TEXAS EVIDENCE COLLECTION PROTOCOL

Recommendations to medical, legal, law enforcement, advocacy and forensic science professionals on the identification, collection and preservation of physical evidence and the minimization of physical and psychological trauma to the victims/survivors of sexual assault
and
Requirements of ECP kits as designated by Chapter 420, Government Code

PREFACE

Few other criminal offenses require as extensive an examination and collection of evidence as a sexual assault. And, but for an occasional assault case, no other crime collects as much evidence from a live person.

While a potentially fatal object (bullet, knife, etc.) may be removed from someone and taken to the forensic lab for analysis, that person is not required to submit to the same intrusive exam as a patient of sexual assault. So, it is not unreasonable to assume that having your person gone over with a fine tooth comb, your blood and saliva samples taken, your fingernails scraped and every orifice that has already been violated swabbed with cotton on a stick can be a devastating experience. This manual is designed to make the examination and collection of evidence from a human being as thorough, timely and humane as we have the knowledge and capacity to do.

Traditionally, the prosecution of adult and child sexual assault cases has been difficult. The patient often is the only witness to the crime. The examination, collection of physical evidence and the documentation of physical injury 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 clothing of the patient. When immediate medical attention is received, the chances increase that some type of injury or physical evidence may be found. Conversely, the chances of finding injury or physical evidence decrease in direct proportion to the length of time which elapses between the assault and the examination.

The examination and collection of physical evidence in sexual assault cases has fallen to physicians and nurses in hospital emergency rooms and pediatric units. The role of medical personnel in this process often can be the key to successful prosecution and can help to promote early emotional recovery for the patient.

The primary purposes of this document are to:

- minimize the physical and psychological trauma to the patient of a sexual assault;
- maximize the probability, through examination, of collecting and preserving the physical evidence for potential use in the legal system; and
- address important issues of current controversy surrounding the examination and collection of physical evidence.

This project was begun in August of 1988 in order to standardize care across the State of Texas. There was no one kit or protocol for the State's 254 counties. Some counties developed their own evidence collection protocol through a local multi-disciplinary task force, others had no protocol at all.

A statewide advisory committee was formed to bring together the medical, legal, law enforcement, advocate and forensic science communities, and committee members represent extensive experience and expertise working with adult and child sexual assault survivors. The procedures in this document are the results of their combined experience and expertise. Procedures are based upon the physical and emotional needs of the patient, reasonably balanced with the basic requirements of the legal system. This document is the third edition of the protocol.

Chapter 420, Section 420.031, Government Code was revised in 1997 to include the Evidence Collection Protocol. [EVIDENCE COLLECTION PROTOCOL: KITS]

- (a) The service shall develop and distribute to law enforcement agencies and proper medical personnel an evidence collection protocol that shall include collection procedures and a list of requirements for the contents of an evidence collection kit for use in the collection and preservation of evidence of a sexual assault or other sex offense. Medical or law enforcement personnel collecting evidence of a sexual assault or other sex offense shall use a service approved evidence collection kit and protocol.

  (b) An evidence collection kit must contain the following items:
  (1) items to collect and preserve evidence of a sexual assault or other sex offense;

  (2) other items recommended by the Evidence Collection Protocol Advisory Committee of the attorney general and determined necessary for the kit by the attorney general.

  (c) In developing evidence collection procedures and requirements, the service shall consult with individuals and organizations having knowledge and experience in the issues of sexual assault and other sex offenses.

(d) A law enforcement agency that requests a medical examination of a victim of an alleged sexual assault or other sex offense for use in the investigation or prosecution of the offense shall pay the costs of the evidence collection kit. This subsection does not require a law enforcement agency to pay any cost of treatment for injuries.

(e) Evidence collected under this section may not be released unless the patient of the offense or a legal representative of the patient signs a written consent to release the evidence.

(f) Failure to comply with evidence collection procedures or requirements adopted under this section does not affect the admissibility of the evidence in a trial of the offense.

Although evidence collection is the primary focus of this document, by necessity basic medical, psychological, and support issues are included as much as possible throughout the protocol.

Thanks from the committee is due to the Department of Justice, Office for Victim Assistance and the Illinois Attorney General's Office for their assistance and groundwork in other states.

For this protocol, the term `sexual assault' will be used to refer to all sex crimes perpetrated against adults. The term `child sexual assault or abuse' will refer to all sex crimes perpetrated against children. Both terms are 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 patient to give consent due to age, mental or physical incapacity.*

ADULT PROTOCOL

GENERAL INFORMATION

Some sexual assault patients 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, patients will experience varying degrees of psychological trauma, the effects of which may be more difficult to recognize than physical trauma.

An individual's perceptions of how sexual assault patients should look, dress or act and the way those perceptions are conveyed will have a major effect upon the patient's recovery process in the weeks and months following the crime. Each person has their own method of coping with sudden stress. When severely traumatized, patients can appear to be calm, indifferent, submissive, jocular, angry, or even uncooperative and hostile toward those who are trying to help. All these responses are within the normal range of anticipated reactions. An inappropriate response to information about the circumstances surrounding the assault or a misinterpretation of a patient's reaction to the assault may lead to further traumatization and hinder the interview or evidence gathering process.

For some patients, the problems of poverty and discrimination already have resulted in a high incidence of victimization, as well as inadequate access to quality hospital treatment. There may be a mistrust of medical and law enforcement personnel who play a vital role in the aftermath of sexual assault. This may be particularly true if there has been a history of negative experiences with these professionals.

Designated medical facilities serving specific or special needs populations should seek the assistance of reliable community consultants, such as the local sexual assault program, 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 patient unacceptable for an honorable marriage. In other cultures, the loss of virginity may not be as great an issue as that of the violence itself.

Also, religious doctrines may prohibit a female from being disrobed in the presence of a male who is not her husband, or forbid a genital examination by a male physician. Such practices are considered a further violation. In such instances, a female physician or nurse examiner should be made available for patients who request them.

Age is also an important factor to consider when responding to any patient of a sexual assault and

when determining the proper method of administering a forensic interview, conducting a medical examination and providing crisis intervention.

WHAT IS CRISIS INTERVENTION?

A response to a crisis that by definition is a stressful situation or emotionally hazardous event which poses a threat to the individual. The individual's usual ways of coping are ineffective and the individual may be unable to maintain their usual pattern of functioning. Crisis intervention then is the immediate short-term support to insure that physical, medical and psychological needs are met. It focuses on immediacy. It focuses on the positive or healthy parts of the personality. Most importantly, crisis intervention involves helping a person handle effectively, the current crisis, by utilizing their own strengths and support systems.

The goals of crisis intervention are:

- ***to reduce the immediate impact of the crisis;***
- ***to understand the precipitating circumstances;***
- ***to assist the person to access healthy coping skills, capitalizing on strengths, support systems and resources in the community from which a base of reintegration may occur;***
- ***to help the person move beyond the crisis.***

Feelings that might be experienced by someone in crisis:

anxiety	***powerlessness***	***shame***
anger	***ambivalence***	***hopelessness***
fear	***humiliation***	***decreased self-image***
embarrassment	***nervousness***	***irritation***

Crisis intervention may consist of the following, previous to the formal collection of evidence at a medical facility, all during the exam and upon completion of the exam:

- ***clarification of the current situation***
- ***anticipatory guidance***
- ***realistic reassurance and support***
- ***discussion of plans and options, offering available information.***

Remember that the sexual assault patient has three needs:

1) physical (medical)
2) emotional (psychological)
3) legal

These needs should be addressed in the above order. All community support services should be coordinated to meet the sexual assault survivors' needs.

TEXAS CRIME VICTIMS' RIGHTS

A victim is:

(1) someone who is the victim of sexual assault, kidnaping, or aggravated robbery or who has suffered bodily injury or death because of the criminal conduct of another,

(2) the close relative(spouse, parent, adult brother or sister, or child) of deceased victim, or

(3) the guardian of the victim. These rights also apply to victims of juvenile crime, including victims who suffer property loss. Victims of crime have the right to:

1) receive adequate protection from harm and threats of harm arising from cooperation with prosecution efforts;

2) have their safety considered by the magistrate when setting bail;

3) advance notification on request, of relevant court proceedings including cancellations and rescheduling;

4) request information from the peace officer about the defendant's right to bail and criminal investigation procedures in the criminal justice system, including plea agreements, restitution, appeals, and parole;

5) information about the Texas Crime Victims' Compensation Fund and, on request, referral of social service agencies that provide other types of assistance;

6) provide pertinent information concerning the impact of the crime to the probation department conducting the pre-sentencing investigation.

7) payment for medical examinations for victims of sexual assault by the law enforcement agency requesting the exam and, on request, the right to counseling regarding AIDS and HIV infection and medical tests;

8) information, on request, about the parole procedures; notification of parole proceedings and of the inmate's release; and the right to participate in the parole process by submitting written information to the Board of Pardons and Paroles for the inclusion in the defendant's file for consideration by the board of parole;

9) be present at all public court proceedings;

10) a safe waiting area at all public court proceedings;

11) prompt return of any property that is no longer needed as evidence;

12) have the prosecutor notify, upon receipt, an employer that the need for the victim's testimony may involve the victim's absence from work;

13) complete a Victim Impact Statement, detailing the emotional, physical and financial impact of the crime on the victim and to have the statement considered by judge at sentencing and by officials prior to the release of the offender(s).

EMERGENCY MEDICAL SERVICES

When medical needs are met first by emergency medical services the following procedure is recommended:

1) Basic A.B.C.s;

2) Crisis intervention for the patient and friends and family at the scene;

3) Maintain integrity of evidence when possible - if something is moved or removed, make note to document with law enforcement:

* handle clothing as little as possible
* do not clean wounds if at all possible
* use paperbags for all articles collected
* bag each clothing item separately
* disturb the crime scene as little as possible

First Responders should convey the following information to the sexual assault patient:

a. The importance of seeking an immediate medical examination.

b. The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the patient that such evidence can inadvertently be destroyed by activities, such as washing showering, brushing teeth, using mouthwash, smoking, eating, drinking, douching, urinating, or defecating.

c. The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault, after the assault and on bedding or other materials involved at the crime scene. A recommendation should be made that a change of clothes

be brought along to the hospital in the event clothing is collected for evidentiary purposes.

d. Advise the patient of the availability of support services (sexual assault programs, victim/witness offices and Crime Victim's Compensation).

4) Be aware of your own safety if law enforcement is not at the scene;

5) Transport to medical facility.

At the treatment facility, EMS should provide the hospital staff with any available information about the assault which may assist in the examination and evidence collection procedures.

LAW ENFORCEMENT

Many adult survivors of sexual assault will have their first real contact with a law enforcement officer following the assault.

The primary responsibilities of the responding officer are to:

1. Ensure the immediate safety and security of the victim.

2. Obtain all information necessary to complete the original offense report. This would include the preliminary interviewing of all the witnesses including the victim, the report, and the outcry witnesses. The elements of the crime or crimes should be listed in the original report.

3. Secure all physical evidence that would be taken at any crime scene including, but not limited to, fingerprints, trace evidence, the victim's clothing, and that evidence which may be collected from the victim.

4. Advise the victim of the availability of a designated sexual assault facility: should the victim elect to seek medical treatment and undergo a sexual assault examination, transportation should be arranged, if necessary.
5. The responding officer should convey the following information to the sexual assault victim:

   a. The importance of seeking an immediate medical examination.

   b. The importance of preserving potentially valuable physical evidence prior to the hospital

examination. The officer should explain to the victim that such evidence can inadvertently be destroyed by activities, such as washing, showering, brushing teeth, using a mouthwash, smoking, eating, drinking, douching, urinating, or defecating.

c. The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault, after the assault and on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought along to the hospital in the event clothing is collected for evidentiary purposes.

d. Advise the victim of the availability of support services (sexual assault program and Crime Victim's Compensation).

Although explicit details of the sexual assault itself are not needed at this point in the investigation, the report should include all crime elements. A preliminary interview with the victim is necessary so that the responding officer can relay information that may be vital to the apprehension of the assailant. The preliminary interviewer should obtain all information necessary to complete the original offense report including:

1. Offense committed including a description of what happened including the elements of the crime or crimes.

2. When and where the assault took place.

3. The extent of injuries, to the victim.

4. Whether a weapon was involved.

5. The identity or description of the offender(s), if known.

6. Where the offender(s) lives and/or works, if known.

7. The direction in which the offender(s) left and by what means, including a description of the vehicle, if any.
8. Names, addresses, phone number of any witnesses and another person who can reach the victim.

9. Victim's home, work and third person contact phone number and addresses.

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

With the victim's permission, the officer may share pertinent information with the support service personnel.

FORENSIC INTERVIEWING AND PROSECUTION PROCEDURES

The legal needs of the victim are the primary responsibility of the law enforcement interviewer. The victim is the most important aspect in the investigation of a sexual assault case. The manner in which the victim is treated has a direct effect on the disposition of the case. Law enforcement and other support services should provide the victim with all the information needed to make an informed decision to prosecute. The interviewer should be a compassionate, understanding and professional person. It is not always necessary that the interviewer be of the same sex as the victim, but should this be requested, every effort should be made to accommodate them.

Privacy is very important when interviewing. The interviewer should select a location that allows visual privacy, sound privacy, and will avoid interruptions. An interpreter will be necessary in some cases. The presence of an advocate during this interview is discretionary with the investigator; however, consideration should be given to the possible need or request by the victim or by the advocate on behalf of the victim for an advocate in the room.

Procedures should be coordinated in each community with law enforcement, medical personnel, advocates, and the prosecutor to present a team concept to meet the sexual assault victim’s needs. Prosecutor involvement in pre-indictment procedures varies in each jurisdiction; however, after indictment the following procedures are recommended for the successful prosecution of a sexual assault case.

Upon receipt of the case, the trial attorney should review the indictment for accuracy of the elements and spelling of names. The case reports and statements should be read to determine everything known about the case. Contact should be made with the victim as soon after indictment as possible either by telephone, letter or personal contact. The prosecutor should at that time:

1. Introduce self as prosecutor and explain the responsibilities of the prosecutor's office;

2. Advise victim of all procedures and court activities that will occur, and expected length of time each step will take;

2. Explain the role of the prosecutor and defense attorney;

3. Advise the victim of what will be expected of them;

4. Discuss the possibility of plea negotiation and a plea bargain;

5. Advise the victim of the benefits available through the victim witness program, Crime Victim Compensation and the sexual assault center;

6. Ensure that the victim is aware of their right to be present at all proceedings. There may be exceptions to this at the trial phase.

** Note: Some of these activities may be delegated to the victim/witness coordinator.

The trial attorney/prosecutor should conduct an in-depth personal interview to discuss details of the offense and begin to prepare the victim for trial. The presence of an advocate during this interview is discretionary with the trial attorney/prosecutor; however, consideration should be given to the possible need or request by the victim or by the advocate on behalf of the victim for an advocate in the room. Discuss direct examination testimony and prepare the victim for cross-examination. Identify key issues of the case or problem areas and, if necessary, have someone (not the advocate) play the role of the defense attorney in actual cross-examination. A tour of the courtroom can be helpful for both the adult and child victim.

