

SEXUAL ASSAULT FORENSIC EXAMINER PROGRAM
GUIDELINES

for the
CARE OF THE SEXUAL ASSAULT PATIENT

Sexual Assault Forensic Examiner Program
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SEXUAL ASSAULT FORENSIC EXAMINER PROGRAM

The following recommendations were developed by a subcommittee of the Sexual Assault Forensic Examiner Program Advisory Board. Reviewers included Sexual Assault Forensic Examiners, emergency department physicians, sexual assault support center advocates, and prosecutors. Many thanks to all who participated in the creation of the guidelines.

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Introduction

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Sexual Assault Forensic Examiner Program Guidelines for the Care of the Sexual Assault Patient

Introduction

The care of the patient who has suffered the trauma of sexual assault or sexual abuse calls for specialized knowledge and training to appropriately meet the emotional and medical needs of the patient, while also addressing the forensic requirements of the criminal justice system. The State of Maine recognizes the importance of a timely, victim-centered medical-forensic exam. This approach can minimize the patient's trauma, may promote healing, and increases the accuracy and sensitivity of evidence collected.

For many reasons discussed below, we believe Sexual Assault Nurse/Forensic Examiners are the best providers to deliver that care. These guidelines, however, are intended not only for Sexual Assault Nurse/Forensic Examiners but also for any health care provider who may need to provide care for the sexual assault patient.

What is a Nurse/Forensic Examiner (SANE/SAFE)?

A Sexual Assault Forensic Examiner is a health care provider who has been specially trained to provide comprehensive care for the sexual assault patient, demonstrates competency in conducting a forensic exam, and has the ability to be a fact and/or expert witness in court. The majority of these providers are registered nurses with specialized training (Sexual Assault Nurse Examiners or SANEs), though physicians, nurse practitioners, and physician assistants can and do train and function as Sexual Assault Forensic Examiners (SAFEs). Any provider who cares for sexual assault patients is encouraged to obtain training.

For the simplification of discussion and to include all practicing examiners, the guidelines will use the term 'SAFE', except when referring to information specific to Registered Nurses serving in this role.

What is the need for the *Guidelines*?

The *Sexual Assault Forensic Examiner Program Guidelines for the Care of the Sexual Assault Patient* have been developed to assist health care providers throughout the state in the challenging process of caring for the sexual assault patient. The goal is to optimize care and reduce unnecessary variations in the practice of the sexual assault medical forensic examination.

These guidelines are intended as recommendations, not mandates. They do not invalidate the protocols, policies, or practices already used within hospitals and communities throughout the state. You are encouraged, however, to adopt recommendations that improve current practices and/or correct potential gaps in treatment.

This document is divided into two sections. The first is a brief section entitled *Clinical Reference Guidelines*, which offer recommendations in an outline form for easy reference. The subsequent “Annotated Guidelines” provide more in depth information and discussion, as well as additional information on Maine sexual assault laws and other topics important to the medical forensic examination.

Each of the two sections covers care of the adult and adolescent patient. Please note that the evaluation of the adult/adolescent patient is substantially different from that of the pediatric patient. The approach to the pediatric patient is discussed briefly to assist those caring for the pediatric patient, but appropriate referral is important in the care of the pediatric patient.

It is also important to recognize that both women and men are victims of sexual assault. In many ways, the care of the male patient presenting with a history of sexual assault is similar to that of the female, but issues specific to the care of the male patient need to be kept in mind. This is true also of other special populations including the elderly, the physically challenged, mentally disabled, gay, lesbian, and transgendered persons. These special considerations are addressed on pages 68-70 of the “Annotated Guidelines.”

Why is there a need for the Sexual Assault Forensic Examiner Program?

The SAFE Program began in response to the need for skilled and timely care of the sexual assault trauma patient, and the consistent and accurate collection of forensic evidence. The program provides training and technical assistance for healthcare providers in the care of patients who have suffered sexual assault, in the use of the Maine sex crimes kit for collection of evidence, and in how to be an effective witness in court. This national model utilizes an interdisciplinary, community-based approach for the dignified and compassionate care and treatment of sexual assault survivors.

**Clinical Reference
Guidelines
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CLINICAL REFERENCE GUIDELINES

SECTION I: ADULT AND ADOLESCENT PATIENTS

A. GOALS OF THE SEXUAL ASSAULT FORENSIC EXAMINATION

1. To recognize the sexual assault patient as a trauma patient with urgent needs.
2. To identify and treat injuries to the patient.
3. To follow standardized procedures for documentation of pertinent history, and collection of forensic evidence from victims of sexual assault.
4. To assess risk and offer prophylactic treatment for STDs.
5. To assess risk and offer treatment for pregnancy prevention.
6. To provide support, crisis intervention, and access to patient advocacy services.
7. To develop discharge and aftercare plans for the patient including assessment and provision for patient safety.

B. CRITERIA FOR THE SEXUAL ASSAULT FORENSIC EXAMINATION: CONSENT AND REPORTING REQUIREMENTS

1. TIMING

- a. An appropriate forensic history and physical examination should be done in all cases of sexual assault regardless of the time elapsed between the time of the assault and the examination.
- b. A forensic evidence collection kit (Maine state sex crimes kit) should be used if there is a history of sexual assault up to 5 days prior to arrival at the emergency department. [Consider a modified examination (vaginal and cervical swabs and known blood sample) up to 14 days post assault depending upon the patient history of assault.]

2. CONSENT

- a. The **patient must consent** to have a forensic examination and evidence collection in addition to the usual consent for medical evaluation and treatment. If the patient is unconscious and unable to give consent and evidence will be lost due to treatment procedures and time, it is recommended that forensic evidence be collected using an “anonymous kit” collection procedure. See page 28 in the “Annotated Guidelines” for collection of forensic evidence from the unconscious patient. See page 11, Section I, or page 28 of the “Annotated Guidelines” for “anonymous kit” collection.
- b. The patient may choose to report the assault to law enforcement, or to have an “anonymous kit” collected.

3. SEXUAL ASSAULT NURSE EXAMINER AND SCOPE OF PRACTICE IN MAINE

If a Sexual Assault Nurse Examiner (SANE) is performing the examination, the patient must be 15 years of age or older. Nurses trained subsequent to January 2007 have been trained to care for patients 13 year of aged and older, as have nurses who attended

specialized training on care of the young adolescent sexual assault patient. However, the SANE may assist and advise in care of younger patients, with direct supervision of the attending physician. This practice is encouraged.

4. MANDATED REPORTING

Guidelines for mandated reporting must also be followed in cases involving minors (any patient under the age of 18), the elderly, autistic, and mentally retarded adults. See detailed discussion of these populations in the “Annotated Guidelines,” pages 69, 70 and Appendix D, Maine laws applicable to the medical forensic exam.

C. INTAKE

1. TRIAGE

The triage nurse should obtain basic information from the patient and avoid further in-depth questioning. Information should include:

- date and time of the assault
- location of the assault (i.e. city or town)
- whether law enforcement has been notified, and, if not, if patient desires law enforcement be notified

2. ASSESS FOR INJURIES OR ACUTE MEDICAL PROBLEMS

Complete triage for physical injuries or any urgent medical needs and provide medical intervention by an emergency department practitioner as needed or if requested by the patient. Strangulation is commonly used by sex offenders as a way to immobilize the victim. It is therefore, important to always assess the patient for signs and symptoms of strangulation and to document any findings. For more information on strangulation injury see page 62.

3. AVOID LOSS OF EVIDENCE

- a. Remain sensitive to the need for preservation of evidence while attending to initial urgent medical needs.
- b. Instruct the patient to not eat, drink, smoke, urinate or defecate if at all possible. Information should be provided to the patient that by not complying with these instructions, evidence can be lost. If patient must urinate, collect a specimen for pregnancy testing and/or drug testing if there is suspicion of drug facilitated sexual assault. Maintain chain of custody of the specimen. Instruct the patient not to wipe or wash before or after urinating.

4. CALL IN RESOURCES

- a. Call in the SAFE. Examiner should be a SAFE if at all possible. Otherwise the provider in the emergency department most experienced with treatment of sexual assault should provide the care.
- b. Contact the Sexual Assault Support Advocate.
- c. Contact the appropriate law enforcement agency if desired by the patient.
- d. Contact any family members or friends as the patient desires.

5. PROTECT PRIVACY, COMFORT, AND CONFIDENTIALITY

- a. Place the patient in a private location or exam room as soon as possible.
- b. Allow the patient to remain fully clothed.
- c. Keep the patient informed regarding the expected arrival of the examiner, sexual assault advocate, and law enforcement officer.

D. EXAMINER'S INITIAL CONTACT WITH PATIENT

ESTABLISH RAPPORT. INTRODUCE THE ROLE OF THE SEXUAL ASSAULT FORENSIC EXAMINER.

1. Examiner should introduce self and discuss the examiner's role in the patient's care.
2. Explain carefully:
 - a. The purpose and components of the examination.
 - b. That other medical concerns, including STD treatment and pregnancy prophylaxis will also be addressed during the assessment.
 - c. The patient's ability to consent to or decline any portion of the exam (as well as the potential impact that declining a given procedure could have on the completeness of the evidence collection).
 - d. The availability of an anonymous forensic evidence collection if the patient has not yet decided to report the assault to law enforcement, and that the evidence will be stored for at least 90 days by law enforcement.
3. Inform the patient that costs of the medical/forensic examination done utilizing the Maine sex crimes kit will be covered by the Victims' Compensation Fund. This includes STI treatment and pregnancy prophylaxis.
4. Fully discuss issues of informed consent with the patient and complete "Informed Consent" forms.

E. HISTORY AND DOCUMENTATION

1. RELEVANT LEGAL CONCERNS

- a. Information given to health care providers for the purposes of medical diagnosis and treatment is not subject to the medical exemption to the hearsay rule (Appendix D). Record the history in the patient's own words, using direct quotations as much as possible.
- b. It is important to identify and document relevant items of the history and examination that speak to any use of compulsion which is "the use of physical force, a threat to use physical force, or a combination thereof that makes a person unable to physically repel the actor, or produces in that person a reasonable fear that death, serious bodily injury, or kidnapping might be imminently inflicted upon that person or another human being" (17-A M.R.S.A. § 251(1)(E)). This documentation is important for medical forensic diagnosis and treatment. See discussion in "Annotated Guidelines," pages 34-35.

2. GENERAL PRINCIPLES

- a. Obtain history in a private, quiet setting. Ideally, limit people in the examination room to the patient, the forensic examiner, sexual assault support center advocate, and other essential medical personnel as needed.
- b. Avoid repetitive questioning when possible. For example, limit history taken at triage desk to essential information as above (on page 4, C. 1. and page 29, “Annotated Guidelines”). Ask questions in words the patient understands. Ask open-ended questions; avoid leading questions.
- c. With the adolescent or developmentally delayed adult, use special caution to avoid leading questions or vague language. Identify how the patient refers to body parts and use that language.
- d. It is advised that each institution have a standard sexual assault forensic medical documentation form for the forensic history and examination (see example attached in Appendix B). **The triplicate Patient History and Inventory forms in the Maine state sex crimes kit must also be completed.** One copy goes into the medical record, one to law enforcement if the patient is reporting the assault, and the other into the kit for the crime lab.
- e. Essential components of the history of assault include all of the below.

Note: Much of this history can be collected with the assistance of the forms in the Sexual Assault Forensic Examination Record and the Maine state sex crimes kit, but do be sure to include a narrative history with the use of direct quotations, as discussed above.

- Date and time of assault
- Place of assault
- Physical surroundings (inside, outside, woods, beach, car, room, rug, dirt, mud, grass, etc.)
- Number of assailants
- Description of the assailant(s)
- Description of the sexual acts demanded and/or performed including presence or absence of vaginal contact, anal contact, oral contact with genitals or anus, non genital contact (licking, kissing, biting, suction injury)
- Contact, penetration or attempted penetration by penis, finger, mouth, tongue, or object and at what site (oral, vaginal, anal)
- Whether ejaculation occurred, if known, and at what location
- Whether lubricants were used
- Whether condom was used
- Whether injuries were sustained during assault, and where
- Whether patient was strangled
- Whether there was use of threats, restraints and/or other physical coercion
- Whether there was use of weapons and, if so, what type
- Whether patient has experienced pain or other medical symptoms since assault
- Whether the assailant was injured during the assault
- Whether there was known or suspected involuntary ingestion of alcohol/drugs
- Whether there was known or suspected involuntary ingestion of alcohol/drugs
- Whether patient experienced loss of consciousness or memory loss

- f. History of post-assault activities of patient should include whether patient has:

- Urinated
- Defecated
- Vomited
- Douched
- Used sanitary pad/tampon
- Brushed teeth, gargled, rinsed, or flossed
- Eaten or had anything to drink
- Washed/bathed/showered
- Changed clothing
- Smoked
- Combed or brushed hair

g. Medical history should include:

- Menstrual history, including last menstrual period
- Pregnancy(ies); vaginal delivery(ies)
- Recent injuries (anal/genital/other) from other sources/events
- Known or possible current pregnancy
- Current use of birth control
- Recent consensual sexual activity (within 72 hours)
- Medication allergies
- Tetanus and Hepatitis B immunization status
- Current medications (include over the counter medications)
- History of constipation, diarrhea, rectal bleeding at any time; other chronic rectal/anal problems; rectal pain preceding the assault
- History of constipation, diarrhea, rectal bleeding at any time; other chronic rectal/anal problems; rectal pain preceding the assault
- Other relevant past medical history and/or surgeries

F. EXAMINATION

GENERAL PRINCIPLES

1. As during the history, limit the number of people in the examination room to the patient, the forensic examiner, sexual assault support center advocate, and other essential medical personnel, as needed. **There is no medical or legal reason for a law enforcement officer or detective to be present during the forensic history taking or to observe the examination, and they should not be present. If the patient requests the presence of a friend and/or family member, these requests should be honored if possible once the potential drawbacks to this are discussed privately with the patient.** These drawbacks include: the potential risk of cross contamination of the evidence in a crowded room, the patient feeling unable to speak freely regarding assault details, and/or the risk that the friend/family member could be called as a witness should the case go to trial. Suggest that the friend/family member leave the exam room during history-taking.
2. Use only the state approved Maine state sex crimes kit. Other materials may be helpful/required. These items are listed in the “Annotated Guidelines” on page 38.
3. Maintain chain of custody. **The examiner should have physical possession of the kit/evidence at all times. Never leave the kit unattended.**
4. Use powder-free gloves throughout the examination, changing gloves frequently and whenever the potential for cross contamination exists.

5. Allow all samples to fully air dry in an appropriate rack (expect a minimum of **one hour** for full drying).
6. Never use heat to dry specimens.
7. Never lick an envelope to seal. All envelopes in the sex crimes kit are self-sealing.
8. Smears are being eliminated from the sex crimes kit. While smears remain in the kits in use at the time of the writing of the guidelines, there is no need to do smears. New kits will not have smears.
9. In general, **complete all segments of the examination unless not indicated or declined by the patient. Always document the reason the specimen was not collected.**
10. Return all components of the kit to the kit box, whether used or not. (If no collection made, indicate that on the appropriate envelope). Place unused items in the plastic bag provided marked “Unused Components.” Place plastic bag in the kit; if there is not space in the kit, put it in the transport bag with the clothing and indicate that you have done so on the kit paperwork. Clothing and additional items should be placed in transport bag.
11. For tracking purposes, each kit is assigned a unique tracking number and contains a group of labels printed with that number. One label should go on each component of the kit that is collected for chain of custody purposes; a label should be placed in the patient’s medical record.
12. Use the bags/containers provided in the kit. **If additional evidence bags are required, use only clean, unused paper bags or clean white envelopes, not plastic.** Close evidence bags with tape. **Do not staple.**
13. Wet evidence should be air dried before packing. If clothing evidence is wet and cannot be fully dried, report this to law enforcement when evidence is picked up.
14. Use non-preserved, sterile water/distilled water, **not saline** to moisten swabs.
15. Be sure that the suspected **source** of all collected specimens is noted on the collection envelope when relevant (e.g.: in the collection of dried secretions it is important for the lab to know if the specimen is suspected saliva or suspected semen).

G. MEDICAL EXAMINATION AND EVIDENCE COLLECTION

INTEGRATE THE MEDICAL AND FORENSIC EXAM

- a. Take the comfort of the patient into consideration when determining the order of the exam.
- b. Conduct parallel physical and forensic exams.

A “head to toe” physical assessment should be completed in parallel with the forensic evidence collection. The physical assessment should include:

- Head to toe palpation of all body surfaces and observation for potential injuries.
- Skin survey.
- Genital and anal exams.
- Vaginal exam using a speculum (unless injuries or patient age or condition prohibit). A bi-manual exam should not be done unless clinically indicated; must be done only by a physician or advanced practice provider.

- c. Be cautious to avoid disturbing forensic evidence during the examination prior to collection (e.g. collect forensic evidence by swabbing prior to palpation).
- d. Ongoing consent. The patient should receive an explanation of each component of the examination and have the option to decline any portion of the examination once the potential consequences of failing to collect that evidence are discussed fully with her/him.
- e. The general components of forensic evidence collection are listed below. **Detailed instructions for each step are found in the “Annotated Guidelines.”**

Components of the forensic examination and collection of evidence include:

- | | |
|--|---------------------------------------|
| 1. Oral swabs | 8. Fingernail Clippings/Swabblings |
| 2. Nasal swabs | 9. Known Blood Collection |
| 3. Debris Collection | 10. Pubic Combing |
| 4. Clothing and Foreign Material Collection | 11. Known Pubic Hair Sample |
| 5. Skin Surface Assessment | 12. Genital/Penile Swabblings |
| 6. Dried Secretions Collection (See below (f) for double swab method of collection of dried secretions) | 13. Genital Examination |
| 7. Known Head Hair Sample | 14. Vaginal Swabs |
| | 15. Cervical Swabs |
| | 16. Anal External Exam |
| | 17. Anal Swabs |
| | 18. Miscellaneous Evidence Collection |

- f. **Double Swab Technique:** With the collection of dried secretions it is helpful to use a **double swab method**. Open a swab packet and moisten two swabs using sterile, distilled water. Use approximately two drops on each swab. Thoroughly swab the area with both swabs using moderate pressure and a circular motion, swabbing from the periphery to the center. Re-swab the area with two additional dry swabs, using similar pressure and movements as the first swabs. The dry tip is rotated over the skin to recover the remaining moisture. Roll over the entire area to ensure all moisture is recovered.

Air dry the two pair of swabs and package each pair separately in the swab boxes provided in the kit.

H. URINE, BLOOD AND EMESIS SPECIMEN COLLECTIONS

1. WHEN TO COLLECT

If the patient presents with drowsiness, memory loss, impaired motor skills, etc., or there is other reason to suspect “rape drug” use, the patient should be asked for consent to have blood and/or urine samples collected for identification of “rape drugs.” In cases of adults, do not collect blood or urine samples if there is no clinical indication for alcohol or drug testing.

2. MINORS

In the case of a minor, if there is any history or clinical suspicion of alcohol or drugs being provided, alcohol and drug levels should be obtained. (If assault cannot be proven, the provision of alcohol/drugs itself is a crime that may be prosecuted and thus requires forensic testing).

3. TIMING

Collect a urine specimen if suspected ingestion is within the preceding 96 hours. If within the preceding 24 hours, collect both blood and urine specimens. If the patient vomits and it has been less than four (4) hours since ingestion, the emesis should be collected in a sterile collection cup. If the emesis is a dried stain (i.e., vomitus on clothing), the stained item should be sent to the lab for testing.

4. METHOD OF COLLECTION

Urine: Using the urine container provided or a sterile hospital urine container, collect at least 100ml of urine. Label the jar with the patient's name. Seal with evidence tape and place in the zip lock bag and close. Place the zip lock in the "Urine Collection" bag. Seal the bag, attach a tracking label and fill out the information requested. Be sure to note **the date and time the specimen was collected and estimated time of drug ingestion.**

Blood: Using two 10 ml **or** five 4ml gray topped (potassium oxalate and sodium fluoride) blood collection tubes, withdraw a sample from the patient allowing blood tube to fill to maximum volume. Label the blood tubes with the patient's name; place the tubes in the enclosed bubble pack; seal. Place the bubble pack in the "Blood Collection" paper bag. Seal the bag, attach a tracking label, and fill out **all information** requested. **Be sure to note the date and time the specimen was collected and estimated time of drug ingestion.**

Emesis: If the patient vomits, and it has been less than four (4) hours since ingestion of drugs, the emesis should be collected in a sterile collection cup. Collect in a urine container, label, attach tracking label and fill out all information requested. **Be sure to note the date and time the specimen was collected and estimated time of drug ingestion.** If the emesis is a dried stain (i.e., vomitus on clothing), then the stained item should be sent to the lab for testing.

5. TRANSPORT

Chain of custody must be maintained.

Urine: The urine should be packaged separately from the sex crimes kit and turned over to law enforcement with maintenance of the appropriate chain of custody. Be sure that law enforcement is aware that if the evidence will not be immediately transported to the Health and Environmental Testing Lab, the urine should be **frozen**. Otherwise, the specimen should be refrigerated.

Blood: The blood specimen should be packaged separately from the sex crimes kit and turned over to law enforcement with maintenance of the appropriate chain of custody. Tell law enforcement that if the blood will not be immediately transported to the Health and Environmental Testing Lab in Augusta, the blood should be kept refrigerated (not frozen) until later transport. **Do not freeze blood tubes, they could explode.**

Emesis: Emesis should be packaged separately from the sex crimes kit, and turned over to law enforcement. Tell law enforcement to freeze the specimen, if possible. Otherwise, refrigerate the specimen if the emesis will not be immediately transported to Health and Environmental Testing Lab in Augusta.

All specimens should be sealed with evidence tape or hospital tape. Write your name and the date across the tape and onto the container.

I. PACKAGING OF EVIDENCE, CHAIN OF CUSTODY, AND DISPOSITION OF KIT

1. Follow the instructions in the Maine state sex crimes kit for packaging of materials.
2. Attach a tracking label to each envelope/bag obtained and fill out all information requested.
3. Tape bags closed; do not staple. Place initials across tape.
4. Return all envelopes to the kit, marking unused envelopes and bags in a way to denote that no sample was collected.
5. Seal the kit with the enclosed “Evidence” seals and initial, partially on/partially off the seal. (If evidence tape tears, any tape may be used to secure the kit.)
6. Complete the Evidence Collection Inventory Sheet from the sex crimes kit.
7. Fill out all information requested on the kit box top UNLESS the kit is anonymous (patient not reporting to law enforcement at this time). For “anonymous kits,” place only the tracking number on the outside of the kit.
8. If the patient has chosen to not report and have the kit collected anonymously, be sure to attach a tracking label to the “Patient Card” in the kit, fill in the number of the law enforcement agency taking possession of the kit, and give it to the patient prior to discharge. This card reviews the patient’s options regarding future reporting to law enforcement. Be sure there is also a record of the patient’s tracking number on the Sexual Assault Forensic Medical Examination Report form in the hospital.
9. To preserve chain of custody, the examiner cannot let the kit out of his/her control until the materials are turned over to law enforcement.
 - a. If the case is **reported** to law enforcement the materials go to the investigating officer from the **location of the assault**.
 - b. If the case is “**anonymous**” the materials go to the law enforcement agency in the town, city, or county **where the hospital is located**.

J. MEDICAL TREATMENT

The following are **brief summaries** of recommended medical treatments. Please refer to the “Annotated Guidelines” for fuller discussion (pages 51-62).

1. Pregnancy Prophylaxis

- The availability of pregnancy prophylaxis should be discussed with each patient of child bearing capacity and, unless the patient is currently using a reliable method of birth control, treatment should be offered.
- Current evidence favors use of Plan B (Levonorgestrel 0.75 mg.) in a combined dose of two tablets (total of 1.5 mg.), taken together at the time of the medical/forensic exam. (Some hospital pharmacies stock Levonorgestrel 1.5 mg.)
- Treatment should be initiated as soon as possible following the assault, but may be effective up to **five days** post assault.
- Pregnancy testing is not medically required for the purpose of pregnancy prophylaxis, but is advised to assess for possible pregnancy predating the assault.

2. **Sexually Transmitted Disease (STD) Prophylaxis** should be offered. Testing for STD's is controversial, but there are strong arguments for proceeding with STD prophylaxis without testing at the time of the initial assessment, and doing STD testing only when clinically indicated for other reasons. Further discussion of this topic and current recommendations for STD prophylaxis can be found in the expanded guidelines (pages 54-62).

The following is a brief summary of treatment guidelines. Please refer to the full discussion in the "Annotated Guidelines."

Gonorrhea

Ceftriaxone 250 mg. IM

OR

Oral Alternatives

Cefixime 400 mg. (Suprax[®])

OR

Ciprofloxacin 500 mg. po in a single dose

(If a serious cephalosporin allergy exists, Cipro might be considered, but the need for follow up testing would need to be emphasized. Because of the emergence of Fluoroquinolone resistance, this is no longer a recommended alternative. For more information about Fluoroquinolone resistance, see page 54.

Chlamydia

Azithromycin 1 gram po in a single dose

OR

Alternative for macrolide antibiotic allergy:

Doxycycline 100 mg. po bid for 7 days.

Bacterial Vaginosis and Trichomoniasis

Metronidazole 2 grams po in a single dose

(Consider delayed treatment. Do not use with recent alcohol ingestion.)

3. **Hepatitis B** vaccination status should be assessed and vaccination series initiated if the patient is unvaccinated.
4. **Genital Herpes** symptoms should be discussed and the patient should be instructed to see their PCP or return for antiviral treatment if symptoms arise.
5. **Syphilis:** Ceftriaxone in the 250 mg. dose may be effective for incubating syphilis. Follow up medical care, including syphilis serology, should be recommended to the patient.
6. The need for **HIV prophylaxis** should be evaluated and recommendations for HIV testing should be discussed with the patient. See the discussion in the "Annotated Guidelines," page 56.
7. **Follow up care** post assault should be encouraged with a primary care physician or Family Planning/Planned Parenthood two to four weeks following the medical forensic examination. Encourage the patient to bring her/his discharge instructions to the follow-up appointment.

K. DISCHARGE PLANNING

1. At the time of discharge the patient should be provided with oral and written discharge instructions. This information should be tailored to the patient's communication skill level and language.
2. If the sex crimes kit is being collected anonymously, remind the patient that law enforcement must hold the kit for at least 90 days. After the 90 days the kit may be discarded. Be sure the patient has the contact information on the card provided in the kit. Let the patient know that some law enforcement agencies keep kits for longer periods of time. A patient can report the crime at any time in their life. If the patient is reluctant to report, remind her/him that the sexual assault support center can assist with the process of reporting.
3. Working with the patient to create a safety plan is a priority. Discuss transportation options to a safe place. The sexual assault advocate can assist in safety planning.
4. Other discharge planning information might include referrals to health care providers for follow-up medical care or mental health needs related to the assault; referral to local sexual assault support center; instruction regarding medications prescribed.
5. In addition to medical follow up, there may be a need to document developing or healing injuries as well as resolution of healing. This documentation is best done by the health care provider who did the initial examination. If this is not possible then this documentation should be done by the patient's primary care provider or other health care provider such as Family Planning or Planned Parenthood.
6. Coordinating patient discharge needs with the sexual assault advocate and law enforcement (if appropriate) can be helpful. See "Annotated Guidelines," page 63.

L. PHOTODOCUMENTATION

Photographs are legally part of the hospital medical record; photographs or copies should not be given to law enforcement or the District Attorney's office without a signed patient consent, or a subpoena. It is recommended that a digital, single lens reflex camera with a good macro lens, ring flash and ring light (for internal photos) be used. Photos can be burned onto a CD or saved on a memory card and stored with the patient's sexual assault medical record.

1. Taking photographs of patient injuries should be routine, with patient consent.
2. Ideally, photos should be taken by the forensic examiner.
3. Explain the purpose of the photos, the extent and approximate number that will be taken, procedures to be used, uses of photographs during investigation and prosecution, who may see the photos, and the need for possible follow-up photos.
4. Photos can be taken at any time during the medical-forensic exam and as injuries are observed.
5. Always create a link between the patient and the photographs. Having a full frontal photo of the clothed patient and one of the patient's face is good practice. Photos need to be clear and framed appropriately using anatomical landmarks whenever possible. Use an inch/centimeter scale or ruler for size; do not use scale in all photos of the

injury. Take at least two to three photos of each injury – one from a distance with body landmarks, one closer, and one quite close. More photos are better than too few. Do not delete photos.

6. Follow-up photos are an important part of the medical record, as they document emerging/evolving injuries as well as healing/resolving injuries. If possible, follow-up photos should be taken by the examiner who cared for the patient. If this is not possible, local law enforcement can take follow-up photos of all but ano-genital injuries.

M. DOCUMENTATION

1. Documentation should be performed using the forms in the state sex crimes kit (Patient Assault Information and Evidence Collection Inventory) and the hospital Sexual Assault Medical Forensic Examination documentation forms (see suggested forms in Appendix B).
2. The two sex crimes kit documentation forms are in triplicate. Copies of the two pages of the Maine state sex crimes kit clinical forms (patient assault information and inventory forms) should be included with the hospital documentation record. The other two copies of these forms should be distributed as directed on the bottom of the triplicate forms to law enforcement and the State Crime Lab.
3. It is recommended that the hospital Sexual Assault Medical Forensic Examination medical record, including photographs, be kept in a separate, locked location in the medical records department. The remainder of the medical record from that visit (for example, the emergency department medical record and labs) should be stored in medical records per usual protocol. If all medical records are computerized it is recommended that access to the sexual assault medical record be limited.

N. BILLING

State law requires that hospitals and other providers of services for sexual assault medical/forensic examinations bill the Victims' Compensation Program directly for services related to the forensic examination and medical treatment relevant to the assault (such as pregnancy and STD prophylaxis). **DO NOT place Victims' Compensation Program paperwork in the sex crimes kit;** rather, follow hospital policy regarding billing. See details in Annotated Guidelines, page 67.

O. QUALITY IMPROVEMENT

Health care providers involved in the SAFE Program should have mechanisms to ensure that the quality of their response to patients is optimal. This can include on-going training and education, supervision, peer chart review, and case review. In addition, it is important that SAFEs obtain feedback and solicit dialogue from other disciplines that work with sexual assault victims including law enforcement, sexual assault support center advocates, prosecutors, victim advocates and others involved in the local Sexual Assault Response Team (SART).

Pediatric Tab

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SECTION II: PEDIATRIC PATIENTS

Evaluation of sexual abuse/assault in pediatric patients requires a significantly revised approach. Some general principles, however, will be covered below to give initial assistance when a pediatric patient presents with a complaint of sexual abuse/assault.

In general, unless the health facility at which the child presents has trained pediatric forensic interviewers and specially trained experienced pediatric forensic examiners, the medical interview and necessary initial examination should be followed by a forensic interview and pediatric forensic evaluation at a qualified facility or by Child Protective Services (CPS) or Law Enforcement.

Pediatric forensic interviews are comprehensive interviews that follow established protocols. They are time consuming, require a specially trained interviewer, and are outside the scope of the pediatric sexual abuse/assault evaluation in the emergency department or other health care facility. Repeated interviews of a child may not only be stressful for a child victim, but may contaminate the forensic interviews.

Any questioning of the child should be limited to that necessary for the immediate medical assessment and treatment and should follow the guidelines below.

