



Virginia's

HOSPITAL PROTOCOL



For the Treatment of Sexual Assault Victims

■ Prepared by
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Hospital Protocol Development Task Force

■ In Coordination with

- Virginia State Crime Commission
- Department of Criminal Justice Services
- Department of General Services, Division of Forensic Science
- Virginia Hospital Association

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Hundreds of hours contributed by these professionals to this project over the last two years have resulted in a comprehensive resource containing the practical information sought by hospital personnel responding to the needs of sexual assault victims. Again, thanks to each of them for their contributions, their patience and their perseverance.

To obtain additional copies of the protocol, more information or to request technical assistance in coordinating training contact: Department of Criminal Justice Services, Victims Services Section, 805 East Broad Street, Richmond, Virginia 23219, (804)786-4000.

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EXECUTIVE SUMMARY

- Adult Protocol Summary**
- Child Protocol Summary**

■ Purpose

This summary provides a general overview of the more detailed information presented in the body of the protocol. The summary also serves as an index; page references at the end of each section refer to pertinent information contained elsewhere in the protocol.

Medical personnel are encouraged to read the entire protocol and to refer to topic-specific literature for more detailed information.

■ General Information

Reports of sexual assaults against adults and children have continued to increase throughout the past decade.

Traditionally, the successful prosecution of both adult and child sexual assault/abuse cases has been difficult. 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. The role of medical personnel in this process often can be the key to successful prosecution and can help to promote early victim recovery.

The primary purpose of this document is to assist hospitals to:

- Minimize the physical and psychological trauma to the victim of a sex crime, and
- Maximize the probability of collecting and preserving physical evidence for potential use in the legal system.

Recommendations were based upon the physical and emotional needs of the sexual assault/abuse victim reasonably balanced with the basic requirements of Virginia's legal system. The resulting protocol provides useful legal, medical and forensic guidance and can serve as a basis for serious discussion of the evidentiary, medical and emotional needs of sexual assault/abuse victims.

For purposes of this protocol, the term "sexual assault" will be used to refer to all sex crimes perpetrated against adults and the term "sexual abuse" will refer to all sex crimes perpetrated against children, both terms 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 PREFACE)

ADULT PROTOCOL SUMMARY

■ Sensitivity to Victim Needs

Victims may have various reactions to the sexual assault. In all cases attending medical personnel should refrain from expressing shock, disbelief, anger, etc., and should never express or imply that the victim is blameworthy.

It is recommended that hospitals serving specific populations seek the assistance of reliable community consultants to help develop procedures and counseling resources which will reflect the special needs of populations in their communities.

(SEE PAGE 17)

■ Payment of Medical Fees/ Designation of Facilities

All medical fees involved in the gathering of evidence for cases involving sexual assault can be paid by the Commonwealth provided that any medical treatment, examination, or service rendered is performed by a physician or facility specifically designated for such purpose by the local Commonwealth's attorney. (Code of Virginia, Section 19.2 - 165.1) Hospital administrators may wish to request formal designation.

(SEE PAGE 19)

■ Transfer

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

(SEE PAGE 20)

■ Intake

The treatment of victims of sexual assault should be considered a medical emergency. A private

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

(SEE PAGE 20)

■ Reporting

The decision to report the assault to law enforcement authorities should be left up to the victim.

Victims of sexual assault should be encouraged to report and cooperate in the police investigation.

(SEE PAGE 20)

■ Victims' Compensation

Victims should be referred, if appropriate, to the Division of Crime Victims' Compensation (CVC), which administers a fund to pay for certain unreimbursed expenses of victims who suffer physical and, in some cases, emotional injuries as a result of a crime. CVC can be reached at (804) 367-8686 or statewide toll free 1-800-552-4007.

(SEE PAGE 21)

■ Support Personnel

Whenever possible, one person who can provide crisis intervention, explanations, and referrals should be assigned to stay with the victim throughout the entire emergency department visit.

(SEE PAGE 21)

■ Victim/Patient Consent

Informed consent should be a continuing process that involves more than obtaining a signature on a form. All procedures should be explained as much as possible and the victim should have the right to refuse tests or to refuse to answer any question. Having a sense of control is important in the healing process for victims, especially at the early stages of the examination and the interview.

It is important to remember that consent to have a support person present must be given by the victim prior to the introduction of that person.
(SEE PAGE 22)

■ The Evidentiary and Medical Examinations

General Information

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

It is vital that the medical and evidence collection procedures be integrated at all times, i.e., blood should be drawn for medical purposes (testing for syphilis) at the same time as blood drawn for evidence collection purposes.

Only the attending clinician, attending nurse and, with the consent of the victim, a trained support person should be with the adult victim in the examining room.
(SEE PAGES 22-23)

■ Evidence Collection

When to Use the Physical Evidence Recovery Kit (PERK)

Physical evidence should be collected utilizing the Physical Evidence Recovery Kit if the assault occurred within 72 hours of the time of the medical examination. In cases of oral and/or anal assault, physical evidence should only be collected if the assault occurred within the past 24 hours.

All evidentiary specimens should be collected from those patients who report only vaginal assault and from those who are incoher-

ent, unconscious or mentally deficient. If a victim insists that contact or penetration involved only the vagina, the victim should be permitted to refuse the additional tests.

If the sexual assault took place more than 72 hours prior to the medical examination, evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises, lacerations or bite marks) and any statements by the victim.
(SEE PAGE 23)

Preserving the Integrity of Evidence

The custody of any evidentiary item must be accounted for from the time of collection until introduction in court as evidence. All evidence handlers should label items with their initials, name of the patient or an identifying number, and the source of the specimen.
(SEE PAGES 23-24)

Hairs and Fibers as Evidence

Hair and fibers provide circumstantial evidence. This, however, does not lessen their importance to an investigation. An eyewitness statement carries more impact when laboratory examinations are corroborative.
(SEE PAGES 25-26)

Clothing Evidence

Clothing may contain the most important evidence in a case of sexual assault. The reasons are:

1. Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs 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 provide evidence of force

Keeping the garments separate permits the forensic scientist to reach certain conclusions regarding reconstruction of criminal actions.
(SEE PAGE 26)

Physical Evidence Recovery Kit Contents

Each individual Physical Evidence Recovery Kit contains all the necessary materials (individual envelopes, boxes, bags, etc.), except a 16 x 75 mm (7 ml) lavender stopper tube (EDTA anticoagulant) for drawing the known blood sample, to complete the evidence collection procedure. This tube should be provided by the hospital. All envelopes, boxes and bags are labeled by step and procedure. There are a total of 19 steps. In addition, each kit contains outlined step-by-step instructions on how to use the Physical Evidence Recovery Kit, a "Specimen Checklist," a "Sexual Assault Information Form," Kit Number labels, police evidence seals and an Evidence Transport Bag.

The Physical Evidence Recovery Kit is designed to assist the examining clinicians in the collection of evidentiary specimens for analysis by the Virginia Division of Forensic Science. It is most important that the evidence be collected in the step-by-step fashion as outlined. Hospitals are not requested or encouraged to analyze any of the specimens/evidence collected for the kit. Any specimens required by the hospital should be collected with hospital supplies. Medical report

forms, anatomical drawings and patient consent forms should be provided by the individual hospital.

(SEE PAGES 26-27)

NOTE: Step-by-step instructions for the PERK are listed in this protocol on pages 27-34.

■ Medical Examination

Body Diagrams/Photographs

Photographs of sexual assault victims should not be taken on a routine basis. Instead written descriptions and diagrams of the human figure should be used to show the location and size of the injury.

Any photographs which are taken should be limited to those instances where there is an opportunity to produce clear pictorial evidence of injury, such as bruises or lacerations. Photographs should only be taken with the specific consent of the victim.

All photographs should be taken by a competent photographer, preferably of the same sex as the victim, and a ruler and color chart should be used to indicate the size and nature of each injury.
(SEE PAGES 34-35)

Documentation/Terminology

Physical examination findings should be documented as completely as possible on the medical record. Sexual assault prosecutions may not always require the presence or testimony of the attending clinician or nurse; however, there will be times when 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.

The attending clinician must be

careful not to include any subjective opinions or conclusions as to whether or not the crime occurred. Hospital personnel should not be expected to expand their role and act as "investigators" for law enforcement. They should not ask for details beyond those necessary to perform the medical and evidence collection tasks; it is the responsibility of the follow-up investigator to ask the more detailed questions.
(SEE PAGE 35)

Date of Last Voluntary Coitus

It is recommended that attending clinicians ask victims if they engaged in voluntary sexual intercourse within 48 hours prior to the assault. If so, victims should also be asked the date of the contact and the partner's relationship to the victim. This information should be noted on the Sexual Assault Information Form.
(SEE PAGE 35)

Toxicology Blood/Urine Screen

Blood/urine screens for determining toxicology should only be done in the following situations:

- 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*

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

(SEE PAGE 35)

Medical Report Form for Sexual Assault Examinations

Throughout the medical examination, the attending clinician should explain to the victim why questions are being asked, why certain medical and evidentiary tests may

be needed, and what treatment may be necessary. Pertinent information to be included on the Medical Report Form may be found in the Adult Protocol.
(SEE PAGE 36)

Analysis of Specimens

All medical and forensic specimens collected during the sexual assault examination must be kept and processed separately.
(SEE PAGE 36)

■ Procedures for Release of Evidence

Transportation/Release of Evidence

Under no circumstances should victims be allowed to handle evidence after it has been collected. Only a law enforcement officer or duly authorized agent may transfer evidence from hospitals to the Division of Forensic Science for analysis.

Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult victim, or an authorized third party acting on the victim's behalf if the victim is unable to understand or execute the release.
(SEE PAGE 37)

Non-Authorization to Release Evidence

Although the vast majority of sexual assault victims consent to having evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be instances when a victim will not authorize such a release. Hospital and/or law enforcement personnel should not react negatively to the victim's initial decision not to release evidence. They should inform the victim that the release of evidence

is not a commitment to prosecute.

If consent is not initially received, kits and clothing bags should be stored on a temporary basis in a locked, refrigerated, area. Hospital personnel should inform victims of the time period the evidence will be held prior to destruction, thereby providing the victim with an opportunity to reconsider authorization for release. (SEE PAGE 37)

■ Post Examination Information

Patient Information Form

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault victims. The Patient Information Form can facilitate this discussion.

Patients should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted diseases, and urinary tract or other infections within four to six weeks after the initial hospital visit. It is vital that both written and verbal information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up. Victim advocates can be quite helpful in explaining the need for a return visit and what types of tests should be performed.

While the victim should be encouraged to seek follow-up counseling, the decision to do so must be voluntary. An appointment with a trained hospital counselor (if available) should be recommended and scheduled. A referral to a victim advocate, social worker, or psychologist in the community who is known to provide quality service could also be made.

(SEE PAGES 37-38)

Follow-up Contact

Any further contact with sexual assault victims must be carried out discreetly. It is recommended that victims be asked, prior to leaving the hospital, whether or not they can be contacted about follow-up services. (SEE PAGE 38)

Brochures

Many victim advocacy agencies and individual hospitals have developed brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to patients some of the common problems they may encounter. They also can provide reassurance to the victim that he or she is not responsible for the assault. (SEE PAGE 38)

Clean-up/Change of Clothing

Many victims want to wash after the examination and the evidence collection process. If possible, the hospital should provide the basics required, such as mouth rinse, soap, shampoo, and a towel. If garments have been collected for evidence purposes and no additional clothing is available, arrangements should be made to ensure that no victim has to leave the hospital in an examining gown. (SEE PAGE 38)

Law Enforcement Investigative Interview

Many police departments, especially within large metropolitan areas, have investigators or detectives whose duties include sexual assault investigations.

In most cases, the investigator will conduct the follow-up interview after the victim has already been interviewed by the responding officer and hospital staff. It is very

important that the need for this third interview be explained to the victim, especially the reasons for more detailed questions. Intimate details of the assault may be traumatic and embarrassing for the victim to recall. However, the details provide information for a thorough investigation and report. (SEE PAGE 38)

Transportation

Finally, transportation should be arranged when the victim is ready to leave the hospital. (SEE PAGE 38)

CHILD PROTOCOL SUMMARY

The principles and recommendations contained in the adult protocol apply to child victims as well. The child protocol provides additional guidance to medical personnel caring for child victims.

■ Definition of Abuse

- Child sexual abuse occurs if a child - any person under the age of 18 - is made to engage in, or made to help someone else engage in, any sexually explicit conduct, such as intercourse, sodomy, or the fondling of genitals.

- It also occurs if the child is molested or raped, is involved in incest, or is sexually exploited, as in child prostitution or pornography.

- A child is abused if he or she is enticed, bribed, threatened, coerced, or forced to engage in any of these acts, or if the child is developmentally not old enough or mature enough to understand the consequences or implications of these acts.
(SEE PAGE 41)

■ General Information

Most child sexual abuse cases are intra-familial but a fair number are extra-familial.

Many children are sexually abused in some way over a period of years. This situation is complicated when the offender is someone the child loves and/or trusts, such as a parent or other close family member. The family member is usually viewed as an authority who "must know what is best," which often allows the perpetrator to convince the child that these sexual contacts are normal and take place in other families.

Some children reach adolescence before realizing through discussions with friends about family life that the sexual contact they have experienced is wrong and doesn't occur in most households.

When a child attempts to disclose abuse, he or she may be vague or inarticulate. At all times the listener should guard against the temptation to dismiss the child's account as imagined or distorted because 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 abused children do not receive immediate medical attention. When attention is received, it is at the request of a third party.

(SEE PAGE 41)

■ Facility

Ideally, each hospital that treats adult victims of sexual assault will also have a multi-disciplinary team available for the evaluation and examination of sexually abused children. Each team member must be trained in the management and psychodynamics of the sexually abused child and should also coordinate with law enforcement and child protective services.

Absent such a specialized team, the minimum requirements should be a readily available physician and nurse, both of whom are experienced in the treatment of children and trained in the medical and psychodynamic aspects of child sexual abuse.

Any health care professional who lacks sufficient skill or experience to do a physical examination of a child for signs of sexual abuse should refer that child to a facility or a team with the requisite skills to handle the assignment.

(SEE PAGE 42)

■ Intake

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.

The child and the adult accompanying the child should be prepared for the physical examination by the nurse or the physician. They should also be told the purposes of any lab tests to be done, and when the results will be available. (SEE PAGE 42)

Support Personnel

Under no circumstances should the child be left alone. Arrangements must be made to provide a support person who can establish 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 can be accomplished by allowing them a choice of the support person to be present during the physical examination. (SEE PAGES 42-43)

Reporting

Virginia law requires that every case of known or suspected child sexual abuse by a caretaker be reported to the local child protective service agency or to the Department of Social Services statewide hotline, 1-800-552-7096. (SEE PAGES 43-44)

Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from a parent or legal guardian of all children under the age of 18 unless the child is legally emancipated.

If consent cannot be obtained from the parent or guardian of the child,

and if the child is in imminent danger from his or her surroundings and requires immediate attention, the attending physician should take the child into custody. Hospitals should have procedures in place for this.