Before disposing of the case in any manner, discuss the possibilities with the victim, i.e. trial, plea bargain or dismissal. Include the victim in the decision but advise her/him that the final decision is the State's. Advise, where necessary, that they can be required to testify under subpoena in trial.

Work with the court in assigning high priority to all sexual assault cases. Contact the victim to inform them of the outcome. If possible, inform the victim how and when to recover any evidence used in the case.

TREATMENT PLAN

Facility & Personnel

It is advantageous for all patients/victims/survivors of sexual assault to seek both medical treatment and evidence collection from a health care facility. Physicians who work primarily in private office-based facilities usually do not have evidence collection kits on hand, and may not be as familiar as hospital- based physicians and nurse examiners with the specific medical and evidence collection procedures relevant to sexual assault patients. Additionally, many private medical offices are not open on a 24-hour basis, and may not have equipment available to make the necessary cultures. However, Texas has many areas in which no hospital is available for 100 - 200 miles. If that is the case, the facility used MUST have adequate equipment available to collect evidence and treat the injuries incurred. (See required equipment list.) The facility should be chosen in consultation with local law enforcement and the local sexual assault program.

The use of Sexual Assault Nurse Examiners (SANEs) to do the forensic examination and collection of evidence is encouraged as an alternative to a physician. SANEs are registered nurses who have completed special training in the forensic examination procedures and issues surrounding sexual assault.

Adults should be treated in medical facilities designated for such treatment. Children should be treated in a pediatrics unit, if available, because staff in these units are specially trained to treat them. The ideal situation is a local child advocacy center if your community has acquired one. However, regardless of who examines and treats the patient or where the examination occurs, they should be specially trained in the examination, recognition and collection of evidence and administering to the special needs of a sexual assault patient. (The Office of the Attorney General, Sexual Assault Prevention and Crisis Services Program can recommend training specifically for this purpose.)

Payment

Texas law (Texas Civil Statutes, Public Health Code, Article 4447m, 1979, 1983) requires that the law enforcement jurisdiction investigating the reported sexual assault be responsible for the payment of medical examinations and collection of evidence in connection with the investigation or prosecution of a sexual assault.

The procedures that this committee recommends are eligible for payment include: nurse examiner's or physician's fee; E. R. fee; evidence collection kit cost; and some diagnostic tests, such as, X-rays, pregnancy test, drug/alcohol screen if the patient reports being involuntarily drugged, and a chlamydia and gonorrhea culture for survivors who have not been sexually active.

Diagnostic tests are included since they may often be used as evidence. Procedures this committee recommends as not eligible for payment by law enforcement include: HIV testing, treatment for injuries and admissions. Treatment costs must be covered by the patient's insurance, Crime Victim Compensation or other arrangements with the hospital.

Medical facilities designated to provide sexual assault treatment should have 24-hour emergency ability with a staff trained in sexual assault examinations. The local sexual assault program should be called in to serve as an advocate for the patient. The ideal situation would also include the on-call availability of a specialty physician if needed for consultation and contingency plans for cases requiring photographs and bitemark impressions.

Transfer

If a patient of sexual assault arrives at a hospital that is not designated or equipped to provide a sexual assault examination, arrangements should be made to transfer the patient to the nearest designated treatment facility. Keep in mind that every transfer and examination of the patient can destroy evidence. Whenever possible, attempts should be made to preserve evidence when examining, treating or transferring the patient. However, if there are acute medical or psychological injuries which must be treated immediately, this should be done at the initial receiving facility. A copy of all records, including X-rays taken, should be transported with the patient to the designated treatment facility. All medical facilities receiving federal funds including Medicare and Medicaid payments are prohibited from refusing treatment or transferring any patient whose condition is not stable. (Consolidated Omnibus Budget Reconciliation Act [COBRA]; Sections 9121, 1888 (a)(1)(i), 1866(a)(1)(l), 1867; 1985.)

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community, and the list of designated medical facilities should then be provided to all local law enforcement agencies and sexual assault programs. This action will greatly reduce the amount of confusion and additional trauma incurred by those survivors who are initially taken or referred to a non-treatment facility and reduce the loss of valuable evidence.

Medical Intake

The treatment of victims of sexual assault should be considered a medical emergency. Although many patients may not have visible signs of physical injury, they will, at the very least, be suffering from emotional trauma. A private location within the designated medical facility should be utilized for the preliminary consultation or admission with the patient. 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 any follow-up law enforcement interview at the conclusion of the examination.

While the patient is being treated at the designated medical facility, the responding officer should wait someplace other than in the examining room. In some jurisdictions, police protocols call for the officer who accompanies the patient to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is complete (or return to the hospital if they need to patrol) before making arrangements to conduct the more in-depth interview with the patient.

Over the past several years, many hospitals have developed coding plans, such as `Code R' or `SA' which they use when referring to a sexual assault case. This eliminates the needless embarrassment to patients and/or their families of being identified in the public emergency or examining room setting as the `rape' or `sexual assault' patient. Other methods can be devised to avoid inappropriate references to sexual assault cases, and designated medical facilities are encouraged to develop their own sensitive coding plans to ensure privacy.

General guidelines for the medical history include the following:

1. The history collection conducted by the examiner, must be held in a private setting which is free of outside interruptions.

2. The presence of an advocate during this time is discretionary with the examiner, however, consideration should be given to the possible need or request by the patient or by the advocate on behalf of the patient for an advocate in the room.

3. The examiner should be empathetic and understanding of the patient's trauma, while at the same time efficient in collecting all information necessary for effective treatment.

4. The examiner should establish rapport as an ally of the patient and try to cushion the patient from pressures by family, friends, and other medical personnel.

5. The patient should be asked only those questions necessary to discover information that will assist the examiner in making a plan of care, diagnosis and treatment of the patient which includes evidence collection..

REPORTING

Texas Civil Statutes has affirmed that the privacy and choice for the patient is of paramount importance, therefore, there is no law in Texas that requires an adult sexual assault patient to report the assault. (Other than those mentioned under the disabled and elderly sections.) If no report is made, law enforcement's payment of the procedures and Crime Victim's Compensation claims are invalid. Many hospitals have policies that direct emergency room staff to notify law enforcement whenever any patient involved in criminal activity, as patient or perpetrator, seeks treatment. If that is the case, adult sexual assault survivors shall be given the courtesy and choice of whether they wish to report.

When the patient chooses not to report, sexual assault programs and law enforcement personnel might encourage the patient to file an Information Report or Third Party Report. It is very important to the investigation of other cases that law enforcement have all available information even if the patient does not choose to report the crime. In any event, the patient should still receive medical treatment and the respect and sensitive treatment accorded to those who do choose to report.

If the patient does report the sexual assault, the law enforcement jurisdiction investigating the case is responsible for the cost of the examination to collect evidence.

Texas law (Texas Civil Statutes, Texas Family Code, Chapter 34, Sections 34.01 and 34.02, 1994) does require that any person who suspects child abuse must report it to either Children's Protective Services of the Texas Department of Protective and Regulatory Services, or the local or state law enforcement. The reports should be made to the local TDPRS office or by calling 1-800-252-5400. The report may be made in writing, by telephone or in person. Those reporting the incident or participating in an investigation or court proceeding are immune from civil or criminal liability, unless that person acts in bad faith or malice. Medical and social services organizations are bound by this statute.

Cases involving minors who are abused by someone other than a caretaker fall under the same procedures as adult survivors.

SUPPORT PERSONNEL

The importance of having a support person available to sexual assault survivors cannot be over-emphasized. Whenever possible, one person should be assigned to be available throughout the medical and evidence collection procedure visit and preferably the entire system.

Well-trained support persons can provide the immediate crisis intervention necessary when patients first enter the designated medical facility for treatment; they can assist hospital medical staff in

explaining the necessity of medical and evidence collection procedures; and they can advise family members or friends of the patient who may be at the hospital. A support person can also help provide counseling referrals and other information, such as the existence and availability of Crime Victim Compensation or other types of assistance, emphasize the importance of follow-up testing for possible venereal disease or other medical problems, and answer additional questions patients may have following their medical evidence collection examinations. They are also able to provide support for the patient throughout the criminal justice process.

As a result of the dedication of women and men involved in the issue of sexual assault, hospitals have entered into working agreements with sexual assault programs. The Office of the Attorney General encourages all hospitals to incorporate the notification of sexual assault advocates into their treatment protocol just as they do law enforcement agencies. The patient has the best chance at emotional recovery if they are able to establish a rapport early with an advocate. Crisis intervention is most effective when it is begun during the first few hours following a sexual assault.

PATIENT CONSENT

Obtaining a patient's written consent prior to conducting a medical examination or administering treatment is standard medical practice. With the advent of evidence collection requirements and crisis intervention services, sexual assault survivors 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 patients may not always understand or remember the reason for or significance of unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained as thoroughly as possible, so that the patient can understand what the attending medical personnel are doing and why. A brochure that is designed to accompany this protocol is free and available from the Office of the Attorney General Sexual Assault Prevention and Crisis Services Division and should be distributed to every sexual assault patient.

Although much of the examination and evidence collection process can be explained by the designated medical facility support person or patient advocate, this function is ultimately the responsibility of the attending medical personnel.

When written consent is obtained, it should not be interpreted as a `blank check' for performing tests or pursuing questions. If a patient expresses resistance or non-cooperation, the medical personnel should immediately discontinue that portion of the process and consider going back to it at a later time in the examination, if the patient then agrees. In either event, the patient should have the right to decline one or more tests or to decline to answer any question. Having a sense of control is an

important part of the healing process for these patients, especially at the early stages of examination and initial interviewing.

It is important to remember that consent to have a support person or advocate present must be given by the patient 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 the severely injured or incoherent patient.

THE ELDERLY PATIENT

As with most others, the elderly patient may experience extreme humiliation, shock, disbelief, and denial. However, the full emotional impact of the assault may not be felt until after initial contact with health care providers, police, legal and advocacy groups, or later, when the patient is alone. It is then that older patients must deal with the violation and possible disease, 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 patients who many times are isolated, have no confidence or 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. Besides possible pelvic injury and sexually transmitted diseases, the older patient may be more at risk for other tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities. The recovery process for elderly patients also tends to be far more lengthy than for younger patients.

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 her or his 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 survivors, or they may not be willing or able to seek or receive assistance. Without encouragement and assistance in locating services, many older patients may be reluctant to proceed with the prosecution of their offenders.

Texas law (Texas Civil Statutes, Human Resources Code, Chapter 48, Section 48.036, 1983) requires that "a person having reasonable cause to believe that an elderly (65 years or older) or disabled person is in the state of abuse, exploitation, or neglect (by a caretaker or one's self) shall report that

information to Adult Protective Services of the Texas Department of Protective and Regulatory Services." Reports should be made to the local office or by calling 1-800-252-5400. The report may be made in writing, by telephone or in person. Those reporting the incident or participating in an investigation or court proceeding are immune from civil or criminal liability, unless that person acts in bad faith or malice.

THE SPECIAL NEEDS PATIENT

The difficulty of providing adequate responses to the sexual assault patient is compounded when the patient is differently abled. Some special needs survivors 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 during the sexual assault. Special needs survivors may be confused or frightened, unsure of what has occurred, or they may not understand that they have been exploited and are survivors of a crime.

Criminal acts committed against the differently abled (physically, mentally or communicatively) generally are unreported and seldom are successfully prosecuted. Offenders often are family members, caretakers, or friends who repeat their abuse because the survivors are unable to report the crimes against them.

Special needs survivors and their families should be given the highest priority. Additional time should be allotted for evaluation, medical examination and the collection of evidence.

The physically challenged patient 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 of the normal protocol may be indicated in some instances.

Under Section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and law enforcement) 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.

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

Texas law (Texas Civil Statute, Human Resources Code, Chapter 48, Section 48.036, 1983) requires

that any person having reasonable cause to believe that a disabled person is in a state of abuse, exploitation or neglect by a caretaker must report that information to Adult Protective Services of the Texas Department of Protective and Regulatory Services. Reports should be made to the local office or by calling 1-800-252-5400. The report may be made in writing, by telephone or in person. Those reporting the incident or participating in an investigation or court proceeding are immune from civil or criminal liability, unless that person acts in bad faith or malice.

RECOMMENDED EQUIPMENT

In addition to the sexual assault examination kit, the following equipment may be needed:

urine specimen containers
Wood's lamp - long wave UV light
microscope
forced air dryer (fan driven) *
large paper bags
catheter
marking pens
vaginal speculum (sm., med., lg.)
manila envelops (preferred)
white table paper
sterile water for irrigation
chlamydia media ruler (with cm measurements)
disposable powder free gloves
scissors
forms
Sharpened lead pencil
blood tubes
scotch tape
Colposcope
sterile test tubes
hemocult slide
spot light
GC culture media
pipettes

* for specifications on the dryer, contact: Office of the Attorney General, SAPCSD

Required Kit Contents

Crush-proof box
white envelopes
3 frosted-ended glass slides with new/unused pap smear mailers
2 small narrow tooth combs
purple-top blood tubes; 1 red- 10cc blood tube
nail file or pick
4 swabs for each (Minimum swabs per area)

1. vaginal
2. oral
3. rectal
4. 2 body surface areas

TOTAL SWABS: 20

2 plain envelops for any other evidence that needs to be included

The Sexual Assault Forensic Examination Form should be stocked separately from the kit. There will be times when the form is used without the kit.

Packaging

Kits can be made from materials readily available at most medical facilities or purchased commercially. If a kit is purchased commercially, the cost should be between $10.00 to $20.00 each. Kits should be packaged in a crush proof box for transportation to the forensics lab.

In order to prevent the loss of hairs, fibers, or other trace evidence, clothing and other evidence specimens must be sealed in paper or cardboard containers because moisture remaining in the evidence items will be sealed in, making it possible for bacteria to quickly destroy biological fluid evidence. Unlike plastic, paper `breathes', and allows moisture to escape. Biological evidence should ***never*** be packed in plastic. However, this does not mean that evidence may be packaged wet in paper. All items should be actively air-dried, without heat, before packaging.

Every item submitted to the forensic lab for analysis must be labeled as to site (vaginal, oral, rectal, penile, etc.), name of patient, date and examiner's initials.

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 patients 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. Also, there may be areas of tenderness which will later develop into bruises but which are not apparent at the time of initial examination.

If the assault occurred **within the 72 hours prior to the examination,** then an evidence collection kit should be used. The time line of 72 hours is not absolute. It is a guideline. Medical and law enforcement should evaluate each case after that time individually.

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

When a forensic examination is performed, it is important that the medical and evidence collection procedures be integrated throughout. This coordination of medical and forensic procedures is crucial to the successful examination of sexual assault survivors.