A. ALL HEALTH CARE PROVIDERS ARE MANDATED REPORTERS.

Details of the Mandated Reporting requirements are in the “Annotated Guidelines,” page 29, and in Appendix D. This includes discussion of the challenges regarding consent and mandated reporting that can arise in treating the adolescent patient. When reporting:

1. **Notify Child Protective Services (CPS) for any suspected abuse;** CPS will determine if an investigation is needed. The Central Intake phone number for all reports is **1-800-452-1999**.
2. Notify the District Attorney’s office in the town/region that the reported incident occurred (see DA telephone numbers in Appendix C).

B. USE AVAILABLE RESOURCES

Suspected child abuse cases are fraught with difficulties. Strongly consider contacting a specialist to discuss the best management of the case and to arrange referral for a specialized pediatric forensic examination.

- Spurwink Child Abuse Clinic phone consultation is available 24 hours a day at 1-800-260-6160.
- Sexual assault support center advocates are available 24 hours a day for both the patient and the parent or caregiver.

C. HISTORY

1. In addition to the presenting history, it is important to obtain a medical, developmental, and social history.
2. **Always get the history from the accompanying adult without the child present.** Neither the triage nurse nor any subsequent providers should obtain a history from the parent (or other accompanying adult) with the child present.
3. The child should be interviewed only if there are medical findings of blunt penetrating trauma on the examination and the clinician feels a medical interview is necessary to establish mechanism of trauma. The pediatric medical interview would therefore follow the examination, and is covered in I., page 19.
4. If a child makes a statement in your presence, record it verbatim.

D. PEDIATRIC EXAM - GENERAL PRINCIPLES

1. **ABOVE ALL, DO NO HARM.**
2. Take time to establish rapport.
3. A vaginal exam is never indicated in the prepubertal female unless unidentified bleeding and trauma are present, and then it should be performed under anesthesia by a specialist. Use your own judgment - consult with the Spurwink Child Abuse Clinic or with the ED physician when considering a vaginal examination on a young adolescent female who has started menstruating.
4. Have a supportive adult available in the room during the exam. Under no circumstances should a possible perpetrator be allowed in the room during evaluation.
5. A speculum **does not** aid in visualization of the hymen and **should not be used** in prepubescent girls.
6. The sexual abuse examination of a child consists of visualization of the external anogenital structures and in girls the hymen, and does not require a speculum or insertion of any other instrument into the vagina.
7. Do not restrain an older child. If an older child is uncooperative, or refuses to be examined, and the examination is critical, consider consultation with a pediatric forensic specialist for emergent referral and examination. **DO NOT** anesthetize an uncooperative child.
8. Digital-anal and anoscopic examinations are **never** indicated.
9. The hymen of a prepubescent child is sensitive and non elastic and should **not** be touched or penetrated with anything, including a swab, speculum, or finger.

E. PEDIATRIC EXAM - WHO TO EXAMINE

1. **Non-acute sexual abuse evaluations do not belong in the emergency department.**
2. If the examiner is uncertain whether forensic evidence collection is indicated, please call the Spurwink Child Abuse Program for advice at 1-800-260-6160.

3. Not all children who present with a concern of sexual abuse need to have forensic evidence collection. Most children require only a brief screening examination to assess for evidence of acute, blunt, penetrating trauma. The mechanism of abuse with children may not involve penetration, contact or ejaculation.
4. If there is not a question of sexual contact within the preceding 72 hours there is time to consider a referral to a **pediatric forensic specialist**. A screening exam for trauma including a complete skin survey and external genital and anal inspections is appropriate.
5. The American Academy of Pediatrics recommends forensic evidence collection if there has been a suspected sexual assault in the previous 72 hours. However, studies suggest that forensic evidence is not likely to be found on the child if the assault is greater than 24 hours old. Over 90% of children with positive forensic evidence were seen within 24 hours. The majority (95%) of evidence was found on clothing and linens. After 24 hours, except for one pubic hair, all evidence was recovered from clothing/linens. No swabs were positive for blood after 13 hours, or for semen/sperm after 9 hours (Christian, et al., *Pediatrics*, July 2000).
6. Forensic evidence collection is not indicated when inappropriate sexual behavior/contact occurs between prepubescent children.

F. PEDIATRIC FORENSIC EXAMINATION -- MODIFIED FROM THE ADULT EXAM

1. In general, avoid invasive procedures in children.
2. Collect oral swabs only if there is a history of very recent oral contact.
3. Do not do nasal swab collection or nasal mucous sample.
4. Do not collect fingernail clippings or scrapings on very young children.
5. Unless blood is otherwise being drawn for medical purposes, do not obtain the known blood collection. This can be collected at a later date, if needed. If appropriate, collect a buccal swab.
6. Do not collect the known head hair sample.
7. **DO** collect clothing and tell law enforcement to get appropriate clothing/linens from home (see E.5. above).
8. In place of collecting pubic hair combings, carefully examine the thighs and external genitalia for any loose hair or fibers. If found, collect and package in the miscellaneous collection envelope. Label appropriately.

G. PEDIATRIC EXAMINATION

Prior to initiating a genital examination, the child should have a head to toe screening examination for signs of physical abuse and neglect.

H. PEDIATRIC GENITAL EXAMINATION

1. The Prepubescent Female and/or Young Adolescent Female
 - a. After external genital inspection, the labia minora are visualized using gentle labial separation. The hymen is then visualized using labial traction. This is done by gently grasping the labia majora and pulling gently outward and downward.

- b. The vaginal mucosa in a prepubescent child is extremely sensitive.
- c. Use damp swabs to wipe the external genitalia, inner folds of the labia majora and inner labia minora, and perineal area, **EXTERNAL** to the hymen. Do not insert swabs into the vagina of a prepubescent girl. This is painful for the child and can cause iatrogenic trauma. Dry the swabs and package in the “external genitalia/penile” envelope of the kit.
- d. A speculum (of any sort) should **never** be used on a prepubescent girl.
- e. If a source of bleeding or the extent of intravaginal trauma in an acute assault cannot be determined, or if a foreign body may be present, immediate referral to a specialist, such as a gynecologist or pediatric surgeon, for examination and evidence collection under anesthesia and if possible surgical repair is indicated.
- f. Positioning:
 - i. Younger children may be examined facing outward on a parent’s lap either on the exam table or on a chair.
 - ii. Labial traction, applied by grasping the labia majora and gently pulling out and down, will allow the examiner to visualize the hymen and surrounding structures.
 - iii. Any suspected hymenal defect should be visualized with the child in both a supine frog leg and prone knee chest position to confirm its presence.
 - iv. Anal examination can be done in a supine knee chest position while applying gentle buttocks traction.

2. Prepubescent Male/Young Adolescent Male

- a. Position the boy in either a semi-recumbent or supine position.
- b. Inspect the genital area.
 - i. In the circumcised child, inspect the glans, urethra, penile shaft, testes and scrotum.
 - ii. In the uncircumcised child, inspect the foreskin, penile shaft, testes and scrotum. If the foreskin easily retracts, inspect the glans and urethra. **Never forcibly retract the foreskin**. This could potentially cause trauma with resulting medical complications.
 - iii. With the child supine, bring the knees up so that he is in a knee chest position, and inspect the underside of the scrotum and the perineum.
- c. Use damp swabs to gently wipe around the penis, including the base of the penis. Dry and place in the appropriate envelope. **Never insert a swab into the urethra**.
- d. Swab the perineum and perianal areas. Dry and put in the appropriate envelope.

Never do a digital-anal, or anoscopic exam on a child during a sexual abuse examination!

I. MEDICAL INTERVIEW OF THE CHILD

It is preferable that children not be interviewed in the emergency department. However, should a medical interview be necessary it should be guided by the recommendations below. Any interview should be a focused medical interview. “Focused” means that the medical interview will only cover such matters or issues necessary to explain the physical findings and not include peripheral details such as location of the incident(s), clothing, or threats, etc. Document any statements from the child including those that may be outside the ‘focused’ medical interview.

1. Criteria for the Focused Medical Interview

- The medical interview of the child is conducted to help establish mechanism of trauma, and need for medical treatment only if there are positive physical findings of blunt penetrating trauma (gross bleeding and submucosal hemorrhage) on physical examination.
- A medical interview is not indicated in suspected sexually transmitted diseases or suspected nonacute sexual abuse.
- Use particular caution interviewing young, non-developmentally delayed children. If in doubt, call the Spurwink Child Abuse Program Forensic Examiner at 1-800-260-6160.

2. General Principles of the Medical Interview

- Only the examiner should question the child. This avoids confusing the child and maintains the integrity of the medical history.
- The parent/accompanying adult should not be present during the interview.
- Use the child’s own language, including their own terms for body parts and description of events.
- Limit questions to those required to establish possible mechanism of injury.
- Verbatim questions and answers should be documented, with the use of quotation marks.
- If the child makes a spontaneous statement, record it verbatim in the medical record.

3. Questions

Questions should be general, open-ended, and non-leading. Some examples include:

- Ask the child to tell you his/her name for body parts, for example:
 - “What do you call these?” and point to the child’s breast.
 - “What do you call the place where pee comes from?”
 - “What do you call the place where poop comes from?”
 - “What do you call the place where a boy’s pee comes from?” (if you are talking to a girl).

- “Do you know why you are here?”

For a negative response, you can progress to:

“Has anything happened to you that you didn’t like?”

“Has someone ever done anything to you that you didn’t like?”

For a positive response, ask the child to tell you about it.

For a nonspecific response like, “I was abused, molested, had sex or was raped,” say something like: “These words can mean different things to different people. When you were _____, what happened?”

- If you need to move toward a more directive question, you can ask: “Were any of your body parts involved?”

For an affirmative response, ask the child to tell you which body parts.

- You can ask who did this to her/him. Ask, “When _____ (restate what the child said), what body parts of _____ were involved?” “Tell me what happened.”
- Ask if _____ touched any other body parts.

4. When **NOT** to Question a Child

If the child is too scared, too traumatized physically or emotionally, or is developmentally unable to answer these question, do not question the child. Do not do repeated interviews. This can confuse a young child.

J. PEDIATRIC EXAM: SEXUALLY TRANSMITTED DISEASES

1. Studies for sexually transmitted diseases should be done if there are findings suggestive of infection, such as discharge, or if there is evidence of another sexually transmitted disease.
2. There is no need to do vaginal cultures for Gonorrhea and Chlamydia. Urine NAAT (nucleic acid amplification test) testing is now used for screening for Gonorrhea and Chlamydia. The specimen **must be a full voided specimen, not a clean catch**. If screen is positive, the child needs to be referred for full pediatric forensic evaluation and cultures.
3. If vesicles are present, herpes culture and typing should be done. Specify on laboratory request form that this is a pediatric case. If the culture is herpes positive, type specific identification testing MUST be done.
4. If there is evidence of perianal infection in either girls or boys, anal cultures for Gonorrhea, Chlamydia and a bacterial culture should be obtained.
5. Urethral cultures in boys are not indicated in the absence of discharge. (Smegma is not a discharge.)
6. If there is evidence of acute blunt penetration by unknown or multiple perpetrators, HIV testing and prophylaxis is indicated after consultation with a Pediatric Infectious Disease specialist (contact hospital ID specialist). HIV prophylaxis must be initiated as soon as possible **within 72 hours** of assault, and after baseline HIV testing and other appropriate bloodwork is done.

7. Prophylactic antibiotics are usually not indicated in prepubescent children unless there is significant trauma requiring surgical repair.
8. If questions, call for consult with Spurwink Child Abuse Program at 1-800-260-6160.

K. DOCUMENTATION

1. Be cautious with use of terminology.
2. The absence of specific findings does not indicate that abuse did not occur. Current research supports diagnostic findings in a minority of children who present with concerns of sexual assault/abuse. Most children have normal examinations. Berenson et al. found findings consistent with prior trauma in < 5% of abused subjects (*Am. J. Obstet. Gynecol.*, April, 2000).
3. When injuries are seen, carefully document by describing the size, location and type of injury.
4. Note if the child's statements were spontaneous or in response to direct questions.
5. Document the identity of the interviewer and record the questions asked verbatim.
6. Document what the child says, using the specific language of the child.
7. Document who is in the room at the time of the history and examination.
8. Document whether Child Protective Services and law enforcement have been notified.
9. Carefully document any observed non-genital injuries consistent with physical abuse.

L. DISCHARGE PLANNING

1. Never send a child home to an unsafe environment. Admit the child to the hospital for safety if necessary. There are diagnostic codes for child maltreatment.
2. Establish follow up plans prior to discharge, including referral to a pediatric forensic specialist. If there is concern that the assault is acute (perpetrated within 72 hours), this referral should be considered emergent. Do not tell the parent to contact the specialist without first contacting the Spurwink Program personally and providing a contact number for the parent.
3. If HIV testing is done and HIV prophylaxis needs to be initiated, it is essential to personally contact the child's primary care provider with this information so that the child's status can be carefully monitored.
4. Advocacy and support services are available at no charge through local Sexual Assault Support Centers. The Crisis Hot Line number is: 1-800-871-7741.

Annotated Guidelines Tab

Sexual Assault Forensic Examiner Program Guidelines for the Care of the Adult/Adolescent Sexual Assault Patient

ANNOTATED GUIDELINES

Introduction: The Problem

I. Incidence and Impact of Sexual Assault

According to the U.S. Department of Justice, a woman is raped every two minutes in the United States. Sexual violence is part of our country's social fabric; it damages the lives of children, adults, families and communities. Abundant research supports this assertion.

The *National Women's Study* (1992) found that approximately one out of six U.S. women and one out of thirty-three U.S. men have experienced an attempted or completed rape, whether as a child and/or an adult. Women are 10 times more likely than men to be victims of sexual assault. (National Crime Victimization Survey, 1997). A study among college women has shown that one out of every five college age women report being forced to have sexual intercourse. (National College Health Risk Behavior Survey, 1997). Rape has the highest annual victim costs, estimated at \$127 billion per year, compared to all other crimes except child sexual assault. (American College of Emergency Physicians, 1999; Miller, 1996). These numbers are staggering in terms of the impact on physical health, productivity, utilization of legal and social services, and on the quality of life for victims and their families.

Equally shocking statistics document the impact of sexual assault on the mental well being of Americans. The *National Women's Study* measured the mental health impact of sexual assault by comparing rates of several mental health problems. Almost one-third (31%) of all rape victims developed Posttraumatic Stress Disorder (PTSD) at some point during their lives. This study also found that rape victims were significantly more likely to have experienced at least one major depressive episode than women who had never been victimized by violent crime. Additionally, 33% of rape victims (compared to 8% of non-victims) had seriously considered suicide. Twenty-six percent of women with bulimia nervosa were raped at some point in their lives.

According to the Maine Coalition Against Sexual Assault, Maine's ten sexual assault centers received calls from survivors: 7,921 in 2007 and 9,527 in 2008. While these numbers reflect repeat calls, they also reflect a much higher rate of sexual assault than is reported to law enforcement. According to the Maine Department of Public Safety's *Crime in Maine Report* there were 373 rapes reported to law enforcement in Maine in 2008.

In 1992, the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) first required emergency departments to have protocols on rape, sexual molestation and domestic abuse (Bobak, 1992). In 1997, hospitals were required to develop and train their staff to use criteria to identify possible victims of rape and other violence (JCAHO, 1997). While JACHO does not require hospitals to have SAFE's, the requirements mean that hospitals "must identify and provide appropriate and complete services to victims of rape and abuse. These requirements

have effectively set the stage for the further development of the SANE role as an important component of the emergency medical response to survivors of sexual assault” (Ledray, 2001).

II. Sexual Assault Forensic Examiner Program

Health care providers are often the first responders for survivors of sexual assault. Because of the time needed to assess and treat injuries and collect forensic evidence, it is cost-effective to have a cadre of SAFEs on call to provide this care. By ensuring that trained nurses are available to perform the medical-forensic exam, the waiting period to receive care is minimized, trauma from the assault is reduced, the needs of the victim are attended to, and evidence is collected in a manner that is uniform and meets state standards.

There are many complex and varied reasons why a victim/survivor may choose not to seek medical attention or report an assault to law enforcement. There may be concerns about being blamed by others, or people finding out about the rape, or their names being made public in the news media (*Rape in America*, 1992). Lack of timely, compassionate care is another. Historically, obstacles to care (OVC Bulletin, 2001) have included:

- Emergency department staff who often regard the needs of sexual assault patients as less urgent because they do not typically sustain severe physical injuries.
- Patients often wait many hours for treatment.
- Patients are often not allowed to eat, drink, or urinate so as to avoid destroying evidence while they wait for a health care provider to conduct the forensic examination.
- Health care providers often have not been trained in evidence collection procedures or do not perform them frequently enough to maintain proficiency.
- Providers often have not been trained in the care of the sexual assault trauma patient; they may blame the victim or not believe a “real rape” occurred and overlook the need to treat victims with respect and sensitivity.
- Some physicians are reluctant to perform forensic exams because they know that they might be called to testify in court and that their qualifications to conduct the exam might be questioned.
- Providers may fail to gather and/or document all available forensic evidence, particularly in non-stranger rape cases.

Having a SAFE Program in place minimizes disruption of care to other patients in the emergency department and allows sexual assault patients to receive prompt, compassionate trauma care from providers who understand sexual assault issues. The quality of the forensic exam is often improved because a SAFE can identify physical injuries, knows how to take a history and collect evidence, and knows how to document injuries and other evidence. SAFEs promote patient safety, are able to refer for follow-up care and counseling if needed, and can provide courtroom testimony. SAFE Programs have become the standard of care in the country and in Maine.

III. Sexual Assault Response Teams

As health care and criminal justice systems learn more about the prevalence of sexual assault and abuse and the low reporting rate, there is increased responsibility to improve response to these crimes. Toward that end, Sexual Assault Response Teams (SARTs) organized by local sexual assault support centers in counties throughout Maine, have been coming together to create a

coordinated community response to sexual assault that is uniform, integrated, and informed. This includes both the immediate and long term community response that is victim-centered, appropriate, streamlined, and comprehensive. The key systems involved in SARTs are health care providers, law enforcement officers, prosecutors, and advocates from sexual assault support centers. Each SAFE is an integral component of the SART responding to this need. SARTs seek to

- develop and strengthen existing sexual assault victim services in Maine;
- familiarize team members with the roles of participating agencies;
- develop and implement guidelines for SARTs; and
- provide ongoing training and education for member agencies and the community.

SECTION I: ADULT AND ADOLESCENT PATIENTS

A. GOALS OF THE SEXUAL ASSAULT FORENSIC EXAMINATION

A patient who has suffered sexual assault must be considered a trauma patient, and must be treated the same way as any other patient who enters an emergency department. This includes: appropriate triage; attention to physical injuries; obtaining an appropriate history; performing a head to toe assessment; and, if the patient chooses, forensic evidence collection and detailed documentation.

It is important to recognize that the care of the sexually assaulted patient extends beyond identification of physical injuries and the collection of “the kit.” It should also include medical treatment for pregnancy and sexually transmitted disease prophylaxis, crisis intervention, and appropriate referrals for medical follow up and support services. It is also critical that these services be delivered in a timely and compassionate fashion.

B. CRITERIA FOR THE SEXUAL ASSAULT EXAMINATION; CONSENT AND REPORTING REQUIREMENTS

Timing and Collection of Forensic Evidence

It is recommended that a medical/forensic examination be done using the Maine state sex crimes kit if the patient presents for examination within 5 days of the reported assault. There should also be consideration of a modified collection (with use of vaginal and/or cervical swabs, and known blood sample/buccal swab only) in appropriate cases up to 5 to 14 days post-assault.

Forensic evidence may be retrievable beyond the traditional 72 hours following the assault. A 72 hour “cut-off” *had* been used as a traditional guideline for the timing of the sexual assault forensic evidence collection with an evidence collection kit. This had been based on the facts that forensic evidence becomes progressively less retrievable with passage of time and that the effectiveness of prophylaxis for pregnancy and STD’s decreases with time. Advancements in DNA technologies, however, have improved the recovery of DNA evidence. In addition, there have been reports of recovery of DNA evidence on exams up to 5 days or longer post-assault with the use of a cervical swab.

Recommendations from the *National Protocol for Sexual Assault Medical Forensic Examinations* (2004) note “some examples of situations where evidence may be found even after considerable periods of time include when patients complain of pain or bleeding, have visible

injuries, or have not washed themselves since the assault, or where there is a history of significant trauma from the assault.” (*National Protocol*, p. 67).

They further recommend that decisions about whether to collect evidence be decided on a “case-by-case basis, guided by the knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected. In any case where the utility of evidence collection is in question, encourage dialogue between law enforcement representatives (if involved), examiners, and forensic scientists regarding potential benefits or limitations.” (*National Protocol*, pp. 67-68).

Timing for the History and Physical Examination

Always collect relevant history and do a relevant examination regardless of the timing of the assault. An appropriate medical and forensic history, a well documented examination, and relevant medical treatment should always be offered, whether or not a patient consents to forensic evidence collection and regardless of the timing of the sexual assault to the patient’s presentation for examination.

Recommendations from the National Protocol stress “the importance of gathering information for the medical forensic history, examining patients and documenting exam findings, separate from collecting evidence.” Their recommendation is that “[e]xaminers should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether or not evidence is gathered for the sexual assault evidence collection kit. The history and documentation of exam findings can help in determining if and where there may be evidence to collect and in addressing patients’ medical needs. In addition, they can be invaluable in and of themselves to an investigation and prosecution if a report is made.” (*National Protocol*, pp. 67-68). It is also important to document a patient’s demeanor during the exam process (e.g., crying, trembling, or showing signs of upset) and statements made related to the assault. If the case is reported to law enforcement this information could be admitted as evidence at trial.

Timing for Medical Treatment

In addition to appropriate history, examination, and evidence collection the patient presenting with a complaint of sexual assault should be given indicated medical treatment regardless of when the assault occurred. Traditionally, this has included prophylaxis for STDs and pregnancy within 72 hours of the assault. It is now recommended that emergency contraception be offered successfully up to **five (5) days** following unprotected intercourse, an extension of the old 72 hour cutoff (Westoff, C.). In the case of delayed examinations, this might include appropriate testing and treatment for STDs, counseling, and follow up. For further information on medical management, see page 51 of these guidelines.

Consent

Generally, the patient will complete a signed consent for general medical evaluation and treatment at the time of registration. However, further consent for the forensic examination and evidentiary collection is required.

Written, informed consent should include consent for the different components of the sexual assault medical forensic evaluation, including:

- medical evaluation and treatment
- forensic evidentiary collection
- documentation with photographs
- transfer of records to primary care physician
- transfer of evidence to law enforcement personnel if patient is reporting OR consent to “anonymous” collection with evidence identified by tracking number only and stored with law enforcement for 90 days pending patient decision to report (See Appendix D, Maine Law, Title 25, §3821.)

A consent form is included in the Maine state sex crimes kit for those institutions that have not yet developed their own form. (This form is for use in the health care facility only and should **not** be returned to the state lab or law enforcement.) A sample of a more fully developed consent form that institutions may wish to adopt is attached in the sample Sexual Assault Medical Forensic Examination documentation packet in Appendix B.

Although written consent is required prior to conducting an evidentiary examination, informed consent should be a continuing process throughout the examination. The procedures in a forensic examination are unfamiliar, and sometimes embarrassing or intimidating to the patient, who may find them difficult to understand. All procedures should be explained as much as possible to make the examination more comfortable and understandable for the patient. The examiner should refrain from any judgment or coercive practice when seeking the patient’s consent.

The written consent does not provide a “blank check” for performing tests or pursuing questions. A sense of control is a critical part of the healing process for victims. If, at any time, a patient expresses reluctance to proceed with a portion of the history or examination, the examiner should discontinue that activity, discuss any concerns or questions the patient may have, and consider returning to that procedure later if the patient agrees.

The patient has the right to decline to answer questions or participate in any portion of the examination with which she/he is not comfortable. If the patient chooses to decline a portion of the examination, this should be documented accurately and in a nonjudgmental manner (e.g., “patient declines due to discomfort/anxiety” vs. “patient refused” or “noncompliant”).

It is important to make the patient who declines a procedure aware of the impact of that decision. This should include discussion of the possible negative impact on the quality of her or his care and the usefulness of the evidence collection. In addition, the patient should be informed that this decision “may have a negative impact on a criminal investigation and/or prosecution both because evidence not collected may have been useful and because defense attorneys may use the fact that the victim declined a procedure to claim that the victim is hiding something that would have been revealed by that procedure. They should understand that declining a procedure might also be used by opposing counsel to discredit the victim at trial” (*National Protocol*, p. 39).

Anonymous Reporting and Payment for Exam

The victim of sexual assault may choose to have collection of evidence “anonymously,” i.e. there is no identifying information on the front of the kit. With “anonymous” collection, the patient does not file a report with law enforcement. An “anonymous sex crimes kit” will be held by law enforcement for a minimum of 90 days. Some departments hold kits for much longer. The patient can report the crime to police at any time in her/his life. Patients should also know that as long as the forensic examination kit is collected, the medical costs for their sexual assault examination and treatment are covered by funds from the Victims’ Compensation Program.

Consent and the Adolescent Patient

A minor (under 18 years of age) is permitted to consent to a sexual assault medical/forensic examination without parental or guardian consent (see Appendix D, Title 22, Ch. 260, §1501). Healthcare providers may maintain confidentiality, even as to the minor’s parent or guardian, unless failing to inform the parent or guardian would jeopardize health or limit treatment. The patient should be told, however, that since she/he is under the age of 18, mandatory reporting to DHHS Child Protective Services and/or the district attorney’s office is required by law and could result in parental notification.

The minor (under age 18) adolescent patient brought into the hospital against her/his wishes should **not** be examined without the patient’s consent.

Consent and the Unconscious/Comatose Patient

An unconscious or comatose patient may present in the emergency department with signs that indicate the possibility that a sexual assault has occurred. Since the patient is unable to give consent and evidence will be lost due to treatment procedures and time, it is recommended that forensic evidence be collected using an “anonymous kit” collection procedure. The provider should document in the medical record the findings that form the basis for believing that the patient was possibly sexually assaulted. Since drugs are often the cause of unconsciousness, collecting urine and blood for analysis is recommended.

Hospitals and health care practitioners who perform sexual assault forensic examinations with due care and in accordance with the Maine Health Security Act are free from legal liability in performing those exams (24 M.R.S.A. § 2986). If a patient does not regain consciousness within 60 days, there are certain procedures that law enforcement must follow to preserve the collected evidence.

Patient privacy is paramount. Caution should be used in communicating with the family and/or caregiver regarding collection of forensic evidence, especially if there is a chance that any of these persons may have perpetrated the assault.

Document the circumstances that led you to believe that a sexual assault may have occurred. This can include: physical injuries such as bruising, bleeding, abrasions, etc; victim appearance; the condition of clothing, or the lack of clothing; where and how the patient was found; any history given by friends/family/acquaintances/police that may support the possibility of sexual assault.

Should the patient regain consciousness, advise the patient of the forensic evidence collection, and allow her/him to decide whether she/he wants to proceed with reporting the assault to law enforcement. It is very important that the patient appreciates that she/he has control over the disposition of the sex crimes kit. It is also **VERY IMPORTANT** that a sexual assault advocate be present when the patient is advised of the evidence collection.

Should the patient die, the police department holding the kit should be notified. The kit should be sent directly to the medical examiner's office.

Sexual Assault Nurse Examiners & Scope of Practice in Maine

Sexual Assault Nurse Examiners may perform sexual assault forensic examinations on patients 13 years of age or older (if trained since January 2007 or completion of young adolescent training offered by the SAFE Program). SAFEs can assist and be a valuable resource in the care of younger patients, but the attending physician/nurse practitioner must assume primary care of the pediatric patient. If the SAFE has attended the Pediatric Sexual Assault Forensic Examination training, the nurse can take the lead in medical/forensic care according to hospital policy. The bi-manual pelvic exam is not taught to nurse examiners in Maine, and is thus outside the scope of practice for the Registered Nurse.

Mandated Reporting

Children

Medical professionals are mandated reporters with the responsibility to “immediately report or cause a report to be made to the department” if that provider “knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected” (Title 22, Subtitle 3, Part 3, Chapter 1071, Subchapter II). Reporting requirements vary depending on the circumstances of the assault. See Appendix D for information about mandated reporting.

Adults

There is no legal mandate to report sexual assault injuries to adults to the police. It is up to the patient to decide whether to report the crime. If, however, there is a gunshot wound, or if the sexual assault was perpetrated upon an incapacitated adult, reporting to adult protective is mandated by law.

C. INTAKE

Triage

Consider sexual assault patients a priority, regardless of whether physical injuries are evident. Although many victims of sexual assault do not have visible signs of physical injury, they will at the least be suffering emotional trauma. They need to be cared for in a compassionate, confidential, and timely fashion. In addition, delays in treatment may cause loss of evidence.

When speaking with the patient, choose words carefully, avoiding judgmental or critical comments. Repeated questioning should be avoided. The triage nurse should obtain the most basic information from the patient and avoid in-depth questioning, both for reasons of patient comfort and to avoid the documentation of multiple, potentially conflicting histories.

Assess the Patient for Injuries or Medical Problems

Take vital signs and triage for problems or injuries that might require immediate medical intervention. Such conditions might include injuries with uncontrolled bleeding, loss of consciousness, abdominal pain, head injury, strangulation, and cervical spine injury.

In the absence of urgent, acute medical problems as above, the triage note should generally be brief. For example:

- Subjective: “Reported Sexual Assault” or “Chief Complaint: sexual assault”
Objective: “Disheveled, tearful young woman accompanied by roommate”
Assessment: “Able to wait for sexual assault nurse/forensic examiner”
Plan: “Sexual assault protocol initiated; SAFE called”

Note: Avoid use of judgmental terms such as “alleged.”

Strangulation is commonly used by sex offenders as a way to immobilize the victim. It is therefore, important to always assess the patient for signs and symptoms of strangulation and document any findings. These changes can become severe over 24 – 36 hours. If strangulation has occurred consider admitting the patient so that continual assessment for breathing changes can take place.

Strangulation is a form of asphyxia characterized by closure of blood vessels and/or air passages of the neck as a result of external pressure on the neck. It is often incorrectly referred to as “choking” which is a blockage of the airway and is internal. Strangulation is external. It can lead to unconsciousness, irreversible neurological damage, and death by causing hypoxia in the brain.

There are three general mechanisms of strangulation: hanging, ligature strangulation, and manual strangulation. These can cause:

- compression of the carotid arteries and/or jugular veins causing cerebral ischemia;
- compression of the laryngopharynx (larynx or trachea) causing asphyxia; and
- stimulation of the carotid sinus reflex causing brachycardia and/or hypotension.

Vascular obstruction is usually the main mechanism. After 50 seconds of continuous oxygen deprivation, the victim rarely recovers without medical intervention.

Internal symptoms of strangulation include:

- Voice changes from hoarseness to complete loss of voice;
- Difficulty or pain when swallowing due to hyoid bone injury/laryngeal fracture/internal bleeding;
- Difficulty breathing which may be due to hyperventilation that accompanies a terrifying event, but more importantly, may be secondary to underlying neck injury. The breathing changes may appear mild, but over time (24-36 hours), the injuries could be fatal;

- Involuntary urination and defecation;
- Behavioral changes including (early) restlessness, violence or hostility, (long term) personality changes, amnesia, and/or psychosis;
- Ringing in the ears.