If time is not of the essence, child protective services should be consulted before taking a child into temporary custody. They can assume custody and authorize medical staff to provide diagnosis and treatment. (SEE PAGE 44)

Child Interviews

Initial Considerations

Interviewing children about abuse of any kind, physical or sexual, requires special skills.

Interviews should be conducted prior to the initiation of any physical examination or evidence collection procedures. Many times the inability or reluctance of children to answer questions relating to abuse is due to embarrassment, shyness, a fear of being thought of as "tattletale" or disloyal, or simply due to a lack of understanding of the question.

Interviewers must be aware of the long-term ramifications of their questions and their own feelings about child sexual abuse and not communicate any attitudes which might create or increase the child's trauma.

Prior to the interview, it is important to determine what reactions the child has been exposed to following the disclosure of the abuse (i.e., whether 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. Hospital staff should be alert for signals from the parent/guardian which may indicate sexual abuse.

An assessment of the child's emotional state is vital to the interview process. It is important to assess the child's verbal skills level and to use terms that are understandable to the child. (SEE PAGES 44-45)

Key interviewing techniques may be found in the Child Protocol. (SEE PAGES 45-46)

Medical Examination

Initial Considerations

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

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

1. Throughout the examination, great care must be taken to minimize additional trauma to the child. Therefore, each step in the examination process should be explained to the child prior to its being performed.

2. It is important for the examiner to be aware that children interpret statements literally.

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 for the physician to do the examination and/or to gather evidence. (SEE PAGES 46-47)

Attending Personnel

As few persons as possible should be present during the physical examination/evidence collection process. Attending personnel should consist of the examining physician, nurse, and if appropriate, an authorized support person. (SEE PAGE 47)

Presence of Parent/Guardian

In all cases of known or suspected child sexual abuse, the medical person in charge must decide whether or not the presence of a parent or guardian is desirable during the interview or medical examination. Under no circumstances, however, should the interview/examination be held in the presence of a parent/guardian who is suspected of perpetrating the abuse. (SEE PAGE 47)

Medical Evaluation

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. (SEE PAGES 47-48)

Medical Indicators of Abuse

Some of the more common medical indicators of child sexual abuse are listed in the Child Protocol. (SEE PAGE 47)

Examination of the Perineal Area

The attending physician must decide on a case-by-case basis the extent to which rectal examinations should be performed on both female and male children during the initial examination. (SEE PAGE 48)

Female Genital Examination

The attending physician must also decide on a case-by-case basis the extent to which vaginal examinations should be performed. The presence of erythema, hematomas, excoriations, abrasions, old scars and bleeding, as well as the overall appearance of the introitus and the interlabial spread should be recorded. Inspection should also be directed to any discharge (seminal or purulent), as well as odors, evidence of a foreign body, tears, skin tags and tenderness. (SEE PAGE 48)

Male Genital Examination

Evidence of erythema, bruises, suction marks, excoriations, burns or lacerations of the glans and frenulum should be recorded. (SEE PAGE 48)

■ Evidence Collection

When a forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times in order to minimize trauma to the child.

If the assault or last sexual contact occurred within the 72 hours prior to the hospital visit or if the time frame cannot be determined, physical evidence from post-pubertal children should be collected utilizing the Physical Evidence Recovery Kit, according to the instructions given for adults on pages 27-34. Physical evidence from pre-pubertal children should be collected utilizing the Physical

Evidence Recovery Kit, according to the instructions on pages 27-34, but with the modifications detailed on page 49.

If it is determined that the last sexual contact took place more than 72 hours prior to the hospital visit, it is unlikely that trace evidence will still be present on the child's body. This is most common in situations involving long-term abuse. Therefore, a careful evaluation of each case must be made to decide which, if any, evidence collection procedures should be implemented.

Regardless of when the assault or last sexual contact might have occurred, valuable evidence can still be obtained through a medical examination and interview of the child. (SEE PAGE 49)

Non-Authorization to Release Evidence

Although there have been instances where a parent or guardian, acting on behalf of the child, has refused to authorize the release of evidence to law enforcement, the actual incidence of this has been very low. If this does happen, the examining physician may be able to sign for the release in the best interest of the child. If the local child protective service or law enforcement agency is not already involved in the case, they should be contacted for assistance by hospital personnel. Each hospital should ascertain policy in its particular legal jurisdiction. (SEE PAGE 49)

■ Post Examination Information

The provision of psychological services for children and their parents or guardians is extremely important. If counseling and other follow-up services are 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 abuse.

It is extremely important that children return for a follow-up visit within one week to re-evaluate any genital or other injuries and to perform follow-up cultures, if necessary.
(SEE PAGE 50)

■ **Law Enforcement
Interview**

It is the responsibility of the investigating officer to ascertain the most supportive environment for the child during the follow-up law enforcement interview.

Hospital personnel should communicate to the interviewer observations about the child's emotional state which would facilitate the interview. For example, some children may be intimidated by weapons or may react negatively to the sex of the interviewer.
(SEE PAGE 50)

PREFACE

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. Some victims still choose not to report the assault because of the associated embarrassment, fear and trauma; others lack faith in the follow-up treatment, investigative and prosecutorial systems.

Reports of child sexual abuse also have increased dramatically in the past few years, although these reports remain even more difficult to document than adult reports. Furthermore, it is believed that although the number of reports has increased, the rate of reporting by either the victim or a third party remains low.

The reasons for this low rate of reporting are complex. Many sexually abused 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 story may be 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 their families if anyone finds out, or that they themselves are responsible for the abuse.

Traditionally, the successful prosecution of both adult and child sexual assault/abuse cases

has been difficult. 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.

Evidence from the offender and the crime scene often may be found on the body and the clothing of the victim. When immediate medical attention is received, the chances increase that some type of physical evidence will be found.

Conversely, the chances of finding physical evidence decrease in direct proportion to the length of time which elapses between the assault and the examination.

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

The primary purpose of this document is to assist hospitals to:

- Minimize the physical and psychological trauma to the victim of a sex crime, and
- Maximize the probability of collecting and preserving physical evidence for potential use in the legal system.

Although several hospitals in Virginia already have protocols, many do not. Some communities are faced with a lack of resources

for formulating or updating a protocol to reflect changes that have taken place in the fields of scientific evidence and support services.

In recognition of these facts and as part of its larger study of victims services, the Virginia State Crime Commission organized a task force for the purpose of drafting a hospital protocol. Task force members included professionals representing law enforcement, the Division of Forensic Science, emergency room medical staff, child protective services, victim/witness programs, sexual assault crisis centers, Commonwealth's attorneys, the Virginia Hospital Association, victim service providers, and staff from the Department of Criminal Justice Services.

In conducting the research for this project, existing protocols were obtained and reviewed. A protocol which was developed by the Illinois State Attorney General's Office and a national advisory committee entitled *Sexual Assault: A Hospital/Community Protocol for Forensic and Medical Examinations* was chosen as the most appropriate document to use as a model for our work. The task force drew heavily from this document and several others.

In order to evaluate how hospitals in Virginia currently treat sexual assault victims, a statewide survey of hospitals was conducted. The survey was designed by the task force and distributed by the Virginia Hospital Association to 120 member hospitals. The primary purpose of the survey was to ensure that the guidance and recommendations contained in the

final protocol would meet the needs of the hospital staff for whom it is designed.

Recommendations were based upon the physical and emotional needs of the sexual assault/abuse victim, reasonably balanced with the basic requirements of Virginia's legal system. The resulting protocol provides useful legal, medical and forensic guidance and can serve as a basis for serious discussion of the evidentiary, medical and emotional needs of sexual assault/abuse victims.

Although evidence collection is the primary focus of the document, basic medical, psychological, and support issues also have been included as much as possible throughout the protocol. For more detailed information on the medical, psychological, investigative and legal aspects surrounding sexual assault treatment, topic-specific literature should be consulted.

For purposes of this protocol, the term "sexual assault" will be used to refer to all sex crimes perpetrated against adults and the term "sexual abuse" will refer to all sex crimes perpetrated against children, both terms 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.

ADULT PROTOCOL

- Sensitivity to Victim Needs**
- Facility**
- Payment of Medical Fees/Designation of Facilities**
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- Victims' Compensation**
- Support Personnel**
- Victim/Patient Consent**
- The Evidentiary and Medical Examinations**
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□ Sensitivity to Victim Needs

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 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 may have a distinct method of coping with sudden stress. When severely traumatized, victims can appear to be calm, indifferent, confused, submissive, jocular, controlled, angry, or even uncooperative and hostile toward those who are trying to help. All of these responses are within the normal range of anticipated reactions. An inappropriate response to information concerning the circumstances surrounding the assault or a misinterpretation of a victim's reaction to the assault may lead to further trauma and hinder the interview or evidence gathering process. In all cases, therefore, attending medical personnel should refrain from expressing shock, disbelief, anger, etc., and should never express or imply that the victim is blameworthy.

Victims' responses to sexual assault may also be influenced by cultural values. It is recom-

mended that hospitals serving specific populations seek the assistance of reliable community consultants to help develop procedures and counseling resources which will reflect the special needs of those populations.

For example, in certain cultures, the loss of virginity is an issue of paramount importance 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.

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 clinician. Such practices are considered a further violation. In such instances, a female clinician should be made available for patients who request one.

Age is also an important factor to consider when responding to any victim of a sexual assault and when determining the proper interviewing method, conducting a medical examination, and providing psychological support.

■ The Elderly Victim

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 clinicians, police, and 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 infected, and when they become more acutely aware of their physical

vulnerability, reduced resilience, 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.

In general, the elderly are physically more fragile than the young, and injuries from an assault are more likely to be life-threatening. In addition to being subjected 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. The recovery process for elderly victims also tends to be longer than for younger victims.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often render the elderly patient unable to make his or her needs known, which may result in prolonged or inappropriate treatment. It also is not unusual for responders to mistake this confusion and distress for senility.

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, many older victims may be reluctant to proceed with the prosecution of their offenders.

■ Marital/Date Sexual Assault

Marital rape victims suffer trauma comparable to that suffered by other victims of sexual assault. Often, the marital rape victim has

been subjected to various forms of sexual assault, including anal penetration and/or sodomy. Also, other forms of physical and/or emotional abuse may have occurred. Marital rape victims suffer from a sense of betrayal, a deep loss of trust, loss of a feeling of control over their lives, and fear of the assaultive/abusive spouse, particularly if they still reside together. Referrals to the local domestic violence program or appropriate advocacy groups are vital to recovery.

Similarly, the trauma suffered by victims of "date rape" or "acquaintance rape" should not be minimized. These victims also may experience a deep loss of trust, compounded by the feeling that they are poor judges of character. Additionally, strong feelings of guilt, taking responsibility for the assailant's behavior, and the lack of social support for their crisis situations all serve to exacerbate the victims' trauma.

Thus, it is important to empathize with these victims and to treat them in a way which is sensitive to their particular needs. Again, appropriate referrals are vital to recovery.

■ The Disabled Victim

Criminal and sexual acts committed against the disabled (physically, mentally or communicatively) may go unreported. In addition certain disabilities may make successful prosecution difficult. Offenders often are family members, caretakers, or friends who repeat their abuse because their victims are not able to report the crimes against them. The difficulty of providing adequate responses to the sexual

assault victim is 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/communication skills to tell what happened. They may be confused or frightened, unsure of what has occurred, or they may not even understand that they have been exploited and are victims of a crime.

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 protocol may be indicated in some instances.

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 patient, also includes an arrangement to provide interpreters who can accurately and fluently communicate information in sign language. Most hospitals already have these procedures.

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 and transportation for follow-up treatment and counseling.

■ The Male Victim

It is believed that the number of adult 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. Although many 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.

There has been significant progress in educating the public toward understanding the concept of sexual assault of both sexes as being an act of violence; however, there still remains a great reluctance on the part of most male victims to report a sexual assault. As with all victims, male victims may suffer significant emotional trauma as a result of the assault.

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

NOTE: Most of this protocol will focus on female sexual assault victims; however, much of the information presented is also applicable to male victims. Where appropriate we have used gender neutral language. We do not intend to imply that male victims are less important or are less deserving of quality care.

Facility

It is advantageous for all victims of sexual assault to seek both medical treatment and evidence collection from a hospital. Clinicians 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 clinicians 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.

Payment of Medical Fees/Designation of Facilities

All medical fees involved in the gathering of evidence for cases involving sexual assault can be paid by the Commonwealth, provided that any medical treatment, examination, or service rendered is performed by a clinician or facility specifically designated for such purpose by the local Commonwealth's attorney. If there has been no prior designation, medical fees can still be paid by the Commonwealth upon authorization by the local Commonwealth's attorney. (Code of Virginia, Section 19.2 - 165.1). Hospital administrators may wish to request formal designation.

Hospitals designated to provide sexual assault treatment should have a 24-hour emergency room facility with a staff trained in sexual assault examinations. The ideal situation would 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.

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

□ Transfer

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community, and the list of properly equipped treatment facilities should then be provided to all local law enforcement agencies and victim advocacy organizations. This action 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.

If a victim of sexual assault arrives at a hospital which is not equipped to provide a sexual assault examination, arrangements should be made to transfer the victim to the nearest properly equipped treatment facility. If there are acute medical or psychological injuries which need immediate treatment, this should be done at the initial receiving facility. A copy of all records, including any X-rays, should be transported with the victim.

□ Intake

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 emotional trauma. A private location within the hospital should be used, 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 facility 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.

□ Reporting

The decision to report the assault to law enforcement authorities should be left up to the victim. Victims of sexual assault should be encouraged to report the crime and/or cooperate in the police investigation. If victims are reluctant to sign a consent form for the collection of evidence, they should be assured that cooperation in collecting physical evidence will not obligate them to either release that evidence or pursue prosecution of their case. However, victims should be advised of the hospital's policy regarding storage of collected evidence. Prompt submission of the PERK to the forensic laboratory is important to reduce biological degradation of the evidence.

□ Victims' Compensation

The Virginia Crime Victims' Act created a fund to pay for certain unreimbursed expenses of innocent victims who suffer physical and in some cases emotional injuries as a result of a crime. The program is funded through fines paid by Virginia felons and misdemeanants and federal grants. Awards of up to \$15,000 are available to pay for certain expenses if they are not paid by other sources such as insurance.

Counseling and medical expenses may be reimbursed by the fund; however, a prescription documenting the need for these services is required. Therefore, if, in the judgement of the attending physician, psychological counseling and/or further medical treatment are necessary, it is recommended that prescriptions be written at the conclusion of the hospital visit.

Victims should be referred to the Division of Crime Victims' Compensation or to a victim advocate for further information and assistance in filing a claim.

Division of Crime Victims' Compensation

Mailing Address

P.O. Box 5423
Richmond, VA 23220

Office Address

1000 DMV Drive, Room 205
Richmond, VA 23219

Contact

Robert Armstrong, Director
(804) 367-8686
Toll Free 1-800-552-4007

□ Support Personnel

The importance of having a support person available to sexual assault victims *cannot be overemphasized*. Whenever possible, one person should be assigned to stay with the victim throughout the entire emergency department visit.