For example, in order to minimize patient trauma, blood drawn for medical purposes, if indicated (pregnancy, syphilis, HIV) should be done at the same time as blood drawn for evidence collection purposes. Also, when evidence specimens are collected from the oral, female sexual organ, or anal orifices, cultures for sexually transmitted disease should be taken immediately following these collection procedures, when indicated.

Attending Personnel

The only people who should be with the adult patient in the examining room are the examining medical personnel, any translator needed and, (with the consent of the patient and attending medical personnel) a specially trained advocate. Every effort should be made to limit the number of people in attendance during the examination. Every person in the room can be considered a witness to the procedure and therefore called to testify in court.

It is not necessary for a law enforcement representative to observe evidence collection procedures to

maintain the chain of evidence or custody. This is the function of the attending medical personnel.

Subjecting sexual assault survivors 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 patient and the examining/support team, is an invasion of the patient's privacy and is an unnecessary practice.

Evidence Collection Documentation

NOTE: Many of the evidence collection issues apply equally to adult and child survivors of sexual assault/abuse, and are discussed in the following sections. However, particular issues regarding the history collection and medical examination needs of children are discussed later in this document.

Preserving the Integrity of Evidence

The custody of any evidence collection kit and the specimens it contains must be accounted for from the moment of collection until the moment it is introduced in court as evidence. This is necessary in order to maintain the legally necessary `chain of evidence'; sometimes called `chain of custody', or `chain of possession'. Therefore, **anyone who handles evidence items should label them with their initials, the date, source of the specimen, the name of the attending medical personnel and of the patient. All outside containers should be sealed with an integrity seal.**

DNA Examination of Sexual Assault Evidence

Research in the last few years has revealed new options for identification in criminal investigations. The analysis of cellular biological materials for DNA (Deoxyribonucleic Acid) has greatly enhanced identification possibilities of criminals. DNA (chromosomal material) contains the genetic code of an individual and if sufficient quantity of DNA exist in a given sample that individual may be identified by DNA comparisons (i.e. comparing blood from a suspect with blood left at a crime scene, etc.). This is especially significant in cases where no witnesses were available to make eyewitness identifications.

DNA is found in biological materials containing a cell nucleus; therefore, spermatozoa can be readily used for identification of an individual provided sufficient sample is available. This technique of identification can be helpful in a sexual assault investigation where the patient cannot identify her/his assailant. DNA can also be identified in blood, saliva, hair (containing hair root with root sheath), tissue and bone marrow.

The technique of sample taking and the number of samples specified in the protocol should leave sufficient material for additional DNA analysis if needed for prosecution. However, the investigating agency should always contact the DNA laboratory for specific information about sample requirements

when DNA analysis is needed.

Seminal plasma is also useful for two purposes:

1. In the absence of spermatozoa, seminal plasma components (p.30 and acid phosphates) can be used to identify semen. p.30 is a prostatic antigen known to exist in the semen of humans and its presence is regarded as a conclusive indication of semen. Acid phosphates is present in high levels in seminal samples but is considered only a presumptive test for the presence of semen because it also appears in samples that are not seminal in origin, such as vaginal fluid.

2. Most of the genetic markers detected in semen which are used to identify the possible donor are also located in seminal plasma. These tests are done by directly studying the liquid extracts made from swabs and other suspected semen stains.

In the past few years, there has been a dramatic increase in the number of vasectomies. Since seminal plasma is produced in the ejaculates of all males, vasectomized or not, the forensic examiner is especially interested in the presence of seminal plasma. It is the seminal plasma, not the spermatozoa, that is used to determine the ABO blood type of secretors and the genetic markers of the donor of the specimen.

NOTE: The ABO blood group is the most commonly known of all blood groups to the general population and divides the population into four types: A, B, O, and AB. Although ABO factors are found in everyone's blood, roughly 75-80% of the population also demonstrate ABO factors in their body secretions (semen, saliva, vaginal secretions, etc.). Such persons are called ABO secretors. The remaining 20-25% are called non-secretors, because they lack ABO factors in their secretions.

Many sexual assault offenders are sexually dysfunctional and do not ejaculate during the assault. Studies indicate that there is no ejaculation in up to 50% of sexual assault cases. Additionally, offenders may use a prophylactic, have a low sperm count (frequent with heavy drug or alcohol use), ejaculate somewhere other than in an orifice or on the patient's clothes or body, or penetration could have been by an object other than a penis. There could also have been a significant time delay between the assault and the collection of specimens. The patient could have inadvertently cleaned or washed away the semen, or the specimens could have been collected improperly. Therefore, a **lack of spermatozoa is not conclusive evidence that an assault did not occur: it only means that spermatozoa may have been destroyed after being deposited or that it may never have been present.**

CLOTHING EVIDENCE

Frequently, clothing contains the most important evidence in a case of sexual assault. The reasons for this are as follows:

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

2. Drainage of ejaculate from the vaginal or anal cavities may collect on the panties/underwear, especially with a child patient. Although bacterial action and breakdown does occur in this environment; it happens at a slower rate than in the body cavities. After 3 - 6 hours, usable semen evidence, if present, is more likely to be found on the patient's undergarment than on vaginal or anal swabs. For a child, undergarments are very important, and parents should be encouraged to bring in the child's underwear.

3. Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the patient with trace evidence collected from the suspect and/or the crime scene. Any item of clothing worn during the assault or prior to the examination may need to be collected.

In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. For example, if semen in the female patient's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear contradictory to the patient's own testimony in court of exactly what events occurred in the assault.

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

Prior to the full examination, great care must be taken by the attending medical personnel to determine if the patient is wearing the same clothing s/he wore during or immediately following the assault. If so, the clothing should be examined for any apparent foreign materials, stains, or damage. When the determination has been made by law enforcement personnel that items may contain possible evidence related to the assault, **with patient consent** those items should be collected.

If it is determined that the patient is not wearing the same clothing, the attending medical personnel should inquire as to the location of the original clothing, such as at the patient'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.** If this clothing was worn before and/or during the assault, trace evidence may be found. Semen may also be found if the assailant ejaculated outside the patient's body. Any briefs, trunks, sanitary napkins, panty liners, diapers or tampons worn by the patient for the period of up to 24 hours after the assault should be obtained as they may contain semen or other evidence.

Collection Procedures

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

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

After air drying items, such as underpants, hosiery, slips or bras, items should be put into small paper bags. It is important to remember that infant diapers may also be valuable as evidence because they may contain semen or pubic hairs. Disposable diapers mold very easily; therefore they should be actively air-dried particularly well and should be placed in a paper bag without folding the item on itself. Diapers should be submitted to the laboratory as expeditiously as possible and the submitting official should make lab personnel aware that there is a diaper in the submission so that it may be frozen or processed quickly. Items such as slacks, dresses, blouses or shirts should be put into larger paper bags.

Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain, so that the stains are not in contact with the bag or other parts of the clothing.

If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed clothing bags should be placed inside a larger paper bag with the top of the second paper bag left open. In these instances, a label should be affixed to the outside of the second paper bag, which will alert the crime laboratory personnel that wet evidence is present inside the paper bag and enable them to remove the clothing and avoid loss of evidence due to putrefaction.

A locked fan-driven dryer may be used to completely dry small articles of clothing.

SWABS AND SMEARS

Smears are made to allow the forensic analyst to test microscopically for the presence of spermatozoa. If they are present the analyst will then proceed to use the swab(s) to identify the seminal plasma components and attempt to identify the donor population based on genetic markers.

The number of tests which crime laboratories can perform is limited by the quantity of semen or other fluids collected; therefore, four swabs should be used when collecting specimens from body orifices. Additional swabs may be needed for medical purposes. For forensic purposes, all swabs should be cotton and used together, if possible, when collecting the sample. Smear the sample from those swabs onto one slide. Air dry all swabs and place them in a cardboard tube for inclusion in the kit when it is submitted to the forensic lab.

Depending upon the type of sexual assault, sperm or sperm particles may be detected in the mouth, vagina and rectum. However, embarrassment, trauma or a lack of understanding of the nature of the assault may cause a patient to be vague or mistaken about the type of sexual contact which actually occurred. Because of these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices to determine the specimen collection indicated.

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

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

If patients must use bathroom facilities prior to the collection of these specimens, they should be instructed to do so in a bedpan so that any evidence can be collected from the discharge, if needed.

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

When packaging evidence, the examiner may use a cardboard tube, an envelop with all openings (including corners) sealed with tape to prevent exit of any evidence. Another way to seal evidence is to pharmaceutically fold paper around the evidence and then place the evidence and paper in an

envelop, seal and label it.

Note: When it is necessary to **slightly** moisten swabs for the comfort of the patient, sterile water is the preferable liquid; saline is acceptable when distilled water is not available. When saline is used, it should be indicated on the label also.

Oral/Collection Procedures

The oral smear can be as important as the vaginal or rectal smears. The purpose of this test is to recover spermatozoa/seminal fluid from recesses in the oral cavity where traces of spermatozoa could survive. This test should be done first, so that the patient can rinse out her or his mouth as soon as possible. Such a practice will reduce a significant source of unnecessary patient distress. Oral washings should be restricted to facilities where immediate laboratory analysis can be performed. If washings are utilized, the oral swabs and smears should be performed prior to the washings.

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

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

When the oral swabs have air-dried, they should be inserted into a cardboard tube. The end flaps should be sealed with cellophane tape, but care must be taken not to cover the air hole on the tube with the tape. If a cardboard tube is not available, a plain, white uncontaminated envelop can be substituted. A white label should then be completed and affixed to the cardboard tube.

At this time have the patient rinse her/his mouth out with clear water. The patient should not eat, drink or smoke for 30 minutes. At that time, the saliva sample will be taken to check for secretor status.

Vaginal/Collection Procedures

Vaginal/cervical specimens are collected on four cotton swabs by swabbing the vaginal vault and cervical cuff, but retained in two ways: one specimen is an air-dried smear on a frosted-end slide from the swabbings, the second is retained on the cotton swabs themselves.

The examiner must be sure that the frosted-end slide is properly labeled and includes the word `vaginal' to indicate the origin of the specimen. The smear should be labeled with pencil as ink may be washed off during the staining procedure at the laboratory. An effort should be made to leave sufficient space on the frosted end for the laboratory to also make their marks on the smear. The glass slide should be placed back into the mailer and air-dried before sealing. Again, slides should not be fixed or stained.

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

The vaginal cotton swabs must be allowed to air dry before being placed in their cardboard tube. If a cardboard tube is not available, a plain, white uncontaminated envelop can be substituted. It should then be labeled and sealed as was done for the oral swabs.

If the assault has occurred in the more recent past and/or the patient has douched prior to specimen collection, serious consideration should be given to obtaining an endocervical specimen by a cotton-type swab and/or pipette aspiration. If this specimen is obtained, it should be properly labeled as such, air-dried and packaged in a cardboard tube as were other specimens.

Check for any contraceptive or sanitary device that may be left in the vagina. These should be retained for evidence. If a sponge or diaphragm is removed before the prescribed time, morning after treatment should be considered. Any device that is removed should be air dried, packaged in an envelop and labeled as to contents, source, name, date and personnel.

In special cases a vaginal wash or aspirate will be used instead of cotton swabs. (See child or special case section). No more than 1 cc's of normal saline/sterile water should be used if a vaginal wash/aspirate is used instead of swabs. This dilutant should then be placed on a cotton swab and air-dried. If the specimen is obtained in this way, it should be properly labeled as such and packaged in a cardboard tube as other specimens.

Note that under certain circumstances a semen-free vaginal swab may have to be collected from the patient at a later time in order for the laboratory personnel to interpret genetic marker results in blood specimens. If this is the case, laboratory personnel will notify the appropriate medical personnel.

Immediately following this procedure, the pelvic examination should be performed and medical cultures taken, if indicated.

Penile/Collection Procedures

For the male patient (both adult and child), the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal vault; and feces or lubricants might be found if rectal penetration occurred. Vaginal secretions cannot reliably be identified microscopically or chemically. However, attempts can be made to detect genetic markers foreign to the male patient and consistent with the suspect.

The proper method of collecting a penile smear is to use two lightly moistened cotton swabs to thoroughly swab the external surface of the penile shaft and glands. All outer areas of the penis and scrotum where contact is suspected should be swabbed.

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

The swabs should be gently rolled over one of the glass slides which is then placed in a mailer. Again, the examiner should not fix or stain the slide. When labeling and sealing the slide mailer, the instructions given for the oral and vaginal smears should be followed.

When the penile swabs are air-dried, they should be placed in a cardboard tube. If a cardboard tube is not available, a plain, white uncontaminated envelop can be substituted. After a white label is completed and affixed to the tube without covering the air hole, the tube flaps should then be sealed with tape.

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

Anal/Collection Procedures

The anal smear is prepared by using four cotton swabs and swabbing the rectum. Be sure that this swab comes in contact only with the rectum. Perianal swabs may also be collected as warranted.

After preparing the slide from the swab, it should be placed in the cardboard mailer, allowed to air dry, then labeled and sealed.

After the anal swabs have air-dried, they should be placed in a cardboard tube, and the tube sealed and labeled in the same manner as the oral, vaginal and penile swabs. If a cardboard tube is not available, a plain, white uncontaminated envelop can be substituted.

At this time, any additional examinations or tests involving the anus should be considered.

Other Dried Fluids/Collection Procedures

Saliva, blood and semen are the most common secretions deposited on the patient by an offender. These secretions can be analyzed by laboratories to aid in the identification of the perpetrator.

It is important that the medical team ask the patient where any body fluid deposit might be and examine the patient's body for evidence of foreign matter. A swab should be taken for each secretion.

If secretions, such as saliva, dried blood or seminal fluid, are identified on other parts of the patient's body during the examination, the materials should be collected by moistening a swab **lightly** with sterile water and swabbing the indicated area. A different swab should be used for every secretion collected from each location on the body and indicated on the body chart. If there is crusted material, it should be scraped rather than swabbed, placed in a separate envelop and labeled for location.

If a cardboard tube is not available, the cotton swab can be placed in a plain, white uncontaminated envelop, then labeled and sealed. The examiner must be sure to indicate on the label and the body chart the location on the patient's body from which the secretion was collected.

BITEMARK EVIDENCE

Bitemarks may be found on survivors as a result of sexual assault and other violent crimes, and should not be overlooked as important evidence. Bitemark impressions can be compared to the teeth of a suspect and can sometimes become as important, for identification purposes, as fingerprint evidence. The collection of saliva and the taking of photographs of the affected area are the minimum procedures which should be followed in cases where a bitemark is present.

Saliva, like semen, demonstrates blood group factors characteristic of their donor. Therefore, the collection of saliva from the bitemark should be made prior to the cleansing or dressing of a wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva. Instead, just the area directly surrounding the bitemarks should be swabbed.