External, visible injuries to the neck may include:

- Redness, scratches, abrasions, and scrapes;
- Pattern redness or bruising;
- Patterned impression marks;
- Rope burns;
- Linear fingernail scrapes, either from the assailant or the victim;
- Petechiae of the sclera, around the eyes, under the eyelids, anywhere on the face, and on the neck above the area of constriction (petechiae can result if pressure is maintained for more than 20 seconds);
- Blood red eyes which suggest significant struggle between the victim and assailant.

Avoid loss of Evidence

If possible, do not wipe blood, fluids, or stains off of the patient. Do not remove any foreign material from the patient's clothing or body. Advise the patient not to wipe, wash, drink, or eat until the examiner arrives. If a female patient must urinate, provide a specimen container and ask her not to wipe. If clothing must be removed, take care not to cut through tears or stains and to package each piece of clothing as it is removed in a separate paper (not plastic) bag (from the sex crimes kit if one has been opened; if not, then any clean paper bag will do).

If there is collection of clothing or urine samples, care should be taken to maintain chain of custody. The evidence should be packaged by the practitioner who does the collection, appropriately sealed, and remain in that practitioner's control until transferred to law enforcement.

Call in Resources

Sexual Assault Forensic Examiner

There are many reasons that a specially trained Sexual Assault Forensic Examiner is preferable for the medical/forensic exam. Please see the discussion of SAFE in the introduction. In the absence of an available SAFE, the examination should be done by the provider most experienced in the sexual assault medical/forensic examination, following best practice guidelines.

Sexual Assault Support Advocate

The sexual assault forensic examiner needs to tend to a detailed, objective examination. Although the examiner must be thoughtful and compassionate, the patient may benefit from additional support during the examination. Advocates from local sexual assault support centers are available to provide victims with free, confidential, non-judgmental, emotional support, information, social service referrals, and guidance (see list of Centers in Appendix C). Patients who feel supported, believed and safe are usually more comfortable and better able to respond to procedures. The advocate can also counsel family members or friends of the victim who may be at the hospital. More than one advocate can be called in if needed.

Experience shows that the victims of sexual assault are much more likely to use the services of an advocate when the advocate is already physically present than they are to request that an advocate be called in. It is therefore preferable that an advocate be contacted when the patient first presents to the emergency department.

Upon the arrival of the advocate, the patient should be informed that the advocate is available if she/he wishes to talk to advocate. When the advocate arrives, the patient should be provided with an opportunity to speak with the advocate alone, and to have the advocate present during the examination. Each institution should have discussions with their local Sexual Assault Support Center and work out a protocol.

Law Enforcement

Call law enforcement **only if the patient wishes to report the assault, except in the case of mandated reporting** as discussed above.

Family and Friends

Family and friends should be called as requested by the patient. It is best, however, not to have family or friends in the room during the history and examination for the reasons discussed in Section F (Examination) below.

Protect Privacy, Comfort, and Confidentiality

For the patient's comfort and privacy obtain an appropriate, private, examination room as soon as possible. Unless there is an urgent medical reason requiring the removal of clothing, allow the patient to remain fully clothed. This is not only for the patient's comfort, but also for the maintenance of the integrity of the forensic evidence, since clothing collection is part of the forensic examination. Do try to keep the patient informed regarding plans, including the expected arrival of the examiner, an advocate, and law enforcement as indicated.

D. Examiner's Initial Contact with Patient

Establish Rapport with the Patient; Introduce the Role of the Sexual Assault Examiner

The examiner should explain her/his role, what she/he can offer to the patient, and what can be expected during the examination and treatment. This discussion should include information regarding the documentation and treatment of injuries, the availability of prophylaxis for STD's and pregnancy where indicated, the provision of crisis intervention, arrangements for follow up support and counseling, and the nature of the forensic evidence collection.

Consider cultural, psycho-social and medical factors (e.g., ethnicity, primary language, age, sexual orientation, physical or mental disabilities, living arrangements, etc.) when providing care and treatment for the patient (see pages 68-69).

Gay, Lesbian, Bisexual, Transgender, Queer Patients

Do not assume the sexual orientation or gender identity of the patient or the assailant; and do not assume that sexual orientation and gender identity are related. The needs of lesbian, gay, transgendered, bi-sexual, intersex, and queer patients who have been sexually assaulted are the

same as all sexual assault patients – a medical/forensic exam, safety planning, referral to appropriate community resources, and police intervention if requested. Due to homophobia and bias in our culture, it may be more difficult for the patient to come forward and report the assault by a same-sex or same-gendered assailant. The patient may be frightened, uncomfortable or unwilling to disclose their sexual orientation, and thus may withhold important facts about the assault that are essential for medical diagnosis and treatment, identity of the attacker, or something the attacker may have said that could reveal sexual orientation. Pay attention to the patient's use of or the absence of gender-specific pronouns when talking about the assailant.

If you have doubts about your ability to provide care for a gay, lesbian, bisexual, intersex, or transgender patient, find another caregiver.

Lesbian, Gay, Bisexual, and Queer Patients

Persons who are lesbian, gay, bisexual or queer can be assaulted by a same-sex or same-gender assailant or by an assailant of a different sex. It is important for providers be sensitive to the possibility that the patient may never have had sexual contact with a person of another sex, which may compound the trauma and the patient's discomfort with describing the details of the assault.

Sometimes persons who are gay, lesbian, bisexual, or queer are assaulted because of their actual or perceived sexuality by a person of the opposite sex. Targeting of this population can exacerbate fears of future attacks. Referring to appropriate local resources for gay, lesbian, bisexual, and queer persons can be helpful.

Respect that patients may not be "out" to their families, friends or workplace. Provide as much confidentiality as allowed by law.

Transgender and Intersex Patients

“Transgender” is an umbrella term used for individuals whose gender identity, expression, or behavior is different from those typically associated with their assigned sex at birth. Use the gender pronoun that is preferred by the patient, which may or may not coincide with the assigned biological sex of the individual. Do not be afraid to gently ask what pronoun the patient prefers.

“Intersex” is a general term used for a variety of circumstances in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of “female” or “male.” People with intersex conditions have distinct needs from people who identify as transgender. Be aware of and sensitive to the differences.

Trans people who have “noncongruent” bodies (bodies that have not been surgically altered to match the public's image of what a “man” or “woman” looks like) do not have the option of being closeted when disrobed. Intersex people are often “invisible” due to a concealment-centered model of care. Lack of disclosure about transgender or intersex status shouldn't be taken as a sign of non-compliance, deceit, or denial—being “out” as a transgender or intersex person can feel or be unsafe in some circumstances. Be aware and sensitive of differing bodies.

Dysphoria of body or gender may be a barrier to seeking care. Sexual violence may involve parts of the body a trans person would rather not think about, let alone have examined, making post-assault care even more traumatic than it might be for a non-trans client.

Discuss Decision to Report to Law Enforcement

Explore the patient's wishes regarding reporting to law enforcement if this has not already been done. Remind the patient forensic evidence collection using the Maine state sex crimes kit can be completed anonymously. The kit will be identified by number, and will be held by the police for at least 90 days. The patient may elect at any time to initiate a report to law enforcement. At the time of discharge the patient will be given a card with the kit number and the telephone number of the law enforcement agency to contact should the patient decide to report the assault. In this way, evidence that might otherwise be lost can be collected and preserved while the patient makes a decision.

Obtain Written Consent

Explain to the patient her/his rights, including the ability to have all questions answered and to consent to or decline any portion of the examination. Obtain written, informed consent (see discussion in Sections B, Consent, pages 26 – 27).

Discuss Payment for the Examination through Victims' Compensation Fund

Inform the patient that the costs of all medical forensic examinations that include evidentiary collections (*with* use of the Maine state sex crimes kit) are paid for by the Victims' Compensation Fund. Payment also covers medical care, including STD and pregnancy prophylaxis. All billing goes directly to Victims' Compensation; neither the patient nor her/his insurance company should receive a bill.

E. History and Documentation

A complete, well-documented history is critical to establish the history of assault, to direct medical diagnosis and treatment, and to guide the appropriate collection of forensic evidence.

Relevant Legal Considerations

A more complete discussion of Maine law relevant to the sexual assault examination is included in Appendix D. In taking a history of sexual assault, however, it is important to briefly review two main concepts: the hearsay exception and the legal definition of gross sexual assault in Maine.

Hearsay Law

Maine law provides a medical hearsay exception for statements made to health care providers for the purpose of medical diagnosis and treatment. A medical practitioner may be allowed to testify in court regarding history obtained in the process of a medical assessment, including the sexual assault evaluation. When documenting the history, it is critical to use the patient's own words, using direct quotes.

Legal Definition of Gross Sexual Assault

Certain elements of Maine law are important for the health care provider to know in caring for the patient presenting with a history of sexual assault. Many other factors are also important from a legal perspective, such as the ability to consent, and the relationship between the defendant and the victim. It is the role of the prosecutor to make these determinations, but

helpful for health care providers to have a basic understanding of three of the most common criteria of gross sexual assault.

In Maine, a person is guilty of gross sexual assault if that person engages in a sexual act with another person and:

1. the other person submits **as a result of compulsion**;
2. the other person, not the actor's spouse, has not reached the age of 14;
3. the actor compels the other to engage in the sexual act by any threat.

“Compulsion” means the use of physical force, a threat to use physical force, or a combination thereof, that makes a person unable to physically repel the actor, or produces in that person a reasonable fear that death, serious bodily injury, or kidnapping might be imminently inflicted upon that person or another human being.”

For purposes of Maine criminal law, “sexual act” means (1) any act between 2 persons involving direct physical contact between the genitals of one and the mouth or anus of the other, or direct physical contact between the genitals of one and the genitals of the other; (2) any act between a person and an animal being used by another person which act involves direct physical contact between the genitals of one and the mouth or anus of the other, or direct physical contact between the genitals of one and the genitals of the other; or (3) any act involving direct physical contact between the genitals or anus of one and an instrument or device manipulated by another person when that act is done for the purpose of arousing or gratifying sexual desire or for the purpose of causing bodily injury or offensive physical contact (17-A M.R.S.A. § 251(1)(C)).

Thus, in the evaluation of a patient presenting with a complaint of sexual assault it is critical to observe and document any elements of the history or examination that indicate any use of physical force or threat.

General Principles

Ensure that you have a quiet and private location for the medical/forensic examination. Limit the number of people in the exam room. Always speak with the patient privately regarding their wishes. For the maintenance of the integrity of the evidence it is helpful to limit those in the examination room to the sexual assault examiner, the sexual assault support center advocate, and an attending nurse if needed. This is especially so for the history taking portion of the examination. In instances where the patient requests the presence of a close friend or family member, these requests should be honored, once the potential drawbacks to this are discussed with the patient. These drawbacks would include the potential risk of cross contamination of the evidence in a crowded room, the risk that the friend or family member could be called as a witness should the case go to trial, or the patient feeling unable to speak freely regarding the details of the assault with a loved one present.

A law enforcement officer or detective should **not** be present during any part of the medical/forensic exam, including the forensic history taking or to observe the examination. There is no medical or legal reason for their presence. The role of the forensic examiner when taking a medical history is for the purposes of medical diagnosis and treatment and to direct the forensic examination. The investigative interview is different and should be conducted

separately. The exception to this is if the patient is a prisoner from a jail or prison. The prisoner should have at least one, if not two guards present.

Allow the patient to give the history as much as possible in her/his own words. Use open-ended questions as much as possible such as: “Tell me what happened to you” or “What happened after that?” Avoid leading questions. Use language that is understandable to the patient. Identify and use the patient’s own words for body parts. Clarify what the patient means by vague terms such as “had sex.” These points are particularly important in dealing with the adolescent or with a mentally retarded, autistic, or incapacitated adult (see page 69).

It is recommended that the examiner use the standard sexual assault forensic medical report form for the documentation of the forensic history and examination. Such a form can help to guide the history and help assure that all relevant areas of information are covered. This form should incorporate the patient information and inventory forms from the Maine state sex crimes kit. A sample form is included in Appendix B.

Essential Components of the History of Assault

- ***Date and time of assault:*** It is imperative to know the period of time that has passed between the assault and the collection of evidence. This will help direct evidence collection and assist in the interpretation of physical examination findings and the forensic evidence collected.
- ***Place of assault:*** This will establish which law enforcement agency needs to be contacted if the patient decides to report the assault. It also is important in dealing with safety issues in discharge planning (for example, the patient may not feel safe returning home if this was the site of assault).
- ***Physical surroundings (inside, outside, car, room, rug, dirt, mud, grass, etc.):*** This information helps direct the search for debris or foreign materials that may have been cross transferred during the assault.
- ***Number of assailants:*** Information regarding the number of suspects assists the crime lab in anticipating the possible number of DNA sources, trace hair/fiber sources, etc.
- ***Description of the assailant(s):*** Suspect information should be gathered that could guide the examination and forensic evidence collection. These questions should include gender, height and weight of the offender(s), jewelry or clothing worn at the time of assault, hair color, presence of facial hair, right/left handedness if noted might also be helpful in interpreting possible injury patterns and directing foreign material collection. There are medical grounds for questions regarding piercing and tattoos because they are implicated in the transmission of blood born pathogens. You should not ask questions regarding distinguishing characteristics, as they are components of an investigatory history rather than a forensic history. If such details are spontaneously given by the patient, however, you should document them.
- ***Description of the sexual acts demanded and/or performed:*** This includes the presence or absence of vaginal contact, anal contact, oral/anal contact, and non-genital oral contact (e.g., licking, kissing, biting, suction injury). This information helps guide the forensic examination by identifying the appropriate areas for collection of dried secretions

specimens. It also directs observations for potential injuries, with the understanding that a thorough head to toe examination is done on all patients. Important details in this history include:

- Location of contact, penetration or attempted penetration, and whether by penis, finger, tongue, or other object.
 - If known, whether ejaculation occurred, and in what location(s).
 - Use of lubricants, if known. Lubricants of any kind are trace evidence and can be compared with potential sources left at the crime scene, or recovered from the body of the assailant.
 - Use of condom or other contraceptives, if known. Use of a condom may explain absence of semen. Certain contraceptive preparations can interfere with the chemical test used by crime labs in the analysis of potential seminal stains. Spermicidals can destroy spermatozoa.
- ***Injuries inflicted during assault:*** This and the following items in the history are important not only in assessing for trauma and guiding treatment, but also in establishing elements of compulsion, if present.
 - ***Compulsion:*** Use of threats, restraints and/or other physical coercion.
 - ***Weapon:*** Use of weapons and, if so, what type.
 - ***Pain or other physical symptoms since assault:*** Information needed to assist medical examination and treatment.
 - ***Injury to assailant:*** Whether the assailant was injured during the assault, especially injuries possibly resulting in bleeding. The crime lab will want to know about the potential presence of the assailant's blood.
 - ***Substances:*** Known or suspected voluntary or involuntary ingestion of alcohol/drugs.
 - ***Loss of consciousness/memory loss:*** This should raise suspicion of "date rape" drug, or significant accompanying injury (head injury, significant strangulation injury) in the assault. Collecting toxicology samples should be considered if there was either loss of memory or lapse of consciousness.

Essential Components of History of Post Assault Activities

The quality of the evidence collected is affected not only by the passage of time, but also by actions which may have been taken by the patient following the assault. It is important to document these activities including:

- Urination
- Defecation
- Vomiting
- Douching
- Use of sanitary pad/tampon
- Eating/drinking
- Washing/bathing/showering
- Changing of clothing
- Combing or brushing of hair
- Brushing of teeth, gargling, rinsing, or flossing

Essential Components of Medical History

The medical history is important both for the direction of medical care, as well as the interpretation of physical findings. Medical history should include the following:

- Menstrual history, including last menstrual period.
- Known or possible current pregnancy.
- Current use of contraceptives.
- Recent consensual sexual activity (within 5 days). This information is essential for the crime lab to identify the possibility of the presence of DNA material not related to either the patient or the perpetrator(s).
- Tetanus and Hepatitis B immunization status.
- Current medications and medication allergies (include over the counter medications).
- Latex allergies.
- Recent (preexisting) injuries or discomfort (genital or other) not related to the assault. It is *critical* to distinguish preexisting injury patterns from new trauma. This history should also include any history of constipation, diarrhea, rectal bleeding, or rectal pain preceding the assault.
- Past medical history, such as surgeries, hospitalizations, allergies, and obstetric history (including vaginal deliveries).

F. Examination—General Principles

See the previous discussion (page 35) regarding limiting the number of people in the exam room. **There is no medical or legal reason for a law enforcement officer or detective to be present during the medical/forensic history taking or for the examination, and they should not be present.** The only exception is if the patient is a prisoner from a jail or a prison.

Materials

By State law, only the Maine state sex crimes kit is allowed for collection of evidence in the State of Maine (see Appendix D).

There are materials not included in the state sex crimes kit that will be needed to complete the forensic examination. They should be available in any facility performing sexual assault examinations. Materials in addition to those in the state sex crimes kit needed to complete the forensic exam:

- Bed sheet to place under foreign materials sheet.
- An alternative light source, such as a Wood's lamp.
- Test tube rack and tubes or alternative apparatus such as cups for holding drying swabs (*newer kits contain a drying rack though there may be a need for more drying apparatus' than is provided in the kit*).
- Non-preserved sterile/distilled water (avoid sterile saline which can leave crystalline residue).

Non-powdered, non-latex examination gloves (open a new box at the start of each examination).

- Tape for sealing evidence bags.
- Marking pens for swab envelopes and swab holders.
- Alcohol swabs for obtaining finger stick known blood sample (kits to be ordered in the future will ask for buccal swabs, doing away with the finger stick).
- Finger-stick lancet (not needed with newer kits requiring buccal swab).
- Camera for photo documentation.
- Sterile scissors and forceps.
- Small ruler or tape measure.
- #16 or #18 Foley catheter with a 30cc balloon.
- Clothing for the patient following the examination.
- Veni puncture equipment: two 10 ml, or five 4ml gray topped (potassium oxalate and sodium fluoride) blood collection tubes and urine specimen cup for cases of drug facilitated sexual assault (see pages 48-49 for collection criteria).

Maintain chain of custody

The examiner should **not leave the kit unattended at any time** from the time it is opened until it is signed off to law enforcement. If appropriate chain of custody is not maintained, the evidence may not be admissible in court. A sample “chain of custody” form can be found in Appendix B.

Further General Principles

- To maintain the integrity of each sample, use gloves throughout the examination. Change gloves whenever the potential for cross contamination exists. Use non-latex, non-powdered gloves.
- Allow all samples to fully air dry in an appropriate rack. Expect a minimum of 1 hour for full drying. *Incomplete drying can lead to degradation of biologic evidence.* To further prevent the degradation of evidence **never use heat to dry specimens.**
- Envelopes in the kit are self-sealing. **Never lick an envelope to seal**, as it is not in the best interest of the examiner, and it can lead to cross contamination of the evidence with examiner DNA.
- In general, complete all segments of the examination unless not clinically indicated or declined by the patient. A full examination and collection of evidence may preserve a component of the assault the patient was unable to relate. If a specimen is not collected, always document the reason the specimen was not collected.
- Return all components of the kit to the kit box, whether used or not. If a particular collection is not made, indicate that on the appropriate envelope. **If a component of the Maine state sex crimes kit is missing without documentation, it could raise questions regarding the integrity of the kit.** All unused envelopes should be placed in the large plastic bag in the kit marked “unused components.”

- For tracking purposes, each kit is assigned a unique tracking number and contains a group of labels printed with that number. For chain of custody purposes, one label should go on each component of the kit that is collected.
- Use the bags/containers provided in the kit. If additional evidence specimens are required, use only clean, unused paper bags, **not plastic**. *Evidence will degrade in plastic containers.*
- Close any bags/envelopes that are not self-sealing with tape (e.g. clothing collection bags). **Do not use staples**. Crime lab personnel specifically request tape for the purpose of preserving the integrity of the evidence, and also to avoid ripped gloves and/or injury to crime lab staff processing the evidence.
- Wet evidence should be air dried before packing. If clothing evidence is wet and cannot be fully dried, report this to law enforcement when evidence is picked up. If saturated, place in an *open* plastic bag *inside* the paper bag. Notify law enforcement of the wet articles.
- Use non-preserved, sterile water/distilled water, **not saline**, to moisten swabs. When saline dries it leaves crystals behind that can interfere with crime lab processing.
- Be sure that the suspected source of all collected specimens is noted on the collection envelope when relevant. If the source of the specimen is not noted correctly, appropriate testing may not be done and evidence may be missed. For example, the crime lab will check all dried secretions for semen, but could miss evidence in saliva or other substances if not specifically identified.

G. Medical Examination and Evidence Collection

Integrate the Medical and Forensic Examinations

For the comfort of the patient, you should begin with the least invasive components of the evaluation, moving to the more invasive components as the examination progresses. However, it is important to be flexible and adjust the order of the examination to the patient and patient needs. For example, consider collection of oral swabs before completion of the history to allow the patient the opportunity to eat, drink, or take pain medication.

The patient should receive an explanation of each component of the examination and have the option to decline any portion of the examination once the potential consequences of failing to collect that evidence are discussed fully with her/him. **Consent should be an ongoing process during the examination.** This empowers the patient to maintain as much control as possible during the examination. A copy of a comprehensive consent form is found in Appendix B.

The sexual assault examination should include a “head to toe” examination for identification and documentation of any physical injuries. As forensic evidence is collected, it is important to continue to assess the patient for signs of injury. Thus, the physical examination should be conducted in parallel with the forensic evidence collection. The physical assessment should include:

- head to toe observation and **palpation of entire body** for potential injuries
- skin survey
- genital and anal exams
- vaginal exam using a speculum (unless injuries or patient age or condition prohibits)

A bi-manual exam should not be done unless clinically indicated. Any bi-manual exam should be performed by a physician, or advanced practice clinician with specialized training, not by a Registered Nurse Sexual Assault Nurse Examiner.

During physical assessment it is important not to disturb forensic evidence before it is collected. (For example, do not palpate an area suspected to contain dried secretions before you obtain appropriate swabs.)

Double Swab Technique

When collecting samples of dried secretions use the Double Swab Technique: Open a swab packet and moisten two swabs using sterile, distilled water. Use approximately two drops on each swab. Thoroughly swab the area with both swabs using moderate pressure and a circular motion, swabbing from the periphery to the center. Re-swab the area with two additional dry swabs, using similar pressure and movements as the first swabs. The dry swab is rotated over the skin to recover the remaining moisture. Roll over the entire area to ensure all moisture is recovered. Air-dry the two pairs of swabs and package each pair separately in the swab boxes provided in the kit.

SPECIFIC INSTRUCTIONS FOR THE SEXUAL ASSAULT FORENSIC EXAMINATION WITH THE USE OF THE MAINE SEX CRIMES KIT

Note: Oral, anal, vaginal and cervical smears are no longer processed by the crime lab. There is no need to do them.

1. ORAL EXAMINATION, SWABS (State Kit Step 1)

Be sure to carefully inspect inner aspects of the patient's lips, cheeks and throat for signs of injury, with particular attention to the frenulum and the junction of the hard and soft palates where injury patterns may be more prominent. The frenulum attaches both the upper and lower lips to the gum, and the tongue to the bottom of the mouth.

Open the swab packets from envelope marked "ORAL SWABS." Carefully swab the oral area, including the area between the cheek and gum, with specific attention to the area behind the back molars on both the upper and lower teeth using the four swabs provided.

Dry, package, and label swabs as instructed.

If the patient is chewing gum, save, package and label in the Miscellaneous envelope (see 17, below).

If the patient has dentures or a partial plate, remove and swab the denture and underlying mucosa.

NOTE: The victim may be allowed to rinse his/her mouth and eat/drink at this time.

2. NASAL SWAB (State Kit Step 2)

In the event of oral assault, biologic secretions may be forced into the nasopharynx. This evidence may be successfully retrieved with the use of nasal swabs.

Lightly dampen each swab with distilled water. Carefully insert one swab in each nostril and swab **only the nasal area**. Air dry the swabs and package and label as instructed.

3. DEBRIS COLLECTION (State Kit Step 8)

Carefully inspect subject's head and other skin surfaces, as well as outer surface of clothing, for any loose debris, such as grass, leaves, fibers, or threads.

Remove the folded sheet of paper from the "Debris Collection" envelope. Unfold the paper and place on a flat surface. Collect any debris present on the patient and place in the center of the paper. Fold the paper so as to retain the debris. Return the folded sheet of paper to the "Debris Collection" envelope. Package and label as instructed. Identify the location from which the samples were removed on the anatomical drawings on the envelope.

The examination for debris should continue throughout the examination since further debris may be located on the patient's skin and not be visible until later in the examination. This material should be collected and packaged in the same manner.

NOTE: Debris from different areas of the body should be collected and packaged in separate envelopes. Use Step 17 for additional packaging material or use clean paper (such as copy paper) and a druggist fold or bindle to hold the sample and place in a clean envelope labeled with identifying information.

4. CLOTHING AND FOREIGN MATERIAL COLLECTION (State Kit Step 7)

If these are *not* the clothes worn at the time of the assault, and the patient is reporting the assault to law enforcement, notify the investigating officer and make them aware of evidence that may need to be secured at the scene of the crime or elsewhere.

Do not cut through any existing holes, rips or stains in the patient's clothing. Do not shake out patient's clothing or trace evidence will be lost. Do not handle clothing more than necessary.

Unfold and place a clean hospital bed sheet on the floor. Remove paper sheet from "Foreign Material Collection" bag, unfold and place over bed sheet. Instruct patient to stand in center of paper sheet and carefully remove each item of clothing. Collect each item as removed and place each in a **separate** clothing bag, as labeled. Clothing items should always be packaged separately from one another to avoid transfer of evidence. Seal each bag with tape. Attach a tracking label as directed.

Underpants should be collected in the bag marked "INNER LOWER CLOTHING," even if they are the second pair worn since the assault. Vaginal secretions may accumulate, even if the subject has bathed or showered.

If the article is wet, place a piece of paper (such as clean copier paper) against the stain prior to folding. Wet or damp clothing should be air dried before packaging, or notify the law

enforcement officer of the need to hang and dry the clothing in the evidence room. If the item is dry, the paper bag should be sealed and labeled as indicated.

Place each item in a separate paper bag. If additional clothing bags are required, use only new, clean paper (grocery-type) bags.

If the victim's clothing has been brought to the exam area already in a paper bag, do not sort it. Seal it with tape and label it appropriately. Mark "VICTIM'S CLOTHING." If the clothing is brought in a plastic bag, transfer to a paper bag with as little disruption as possible.

Each bag should be taped shut and labeled as instructed. Refold the paper sheet on which the patient stood in such a manner as to retain any debris present, and then return it to the "Foreign Material Collection" bag. Seal bag, attach a tracking label and label as indicated.

Shoes and coats should only be collected if the possibility exists to link the victim to the crime scene.

Please describe any unusual aspects of clothing such as rips, stains, missing buttons, or stretched elastics, and also note this on the receipt form.

5. SKIN SURFACE ASSESSMENT (No State Kit Step)

Carefully perform a visual inspection of the patient's external skin surfaces. Locate, describe, and photograph any evidence of injury or adherent foreign matter. Use anatomic diagrams to document a description of injuries, including location, size and appearance.

To avoid disruption of evidence, the order of the assessment should be:

- a. look
- b. photograph
- c. collect Specimen(s) (see step 6 below)
- d. palpate to determine point tenderness

Utilize appropriate body diagrams (see Appendix A) to document all injuries and findings, including cuts, lacerations, bruises, abrasions, redness, swelling, bites, burns, scars and stains/foreign material on patient's body. Distinguish pre-existing injuries from those resulting from assault. Record/document size, color and appearance of all injuries. If a Wood's Lamp is used to assist in visualizing secretions, denote areas of positive fluorescent Wood's Lamp findings.

6. DRIED SECRETIONS AND SKIN SURFACE ASSESSMENT (State Kit Step 9)

NOTE: This step is provided for the collection of dry or damp secretions which may be present on the patient's body. This could include blood, semen, saliva, lubricants, or other substances found because of kissing, sucking, biting, ejaculation, etc.

Secretions

A Wood's (UV) lamp or another appropriate alternative light source may be helpful in visualizing dried secretions. Dried semen fluoresces blue-white or orange and usually appears as smears, streaks, or splash marks. Note, however, that saliva does not fluoresce and semen may not always fluoresce. Also, substances other than semen, such as detergents, dandruff, lint, and

deodorants, will fluoresce. Be sure to use the history to help direct the collection of dried secretions. For example, use the direction of the patient to obtain swabs from areas with a history of exposure to secretions, but no grossly visible evidence.

With the collection of dried secretions it is helpful to use a **double swab method**. Open a swab packet and moisten two swabs using sterile, distilled water. Use approximately two drops on each swab. Thoroughly swab the area with both swabs using moderate pressure and a circular motion, swabbing from the periphery to the center. Re-swab the area with two additional dry swabs, using similar pressure and movements as the first swabs. The dry swab is rotated over the skin to recover the remaining moisture. Roll over the entire area to ensure all moisture is recovered.

Air dry the two pairs of swabs and package each pair in separate swab boxes provided in the kit. Mark on each swab box whether the swabs are the first or second swabs.

Indicate on the swab box, whether the secretion is suspected to be saliva, blood, semen, or another substance (other), and mark whether the swabs are from the first or second swabbing.

If another substance, please describe. **Identification of the source of the sample is critical since the lab may not test correctly for the suspected secretion if they are not aware of the suspected source. Unidentified specimens will only be tested for semen, and other evidence could be lost.**

Place swab boxes in “Dried Secretions” envelope. Seal the envelope, attach a tracking label and label as indicated. Identify the part of the patient’s body from which the samples were taken on the anatomical drawings on the envelope. Be certain that you have identified areas of fluorescence.

If multiple secretions are present, repeat the procedure using the additional swabs found in Step 17. **Do not** package swabs from two different areas in the same swab box or envelope. If more collections are needed they may be done using sterile hospital swabs packaged in clean paper folded to contain the evidence, then placed in a clean, white envelope that is appropriately labeled (see 3, Debris Collection, above).

Bite Marks

If bite marks are noted, describe and document their location on the anatomic diagram. Photograph the bite mark(s) with and without scale. It is best to take the photo directly over the bite.

Contact the State Crime Lab regarding possible urgent referral of the patient to a forensic odontologist.

Collect a saliva specimen as specified under “Dried Secretions” by using the double swab technique (above), making the collection inside the parameters of the bite mark. Be sure to make this collection before handling or touching the skin involved.

7. **KNOWN HEAD HAIR SAMPLE (State Kit Step 6)**

If hair appears matted, cut matted hair and place in separate envelope. If patient declines cutting, comb or swab the matted hair. Dry the swabs and place the swabs in a miscellaneous envelope. Label the envelope, including the suggested source of the substance (e.g., semen).

Collect 10-12 full-length head hairs, including the root, from different areas of the scalp – front, crown, back, and both sides. If patient declines hair pulling, run your gloved fingers through the patient's hair to collect any loose hairs.

Remove folded paper from envelope and place, unfolded, on a flat surface. Place the hairs in the center of the paper and refold paper so as to retain the hairs. Place the paper in the "Known Head Hair" envelope. Package and label as instructed.

If the victim is wearing a hairpiece such as a wig, extension or weave, pull hair from the hairpiece and place into a clean, white, hospital envelope marked "Hairpiece Hair Sample."

8. **FINGERNAIL CLIPPINGS/SWABBINGS (one for each hand) (State Kit Steps 3 & 4)**

Carefully inspect dorsal and palmar surface of hands for any signs of trauma. Document and photograph any findings.