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, and they can counsel family members or friends of the victim who may be at the hospital. A support person also can help provide counseling referrals and other information, such as the existence and availability of victims' compensation programs or other types of assistance, emphasize the importance of follow-up testing for possible sexually transmitted diseases or other medical problems, and answer additional questions which victims may have following their medical and evidence collection examinations.

Some hospitals 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. Many 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 advocates involved in the issue of sexual assault, increasing numbers of communities through-

out the state now have resources for counseling, and many hospitals have entered into working agreements with victim advocate organizations. 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 to the victim throughout the entire criminal justice process.

□ Victim/Patient Consent

Obtaining a patient'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 always understand or remember the reason for or significance of unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained so that the victim understands what the attending clinician and nurse are doing and why. Although much of the examination and evidence collection process can be explained by the hospital support person or 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 non-cooperation, the examining clinician 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 patient 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.

It is important to remember that consent to have a support person present must be given by the victim prior to the introduction of that person. Also, at any time throughout the treatment and evidence collection process, the patient should be able to refuse further interaction with the designated support person and/or request that the support person leave. Hospitals should follow their usual procedures for obtaining consent in extraordinary cases, e.g., for severely injured or incoherent patients.

□ The Evidentiary and Medical Examinations

A physical examination should be performed in all cases of sexual assault, regardless of the length of time which may have elapsed between the time of the assault and the examination. Some victims may ignore symptoms which would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices.

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 patients. For example, in order to minimize patient trauma, blood drawn for medical purposes, i.e., testing for syphilis, should be taken at the same time as blood drawn for evidence collection purposes. Also, when evidence specimens are collected from the mouth, vagina, or rectum, cultures for sexually transmitted disease should be taken immediately following these collection procedures.

■ Attending Personnel

The only people who should be with the adult victim in the examining room are the examining clinician, 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.

Historically, some jurisdictions have sanctioned and even encouraged the presence of law enforcement personnel during the medical examination and evidence collection process. The justification for this presence was the need for officers or investigators to be able to ensure that the specimens were properly collected, labeled and sealed, as well as to testify to the chain of custody in court. There is no medical or legal reason for a law enforcement representative, male or female, to observe these procedures. Maintaining the chain of custody during the examination should be the sole function of the attending medical personnel and one which should require no outside assistance. Subjecting patients to the observation of law enforcement personnel during this process, as well as having the law enforcement representative privy to the private communications between the victim and the hospital examining/support team, is an invasion of the patient's privacy and is an unnecessary practice.

□ Evidence Collection

■ When to Use the Physical Evidence Recovery Kit (PERK)

Physical evidence should be collected utilizing the Physical Evidence Recovery Kit if the assault occurred within 72 hours of the time of the medical examination. Although the survival time of spermatozoa in the vagina, mouth, and rectum following ejaculation varies considerably, there is fairly wide consensus that they may remain for up to 72 hours in the vagina/cervix (persisting longer in the cervical mucosa), and up to several hours or more in the mouth, and rectum. In cases of oral and/or anal sodomy, physical evidence should only be collected if the assault occurred within the past 24 hours.

All evidentiary specimens should be collected from those patients who are incoherent, unconscious or mentally deficient, since they are unable to communicate the nature of the assault. Additionally, it is strongly recommended that all evidentiary specimens be collected from those patients who report only vaginal assault. Embarrassment, physical and/or mental 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 which actually occurred. However, in cases where a victim insists that contact or penetration involved only the vagina, it is important for the victim to be able to refuse the additional tests. The right of refusal also will serve to reinforce a primary therapeutic principle - that of returning control to the

victim. When the patient reports only anal or oral sodomy, it is recommended that the specimen collection be confined to the orifice violated. However, in these cases, a blood sample, saliva sample and hair standards must also be collected.

If it is determined that the sexual assault took place more than 72 hours prior to the medical examination, the use of a Physical Evidence Recovery Kit is generally not necessary since 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, lacerations or bite marks) and any statements about the assault made by the victim.

■ Preserving the Integrity of Evidence

The custody of any evidentiary item must be accounted for from the time of collection until it is introduced in court as evidence. This is necessary to maintain the legally required "chain of custody." Therefore, anyone who handles evidence items should label them with their initials. For identification purposes each item must be labeled with the name of the patient or an identifying number and the source of the specimen.

It is also legally necessary to show in court that the evidence was not tampered with prior to the forensic examinations being conducted. This is accomplished by sealing evidence packages with a permanent seal, e.g., tape. It is not necessary to seal each individual specimen placed in the Physical

Evidence Recovery Kit. After placing the specimens in the kit, seal the kit box with the evidence seals provided.

■ Importance of Seminal Fluid

The following brief explanation is offered to emphasize the importance of the proper recovery and preservation of seminal fluid.

Historically, medical, law enforcement and legal personnel have placed significant emphasis on the presence of seminal fluid in or on the body or clothing of a sexual assault victim as the most positive indicator of sexual assault.

Conversely, when no seminal fluid was found, a shadow of doubt was sometimes cast upon the victim's allegation of sexual assault, contributing to the misconception that the absence of seminal fluid meant that no sexual assault occurred. However, sexual assault offenders may be sexually dysfunctional and may not ejaculate during the assault. Additionally, offenders may use a prophylactic, have a low sperm count (frequently associated 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. Therefore, if seminal fluid is not identified, this does not mean that an assault did not occur. For example, there could have been a significant time delay between the assault and the collection of specimens, 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 specimens could have been collected or preserved improperly. Therefore, although the finding of semen

may corroborate the fact that sexual contact 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.

In the forensic laboratory, specimens collected for the Physical Evidence Recovery Kit, as well as other evidentiary items, are examined for the presence of seminal fluid. The identification of seminal fluid is used to help substantiate that sexual contact occurred. The examiner uses a rapid color screening test to detect the presence of acid phosphatase, an enzyme present in high concentration in seminal fluid. Acid phosphatase does not positively identify seminal fluid; therefore, when acid phosphatase is detected, the stains are extracted and examined microscopically for the presence of spermatozoa. In the absence of spermatozoa, the presence of seminal fluid can be conclusively determined by testing for p30, a protein of prostatic origin specific for seminal fluid.

The genetic markers detected in seminal fluid found on the victim's body, clothing, and other evidentiary items are determined and compared to the genetic markers of the victim and suspect. These "known" genetic markers are determined by using blood and saliva. Making these comparisons enables the examiner to determine whether a suspect is included or excluded as a possible donor of the seminal fluid. For example, the ABO blood group is the most commonly known of all blood groups in the general population and divides the population into four types: A, B, O and AB.

Although ABO factors are found in everyone's blood, approximately 75-80% of the population also demonstrate their ABO factors in their body secretions (semen, saliva, vaginal secretions, etc.). Such persons are referred to as secretors. The remaining 20-25% of the population are referred to as nonsecretors because they do not express their ABO factors in their body secretions. It is possible, therefore, to determine the ABO type from stains of semen, saliva, vaginal fluid and other secretions derived from secretors.

In addition to the ABO system, enzymes found in seminal fluid such as Phosphoglucomutase (PGM) and Peptidase A (PepA) may vary in form among people in the population. These enzyme types can often be determined. The detectability of these enzymes is not related to the secretor status of an individual. The determination of types within a particular enzyme system may be of extreme importance in sexual assault investigations where an exchange of body secretions takes place, especially in those instances where the victim and the suspect have the same ABO type.

Thus, when a victim of rape is examined by a clinician soon after the assault, the vaginal/cervical and thigh/external genitalia swabs taken as part of the evidentiary examination may not only show the presence of seminal fluid, but may also indicate the blood type of the assailant through secretions which were deposited. In order to interpret the results of the tests conducted on secretions or mixtures of secretions, i.e., vaginal/cervical swabs collected by the clinician not only contain the

victim's vaginal fluid but may also contain seminal fluid, blood and saliva samples from both the victim and the suspect are necessary.

Although many of the genetic markers are found in seminal fluid (noncellular material), DNA (deoxyribonucleic acid) markers are found in the cellular material (spermatozoa). DNA analysis conducted on seminal stains from the victim's body, clothing, and other evidentiary items can be compared to DNA in the blood of a suspect. It may be possible, using DNA analysis, to not only exclude a suspect, but also to determine with an extremely high degree of probability that he is the contributor of the semen.

■ Hairs and Fibers As Evidence

If, in the commission of a crime, physical contact occurs between the suspect and the victim, there is an excellent possibility that hairs and fibers from either of these sources may be found at the crime scene and interchanged on the clothes and/or the persons of the suspect or victim. The toughness of hairs and fibers and their tendency to cling to many surfaces greatly facilitate the possibility that they may become attached to people, clothing, or other items that compose a crime scene. For these reasons, hairs and fibers are the most commonly recovered items of trace evidence encountered during the investigation of a contact crime such as sexual assault.

During a sexual assault, the possibilities for an exchange of hairs and fibers are numerous: pubic hairs of the victim may be

found on the suspect or at the scene; pubic hairs of the suspect may be found on the victim or at the scene; hair from other body areas may be exchanged or left at the scene; fibers from the victim's clothing or from the scene may be found adhering to the suspect or the suspect's clothing; and fibers originating from the clothing of the suspect may be found on the victim or the victim's clothing. The more contact between the suspect, the victim, and the scene, the greater the possibility of an exchange of these materials.

Hairs and fibers provide evidence that is circumstantial by nature. This, however, does not lessen their importance to an investigation. An eyewitness' statement carries more impact when laboratory examinations corroborate the account of what happened, thus adding credence to the statement.

Hair, under the careful examination of a qualified forensic analyst, can often reveal a significant quantity of information concerning its donor. Observed microscopically, human hair can display characteristics indicative of a certain race. The examiner is able, in many instances, to determine the body area from which the recovered hair originated. If abnormalities exist in the hair shaft due to genetic inheritance, disease, chemical treatment (bleach, dye), or damage (excessive heat), it is often possible to relate such abnormalities to their source. The forensic analyst also examines hair samples to determine if they have been recently cut (with sharp or dull instruments), whether they have fallen out or have been pulled out, if they contain foreign bodies (such as

crab lice), or if they have other unusual characteristics.

Thus, hair may be a significant source of evidential information. Using this information effectively, the crime scene investigator can obtain important leads to assist in the identification and prosecution of a suspect. The study of even a single hair from the crime scene may reveal important information about a possible suspect.

Hairs occur in three growth stages: anagen (actively growing), catagen (resting stage), and telogen (ready to be shed). There are subtle morphological differences which can be detected microscopically by a trained examiner as the growth stages progress. During an assault, the hairs most likely to be transferred from suspect to victim or victim to suspect tend to be telogen. Other hairs transferred during an assault are pulled out by friction or other means of forcible removal. Most of these hairs tend to be anagen or catagen. Therefore, head and pubic hair standards, consisting of a total of 25 or more combed and pulled hairs from each body region sampled, are needed for comparison with hairs recovered from evidentiary items, such as the victim's and suspect's clothing, the victim's pubic combings, the crime scene, etc. By combing and pulling, all growth stages should be represented in the known standards.

The importance of collecting sufficient known hairs from the victim at the time of the physical and evidentiary examinations cannot be overemphasized. Routine cosmetic changes to the victim's hair frequently occur

between the time of the initial examination and the weeks or months that follow. Hair alterations may include cutting, shaving, bleaching by the sun, chemical bleaching, dyeing, frosting, straightening, or the use of permanents. Additionally, lice or other parasites may be present on the hair at the time of the initial examination and subsequently disappear, as well as the reverse being true.

As characteristic as hair might be, the examiner, in almost all cases, cannot testify that a recovered hair is from a certain person to the exclusion of all others. Some of the conclusions the examiner might reach when known samples of hair are submitted for comparison are as follows: (a) The individual characteristics of the questioned hair are the same as the known samples of hair and both could have originated from the same source; (b) The hair samples are not similar and did not originate from the same source; (c) There are not sufficient individual characteristics to reach a conclusion; or (d) The individual characteristics of known hair from the victim and suspect are so similar that no conclusion can be reached regarding the questioned hairs.

Even though hair as evidence is circumstantial by nature, it remains an important factor both in the investigation and in the trial. Forensic laboratory findings can be used to corroborate the story of a witness or provide credence to a probable situation.

■ Clothing Evidence

Clothing may contain 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, hairs 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 provide evidence of force.

Prior to the full examination, great care must be taken by the attending clinician or nurse to determine if the patient is wearing the same clothing he or she wore during or immediately following the assault. If so, the clothing may contain possible evidence related to the assault, and with patient consent, those items should be collected.

If it is determined that the patient is not wearing the same clothing, the attending clinician 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 arrangements can be made to retrieve the clothing before any potential evidence is destroyed.

The most common items of clothing collected from victims and submitted to crime laboratories for analysis are underwear, hosiery, blouses, shirts and slacks. There also are instances when coats and even shoes must be collected. During a crime, 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 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 in its own bag to prevent cross-contamination of hairs, fibers and bodily fluids from occurring.

■ Physical Evidence Recovery Kit (PERK) Contents

Each Physical Evidence Recovery Kit contains all the necessary materials, except a 16 x 75 mm (7 ml) lavender stopper tube (EDTA anticoagulant) for drawing the known blood sample, to complete the evidence collection procedure. The blood collection tube is not provided due to the manufacturer's expiration date. This tube should be provided by the hospital. Individual envelopes, boxes and bags are labeled by step and procedure. Each envelope includes all the materials, except the known blood sample collection tube, needed to complete the appropriate evidence collection step. There are a total of 19 steps. In addition, each kit contains: outlined step-by-step instructions on how to use the Physical Evidence Recovery Kit, a "Specimen Checklist", a "Sexual Assault Information Form", Kit Number labels, police evidence seals and an Evidence Transport Bag.

The Physical Evidence Recovery Kit is designed to assist the examining clinicians in the collection of evidentiary specimens for analysis by the Virginia Division of Forensic Science. It is most important that the evidence be collected in the step-by-step fashion as outlined. Hospitals are not requested or encouraged to analyze any of the specimens/evidence collected for the kit. Any specimens required by the hospital should be collected with hospital supplies. Do not include specimens for hospital tests in the PERK. Medical report forms, anatomical drawings and patient consent forms should be provided by the individual hospital.

NOTE: These items should not be included in the PERK.

■ Evidence Collection Considerations

When using swabs, the clinician should take special care not to contaminate the individual collections with secretions from other areas, such as vaginal to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

If patients must use bathroom facilities prior to evidence collection, 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. Do not submit urine samples in the PERK.

When distilled water is used to moisten swabs to facilitate the collection of secretions, use a

minimal amount of water to moisten the swabs (2-3 drops per swab). Do not use saline; saline may interfere with some of the procedures conducted by the forensic examiner. By using a minimum amount of water, the secretions will be more concentrated. The number of tests which the forensic analyst can perform is limited by the quantity of the semen or other fluids collected.

The purpose of making smears is to enable the forensic analyst to microscopically look for spermatozoa without consuming potentially valuable portions of the correspondingly labeled swabs. A pencil should be used when labeling frosted-end slides to lessen the chance that labeling information will become smudged. If no spermatozoa are present on the slides, the analyst will then proceed to use the swabs to identify the presence of seminal fluid.