It is important that photographs of bitemarks be taken properly. It is recommended that a local law enforcement agency representative be contacted when the hospital protocol is developed, to provide the proper instructions on how to take photographs of bitemark evidence. A ruler should be used to document the size of the bitemark in the photograph.

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

further document findings. Hospitals should either contact their nearest crime laboratory for listing of qualified forensic odontologists who can assist in this process, or the American Board of Forensic Odontology, Inc., which can furnish a list of their members.

Collection Procedures

Saliva is collected from the bitemark area by **lightly** moistening a swab with sterile water and gently swabbing the affected area, following the same procedures as instructed for other dried fluids.

To demonstrate the size of the bitemark, a colored ruler should be placed adjacent to but not covering the bitemark, and then photographed perpendicular to the injury. Document any bitemarks on the body charts included with the kit. Please consult law enforcement before taking any photographs.

HAIR EVIDENCE

During an assault, hairs may be transferred from one individual to the person or clothing of the other or to the crime scene. Other hairs transferred during an assault are pulled out by friction or other means of forcible removal.

These hairs can be microscopically compared to known hair samples from both individuals to determine the origin. Head and pubic hairs are the only hairs on the body that have enough individual characteristics for this type of analysis. Hair characteristics are affected by many factors including stress, diet and hair care products. Time delay in the collection of hair samples of the patient may adversely affect future comparisons.

Collection Procedures

Combings

Where there is evidence of semen or other matted material on pubic or head hair, it may be collected by clipping around the matted area and placing the sample in a separate white paper envelop and labeled `matted hair sample from head (pubic) area'. It is important to obtain the **patient's permission** prior to cutting any significant amount of hair. If the sample cannot be cut, it may be collected in the same manner as other dried fluid. The swab should then be placed in a small paper envelop and labeled as described above.

The top, back, front and sides of the patient's head hair should be combed over a piece of paper to collect all loose hairs and fibers. The combings and the comb are folded into the paper and placed in an envelop marked `head hair combings'; the labeling information should then be completed and the envelop sealed with tape.

A second comb should be used to collect any loose hairs or fibers from the pubic area over a piece of paper or paper towel. **Patient's may prefer to do the combing themselves to reduce embarrassment and increase their sense of control.** The pubic hair combings and the comb are folded into the paper and placed in a second envelop marked 'pubic hair combings'. After the labeling information is completed the envelop should be sealed with tape. Combing should be done vigorously and thoroughly to lessen the chance that valuable evidence may be missed.

Pulled Standards

There is a division of opinion among professionals as to the value of hair comparison evidence to successful prosecution, as weighed against the discomfort of the patient whose known hairs are collected. Each elected district attorney should make a determination whether comparison hair evidence should be collected and when it should be collected and inform their respective medical and law enforcement personnel accordingly.

If your jurisdiction chooses to collect pulled hair standards, care should be taken prior to collection to inform the patient of the procedures which will be used and why it is being collected at that time. Every effort should be made to reduce the discomfort and stress of the examination to avoid further traumatizing the patient. Evidence should never be taken without the informed consent of the patient. If pulled hair standards are to be collected, the following procedures should be followed.

The combing of the patient's head and pubic hair will remove any foreign hairs which then can be compared to pulled hairs from the patient and the suspect. It is necessary that the pulled hairs possess roots for a complete and accurate comparison.

These collection procedures can be performed by the patient.

A standard sample of ten to twenty head hairs may be pulled, consisting of five hairs collected from each of the following areas: back, top, front, left side and right side. To minimize discomfort, the hairs can be pulled two or three at a time, using the thumb and forefinger. A topical anesthetic can be used if warranted. The pulled head hairs should be placed into an envelop, which is then labeled and sealed with tape.

A standard sample of ten to twenty pubic hairs may be pulled from various areas of the pubic region. The hairs should be plucked two or three at a time with the thumb and forefinger. The pulled hairs should be placed into an envelop which is then labeled and sealed with tape.

Only if the length of the hair makes it impossible to pull with the fingertips can flat- surface forceps be used to pull the hairs due to the damage to the hair shaft. If forceps are used this should be noted on the envelop.

Additional hairs may be needed at a later time.

The absence of pubic or head hairs should be noted.

FINGERNAIL SCRAPINGS

The purpose of collecting fingernail scrapings is to collect potentially useful evidence of cross-transfer. During the course of a physical crime, the patient will be in contact with the environment as well as with the assailant. Trace materials, such as skin, blood, hairs, soil and fibers (from upholstering, carpeting, blankets, etc.) can collect under the fingernails of the patient.

Collection Procedures

The patient should be asked whether they scratched the offender's face, body or clothing. If so, or if fibers or other materials are observed under the patient's fingernails, the nails should be scraped, one hand at a time, using an orange stick, plastic pick, any appropriate hard pointed implement or a small cotton swab lightly moistened with sterile water to clean under the finger nails. This swab would need to be dried prior to packaging. This procedure is at the medical and law enforcement personnel's discretion.

This is a procedure which patients may want to perform themselves, and they should be encouraged to do so. It is important that scrapings be made for each hand over a separate piece of paper. The paper should then be folded and placed in small, individual envelopes along with the pick.

The examiner should complete the labeling information for each envelop making certain to differentiate between `left' and `right' hand on the labels. The flaps should then be sealed with tape.

WHOLE BLOOD SPECIMEN

Any semen found on the clothing or in the body cavities of the patient is likely to be mixed with her/his body fluid (vaginal secretions, saliva, etc.). Therefore, a blood sample must be collected from the patient to determine the contribution of her/his genetic markers to the mixture or unidentified stains.

Note that under certain rare circumstances a semen-free vaginal swab may have to be collected from the patient at a later time in order for the laboratory personnel to interpret genetic marker results. This would entail the patient abstaining from intercourse for one week then having a vaginal swab collected by a medical professional.

Only one purple top tube should be included in the kit for evidence collection purposes and at the same time consider additional blood collection necessary to meet the medical needs of the patient.

Collection Procedures

For adults, 5-7 milliliters of blood should be collected in a purple-top blood tube. Assure that the tube has been completely filled and then affix a white label with appropriate identification to the tube.

SALIVA SPECIMENS

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

Collection Procedures

It is important that this specimen not be contaminated by outside elements. Therefore, the patient should not smoke or have anything to eat or drink for at least 30 minutes prior to this procedure. If there is trauma to the mouth, this specimen can be obtained from under the arm by first cleaning the area, waiting 30 minutes, and placing swabs in axilla to absorb sweat deposit for approximately 20-30 minutes. Please note this on the evidence collection form.

The examiner should collect a saliva sample by using two swabs which are already packaged in a small, pre-sealed envelop. The patient should place the swabs in her or his mouth, saturating them with saliva.

Patients should be reminded not to chew the swabs; moistening them for a few seconds is usually sufficient. Patients should also be instructed to remove the swabs with their own fingers. **The swabs must not be removed by anyone other than the patient unless a hemostat or a clean gloved hand is used, because the slightest contamination from another person's secretions may be detected by the forensic analyst.**

When completely dry, the swabs should be completely inserted into a ventilated cardboard box and the box sealed with tape and labeled as to source, date, patient and examiner.

HEALTH SAFETY PRECAUTIONS

The same health safety precautions taken when handling the body fluids of survivors and offenders involved in other types of crimes should also apply to the collection and examination of sexual assault evidence. When handling the clothing and body fluids, universal precautions must be utilized, analysts must exercise all precautions to minimize their risk. The use of plastic gloves, masks and eye protectors when necessary, frequent clean-up of all work areas with a chlorine bleach solution, and education about the possible health hazards of analyzing physical evidence is recommended. The Center for Disease Control protocols for universal precautions for health care workers are available from the Texas Department of Health.

Blood screening tests and immunization of high risk personnel in crime laboratories and treatment facilities should be considered as routine policy.

SEXUAL ASSAULT FORENSIC EXAMINATION

Throughout the examination, the attending medical personnel should explain to the patient 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 details of the assault should be recorded. This description should include any oral, rectal, or vaginal penetration, whether the assailant penetrated the patient with finger(s) or foreign object(s), whether any oral contact occurred, and whether ejaculation occurred (if known). The patient's account of what happened should be recorded accurately, briefly, and in the patient's own words.

3. Gynecological history information including menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy), and contraceptive history should be evaluated and recorded. In patients at risk for pregnancy, a pregnancy test should be done to establish a baseline for possible pre-existing pregnancy.

4. During the general physical examination, record all details of trauma, such as bruises, abrasions, lacerations, bitemarks, blood or other secretions, with particular attention paid to the genital and rectal areas of both male and female patients. 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 neck, side of the face, 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 I of this protocol. 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. Because some survivors 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.

SEXUAL ASSAULT FORENSIC EXAMINATION FORM

The following is taken from the SANE Council, International Association of Forensic Nursing, 1996

"STANDARD II. DATA COLLECTION

The SANE systematically collects data as indicated. The data is recorded, communicated, and stored in a retrievable manner.

Rationale

Sources of data include the interview and physical assessment. The nurse modifies collection techniques to accommodate the needs of various age groups, developmental levels, ethnic and cultural backgrounds, and value systems. Forensic data is available to participants in the investigative and legal process.

Structure Criteria

1. A data collection method is used which provides for:
   a. standardization and systematic collection of data,
   a. separate forensic and medical data,
   b. confidentiality,
   c. assessment of injury, deviations of normal and abnormal, and
   d. equipment for collecting data.
2. The practice setting allows for modifications of data collection process as needed.

3. The record keeping system provides for concise, accurate, and appropriate recording.
4. The agency has in place a system of collection and storage such that retrieval of data for law enforcement or other disciplines is facilitated.

Process Criteria

The SANE:

1. collects data with the informed consent of the victim;
2. uses data sources such as history, physical assessment, and law enforcement reports;
3. records data in a standardized, systematic, and concise form; and
4. plans interventions within the medical/nursing protocol of the agency.

Outcome Criteria

1. The client participates in the data gathering process.
2. The client validates data collected.
3. Complete data is recorded in a standardized and retrievable form.
4. SANE interventions are consistent with the policies, procedures and protocols of the practice institution and the nursing profession."

The following information should be included on the form.

1. Date and time of Assault/Date and Time of Examination and Collection It is essential to know the period of time which has elapsed between the assault and the examination and collection of evidence.

2. Number of Offenders Forensic serologists seek evidence of cross-transfer of trace materials among the patient, offender(s) and scene of the crime. These trace materials include foreign hairs and the deposit of secretions from the offender(s) on the patient. The gender and race of the offender may determine the type of foreign secretions which might be found on the patient's body and clothing. Therefore, the serologist should be informed whether to search for foreign semen or vaginal secretions, and to focus the analysis on the relevant stains.

3. Action of Patient Before and Since Assault The quality of evidence is critically affected both physically and chemically by actions taken by the patient and by the passage of time. For example, the length of time which elapses between the assault and the collection of evidence as well as self-cleansing efforts of the patient, can affect the presence of semen in the oral, vaginal, or anal cavity. Trace evidence such as foreign hairs, fibers, plant material or other microscopic debris deposited on the patient by the assailant or transferred to the patient at the crime scene also can be lost.

   It is important for the analyst to know what, if any, activities were performed prior to the examination, including bathing, urination, defecation, brushing teeth, and changing clothes, any of which could help explain the absence of secretions or other foreign materials. For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina. Failure to explain the circumstances under which semen could have been destroyed might jeopardize criminal prosecution if apparent contradictions can not be accounted for in court.

   Forensic scientists may find evidence of two blood groupings indicating that the patient may have had multiple offenders or had intercourse with a partner sometime before the assault. Information about the most recent intercourse up to one week prior can explain any discrepancies.

4. Contraceptive/Menstruation Information Certain contraceptive preparations can interfere with accurate interpretation of the preliminary chemical test frequently used by crime laboratories in the analysis of potential seminal stains. In addition, contraception foams, sponges or creams can destroy spermatozoa. Lubricants of any kind, including oil or grease, are trace evidence and may be compared to potential sources left at the crime scene or recovered from the body of the assailant. Knowing whether a condom was used also may be helpful in explaining the absence of semen.

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

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

crime laboratory which corroborate the patient's account will support the patient's testimony in court.

6. Physical and Examination Details In the search for cross-transfer of trace evidence, it is essential to know the location and extent of the injuries sustained by the patient. For instance, blood from the patient's injuries could be found on the body or clothing of the offender or at the crime scene; or if the patient did not bleed at all, the blood located on her/his clothing could be from the offender.

   Sometimes saliva and semen stains are more easily visualized under ultraviolet light. The use of a hand held UV lamp (Wood's Lamp) will assist in locating the presence of such stains on the body of the patient during the medical examination. Sometimes the most effective method is to ask the patient.

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

7. Date and Race 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 patient and the offender. A mixture of semen from an offender and the patient's previous male sexual partner could lead to blood grouping results which, if unexplained, could conflict with the patient's own account of the assault.

   Patients are asked if they engaged in voluntary sexual intercourse with a male within a week prior to the assault. If so, patients are then asked the date and race of the contact in order to help determine the possible significance of semen remaining from the prior sexual contact.

   Legally, the patient's prior sexual activity and/or date of last coitus with a person other than the offender, is information which should be protected from open court by the Texas statute. This person's identity is not relevant either to the medical examination or for the initial findings of the crime laboratory and should not be sought at time of initial examination. The patient should, however, be instructed to remember the identity of that person and how to reach him should a blood or hair sample be needed later.

   For medical purposes, evaluate the date of the last voluntary coitus in conjunction with the patient's menstrual history to determine the possibility of a pre-existing pregnancy. Medication to prevent pregnancy cannot be administered if a patient is currently pregnant.

8. Communicable Disease of Risk to Crime Laboratory Personnel Crime laboratory personnel

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

Due to not having conclusive information at the time of the examination, universal precautions should be followed by all personnel when handling any specimens.

MEDICAL EXAMINATION DOCUMENTATION

Body Diagrams/Photographs

Photographs of sexual assault patients **should not be the only form of documentation.** Instead, a drawing of the human figure should be used to show the location and size of the injury as well as a written description of the trauma. Drawings provided consist of adult, child and infant figures and contain genitalia for males and females.

Photographs of extremely brutal injuries and of bitemarks can prove quite beneficial in court; however, many times injuries, such as bruises, will become apparent only after several days. There is no guarantee that photographs will develop to show the actual severity of the injury. Once taken, photographs can be subpoenaed into evidence.

Therefore, 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 patient**.

Further, **photographs should not be taken of the genital areas unless the patient specifically gives permission for this procedure**. 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 camera operator, preferably of the same sex as the patient, and that a ruler and color chart be used to indicate the size and nature of each injury. If the examiner is not the one taking the photographs, the examiner should remain in the room while the photographs are being taken.