Prior to clipping nails, photograph any broken or chipped fingernails. Collect fingernail clippings with the clippers from the kit. If the patient declines clippings, collect swabbings using the swabs from the miscellaneous envelope or sterile packaged swabs from hospital supply.

Clippings: Remove folded paper from envelope, unfold, and place on a flat surface. Hold patient's hand over the paper and gently clip the entire nail, allowing the clippings to fall on the paper. Protect the clipped fragments from flying out of control by using a cupped, gloved hand or clean folded paper over the nail as you clip. If a fingernail is broken, try to avoid cutting through or damaging the area where the break occurred.

Swabbings: Dampen the sterile swab with sterile water and swab under the nails using a separate swab for each hand. Air dry the swabs and place in the paper.

Place the refolded paper in the "Fingernail Clippings/Swabbings [right or left] hand" envelope and mark the appropriate contents. Package and label as instructed. Repeat for the other hand.

9. **KNOWN BLOOD COLLECTION (State Kit Step 5)**

Remove components from envelope. Using a lancet from hospital supply, prick the patient's finger. While holding the patient's finger over one of the four circles printed on the "Blood Collection Card," milk the patient's finger, allowing two to four drops of blood to fall on the circle. Repeat the procedure using the three remaining circles. (The blood does not need to fill the circles completely, but a specimen should be placed in each circle.) Allow the "Blood Collection Card" to air dry for approximately 30 minutes. Return card to "Known Blood Collection" envelope. Package and label as instructed.

Do not place used lancet back in the envelope or kit. Dispose of the lancet in a sharps container.

This step is being replaced by buccal swab. If the kit that you are using calls for a buccal swab follow the detailed directions on the envelope/in the kit. **Collect oral swabs prior to buccal swabs.**

10. PUBIC COMBING (State Kit Step 10)

Remove the folded paper and comb from the “Pubic Combing” envelope in the kit. Unfold the paper and place under patient’s buttocks. If hair appears matted, cut area and place hair in separate envelope as in step 7 above. Using the comb provided, comb pubic hair in downward strokes so that any loose hair and/or debris will fall onto paper. Carefully remove the paper to retain debris. Place comb in center and refold so as to retain the comb and any evidence collected. Return the paper to “Pubic Combing” envelope. Package and label as instructed.

11. KNOWN PUBIC HAIR SAMPLE (State Kit Step 11)

Remove a representative sample of 3-5 full-length pubic hairs from different regions of the pubic area. A portion of the known pubic hairs may be cut close to the skin. Remove folded paper from envelope and place, unfolded, on a flat surface. Place hairs in the center of the paper and refold so as to retain the hairs. Return the paper to the “Known Pubic Hairs” envelope. Package and label as instructed. **Do not** use tweezers to pull hairs.

NOTE: Patient may pull own hairs if they are more comfortable with this procedure.

NOTE: If patient has shaved, disregard this step.

12. EXTERNAL GENITAL AND PENILE / VAGINAL EXAM (No State Kit Step)

With patient in lithotomy position, first carefully inspect entire genital area for signs of injury. Look closely at the posterior fourchette, and margins between the labia minora and majora. Describe findings and document on body diagrams of genitalia.

Visualization will be assisted by using gentle, but firm downward, and outward traction on the labia majora. This will create a “tunnel” through which hymenal tissue can be visualized.

Photograph any observed injuries.

If colposcopy equipment is available, use colposcope to examine for injuries and document any tears, abrasions, bruises, redness or swelling.

13. GENITAL/PENILE SWABBINGS (State Kit Step 12)

Assess genital area with Wood’s lamp. Include inner thighs and anal area. Note any suspicious fluorescing areas and collect specific dried secretion samples from those areas as discussed in section 6 above.

Moisten swabs provided with distilled water. Holding the swabs together, briskly swab the external genitalia making sure to rotate the swabs during the collection procedure.

Female patient: Swab the external genital area (vulva) including the labia majora, labia minora, clitoral hood, fossa navicularis, posterior fourchette and the adjacent inner portions of the thighs. Pay particular attention to swabbing the creases between the labia majora and minora where secretions can be trapped.

Male patient: Swab the entire penis and scrotum. Be sure to swab under the foreskin in uncircumcised males. Do not insert swabs into the urethra.

Allow the swabs to air dry. Place the swabs in the swab box and check “Genital/Penile.” Place the swab box in the “Genital/Penile Swabbings” envelope. Package and label as instructed.

14. ANAL EXAMINATION, SWABS (State Kit Step 13)

To avoid cross contamination, obtain anal swabs before vaginal swabs.

With the patient in the lithotomy, prone, supine knee chest, or side lying position, carefully evaluate the anus and buttocks for signs of injury. Document any positive findings on the appropriate genital body diagram.

Swabs may be moistened with distilled water for the comfort of the patient. Carefully swab the peri-anal area using four swabs. Use individual swabs to gently swab the anal canal. It is recommended that time be spent allowing natural relaxation and dilatation of the anus prior to obtaining swabs.

Allow swabs to air dry. Package and label as instructed.

Note: If there is bleeding from the anus and rectal injury is suspected the physician should be consulted for possible anoscopy.

15. VAGINAL EXAMINATION, SWABS (State Kit Step 14)

Open swab packet and remove four swabs. Using the four unmoistened swabs, swab the vaginal cavity thoroughly. Be sure to sample the posterior vaginal pool. Allow swabs to air dry. Package and label as directed.

Speculum examination is helpful in visualizing intravaginal and cervical injuries and directing evidence collection. Size and type of speculum should be chosen taking into consideration the age and anatomy of the patient. Be sure to document any bleeding or pre-existing injury prior to inserting the speculum.

NOTE: Only use **water** for speculum lubrication as other lubricants can interfere with crime lab testing. Use lubricant for older patients if needed.

NOTE: Please use your judgment regarding use of a speculum on young adolescent patients. It is recommended only if the adolescent is sexually active and/or has had a speculum used in the past. Discuss this with the patient. Without using a speculum you will not be able to visualize the vagina or cervix for injury. If a speculum is not used, gather specimens by gently inserting swabs into the vagina. Blind swabs can cause injury; take great care.

NOTE: The bi-manual examination is not a standard component of the sexual assault medical/forensic exam. It should be performed only when there is clinical indication, such as pelvic pain. The exam is within the scope of practice of a physician and advanced practice health care provider, but not of the Registered Nurse.

16. CERVICAL EXAMINATION, SWABS (State Kit Step 15)

This step should only be performed with the use of a speculum to ensure visualization of the cervix.

Carefully swab the cervix using the four dry swabs. Collect secretions from the cervical os using the swabs one at a time. Allow swabs to air dry. Package and label as instructed.

17. MISCELLANEOUS EVIDENCE COLLECTION (State Kit Step 16)

Miscellaneous evidence includes those items that may have clinical and evidentiary relevance, but have not been collected during other portions of the examination. These items may include gum, tampons, sanitary napkins, chux, or other incontinence items.

Collect item and allow to air dry if necessary and possible. Place in glassine envelope. Place envelope in paper bag labeled "Miscellaneous." Seal, attach a tracking label and label contents. If you are unable to dry an item, package it separately from the kit and notify law enforcement about the item and the need to dry it, or place in their evidence freezer for preservation.

18. ADDITIONAL SWABS (State Kit Step 17)

The materials in this envelope are provided for collection of additional swabs for any of the steps above (e.g., additional dried secretions).

Be sure to label the envelope with the source of the specimens collected.

H. Urine, Blood and Emesis Specimen Collections

Note: Sex crimes kits provide separate boxes for blood and urine transport.

Urine and blood samples for drug screening are not routinely indicated in sexual assault forensic examinations, but should be collected when indicated.

When to Collect

1) When there is suspicion of the use of a "date rape drug," indicated by:

- History of periods of unconsciousness or lack of motor control;
- Amnesia, or a confused state with factors suspicious of sexual assault. (Particularly consider if patient has amnesia or confused state after no known drug ingestion, or a minimal consumption of alcohol. Also consider if the patient has a suspicion or belief they were drugged prior to or during sexual assault.)

2) When the patient is a minor and drugs/alcohol were involved. Even if sexual assault cannot be proven in these cases, the provision of alcohol and/or drugs to a minor is a crime.

Timing of Collections

Collect blood and urine if suspected ingestion was within 24 hours; collect only urine if more than 24 hours but fewer than 96 hours have passed.

Be sure to indicate suspected drugs, if known, as well as the approximate time of ingestion and the time blood/urine/emesis samples were collected.

Method of Collection

Urine Collection

Using normal hospital procedure and a urine container from hospital stock, collect at least 100ml of urine. Label the jar with the patient's name. Seal with evidence tape and place in the zip lock bag and close. Place the zip lock bag in the "Urine Collection" box. Seal the box, attach a tracking label and fill out all information requested. Be sure to note the date and time the specimen was collected and estimate time of ingestion.

If the quantity of urine is sufficient and there are medical indications for testing of the urine, such as pregnancy testing, a portion of the urine sample should be sent to the hospital laboratory. If not, use the first voided sample for drug testing and wait until the patient can provide another specimen for pregnancy testing.

The urine should be packaged **separately from the sex crimes kit** and turned over to law enforcement with maintenance of the appropriate chain of custody. Be sure that law enforcement is aware that if the evidence will not be immediately transported to the Health and Environmental Testing Lab, the urine should be **frozen**. Otherwise, refrigerate the specimen.

Blood Collection

Using normal medical procedure and two 10 ml or five 4ml gray topped (potassium oxalate and sodium fluoride) blood collection tubes, withdraw a sample from the patient allowing blood tube to fill to maximum volume. Label the blood tubes with the patient's name. Then place the tubes in the enclosed bubble pack and seal. Place the bubble pack in the "Blood Collection" box. Seal the box, attach a tracking label, and fill out **all** information requested. **Be sure to note the date and time the specimen was collected and estimated time of ingestion**

The blood specimen should be packaged separately from the Sex Crimes Kit and turned over to law enforcement with maintenance of the appropriate chain of custody. If the **blood** will not be immediately transported to the Health and Environmental Testing Lab in Augusta, the blood should be kept refrigerated (**not frozen**) until later transport.

Do not freeze blood tubes.

Emesis Collection

If the patient vomits while under the influence of a suspected drug used to facilitate sexual assault, and it has been less than four (4) hours since ingestion, the emesis should be collected. Collect the emesis in a sterile collection cup. If the emesis is a dried stain (e.g., vomitus on clothing), collect the item on which the stain is present.

The emesis (or the stained item) should be packaged separately from the sex crimes kit and turned over to law enforcement with maintenance of the appropriate chain of custody. Be sure that law enforcement is aware that if the evidence will not be immediately transported to the Health and Environmental Testing Lab, the emesis should be **frozen**. Otherwise, refrigerate the specimen. Be sure to note the date and time the specimen was collected and estimated time of ingestion.

I. Packaging of Evidence, Chain of Custody, & Appropriate Disposition of Kit

Packaging of Evidence

Instructions for packaging of the materials collected during the forensic examination are provided in the state sex crimes kit. Particular attention needs to be paid to the following areas in order to maintain appropriate chain of custody and provide proper identification of the materials within the kit. Failure to do so can compromise the ability of the lab to process the evidence and/or compromise the integrity of the evidence when presented in court.

- The tracking labels provided in the kit should be attached to each item of collected evidence and all requested information on the evidence envelopes/boxes should be completed.
- Clothing bags should be taped shut, **not stapled**. Staples can lead to injury of crime lab staff which could contaminate evidence, and are less effective seals.
- All collection envelopes should be returned to the kit, whether used or not. Unused envelopes should be marked to indicate that no sample was collected and placed in the large plastic bag marked ‘unused items’. Make a note in the kit if an envelope was missing.
- Evidence envelopes in the new kits are self sealing. Older envelopes should be sealed using a moistened swab or moistened gloved finger. Never lick an evidence envelope to seal.
- The evidence seals in the kits should be used to seal the kit. If the seals are lost or torn, any sturdy tape may be used to seal the box. Place your initials across the tape, partially on/partially off the seal.
- Complete the Evidence Collection Inventory Sheet from the sex crimes kit.
- The requested information on the box top of the sex crimes kit should be completed only if the patient is reporting to law enforcement. With an “ANONYMOUS KIT” ONLY THE TRACKING NUMBER should be on the outside of the kit; DO NOT put the patient’s name on the top of the kit.

Patient Notification

If the patient chooses not to report to law enforcement, it is very important to complete the “Patient Card” in the sex crimes kit by filling in the telephone number of the law enforcement agency where the kit is to be stored and attaching the tracking number to the card. Inform the patient that if the card is lost, the tracking number can also be retrieved from their medical record. Also discuss the availability of support through the Sexual Assault Support Center if the patient decides to report but is finding it difficult to contact law enforcement on her/his own.

Chain of Custody

Maintenance of chain of custody requires that the kit and all materials in the kit remain in the control of the examiner until the kit has been signed over to law enforcement. This means the examiner must be physically present with the kit at all times, or that the kit and all materials in the kit be placed in a locked space for which only the examiner holds the key. Some emergency departments have a special space, such as a designated locked cabinet, for this purpose. If this is

the case, only the examiner can have the key and access to that cabinet until the evidence is turned over to law enforcement. A sample 'chain of custody' form can be found in Appendix B. It is recommended that the form be completed and maintained in the medical record. Be sure to sign the kit, and all clothing, blood and urine evidence bags.

Disposition of the Sex Crimes Kit

- If the patient is choosing to REPORT to law enforcement, the kit and any other collected evidence materials (such as clothing, urine/blood samples) go to the law enforcement agency in the town/city/county where the assault took place.
- If the case is ANONYMOUS, the materials go to the law enforcement agency in the town, city, or county WHERE THE HOSPITAL IS LOCATED.
- Sign the top of the kit.

J. Medical Treatment

The appropriate triage and treatment of acute injuries is a priority at the time of initial presentation of the patient. Other critical areas of medical management include pregnancy testing, offering pregnancy prophylaxis, and evaluation for risk of Sexually Transmitted Disease (STD), including HIV, and offering appropriate education, testing and prophylaxis.

It is also important to attend to patient safety issues, mental health issues and planning for follow up care as discussed in the section below on discharge planning (page 63).

Pregnancy Prophylaxis

The fear of pregnancy secondary to assault is often a major motivator for the patient to seek care. It is critical to address these concerns and offer appropriate counseling and prophylaxis when indicated.

The risk of pregnancy from rape is the same as the risk of pregnancy from a one time sexual encounter, approximately 2 - 8%. The latter figure comes from a large prospective study of couples actively attempting pregnancy having a single act of unprotected intercourse approximately one to two days before ovulation (Wilcox, A., Weinberg, C., et al.). In women age 19 to 26, whose fertility is higher, the risk of pregnancy may be up to 50% with unprotected intercourse in this period of the menstrual cycle (Dunson, D. B., et al.).

The immediate use of emergency postcoital contraception reduces the risk of pregnancy to 1 to 2%. The effectiveness of the contraception is dependent on the method used and the interval between intercourse and treatment (Westoff, C.).

The availability of pregnancy prophylaxis should be discussed with each patient of child bearing capacity and treatment should be offered.

Because of the variability in the length of menstrual cycles and the inability to predict accurately the timing of ovulation, "rhythm" methods should not be relied upon and treatment should be offered regardless of the timing of the assault relative to the menstrual cycle.

A survey of the availability of emergency contraception published in the *Annals of Emergency Medicine* found that staff at 42% to 55% of surveyed hospitals said that they do not dispense

emergency contraception, even in cases of sexual assault. Among staff who said that their hospital does not provide emergency contraception under any circumstances, only about half gave callers a valid referral, and most referrals were ineffective (Harrison, T.).

The American College of Emergency Physicians recommends in their guidelines for management of the sexually assaulted patient that victims of sexual assault be offered pregnancy prophylaxis. They further recommend that practitioners who find this morally objectionable or practice at hospitals that do not provide prophylaxis or contraceptive therapies should offer referral to another provider who can provide these services and do so in a timely manner (American College of Emergency Physicians, 1999).

Medications for Pregnancy Prophylaxis

There are now two alternatives for post coital contraception. The advantages of Plan B far outweigh the second, older Yuzpe regimen.

1. Levonorgestrel (Plan B)

This is a newer progestin-only alternative to the historically first post-coital contraceptive method (Yuzpe, combined estrogen-progestin regimen) discussed below. Given its efficacy and reduced side effect profile, **this is the post-coital contraceptive of choice in sexual assault**. It can be given up to 5 days post assault.

Traditionally, Levonorgestrel 0.75 mg is taken as soon as possible after the assault with a second 0.75 mg tablet taken 12 hours later. It has been shown, however, that the Levonorgestrel can be taken in a single dose (two 0.75 mg pills, for a total of 1.5 mg of Levonorgestrel in a single dose) with the same efficacy as the original divided dose (Von Hertzen, H., et al.).

Clinical trials have shown the progestin-only regimen to be more effective than the combined estrogen-progestin regimen, resulting in a reduction of pregnancy risk to 1%. The same studies also show that this newer regimen has significantly less associated nausea and vomiting (*Lancet* 1998:353:428-32).

The incidence of nausea and vomiting is so low, an anti-emetic is given only on an as-needed basis rather than prophylactically. It also is not associated with the potential thromboembolic complications of the Yuzpe regimen. The only contraindication to use is allergy to the medication.

2. Yuzpe Regimen (Levonorgestrel 0.5mg, plus ethinyl estradiol 0.1mg)

This regimen was developed in the 1970's and entails the use of two doses of a combination oral contraceptive (Ovral, Preven). It had been the prior standard regimen for pregnancy prophylaxis. Two tablets are taken immediately, followed by 2 tablets twelve hours later.

Side effects include nausea, as well as breast tenderness and possible menstrual irregularity. Extrapolating from the risks of the regular use of oral contraceptives, there is a theoretical potential for rare side effects such as thromboembolic disease, stroke, or MI, though studies have not clearly demonstrated this (Glazier, A.). Theoretical relative contraindications to treatment would be a history of thromboembolic disease, breast cancer, stroke, coronary disease, liver disease, history of abnormal vaginal bleeding, or sickle cell disease. Given the brief hormonal exposure involved in the emergency contraceptive regimen, however, the relative risk of this

exposure appears small and is outweighed by the benefit of prevention of a potentially high risk pregnancy. This dilemma can be avoided altogether by the use of Plan B.

Because of the absence of any clinical advantages to the Yuzpe Regimen, the lower side effect profile of the Plan B regimen and the ability to complete treatment in one dose with Plan B, the only reason for using the combined estrogen-progestin regimen is if the Plan B alternative is not available.

Timing of Pregnancy Prophylaxis

Current recommendations indicate emergency contraceptive medications can be effective **up to 5 days following unprotected intercourse.**

In her 2003 review, Westhoff recommends that “[e]mergency contraception should thus be offered for any act of unprotected intercourse that has occurred in the preceding five days, even if the patient has had other unprotected acts earlier in the same menstrual cycle.” (Westhoff, C.) Previous recommendations had been that medication be started within 72 hours of the assault (as soon after the assault as possible). This was related to the fact that the initial studies involved use of emergency contraceptive medications up to three days after unprotected intercourse. Observational studies, however, have shown reduction in pregnancy rates similar to those of earlier treatment in patients treated with emergency contraceptive medications up to 72 to 120 hours after intercourse (Ellertson, C., et al.; Rodrigues, I., et al.).

Testing Prior to Treatment

Studies have shown that Plan B does not affect an already established pregnancy. Westhoff reviews the literature regarding outcomes of pregnancy after emergency contraception and concludes that “patients who had a recent menstrual period at the usual time and with the usual flow do not need a pregnancy test before using emergency contraception.” Pregnancy testing if “the menstrual history is either vague or unusual” is recommended, mainly to facilitate earlier diagnosis and management of a pregnancy that is already established (Westhoff, C.).

While pregnancy testing in cases of sexual assault is not medically necessary prior to use of emergency contraception, the other dynamics active in the case of sexual assault would argue for pregnancy testing at the time of the examination to document presence or absence of pregnancy predating the assault.

Follow-up

Treatment is not 100% effective, and the patient should be warned that pregnancy is still possible. If the patient does not have a menses within 2 to 4 weeks, she should have a pregnancy test.

Sexually Transmitted Diseases (STD)

A primary concern regarding the possible contraction of an STD is common in patients presenting to the emergency department following sexual assault. The Centers for Disease Control and Infection report that trichomoniasis, bacterial vaginosis, chlamydia, and gonorrhea are the most frequently diagnosed infections among women who have been sexually assaulted (CDC, *STD Treatment Guidelines*, 2010). Of these, chlamydia and gonorrhea are of particular concern because of the risk of ascending infection, more serious illness, and impaired fertility. Hepatitis B, genital herpes, and human immunodeficiency virus (HIV) infection are also discussed below.

The Issue of Testing for STD Prior to Treatment

Though testing for STD at the time of sexual assault evaluation has been a norm in the past, there are some good arguments for reconsidering this practice. Unless there are signs or symptoms suggesting ongoing infection, it is hard to identify clinical or legal indications for testing.

Most positive cultures obtained within 72 hours of the assault will reflect infection antedating the assault. Assuming prophylactic treatment and follow up are going to be pursued, cultures will add nothing to the plan for clinical treatment.

Testing should be done if clinically indicated for other reasons such as pre-existing symptoms, findings on physical examination, or if the patient declines prophylactic treatment.

Prophylactic Treatment for STDs

Prophylactic treatment for the most common STDs is indicated at the time of the initial examination. The following recommendations are based on the most recent Centers for Disease Control Guidelines, published in 2010.

Treatment Regimens for STD Prophylaxis

Gonorrhea

Ceftriaxone (Rocephin) 250 mg. IM in a single dose

OR

Cefixime 400 mg. orally in a single dose

Fluoroquinolone Resistance

Since 1993, Fluoroquinolones (i.e., ciprofloxacin, ofloxacin, or levofloxacin) have been used frequently in the treatment of gonorrhea because of their high efficacy, ready availability, and convenience as a single-dose, oral therapy. However, prevalence of fluoroquinolone resistance in *Neisseria gonorrhoeae* has been increasing and is becoming widespread in the United States, necessitating changes in treatment regimens. On the basis of the most recent evidence, CDC no longer recommends the use of fluoroquinolones for the treatment of gonococcal infections and associated conditions such as pelvic inflammatory disease (PID). Consequently, only one class of drugs, the cephalosporins, is still recommended and available for the treatment of gonorrhea (MMWR April 13, 2007/56(14):332-226 Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2006: Fluoroquinolones No Longer Recommended for Treatment of Gonococcal Infections).

Chlamydia

Azithromycin (Zithromax) 1 gram po in a single dose is the drug of choice.

It is particularly advantageous to be able to give the medication in a single dose at the time of evaluation, thus improving compliance.

Alternative for the patient allergic to macrolide antibiotics

Doxycycline 100 mg po bid for 7 days.

Note: May interfere with efficacy of oral contraceptives; advise patients to use a back up method of birth control during the period of treatment.

Syphilis

No specific prophylaxis recommended by the CDC for syphilis. Ceftriaxone 250mg. IM can provide protection against incubating syphilis. Serology at the follow up examination should be done.

Bacterial Vaginosis and Trichomoniasis

Metronidazole (Flagyl) 2 grams in a single dose

Metronidazole might aggravate the potential nausea and vomiting already associated with the other prophylactic medications. Also, the recent ingestion of alcohol is a common factor at the time of initial evaluation and this is a contraindication to the use of Metronidazole.

The provider may want to defer treatment as needed to the time of the follow-up exam or dispense the Metronidazole to be taken a day later at home once other STD and pregnancy prophylaxis treatments have been successfully completed and alcohol has been metabolized.

Hepatitis B

Recommendations of the CDC indicate that post-exposure Hepatitis B vaccination, without HBIG, is adequate protection against Hepatitis B virus exposure in the setting of sexual assault (CDC, STD Treatment Guidelines, 2010). If a patient is already immunized, no further intervention is needed. In the absence of prior completed, full series of three Hepatitis B vaccines, the Hepatitis B immunization should be initiated. (As of the early 1990's Hepatitis B vaccine became a component of routine childhood immunizations.)

When indicated, the first dose should be administered at the time of the initial examination, with follow up doses at 1-2 and 4-6 months after the first. It is very important to make clear to the patient that the full series of immunization will be required.

If there is a known high risk of exposure (e.g., multiple perpetrators, a known Hepatitis B positive assailant, or assailant at high risk for Hepatitis B), Hepatitis B Immune Globulin may be considered in addition to the vaccine (at the time of the first dose of vaccine), but is not routinely recommended.

Herpes Simplex/Genital Herpes

Although there is no regimen for prophylaxis against herpetic infection, patients should be educated regarding the symptoms of primary genital herpes so they know to see their primary care provider should symptoms arise.

Summary of STD Prophylaxis Guidelines

| STD | Treatment | Alternative |
|--|--|--|
| Gonorrhea | Ceftriaxone 250 mg. IM | Cefixime 400 mg. po |
| Chlamydia | Azithromycin 1 gram po | Doxycycline 100 mg. po bid for 7 days |
| Syphilis | No separate treatment. (Ceftriaxone 250 mg. IM for GC probably protective) | Serology should be done at the follow up visit |
| Bacterial Vaginosis and Trichomoniasis | Metronidazole 2 grams po in a single dose (Consider need for delayed treatment) | |
| Hepatitis B | Begin series of Hepatitis B vaccine if not already completed | Consider also adding HBIG <u>only</u> if high risk situation |
| Genital Herpes | No preventive medication, but educate patient re coming in for antiviral therapy if symptoms arise | |

Human Immunodeficiency Virus (HIV)

Given the profound consequences of HIV infection, it is not surprising that potential exposure to HIV is a source of concern in patients presenting with a history of sexual assault. Unfortunately, Post Exposure Prophylaxis (HIV PEP) following sexual assault is not as simple or straightforward as prophylaxis of GC or Chlamydia. (See further discussion in the section below: HIV Post Exposure Prophylaxis.) It is clear, however, that HIV testing should be performed.

HIV Testing

Even if HIV PEP is not used, the patient should still have HIV testing at baseline, with follow up testing at 6 weeks, 3months, and 6 months from the time of assault. (CDC, 2010)

HIV testing should not be done without appropriate counseling and follow-up. Testing should be done in the emergency department **ONLY** if the patient has an identified physician to whom the results will be sent and with whom that patient will have a scheduled appointment to discuss the results and arrange further follow-up testing.

An anonymous testing center offers both appropriate counseling as well as better protection of patient confidentiality. A listing of counseling and testing centers can be found in Appendix C.

With questions involving adolescent patients, a pediatric ID specialist should be contacted.

HIV Post Exposure Prophylaxis (HIV PEP)

There are no randomized, controlled trials studying the efficacy of HIV Post Exposure Prophylaxis in cases of sexual assault. Recommendations need to be extrapolated from other studies, such as those performed in the setting of occupationally exposed patients.

In January 2005, the CDC published recommendations for *Antiretroviral Post-exposure Prophylaxis After Sexual, Injection-Drug Use, or Other Non-occupational Exposure to HIV* in the United States (MMWR January 21, 2005). The practical application of these guidelines in cases of sexual assault is difficult since critical information, most notably the HIV status of the assailant, is most frequently absent. In these circumstances it is necessary to weigh risks and benefits on a case by case basis. The following review will hopefully assist medical providers in this process.

Risk of HIV Transmission in Sexual Assault

The probability of acquiring HIV infection through sexual assault is believed to be low, but clearly possible. HIV-antibody seroconversion has been reported in patients whose only known risk factor was sexual assault or sexual abuse.

CDC Guidelines for HIV Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Non-occupational Exposure to HIV in the United States were published in MMWR January 21, 2005/54(RR02); 1-20.

The following table, taken from these guidelines shows the relative risk per act, for acquisition of HIV by exposure, assuming an HIV positive source or partner and, in the case of sexual acts, no condom use.

Table 1

| Exposure Route | Risk per 10,000 exposures to an infected source |
|--------------------------------------|---|
| Blood Transfusion | 9,000 |
| Needle-sharing IV drug use | 67 |
| Receptive anal intercourse | 50 |
| Percutaneous needle stick | 30 |
| Receptive penile-vaginal intercourse | 10 |
| Insertive anal intercourse | 6.5 |
| Insertive penile-vaginal intercourse | 5 |
| Receptive oral intercourse | 1 |
| Insertive oral intercourse | 0.5 |

These rates may be higher in sexual assault due to the violent nature of the act and increased risk of transmission through traumatized, open tissues.

Of course, in the case of the unknown assailant, the risk would also vary depending on the likelihood that the assailant is actually infected with HIV.

Evidence of the Potential Benefit of HIV Post Exposure Prophylaxis (PEP)

Evidence indicating that HIV PEP might reduce the risk of HIV infection after sexual assault and other non-occupational exposures comes from a variety of studies, including animal studies, perinatal clinical trials of postnatal prophylaxis, studies of occupational PEP, and observational studies (see discussion in CDC recommendations, US DHHS, 2005). An example of one such study involved the case-control study of needle stick injuries in health care workers in which it was found that there was an 81% decrease in the risk of acquiring HIV with the timely use of Zidovudine (Cardo, D.M., et al.). Extrapolation from these studies would support the potential benefit of HIV PEP in the case of the sexual assault patient exposed to an HIV positive perpetrator.

HIV PEP: Risks, Costs, and Compliance

Unfortunately, the use of HIV PEP is not without risk and expense. Side effects of antiretroviral therapy include GI intolerance, fatigue, malaise, skin reactions, myalgia, headaches, insomnia, nephrolithiasis, hepatotoxicity, and bone marrow suppression.

The cost of a typical 4-week course of antiretroviral therapy is \$800 to \$1,200, not including the costs of laboratory testing and medical follow up.

One study of 492 health care workers in the occupational PEP registry showed 76% had complaints of side effects such as nausea (57%), fatigue or malaise (38%). Six in this group reported severe adverse events, four of whom stopped taking PEP due to these events. Sixty-eight workers stopped PEP despite exposure to a known HIV positive source; 43% of these stopped due to side effects (Wang, S.A., et al.).

Another study, this one of the U.S. non-occupational PEP surveillance registry, noted 22% modification or cessation of PEP, half of these modifications or stops being secondary to side effects (Grohskopf, L.A., et al.).

A Vancouver study looked at the completion of HIV PEP treatment in a group of sexual assault survivors. Seventy one of 258 accepted a 5 day starter pack of nonoccupational PEP. Twenty-nine returned for additional doses, with only 8 of those actually completing four weeks of therapy (Wiebe, E.R., et al.).

An Approach to the Question of HIV PEP

The Non-occupational HIV PEP Task Force from Brown University AIDS Program and the Rhode Island Department of Health present a model in which to develop a “case by case” analysis for the use of HIV PEP (Nonoccupational HIV PEP Task Force). The model is as follows:

1. Determine if exposure meets criteria for HIV PEP evaluation. In the case of the sexual assault patient this would include exposure consisting of:
 - Unprotected vaginal or anal penetration by persons at risk or known to be infected with HIV;
 - Oral sex involving exposure to seminal or vaginal secretions from sources that are HIV infected or at risk of HIV infection;

- Blood/body fluids exposures to injured/damaged (non-intact) skin or mucosa from sources that are HIV infected or at risk of HIV infection;
- Treatment could be initiated within 72 hours from time of assault;
- The patient is not already HIV infected;
- Patient is able to give consent and willing to continue 28 days of uninterrupted therapy.