■ Physical Evidence Recovery Kit (PERK) Step-By-Step Instructions

Step 1: Sexual Assault Information Form

The information contained on this form is helpful to the forensic analyst in interpreting the scientific findings.

1. Fill out all information requested and return completed form to envelope.
2. Affix Kit Number label on envelope where indicated.

The appropriate clinician is responsible for explaining to the victim the purpose of documenting the events of the sexual assault, the purpose of the evidentiary and

medical examinations, the medical treatment choices available to him/her, and the emotional effects of the assault. Additionally, the importance of obtaining medical-legal information should be explained to the victim. If the victim has not reported the crime to the police, discuss the importance of reporting the incident, but reassure the patient that the decision to do so is his/hers. Sexual assault of an adult is not a mandated reportable crime in the Commonwealth of Virginia.

Step 2: Clothing and Debris Collection

The Debris Collection envelope contains one paper sheet. Five paper bags for clothing items are also provided. There are two sizes of bags to accommodate small and large clothing items. One of the small bags is labeled "Under-pants." Additionally, a bag is provided for the collection of a tampon/sanitary napkin. If additional clothing bags are required, use only new, grocery-type paper bags. If the bags are plastic, any moisture remaining in the clothing will be sealed in, making it possible for bacteria to quickly destroy biological fluid evidence. Unlike plastic, paper allows air into the bag and moisture to escape. Previously used bags may contain contaminants unrelated to the crime. Upon completion of all the evidence collection steps, clothing sealed in small and/or large paper bags will be placed in the Evidence Transport Bag. The bag labeled "Tampon/Sanitary Napkin" will be placed in the kit box.

If patient is not wearing the clothing worn at the time of the assault, collect only the items that

are in direct contact with patient's genital area.

If patient changed clothing after the assault, inform the officer in charge so the clothing worn at the time of the assault can be collected by the police as soon as possible. Do not shake out patient's clothing. Trace evidence may be lost.

To minimize loss of trace evidence, the patient should disrobe over a clean sheet of paper or a clean white cloth. If patients cannot undress themselves, and due to their condition it is necessary to cut off items of clothing, be sure not to cut through existing rips, tears, or stains.

1. Unfold and place a clean bed sheet on the floor.
2. Remove the paper sheet from the Debris Collection envelope, unfold and place over bed sheet.
3. Instruct the patient to stand in the center of the sheet and to carefully disrobe. Give the patient some type of loose cover-up to wear.
4. Collect each item as it is removed and place in a separate clothing bag.
5. Place the patient's underpants in the bag labeled "Underpants."

NOTE: Tampons and sanitary napkins may contain valuable evidence and should be collected in the bag labeled "Tampon/Sanitary Napkin."

6. Seal each bag with tape.
7. Carefully refold the Debris Collection sheet to retain trace evidence that has fallen from the clothing during disrobing and

return to Debris Collection envelope and seal the envelope.

8. Fill out all information requested on the Debris Collection envelope and clothing bags, including the "Tampon/Sanitary Napkin" bag.
9. Affix Kit Number label on the Debris Collection envelope and each clothing bag where indicated. If the "Tampon/Sanitary Napkin" bag is used, affix a Kit Number label where indicated.
10. Return bed sheet to the hospital laundry.

Step 3: Head Hair Standard
This envelope contains 1 piece of folded white paper and 1 comb.

The purpose of this step is to collect a representative sample of a total of 25 or more pulled and combed full length hairs for the forensic examiner to use to determine the range of visual and microscopic characteristics associated with the victim's head hair. These hairs will be used by the examiner for comparison with any evidentiary head hairs associated with the case.

1. Remove the folded paper and comb from the Head Hair Standard envelope.
2. Unfold the paper and place it on a flat surface.
3. Gently pull out and comb out (using the comb provided) a total of 25 or more full length hairs from the following scalp locations: center, front, back, left side, and right side. Comb and pull the hairs so that they will fall onto the paper. It is extremely important

that full length hairs be obtained since characteristics that occur from the root to the tip of the hair are examined by the forensic analyst. Pulling out hairs is the best method to obtain an adequate sampling of anagen (actively growing) and catagen (resting stage) hairs. Combing results in the collection of an adequate representative sample of telogen (ready to be shed) hairs from the victim. Do not cut the hairs. Cut hairs lack essential features found at or near the root of the hair. In order to minimize the pain and trauma of the pulled hair procedure, gently pull the hairs or have the patient pull them. Patients may prefer to do the combing and pulling themselves to increase their sense of control.

4. Refold the paper to retain both the hairs and the comb.
5. Return the folded paper to the Head Hair Standard envelope.
6. Seal the envelope.
7. Fill out all the information requested on the face of the envelope.
8. Affix Kit Number label on envelope where indicated.

Step 4: Pubic Hair Combing (Vaginal and/or Anorectal Assault)
This envelope contains 1 folded paper towel and 1 comb.

The purpose of this step is to collect possible hairs and other debris transferred to the patient's pubic area from the suspect or crime scene during the assault. These hairs will be compared by the forensic analyst to the

standard hair samples submitted.

1. Remove the folded paper towel and comb from the Pubic Hair Combing envelope.
2. Unfold the paper towel and with the patient in the lithotomy position, place the towel under the patient's buttocks.
3. Using the comb provided, gently but thoroughly comb patient's pubic hair in downward strokes so that any loose hairs and/or debris will fall onto the paper towel.
4. Fold the towel to retain both the comb and any hairs and/or debris.
5. Return the folded towel to the Pubic Hair Combing envelope.
6. Seal the envelope.
7. Fill out the information requested on the face of the envelope.
8. Affix Kit Number label on envelope where indicated.

Step 5: Pubic Hair Standard

This envelope contains 1 piece of folded white paper and 1 comb.

The purpose of this step is to collect a representative sample of a total of 25 or more pulled and combed full length hairs for the forensic examiner to use to determine the range of visual and microscopic characteristics associated with the victim's pubic hair. These hairs will be used by the examiner for comparison with any evidentiary pubic hairs associated with the case.

1. Remove the folded paper and

comb from the Pubic Hair Standard envelope.

2. Unfold the paper and place it under the patient's buttocks.
3. Gently pull out and comb out (using the comb provided) a total of 25 or more full length hairs from various locations in the pubic region. Comb and pull the hairs so that they will fall onto the paper. It is extremely important that full length hairs be obtained since characteristics that occur from the root to the tip of the hair are examined by the forensic analyst. Pulling out hairs is the best method to obtain an adequate sampling of anagen (actively growing) and catagen (resting stage) hairs. Combing results in the collection of an adequate representative sample of telogen (ready to be shed) hairs. Do not cut the hairs. Cut hairs lack essential features found at or near the root of the hair. In order to minimize the pain and trauma of the pulled hair procedure, gently pull the hairs or have the patient pull them. Patients may prefer to do the combing and pulling themselves to reduce embarrassment and increase their sense of control.
4. Refold the paper to retain both the hairs and the comb.
5. Return the folded paper to the Pubic Hair Standard envelope.
6. Seal the envelope.
7. Fill out all the information on the face of the envelope.
8. Affix Kit Number label on envelope where indicated.

Step 6: Lips/Lip Area Swabs and Smear (Oral Assault)

NOTE: These specimens should only be collected if an oral assault occurred within 24 hours of the patient arriving at the emergency room.

This envelope contains 2 sterile cotton swabs, a small box and 1 microscope slide with a mailer.

The purpose of this step is to collect any seminal fluid residue remaining on the mucosal surfaces of the lips and the cutaneous zone around the lips. The forensic examiner uses these specimens for seminal fluid identification and genetic marker typing.

1. While holding both swabs together, slightly moisten them with a minimal amount of distilled water.
2. Using both swabs simultaneously, briskly rub over the mucosal surfaces of the lips and the cutaneous zone around the lips in such a way as to distribute the secretions evenly over the swabs.
3. Prepare the smear by rubbing the swabs together over an area approximately 1" long by 1/2" wide on the surface of the slide. **Do not stain or chemically fix smear.**
4. Place the lips/lip area swabs in the small box provided.
5. Affix Kit Number label on box where indicated.
6. Label the frosted end of the slide "lips/lip area."
7. Affix Kit Number label to slide mailer. Label the slide mailer "lips/lip area." Place the smear in

the slide mailer. Allow the smear to air dry before sealing it in the mailer.

8. Return the slide mailer and the small box to the envelope.

9. Seal the envelope.

10. Fill out all the information requested on the face of the envelope.

11. Affix Kit Number label on envelope where indicated.

Step 7: Oral Rinse (Oral Assault)

NOTE: This specimen should only be collected if an oral assault occurred within 24 hours of the patient arriving at the emergency room.

This envelope contains a zip lock plastic bag and a screw top vial.

The purpose of this step is to recover seminal material from recesses in the oral cavity, such as the gum line and between the teeth, where it might remain for the longest amount of time. The forensic examiner uses this specimen for seminal fluid identification.

1. Give the patient 15 cc of distilled water to swish around in his/her mouth. Recover this in a paper cup.

2. Transfer the oral rinse from the cup to the screw top vial provided. Be sure the vial is capped tightly.

3. Label the vial "oral rinse" and affix Kit Number label on vial.

4. Place the vial in the zip lock plastic bag provided. Be sure the zip lock is securely fastened. In case of vial leakage this bag will

help contain the sample.

5. Return the zip lock bag to the envelope.

6. Seal the envelope.

7. Fill out all the information requested on the face of the envelope.

8. Affix Kit Number label on envelope where indicated.

Step 8: Hair Contaminated With Semen (Oral Assault)

The purpose of this step is to collect strands of hair matted with seminal fluid. The forensic examiner uses this specimen for seminal fluid identification and genetic marker typing.

Examine the patient's scalp hair for seminal fluid. Additionally, in the case of a male patient with facial hair, i.e., moustache, beard, closely examine this hair for seminal fluid. If present, refer to Step 13B - Foreign Material Collection. These matted hairs may be cut.

If seminal fluid is present on the hair and the victim does not want the hair cut, refer to Step 13A - Additional Swabbings and Smears.

Step 9: Thighs/External Genitalia Swabs and Smear (Vaginal Assault and/or Oral Genital Contact)

This envelope contains 2 sterile cotton swabs, 1 small box, and 1 microscope slide with a mailer.

The purpose of this step is to collect any seminal fluid (or saliva, in the case of oral genital contact) from the patient's exter-

nal genitalia and upper inside thigh areas. The forensic examiner uses these specimens for seminal fluid and/or saliva identification and genetic marker typing.

1. While holding both swabs together, slightly moisten them with a minimal amount of distilled water.

2. Using both swabs simultaneously, briskly rub over the upper inside thigh areas and the external genitalia in such a way as to distribute the secretions evenly over the swabs.

3. Prepare the smear by rubbing the swabs together over an area approximately 1" long by 1/2" wide on the surface of the slide. (If only oral genital contact, do not make smear.)

Do not stain or chemically fix smear.

4. Place the swabs in the small box provided.

5. Affix Kit Number label on box where indicated.

6. Label the frosted end of the slide "thighs/external genitalia."

7. Affix Kit Number label to slide mailer. Label the slide mailer "thighs/external genitalia." Place the smear in the slide mailer. Allow the smear to air dry before sealing it in mailer.

8. Return the slide mailer and the small box to the envelope.

9. Seal the envelope.

10. Fill out all the information requested on the face of the envelope.

11. Affix Kit Number label on envelope where indicated.

Step 10: Vaginal/Cervical Swabs and Smear (Vaginal Assault - Female Patients Only)

This envelope contains 4 sterile cotton swabs (2 swabs per package), 1 small box, and 1 microscope slide with a mailer.

The purpose of this step is to collect seminal fluid from the vagina and cervix. The forensic examiner uses these specimens for seminal fluid identification and genetic marker typing. It is important not to aspirate the vaginal orifice or to dilute the secretions in any way. Do not moisten swabs prior to sample collection.

1. Carefully swab the vaginal walls and cervix, taking care to recover the vaginal pool if sufficient secretions are present. Depending on the amount of secretions present, use up to 4 swabs.

2. Using the swabs simultaneously, prepare the smear. **Do not stain or chemically fix smear.**

3. Place the swabs in the small box provided.

4. Affix Kit Number label on box where indicated.

5. Label the frosted end of the slide "vaginal/cervical."

6. Affix Kit Number label to slide mailer. Label the slide mailer "vaginal/cervical." Place the smear in the slide mailer. Allow the smear to air dry before sealing it in mailer.

7. Return the slide mailer and the small box to the envelope.

8. Seal the envelope.

9. Fill out all the information requested on the face of the envelope.

10. Affix Kit Number label on envelope where indicated.

NOTE: Immediately following this procedure, it is recommended that the pelvic examination be performed and necessary medical cultures taken. Do not include these samples in the PERK.

Step 11: Perianal/Buttocks Swabs and Smear (Anorectal Assault)

This envelope contains 2 sterile cotton swabs, 1 small box, and 1 microscope slide with a mailer.

The purpose of this step is to collect any seminal fluid from the patient's perianal and buttocks areas adjacent to the anal verge. The forensic examiner uses these specimens for seminal fluid identification and genetic marker typing.

1. While holding both swabs together, slightly moisten them with a minimal amount of distilled water.

2. Using both swabs simultaneously, briskly rub over the perianal area and buttocks area adjacent to the anal verge in such a way as to distribute the secretions evenly over the swabs.

3. Prepare the smear by rubbing the swabs together over an area approximately 1" long by 1/2" wide on the surface of the slide. **Do not stain or chemically fix smear.**

4. Place the swabs in the small box provided.

5. Affix Kit Number label on box where indicated.

6. Label the frosted end of the slide "perianal/buttocks."

7. Affix Kit Number label to slide mailer. Label the slide mailer "perianal/buttocks." Place the smear in the slide mailer. Allow the smear to air dry before sealing it in mailer.

8. Return the slide mailer and the small box to the envelope.

9. Seal the envelope.

10. Fill out all the information on the face of the envelope.

11. Affix Kit Number label on envelope where indicated.

Step 12: Anorectal Swabs and Smear (Anorectal Assault)

These specimens should only be collected if the anorectal assault occurred within 24 hours of the patient arriving at the emergency room.

This envelope contains 2 sterile cotton swabs, 1 small box, and 1 microscope slide with a mailer.

The purpose of this step is to collect seminal fluid from the anorectal canal. Do not moisten swabs prior to sample collection. The forensic examiner uses these specimens for seminal fluid identification and genetic marker typing.

1. Using both swabs simultaneously, carefully swab the anorectal canal.

2. Using the swabs simultaneously, prepare the smear. **Do not stain or chemically fix smear.**
3. Place the swabs in the small box provided.
4. Affix Kit Number label on box where indicated.
5. Label the frosted end of the slide "anorectal."
6. Affix Kit Number label to slide mailer. Label the slide mailer "anorectal." Place the smear in the slide mailer. Allow the smear to air dry before sealing it in the mailer.
7. Return the slide mailer and the small box to the envelope.
8. Seal the envelope.
9. Fill out all the information on the face of the envelope.
10. Affix Kit Number label on envelope where indicated.