Terminology

Findings from the physical examination should be documented as completely as possible on the examination record. Sexual assault prosecutions may not always require the presence or testimony of the attending medical personnel; however, there will be times when it is necessary. If testimony is needed, a thoroughly completed and legible examination record and accompanying body diagram will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical and evidentiary examination, the attending medical staff must be careful not to include any subjective opinions or conclusions as to whether a crime occurred. The indiscriminate use of the term `rape' or `sexual assault' on a medical/forensic document is a conclusion that may prejudice future legal proceedings. Instead, the chart should reflect that the sexual assault examination was conducted and should include any pertinent forensic/medical findings.

An important distinction must be made between information gathered for providing medical treatment, and that which is gathered for the follow-up investigation and potential prosecution. Medical personnel should not be expected to further expand their role to act as an `investigator' 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.

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 patients.

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

if the patient or accompanying person (such as a family member, friend or police officer), states that the patient was involuntarily drugged by the assailant(s),

AND/OR

if in the opinion of the attending medical personnel, the patient's medical condition appears to warrant toxicology screening for optimal care.

Great care should be exercised to ensure that toxicology screens are not routine for survivors of sexual assault.

PROPHYLACTIC TREATMENT FOR SEXUALLY TRANSMITTED DISEASES AND

PREGNANCY

All patients should be given information about the possibility of contracting sexually transmitted diseases from the assault. Only a follow-up test at a later time will confirm any transmission. The patient should be consoled with the fact that because a sexual assault has occurred does not necessarily result in the transmission of a disease or pregnancy. However, a follow-up exam and test six weeks after the assault should be encouraged. Prophylactic treatment for sexually transmitted diseases should be offered routinely at the time of the initial exam. (See appendix I)

If the medical team determines that the female patient of child-bearing years is at high-risk for pregnancy, prophylactic treatment for pregnancy should be discussed and offered. A thorough history should be taken to determine the patient's method of birth control and whether it was in use during the assault. Should the medical facility have a policy that is philosophically opposed to "morning after treatment", the patient should still be alerted to her risk for pregnancy, informed of her options and referred to a facility that will prescribe treatment if she chooses it. Treatment staff is also encouraged to consult an obstetrics gynecology committee to pick the most appropriate morning after therapy and a develop standing policy for its use.

PROCEDURES FOR RELEASE OF EVIDENCE

Preliminary Procedures

When all evidence specimens have been collected, they should be placed back into the kit, making certain that everything is properly labeled and sealed.

The original copy of the sexual assault forensic examination form is to be maintained at the facility where the exam was completed. The second copy is for the law enforcement officer to take and the third copy is included in the kit. All copies should be legible.

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

All medical and forensic specimens collected during the sexual assault examination must be kept separate in terms of collection and processing. Those required only for medical purposes should be kept and processed at the examining medical facility, and those required strictly for forensic analysis should be transferred by law enforcement with the evidence collection kit to the crime laboratory for interpretation.

Transportation of Evidence

Under no circumstances should patients be allowed or expected to handle evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer physical evidence from hospitals to crime laboratories for analysis. In order to inhibit deterioration and assure the best possible test results, kits should be refrigerated immediately and kept so until transported to the forensic lab by law enforcement personnel. Kits should be taken directly from the medical facility to the lab where the contents will be frozen until processed.

Release of Evidence

Evidence collection items should not be released from a medical facility without the written authorization and consent of the informed adult patient, or an authorized third party acting on the patient's behalf if the patient is unable to understand or execute the release. An authorization for release of information and evidence form should be completed, making certain that all items being transferred are checked off. Besides obtaining the signature on this form, signatures must be obtained from the medical facility staff person turning over the evidence as well as the law enforcement representative who picks up the evidence.

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

Non-authorization of Release

Although most sexual assault survivors consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be a few instances when a patient will not authorize such a release. Medical facilities and/or law enforcement personnel should not react negatively to a patient's initial decision not to release evidence. They should inform the patient 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 considered by prosecutors to be a serious problem.

If consent is not initially received, kits and clothing bags can be stored on a temporary basis in a locked, secure area. To retard spoilage, kits should be refrigerated for up to two weeks, if possible, before being destroyed. If refrigerated storage is not available, the evidence should remain sealed and be placed in a secure cool dry place. (Although some medical facilities have limited storage and/or refrigeration facilities, space should not present any major problem since the number of actual cases in which release is not authorized is very low). Hospital personnel and/or the patient's advocate must inform patient of the length of time the evidence will be held prior to destruction, thereby providing the patient with an opportunity to reconsider authorization for release within a reasonable period of

time after the initial hospital examination. It is the responsibility of the law enforcement agency to contact the patient to inquire about any change of decision.

POST-EXAMINATION INFORMATION

Information Brochures

The Office of the Attorney General has developed an informational brochure about sexual assault. 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 syndrome. They also provide reassurance to the patient that sexual assault survivors are not responsible for the assault. Copies of the brochure are available from the hospital, local sexual assault program or Office of the Attorney General, Sexual Assault Prevention and Crisis Services Division.

Arrangements should be made to provide a copy of such publications to sexual assault survivors and their families when they leave the hospital. Many kits come with this prepackaged.

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault survivors. Before leaving the hospital, the medical facilities portion of the information booklet mentioned above should be completed. The type and dosage of any medication prescribed or administered should be recorded in the section provided.

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

Patients should be encouraged to obtain follow-up tests, if needed or indicated, for possible pregnancy, sexually transmitted disease, 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 patient does not wish to return to the treating facility. Advocates can be helpful in explaining the need for a return visit and what types of tests should be performed.

Another section of the booklet is used to record follow-up counseling information. While the patient should be encouraged to seek follow-up counseling, the decision to do so must be voluntary. Some patients may be reluctant to talk with a counselor; however, they are more likely to participate if counseling has been coordinated with the examination process. A referral to an advocate, social worker, or psychologist in the community who is known to provide quality service could also be made.

Follow-up Contact

Any further contact with sexual assault survivors must be carried out in a very discreet manner. In an effort to avoid any breech of confidentiality or unnecessary embarrassment, it is recommended that survivors be asked, prior to leaving the medical facility, whether they may 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.

Clean-up/Change of Clothing

Many patients would like to wash after the examination and evidence collection process. If possible, the medical facility should provide the basics required, such as mouth rinse, soap and a towel.

If garments have been collected for evidence purposes and no additional clothing is available, arrangements should be made to insure that no patient has to leave the hospital in an examination gown. In those instances where police officers transport victims from their homes to the hospital, officers should be instructed to advise survivors to bring an additional set of clothing with them in the event any garments are collected. Some patients may wish to have a family member or friend contacted to provide substitute clothing. When the patient has no available personal clothing, necessary items could be supplied by volunteer organizations and/or the local sexual assault program. A list of agencies should be developed by the local task force.

This and other issues can be addressed by developing a community plan with local law enforcement agencies and sexual assault programs.

Law Enforcement Investigative Interview

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

In many cases, the investigator will conduct the follow-up interview after the patient already has been interviewed by the responding officer and the hospital staff. Therefore, it is very important that the need for this third interview be explained to the patient, especially the reason more detailed questions must be asked. Intimate details of the attack may be traumatic and embarrassing for the patient 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 prosecutor.

Transportation

Finally, transportation should be arranged when the patient is ready to leave the hospital. In some cases this will be provided by a family member, friend or patient advocate who may have been called to the hospital for support. In other cases, transportation can be provided by the local law enforcement agency as a community service or by the local advocacy agency.

CHILD PROTOCOL

Many of the same information and principles that apply to examining and interviewing an adult sexual assault survivor also apply to children. The following pages contain information that may be different for child cases.

GENERAL INFORMATION

Sexual abuse of children falls into three major categories:

1. Sexual abuse of a child by a family member, caretaker, or other person known to the child.

2. Sexual abuse of a child by using pornographic materials and exploitation. Many of those involved are 'runaway' or 'throwaway' children who are dependent upon the exploiters for physical survival, and in some cases, even affection.

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

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

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

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

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

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

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

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 continue well into adolescence or even after the child leaves 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 educated about proper and improper touching and the importance of telling someone when inappropriate behavior occurs, many children do not understand that they should report the incident(s), or are afraid to do so. The situation is made even more complicated when the offender is someone whom the child loves and/or trusts, such as a parent or other close family member.

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 full intercourse usually after an extended period of time. The family member is usually 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 become adolescents before realizing, through normal discussions with friends about family life and events, that the sexual contact they have experienced is wrong and does not usually occur in most households. By that 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 an attempt is made to talk to someone about the abuse many children are unable to communicate what is happening. Even when the child is quite verbal, the listener may dismiss the story as 'make believe' or accuse the child of lying. When no action is taken to protect the child from further abuse, the child may decline to initiate the subject again.

TREATMENT PLAN

Facility

Because of the inability of most children to secure medical treatment on their own, most 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 physician who discovers gonorrhea from a vaginal, urethral or throat culture.

Ideally, each community should provide medical facilities and a multi- disciplinary team, available on an on-call basis, for the examination and treatment of child sexual abuse cases. The team should consist of the examiners for the physical examination, law enforcement officers, Child Protective Services and an advocate. Ideally, this team should be supplemented by on-call personnel consisting of an obstetrician/gynecologist, pedi-SANE, and other specialists. Each team member must be trained in the management and psychodynamics of the sexually abused child.

Without such a specialized team, the minimum requirements should be a readily available physician and nurse, both of whom are trained in the medical forensic and psychodynamic aspects of child sexual abuse.

Intake

Children are often brought to the medical facility by a police officer and/or parents who are seeking examination and treatment. When the child is accompanied by an officer, the officer should be directed immediately to the emergency/pediatric department so that a brief history of the assault can be provided to the attending medical staff.

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

In the course of the intake it should be determined if this is an acute or chronic problem. If it is chronic, the child has been interviewed all day and the child has no immediate trauma, the examining team may want to delay the exam until the following day. If the abuse is suspected to be familial, provisions should be made to keep the child safe overnight. A detailed protocol should be developed to cover this eventuality by the local task force on child sexual abuse.

Reporting

Texas law (Family Code, Section 34.01 amended 1987) states that "Any person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by a person responsible for the child's care, custody, or welfare shall report in accordance with Section 34.02 of this code." The report must be made to Children's Protective Services of the Texas Department of Human Services or the local law enforcement agency. Reports should be made to the local office or by calling the hotline. The report may be made in writing, by telephone or in person. Those reporting the incident or participating in an investigation or court proceeding are immune from civil or criminal liability, unless that person reports their own conduct or acts in bad faith or with malice.

The obligation to report is a continuing process and includes cooperation in the investigation.

Support Personnel

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

It is not always necessary that the interviewer be of the same sex as the survivor, but should the child or parent request this, every effort should be made to accommodate her/him. Some facilities require same sex examiners in their protocol. Privacy is very important when interviewing. The interviewer should select a location that allows visual privacy, sound privacy, and will avoid interruptions. An interpreter will be necessary in some cases. The presence of an advocate during this interview is discretionary with the investigator, however, consideration should be given to the possible need or request by the survivor or by the advocate on behalf of the survivor for an advocate in the room.

Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from parents/guardians of all children under the age of 18. However, Texas law provides that an examination may be done in cases of suspected child abuse or suicide prevention with the consent of the minor only, court order or on the opinion of the physician in emergencies. Examination may not be done if the child is 16 or older and refuses to consent or if consent is refused by a court order. (Family Code, Sections 35.03 (g), 1985 and 35.04, 1975)

Child Interviews

Many sexually abused children who are brought to a medical facility for examination and treatment have not yet been interviewed by law enforcement or a Child Protective Service worker. Therefore,

it is likely that the examining personnel will be the first person to interview the child about the event(s). The following guidelines will assist in this process.

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 a rapport with children.

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

With children, 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 her/his 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 with 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, however, are not always concrete. Therefore, hospital staff should be alert for signals from the parent/guardian which may indicate sexual abuse, including but not limited to the following:

1. the child stays inside the house more frequently

2. the child does not want to go to school or stays at school for prolonged hours

3. the child cries without provocation

4. the child bathes excessively

5. the child exhibits a sudden onset of bed wetting or fecal soiling.

An assessment of the child's emotional state is a vital part of the interview process. This is an age-dependent interpretation, such as how the child relates, her or his body posture, and the language used. It is also important to assess the child's verbal skills level and to use terms that are understandable to the child. This assessment can many times be accomplished by asking topical questions about family, school, television and everyday events. After a degree of rapport has been established, the child can then be asked to describe what happened.

One of the goals of the protocol is to prevent extensive interviewing of the child. It is all right to ask children why they think they are there and who hurt them. Any answers and information that is volunteered by the child should be recorded. It is best not to do a detailed interview at this time. If the child has been interviewed previously, the history of the incident can come from that source.

MEDICAL HISTORY INTERVIEW

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

If the interview is held it must be in a private setting in the emergency or pediatrics department, and must be free from interruptions. The interviewer should explain her/his need to know what happened and what procedures will be done. S/he should also use simple terms, including the child's vocabulary for body parts, acts and people. Ask only what is needed to conduct the exam. If the child should volunteer information or answer questions, that information should be written down.

Value judgments and expressions of shock or surprise should be avoided. 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 her/him.

Attending Personnel

As few persons as possible should be present during the medical interview/evaluation or examination/evidence collection process. Attending personnel should consist of the examining medical personnel and 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 these procedures.**

Presence of Parent/Guardian

Since children many times will tell health professionals information they may not tell in the presence of parents or other adults, adolescents and older children should be encouraged to provide much of their own medical history, as appropriate. This interview should be conducted in a private area, and information regarding sexual history (of both males and females), menstrual history and use of birth control should be recorded. Encourage the child to be interviewed alone (without parent or guardian) if it does not cause too much stress for the child.

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

If a parent or guardian is present, the purpose of the interview should be explained in a straight-forward manner, and cooperation should be elicited to reassure the child that it is 'safe' to talk with the interviewer. The parent/guardian should also be told that any facial expressions of shock, disbelief or disapproval, or any verbal or physical signals to the child could impede the investigation.

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

EVIDENCE COLLECTION

Regardless of when the assault or last sexual contact might have occurred, valuable evidence may still be obtained through a medical examination and interview of the child. Therefore, it is vital that such an examination still be performed and that all paperwork be completed, whether evidence specimens are collected. The examination and evidence collection procedures have different purposes. Anytime that a child reports abuse, an examination should be done. This holds true no matter how long it has been since the last incident.

If it was determined during the medical history interview that the last sexual contact took place more than one week prior to the medical visit, the percentage of cases where trace evidence is still present on the child's body or clothing will be significantly low. 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.

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

> Drawing blood is rarely needed in young children but if the need is present, the amount of blood collected for forensic purposes should be limited to only 3 milliliters.

If it is determined that simultaneous use of two swabs would be traumatic, swabs should be obtained one at a time. For forensic purposes, cotton swabs should be used.

For the young female child and the adolescent female who is too traumatized to have a full pelvic examination, evidence specimens can be obtained by gently swabbing the exterior vulvar areas, using a **slightly** moistened 2 X 2 gauze.