HIV PEP would generally not be necessary for sexual acts that did not involve vaginal or anal intercourse, or oral receipt of seminal or vaginal fluids or human blood.

2. Determine source HIV status or risk factors of the source(s), when known. Though this is often not possible in the case of sexual assault, certain factors may provide clues to a HIGHER risk situation. These HIGHER RISK FACTORS would include:

- assault by multiple perpetrators;
- perpetrator with known multiple sexual partners;
- perpetrator with history of sexually transmitted disease;
- perpetrator with known engagement in male-male sex;
- perpetrator with history of IV drug use or trading of sex for money or drugs;
- anal penetration by an unknown assailant;
- anal penetration or vaginal penetration with associated traumatic tearing injury;
- the presence of other STD's that would threaten the integrity of the vaginal mucosa.

All of these factors could increase risk of transmission if HIV were present.

The local epidemiology of HIV would also influence the relative risk. For example, an assault in prison is more apt to be high risk than one in the community at large. In addition, the rate of HIV varies from one area of the country to another.

3. Recommendations for Treatment Based on Risk Stratification.

Risk Stratification, with recommended drug treatments (see table below) as follows:

RECOMMENDED: Known exposure to HIV source. **Treatment strongly advised.**

OFFERED: Unknown source but with higher risk factors. Discuss potential risk with the patient and offer treatment if they so desire after informed discussion of risks and benefits.

CONSIDERED: Unknown source with lower risk factors. **Treatment not recommended or routinely offered** but might be considered in the face of “compelling” circumstances, such as a strong patient desire for treatment after informed consent.

In general, given the current incidence of HIV in the Maine population, most patients would fall into the “considered” category.

Guidelines For HIV PEP After Sexual Assault

| Action | Indication/Exposure | Medication |
|--|---|--|
| <p style="text-align: center;">Recommend PEP</p> | <p>Unprotected vaginal or anal intercourse with a KNOWN HIV infected assailant.</p> <p>Unprotected oral sex with a KNOWN HIV-infected assailant when transfer of seminal or vaginal secretions occurred.</p> | <p>Assailant’s medications are UNKNOWN; assailant is not using HIV medications:</p> <p>Three drug regimen (See page 61)</p> <p>Assailant’s medication regimen is KNOWN or known resistance is present: Discuss options with HIV specialist as soon as possible. (If advice is unavailable, a regimen is different from the medications the assailant currently uses can be used at the initial dose. Choose two nucleoside reverse transcriptase inhibitors and a protease inhibitor).</p> |
| <p style="text-align: center;">Offer PEP</p> | <p>Unprotected vaginal or anal intercourse with an assailant whose HIV status is UNKNOWN AND could be at a HIGHER (see above) risk of HIV infection.</p> <p>Unprotected oral sex when DEFINITE transfer of seminal or vaginal secretions occurred, with an assailant whose HIV status is UNKNOWN AND could be at a HIGHER risk of HIV infection.</p> | <p style="text-align: center;">Two drug regimen (See page 61)</p> <p>Consider moving to three drug regimen (adding protease inhibitor) when:</p> <ol style="list-style-type: none"> a. the assailant has multiple risk factors for HIV infection, AND/OR, b. the patient has a sexually transmitted disease or is pregnant, AND/OR c. other compelling circumstances exist. |
| <p style="text-align: center;">Consider PEP</p> | <p>Unprotected vaginal or anal intercourse with an assailant whose HIV status is UNKNOWN AND could be at a LOWER risk of HIV infection.</p> <p>Unprotected oral sex when transfer of seminal or vaginal secretions occurred with an assailant whose HIV status is UNKNOWN AND could be at a LOWER risk of HIV infection.</p> | <p style="text-align: center;">Two drug regimen (See page 61)</p> |

Drug Regimens for HIV PEP

There are a variety of drugs available for HIV PEP. The following are possible regimens. **We recommend each institution review options with their infectious disease specialists and maintain a protocol that includes availability of 3 to 5 day starter packs of medications and relevant written medication information for the patient.**

- **Possible Two Drug Regimen**

Truvada (Emtricitabine 200 mg. and Tenofovir 300 mg.) OR, Combivir (Zidovudine 300 mg. + Lamivudine 150 mg.), one tablet, twice daily.

- **Possible Three Drug Regimen (one of above combinations PLUS protease inhibitor)**

Kaletra (Lopinavir 200 mg. and Ritonavir 50 mg.), two tablets, twice daily, OR Indinavir 400 mg., two capsules every 8 hours on an empty stomach.

Other Factors in Treatment

Treatment timing: The first dose of HIV PEP should be administered as soon as possible for the best chance of success, preferably within the first hour. Treatment should begin within 72 hours of exposure.

Duration of treatment: A full 28 days of uninterrupted treatment is recommended.

Patient consent: As a component of consent, patients should be informed that HIV PEP is still of unknown efficacy, is not a cure for HIV infection, and must be taken under the care of a specialist with regular follow up visits and laboratory testing.

Starter medication: The patient should receive an initial prescription for three to five days to cover the time to the first appointment with the HIV specialist. It is advised that starter packs should be packaged and available through the hospital pharmacy, and should contain the starting days of medication as well as instructions and drug information for the patient.

Testing: Patients should have baseline laboratory testing within 72 hours of receiving HIV PEP. This testing should include HIV, Hepatitis B and C, chemistry panel including liver function tests and CBC. Women of childbearing age should have pregnancy testing.

Prior to Discharge: Follow up medical care, preferably with an HIV specialist, must be arranged prior to discharge. This can be coordinated with the infectious disease specialist at your hospital or the patient's primary care physician.

Resources

National HIV/AIDS Clinicians' Consultation Center; **24 hour a day** telephone consultations are available through:

1. PEpline (National Clinicians' Post-Exposure Prophylaxis Hotline) 1-888-448-4911, 24 hours/day, 7 days/week. Offers healthcare providers around the clock advice on managing occupational exposures to HIV, and Hepatitis B and C. They do take calls re PEP in cases of sexual assault.
2. Warmline (National HIV Telephone Consultation Service) 1-800-933-3413, Monday –Friday, 8am – 8pm EST. Voicemail 24 hours/day, 7 days/week. Offers healthcare providers expert clinical consultation on antiretroviral treatment options, drug interactions and toxicity, resistance testing, prophylaxis and management of opportunistic infections, and primary care of persons with HIV/AIDS.

HIV Testing and Medical Follow-Up

Even if HIV PEP is not used, the patient should still have HIV testing at baseline, with follow up testing at 6 weeks, 3 months and 6 months from the time of assault. (CDC 2010)

HIV testing should not be done without appropriate counseling and follow-up care. Testing should be done in the emergency department ONLY if the patient has an identified physician to whom the results will be sent and with whom the patient will have a scheduled appointment to discuss the results and arrange further follow-up testing.

An anonymous testing center offers both appropriate counseling as well as better protection of patient confidentiality. A listing of counseling and testing centers can be found in Appendix F.

With questions involving adolescent patients, a pediatric ID specialist should be contacted.

K. Strangulation

Strangulation is commonly used by sex offenders (and domestic violence perpetrators) as a way to immobilize the victim. It is therefore important to always assess the patient for signs and symptoms of strangulation and document any findings. Because serious, perhaps life threatening breathing changes can occur hours after the assault, consider admitting the patient who has suffered strangulation so that breathing/airway can be monitored.

Strangulation is a form of asphyxia characterized by closure of blood vessels and/or air passages of the neck as a result of external pressure on the neck. It is often incorrectly referred to as “choking” which is a blockage of the airway, and is internal. Strangulation is external. It can lead to unconsciousness, irreversible neurological damage, and death by causing hypoxia in the brain. It differs from suffocation which is the covering of the mouth and nose with hands, pillow, plastic bag, or by the perpetrator sitting on the victim’s chest.

There are three general mechanisms of strangulation: hanging, ligature strangulation, and manual strangulation. These can cause:

- Compression of the carotid arteries and/or jugular veins causing cerebral ischemia;
- Compression of the laryngopharynx (larynx or trachea) causing asphyxia; and,
- Stimulation of the carotid sinus reflex causing brachycardia and/or hypotension.

Vascular obstruction is usually the main mechanism. After 50 seconds of continuous oxygen deprivation, the victim rarely recovers.

Internal symptoms of strangulation include:

- Voice changes from hoarseness, to complete loss of voice.
- Difficulty or pain when swallowing due to hyoid bone injury/laryngeal fracture/internal bleeding. (The injury may appear mild but can kill within 36 hours).

Difficulty breathing which may be due to hyperventilation that accompanies a terrifying event, but more importantly, may be secondary to underlying neck injury. The breathing changes may appear mild, but over time (24 – 36 hours), the injuries could be fatal.

- Involuntary urination and defecation can occur.
- Behavioral changes including (early) restlessness, violence or hostility; (long term) personality changes; amnesia; psychosis.
- Ringing in the ears.
- Unconsciousness.
- Miscarriage hours or days later.

External, visible injuries to the neck may include:

- Redness, scratches, abrasions, and scrapes (claw marks).
- Pattern redness or bruising, may be evident.
- Patterned impression marks (thumb print bruising).
- Rope burns.
- Linear fingernail scrapes either from the assailant or the victim.
- Petechiae of the sclera, around the eyes, under the eyelids, anywhere on the face, and on the neck above the area of constriction. Petechiae can result if pressure is maintained for more than 20 seconds.
- Blood red eyes which suggest significant struggle between the victim and assailant.

L. Discharge Planning

Patients must leave the hospital with information related to follow up care including:

- medical and mental health needs
- injury management
- physical comfort
- community resources and referral

Information must be clear and concise and should be tailored to the patient's communication skill level and language. Contact information for the local sexual assault support center should be provided.

Documentation of developing or healing injuries or resolution of healing should also be considered when indicated. Occasionally there may be injuries seen on the exam that call for re-examination at a later date to document progression or resolution of acute injury. Examples would include areas of tenderness that might be expected to develop into visible bruises in 1 to 2 days, or genital findings suspicious for injury that could be expected to resolve over 1 to 2 weeks, whereas normal variants will be unchanged.

Protocols for follow up examinations need to be developed at a local level, but best practice calls for reexamination and documentation, including photographs, of evolving/healing injuries by the

provider who did the original exam. If this is not feasible, the patient should be referred to their PCP or local clinic, such as Family Planning or Planned Parenthood. Non-genital bruises or other evolving injuries could be documented and photographed by law enforcement.

The following issues should also be addressed at time of discharge:

- Medical Discharge Instructions: Oral and written instructions should be provided, including treatment received, a list of medications prescribed or provided, and referrals for follow up. Be certain that the patient's physical comfort needs have been met.
- Safety Planning: Determine if the patient feels safe returning to her/his residence. If not, assist the patient in exploring alternatives, such as staying with relatives, friends, or in an emergency shelter. If the patient has physical disabilities, the shelter must be accessible and staff able to meet the patient's needs. If the patient lives in an institutional setting (group home, nursing home, etc.) and may have been assaulted by another resident, staff person, or someone with access to residents, alternative living arrangements must be made to avoid having the patient come in contact with the suspected perpetrator. This arrangement should provide the patient with the services she/he needs and that are designed to promote recovery from the assault. A state agency such as Adult Protective, may be of help.
- Transportation: If necessary, assist with transportation to allow the patient to safely reach home or an alternative safe location.
- Emotional Support: Ideally, the patient should have support from a Sexual Assault Support Center advocate during the medical/forensic exam. If the patient is suicidal or otherwise seriously distraught, consider immediate consultation with crisis services/social services.
- Mental Health: A list of names of therapists or community mental health agencies appropriate for sexual assault survivors may be available to patients from the local sexual assault support center.
- Resources and Referral: On discharge, the patient should be provided with information regarding ongoing support services and any medical treatment necessary. Provide contact information for who will be taking follow up photos if indicated. Provide referral information for STD follow up testing as well as HIV testing and counseling sites. If the patient wants an Order for Protection from Abuse, the local sexual assault support center can help. Be sure to give the patient information about the Victim Compensation Program.
- Coordination of Follow Up: Follow up care may have to be coordinated among various providers/agencies, depending on the case. These may include schools, law enforcement, prisons or jails, agencies that provide services to teen, immigrant, refugee, or homeless populations, or state agencies such as child or adult protective services.
- Sexual Assault Support Centers: Advocacy programs offer a host of services for survivors of sexual assault. Knowledge of services and relationships with advocates who respond to hospital calls can be helpful. Advocates can help with safety planning prior to

discharge and can follow up with the patient. They can accompany the survivor to court for a Protection from Abuse Order. Most programs offer support groups and counseling referrals in the community. There is a free and confidential statewide sexual assault crisis and support line available 24 hours a day at 800-871-7741, TTY 800-458-5599.

- **Investigative Process:** If the patient is reporting the assault to law enforcement, explain that investigators will want to interview her/him (if that has not already occurred), explain the criminal justice process, and assess safety. The advocate can help with this. Remember that it is the patient's choice whether to involve law enforcement. Remind the patient that the sex crimes kit will be held by police for up to 90 days (often longer) giving the patient time to decide whether to report. The patient can report her/his case to law enforcement at any time in her/his life, though the evidence may be destroyed after 90 days.

M. Photo Documentation

Much of the information below was adapted from the National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents, US DOJ, Office on Violence Against Women, September 2004.

Legally, photographs are part of the medical record and should not be put in the state sex crimes kit, nor should they be given to law enforcement without patient written, informed consent or a subpoena.

Taking photographs of patient injuries should be routine, but requires patient consent.

Photographs can be a powerful adjunct to the forensic history, documentation, and physical findings for the medical record. It is important for each hospital to develop its own protocol regarding forensic photography, taking into account equipment used, who will be taking the photographs, and storage of photographs in the medical record.

Hospitals vary in the photographic equipment available to the forensic examiner. Ideally, a digital camera is used. The camera should be a single lens reflex, have macro capability, a ring flash attachment, a ring light attachment, and have a minimum of 5 mega-pixels.

Digital Photos: Digital photos should be downloaded onto two CDs or a memory card, and stored with the medical record. If on CD, one copy should remain with the medical record; the other will be available should the prosecutor subpoena the photos.

35 mm Photos: Most 35 mm film is sent to the crime lab with the sex crimes kit since hospitals do not have a mechanism to have the film developed confidentially. Document in the medical record that the film was placed in the sex crimes kit. If your hospital develops 35 mm film it is important to create a mechanism to ensure that the photos and negatives are stored with the patient's medical record and that the chain of custody of the photos is maintained. The biggest disadvantage of 35mm is that there is no way to tell if good images were achieved.

Poloroid Photos: This is rarely used. Poloriod prints are often of such poor quality that they are of questionable use for forensic purposes, and they may degrade over time. If Poloroid photos are taken, take two of each image so that one will be available to the prosecutor should the photos be subpoenaed.

Your hospital protocol should include how to label photographs, how film is to be developed, duplication of prints, storage of photographs, and follow-up photo procedures. Again, do not include digital or Poloroid photographs in the sex crimes kit. However, 35mm film can be included unless the hospital protocol specifies otherwise. The crime lab will develop 35mm film. Always maintain chain of custody. Involve prosecutors, law enforcement, forensic examiners, and advocates in protocol development, and work with local police departments regarding follow-up photographs.

Photographs ideally should be taken by the forensic examiner because the patient is more comfortable and less traumatized by the caregiver who has developed a rapport with the patient. Patient privacy and comfort must be considered. Drape the patient appropriately. Explain the purpose of the photos, the extent and approximate number of photos that will be taken, procedures to be used, potential uses of photographs during the investigation and prosecution (especially if ano-genital photos are taken), who may see the photos, and the possible need to get follow-up photographs.

Photos can be taken at any time during the medical forensic exam as injuries are observed. Mechanisms should be in place to protect patient privacy and confidentiality related to the photographs.

Patient Identification: There must be a link between the patient and the photographs. Some jurisdictions ask that a photo of the patient's face be taken; another way to create a link is the write the patient's name, medical ID number, kit tracking number, date of exam, and the photographer's name/initials on a plain sheet of paper, and take a photo of this at the beginning and end of the roll of 35 mm film or CD, or place this information on the back of Poloroid photos.

Photo Clarity: Photos need to be clear, with sharp focus, taken at eye level, and framed accurately. Use the shutter speed and lens aperture to control exposure. Use adequate lighting. All forensic examiners must have training on the proper use of photographic equipment. The protocol should include an information guide for reference. Some photos should be taken in both color and black and white if possible; this can be done with some digital cameras.

Scale: Use an inch scale or ruler for size reference in photos. It is suggested that several photos be taken of each injury, one with the scale and one without, showing that the scale did not cover up any part of the injury.

Orientation of Photos: Always document the position of the patient when photos are taken. When taking photos of cuts, bruises, bite marks, swelling, lacerations, or abrasions take several photos of each injury – sides, top, and bottom – and take a shot showing the injury in relation to a region of the body. Include anatomical landmarks. For example, a bruise on the arm should be photographed closely from different angles, with and without a scale, and then photographed to include an anatomical landmark like the shoulder, elbow or wrist.

Take close up photos of hands and fingernails if there is blood, hair or skin under the nails, or if a fingernail is broken or missing. Photograph debris evidence on the body such as dirt, gravel, leaves, etc. Photograph restraint marks from the wrists, ankles or neck. If taken close up they may be compared to items used to restrain the patient.

Follow-up Photographs: Follow-up photos should be taken as bruises or other injuries change over time. These photos can document emerging/evolving injuries, as well as healing/resolving injuries.

Accountability: Clearly label all photos and maintain chain of custody. Follow hospital policy/jurisdictional policy for development of film, transfer, duplication and storage of prints or CDs.

N. Documentation

The provider is responsible for completing all of the records in the sex crimes kit as well as documentation in the hospital medical record. The documentation should include history, details of the examination findings, treatment, and discharge and follow up plans. It should be thorough and accurate. Include a description of the patient's demeanor and statements (direct quotes) related to the assault. The record has the potential to be used in the case investigation as well as the criminal proceedings should the case go to court. In addition, the examiner will need the record to refresh her/his memory should she/he be called upon to testify at trial.

Do not white out any portion of the record; cross out errors and initial. Write legibly. Sign your name so that it is easily identifiable. Nurses who are nationally certified through IAFN may write 'SANE-A' after their name. The acronym 'SANE' is copyrighted by the International Association of Forensic Nurses. Nurses who are Maine state certified, but not nationally certified, may write out "Sexual Assault Forensic Examiner," or "SAFE" after their name. Advanced practice nurses, physicians, and PA's may write 'SAFE' after their name if they are ME state certified.

"Forensic exam records should be maintained separately from other records (preferably in locked files) to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The medical record is stored at the exam site. The exam site should have clear policies about who is allowed access to these records." (A National Protocol for Sexual Assault Medical Forensic Examinations, p.79). The records should preferably be stored in a locked file cabinet. This is of particular importance in smaller, rural communities where health care providers and medical records staff may be acquaintances, friends or relatives of the patient or suspect.

O. Billing

State law requires that hospitals and other providers of services for sexual assault examinations bill the Victims' Compensation Program directly for services related to the forensic examination and medical treatment relevant to the assault (such as pregnancy and STD prophylaxis). The Gross Sexual Assault Forensic Examination Claim Form provided by the Victims' Compensation Board is in the sex crimes kit. It must be completed and submitted to Victims' Compensation for payment. **DO NOT place Victims' Compensation Program paperwork in the state sex crimes kit;** rather, follow hospital policy regarding billing.

The use of the sex crimes kit must be noted on the medical record and in the billing or there will be no compensation to the hospital.

If there are associated injuries or problems that require evaluation or treatment beyond the scope of the usual forensic examination and treatment (i.e. laceration requiring suturing, fracture, etc.),

these services need to be billed separately to the victim or the victim's insurer as per usual protocols. If the patient is reporting the assault to law enforcement, she/he is eligible to submit further expenses for reimbursement to the Victims' Compensation Program.

Neither the patient nor their insurance carrier can be billed for charges for the sexual assault forensic examination and treatment that exceed the amount allotted by the Victims' Compensation Program.

P. Quality Improvement

The quality of the care of the sexual assault patient must be evaluated periodically in each health care setting. Tools that promote consistent, high-quality response include continuing education, appropriate supervision, performance evaluations, and peer review of the medical forensic record. Case presentations at SAFE Program quarterly meetings provide all nurses with opportunity for critical peer review and quality improvement. Case presentations at Sexual Assault Response Team meetings involve all responders, and can provide feedback on the adequacy of the response as well as an opportunity to examine ways to improve coordinated response to victim/survivors of sexual assault. Attendance at SART meetings and SAFE quarterly meetings is an expectation of the role of the SAFE.

Q. Special Considerations

This section was adapted from the *National Protocol for Sexual Assault Medical Forensic Examinations*, pp. 29-34.

Patients react differently in the immediate aftermath of a sexual assault. There are many things that influence the reaction – gender, age, culture, disability, language skills and abilities, and personal beliefs about sexual assault. SAFEs must identify specific populations in their area so that information is available to better serve patients from these populations. This will enhance care, interventions and services post-assault. “However, do not assume that patients will hold certain beliefs or have certain needs and concerns merely because they belong to a specific population” (p. 29).

This document does not seek to explore all populations of victims. You are encouraged to explore the needs of potential patients in your own community, and network with providers and agencies that serve specific populations. Keep in mind barriers to quality care that may exist for patients; consider any equipment or supplies needed to assist the patient, such as a hydraulic lift, TTY, or an interpreter.

1. Patients from cultural groups and those with limited English proficiency:

- Culture can influence beliefs “about sexual assault, its victims, and offenders. It can affect health care beliefs and practices, treatment outcomes, and emotional healing. It can also impact the victim's response to and involvement in the criminal justice system. It is important to help patients find culturally specific assistance and/or referral if possible” (p. 30).
- Some victims may be apprehensive about interacting with providers from cultures other than their own. They may fear or distrust providers or assume they will be treated insensitively. They may “benefit from providers of the same background or who understand their culture” (p. 30).

- “Be aware that some cultures preclude a member of the opposite sex from being present when victims disclose, or to speak about the assault with members of the opposite sex” (p. 30).
- Victims may not report or discuss the assault because of cultural stigma, intense embarrassment and shame.
- “Be aware that beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among victims of different cultures.” (p. 30). What may help one patient deal with the trauma of sexual assault may not be the same for another.
- “Be patient and understanding toward patients’ language skills and barriers, which may worsen with crisis” (p. 30).
- Provide interpreter services and translated material for non-English speaking patients. For many reasons, it is important to use certified interpreters, not the patient’s family or friends, especially if the patient plans to report the assault to law enforcement. If using the language line be certain that the interpreter you are connected with is not from the patient’s circle of friends/family/neighborhood.
- Interpreters need to be trained about issues related to sexual assault and abuse, confidentiality and cultural concerns.

2. Patients with Disabilities:

- Some patients may have several disabilities, including physical, mental or sensory disabilities, or a combination of disabilities. Make every effort to accommodate patient needs.
- “Be aware that the risk of criminal victimization, including sexual assault for people with disabilities, appears to be much higher than for people without disabilities. People with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault” (p. 31).
- This may be the first time that the patient has had an internal exam. Be certain to explain each step in language that is understood. She/he may not be aware that a crime has been committed against her/him.
- A patient may want a caretaker, friend or family member with her/him in the exam room to assist with communication. This assistance may influence patient responses, so care must be taken to prevent this from occurring. Ideally, assistance should come from someone not associated with the patient.
- “Recognize that patients may have some degree of cognitive disability: mental retardation, mental illness, developmental disabilities, traumatic brain injury, neurodegenerative conditions such as Alzheimer’s disease, or stroke. Note that not all developmental disabilities affect cognitive ability (e.g., cerebral palsy may result in physical rather than mental impairment). Be aware that patients with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions, conduct the exam in an area that is void of bright lights and loud noises. Speak to patients in a clear and calm voice, and ask very specific and concrete questions. Be exact when explaining what will happen during the exam process and why” (p. 31)

3. Male Patients:

- Reinforce for male patients that the assault was not their fault and that male sexual assault is not uncommon. If possible, provide a sexual assault support center advocate of the gender with which the patient feels most comfortable.
- “Because some male victims may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process” (p. 32).
- Do not assume the sexual orientation of the patient regardless of the gender of the attacker.
- “Male victims may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided” (p. 32).
- Work with your local SART team to enhance the capacity of all members, local mental health services and sexual assault support center staff to serve male victims.

4. Older Patients:

- Caretakers, including family members, may sexually assault older dependents. The offender may bring the victim to the hospital for treatment. Policies need to be in place that provide for the safety of older patients, including involving adult protective services.
- Physical conditions common in the elderly coupled with the emotional impact of the assault may make the patient appear confused. Meeting the emotional needs of the patient may enhance your ability to provide more effective care and treatment (Linda Ledray, SANE Development and Operation Guide, 1998, p. 87).
- “Older victims may be reluctant to report the crime or seek treatment because they fear the loss of independence. Although some relatives wish to place older victims in an assisted living situation after an assault occurs, such an action is not always necessary or useful to a victim’s recovery. When a change in living environment is truly needed, assist victims and their relatives in making plans that maximize independence yet enhance safety” (p. 32).
- Encourage follow up medical care. Refer to appropriate legal and non-legal services as needed.
- “Older women are at an increased risk for vaginal tears and injury when they have been vaginally assaulted. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. Because of these physiological changes, a Pedersen speculum, which is longer and thinner than the Graves speculum, should be used during the pelvic exam for evidence collection. Special care should also be taken to assess for intravaginal injury. In some older women, examiners will need to simply insert the swabs and avoid the trauma of inserting a speculum. If there are external tears in the introitus, internal injuries must also be considered. The recovery process for older victims also tends to be longer than for younger victims” (SANE Development and Operation Guide, pp. 86-87)