NOTE: At this time, any additional examinations or tests involving the anorectal canal should be conducted.

Step 13A: Additional Swabbings and Smears

Two envelopes are provided, each containing 2 sterile cotton swabs, 1 small box, and 1 microscope slide with a mailer.

This step is provided for the collection of dry or damp blood, semen, saliva, etc. which may be present on the patient's body, i.e., the area of a bite mark for saliva; stomach, chest or leg areas for ejaculate; lubricant not collected

elsewhere.

1. While holding both swabs together, slightly moisten them with a minimal amount of distilled water.
2. Using both swabs simultaneously, collect the sample in such a way as to distribute it evenly over the swabs.
3. Prepare the smear by rubbing the swabs together over an area approximately 1" long by 1/2" wide on the surface of the slide. (Do not make smear if blood or saliva is collected.) **Do not stain or chemically fix smear.**
4. Place the swabs in the small box provided.
5. Affix Kit Number label on box where indicated and label box to show the location from which the sample was taken.
6. Label the frosted end of the slide with the location from which the sample was taken.
7. Affix Kit Number label to slide mailer. Label the slide mailer with the location from which the sample was taken. Place the smear in the slide mailer. Allow the smear to air dry before sealing it in the mailer.
8. Return the slide mailer and the small box to the envelope.
9. Seal the envelope.
10. Fill out all the information requested on the face of the envelope.
11. Affix Kit Number label on

envelope where indicated.

Step 13B: Foreign Material Collection

Two envelopes are provided, each containing 1 piece of folded white paper.

This step is provided for the collection of additional evidence, not specified elsewhere, and should be used only when indicated.

1. Remove the folded paper from the Foreign Material Collection envelope.
2. Unfold the paper and place it on a flat surface.
3. Collect any foreign material found on the patient's body, such as leaves, fibers, hair, etc., that was not collected elsewhere, and place the material in the center of the paper. Refold the paper to retain the debris.
4. Label the paper with the location from which the debris was collected.
5. Return the folded paper to the Foreign Material Collection envelope.
6. Seal the envelope.
7. Fill out all the information requested on the face of the envelope.
8. Affix Kit Number label on envelope where indicated.

Step 14: Control Swabs

This envelope contains 2 sterile cotton swabs and 1 small box.

These swabs are used by the

forensic analyst to confirm that the distilled water used during the evidence collection procedures was not contaminated.

1. Slightly moisten both swabs with the same distilled water used for Steps 6, 9, 11 and 13A.
2. Place the swabs in the small box provided.
3. Affix Kit Number label on box where indicated.
4. Return the small box to the envelope.
5. Seal the envelope.
6. Fill out all the information on the face of the envelope.
7. Affix Kit Number label on envelope where indicated.

Step 15: Saliva Sample

This envelope contains 2 sterile cotton swabs and 1 small box.

A saliva sample is collected for the forensic examiner to determine the patient's secretor status and should be collected even if there was no oral contact. Do not moisten swabs prior to sample collection.

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

1. Have the patient saturate the 2 swabs with saliva.
2. Place the swabs in the small box provided.
3. Affix Kit Number label on box where indicated.

4. Return the small box to the envelope.

5. Seal the envelope.

6. Fill out all the information on the face of the envelope.

7. Affix Kit Number label on envelope where indicated.

Step 16: Known Blood Sample

This envelope contains 1 zip lock plastic bag.

The purpose of this step is to collect a known blood sample from the patient. The forensic examiner uses this specimen to determine the patient's genetic markers.

1. Using a 16 x 75 mm (7 ml) lavender stopper tube (EDTA anticoagulant), draw a blood sample from the patient, allowing the tube to fill to maximum volume.
2. Affix Kit Number label on tube.
3. Place the filled blood tube in the zip lock plastic bag provided. Be sure the zip lock is securely fastened. In case of tube breakage this bag will help contain the sample.
4. Return the zip lock bag to the envelope.
5. Seal the envelope.
6. Fill out all the information requested on the face of the envelope.
7. Affix Kit Number label on envelope where indicated.

NOTE: It is recommended that all blood work to test for sexually transmitted diseases, pregnancy, etc. be completed at this time. Do not include these samples in the PERK.

Step 17: Fingernail Scrapings

NOTE: Collect only if patient scratched assailant's skin or clothing or if possible foreign debris is noted.

This envelope contains 2 folded papers with fingernail scrapers provided with each folded paper.

The purpose of collecting fingernail scrapings is to obtain potentially useful evidence of cross-transfer, such as blood or hairs from the assailant or fibers from the assailant's clothing or the crime scene.

This is a function which patients may want to perform themselves, and they should be encouraged to do so.

1. Remove one of the folded papers and fingernail scrapers from the Fingernail Scrapings envelope.
2. Unfold the paper and place it on a flat surface.
3. Hold the patient's left hand over the paper and scrape under all five fingernails, allowing any debris present to fall onto the paper. Place the used scraper in the center of the paper and refold paper to retain debris and scraper.
4. Mark folded paper "left hand."
5. Remove the unused folded paper and fingernail scraper from the Fingernail Scrapings envelope.
6. Unfold the paper and place it on a flat surface.
7. Hold the patient's right hand over the paper and scrape under all five fingernails, allowing any debris present to fall onto the paper. Place the used scraper in

the center of the paper and refold the paper to retain debris and scraper.

8. Mark second folded paper "right hand."

9. Return both of the folded papers to the Fingernail Scrapings envelope.

10. Seal the envelope.

11. Fill out all the information requested on the face of the envelope.

12. Affix Kit Number label on envelope where indicated.

Step 18: Specimen Checklist

1. Review the "Specimen Checklist" to ensure that all appropriate evidentiary specimens/items have been collected. For those specimens/items not collected please note the reason. Return completed checklist to envelope.

2. Affix Kit Number label on envelope where indicated.

Step 19: Final Instructions

1. Check all envelopes and bags to ensure they are sealed and all requested information has been completed.

2. Return all used evidence collection envelopes to the kit box. If the "Tampon/Sanitary Napkin" bag was used, include this in the kit box as well.

Do not return unused evidence collection envelopes.

3. Affix Kit Number label on the front of the kit box where indicated.

4. Fill out all requested informa-

tion under "For Hospital Personnel" on the top of the box.

5. Initial the 2 red evidence seals where indicated.

6. Affix each of these red evidence seals where indicated on the sides of the box.

7. Affix Kit Number label where indicated on the Evidence Transport Bag.

8. Fill out the information requested on the front of the Evidence Transport Bag.

9. Place the sealed Physical Evidence Recovery Kit, all Clothing bags and the Underpants bag in the Evidence Transport Bag and staple the Evidence Transport Bag closed.

10. Make the first entry on the Chain of Custody label on the Evidence Transport Bag and hand the bag to the investigating officer present at the hospital. If an officer is not present at this time, place the sealed Evidence Transport Bag in a secure and refrigerated area until it is picked up by an official of the investigating agency. Under no circumstances should victims be allowed to handle evidence after it has been collected. Evidence must be submitted to the Division of Forensic Science by a law enforcement agency. See page 37 for further information regarding transportation and release of evidence.

☐ Medical Examination

■ Body Diagrams/ Photographs

Photographs of sexual assault victims should not be taken on a routine basis. Instead diagrams of the human figure should be used to show the location and size of the injury, accompanied by a written description of the trauma. Diagrams of both child and adult figures including genitalia for males and females should be available. (*Examples may be found in Appendix 3.*)

Many times injuries, such as bruises, will become apparent only after several days. Also, there is no guarantee that photographs will develop to show the actual severity of the injury. Once taken, photographs can be subpoenaed into evidence. Because the best photographs may not accurately capture the extent of injuries, written descriptions are very important.

Any photographs which are taken should be limited to those instances where there is an opportunity to produce 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.

Further, 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 probable and unnecessary 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.

■ Documentation/ Terminology

Findings from the physical examination should be documented as completely as possible on the medical record. Sexual assault prosecutions may not always require the presence or testimony of the attending clinician or nurse; however, there will be times when 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 examinations, the attending clinician must be careful not to include any subjective opinions or conclusions as to whether or not the 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 medical chart should reflect that a sexual assault examination was conducted and should include any pertinent medical findings. 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 expand their role and act as "investigators" for law enforcement. They should not ask

for details beyond those necessary to perform the medical and evidence collection tasks; it is the responsibility of the follow-up investigator to ask the more detailed questions.

■ Date of Last Voluntary Coitus

When analyzing semen specimens in sex-related crimes, forensic analysts sometimes find genetic markers which are inconsistent with a mixture from only the victim and the defendant. A mixture of semen from the 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.

Factors which can influence the interpretation of the scientific findings include the following:

1. Semen can remain in the vagina for several hours to several days, and for shorter periods of time also can be found in the rectum, particularly if the victim has not defecated since the assault. The disappearance of semen from the vagina or rectum usually is gradual, not sudden. The amount of residual semen can be extremely variable, depending on the victim's own particular physiology, any cleansing activities following coitus, the original volume of semen, the effectiveness of the medical collection procedure, and the sensitivity of the analytical method employed by the forensic laboratory.
2. The recollections of the victim may become less accurate if they go unsolicited until after the forensic laboratory identifies

discrepancies between the assailant's known blood type and the blood type of the seminal stains. In some cases, several months may elapse between the initial medical examination, the forensic laboratory analysis, and the follow-up interview with the Commonwealth's Attorney and the victim.

It is recommended that clinicians ask victims if they engaged in voluntary sexual intercourse within 48 hours prior to the assault. If so, victims should also be asked the date of the contact and the partner's relationship to the victim. This information should be noted on the Sexual Assault Information Form.

■ Toxicology Blood/Urine Screen

Some hospital protocols include the routine procedure of testing for the presence of alcohol and other drugs in the systems of sexual assault victims; others also allow the recording of any odor of alcohol on the victim's breath.

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

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

It is recommended that great care be exercised to ensure that toxicology screens do not become routine for victims of sexual assault unless hospital policy dictates that all patients be screened.

■ Medical Report Form for Sexual Assault Examination

Throughout the evaluation and medical examination, the attending clinician 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 patient's own words as much as possible.
3. Information regarding the physical location of the assault should be recorded i.e., 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 hairs, fibers, or other trace evidence.

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

5. Gynecological 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. Victims at risk for pregnancy should have a pregnancy test to determine possible pre-existing pregnancy.

6. During the general physical examination, record all details of trauma, such as bruises, abrasions, lacerations, bite marks, blood or other body fluids, 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.

NOTE: Information concerning sexually transmitted diseases is contained in Appendix 1 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 examination. Since 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 observation.

■ Analysis of Specimens

All medical and forensic specimens 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 placed in the containers provided in the PERK. These forensic samples will be analyzed at the Division of Forensic Science.

Procedures for Release of Evidence

■ Transportation/Release of Evidence

Under no circumstances should victims be allowed to handle evidence after it has been collected. Only a law enforcement officer or duly authorized agent may transfer evidence from hospitals to the Division of Forensic Science for analysis. Any other procedure will violate forensic laboratory policy and could prompt defense allegations of evidence tampering, switching, altering or improper preservation. Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult victim, or an authorized third party acting on the victim's behalf if the victim is unable to understand or execute the release.

■ Non-Authorization to Release Evidence

Although the vast majority of sexual assault victims consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be instances when a victim will not authorize such a release. Hospital and/or law enforcement personnel should not react negatively to the victim's initial decision not to release evidence. They should inform the victim that the release of evidence is not a commitment to prosecute. Although the lack of authorization on the date of collection could later be questioned if the case goes to court, such reluctance can be explained easily and is not generally consid-

ered by Commonwealth's attorneys to be a serious problem. However, victims should also be informed that a refusal to release evidence may obligate the victim to pay costs associated with the collection of evidence. The intent here should be to enable the victim to make an informed decision and not to coerce or intimidate him or her.

If consent is not initially received, kits and clothing bags should be stored on a temporary basis in a refrigerated, locked, secure area. Hospital personnel should inform victims of the length of time the evidence will be held prior to destruction, thereby providing the victim with an opportunity to reconsider authorization for release within a reasonable period of time after the initial hospital examination.

Post-Examination Information

■ Patient Information Form

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault victims. Before the patient leaves the hospital, a Patient 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.

Many hospitals report that the majority of sexual assault victims do not return to the facility for these follow-up tests. Denial of the assault or the need for follow-up testing, especially if no unusual symptoms are experienced, and inadequate information provided by many hospitals concerning the necessity for follow-up treatment are common reasons for a failure to return.

Patients should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted diseases, and urinary tract or other infections within four to six weeks after the initial hospital visit. It is vital that both written and verbal information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up if the victim does not wish to return to the treating hospital. Victim advocates can be quite helpful in explaining the need for a return visit and what types of tests should be performed.

The second portion of the Patient Information Form should be used to record follow-up counseling

information. While the victim should be encouraged to seek follow-up counseling, the decision to do so must be voluntary. 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. An appointment with a trained hospital counselor (if available) should be recommended and scheduled. A referral to a victim advocate, social worker, or psychologist in the community who is known to provide quality service could also be made.

The original copy of the Patient Information Form should be given to the patient and a second copy should be made for the hospital's records.

■ Follow-Up Contact

Any further contact with sexual assault victims must be carried out in a very discreet manner. In an effort to avoid any breach of confidentiality or unnecessary embarrassment, it is recommended that victims be asked, prior to leaving the hospital, whether or not they can be contacted about follow-up services. If so, they should be asked to provide an appropriate mailing address and/or telephone number where they can be reached.

■ Brochures

Many victim advocacy agencies and hospitals have developed brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to patients some of the common problems they may encounter, such as disturbances in sleeping or eating patterns, flashbacks of the attack, and post-traumatic stress disorder.

They also can provide reassurance to the victim that he or she is not responsible for the assault.

In addition, brochures should contain information about local and state resources such as victims' compensation programs, counseling services, and information on home security and personal safety. 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.

■ Clean-Up/Change of Clothing

Many victims want to wash after the examination and the evidence collection process. If possible, the hospital should provide the basics required, such as mouth rinse, soap, shampoo, and a towel.

If garments have been collected for evidence and no additional clothing is available, arrangements should be made to ensure that no victim has to leave the hospital in an examining gown. In those instances where police officers transport victims from their homes to the hospital, officers should 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 a friend contacted to provide substitute clothing. When the victim has no available clothing, necessary items could be supplied by hospital volunteer organizations and/or local victim assistance agencies.

Hospitals can address this issue by developing a community plan with local law enforcement agencies and victim assistance agencies.

■ Law Enforcement

Investigative Interview

Many police departments, especially within large 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 an initial 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 has already been interviewed by the responding officer and 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 assault 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 case and to prepare a report for the Commonwealth's attorney.

■ Transportation

Finally, 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 some jurisdictions, transportation may be provided by the local law enforcement agency as a community service.

CHILD PROTOCOL

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- General Information**
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- Reporting**
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- Post-Examination Information**
- Law Enforcement Interview**

NOTE: The principles and recommendations contained in the adult protocol apply to child victims as well. The following protocol provides additional guidance to medical personnel caring for child victims.