Another technique would be to use the distal 4" of a number 12 bladder catheter through which is passed the proximal 4" of butterfly I.V. tubing to which is attached a 1 cc tuberculin syringe with 0.5 to 1 cc of distilled water. The outer bladder catheter keeps the vaginal walls from sucking against the inner catheter so that almost the entire amount of vaginal wash solution can be aspirated back into the syringe. The vagina can thus be flushed in this manner and the vaginal wash material can be placed on the appropriate forensic swabs and slides and, if performed in an aseptic manner, used for appropriate cultures and wet mount examination.

MEDICAL/EVIDENTIARY EXAMINATION

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

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

To minimize loss of evidence, the child should disrobe over a white cloth or sheet of paper. If a child cannot undress on their own, 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.

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

After air drying items, such as underpants, hosiery, slips or bras, they should be put into small paper

bags. It is important to remember that infant diapers may also be valuable as evidence because they may contain semen or pubic hairs. Disposable diapers mold very easily; therefore they should be actively air-dried particularly well and should be placed in a paper bag without folding the item on itself. Diapers should be submitted to the laboratory as expeditiously as possible and the submitting official should make lab personnel aware that there is a diaper in the submission so that it may be frozen or processed quickly. Items such as slacks, dresses, blouses or shirts should be put into larger paper bags.

Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain, so that the stains are not in contact with the bag or other parts of the clothing.

If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed clothing bags should be placed inside a larger paper bag with the top of the second paper bag left open. In these instances, a label should be affixed to the outside of the second paper bag, which will alert the crime laboratory personnel that wet evidence is present inside the paper bag and enable them to remove the clothing and avoid loss of evidence due to putrefaction.

In preparation for the examination, the child should be completely undressed and be wearing an examination 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 environment. Factors such as the presence of unfamiliar equipment, most of which can be quite 'scary' in appearance, and the necessity of darkening the examining room in order to conduct the Wood's Lamp procedure properly can be extremely disconcerting and frightening to a child. Therefore, 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 to do the examination and/or to gather evidence. If the child is visibly upset, the examiner should determine what measures are to be taken to reduce

her/his anxiety.

Some cases may require the use of sedation; however, it is recommended that general anesthesia not be administered unless there is evidence of acute trauma which needs further evaluation and treatment. Careful explanation of any sedation or anesthetic should be provided to both family and to the child.

MEDICAL EXAMINATION

General Information

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.

Some 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 on the underwear
5. lesions, bruising or swelling of the genital 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 location of these injuries should be recorded on drawings 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. Nonetheless, the lack of any specific injury/finding in no way detracts from the likelihood that the abuse occurred.

A lack of physical finding 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 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 bitemarks should be recorded, all are helpful in providing further confirmation of victimization.

Genitalia

As a point of reference, it is often helpful to estimate the level of sexual maturation of the child (Tanner staging scales See Appendix III). The following is a description of the specific exam for the prepubertal child. Alterations may be indicated by maturity.

Examination of the Female Genitalia

The approach to the examination of the prepubertal or premenstrual child is different than that of the adolescent or postmenarchal survivor.

For the young female child, a internal gynecological exam is not recommended if there is evidence or reasonable suspicion of upper genital trauma, an exam under anesthesia should be arranged. However, a careful visual inspection should always be made. The extent of the exam is dependent upon each case.

Prepubertal or Premenstrual Child

The young child should be examined in the most comfortable and reassuring place for that individual child. The child may be placed on an examining table or examined on a caretaker's lap. Older children may need to place their feet in the stirrups on an examining table, whereas younger children don't need the stirrups. They should be examined in the lithotomy position and also if possible in the knee chest position. The latter position occasionally allows the introitus to open up to allow better visualization of the hymen. (This position is a more anxiety provoking position for the child.) The labia majora, minora, and clitoral hood are carefully inspected for any evidence of acute trauma including erthema, swelling, abrasions, hematomas and lacerations. The remainder of the external genitalia are then carefully inspected by placing gentle traction on the labia majora laterally and posteriorly. This allows for visualization of the vestibule including the urethral meatus, hymen and posterior fourchette. Any evidence of trauma to this area should be noted.

An attempt to visualize the hymen is usually successful in prepubescent girls. The hymen is a thin membrane originating from the edges of the vaginal entrance and the examiner should be familiar with normal variations in types and sizes of openings. The shape or morphology of the hymen and surrounding structures especially the posterior fourchette, are areas frequently traumatized during an acute assault. The border of the hymen should be inspected noting any breaks, tears or lacerations. The tissues, especially the hymen, are best observed in a fully stretched state so that the outline of the hymen can be accurately assessed. This can be frequently best done in the knee chest position. One may measure the opening of the introitus (diameter and height) in millimeters (mm) or document gross abnormalities. (document the position in which the child was placed to achieve the measurements.) One may also gently hold the labia majora between the thumb and index finger and pull laterally and posteriorly to visualize the internal genitalia. It is not necessary to place the examiners finger inside the vagina to palpate the internal structures. It is also not necessary to examine the prepubertal child with a speculum. If there is evidence of lacerations in the genitalia, then a consultation with a gynecologist should be strongly considered to rule out severe internal injury. The hymen however may become distorted and remnants of the tissue may be visualized circumferentially around the mouth of the vagina.

The most important thing the examiner can do, however, is to describe in ANATOMICALLY CORRECT terms where, if any, there is disruption of the usually smooth collar of tissue which surrounds the mouth of the vagina or other evidence of trauma to the genitalia. Physical findings on the hymen or surrounding tissues should be recorded using the standard orientation of 12 o'clock being towards the urethra and 6 o'clock towards the anus when the child is in the supine position.

The Wood's Lamp examination may reveal areas of fluorescence indicating possible semen deposition. These areas may be swabbed with cotton swabs damp with sterile water, air dried, packaged, labeled and placed in the evidence kit. Any evidence for STDs should be noted as well including vesicles, ulcers, condylomata, chancres, etc.

A normal physical examination does not preclude penile or digital contact.

Vaginal swabs for the evidence kit (cotton) and/or cultures (dacron masopharyngeal) for STDs may be obtained by swabbing the wall of the vagina while the prepubertal child is in the knee chest position being careful not to touch the sides of the vestibule or hymen when placing the swab inside the vagina. The most sensitive tissue is the hymen and vestibule.

A careful examination of the anus and surrounding tissues should be done in every prepubertal child as this is a frequent site of trauma due to sexual abuse and assault.

Post Menarchal Child

Careful inspection of the external genitalia should be done in the same manner as described for prepubertal child. Visualization of the vestibule and the hymen can be done using the same techniques. The postmenarchal child does not need to be examined in the knee chest position. The morphology of the hymen should be noted and the border of the hymen carefully examined for any tears, lacerations or breaks. The postmenarchal hymen is estrogenated and appears thickened and hypertrophied compared to the prepubertal child's hymen. One should be careful not to over interpret indentations in the hymen as secondary to trauma. An eight (8) cm long narrow blade speculum should be used to visualize the vagina and cervix. The speculum can be lubricated with warm water but not with petroleum based lubricants. The walls of the vagina should be inspected for any abrasions or lacerations. The vaginal vault should be inspected for secretions. Swabs of these areas should be placed in the evidence kit and swabs of the cervix taken for any cultures and a wet mount.

A careful examination of the anus and perianal tissues should be performed as with the prepubertal female.

Anal, Perianal and Perineal Examination

The anus, perianal and perineal areas should be carefully inspected for evidence of trauma in every age child suspected of being sexually abused or assaulted. This can be done by either placing a small child in the knee chest position or the larger patient on their side with their knees pulled up touching their stomach. Gentle traction is applied to each side of the buttocks lateral to the anus with the thumb and index fingers of both hands. With relaxation of the patient the anus may be completely visualized. Erthema, abrasions, lacerations, tears, hematomas, ecchymoses and any distortions of the normal "sun burst" appearance of the anal and perianal tissues should be noted. The depth and shape of any anal lacerations should be documented. Bands of scar tissue may be seen in some children with past history of anal trauma. Digital rectal examination for anal tone may be performed at the discretion of the examiner but rarely adds forensic information. Visual inspection of the anus can allow an estimate of the patulousness of the anus.

Severe rectal bleeding should raise the suspicion of possible severe internal injuries requiring consultation and/or protoscopy. Routine protoscopy is not indicated. Rectal swabs or damp swabs of the perianal and/or the perineal areas may be taken for cultures and/or the evidence kit.

Magnification of the genitalia and anal area with a hand held magnifying lens or a colposcope can be very helpful to identify fine detail as well as small tears, and scars. Small rulers calibrated in mms can also be very helpful for measurement of the introital opening and other physical findings.

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. Since child abuse must be reported, the parent/guardian does not have a choice in whether the evidence is released to the law enforcement agency.

POST-EXAMINATION INFORMATION

Information Form

An Information Brochure should be filled out, providing the same information as is given to the adult survivor. The child's parent or guardian should sign the release form which will be retained by the medical facility.

The provision of psychological services for children and their parents or guardian is just as important as for adults. A referral should be made to an appropriate agency or individual with approved credentials and training in the field of child sexual abuse. The Children's Protective Services, Child Advocacy Centers, and/or the local sexual assault program will have a referral list. Coordination and communication of referrals to support services is encouraged.

After an acute assault, 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 counseling has been received or is necessary.

Key Interviewing Techniques (for all disciplines)

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. (Please refer to Presence of Parent/Guardian)

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

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

It must be made very clear to the child, as often as needed throughout the interview, that the child was not at fault.

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

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

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

The use of interview aids is extremely helpful. Drawings, pictures and anatomical dolls are particularly effective **when used by trained personnel.**

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.

Finally, it is important for all interviewers to be aware that many times it is necessary to conduct more than one interview over a period of days in order to ascertain the circumstances of the abuse.

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

The goal of the interview with the child survivor of sexual abuse, whether the abuse was committed by a stranger, family member or other trusted adult, is twofold:

1. To avoid further trauma to the child.

2. To obtain accurate information needed for case investigation.

Ideally, the interview should be conducted by the team approach. Law enforcement and a Children's Protective Services representative may do the interview together, so that the trauma of multiple interviews is curtailed. It also can be helpful to have a support person present who established a good rapport with the child during the medical examination/interview. To avoid confusion, however, it is important that only one person be the primary interviewer. In all cases, the people present during the interview must be there for a specific purpose and must be psychologically supportive to the child.

Depending upon the circumstances surrounding the case, some child patients will be interviewed by law enforcement and/or Children's Protective Services representatives at a location away from the hospital, such as the child's home, school or an agency facility. The child should only be removed from school as a last resort. Space adjacent to the emergency room or pediatric 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.

Great care should be taken by the juvenile officer/investigator to minimize visibility of weapons and standard equipment (such as handcuffs and nightsticks) carried during the interview so that the child is not further intimidated or traumatized.

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

Appendix I

SEXUALLY TRANSMITTED DISEASES (STD's)

General Information

The risk of contracting a sexually transmitted disease as a consequence of sexual assault is not known; however, the situation may dictate that a baseline for STD be established at the initial hospital examination.

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

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 an STD is present. Therefore, all cases of sexually transmitted disease in children should be reported to the appropriate law enforcement agency, Child Protective Services, and to the local health department.

Due to continuing research and discussion of the most effective treatment of sexually transmitted diseases specific to sexual assault survivors, 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 their latest treatment recommendations: "Sexually Transmitted Diseases Treatment Guidelines", 1985.

Traditionally, tests for sexually transmitted disease in sexual assault and abuse survivors have been focused on screening tests 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 sexually abused person.

Chlamydia

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

Chlamydial organisms are unusual in that they are completely dependent upon their host cell for energy and therefore are only able to survive outside of their host environment for the briefest period of time. Transmission of organism, except in the newborn who can acquire Chlamydial conjunctivitis and/or pneumonitis during passage through the birth canal, is almost always through sexual contact.
In adults, chlamydial infections may be asymptomatic but more frequently are manifested in a wide variety of symptoms ranging from nonspecific urethritis to PID, orchitis, epididymitis, perihepatitis and procitis.

In children, the exact incidence of this problem is unclear but infection with this organism has been shown to be significantly more frequent than was previously recognized. Moreover, children appear to be asymptomatically 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 a most common clinical picture.

In the past, hospitals were reluctant to test routinely for chlamydia because the method for detection was expensive and time consuming. Recently, inexpensive fluorescent antibody tests have become available and, although not as sensitive as chlamydial cultures, are adequate for screening adults. Multiple studies have indicated, however, a very high false positive rate in children. For this reason, cultures (and not the quick test) should be used for screening this sexually transmitted disease in children (premenarchal). The best test available should be done.

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

Due to the prevalence and severity of the infection, it is recommended that chlamydia cultures be included in hospital protocols for detection of sexually transmitted disease. Antibiotics for prevention or treatment of chlamydia include tetracycline.

Gonococcal Infections

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

A definitive diagnosis of gonorrhea is dependent in both males and females on a positive culture using Thayer Martin media and a differential sugar fermentation test.

Asymptomatic infections are not uncommon and should be treated. It is important to recognize that chlamydial infections commonly occur in conjunction with gonorrheal infections. Antibiotics for prevention or treatment of gonorrhea include tetracycline; procaine penicillin and probenecid; spectinomycin; or amoxicillin and probenecid.

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 survivor: 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 persons suspected to have syphilis. A survivor should be encouraged to have a follow-up test done 6 weeks after the assault.

Antibiotics for prevention or treatment of syphilis include tetracycline; or amoxicillin and probenecid.

Genital Herpes Simplex Virus Infection (HSV)

Genital herpes is the result of an infection with HSV type 1 or 2. This infection can be either symptomatic or asymptomatic and can reflect a primary, latent or recurrent process.

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

Transmission of the virus occurs during both its active and latent phases. The diagnosis of genital herpes is usually obvious from the clinical picture but immunofluoresent and serologic tests, as well as cultures, can be used to confirm the diagnosis. It is important to recognize that the presence of

HSV-2 is almost always acquired through sexual contact and that HSV-1, when present in the genital area, should also arouse a suspicion of sexual activity.

Trichomonas Vaginalis

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

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

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 felt to be through sexual contact.

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

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

Nonspecific Vaginitis

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

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

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

AIDS

Survivors of sexual assault and parents of child survivors of sexual assault frequently request HIV antibody testing at the time of the sexual assault exam. The fear and anxiety are to be expected, however, HIV testing at the time of the initial exam is not recommended unless there are other high risk factors involved. The survivor should be advised to have HIV antibody tests three months after the assault. Consideration must be given to the emotional well being of the survivor. If after being advised of the recommended procedure for HIV testing the survivor still requests HIV testing, their request should be honored with the explanation that the results at the time of the assault will only give a baseline for further testing.

MORNING AFTER THERAPY

Options for morning after therapy include: Ovral - 2 by mouth every 12 hours for a total of four; Ortho Novum - 1/50 3 now and 3 in 12 hours by mouth; conjugated estrogen - 30 ml for 5 days; or Diethylstilbesterol - 25 mg twice daily for 5 days with antimetics to counteract nausea and vomiting.