Appendices

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APPENDICES

APPENDIX A – Body Maps

APPENDIX B – Sample Paperwork

MGMC Medical/Forensic Exam Paperwork

APPENDIX C – Community Resources

Sexual Assault Crisis & Support Resources

Domestic Violence Projects

HIV Information & Support – National / State Toll-Free Information

Anonymous HIV Antibody Testing & Counseling Sites

Confidential HIV Antibody Testing & Counseling Sites

Sexually Transmitted Disease Testing Sites

Viral Hepatitis Testing Sites

Viral Hepatitis Vaccine Sites

Services for Gay, Lesbian, Bisexual, Transgender &

Questioning Youth

Mental Health Crisis Hotline

Reporting Abuse and Neglect

Maine State District Attorney Offices

Family Planning Association of Maine Clinic Listings

DHHS Regional Offices for

Office of Adults with Cognitive and Physical Disabilities

APPENDIX D – Maine Laws and Rules

Title 25 Internal Security and Public Safety

Maine Court Rules / Maine Rules of Evidence

Hearsay

Title 22 Health and Welfare

Chapter 260: Consent of Minors for Health Services

§1823. Treatment of minors

§3577. Persons mandated to report

§4011-A. Reporting of suspected abuse or neglect

Collection of Forensic Evidence from an Unconscious Patient

APPENDIX E – Bibliography

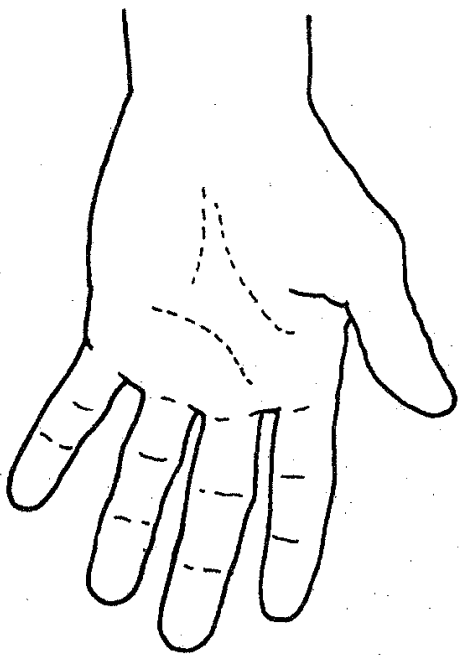
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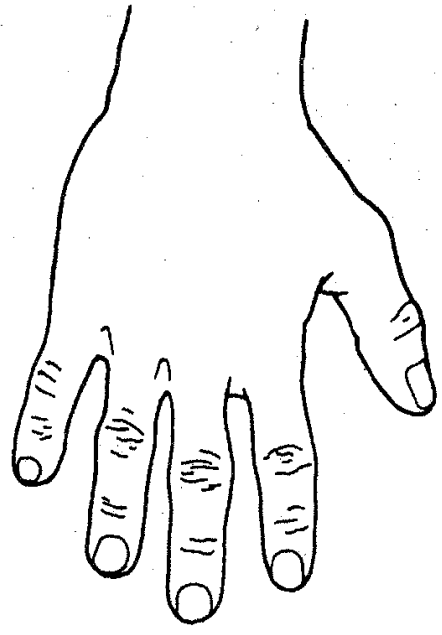
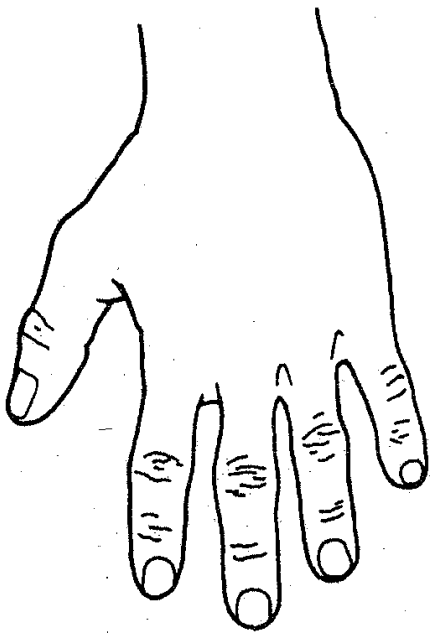
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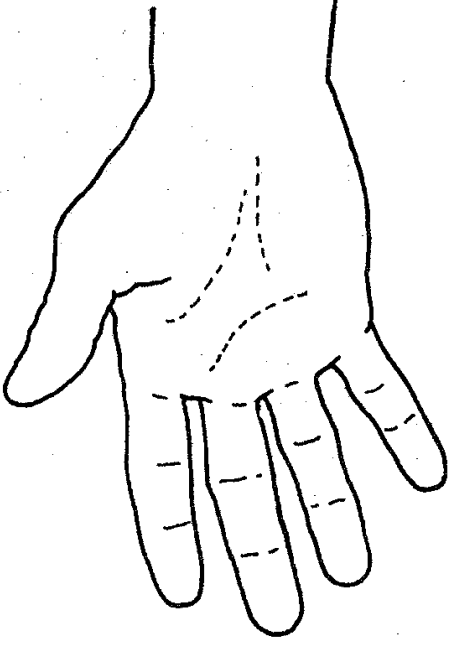
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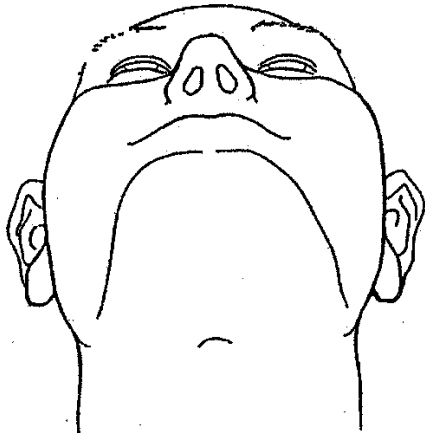
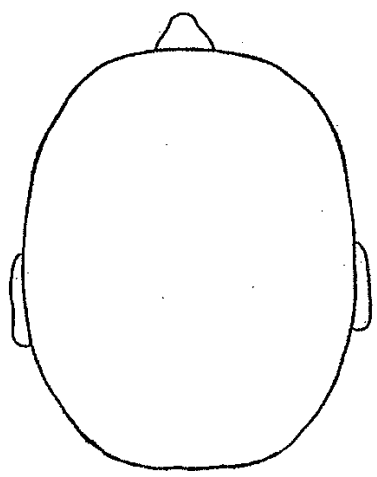
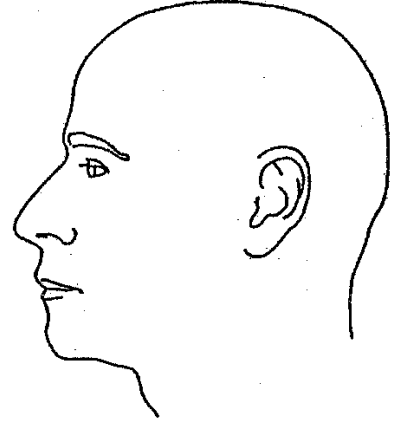
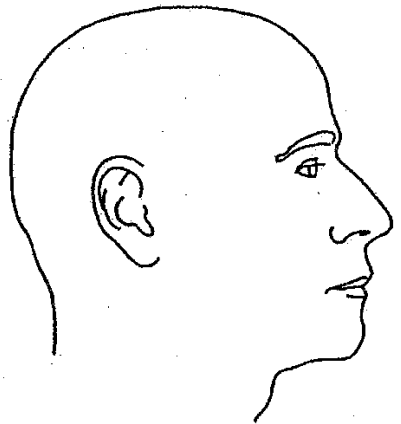
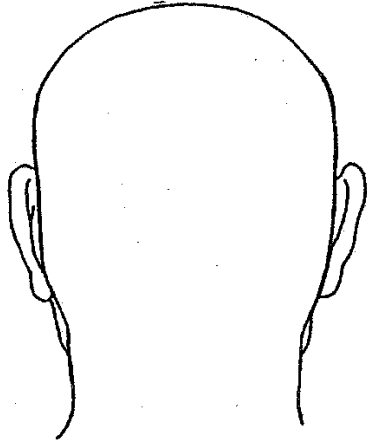
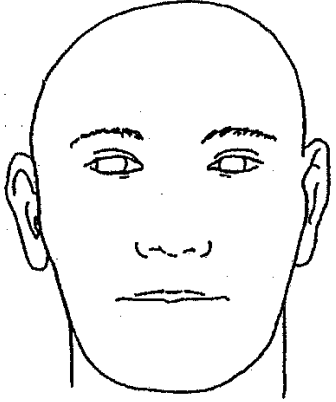
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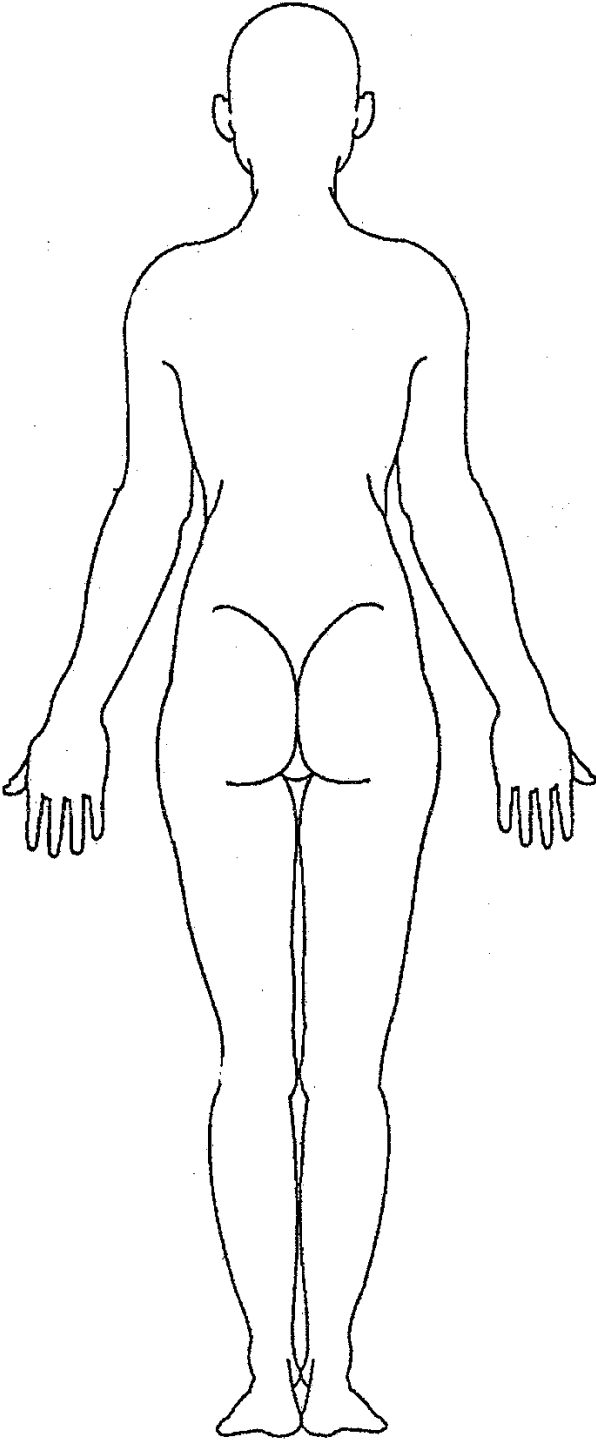
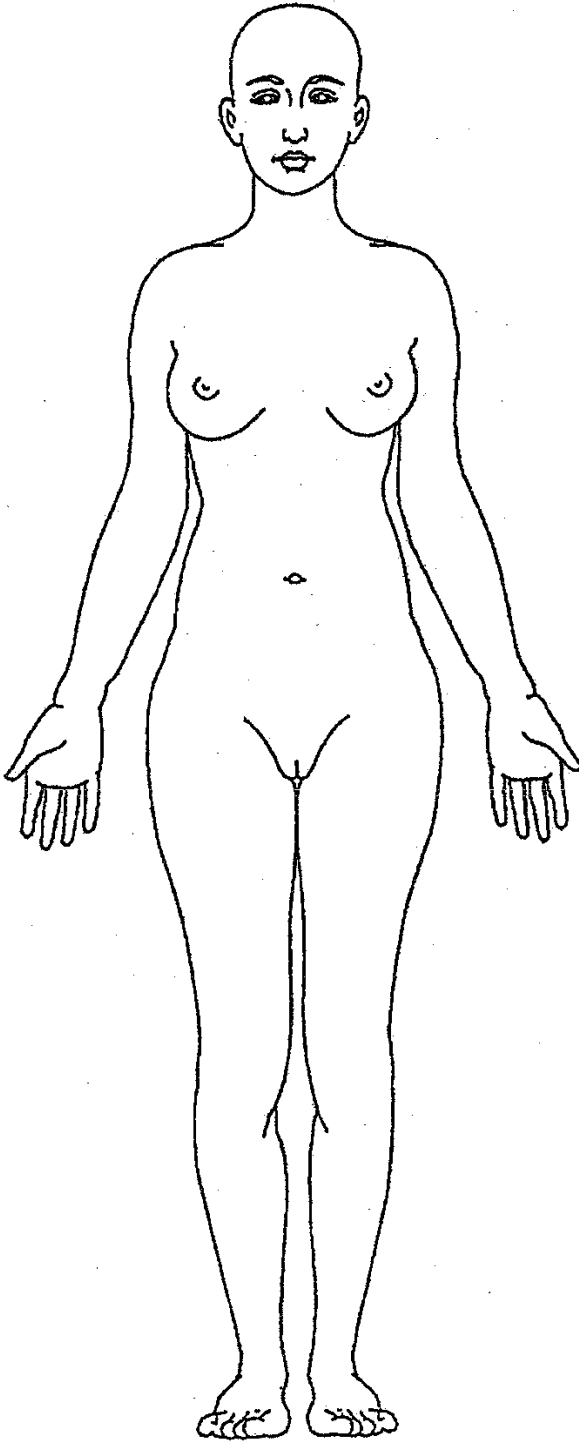
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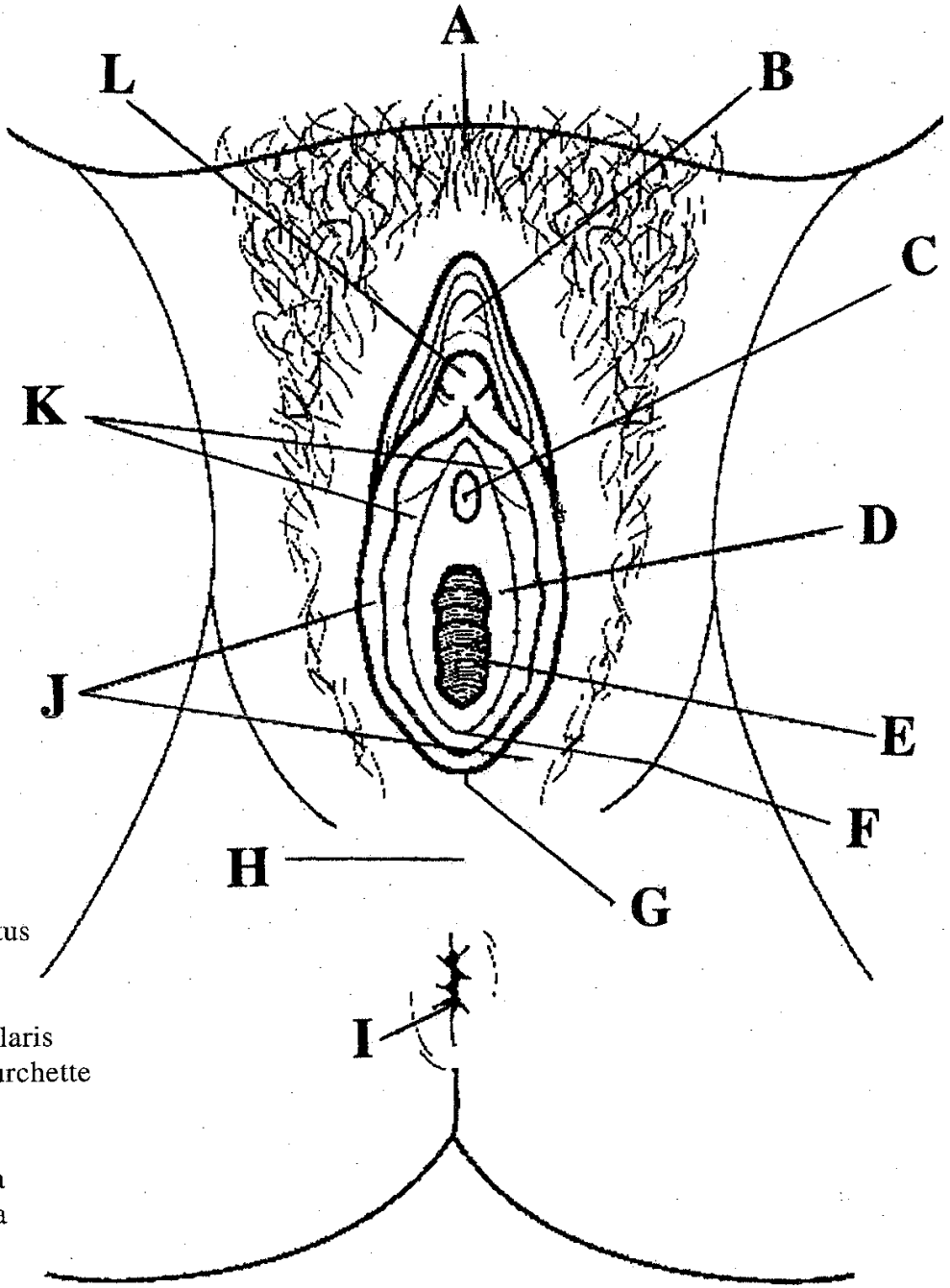
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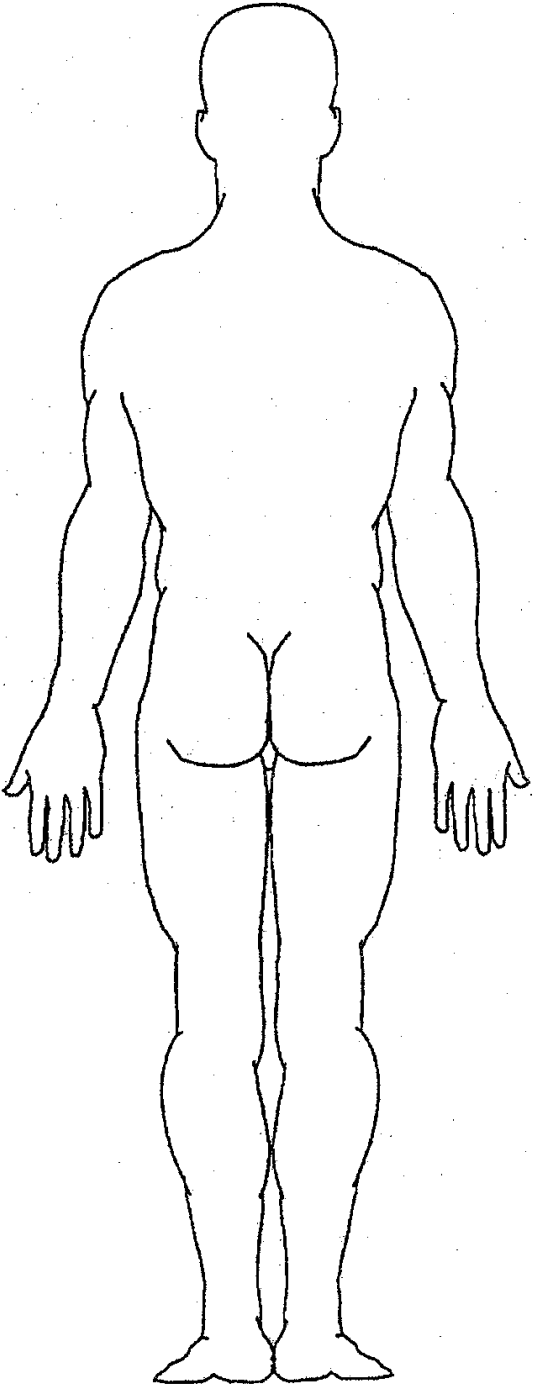
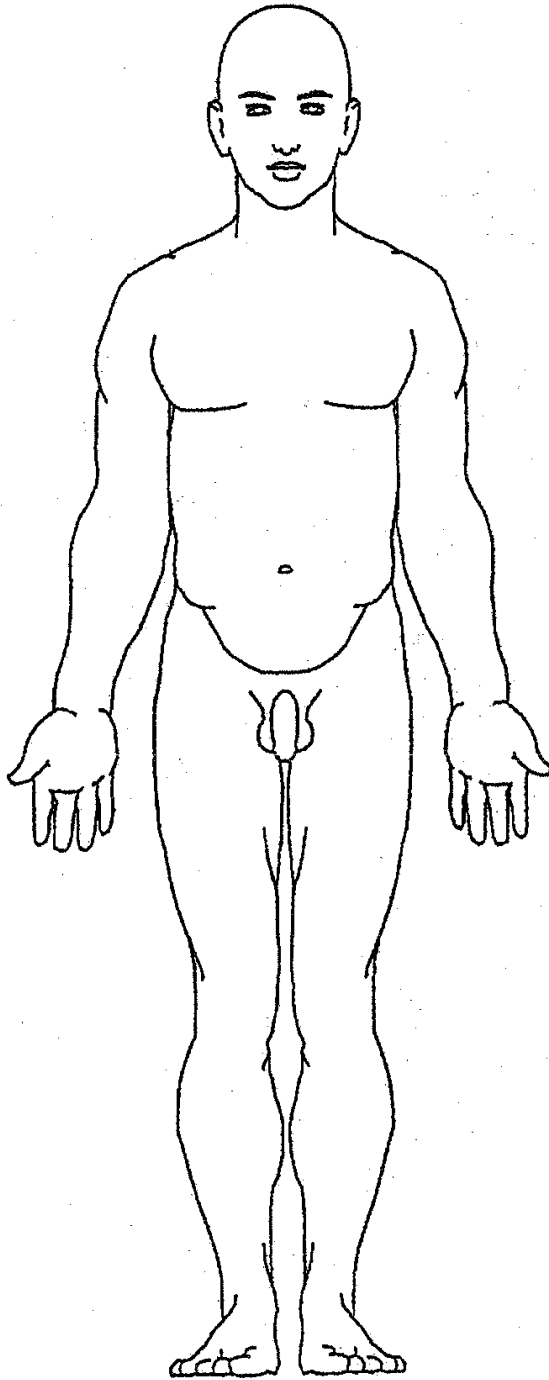


- Legend:**
A - Mons Pubis
B - Perpuce
C - Urinary Meatus
D - Vestibule
E - Vagina
F - Fossa Navicularis
G - Posterior Fourchette
H - Perineum
I - Anus
J - Labia Majora
K - Labia Minora
L - Clitoris

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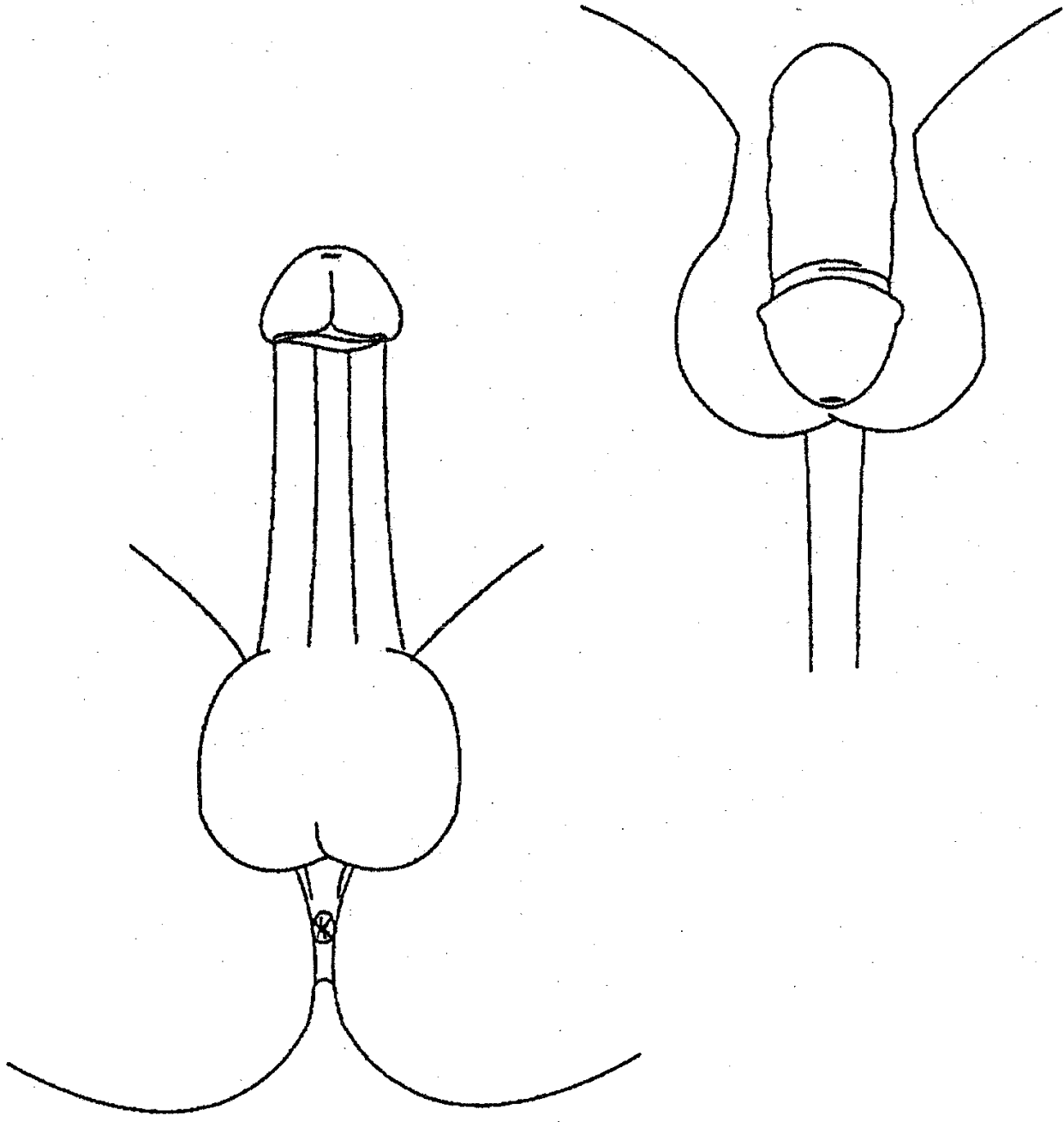
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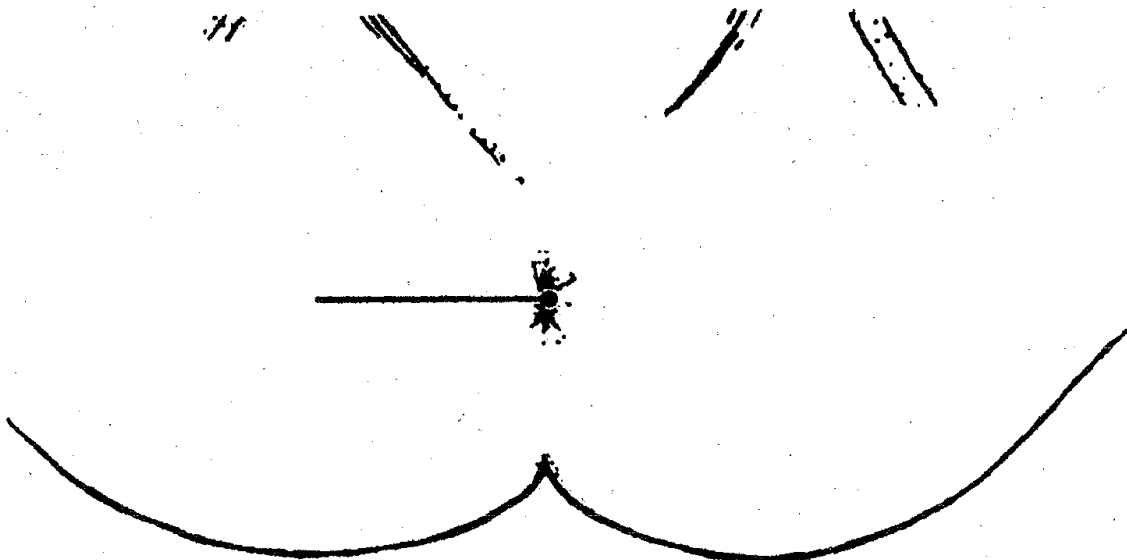
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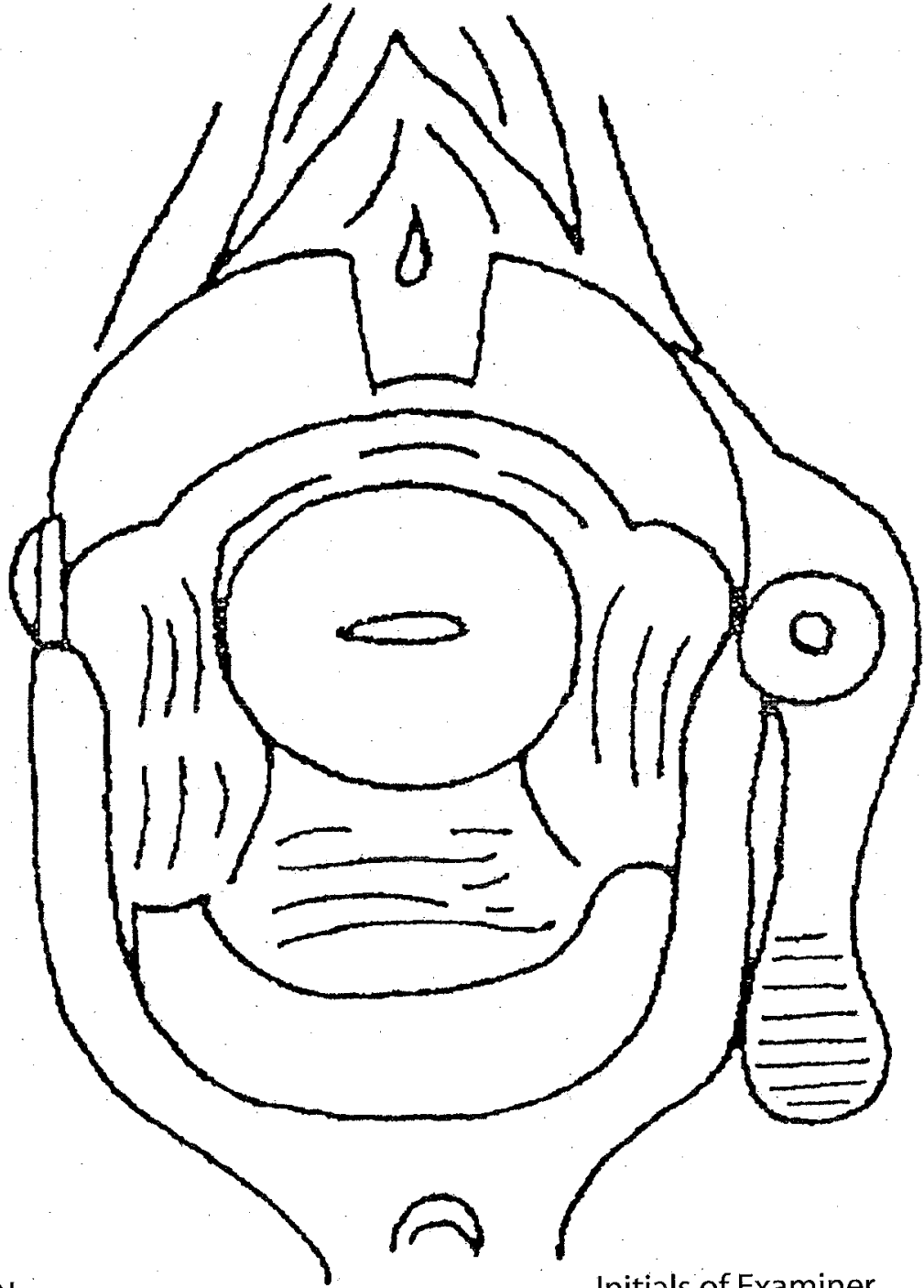
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Appendix B

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Sample

MGMC Medical/Forensic Exam Paperwork

CHAIN OF CUSTODY

Each person taking possession of this evidence MUST affix his/her signature upon accepting and relinquishing custody of this evidence).

I have collected the following item(s) within these containers and sealed with my signature.

Check all that apply and fill in relevant information as needed:

Sex Crimes Kit: contents on inventory sheet, unused portions inside if space allows. Otherwise, place in white bag with handles.

Clothing **not** inside kit: _____

Urine Specimen (specimen should be frozen if possible, refrigerated if no freezer available)

Blood Specimen (specimen should be refrigerated)

Emesis Specimen (specimen should be frozen if possible, refrigerated if no freezer available)

Other: _____

Signature, original packager date/time of sealing and packing kit

I, _____ relinquish possession to _____
(Signature, giver) (Signature, receiver date/time)

I, _____ relinquish possession to _____
(Signature, giver) (Signature, receiver date/time)

I, _____ relinquish possession to _____
(Signature, giver) (Signature, receiver date/time)

I, _____ relinquish possession to _____
(Signature, giver) (Signature, receiver date/time)

Kit Number

Initials of Examiner

MaineGeneral Medical Center
Informed Consent for Sexual Assault Forensic Examination and Evidence Collection

By signing below, I hereby consent to allow a MaineGeneral Medical Center Sexual Assault Forensic Examination Nurse or other qualified forensic examiner to conduct a sexual assault forensic examination of my body and my clothing for the purpose of collecting and preserving forensic evidence that may be used to apprehend and prosecute the person responsible for the sexual assault against me, and for the purpose of identifying, documenting, diagnosing and treating my injuries and conditions resulting from the sexual assault.

I acknowledge that the sexual assault forensic examination has been fully explained to me, and that it may include (i) tests for the presence of sperm and sexually transmitted diseases, (ii) clinical observation for physical evidence of penetration, sexual contact and injury to my body, and (iii) the collection of other specimens such as urine and blood samples for laboratory analysis. I understand that the potential risks associated with a sexual assault forensic examination include:

I understand that the potential benefits associated with a sexual assault forensic examination include: (i) pregnancy prevention, (ii) the prevention, early detection and treatment of sexually transmitted diseases, and (iii) the collection and preservation of evidence that may be used to apprehend and prosecute the person responsible for the sexual assault if I choose to report the sexual assault to law enforcement officials.

I understand that I have the right to refuse any part of the examination, but that any such refusal may limit the ability of my examining healthcare providers to effectively diagnose and treat my injuries and conditions, as well as limit the ability of law enforcement officials to apprehend and prosecute the person(s) responsible for the sexual assault.

I understand that if I choose not to authorize the release of the information and evidence gathered from the sexual assault forensic examination (the "sex crimes kit") to law enforcement officials at the present time, the sex crimes kit will be sent to law enforcement anonymously and will be secured by law enforcement in a confidential manner (using a tracking number for identification purposes) for ninety (90) days in case I wish to notify law enforcement about the sexual assault during that time period.

I also understand that my examining healthcare provider may, under certain circumstances, be required to report to State agencies information gathered from the sexual assault forensic examination in order to comply with certain mandatory reporting laws.

I also: **CONSENT** to have photographs taken of my injuries.

DO NOT CONSENT to have photographs taken of my injuries.

| | | |
|--|------|---|
| Date | Time | Signature of Patient or Patient's Authorized Representative |
| Printed Name of Patient or Authorized Representative | | Authorized Representative's Relationship to Patient (Parent, guardian, healthcare power of attorney, healthcare surrogate) |
| Date | | Signature of Witness |
| | | Business Address of Witness |
| Date | Time | Signature of Examining Healthcare Provider |
| | | Printed Name of Examining Healthcare Provider |
| Kit Number | | Initials of Examiner |

Authorization to Notify Law Enforcement of Sexual Assault and to Disclose Sexual Assault Forensic Examination Information

MaineGeneral Medical Center

Patient's Name: _____ Date of Birth: _____

I authorize **MaineGeneral Medical Center** and my examining healthcare provider(s) to (check all that apply):

- Report the sexual assault committed against me to law enforcement officials for the purpose of initiating an investigation of the sexual assault.
- Disclose to law enforcement officials the evidence and information collected from my sexual assault forensic examination and documented in the Maine State Sex Crimes Evidence Collection Kit, including any specimens, photographs, and medical records relating to the sexual assault examination and treatment I received, so that law enforcement officials may use such information to investigate, identify, apprehend and prosecute the person responsible for the sexual assault.

If you elect not to notify law enforcement of the sexual assault, the evidence collected from your sexual assault forensic examination and documented in the Maine State Sex Crimes Evidence Collection Kit will be sent to law enforcement anonymously for the limited purpose of preserving and storing evidence of the sexual assault for 90 days. During the 90 days law enforcement officials will not access the information and contents of the Sex Crimes Evidence Collection Kit without your consent, and you may elect at any time during the 90 days to report the sexual assault to law enforcement. If you elect not to notify law enforcement of the sexual assault during the 90 days, the evidence stored by law enforcement will be discarded and will not be available for use in prosecuting the person responsible for the sexual assault.

