complaining witness.
2. The written motion shall be accompanied by an affidavit in which the offer of proof shall be stated.
3. If the court finds that the offer of proof is sufficient, the court shall order a hearing out of the presence of the jury, if any, and at such hearing allow the questioning of the complaining witness regarding the offer of proof made by the defendant.
4. At the conclusion of the hearing, if the court finds that evidence proposed to be offered by the defendant regarding the sexual conduct of the complaining witness is relevant in accordance with section 12.1-20-14 and is not legally inadmissible, the court may make an order stating what evidence may be introduced by the defendant, and the nature of the questions to be permitted. The defendant may then offer evidence pursuant to the order of the court.

12.1-20-16. Appointment of a guardian ad litem in prosecution for sex offenses. A minor who is a material or prosecuting witness in a criminal proceeding involving an act in violation of sections 12.1-20-01 through 12.1-20-08, or section 12.1-20-11 may, at the discretion of the court, have the witness' interests represented by a guardian ad litem at all stages of the proceedings arising from the violation. The appointment may be made upon the order of the court on its own motion or at the request of a party to the action. The guardian ad litem may, but need not, be a licensed attorney and must be designated by the court after due consideration is given to the desires and needs of the child. A person who is also a material witness or prosecuting witness in the same proceeding may not be designated guardian ad litem. The guardian ad litem shall receive notice of and may attend all depositions, hearings, and trial proceedings to support the child and advocate for the protection of the child but may not separately introduce evidence or directly examine or cross-examine witnesses. The expenses of the guardian ad litem, when approved by the judge, must be paid by the county wherein the alleged offense took place if the action is prosecuted in county court, and by the state if the action is prosecuted in district court. The state shall also pay the expenses of the guardian ad litem in commitment proceedings held in county court pursuant to subsection 7 of section 27-07.1-17.

14-10-17. Minors — Treatment for venereal disease — Drug abuse — Alcoholism. Any person of the age of fourteen years or older may contract for and receive examination, care, or treatment for venereal disease, alcoholism, or drug abuse without permission, authority, or consent of a parent or guardian.

14-10-17.1. Minors emergency care. Any minor may contract for and receive emergency examination, care, or treatment in a life threatening situation without permission, authority, or consent of a parent or guardian.

23-07-01. Powers of state department of health.—The state department of health shall designate the diseases which shall be reported as prescribed in this chapter, and it may classify such diseases as contagious or infectious, venereal, and dangerous.

23-07-02. Who to report reportable diseases.—The following persons shall report to the nearest health officer having jurisdiction any reportable disease coming to his knowledge:

1. All physicians.
2. All persons who treat or administer to the sick by whatever method.
3. Householders.
4. Keepers of hotels, boardinghouses, or lodginghouses.
5. Nurses.
6. School teachers.
7. All other persons treating, nursing, lodging, caring for, or having knowledge of the existence of any reportable disease.

If the person reporting is the attending physician, he shall report not less than twice a week, in the form and manner directed by the state department of health, the condition of the person afflicted and the state of the disease.

23-07-03. Report of cases of venereal disease.—The superintendent or manager of a hospital, dispensary, or charitable or penal institution, in which there is a case of venereal disease, shall report such case to the nearest health officer having jurisdiction. The report shall be made in the form and manner directed by the state department of health.

23-07-04. Report of reportable disease by township board of health.—Each township board of health shall report to the county superintendent of public health all cases of reportable diseases occurring within its jurisdiction. Such reports shall be made on blanks furnished by the county superintendent of public health at the expense of the county board of health.

23-07-05. Local health officers to report reportable disease to state department of health.—At such time as may be required by the state department of health, each local health officer shall submit to such department, on blanks furnished by the department for that purpose, a summarized report of the reportable diseases reported to him during the week. When no cases have been reported during the week, the report shall be made with the notation "No cases reported".

23-07-07. Venereal diseases—Additional powers and duties of health officers.—The state health officer, and each county and city health officer within his jurisdiction, when necessary for the protection of public health, shall:

1. Make examination of any person reasonably suspected of being infected with venereal disease and detain such person until the results of the examination are known.
2. Require any person infected with venereal disease to report for treatment to a reputable physician and to continue such treatment until he is cured or to submit to treatment provided at public expense until he is cured.
3. Investigate sources of infection of venereal disease.
4. Cooperate with the proper officials whose duty it is to enforce laws directed against prostitution, and otherwise to use every proper means for the repression of prostitution.

23-07-07.2. Definitions.—A standard serological test shall be a laboratory test for syphilis approved by the state health officer. The term "approved laboratory" shall mean the North Dakota state public health laboratories or any other laboratory approved by the state health officer.

29-04-02. Prosecution for felony other than murder within three years. Except as otherwise provided by law, a prosecution for any felony other than murder must be commenced within three years after its commission. Nothing in this section prevents a person prosecuted for murder from being found guilty of any included offense and punished accordingly.

29-04-03. Prosecution for misdemeanor or infraction within two years. A prosecution of a misdemeanor or infraction, except as otherwise provided by law, must be commenced within two years after its commission.