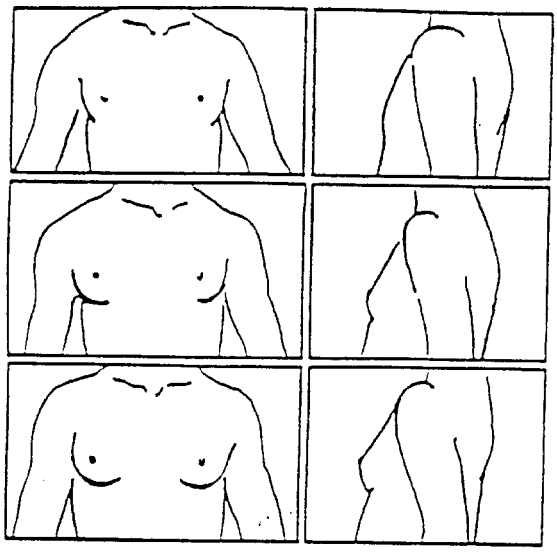
APPENDIX II

TANNER STAGING SCALE/CLASSIFICATION OF SEXUAL MATURITY

Stage 1

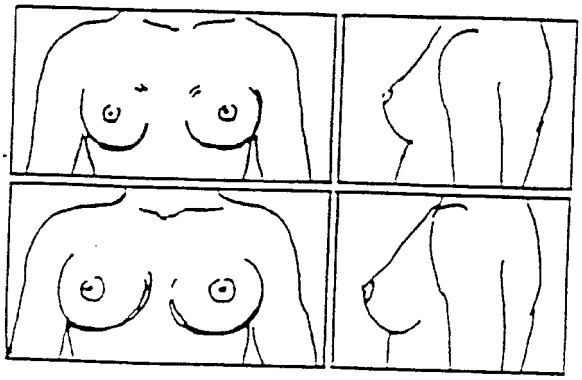
Stage 2

Stage 3



Stage 4

Stage 5



Stages	Breast Growth
1 = Newborn to 15 years old	Preadolescent
2 = 8 to 15 years old	Breast budding; Areolar hyperplasia with small amounts of breast tissue
3 = 10 to 15 years old	Further enlargement of breast tissue and areola, with no separation of their contours
4 = 10 to 17 years old	Separation of contour; areola and nipple form secondary mound above level of breast

5 = 12 to 18 years old	Larger breast with single contour (areola not elevated)

Adapted from Tanner JM: Growth at Adolescence. Ed 2. Oxford. Blackwell Scientific Publications. 1962

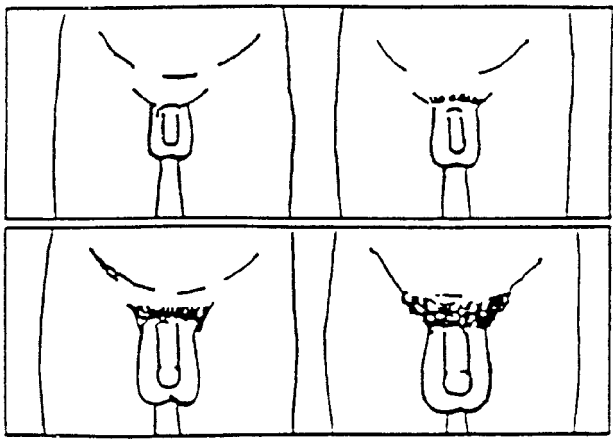
APPENDIX II

TANNER STAGING SCALE/CLASSIFICATION OF SEXUAL MATURITY

GENITAL/PUBIC

Boys - Adolescent Males

Stage 2



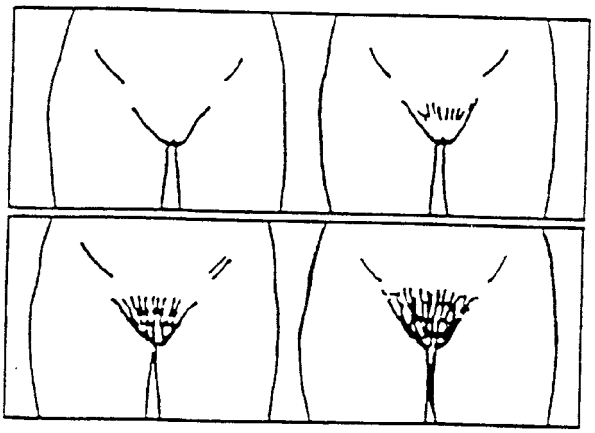
Stage 3

Stage 4

Stage 5

Girls – Adolescent Females

Stage 2



Stage 3

Stage 4

Stage 5

Stages	Pubic Hair Growth/Boys & Girls	Testes Growth	Penis Growth
1 = newborn to 15 yrs old	None	Preadolescent	Preadolescent
2 = 8 to 15 years old	Long, downy hair near the labia, straight or slightly curly	Enlargement of test; increased stippling and pigmentation of scrotal sac	Minimal or no enlargement

3 = 10 to15 years old	Increase in amount and pigmentation of hair, coarser and more curled	Further enlargement	Significant enlargement, especially in diameter
4 = 10 to 17 years old	Adult in type but covers smaller area than in adult	Further enlargement; scrotal skin darkens	Further enlargement, especially in diameter
5 = 12 to 18 years old	Adult in distribution	Adult in size	Adult in size

Appendix III

RESOURCE LIST

Bashinski, Sexual Assault Evidence and the Criminalistics Laboratory, Oakland Police Department Criminalistics Laboratory, pp. 141-152.

Citizen Committee for Victim Assistance, "Interviewing Child Victims of Sexual Abuse," Rape Protocol and Child Interview Techniques: A Basic Guide for Professionals Who Deal With Adults and Child Victims of Sexual Abuse, Chicago, 1979, pp. 7-10.

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Appendix IV

QUICK REFERENCE GUIDE FOR EXAMINING TEAM

REMOVE THIS APPENDIX AND USE IT AS A HOSPITAL PROTOCOL OR REFERENCE DURING THE EXAM.

This kit was developed for hospital use in collecting specimens from survivors of sexual assault and for submitting the specimens to forensic science laboratories for analysis. The specimen results will ultimately be used in court by (state or district) attorneys when prosecuting sexual assault cases; therefore, it is very important that the initial examination of the patient be conducted according to the enclosed instructions.

Familiarity with the contents of the kit on the part of the examining team will facilitate examinations of the patient.

The kit will contain the following materials for evidence collection, forms and drawings (Health and Safety Code, Chapter 44, Section 44.031):

Crush-proof box
white envelops
3 frosted-ended glass slides with new/unused pap smear mailers
12 cotton swabs with 4 cardboard boxes for swabs
2 small narrow tooth combs
purple-top blood tube
nail file, pick or orange stick

The Sexual Assault Forensic Examination Form should be stocked separately from the kit. There will be times when the form is used without the kit.

Sexual Assault Forensic Examination Form -- the completed original is to be included in the kit before sealing. It is important for the examining team to thoroughly complete the Forensic Laboratory Form because it is the only record the forensic scientist will have for reference when analyzing the evidence. Please avoid phrases such as, "see chart", "see E.R. sheet", or "see nursing notes" in the spaced for "history" and "physical examination".

Request for Medical Examination, Treatment, Collection of Forensic Evidence, and Release of Medical Records -- the completed original remains with the survivor's records at the hospital; the carbon copy goes to the law enforcement agency representative who picks up the kit.

Receipt of Information -- this form is for law enforcement use to track the chain of custody of the evidence. It should be signed by the medical personnel releasing the kit and records and the original sent along with the kit. A copy should be kept at the medical facility for their records.

Authorization to Assign Payment -- law enforcement will use this form to authorize their jurisdiction to pay for the exam.

Survivor Information Booklet -- the completed booklet is to be given to the survivor before leaving the hospital.

Anatomical Drawings -- use the one that most closely represents the survivor.

ADDITIONAL MATERIALS NEEDED FOR EXAMINATION

urine specimen containers	scotch tape
calendar - to determine the date of the last menses	Wood's lamp - long wave UV light
forced air dryer (fan driven)	OB wheel
large paper bags	vaginal speculum (sm., med., lg.)
marking pens	nasal speculum
GC culture media	ruler (with cm measurements)
chlamydia media	sterile water for irrigation
disposable gloves	manila envelops (preferred)
hemoccult slide	white table paper
spot light	pipettes
sharpened lead pencil	sterile test tubes (plastic or glass)
Colposcope or magnifying device	scissors
catheter	microscope
forms	blood tubes

In addition to collecting specimens for evidentiary purposes, the following tests should be conducted:

1. General physical examination, including examination of genitalia as indicated by the nature of the

assault. (To be done whether or not evidence is collected.)

2. Serological test for syphilis.

3. Appropriate stains and cultures for gonorrhea, chlamydia and other sexually transmitted diseases collected from the vagina, cervix, penile urethra, and/or oropharynx, as indicated by the nature of the assault.

4. Urine analysis (for purposes of identifying trichomoniasis of fungus).

5. Pregnancy test, when appropriate, to determine pre-existing pregnancy.

These tests and results should remain with the hospital records and should not be included in the completed evidence collection kit.

Appendix V

Texas Sexual Assault Programs

alphabetical by city

ABILENE
Regional Crime Victims Crisis Center
PO Box 122
Abilene, TX 79604
(915) 670-5045 Administrative
(915) 677-7895 Hotline
(915) 670-5014 Fax

ALPINE
Family Crisis Center Of the Big Bend, Inc
PO Box 1470
Alpine, TX 79831
(915) 837-7254 Administrative
(800) 834-0654 Hotline
(915) 837-1303 Fax

AMARILLO
Family Support Services
1001 S Polk
Amarillo, TX 79101
(806) 372-3202 Administrative
(800) 749-9026 Hotline
(806) 372-2433 Fax

ANGLETON
Women's Center of Brazoria County
PO Box 476
Angleton, TX 77516-0476
(409) 849-9553 Administrative
(800) 243-5788 Hotline
(409) 849-1378

AUSTIN
Safe Place
PO Box 19454
Austin, TX 78760
(512) 445-5776 Administrative
(512) 385-5181 Administrative
(512) 440-7273 Hotline
(512) 445-4734 Fax

BASTROP
Family Crisis Center
PO Box 736
Bastrop, TX 78602
(512) 321-7760 Administrative
(888) 311-7755 Hotline
(512) 303-7755 Hotline
(512) 321-7771 Fax

BAY CITY
Matagorda County Women's Crisis Center, Inc
PO Box 1820
Bay City, TX 77404-1820
(409) 245-9109 Administrative
(800) 451-9235 Hotline
(409) 245-3426 Fax

BAYTOWN
Bay Area Women’s Center
PO Box 3735
Baytown, TX 77522-3735
(281) 424-3300 Administrative
(281) 422-2292 Hotline
(281) 428-1699 Fax

BEAUMONT
Rape & Suicide Crisis Center of Southeast Texas, Inc.
PO Box 5011
Beaumont, TX 77726-5011
(409) 832-6530 Administrative
(800) 793-2273 Hotline
(409) 832-4324 Fax

BIG SPRING
Rape Crisis and Victim Services
PO Box 1693
Big Spring, TX 79721-1693
(915) 263-3312 Administrative/Hotline
(915) 267-3626 Fax

BORGER
Hutchinson County Crisis Center, Inc
PO Box 182
Borger, TX 79008
(806) 274-9677 Administrative
(806) 273-2313 Hotline
(806) 274-2482 Fax

BRYAN
Brazos County Rape Crisis Center, Inc
PO Box 3082
Bryan, TX 77805
(409) 268-7273 Administrative
(800) 922-7273 Hotline
(409) 260-4562 Fax
Brcc@cy-net.net
Http://rapecrisis.txcyber.com

CARRIZO SPRINGS
Wintergarden Women's Shelter
PO Box 1382
Carrizo Springs, TX 78834
(830) 876-5676 Administrative
(800) 363-9441 Hotline
(830) 876-5373 Fax

CORPUS CHRISTI
Women's Shelter of Corpus Christi Area, Inc
PO Box 3368
Corpus Christi, TX 78463-3368
(512) 881-8888 Hotline
(512) 881-9674 Fax

DALLAS
The Family Place
PO Box 7999
Dallas, TX 75209
(214) 559-2170 Administrative
(214) 941-1991 Hotline
(214) 443-7797 Fax

DALLAS
Victim's Outreach
PO Box 515727
Dallas, TX 75251-5727
(214) 358-5173 Administrative/Hotline
(214) 358-5697 Fax

DEL RIO
Amistad Family Violence
& Rape Crisis Center
PO Box 1454
Del Rio, TX 78841
(830) 775-9612 Administrative
(888) 774-2744 Hotline
(830) 775-2875 Fax

DENTON
Denton County Friends of the Family, Inc
PO Box 640
Denton, TX 76202
(940) 387-5131 Administrative
(800) 572-4031 Hotline
(940) 383-1816 Fax

DUMAS
Safe Place, Inc
PO Box 317
Dumas, TX 79029
(806) 935-7585 Administrative
(800) 753-7553 Hotline
(806) 934-1143 Fax

EASTLAND
Eastland County Crisis Center
P O Box 1010
Eastland, TX 76448
(817) 629-3223 Administrative
(888) 686-3222 Hotline
(254) 629-8685 Fax

EL PASO
Stars
710 N Campbell
El Paso, TX 79902
(915) 533-7700 Administrative
(915) 779-1800 Hotline
(915) 533-6727 Fax

FORT WORTH
Women's Center of Tarrant County, Inc
PO Box 11860
Fort Worth, TX 76110-0860
(817) 927-4039 Administrative
(817) 927-4006 Administrative
(817) 927-2737 Hotline
(817) 924-2562 Fax

GAINESVILLE
Cooke Co Friends of the Family, Inc
PO Box 1221
Gainesville, TX 76241-1221
(940) 665-2873 Administrative/Hotline
No Fax

GALVESTON
Women's Resource & Crisis Ctr of Galveston
County, Inc
PO Box 1545
Galveston, TX 77553
(409) 763-1441 Administrative
(409) 765-7233 Hotline
(888) 919-7233 Hotline
(409) 763-8809 Fax
Wrcchsl@aol.com

GRAND PRAIRIE
Brighter Tomorrows
PO Box 532151
Grand Prairie, TX 75053
(972) 263-0506 Administrative
(972) 262-8383 Hotline
(972) 237-2565 Fax

HARLINGEN
Family Crisis Center
513 E Jackson, #209
Harlingen, TX 78550
(956) 423-9306 Administrative
(956) 423-9304 Hotline
(956) 423-9306 Fax

HONDO
Southwest Family Life Centers, Inc
PO Box 393
Hondo, TX 78861
(830) 426-5972 Administrative
(830) 426-5131 Hotline
(830) 426-3367 Fax