□ Definition of Abuse

• Child sexual abuse occurs if a child - any person under the age of 18 - is made to engage in, or made to help someone else engage in, any sexually explicit conduct, such as intercourse, sodomy, or the fondling of genitals.

• It also occurs if the child is molested or raped, is involved in incest, or is sexually exploited, as in child prostitution or pornography.

• A child is abused if he or she is enticed, bribed, threatened, coerced, or forced to engage in any of these acts, or if the child is developmentally not old enough or mature enough to understand the consequences or implications of these acts.

□ General Information

Most child sexual abuse cases are intra-familial, i.e., they occur within the family, but a fair number are extra-familial, involving persons outside the family. Hence, the abuser can be a parent, sister, brother, other relative of the child, family friend, baby sitter, teacher, coach, or stranger of any age or sex. In fact, the great majority of children are abused by someone they know and often trust. Child sexual abuse also occurs among all segments of society. It is a public health issue that crosses all economic, social, racial, and ethnic boundaries.

Many children are sexually abused in some way over a period of years. Long-term abuse in intra-familial situations may begin when the child is three or four years of age or younger, and may continue well into adolescence or even after the child leaves the home.

Until recently, there has been little opportunity for many young children to learn 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, they will not understand the importance of reporting the incident(s). Additionally, in other cases the child may simply be afraid to disclose the incident(s).

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

In some instances, intra-familial abuse may be restricted to fondling or gentle touching. Other instances may begin this way and escalate to digital penetration or intercourse, usually after an extended period of time. The family member is typically viewed as an authority who "must know what is best," which often allows the perpetrator to be able to convince the child that these types of sexual contacts are normal and take place in other families.

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

When a child attempts to disclose abuse, he or she may be vague or inarticulate. At all times the listener should guard against the temptation to dismiss the child's account as make-believe or distorted because the child may decline to initiate the subject again.

□ Facility

Because of the inability of most children to secure medical treatment on their own, the majority of sexually abused 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 medical professional who discovers a sexually transmitted disease from a vaginal, urethral or throat culture.

Ideally, each hospital that treats adult victims of sexual assault will also have a multi-disciplinary team, available on an on-call basis, for the evaluation and examination of sexually abused children. This team should consist of a pediatrician, a nurse, and a social worker. 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 sexually abused child. This team should also coordinate with law enforcement and child protective services.

In the absence of such a specialized team, the minimum requirements should be a readily available physician and nurse, both of whom are experienced in the treatment of children and trained in the medical and psychodynamic aspects of child sexual abuse.

Any health care professional who lacks sufficient skill or experience to do a physical examination of a child for signs of sexual abuse should refer that child to a facility or a team with the requisite skills to handle the assignment.

□ Intake

Children are often brought to the hospital by a police officer and/or parent. 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 is present, he or she should be asked if there is any additional information about the event which 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.

Many times children will tell health professionals things they may not disclose in the presence of parents or other adults. For this reason, adolescents and older children should be encouraged to provide much of their own medical history. 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 and the adult accompanying the child should be informed about and prepared for the physical examination by the nurse or the physician. They should also be told what specific lab tests will be done, the purpose of each test, and when the results will be available.

■ Support Personnel

Under no circumstances should the child be left alone. Arrangements must be made to provide a

support person who can establish 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 can be accomplished 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, nurse, trained victim advocate, or family member. A support person of the same sex as the child can be quite reassuring and may be required by many institutions.

□ Reporting

Virginia law requires that every case of known or suspected child sexual abuse by a caretaker be reported to the child protective services unit of the Department of Social Services. All other cases of known or suspected child sexual abuse should be reported to local law enforcement and/or child protective services. All cases should be considered a medical emergency and be seen without delay (Code of Virginia, Section 63.1-248.3).

■ Suspicion of Abuse

Here are some circumstances in which you should "suspect" child sexual abuse:

1. A parent brings in a child who shows signs of physical injury in the genital area and is experiencing pain. When asked about these symptoms the child offers history which is not consistent with your own clinical findings (was roughhousing with friends, fell off playground equipment, etc.). But the clinical information and your own judgment tell you otherwise; you suspect that the child may have been sexually abused. You must, therefore, report your suspicion to the child protective services agency.

You don't know who may have sexually abused the child and you don't know where or when the abuse occurred. But as a health professional you don't have to know. If, in your own best clinical judgment you suspect the child has been abused, then you must report that suspicion to your local or state child protective services agency.

2. A child is brought in who shows no outward signs of injury or abuse, but is presented as "not feeling quite right." The child is reticent and even sullen, avoids eye contact with both you and the parent, and cannot — or will not — tell you what or where the trouble is. As you begin a routine physical examination, the child becomes fearful and highly stressed. When you begin to examine the genital and anal areas, the child becomes violent and tries to break free. (Some child victims may do just the opposite: flop back in a highly suggestive position of total surrender.)

You may not know who abused the child, but it's not your responsibility to find out. If you suspect that the child is or has been the victim of sexual abuse, that's reason enough for you to make a report. And, by law, you must.

3. A child shows up for his or her annual physical examination. In the course of your workup, you discover the child has a sexually transmitted disease, vaginitis or urinary tract symptoms, or other signs and symptoms that raise serious suspicions of possible sexual abuse. Again, you should report your suspicions to the local or state child protective services agency.

But what if you are wrong? What if, in any one of these cases, the child has not been abused or your suspicions cannot be substantiated?

Virginia laws recognize this concern and provide immunity for anyone who reports in good faith. A health professional who reports a suspected case of child abuse is protected by a "cloak of immunity"

from any civil or criminal liability that might arise because of the report and subsequent events (Code of Virginia, Section 63.1-248.5).

The reverse, however, is not true. For example, a health professional who fails to report a suspected case of child abuse that actually did occur, has no "cloak of immunity" and can be prosecuted by the state for failing to report and fined up to \$1,000 (Code of Virginia, Section 63.1-248.3). Additionally, health professionals can be sued for malpractice by the victim's family. A number of such cases have indeed been brought — and won — against health professionals in the last few years.

All reports should be made to the local child protective service agency or to the statewide hotline (1-800-552-7096).

Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from a parent or legal guardian of all children under the age of 18 unless the child is legally emancipated.

Fortunately, there are few situations where the parent/guardian refuses consent to these procedures. However, if consent cannot be obtained from the parent or guardian of the child, and if the child is in imminent danger from his or her surroundings and requires immediate attention, the attending physician should take the child into custody. Hospitals, in cooperation with law enforcement, should have procedures for this.

If time is not of the essence, child protective services should be consulted before taking a child into temporary custody. They can assume custody and authorize medical staff to provide diagnosis and treatment.

Child Interviews

■ Initial Considerations

Many sexually abused 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).

The interview should be conducted prior to the initiation of a physical examination or evidence collection procedures.

Interviewing children about abuse of any kind, physical or sexual, requires special skills. It can often be difficult to get the child to talk or to understand what the child says. Many professionals are not 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 "tattletale" or disloyal, or simply due to a lack of understanding of the question.

With children, to a much greater extent than with adults, interviewers must be aware of the long-term ramifications of their questions. 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 child sexual abuse and not communicate any attitudes which might create or

increase the child's trauma. This is especially important in cases of sexual abuse by 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 abuse. 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 child sexual abuse perpetrated by a family member or other trusted individual are not always concrete. Therefore, hospital staff should be alert for signals from the parent/guardian which may indicate sexual abuse.

Ask about such symptoms as:

- Trouble urinating (dysuria) / blood in the urine (hematuria) / involuntary urination, especially bed-wetting (enuresis) / and any pain, fever, discharge, or itching that may be related to urinary tract infections or genital lesions.
- Abdominal pain / anorectal problems such as itching, bleeding and pain / fecal incontinence (encopresis) / and other evidence of bowel habit dysfunction.
- Excessive masturbation, indications of sexual knowledge unusual or inappropriate for a child that age / and sexual experience, including knowledge of, and

experience with, oral, rectal, and/ or vaginal penetration during prior abusive incidents.

- Rash or sores in the genital area/ sexually transmitted diseases / and, for female patients, vaginal odor, pain, itching, bleeding, or unusual discharges.
- For adolescent patients in particular, the frequency and severity of headaches / dramatic weight changes / trouble sleeping, including nightmares and other disturbances / serious problems in school / the abuse of drugs and alcohol / depression / thoughts of, or attempts at, suicide / phobias of one kind or another / use of birth control methods / and pregnancy.

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

■ Key Interviewing Techniques

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 the story with as few interruptions as possible and to use his/her own words in describing what happened. The child's story should not be discounted and should be taken at face value.

The following pointers on conducting an interview, while generally applicable, are particularly useful with children age three and above who may have been sexually abused:

- Value judgments and expression of shock or surprise should be avoided.
- Make sure the child is comfortable. If you show impatience and other signs of not caring, you may be identified in the child's mind with the abuser and the assessment will go badly.
- 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.
- Even though you may know or strongly suspect that the child has been sexually abused, you should take care to restrict your questions to the realm of the physical and mental health of the child. Also,

as in your initial report, be sure that you don't influence the interview so that it merely reinforces your own judgment as to whether or not the child was sexually abused. That determination will be made elsewhere through due process.

- Note the child's use of any sexually provocative mannerisms directed toward you. This kind of learned behavior is often presented by very young sexually abused children. Note also the child's tone of voice and, to the extent possible, write down verbatim any especially revealing remarks by the child.

- Ask the child about his or her physical, emotional, and mental health. But remember that each possible symptom of abuse is of limited significance by itself. This is precisely where good clinical judgment is so important. You must ask yourself: Is this or that symptom truly out of the ordinary given this particular child, at this age, in this family, in this particular state of health?

- 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 the child's favorite events or activities. These could include asking about television shows, a vacation or trip to see a relative, going to the zoo, or shopping.

- Younger children also are somewhat concrete and have a short span of attention. Therefore, the interviewer should avoid long questions and provide short rest periods at appropriate intervals during the interview.

- 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.

- If the interview is not going well, don't force it by asking leading questions; stop and get assistance from child protective services or local law enforcement personnel who have more experience in these cases. Do not let your own eagerness, curiosity, sense of outrage, or any other personal feelings influence you to continue the interview along lines that lie outside your own professional competence and experience.

☐ Medical Examination

■ Initial Considerations

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

A physical examination should be performed in all cases of sexual abuse, regardless of the length of time which may have elapsed between the time of the abuse and 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. Woods Lamp (ultraviolet illuminator)
6. Physical Evidence Recovery Kit (if appropriate)
7. All medical and evidence collection paperwork

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

Special considerations which will

increase the child's sense of well-being include the following:

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. Factors such as the presence of unfamiliar equipment, most of which can be quite "scary" in appearance, and the possible need to darken the examining room in order to conduct the Wood's Lamp procedure properly can be extremely disconcerting and frightening to a child. Therefore, each step in the examination process should be explained to the child prior to its being performed.
2. It is important for the examiner to be aware that children interpret statements literally. For example, statements such as "I'm doing cultures to see if there are bugs in there" should be avoided. 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 for the physician 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.

■ Attending Personnel

As few persons as possible should be present during the physical examination/evidence collection process. Attending personnel should consist of the examining physician, nurse, and if appropriate, an authorized support person. Those persons involved in the investigation, such as law enforcement or child protective agency representatives, should not be in attendance during the physical examination/evidence collection procedures.

■ Presence of Parent/Guardian

In all cases of known or suspected child sexual abuse, the medical person in charge must decide whether or not the presence of a parent or guardian is desirable during the interview or examination. To minimize confusion and additional trauma to the child, and/or to obtain information that might otherwise be censored it may be preferable to not have a family member present. 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 their presence may be appropriate if they are supportive to the child.

Under no circumstances, however, should the interview/examination be held in the presence of a parent/guardian who is suspected of perpetrating the abuse.

■ Medical Evaluation

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 and/or sites of bleeding. If present, their control/stabilization must be the priority.

The more common medical indicators of child sexual abuse are:

1. the presence of sexually transmitted disease
2. unexplained vaginal bleeding, discharge or trauma
3. inappropriate sexual behavior for the child's age
4. suspicious stains or blood in the underwear
5. lesions, bruising or swelling of the genital or anal area not consistent with history
6. pain in the anal or genital area
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 physician should also note in the medical record the position in which the child was examined. The location of injuries should be recorded on diagrams of the young female and male body. 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 abused child may, in many cases, be negative. There are, in fact, many types of sexual abuse which may not result in identifiable physical injury. 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 fluoresce a characteristic light blue color. If fluorescence is present, specimens from these areas should be taken for submission to the forensic laboratory. The presence of any bruises, abrasions, lacerations, burns or other dermatologic lesions should be recorded. An attempt should be made to estimate the age of the injury, i.e., noting the color of a hematoma and the degree of healing of an abrasion. Any fractures, loose or absent teeth, grab marks, suction or bite marks should be recorded, all of which are helpful in providing further confirmation of victimization.

■ Examination of Perineal Area

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

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 may be important, and any findings should be noted.

If anal tears or bleeding are present, an anoscope should be performed. Findings and the position in which the child was examined should be carefully noted in the medical record.

■ Genitalia

It often is helpful at the beginning of the genital examination to use Tanner Staging (a method to estimate the level of sexual maturation of children).

■ 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.

When a pelvic examination is conducted, a small speculum may need to be used, although this is rarely necessary. For patient comfort, the speculum can be moistened with warm water, but no lubricants of any kind should be used.

With the young child present on the mother's/caretaker's lap (if appropriate), supine on the examining table, or in the knee chest position, the vaginal and perineal areas are inspected. The presence of erythema, hematomas, excoriations, abrasions, old scars and bleeding, as well as the overall appearance of the introitus and the interlabial spread should be recorded. The urethral meatus should be examined for any signs of trauma or abnormal dilation.

An attempt to visualize the hymen is usually successful in prepubescent girls. The hymen most often is a circular membrane originating from the edges of the vaginal entrance. Most frequently, there is a central opening or openings. There are anatomical variations in both the size and types of openings, ranging from unusually small and/or imperforate to completely absent. 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.

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

■ Male Genital Examination

Both the glans and the scrotal area are targets of trauma. 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.

□ Evidence Collection

When a forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times in order to minimize trauma to the child.

If the assault or last sexual contact occurred within the 72 hours prior to the hospital visit or if the time frame cannot be determined, physical evidence from post pubertal children should be collected utilizing the Physical Evidence Recovery Kit, according to the instructions given for adults on pages 27-34. Physical evidence from pre-pubertal children should be collected utilizing the Physical Evidence Recovery Kit, according to the instructions on pages 27-34, however, with the following modifications:

- It is recommended that the blood sample for forensic purposes not be taken at the time of the initial examination unless blood is being drawn for medical purposes. The amount of blood collected from pre-pubertal children for forensic purposes should be limited to 3 milliliters.

- If it is determined that the simultaneous use of two swabs for the collection of the vaginal/cervical specimen and/or anorectal specimen may cause unnecessary discomfort or additional trauma to the patient, the swabs should be used one at a time.