- Disclose to law enforcement officials the results of any tests for pregnancy and sexually transmitted diseases such as HIV conducted as part of my sexual assault forensic examination, so that law enforcement officials may use such information to prosecute the person responsible for the sexual assault. *I understand that persons who have authorized the disclosure of HIV test results and records have experienced adverse consequences, including the loss or denial of employment, the loss or denial of health insurance benefits, the loss or denial of life insurance benefits, alienation from friends and family members, and other forms of discriminatory treatment, whether lawful or unlawful.*
- Notify a Rape Crisis Center volunteer advocate to talk with me about crisis intervention and medical and legal advocacy resources and services available to victims of sexual assault, and to assist me through the sexual assault forensic examination process.
- Disclose to my primary healthcare provider, _____, the medical records relating to my sexual assault forensic examination and relating to any treatment I received in connection with the sexual assault, including any pregnancy and HIV test results contained in such records, so that my primary healthcare provider can provide me with appropriate follow-up care.

This authorization shall expire on _____, or 1 year from the date of this authorization, whichever occurs earlier.

I authorize that subsequent disclosures may be made pursuant to this same authorization *unless I strike out this sentence.*

Kit Number

Initials of Examiner

By signing below, I acknowledge that I have read this authorization and that:

- I understand that MaineGeneral Medical Center and its clinical staff will not condition medical treatment or a sexual assault forensic examination, or payment for such examination and treatment, upon whether I authorize a report of the sexual assault to law enforcement or upon whether I authorize any of the above disclosures.
- I may refuse to authorize to disclose all or some of the above healthcare information but that my refusal may result in the loss and unavailability of evidence that could be used to prosecute the person responsible for the sexual assault.
- I have the right to revoke this authorization at any time, either orally or in writing, in the manner described in MaineGeneral Medical Center's Notice of Privacy Practices, except to the extent that any person has already acted in reliance on it.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons receiving the information and that as a result the information may no longer be protected.
- I have the right to a copy of this signed authorization.

Date: _____

Patient's or Authorized Representative's Signature

Authorized Representative's Legal Authority (e.g. parent, healthcare power of attorney agent, guardian, healthcare surrogate)

FORENSIC EXAM RECORD
MaineGeneral Medical Center

NOTE: The likelihood of evidence retrieval decreases with time. If the sexual assault occurred within 120 hours evidence may be present on the victim's body, and may be recoverable by proper evidence collection.

Locale/Jurisdiction of assault: Town: _____ County: _____

Law enforcement notified: Yes No

Investigating Agency: _____ Investigating Officer: _____

Others present for exam: _____

1. State of Maine sex crimes kit **is** **is not** being completed.
2. Is the victim under 18 years of age? **no** **yes**. If yes, then **all health care providers are mandated reporters**.
Notify Department of Health and Human Services (1-800-452-1999). If notified,
document with whom you spoke _____ Notify law enforcement / District Attorney's Office
of Kennebec County (207-623-1156) or Somerset County (207-474-2423). Document with whom you
spoke _____.
3. Spurwink Child Abuse Program is available for consult, if needed. (1-800-260-6160).

Patient Information: Race: _____ Age: _____ Sex: _____

PAST MEDICAL HISTORY

History of medical problems? Yes No

Describe _____

History of hospitalizations/surgeries (including C sections, Hysterectomy) Yes No

Describe _____

Medications currently in use? Yes No

List (name and dosage): _____

Does patient use contraception? Yes No

If yes, list type _____

Medication allergies? Yes No

List name and type of reaction: _____

Most recent tetanus shot _____ is update indicated? Yes No

History of complete Hepatitis B vaccination series? Yes No

Is update indicated? Yes No

Any history of preexisting injuries or symptoms (prior trauma, anal bleeding, fissures, hemorrhoids, etc.)?

Kit Number

Initials of Examiner

History of Assault, continued

Offender Description:

If more than one offender, document additional description(s) under "Additional Information".

Sex: F M Age _____ Race _____ Hair Color _____ Height _____ Weight _____

Build: Slim Average Muscular Stocky Obese

Describe Offender's Clothing _____

Describes any other characteristics such as facial hair, tattoos, piercing, etc. _____

Additional Information: _____

REVIEW OF SYSTEMS

Last Menstrual Period _____ G _____ P _____ Ab _____

Current Pregnancy? Possibly No Yes _____ weeks / _____ months

Name of physician and/or gynecologist _____

Any physical discomfort since the assault? Yes No

Describe _____

Genitourinary _____ pain _____
urinary symptoms _____

Abdominal _____
pain _____ nausea / vomiting _____
other _____

Skin injury _____

Neurologic: headache _____ LOC _____ AMS _____
focal neurological complaints _____

PHOTOGRAPHS TAKEN Yes No

Type of camera used: _____

Photographer's name: _____

Photographs (memory card/disk) attached to chart: Yes No

INSERT TOP COPIES OF MAINE SEX CRIMES KIT FORMS:

1. Patient's History of Assault
2. Evidence Collection Inventory

Kit Number

Initials of Examiner

FORENSIC MEDICAL PHYSICAL EXAM (with evidence collection, if appropriate)

Describe general appearance of patient, patient's emotional state, and patient's clothing (document if same clothing worn at time of assault?): _____

Describe positive findings and document on body diagrams, or check appropriate box if no acute injury seen.

Head: _____ no acute injury seen / see diagram

ENT: _____ no acute injury seen / see diagram

Chest: _____ no acute injury seen / see diagram

Back: _____ no acute injury seen / see diagram

Breasts: _____ no acute injury seen / see diagram

Abdomen: _____ no acute injury seen / see diagram

Extremities: _____ no acute injury seen / see diagram

Anus: _____ no acute injury seen / see diagram

Female Genitalia

Labia majora: _____ no acute injury seen / see diagram

Labia minora: _____ no acute injury seen / see diagram

Hymen: _____ no acute injury seen / see diagram

Vagina: _____ no acute injury seen / see diagram

Cervix: _____ no acute injury seen / see diagram

Perineum: _____ no acute injury seen / see diagram

Urinary meatus: _____ no acute injury seen / see diagram

Clitoris and clitoral hood: _____ no acute injury seen / see diagram

Fossa navicularis: _____ no acute injury seen / see diagram

Posterior fourchette: _____ no acute injury seen / see diagram

Male Genitalia

Penis: _____ no acute injury seen / see diagram

Foreskin: circumcised _____ no acute injury seen / see diagram

Glans: _____ no acute injury seen / see diagram

Urethra: _____ no acute injury seen / see diagram

Scrotum: _____ no acute injury seen / see diagram

Testicles: _____ no acute injury seen / see diagram

Perineum: _____ no acute injury seen / see diagram

SKIN SURFACE ASSESSMENT

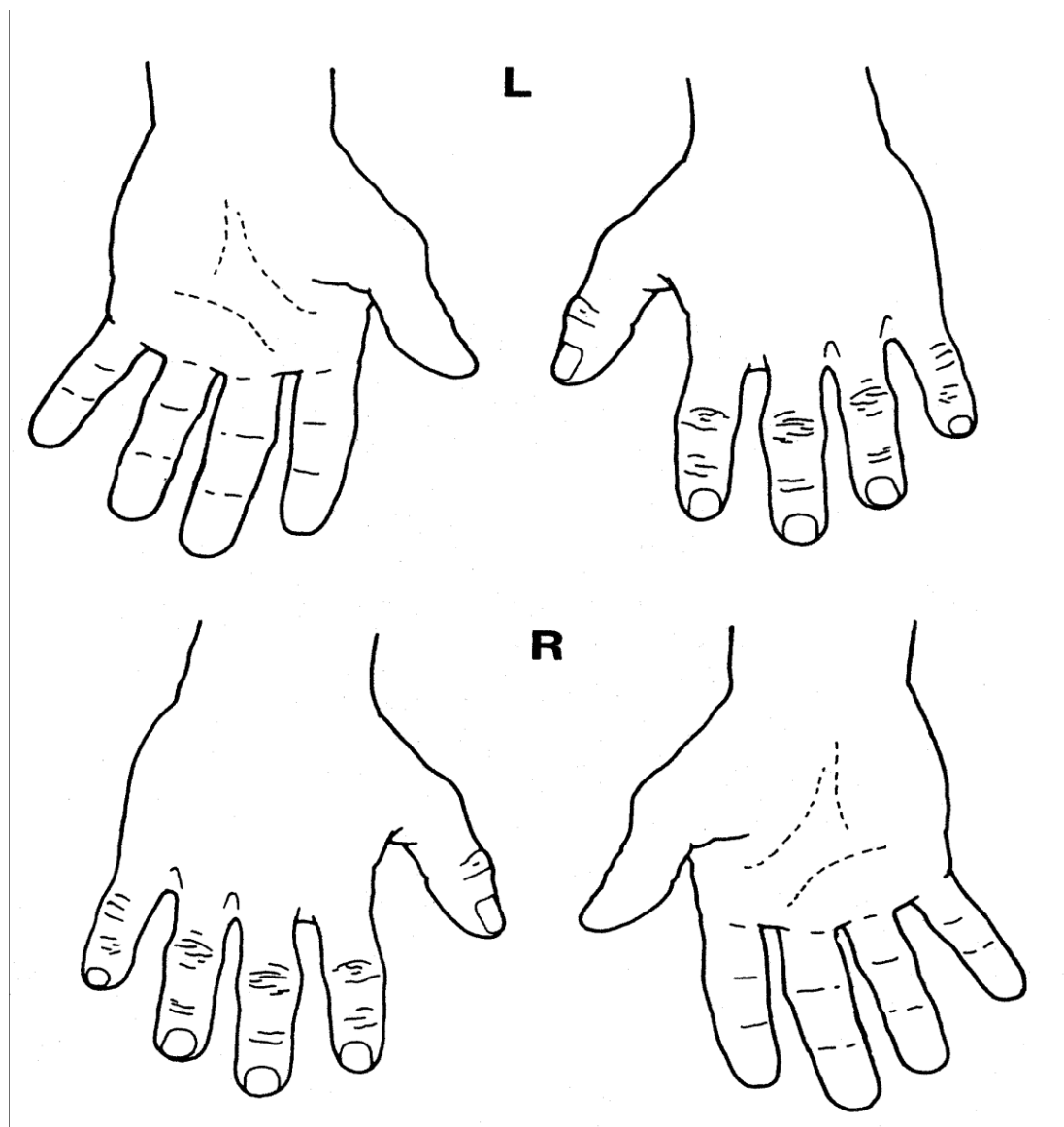
Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. Record the size, color and appearance of all injuries.

KEY:

A = abrasion
B = bleeding
BM = bite marks
BR = burn
C = cuts

DS = dried secretion
E = ecchymosis
FB = foreign body
L = laceration
P = petechiae

R = redness
S = swelling
T = tenderness
WS = wet secretion
+ = alternate light source used



Kit Number

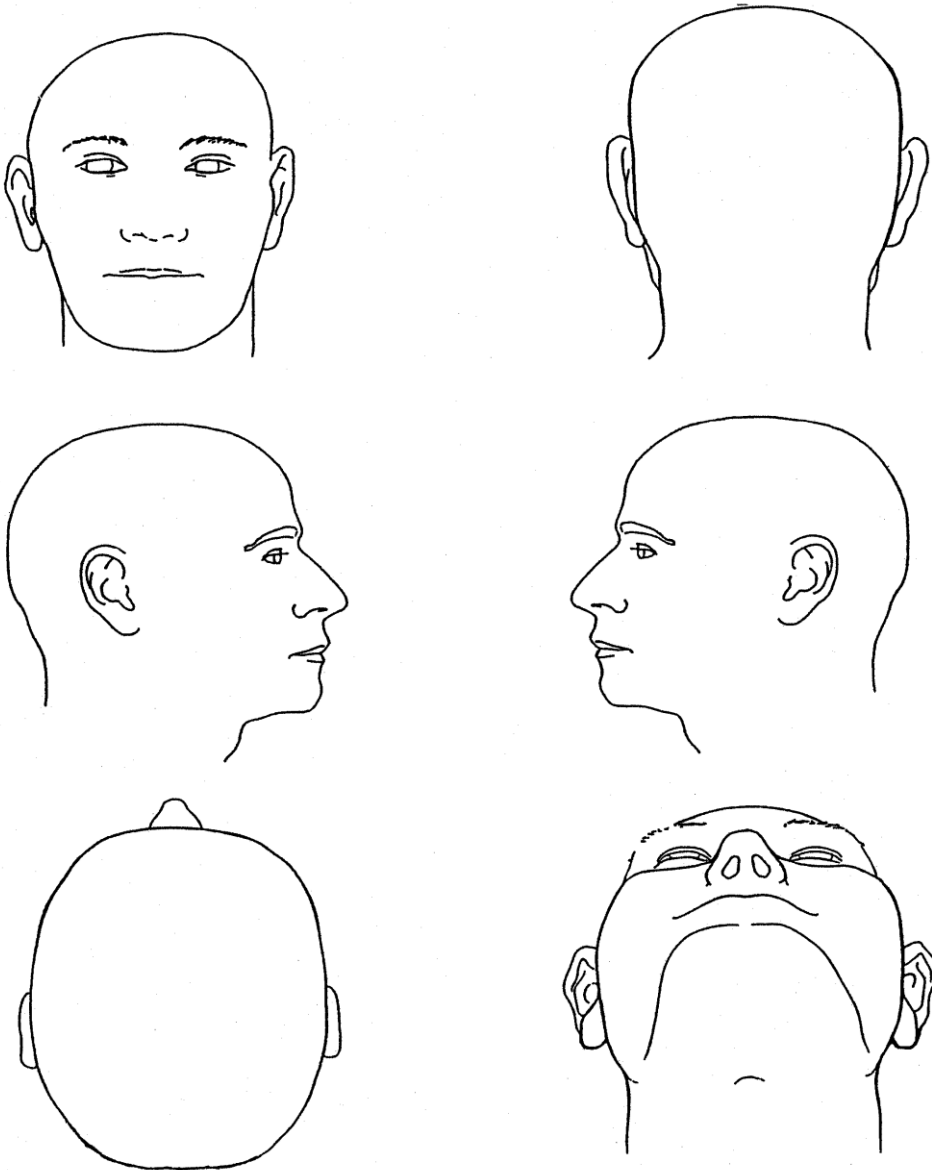
Initials of Examiner

SKIN SURFACE ASSESSMENT cont'd

Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. Record the size, color and appearance of all injuries.

KEY:

- | | | |
|------------------------|-----------------------------|--|
| A = abrasion | DS = dried secretion | R = redness |
| B = bleeding | E = ecchymosis | S = swelling |
| BM = bite marks | FB = foreign body | T = tenderness |
| BR = burn | L = laceration | WS = wet secretion |
| C = cuts | P = petechiae | + = alternate light source used |



SKIN SURFACE ASSESSMENT cont'd

ASSESSMENT N/A

Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. Record the size, color and appearance of all injuries.

Kit Number

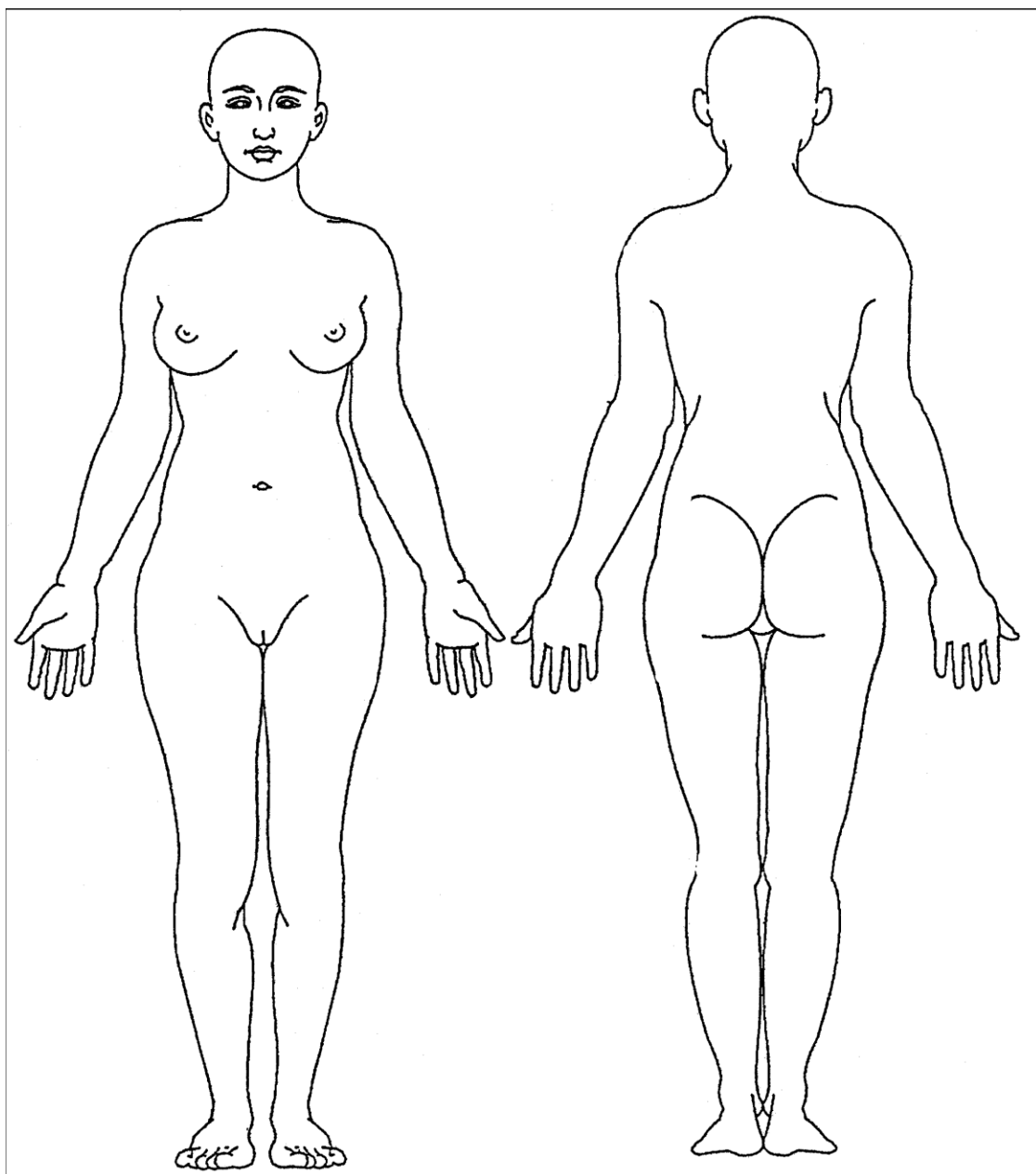
Initials of Examiner

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S = swelling
T = tenderness
WS = wet secretion
+ = alternate light source used



SKIN SURFACE ASSESSMENT cont'd

ASSESSMENT N/A

Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. Record the size, color and appearance of all injuries.

Kit Number

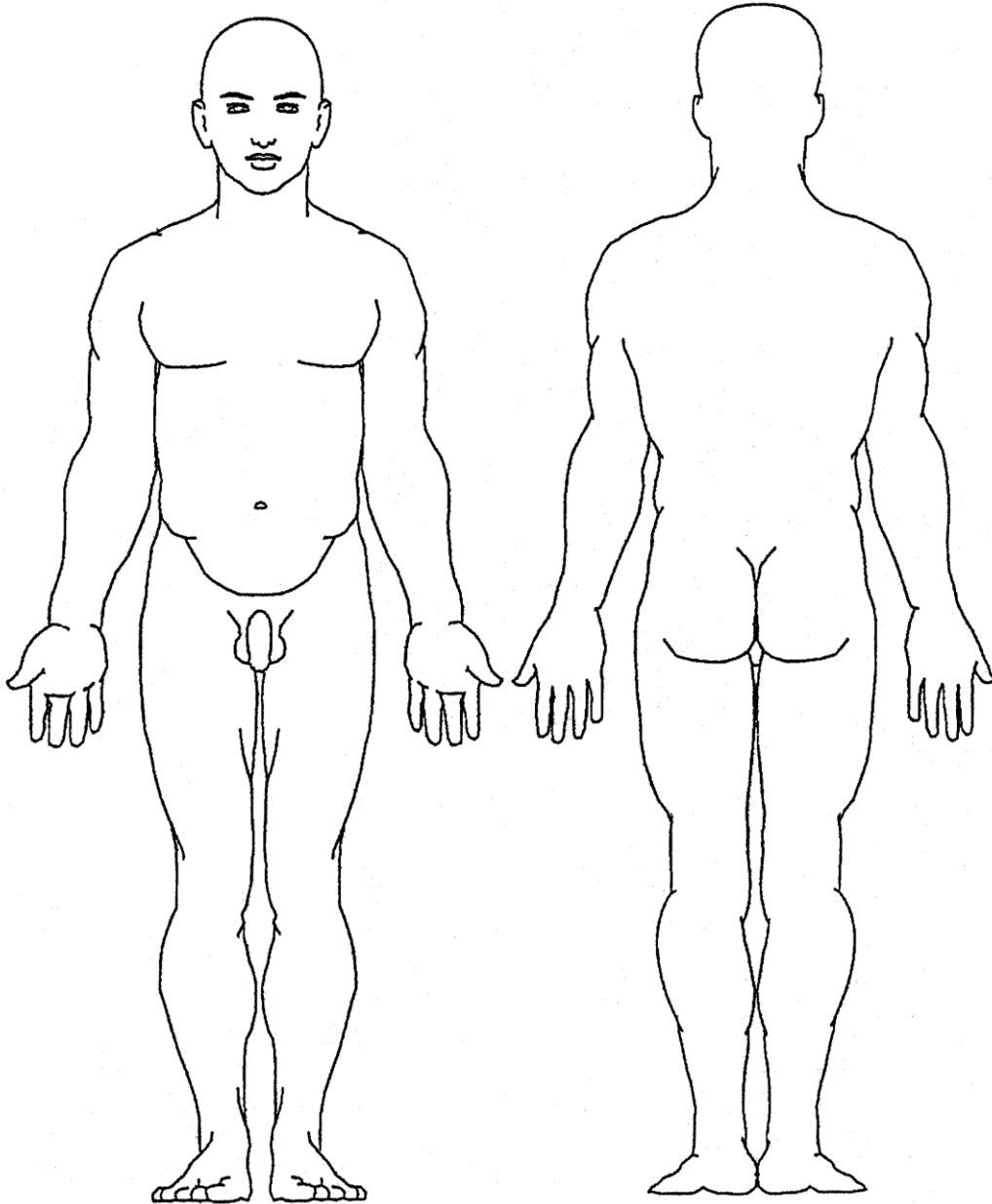
Initials of Examiner

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E = ecchymosis
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P = petechiae

KEY:

R = redness
S = swelling
T = tenderness
WS = wet secretion
+ = alternate light source used



Kit Number

Initials of Examiner

GENITAL EXAMINATION - FEMALE

ASSESSMENT N/A

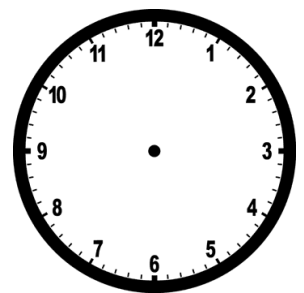
Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. Record the size, color and appearance of all injuries.

KEY:

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R = redness
S = swelling
T = tenderness
WS = wet secretion
+ = alternate light source used



Kit Number

Initials of Examiner

GENITAL SPECULUM EXAMINATION - FEMALE

ASSESSMENT N/A

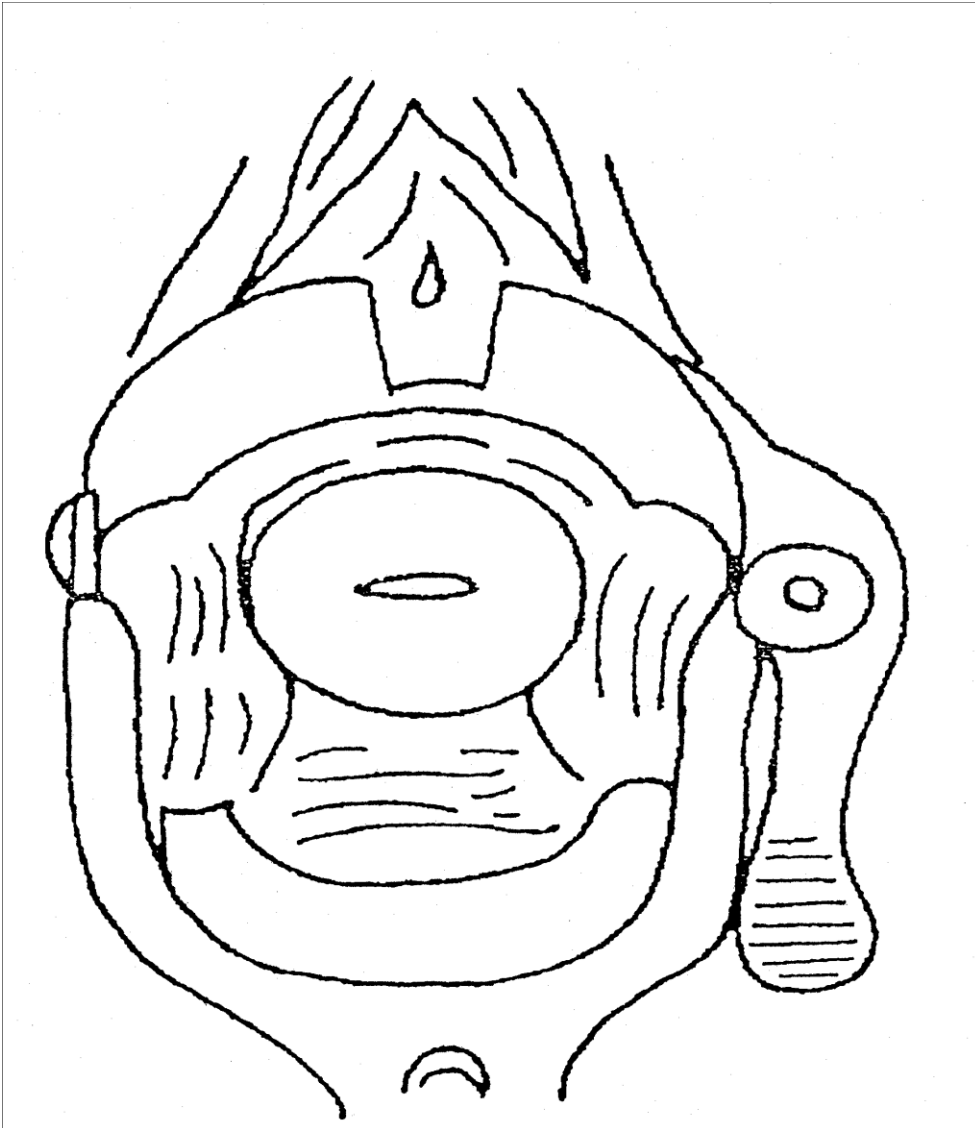
Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. Record the size, color and appearance of all injuries.

KEY:

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BR = burn
C = cuts

DS = dried secretion
E = ecchymosis
FB = foreign body
L = laceration
P = petechiae

R = redness
S = swelling
T = tenderness
WS = wet secretion
+ = alternate light source used



Kit Number

Initials of Examiner

GENITAL EXAMINATION - **MALE**
ASSESSMENT N/A



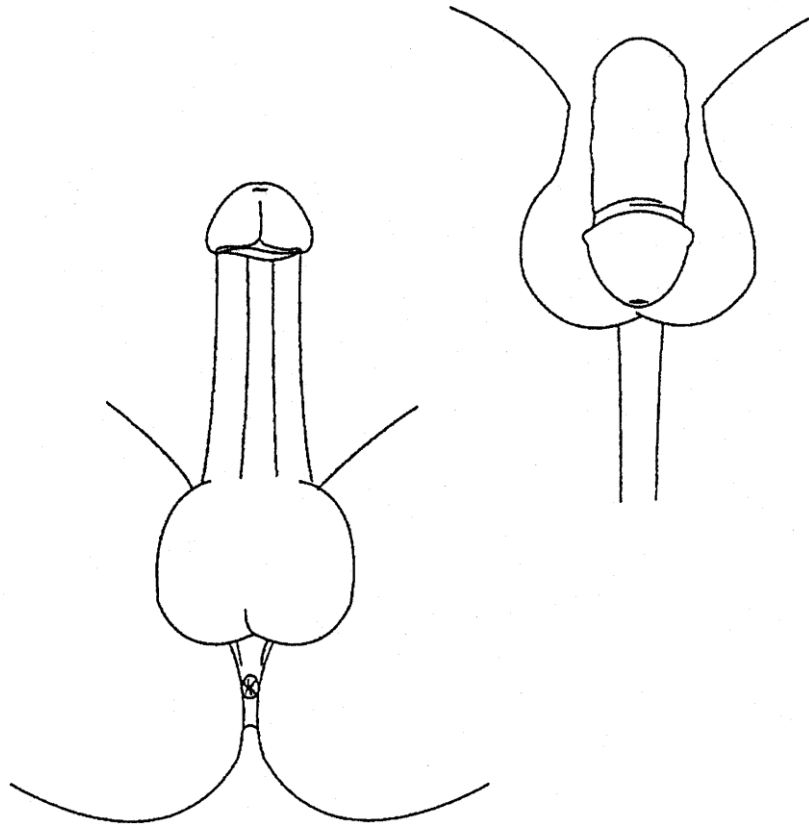
Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault.
Record the size, color and appearance of all injuries.

KEY:

A = abrasion
B = bleeding
BM = bite marks
BR = burn
C = cuts

DS = dried secretion
E = ecchymosis
FB = foreign body
L = laceration
P = petechiae

R = redness
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T = tenderness
WS = wet secretion
+ = alternate light source used



Kit Number

Initials of Examiner

GENTIL EXAMINATION – ANUS

ASSESSMENT N/A

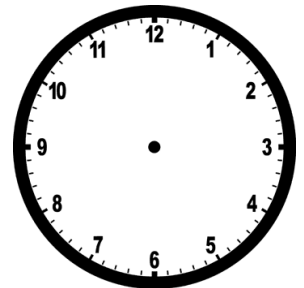
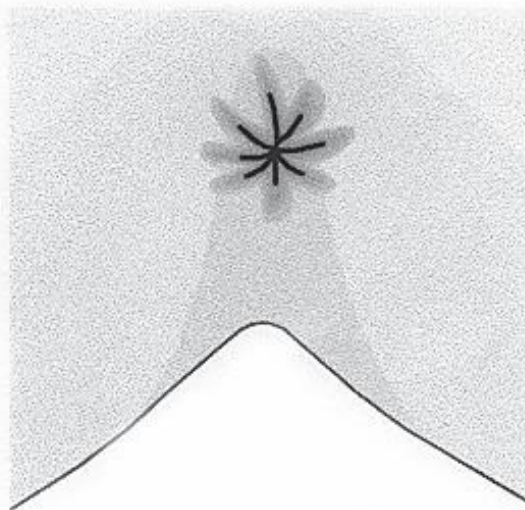
Utilize diagrams to document all injuries and findings. Distinguish pre-existing injuries from those resulting from the assault. **Record the size, color and appearance of all injuries.**

KEY:

A = abrasion
B = bleeding
BM = bite marks
BR = burn
C = cuts

DS = dried secretion
E = ecchymosis
FB = foreign body
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Kit Number

Initials of Examiner

MaineGeneral Medical Center
Sexual Assault Examination
Discharge Instructions

Pregnancy Prevention

Levonorgestrel 1.5mg (Plan B)

Plan B reduces the risk of pregnancy to 1% following a single episode of unprotected intercourse. It can be taken up to 5 days after unprotected intercourse.