HOUSTON
Houston Area Women's Center
1010 Waugh Dr
Houston, TX 77019
(713) 528-6798 Administrative
(800) 256-0661 RCC
(713) 528-7273 Hotline
(713) 535-6363 Fax

HUMBLE
Familytime Foundation
PO Box 893
Humble, TX 77347
(281) 446-2615 Administrative/Hotline
(281) 446-3691 Fax

HUNTSVILLE
SAAFE House
PO Box 1893
Huntsville, TX 77342-1893
(409) 291-3529 Administrative
(409) 291-3369 Hotline
(888) 464-5218 Hotline
(409) 291-1327 Fax

JACKSONVILLE
Crisis Center of Anderson and Cherokee Counties
PO Box 8371
Jacksonville, TX 75766
(903) 586-9118 Administrative
(800) 232-8519 Hotline
(903) 589-3992 Fax
(903) 723-5858 (Palestine)
Crsscntr@e-tex.com

KERRVILLE
Hill Country
Crisis Council, Inc
PO Box 1817
Kerrville, TX 78029-1817
(830) 257-7088 Administrative
(830) 257-2400 Hotline
(830) 257-7097 Fax

KILGORE
Kilgore Community Crisis Center
905 Broadway
Kilgore, TX 75662
(903) 984-3019 Administrative
(903) 984-2377 Hotline
(800) 333-9148 Hotline
(903) 983-7739 Fax

KILLEEN
Families in Crisis, Inc
PO Box 25
Killeen, TX 76540-0025
(254) 634-1184 Administrative
(888) 799-7233 Hotline
(254) 526-6111 Fax

LAREDO
Stop Child Abuse & Neglect, Inc
2387 E Saunders
Laredo, TX 78041-5434
(956) 724-3177 Administrative
(800) 355-7226 Hotline
(956) 724-4861 Fax

LONGVIEW
Women's Center of East Texas, Inc
PO Box 347
Longview, TX 75606
(903) 757-7878 Administrative
(903) 757-9308 Hotline
(800) 441-5555 Hotline
(903) 757-8798 Fax

LUBBOCK
Lubbock Rape Crisis Center, Inc
PO Box 2000
Lubbock, TX 79457
(806) 763-3232 Administrative
(806) 763-7273 Administrative
(806) 763-1801 Fax

MARBLE FALLS
Family Crisis Center
PO Box 805
Marble Falls, TX 78654
(830) 693-3656 Administrative
(830) 693-5600 Hotline
(800) 664-3574 Hotline
(830) 693-5624 Fax

MCALLEN
Women Together
420 North 21st Street
Mc Allen, TX 78501
(956) 630-4878 Administrative
(800) 580-4879 Hotline
(956) 687-4715 Fax

MIDLAND
Midland Rape Crisis Center
PO Box 10081
Midland, TX 79702
(915) 682-7278 Administrative
(915) 682-7273 Hotline
(915) 685-0108 Fax
Rapecrisis@aol.com

NEW BRAUNFELS
Comal County Women's Center
PO Box 310344
New Braunfels, TX 78131-0344
(830) 620-7520 Administrative
(830) 620-4357 Hotline
(800) 434-8013 Hotline
(830) 625-2984 Fax
Ccwc@sat.net OR Www.sat.net.vccwc/ccwc.htm

ODESSA
Rape Crisis Center
PO Box 7741
Odessa, TX 79760
(915) 333-2527 Administrative
(915) 366-7273 Hotline
(800) 658-6779 Hotline
(915) 580-3148 Fax

PAMPA
Tralee Crisis Center
PO Box 2880
Pampa, TX 79066-2880
(806) 669-1131 Administrative
(806) 669-1788 Hotline
(800) 658-2796 Hotline
(806) 669-1137 Fax
Tralee@pan-tex.net

PARIS
Family Haven
1220 Clarksville St
Paris, TX 75460-6031
(903) 784-6901 Administrative
(903) 784-6842 Hotline
(800) 444-2836 Hotline
(903) 784-5703 Fax
Famhaven@koyote.com

PASADENA
The Bridge
PO Box 3488
Pasadena, TX 77501
(713) 472-0753 Administrative
(713) 473-2801 Hotline
(713) 472-8759 Fax

PERRYTON
Panhandle Crisis Center, Inc
PO Box 502
Perryton, TX 79070
(806) 435-5008 Administrative
(800) 753-5308 Hotline

PLAINVIEW
Hale Co Crisis Center
PO Box 326
Plainview, TX 79073-0326
(806) 293-9772 Administrative
(806) 293-7273 Hotline
(806) 293-3686 Fax

PLANO
Rape Crisis Center of Collin County, Inc
PO Box 866754
Plano, TX 75086
(972) 985-0951 Administrative
(800) 886-7273 Hotline
(972) 612-2582 Fax

RICHMOND
Shelter Outreach Solutions/ Ft Bend County Women 's Center, Inc
PO Box 183
Richmond, TX 77406-0183
(281) 342-0251 Administrative
(281) 342-4357 Hotline
(281) 342-9248 Fax

ROUND ROCK
Williamson County Crisis Center
211 Commerce #103
Round Rock, TX 78664
(512) 255-1212 Administrative/Hotline
(800) 460-7233 Hotline
(512) 248-3246 Fax

SAN ANGELO
Assault Victims Services of the Concho Valley, Inc
315 Koberlin
San Angelo, TX 76903
(915) 944-8728 Administrative
(915) 658-8888 Hotline
(915) 655-6439 Fax
Assvic@gte.net

SAN ANTONIO
The Rape Crisis Center
5835 Callaghan Rd, Ste 260
San Antonio TX 78228
(210) 521-7273 Administrative
(210) 349-7273 Hotline
(800) 656-4673 Hotline
(210) 521-7278 Fax

SAN MARCOS
Hays-Caldwell Women's Center
PO Box 234
San Marcos, TX 78667-0234
(512) 396-3404 Administrative
(512) 396-4357 Hotline
(800) 700-4292 Hotline
(512) 353-2018 Fax

SHERMAN
Crisis Center
PO Box 2112
Sherman, TX 75091-2112
(903) 893-3909 Administrative
(903) 893-5615 Hotline
(800) 259-3909 Hotline
(903) 893-0892 Fax

STEPHENVILLE
Cross Timbers
Family Services
PO Box 978
Stephenville, TX 76401
(254) 965-5516 Administrative
(254) 965-4357 Hotline
(254) 965-6774 Fax

TEXARKANA
Domestic Violence Prevention
PO Box 712
Texarkana, TX 75504-0712
(903) 794-4000 Administrative
(903) 793-4357 Hotline
(800) 876-4808 Hotline
(903) 792-2924 Fax

THE WOODLANDS
Montgomery County Women's Center
PO Box 8666
The Woodlands, TX 77387-8666
(281) 292-4155 Administrative
(888) 844-6289 Administrative
(281) 292-4338 Hotline (Spring)
(409) 441-7273 Hotline (Conroe)
(281) 292-2709 Fax

TYLER
East Texas Crisis Center
2026 Republic Dr
Tyler, TX 75701
(903) 509-2526 Administrative
(903) 595-5591 Hotline
(800) 333-0358 Hotline
(903) 509-2283 Fax

VICTORIA
Hope of South Texas
314 E Rio Grande
Victoria, TX 77901
(512) 573-5868 Administrative
(512) 573-3600 Hotline
(800) 365-7345 Hotline
(512) 573-5913 Fax
Hope@tisd.net

WACO
Advocacy Center for Crime Victims & Children
2323 Columbus
Waco, TX 76701
(254) 752-9330 Administrative
(254) 752-7233 Hotline
(888) 867-7233 Hotline
(254) 752-9655 Fax
Opendoor@eramp.net

WEBSTER
Bay Area Turning Point
PO Box 57543
Webster, TX 77598-7543
(281) 286-5133 Administrative
(281) 286-2525 Hotline
(281) 286-8687 Fax

WICHITA FALLS
First Step, Inc
PO Drawer 4085
Wichita Falls, TX 76308
(940) 723-7799 Administrative
(940) 723-1132 Fax
(800) 658-2683 Hotline
(940) 692-4494 (Shelter)
(940) 696-2040 (Shelter Fax)
Kgrundy@wf.net

Appendix VI
Sexual Assault Forensic Examination Forms

SEXUAL ASSAULT FORENSIC EXAMINATION FORM

Please print legibly. To be filled out with medical information gathered from the patient. Please inform the patient that, should the case go to court, it may be necessary to gather additional evidence at a later time. Please fill in all spaces with information or N/A.

Name: _____ DOB: _____ Sex: _____ Race:_____

Address: _____ Phone: _____

Patient Brought in By: _____ Agency or Relationship of Escort: _____

Hospital Number: _____ Law Enforcement Case Number: _____

Exam Date: _____ Beginning Time of Exam: _____

VITAL SIGNS: Time _____ Temp _____ Pulse _____ Resp _____ B/P _____

Known Allergies: _____

Current Medications: _____

HISTORY OF ASSAULT: (**Patient's description** of pertinent details of the assault) if known by patient, such as: orifice penetrated, digital penetration or use of foreign object, oral contact by assailant, oral contact by patient) _____

_____

_____

_____

_____

_____

_____

Date of Assault: _____ Time of Assault: _____ Number of Assailants _____

Prior to evidence collection, patient has:

___ Douched ___Wiped/Washed ___ Bathed ___ Showered ___ Urinated ___ Defecated
___ Vomited ___ Had Food or Drink ___ Brushed Teeth or Used Mouthwash ___Changed Clothes
___ Smoked ___ Other: _____ ___ None of the Above

At time of assault, was:

Contraceptive foam or spermicide present? ___ Yes ___ No ___ Unknown
Lubricant used by assailant? ___ Yes ___ No ___ Unknown
What kind? _____
Condom used by assailant? ___ Yes ___ No ___ Unknown
Tampon present during assault? ___ Yes ___ No ___ Unknown
Patient menstruating? ___ Yes ___ No ___ Unknown
Assailant injured during assault? ___ Yes ___ No ___ Unknown
If known, where? _____
Was there penetration? ___ Oral ___ Female Sexual Organ ___ Anus ___ Unknown
Did ejaculation occur? ___ Oral ___ Female Sexual Organ ___ Anus ___ Unknown
___ Other (specify) _____

At time of **exam**, was tampon present? ___ Yes ___ No

Menstruation at time of exam? ___ Yes ___ No

When was the patient's most recent sexual contact up to 1 week prior to the assault? _____

Race of that individual? _____

If the response is less than 48 hours, inform the patient of the possibility that bodily fluid samples may be requested from that individual at a later time.

_____

Signature of Examiner

Significant Past Medical History:
Last normal menstrual period: _____ Vaginal tampons used in the past? _____

G _____ P _____ AB _____

Contraceptives used: _____

Genital surgical procedures: _____

General Appearance: (behavior, affect)_____

_____

Body Surface Injuries: (Include all details of trauma: i.e. abrasions, bitemarks)
□ No body surface injuries noted.

_____

_____

_____

_____

_____

Body Surface Diagrams: Document injuries and observations on the attached body diagrams.

Genital Examination: Tanner Stage ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5

Labia Majora _____

Labia Minora _____

Hymen _____

Vagina _____

Cervix _____

Perineum _____

Anus _____

Penis _____

Scrotum _____

Check for Sperm: ___ Not Done ___ Positive ___ Negative Motile: ___ Yes ___ No

Genital Diagrams: Document injuries and observations on the attached genital diagrams.

Document all diagnostic tests and treatment on medical record.

Ending Time of Exam: _____

Impressions From Exam: _____

___

_____

____

_____

____

_____

____

_____

____

_____

___

_____

Signature of Examiner

EVIDENCE ITEMS INCLUDED IN KIT

___ Oral Swabs (4)
___ Oral Smear (1)
___ Vaginal Swabs (4)
___ Vaginal Smear (1)
___ Dried Body Fluids
___ Pubic Hair Combings & Comb
___ Pubic Hair Pulled Standard
___ Anal Swabs (4)
___ Anal Smear (1)

___ External Penile Swabs (2)
___ External Penile Smear (1)
___ Saliva Swabs (2)
___ Yellow Blood Tube
___ Purple Blood Tube
___ Red Blood Tube
___ Tampon, diaper, sanitary pad, sponge
___ Panties (if they fit in box)
___ Other _____

___ Fingernail Scrapings
___ Head Hair Combings & Comb
___ Head Hair Pulled Standards
___ Foreign Matter

EVIDENCE ITEMS NOT INCLUDED IN KIT

___ # of paper bags ___ Photographs ___ X-Rays (Available) ___Other _____ (Specify)

(Please list clothing or miscellaneous items)

Article	Description (tears or stains)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT FOLLOW-UP CARE/LEGAL CHECKLIST:

GYN/Medical/STD follow-up appointment recommended ___ yes ___ no
Sexual assault counseling referral given ___ yes ___ no
Written and verbal information given to patient ___ yes ___ no
Medical facility received permission to contact patient ___ by telephone ___ by mail ___ permission not obtained
Authorization for Release of Evidence to Law Enforcement Agency completed ___ yes ___ no
Law enforcement/Children's Protective Services notified if suspect child abuse ___ yes ___ no

Signature of Examiner

Printed Name of Examiner

REQUEST FOR MEDICAL FORENSIC EXAMINATION, TREATMENT, COLLECTION OF EVIDENCE, AND RELEASE OF MEDICAL RECORDS

I hereby authorize _____, a representative of _____

(Name of Examiner) (Name of Hospital)

to perform a medical forensic examination, treatment and the collection of evidence. I further permit the photographic documentation and release of copies of the complete report to the law enforcement agency.

I release _____ and its representatives from legal responsibility or liability for the release of this information.
(Name of Hospital)

_____ _____

Signature of Patient (parent or guardian) Signature of Witness

Note: If the parent or guardian is not available for signature, child may be examined for sexual abuse under Texas Family Code.

RECEIPT OF INFORMATION

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

_____ One sealed evidence kit
_____ # of sealed clothing bag(s)
_____ X-rays or copies of X-rays
_____ Photographs
_____ Other: _____

Name of person releasing articles:

_____

___
Signature Printed Name Date Time

Received by:

_____

___
Signature Printed Name Date Time

_____

___
ID Badge# Agency

AUTHORIZATION FOR EXAMINATION AND PAYMENT

I hereby authorize _____ to perform a
(Name of Hospital)

sexual assault examination and request payment for this forensic examination from the law enforcement jurisdiction to which the crime was reported.

_____ _____
Printed Name of Patient Date of Examination

Case # _____

Note: Once this form is signed, it should be sent to the law enforcement jurisdiction of authorization for payment.

_____
Law Enforcement Agency

_____
Authorized Signature of Law Enforcement Date Time

_____
Printed Name of Law Enforcement

Note: Please return this form to the hospital within 10 days. Texas Civil Statute Article 44471 requires that law enforcement agencies pay of for the evidence collection examinations in the case of reported sexual assault.

Appendix VII
Anatomical Drawings