- For the young female child and the adolescent female who is too traumatized to have a pelvic examination, evidence specimens can be obtained by gently swabbing the thighs/genitalia using two swabs slightly moistened with distilled water.

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

- Instead of collecting pubic hair combings from pre-pubertal children, carefully examine the thighs and external genitalia for any loose hairs or fibers. If found, collect according to the instructions given for adults in step 13 B on page 32.

- If it is determined that the last sexual contact took place more than 72 hours prior to the hospital visit, it is unlikely that trace evidence will still be present on the child's body. This is most common in situations involving long-term abuse. Therefore, a careful evaluation of each case must be made to decide which, if any, evidence collection procedures should be implemented.

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

■ Non-Authorization to Release Evidence

Although there have been instances where a parent or guardian, acting on behalf of the child, has refused to authorize the release of evidence to law enforcement, the actual incidence of this has been very low. If this does happen, the examining physician may be able to sign for the release in the best interest of the child. If the local child

protective service or law enforcement agency is not already involved in the case, they should be contacted for assistance by hospital personnel. Each hospital should ascertain policy in its particular legal jurisdiction.

Post-Examination Information

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

The provision of psychological services for children and their parents or guardians is just as important as it is for adult victims. If counseling and other follow-up services are 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 abuse.

It is extremely important that children return for a follow-up visit within one week to re-evaluate 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.

Law Enforcement Interview

It is the responsibility of the investigating officer to ascertain the most supportive environment for the child during the follow-up law enforcement interview.

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. 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.

Hospital personnel should communicate to the interviewer observations about the child's emotional state which would facilitate the interview. For example, some children may be intimidated by weapons or may react negatively to the sex of the interviewer.

-
- Bibliography**
 - Hospital Protocol Development Task Force
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 - Acknowledgements**

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APPENDICES

- Sexually Transmitted Diseases (STD)**
- Sample Forms**
- Sample Body Diagrams**
- State Level Referral Resources**

APPENDIX 1 Sexually Transmitted Diseases (STD)

□ Testing

The risk of contracting a sexually transmitted disease as a consequence of sexual assault is not known; however, baseline STD status should always be established during the initial hospital examination.

It could be helpful to the prosecution to have information on the presence or absence of STDs at the time of the initial examination so an informed decision could be made as to whether to order additional tests of both the victim and the offender. If tests are initially negative, but at the follow-up examination the results are positive, the presumption is that the disease was contracted from the assailant. 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 patients will request immediate treatment as a precautionary measure, and unless contraindicated, prophylaxis can be given at this time.

□ Children and Sexually Transmitted Diseases

In the case of children, the presence of a sexually transmitted disease is a strong indication of sexual abuse, and the presence of certain STDs might in some way link the offender to the crime. Although many infections, including gonorrhea and herpes simplex, 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 abused if STDs are present. Therefore, all cases of sexually transmitted disease in children should be reported to the appropriate law enforcement agency and child protective services unit, and to the local department of health.

□ Research Findings and Treatment

Due to continuing research and discussion of the most effective treatment of STDs specific to sexual assault victims, treatment regimens have not been included in this report. 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 its latest treatment recommendations.

□ Types of Sexually Transmitted Diseases

Traditionally, tests for sexually transmitted diseases in sexual assault and abuse patients have focused on screening for syphilis and gonorrhea. There are many types of sexually transmitted diseases; however, the following represents a brief overview of those most likely to be seen in the sexual assault/abuse victim.

■ Chlamydia

In the past few years, chlamydia has been recognized as the most prevalent cause of sexually transmitted disease in the United States.

Chlamydial organisms are unusual in that they are completely dependent on their host cell for energy and therefore are only able to survive outside their host environment for the briefest period of time. Transmission of the 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 than previously recognized. Moreover, children

appear to be asymptotically infected more often than adults, especially when the infection is oral or rectal.

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 or without painful urination, is common.

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; however, these tests are not as sensitive as chlamydial cultures and may not be accepted in court because of questions concerning the validity and reliability of test results.

Unlike tests for 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 hospital protocols for detection of STDs. In order to ensure the validity and reliability of test results it is also recommended that hospitals take chlamydial cultures instead of using fluorescent antibody tests.

■ Gonococcal Infections

Gonococcal infections are caused by *Neisseria gonorrhoeae*. 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 newborn conjunctivitis, pelvic inflammatory disease, orchitis, epididymitis, urethritis, perihepatitis, proctitis, pharyngitis, vaginitis and disseminated gonococcaemia.

The diagnosis of gonorrhoea can tentatively be made with a gram stain. However, a definitive diagnosis of gonorrhoea is dependent on a positive culture result.

Asymptomatic infections are common and should be treated. It is important to recognize that chlamydial infections commonly occur in conjunction with gonorrhoeal infections.

■ Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)

Definitions

•**HIV Infection:** The human immunodeficiency virus (HIV) attacks and destroys certain kinds of white blood cells, almost always resulting in acquired immunodeficiency syndrome (AIDS). The virus is transmitted through exposure to contaminated blood, semen, vaginal secretions, and other body fluids containing visible blood, and its antibodies are confirmed in the blood stream via a series of blood tests. Individuals infected with HIV may be entirely asymptomatic for five to ten years or more, but are capable of infecting others. Symptoms of infection may include tiredness, persistent fever, loss of appetite

and weight, diarrhea, night sweats, and swollen lymph nodes in the neck, armpit, or groin.

•**Acquired Immunodeficiency Syndrome (AIDS):** This disease is a defect in natural immunity against other diseases due to infection with HIV and results in vulnerability to serious illnesses that would not normally be a threat (opportunistic diseases). Diagnosis depends on the presence of opportunistic diseases that indicate the loss of immunity and the confirmation of HIV infection. The two most common opportunistic diseases are *Pneumocystis Carinii* pneumonia and Kaposi's sarcoma, but the list of opportunistic diseases has been expanded with each new revision of the Centers for Disease Control's surveillance definition of AIDS. HIV may also attack the central nervous system causing progressive dementia, loss of coordination, partial paralysis, or memory loss.

Means of HIV Transmission

•**Sexual Contact:** HIV is transmitted via intimate physical contact - oral, anal, or vaginal - with someone who is infected with the virus. HIV can thrive in semen, blood, and vaginal fluids.

•**Inoculation of blood:** Bloodborne HIV transmission occurs primarily through needle sharing by intravenous drug users. Transmission has also been traced to blood transfusions and to blood products given to hemophiliacs. However, the nation's blood supply is now considered nearly safe as a result of universal screening of donated blood and heat treatment of blood products. Other possible means of blood-

transmitted HIV infection include medical injections with unsterile needles, accidental needle sticks, and open-wound and mucous-membrane exposure.

(The above language is reprinted from: "AIDS and HIV Training and Education in Criminal Justice Agencies," National Institute of Justice, AIDS Bulletin, August, 1989).

Risk

Because of health factors, trauma, and many unknown variables, it is inappropriate to attempt to quantify the risk of HIV infection in cases of sexual assault. What is known is that infection can occur after a single sexual encounter with a positive partner but may not occur even after repeated exposures.

Relevant Information and Recommendations

HIV testing is confidential if performed at a site which tests anonymously. If the test is performed at a hospital or a physician's office, the results become a part of the medical record and will be reported to the Virginia Department of Health with individual identifiers.

Virginia law requires that prior to testing for HIV infection, the subject of the test must be given an oral or written explanation of the meaning of the test and, in nearly all cases, informed consent must be obtained prior to testing. Virginia law also requires that HIV test subjects must be "afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling" unless the test is conducted by a blood collection agency. (Code of Virginia, Section 32.1 - 37.1).

It is recommended that pre- and post-test counseling be provided by a qualified counselor, i.e., a health care provider that has attended a training course conducted by the regional AIDS Coordinator of the Public Health Office.

Non-mandatory tests for HIV infection are recommended for persons who have been sexually assaulted. Because early test results may be negative, tests should be done as follows: baseline (within 1- 2 weeks of assault or report), 3 months, 6 months, and 12 months. The victim should be encouraged to choose the most appropriate or desirable test site (hospital vs. site which tests anonymously) and should be provided with or referred for pre- and post-test counseling. All sexual assault victims should be advised to assume that they are HIV positive until the testing sequence is complete. They should also be encouraged to take appropriate precautions (safe sex, pregnancy counseling, etc.). Appropriate referrals for counseling and further information are essential.

NOTE: A sample form entitled "Consent to Test for Antibodies to HIV" is included in Appendix 2. The form, provided for informational purposes only, is recommended by the Virginia Hospital Association and the Medical Society of Virginia. All information in this section is intended to assist hospital staff in their efforts to provide quality patient care. Hospitals should develop policies and procedures regarding HIV and AIDS in consultation with legal counsel.

■ 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 which of the four stages are manifested in the patient: 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 patients suspected of having syphilis.

■ Genital Herpes Simplex Virus Infection (HSV)

Genital herpes is the result of an infection with HSV type 1 or 2. This virus 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 immunofluorescence and serologic tests, as well as cultures, can be used to confirm the diagnosis. It is important to recognize that 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.

■ *Trichomonas Vaginalis*

Trichomonads are protozoans which can infect the genitourinary tract. The presence of these organisms, except in newborns who can become infected during passage through the birth canal, should be considered an indicator 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 mobility.

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.

■ 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 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.

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

■ 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.

Vaginosis is 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.

APPENDIX 2
Sample Forms

Medical Report Form for Sexual Assault Examination

Name of Patient: _____ **Patient Hospital No.:** _____
Address: _____ **Age:** _____ **Sex:** _____
Patient brought in by: _____
Agency/Relationship of Escort: _____
Date of Assault: _____ **Time:** _____

Date of Exam: _____ **Time:** _____
Vital Signs: Time _____ B.P. _____ Pulse _____ Resp. _____ Temp. _____

History of Assault: (Patient's description of pertinent medical details of assault - oral, rectal, vaginal penetration; digital penetration or use of foreign object; oral copulation; ejaculation.)

Significant Past Medical History: _____

Physical Examination: (Include all details of trauma, abrasions, lacerations, bite marks, insertion of foreign objects; presence of blood or other secretions.)

Genital Examination:

External Genitalia _____
Vagina _____
Hymen _____
Cervix _____ **Penis/Scrotum** _____
Uterus _____ **Rectum** _____

Diagnostic Tests: (Do not include in PERK)

_____ **Pregnancy Test:** _____ Positive _____ Negative
 _____ **VDRL/FTA**
 _____ **GC Cultures:** _____ Oral _____ Vaginal _____ Urethral _____ Rectal
 _____ **Chlamydia Cultures:** _____ Oral _____ Vaginal _____ Urethral _____ Rectal
 _____ **Other (Specify):** _____

Treatment:

Prophylaxis for STD: _____ Yes _____ No
Medication: _____ **Dosage:** _____ **Time:** _____ **RN:** _____
Other prescribed medication: Problem: _____
Medication: _____ **Dosage:** _____ **Time:** _____ **RN:** _____
Tetanus Toxoid Given: _____ Yes _____ No
Surgical Procedures: _____

Patient Follow-up Care/Legal Checklist:

___ GYN/Medical/STD follow-up appointment

___ Sexual assault counseling referral

___ Written and verbal information given to patient

___ Hospital received permission to contact patient by: ___ phone ___ mail ___ permission denied

___ Authorization for Release of Information and Evidence To Law Enforcement Agency completed:

___ Yes ___ No

___ Appropriate law enforcement/child protective agency notified, if patient is a minor and has not been legally emancipated: ___ Yes ___ No

Attending Physician - Signature

Attending Nurse - Signature

Physician - Printed Name

Nurse - Printed Name

Authorization for Release of Information and Evidence to Law Enforcement Agency

(Patient Stamp)

Patient's Name: _____
Date of Birth: _____
Hospital Number: _____

I hereby Authorize _____ to release the following information covering treatment given to me on: ____/____/____ to: _____
Month Day Year (Name of law enforcement agency)

	Authorized for Release	NOT Authorized for Release
<input type="checkbox"/> One sealed Physical Evidence Recovery Kit (PERK).....	_____	_____
<input type="checkbox"/> X-rays or copies of X-rays taken in connection with examination.....	_____	_____
<input type="checkbox"/> Photographs.....	_____	_____
<input type="checkbox"/> Clothing.....	_____	_____
<input type="checkbox"/> Copies of medical and laboratory reports.....	_____	_____
<input type="checkbox"/> Authorized for release (please list clothing or miscellaneous items):		

Article	Description
_____	_____
_____	_____
_____	_____
_____	_____

Name of person authorizing release of information: _____ Date: _____

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

Signature of person authorizing release of information: _____

Receipt of Information

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

- One sealed PERK
- X-rays or copies of X-rays
- Photographs
- Sealed clothing bag(s) *(if more than one please note)*: _____
- Copies of medical and laboratory reports
- Other: _____

Signature of person receiving information and article(s):

Date: ____/____/____ Time: _____

ID #/Shield #/Star #/Title: _____

Precinct/Command/District: _____

Person receiving article(s) is representative of: _____

Name of person releasing articles: _____
(Printed Name)

(Signature)

Patient Information Form

(Patient Stamp)

Patient's Name: _____
 Hospital Name: _____
 Date of Examination: _____
 Examining Physician: _____
 Hospital Phone Number: _____

With your consent, a number of specimens were collected from you to provide evidence in court should your assailant(s) be apprehended and the case prosecuted. Additional tests were conducted as follows:

- A blood test for syphilis: ___ Yes ___ No
- Smear and culture for:
 - Gonorrhea ___ Yes ___ No
 - Chlamydia ___ Yes ___ No
- Pregnancy test to determine pre-existing pregnancy only: ___ Yes ___ No

___ You were given an antibiotic to prevent gonorrhea. However, you must return in 4-6 weeks following this treatment for another test to be sure 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 sexually transmitted disease because:

If you wish counseling, referrals and/or follow-up testing and treatment for sexually transmitted diseases 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:

___ No appointment was made for follow-up treatment.

___ An appointment was made for you at this hospital for follow-up counseling on:

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

___ I do not wish to receive this form _____
(Patient/Parent/Guardian Signature)

CONSENT TO TEST FOR ANTIBODIES TO HIV VIRUS

(name of hospital or physician's practice)

Name: _____

Responsible Physician: _____

Date: _____ Time: _____ A.M./P.M.

I understand that the purpose of HIV blood testing is to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), and related disorders.

I understand that this is not a direct test for the virus, but a test for antibodies to the virus. The sample of blood is tested in two ways to confirm a positive test. I further understand that a positive blood test result does not mean that I have AIDS and that in order to diagnose AIDS, other means must be used in conjunction with the blood test.

I have been informed that the HIV blood test results may, in some cases, indicate that a person has antibodies to the virus when the person does not (false positive) or fail to detect that a person has antibodies to the virus when the person has antibodies (false negative). The possibility of a false positive result is minimized by performing other antibody tests when the first test is positive.

I understand that state law requires physicians to report to the local health department the identity of any patient who has tested positive for exposure to HIV.

I have been advised of the procedure for taking blood and the possible risks and consequences of such a procedure.