29-04-03.1. Prosecution for sexual abuse of minors to be commenced within seven years. A prosecution for violation of sections 12.1-20-03 through 12.1-20-08 or of section 12.1-20-11, where the victim was under eighteen years of age at the time the offense was committed must be commenced in the proper court within seven years after the commission of the offense.

29-04-03.2. Statute of limitations as to child victim. If the victim of a violation of chapter 12.10-20 is under the age of fifteen, the applicable period of limitation, if any, does not begin to run until the victim has reached the age of fifteen.

29-04-04. **Time of defendant's absence not part of limitation.**—If, when a crime or public offense is committed, the defendant is out of the state, or if he is within the state and subsequently leaves the state, the information may be filed, or the indictment found, within the time herein limited, after his returning to the state. No time during which the defendant is not an inhabitant of, or usually resident within, this state, is part of the limitation.

29-04-05. **When action is commenced.**—An information is filed or an indictment found within the meaning of this chapter when it is presented, if an information, by the state's attorney or person appointed to prosecute, or, if an indictment, by the grand jury, in open court, and there received and filed, or if a complaint, when filed by a magistrate having jurisdiction to hear, try, and determine the action.

43-17-41. Duty of physicians and others to report injury—Penalty.—

1. Any physician or other medical or mental health professional, who has under his charge or care or performs any professional services for any person suffering from any wound, injury, or other physical trauma inflicted by his own act or by the act of another by means of a knife, gun, or pistol, or which he has reasonable cause to suspect was inflicted in violation of any criminal law of this state, shall as soon as practicable report the same to the sheriff or state's attorney of the county in which such care was rendered. The report shall state the name of the injured person, if known, his whereabouts, and the character and extent of his injuries.
2. The reports mandated by this section shall be made as soon as practicable and may be either oral or in writing. Oral reports shall be followed by written reports within forty-eight hours if so requested by the sheriff or state's attorney to whom the oral report is originally made.
3. Any person required to report as provided by this section who willfully fails to do so is guilty of an infraction.
4. Any person making a report in good faith pursuant to this section shall be immune from liability for making said report.

50-25.1-01. Purpose. It is the purpose of this chapter to protect the health and welfare of children by encouraging the reporting of children who are known to be or suspected of being abused or neglected and to encourage the provision of services which adequately provide for the protection and treatment of abused and neglected children and to protect them from further harm.

50-25.1-02. Definitions.

1. "A person responsible for a child's welfare" means the child's parents, guardian, foster parent, an employee of a public or private school or nonresidential child-care facility, an employee of a public or private residential home, institution, or agency, or other person responsible for the child's welfare in a residential setting.
2. "Abused child" means an individual under the age of eighteen years who is suffering from serious physical harm or traumatic abuse caused by other than accidental means by a person responsible for the child's health or welfare.
3. "Division" means the division of community services of the department of human services.
4. "Harm" means negative changes in a child's health which occur when the parent or other person responsible for his health:
   a. Inflicts or allows to be inflicted, upon the child, physical or mental injury, including injuries sustained as a result of excessive corporal punishment; or
   b. Commits, allows to be committed or conspires to commit, against the child, a sex offense as defined in chapter 12.1-20.
5. "Institutional child abuse or neglect" means situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is an employee of a residential child-care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home or any residential facility owned or managed by the state or a political subdivision of the state.
6. "Neglected child" means a deprived child as defined in chapter 27-20.
7. "State child protection team" means a multidisciplinary team consisting of the designee of the director of the division and, where possible of a physician, a representative of a child-placing agency, a representative of the state department of health, a representative of the office of the attorney general, a representative of the department of public instruction, a representative of the director of institutions, one or more representatives of the lay community, and, as an ad hoc member, the designee of the chief executive official of any institution named in a report of institutional abuse or neglect. All team members, at the time of their selection and thereafter, shall be staff members of the public or private agency which they represent, or shall serve without remuneration. In no event shall an attorney member of the child protection team be appointed to represent the child or the parents at any subsequent court proceeding nor shall the child protection team be composed of fewer than three persons.

50-25.1-03. Persons required and permitted to report — To whom reported.

1. Any physician, nurse, dentist, optometrist, medical examiner or coroner, or any other medical or mental health professional, religious practitioner of the healing arts, schoolteacher or administrator, school counselor, social worker, day care center or any other child care worker, police or law enforcement officer having knowledge of or reasonable cause to suspect that a child coming before him in his official or professional capacity is abused or neglected shall report the circumstances to the division.
2. Any person having reasonable cause to suspect that a child is abused or neglected may report such circumstances to the division.

50-25.1-04. Method of reporting. All persons mandated or permitted to report cases of known or suspected child abuse or neglect shall immediately cause oral or written reports to be made to the division. Oral reports shall be followed by written reports within forty-eight hours if so requested by the director of the division or his designee. Reports involving known or suspected institutional child abuse or neglect shall be made and received in the same manner as all other reports made under this chapter.

50-25.1-13. Penalty for failure to report. Any person required by this chapter to report a case of known or suspected child abuse who willfully fails to do so is guilty of a class B misdemeanor.