I understand that the results of my HIV testing will be explained to me by my physician.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the HIV antibody blood testing and all of my questions have been answered to my satisfaction.

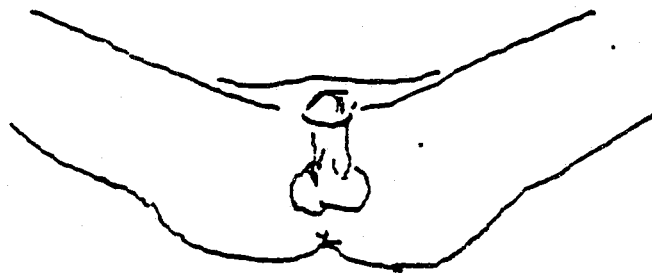
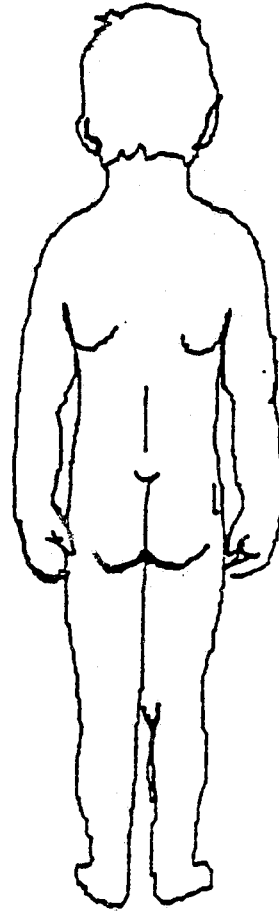
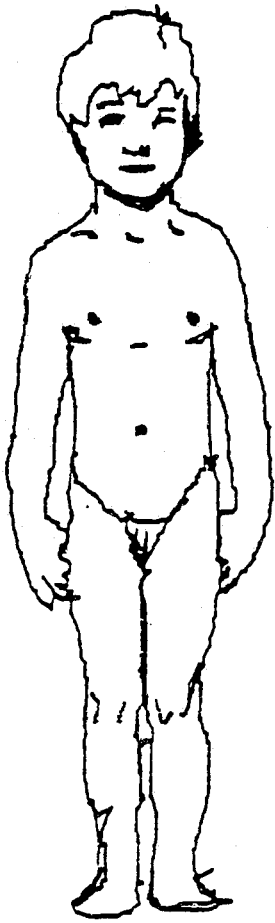
DO NOT SIGN UNTIL YOU READ AND UNDERSTAND THIS FORM

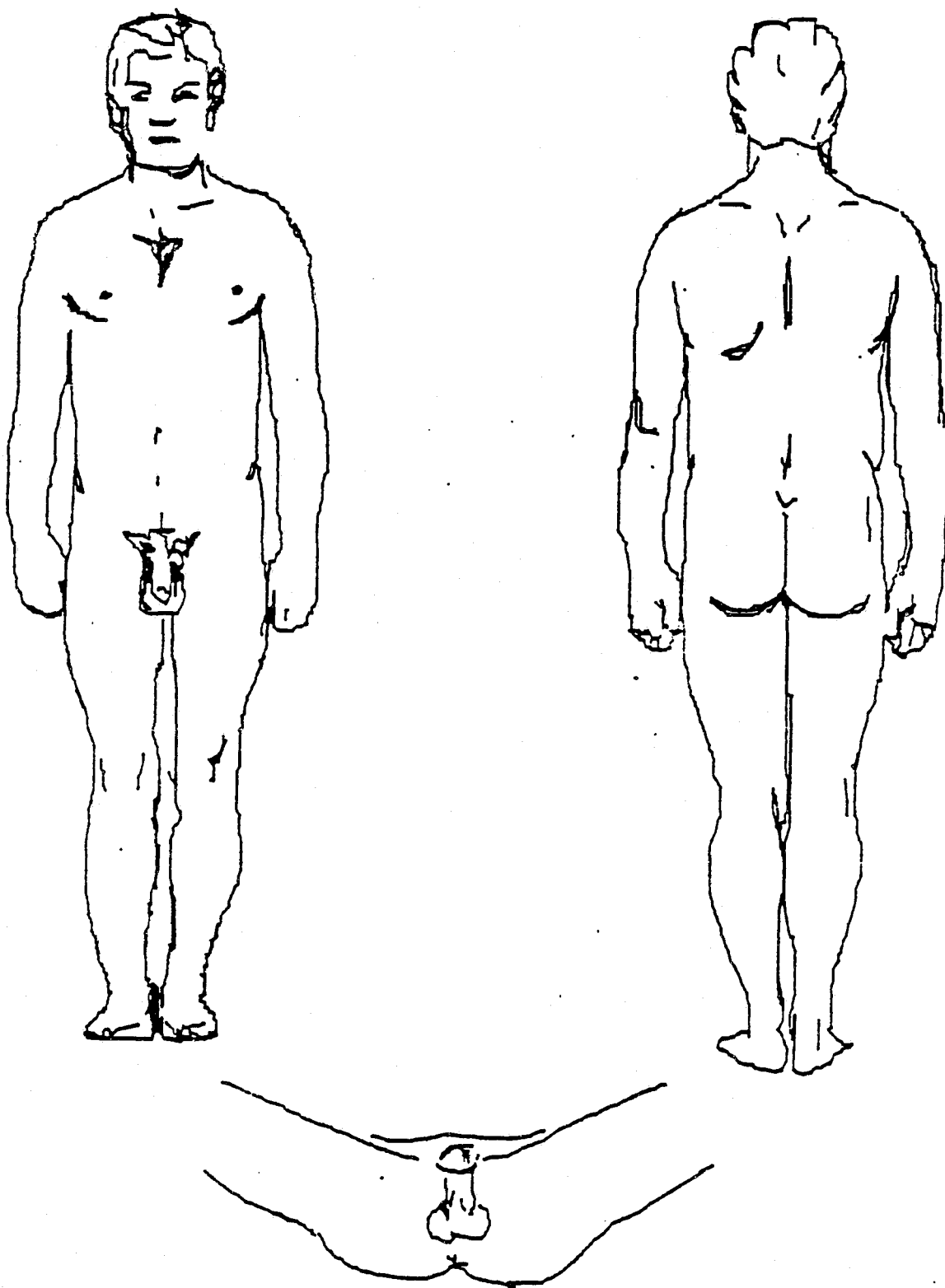
I consent to the performance of blood testing to detect antibodies to the HIV virus.

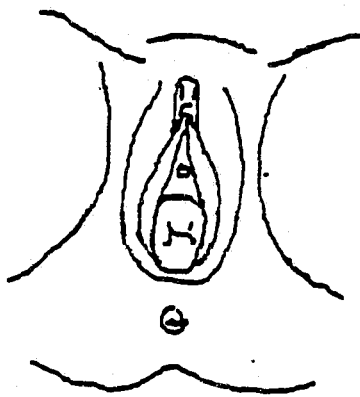
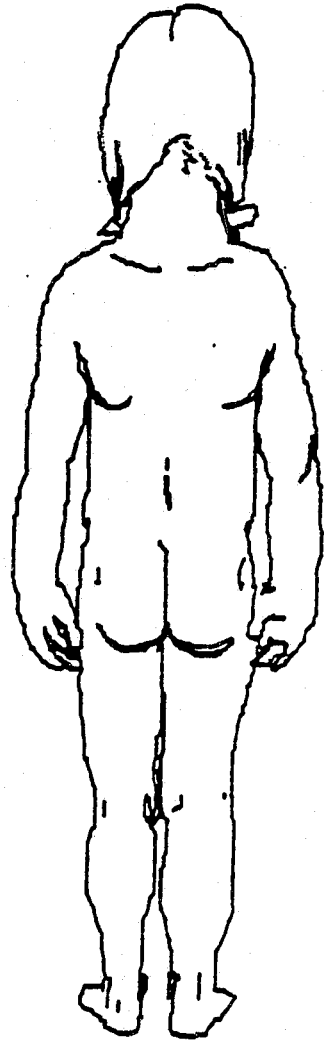
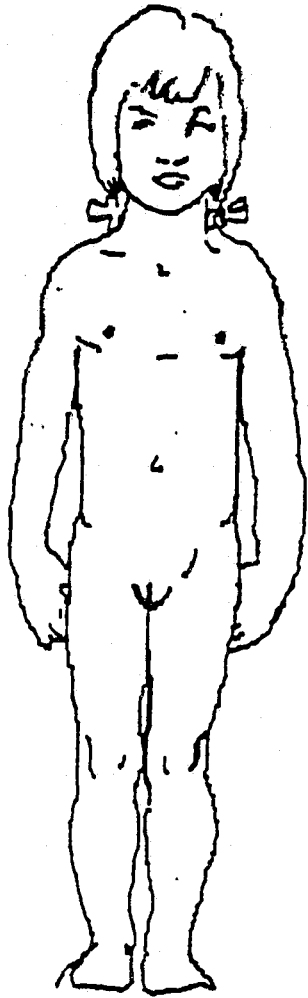
Signature: _____ Date: _____

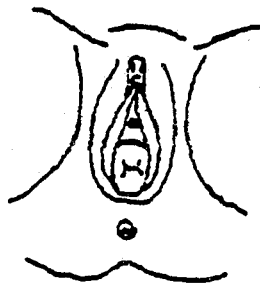
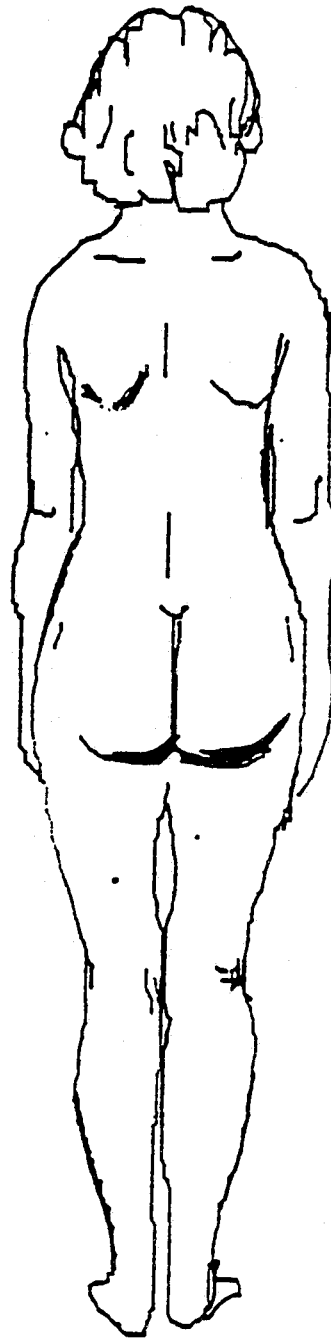
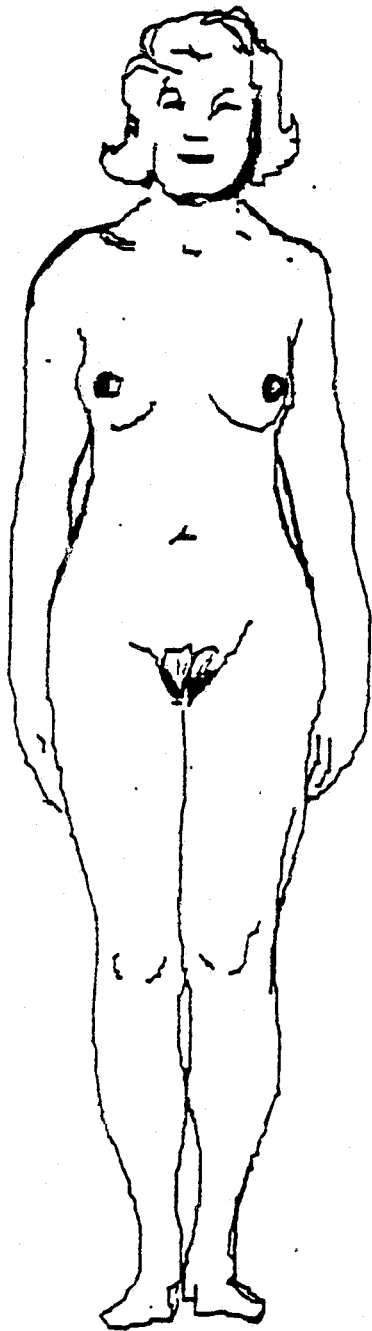
*** This sample consent form is intended as useful information for physicians and hospitals in their efforts to implement the AIDS legislation enacted in 1989. It is not intended, and should not be used, as a substitute for consultation with legal counsel.

APPENDIX 3
Sample Body
Diagrams









APPENDIX 4
State Level
Referral Resources

HIV/AIDS

Contact the Virginia AIDS Hotline (1-800-533-4148) or the AIDS Activity Program (804)225-4844 at the Virginia Department of Health for information about:

- AIDS service organizations in Virginia
- Regional AIDS coordinators
- Facilities which provide anonymous or confidential testing
- Medical/counseling referrals for persons seropositive for HIV antibodies
- AIDS pamphlets available through the Virginia Department of Health and other agencies
- Other AIDS-related services and educational materials

Victims' Compensation

In 1976 the Virginia General Assembly created the Criminal Injuries Compensation Fund in order to pay certain unreimbursed expenses of innocent victims who suffer injuries as a result of a crime. The program is funded with fines paid by Virginia felons and misdemeanants and federal grants. It is administered by the Industrial Commission of Virginia. Further information and applications may be obtained from:

Division of Crime Victims' Compensation

1000 DMV Drive
P.O. Box 5423
Richmond, VA 23220
Richmond: (804) 367-8686
(Voice/TDD)
Statewide: 1-800-552-4007
(Voice/TDD)

☐ Victims Services Programs

Federal, state, and local funds support a variety of direct services for crime victims, including domestic violence programs, services for victims who are children, sexual assault crisis programs, victim/witness programs, and victim assistance programs. For information about specific programs contact the appropriate individuals listed here.

☐ Statewide Child Abuse Hotline

☐ Free Brochure Available

■ Program

■ Contact

Child Victims

Ms. Linda Struck
 Child Welfare Services
 Department of Social Services
 8007 Discovery Drive
 Richmond, VA 23229
 (804) 662-9081

Domestic Violence

Ms. Deb Downing
 Bureau of Adult and Family Services
 Department of Social Services
 8007 Discovery Drive
 Richmond, VA 23229
 (804) 662-9029

Sexual Assault Crisis Centers

Ms. Ramona Schaeffer
 Office of Health Education & Information
 Department of Health
 109 Governor Street, Suite 515
 Richmond, VA 23219
 (804) 786-3551

Victim/Witness

Ms. Mandie Patterson
 Victims Services Section
 Department of Criminal Justice Services
 Richmond, VA 23219
 (804) 786-4000

Victim Assistance

Known or suspected child sexual abuse should be reported to the local child protective service agency and/or to the statewide hotline 1-800-552-7096.

To obtain free copies of a brochure entitled "Sexual Assault: A Handbook for Victims" contact:
 Department of Criminal Justice Services
 Victims Services Section
 805 East Broad Street, 10th Floor
 Richmond, VA 23219
 (804) 786-4000