The hormone in Plan B can prevent pregnancy but will not end one that has already begun. We will check a pregnancy test today before you take this treatment to be sure you are not already pregnant. If there is a delay in the onset of your menstrual period beyond 1 week of it's expected date, another pregnancy test should be done.

You should not take Plan B if you have a known allergy to levonorgestrel. The effectiveness of Plan B may be affected if you are taking Dilantin, Tegretol, or Rifampin.

Occasionally this medication may cause nausea, vomiting, diarrhea, headache, abdominal cramps, fatigue, dizziness, and breast tenderness.

If you decide to use this medication you will receive:

_____ **Plan B, 1.5mg now** (pregnancy prevention)

Sexually Transmitted Infections

The examination performed was for the purposes of identifying and collecting evidence of sexual assault. You were not tested for sexually transmitted infections (STI's). Instead, you were offered or given medications to prevent some common STIs. You received:

_____ **Ceftriaxone (Rocephin) 250 mg shot one time dose** (Gonorrhea prevention/treatment)
or

_____ **Cefixime (Suprax) 400 mg pill, one time dose** (Gonorrhea prevention/treatment)

_____ **Azithromycin (Zithromax) 1 gm in pills or liquid one time dose**
(Chlamydia prevention/treatment)

or

_____ **Doxycycline 100 mg pill 2 times a day for 7 days** (Chlamydia prevention/treatment)

_____ **Metronidazole (flagyl) 2 gm p.o. One-time dose sent home to be taken tomorrow**
(Bacterial Vaginosis and Trichomoniasis prevention/treatment)

**** If you received Metronidazole (Flagyl), you must avoid drinking alcohol for 72 hours. ****

_____ **Td / Tdap given** (Tetanus/Diphtheria/Pertussis prevention/treatment)

_____ **Hepatitis B** (first dose)

Patient initials _____

Kit Number

Initials of Examiner

HIV Risk

It is rare that the virus which causes AIDS is transmitted during one sexual encounter with an infected person. However, a blood test to detect the virus is recommended. This blood test is not always able to identify an infection within the first several weeks after exposure. It is recommended that you have HIV testing done now, at three (3) months, and six (6) months after the assault.

You may want to discuss this issue with your doctor or you may obtain confidential counseling and testing by calling Sexual Assault Crisis and Support Services at **1-800-871-7741**. You may also contact Family Planning at the numbers above.

We do not recommend routine preventative treatment for HIV. In high risk situations or in some areas where there is a high incidence of HIV, preventative treatment is sometimes suggested. Please discuss this further with us today if you have questions or concerns.

Hepatitis B

The Hepatitis B virus can be transmitted through sexual contact. Vaccination with Hepatitis B vaccine is very effective in preventing infection. If you have not already received Hepatitis B vaccine, we would suggest starting a series. If you decide to start, you will receive your first dose today. You then need a second dose in 1-2 months and a third in 6-12 months. The remainder of this series should be arranged through your primary care doctor.

Follow Up:

It is strongly suggested that you have a gynecological examination approximately two to four (2-4) weeks from today. You may schedule this examination with your own doctor or you may wish to call Waterville (207-859-1638) or Augusta (207-626-3426) Family Planning.

When you have your follow-up examination, you should bring this sheet with you so that the doctor will know what treatment you have received and can perform tests to be sure the medications were effective.

There is no treatment to prevent herpes. If you develop any sores or blisters on your genitals, you should see your doctor or family planning. You should also report to your doctor or family planning any unusual bleeding, pelvic pain or other new problems.

Other Information:

Many survivors of sexual assault experience symptoms such as anxiety, sleep disturbances, loss of appetite, irritability or depression. These are all normal reactions to trauma. You are urged to seek help in dealing with the psychological aspects of surviving an assault. The Rape Crisis Assistance and Prevention centers offer numerous services including counseling which you may find helpful. The state-wide Crisis number is 1-800-871-7741. Please call to contact your closest one.

If, at any time in the next 2-3 days you experience severe pain, ongoing nausea, or vomiting, or any other unusual medical complaints, please see your family doctor or go immediately to the closest Emergency Room.

Patient Signature _____

Time of Discharge _____

Date of Discharge _____

Attachment C

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Elizabeth Ward Saxl, Executive Director
83 Western Avenue, Suite 2, Augusta, ME 04330
Office: (207) 626-0034 ✦ Fax: (207) 626-5503
www.mecasa.org ✦ info@mecasa.org

Sexual Assault Resources

**Statewide Crisis and Support Line:
1-800-871-7741 (TTY: 1-888-458-5599)**

**Confidential 24-hour, toll-free hotline accessible from anywhere in Maine.
Calls are automatically routed to the closest sexual assault support center.**

Sexual Assault Crisis & Support Center
Serving Kennebec, Knox, Somerset & Waldo Counties
PO Box 417 ✦ Winthrop, ME 04364
Office (207) 377-1010
Hotline 1-800-822-5999

**Sexual Assault Victims
Emergency Services**
Serving Franklin County
P.O. Box 349 ✦ Farmington, ME 04938
Office (207) 778-9522
Hotline 1-800-871-7741
via cell 1-866-740-9516

Rape Response Services
Serving Penobscot and Piscataquis Counties
262 Harlow Street ✦ Bangor, ME 04401
Office (207) 973-3651
Hotline 1-800-310-0000

Sexual Assault Crisis Center
Serving Androscoggin County
P.O. Box 6 ✦ Auburn, ME 04212
Office (207) 784-5272
Hotline 1-800-871-7741

**Sexual Assault Support Services of Midcoast
Maine**
Serving Eastern Cumberland, Sagadahoc & Lincoln Counties
P.O. Box 990 ✦ Brunswick, ME 04011
Office (207) 725-2181
Hotline 1-800-822-5999

**Sexual Assault Response Services of
Southern Maine**
Serving York and Cumberland Counties
P.O. Box 1371 ✦ Portland, ME 04104
Office (207) 828-1035
Hotline 1-800-313-9900

Downeast Sexual Assault Services
Serving Hancock & Washington Counties
52 Christian Ridge Road ✦ Ellsworth, ME 04605
Office 1-800-492-5550
Hotline 1-800-228-2470

AMHC Sexual Assault Services
Serving Aroostook County
162 Main Street ✦ Presque Isle, ME 04769
Office (207) 762-4851
Hotline 1-800-550-3304

Rape Education and Crisis Hotline
Serving Oxford County, Harrison & Bridgton
PO Box 300 ✦ South Paris, ME 04281
Office (207) 743-9777
Hotline 1-800-871-7741
Bridgton/Harrison callers 1-800-213-6937

Domestic Violence Projects

MAINE COALITION TO END DOMESTIC VIOLENCE
Statewide Domestic Violence Helpline: 1-866-834-4357 ♦ <http://mcedv.org/>

NATIONAL DOMESTIC VIOLENCE HOTLINE: 1-800-799.7233 ♦ 1-800-787-3224 (TTY) ♦ www.thehotline.org/

ANDROSCOGGIN, OXFORD, FRANKLIN COUNTIES

SAFE VOICES
(formerly ABUSED WOMEN'S ADVOCACY PROJECT)
1-800-559-2927
<http://www.safevoices.org/index.php>

CUMBERLAND, SAGadahoc COUNTIES

FAMILY CRISIS SERVICES
1-866-834-4357
<http://www.familycrisis.org>

KENNEBEC, SOMERSET COUNTIES

FAMILY VIOLENCE PROJECT
1-877-890-7788
<http://www.familyviolenceproject.org/index.php>

PENOBSCOT COUNTY

SPRUCE RUN
1-800-863-9909
1-800-437-1220 (TTY)
<http://www.sprucerun.net/>

YORK COUNTY

CARING UNLIMITED
1-800-439-239-7298
<http://www.caring-unlimited.org/>

WABNAKI TRIBES OF MAINE

AROOSTOOK BAND OF MICMAC'S FAMILY SUPPORT SERVICES

207-764-1972 or 1-800-439-2323 (Hope & Justice Project, Inc.)

PENOBSCOT NATION DOMESTIC VIOLENCE & SEXUAL ASSAULT SERVICES

207-631-4886 (24 hr. hotline)
Alternative number: **1-800-863-9909 / 1-800-437-1220 for TTY**

AROOSTOOK COUNTY

HOPE AND JUSTICE PROJECT, INC.
(formerly BATTERED WOMEN'S PROJECT)
1-800-439-2323

HANCOCK, WASHINGTON COUNTIES

THE NEXT STEP
Hancock County: 1-800-315-5579
Washington County: 1-888-604-8692
<http://www.nextstepdvproject.org/>

KNOX, WALDO, LINCOLN COUNTIES

NEW HOPE FOR WOMEN
1-800-522-3304
<http://www.newhopeforwomen.org/>

PISCATAQUIS COUNTY

WOMANCARE
1-888-564-8165
<http://www.wmncare.org/>

CULTURALLY SPECIFIC DOMESTIC VIOLENCE SERVICES IN MAINE

TENGO VOZ
207-553-2252 (Week days- 9 AM to 5 PM)

UNITED SOMALI WOMEN OF MAINE
207-753-0061 (Week days 9 AM to 5 PM)

MALISEET DOMESTIC VIOLENCE & SEXUAL ASSAULT PROGRAM

207-532-6401 (24 hr. hotline)

PASSAMAQUODDY PEACEFUL RELATIONS

207-853-2613 (24 hr. hotline)

HIV Information & Support

National / State Toll-Free Information & Support

MAINE AIDS HOT LINE

1-800-851-2437

NATIONAL AIDS HOTLINE

1-800-342-2437

NATIONAL STD HOTLINE

1-800-227-8922

NATIONAL PREVENTION INFORMATION NETWORK

1-800-458-5231

TTY/TDD: 1-888-480-3739

<http://www.cdcnpin.org>

Anonymous HIV Antibody Testing & Counseling Sites

(No name required)

AUBURN:

AUBURN/LEWISTON STD CLINIC

207-795-4019 or 1-800-587-9354

<http://www.wmca.org>

AUGUSTA:

HEALTHREACH HARM REDUCTION

207- 621-3793

JUST GUYS

207-620-1448 (confidential phone)

<http://www.justguys.info>

BANGOR:

BANGOR STD CLINIC

207-947-0700

http://www.bangormaine.gov/cs_healthservices.php

EASTERN MAINE AIDS NETWORK

207-990-3626 or 1-877-990-3626

<http://www.maineaidsnetwork.com/contact.html>

CALAIS:

DOWNEAST HEALTH SERVICES

1-800-924-2628

http://www.downeasthealth.org/family_plan.html

DAMARESCOTTA:

DAMARISCOTTA FAMILY PLANNING

207- 338-3736 / 207-563-1224

<http://www.mainefamilyplanning.org/clinic-locations/midcoast-maine/damariscotta>

LUBEC:

HEALTHWAYS HIV PROGRAM

207-733-4763 or 1-877-270-4139

ELLSWORTH:

DOWNEAST AIDS NETWORK

207-667-3506

<http://downeastaidsnetwork.homestead.com/>

DOWNEAST HEALTH SERVICES

207-667-5304 or 1-800-492-5550

http://www.downeasthealth.org/family_plan.html

FARMINGTON:

TRI-COUNTY HEALTH SERVICES

Farmington: 207- 778-4553

<http://www.wmca.org>

FORT KENT:

ACAP HEALTH SERVICES

Tel: 834-3513

<http://www.acap-me.org/>

HOULTON:

ACAP HEALTH SERVICES

207-532-0503

<http://www.acap-me.org/>

KITTERY:

FRANNIE PEABODY CENTER

(services provided in Portland & Ogunquit)

207-774-6877

<http://www.peabodycenter.org>

LEWISTON:

AUBURN/LEWISTON STD CLINIC

207-795-4019 or 1-800-587-9354

[http:// www.wmca.org](http://www.wmca.org)

MACHIAS:

DOWNEAST HEALTH SERVICES
1-800-492-5550
http://www.downeasthealth.org/family_plan.html

NORWAY:

TRI-COUNTY HEALTH SERVICES
207-743-2066
<http://www.wmca.org>

PORTLAND:

FRANNIE PEABODY CENTER
207-774-6877
<http://www.peabodycenter.org>

PORTLAND STD CLINIC
207-874-8446
<http://www.ci.portland.me.us>

PRESQUE ISLE:

ACAP HEALTH SERVICES
207-768-3062 or 1-800-432-7881
<http://www.acap-me.org>

ROCKLAND:

MIDCOAST HEALTH & FAMILY PLANNING
207-594-6880

YORK:

FRANNIE PEABODY CENTER
(services provided in Portland & Ogunquit)
207-774-6877
<http://www.peabodycenter.org>

Confidential HIV Antibody Testing & Counseling Sites

AUBURN:

AUBURN/LEWISTON STD CLINIC
207-795-4019 or 1-800-587-9354
<http://www.wmca.org>

AUGUSTA:

HEALTHREACH HARM REDUCTION
207- 621-3793 or 621-3770
<http://www.maine-general.org>

AUGUSTA FAMILY PLANNING
207-626-3426
<http://mainefamilyplanning.org/clinic-locations/midcoast-maine/augusta>

BANGOR:

BANGOR STD CLINIC
207-947-0700

EASTERN MAINE AIDS NETWORK
207-990-3626 or 1-877-990-3626
<http://www.maineaidsnetwork.com/>

PENQUIS FAMILY PLANNING
207-973-3650
http://www.penquis.org/index.php?cPath=75_76

BANGOR continued)

WABANAKI MENTAL HEALTH
207-990-0605
<http://www.wabanaki.org/>

BELFAST:

BELFAST FAMILY PLANNING
207-338-3736

BIDDEFORD:

BIDDEFORD FAMILY PLANNING
207-282-6620
<http://www.maine-familyplanning.org/>

BRUNSWICK:

ALL ABOUT PREVENTION
(Formerly Merrymeeting AIDS Support Services)
207-725-4955
<http://www.allaboutprevention.org/>

TOPSHAM FAMILY PLANNING
207-725-8264
<http://www.maine-familyplanning.org/clinic-locations/southern-maine>

CALAIS:

DOWN EAST AIDS NETWORK
207-454-3634
<http://downeastaidsnetwork.homestead.com/>

DAMARESCOTTA:

DAMARISCOTTA FAMILY PLANNING
207-563-1224
<http://www.mainefamilyplanning.org/clinic-locations/midcoast-maine/damariscotta>

DEXTER

PENQUIS DEXTER FAMILY PLANNING
207-924-7383
http://www.penquis.org/index.php?cPath=75_76

DOVER-FOXCROFT

PENQUIS DOVER-FOXCROFT FAMILY PLANNING
207-564-2847
http://www.penquis.org/contact_us.php

ELLSWORTH:

DOWN EAST AIDS NETWORK
207-667-3506 or 1-800-669-0893
<http://downeastaidsnetwork.homestead.com/>

FARMINGTON:

WMCA – FARMINGTON FAMILY PLANNING
207-778-4553
<http://www.wmca.org/HealthServices.htm>

FORT KENT:

ACAP HEALTH SERVICES
207-834-3513
http://www.acap-me.org/health_services/family_planning.cfm

HOULTON:

ACAP HEALTH SERVICES
207-532-5303
http://www.acap-me.org/health_services/family_planning.cfm

LEWISTON:

AUBURN/LEWISTON STD CLINIC
207-795-4019 or 1-800-587-9354
<http://www.wmca.org>

LEWISTON: (continued)

WMCA - HEALTH SERVICES
LEWISTON FAMILY PLANNING
207-795-4007 or 1-800-587-9354
<http://www.wmca.org/HealthServices.htm>

LINCOLN:

PENQUIS LINCOLN FAMILY PLANNING
207-794-3313
http://www.penquis.org/index.php?cPath=75_76

LUBEC:

HEALTHWAYS HIV PROGRAM
207-733-1090 x 2156 or 1-877-270-4139
<http://rmcl.org/>

MACHIAS:

DOWN EAST AIDS NETWORK
207-255-5849 or 1- 888-991-7400
<http://downeastaidsnetwork.homestead.com/>
DOWNEAST HEALTH SERVICES
207-667-5304 or 1-800-492-5550
http://www.downeasthealth.org/family_plan.html

NORWAY:

NORWAY FAMILY PLANNING
207-743-2066
<http://www.wmca.org/HealthServices.htm>

PORTLAND:

PORTLAND COMMUNITY FREE CLINIC
207-874-8446
<http://www.portlandmaine.gov/hhs/phcommunityfreeclinic.asp>

PORTLAND COMMUNITY HEALTH CENTER
207-874-2141
<http://www.portlandmaine.gov/hhs/phpchemain.asp>

PORTLAND FAMILY PLANNING
207-797-8881
<http://www.plannedparenthood.org/index.htm>

PORTLAND: (continued)

HOMELESS HEALTH CLINIC
207-874-8445
<http://www.portlandmaine.gov/hhs/phindigentcare.asp>

PRESQUE ISLE:

ACAP HEALTH SERVICES
207-768-3062 or 1-800-432-7881
http://www.acap-me.org/health_services/family_planning.cfm

ROCKLAND:

ROCKLAND FAMILY PLANNING
207-594-3114
<http://www.maine-familyplanning.org/clinic-locations/midcoast-maine/rockland>

RUMFORD:

WMCA-HEALTH SERVICES
RUMFORD FAMILY PLANNING
207-364-3960
<http://www.wmca.org/HealthServices.htm>

SANFORD:

SANFORD FAMILY PLANNING
207-324-9385
<http://www.plannedparenthood.org/index.htm>

TOPSHAM:

TOPSHAM FAMILY PLANNING
207-725-8264
<http://www.plannedparenthood.org/index.htm>

WATERVILLE:

WATERVILLE FAMILY PLANNING
207-859-1638
<http://www.kvcapfamilyplanning.org/index.php>

YORK

FRANNIE PEABODY CENTER
(services provided in Portland & Ogunquit)
1-866-701-3897 or 207-251-4930
<http://www.peabodycenter.org/testing.htm>

Sexually Transmitted Disease Testing Sites

AUGUSTA:

FAMILY PLANNING ASSOCIATION OF
MAINE
207-626-3426
<http://www.fpam.org>

BANGOR:

BANGOR STD CLINIC
207-94/0700
<http://www.bangor.std@bgrme.org>

DAMARISCOTTA:

FAMILY PLANNING ASSOCIATION OF
MAINE
207-563-1224
<http://www.fpam.org>

DEXTER:

DEXTER HEALTH SERVICE
207-924-7383
<http://www.penquis.org>

FARMINGTON:

WMCA-FARMINGTON
207-778-4553
<http://www.wmca.org>

LEWISTON:

LEWISTON STD CLINIC
207-795-4019
<http://www.wmca.org/Locations.htm>

LINCOLN:

LINCOLN HEALTH SERVICES
207/794-3313
<http://www.penquis.org>

PORTLAND:

PORTLAND STD CLINIC
207-874-8446
<http://www.portlandmaine.gov>

PLANNED PARENTHOOD of
NORTHERN N.E.
207-797-8881
<http://www.ppnne.org>

BELFAST:

FAMILY PLANNING ASSOCIATION
OF MAINE
207-338-3736
<http://www.fpam.org>

BIDDEFORD:

PLANNED PARENTHOOD of
NORTHERN N.E.
207-282-6620
<http://www.ppnne.org>

PRESQUE ISLE:

ACAP HEALTH SERVICES
207-768-3062
<http://www.acap-me.org>

ROCKLAND:

FAMILY PLANNING ASSOCIATION
OF MAINE
207-594-3114
<http://www.fpam.org>

SANFORD:

PLANNED PARENTHOOD of
NORTHERN N.E.
207-324-9385
<http://www.ppnne.org>

SKOWHEGAN:

SKOWHEGAN FAMILY PLANNING
207-859-2507
<http://www.kvcapfamilyplanning.org>

TOPSHAM:

PLANNED PARENTHOOD of
NORTHERN N.E.
207-725-8264
<http://www.ppnne.org>

WATERVILLE:

WATERVILLE FAMILY PLANNING
207-859-1638
<http://www.kvcapfamilyplanning.org>

Viral Hepatitis Testing Sites

BANGOR:

BANGOR STD CLINIC
207-947-0700
http://www.bangormaine.gov/cs_healthservices.php

BELFAST:

FAMILY PLANNING ASSOCIATION OF MAINE
207-338-3736
<http://www.mainefamilyplanning.org/clinic-locations/midcoast-maine/belfast>

CALAIS:

DISCOVERY HOUSE
207-454-1300

DAMARISCOTTA:

FAMILY PLANNING ASSOCIATION OF MAINE
207-563-1224
<http://www.mainefamilyplanning.org/clinic-locations/midcoast-maine/damariscotta>

FORT KENT:

ACAP HEALTH SERVICES
207-834-3513
<http://www.acap-me.org>

HOULTON:

ACAP HEALTH SERVICES
207-532-5303
<http://www.acap-me.org>

LEWISTON:

LEWISTON STD CLINIC
207-795-4019 or 1-800-587-9354
<http://www.wmca.org/Locations.htm>

LUBEC:

RMCL-Healthways
207-773-5541
<http://www.rmcl.org>

PORTLAND:

Public Health HIV/STD Clinic
207-874-8446
<http://www.portlandmaine.gov>

PRESQUE ISLE:

ACAP HEALTH SERVICES
207-768-3062
<http://www.acap-me.org>

ROCKLAND:

FAMILY PLANNING ASSOCIATION
OF MAINE
207-594-3114
<http://www.mainefamilyplanning.org/clinic-locations/midcoast-maine/rockland>

Viral Hepatitis Vaccine Sites

Northern Region

BANGOR IMMUNIZATION CLINIC
207-207-941-0259x407
http://www.bangormaine.gov/cs_healthservices.php#stdc

Southern Region

PORTLAND HIV/STD CLINIC
207-874-8446
<http://www.portlandmaine.gov>

Services for Gay, Lesbian, Bisexual, Transgender & Questioning Youth

Regional Resources

SOUTHERN MAINE

Proud Rainbow Youth of Southern Maine (PRYSM)
874-1030, ext. 403
<http://www.commcc.org/PRYSM/index.html>

ANDROSCOGGIN COUNTY

Sexual Assault Crisis Center
1-800-871-7741 – 24 hour hotline
TTY: 1-888-458-5599
784-5272. (SACC office for non-emergency issues)

University Campus-Based Programs

(Website contact only)

BATES COLLEGE

Outfront
(For Bates students and those considering attending
Bates.)
<http://abacus.bates.edu/people/orgs/outfront/>

BOWDOIN COLLEGE

Bowdoin Queer Straight Alliance (BQSA)
(For Bowdoin students, applicants, alum and for the
Brunswick community.)
<http://www.bowdoin.edu/queer/q-s-alliance/bqsa.shtml>

UNIVERSITY OF MAINE at MACHIAS

100% Club
(Primarily for UMM students, but they list links to
other non-university groups that serve the area.)
<http://www.umm.maine.edu/100percent.html>

UNIVERSITY OF SOUTHERN MAINE

Center for Sexualities and Gender Diversity
(For students and employees at USM.)
<http://www.usm.maine.edu/glbtdqa/>

UNIVERSITY OF MAINE

University of Maine: Wilde-Stein
(Primarily for the UM campus community, but
they do not turn away anyone.)
<http://umaine.edu/glbtd/wilde-stein/>

Free Helplines on GLBTQ Issues

The Trevor Project Helpline

Nation's only 24/7 crisis and suicide prevention hotline
for gay, lesbian, bisexual, transgender and questioning
youth. <http://www.thetrevorproject.org/home2.aspx>
1-866-488-7386

Fenway Health Toll-Free Help Lines

Fenway Health Toll-Free Listening Lines
[http://www.fenwayhealth.org/site/PageServer?pagenam
e=FCHC_srv_services_tollfree](http://www.fenwayhealth.org/site/PageServer?pagenam e=FCHC_srv_services_tollfree)

Gay, Lesbian, Bisexual and Transgender Helpline

617.267.9001
Toll-free: 888-340-4528

Peer Listening Line

617-267-2535
Toll-free: 800-399-7337

Mental Health Crisis Hotline

24-hours a day, 7 days per week

1-888-568-1112 (voice and TTY)

Reporting Abuse and Neglect

Child Abuse and Neglect Reports

Maine Department of Health and Human Services

1-800-452-1999

TTY (deaf and hard of hearing) – 1-800-963-9490

Adult Abuse-Neglect Reports

Maine Department of Health and Human Services

1-800-624-8404

TTY (Deaf and Hard of Hearing) – 1-800-963-9490

Abuse of anyone over the age of 18 who is mentally incapacitated or who is a dependent for care.

(This program is located within the Maine DHHS Office of Elder Services.)

1-800-624-8404

1-800-606-0215 ~ TTY

24 hours per day, 7 days per week. After regular business hours (8 AM to 5 PM), listen to the full voice recording to select the option to connect to after-hours staff.

Maine State District Attorney Offices

District 1 – York

York County Courthouse
45 Kennebunk Road
PO Box 399
Alfred, ME 04002
207-324-8001
FAX 207-490-6990

Springvale District Court
455 Main Street
Springvale, ME 04083
207-324-8214
FAX 207-490-1741

York District Court
11 Chases Pond Road
PO Box 776
York, ME 04909
207-363-7437
FAX 207-363-1219

Biddeford District Court
25 Adams Street
Biddeford, ME 04005
207-282-0466
FAX 207-284-6736

District II – Cumberland

Cumberland County Courthouse
142 Federal Street
Portland, ME 04101
207-871-8384
FAX 207-775-3561

West Bath District Court
147 New Meadows Road
W. Bath, ME 04530
443-5104
Fax 443-2229

District III – Androscoggin, Franklin, Oxford

Androscoggin County Courthouse
2 Turner Street
Auburn, ME 04210
207-784-1397
FAX 207-784-3282

Lewiston District Court
71 Lisbon Street
Lewiston, ME 04240
207-783-7311
FAX 207-784-3265

Franklin County Courthouse
140 Main Street
Farmington, ME 04398-1818
207-778-5890
FAX 207-779-0892

District IV – Kennebec, Somerset

Kennebec County Superior Courthouse
95 State Street
Augusta, ME 04330
207-623-11565
FAX 207-622-5839

Somerset County Courthouse
41 Court Street
Skowhegan, ME 04976
207-474-2423
FAX 474-7407

Waterville District Court
18 Colby Street
Waterville, ME 04901
207-873-7317
FAX 207-873-0082

District V – Penobscot, Piscataquis

Penobscot County Courthouse
97 Hammond Street
Bangor, ME 04401
207-942-8552
1-800-696-5404
FAX 207-945-4748

Piscataquis County Courthouse
159 East Main Street
Dover-Foxcroft, ME -4426
207-564-2181
FAX 207-564-6503

District VI – Knox, Sagadahoc, Lincoln, Waldo

Knox County Courthouse
62 Union Street
Rockland, ME 04841
207-594-0425
FAX 207-594-0434

Lincoln County Courthouse
32 High Street
Wiscasset, ME 04578
207-882-7312
FAX 207-882-4323

Waldo County Courthouse
137 Church Street
Belfast, ME 04915
207-338-2512
FAX 207-338-6792

Sagadahoc County Courthouse
752 High Street
Bath, ME 04530
207-443-8204
FAX 207-443-8208

District VII – Hancock, Washington

Hancock County Courthouse
70 State Street
PO Box 722
Ellsworth, ME 04605
207-667-4621
FAX 207-667-0784

Machias Courthouse
34 Center St.
PO Box 297
Machias, ME 04654
207-255-4425
FAX 207-255-6423

Calais Courthouse
382 South Street
PO Box 333
Calais, ME 04619
207-454-3159
FAX 207-454-2665

District VIII – Aroostook

Aroostook County Courthouse
144 Sweden Street
Caribou, ME 04736
207-498-2557
FAX 207-493-3493

Presque Isle Courthouse
27 Riverside Drive
Presque Isle, ME 04769
207-764-0504
FAX 207-764-2046

Houlton Courthouse
25 School Street
Houlton, ME 04730
207-532-4294
FAX 207-532-1504

Family Planning Association of Maine
Clinic Listings
(Title X funded sites)

DFD Russell Medical Center (FQHC)

Leeds

180 Church Hill Road, Suite 1
Leeds ME 04263-3348
524-3501/Fax: 524-2459

Monmouth

11 Academy Road
Monmouth ME 04259
933-9646

Turner

7 So. Main Street
Turner ME 04282
225-2676

Downeast Health Services

[Includes Maine Maritime Academy,
Castine, (SBHC); Calais High School (SBHC);
Stonington (FQHC); Jonesport (FQHC);
Milbridge (FQHC); Harrington (FQHC)]

Calais

Calais Family Planning Program
37 Union Street
Calais, ME 04619
454-3634/454-1800/1-800-924-2628
Fax: 454-2997

Ellsworth

Family Planning Program
52 Christian Ridge Road
Ellsworth, ME 04605
667-5304 & 1-800-492-5550
Fax: 667-6117

Machias

Machias Family Planning
71 Court Street
Machias, ME 04654
255-3391/1-800-313-1223
Fax: 255-8625

**Family Planning Association of
Maine**

Augusta

Augusta Family Planning
43 Gabriel Drive, PO Box 587
Augusta, ME 04332-0587
626-3426/Fax: 621-8393

Belfast

Belfast Family Planning
147 Waldo Avenue
P.O. Box 18
Belfast, ME 04915
338-3736/Fax: 338-0704

Damariscotta

Damariscotta Family Planning
Pine Grove Plaza, Route 1
P.O. Box 610
Damariscotta, ME 04543
563-1224/Fax: 563-2214

Readfield

Maranacook Community School
(SBHC)
2250 Millard Harrison Drive
Readfield ME 04355
207-685-4923 x318

Rockland

Rockland Family Planning
22 White Street
P.O. Box 866
Rockland, ME 04841
594-3114/Fax: 594-3108

Vinalhaven

Island Community Medical
Services (FQHC)
15 Medical Center Loop
PO Box 812
Vinalhaven ME 04863
863-4341/Fax: 863-2737

ACAP Health Services

Fort Kent

Family Planning
486 Frenchville Road
RR 2 Box 95
Fort Kent, ME 04743
834-3513/Fax: 834-3513

Houlton

Family Planning
91 Military Street
Houlton, ME 04730
532-5303/Fax: 521-0049

Presque Isle

Family Planning
169 Academy Street
Presque Isle, ME 04769
768-3062/Fax: 768-3057

KVCAP

Waterville

Family Planning
97 Water Street
Waterville, ME 04903-1529
859-1638/Fax: 859-1696

Skowhegan

Skowhegan Family Planning
26 Mary St.
Skowhegan, ME 04976
474-8487/1-800-542-8227
Fax: 474-6614

Noble High School (SBHC)

North Berwick

Noble High School
388 Somersworth Road
North Berwick, Maine 03906
Phone 1-207-676-2175
Fax 1-207-676-2204

Health Reach Network (FHHC)

Albion

Lovejoy Health Center
7 School Street
Suite 1 Albion, ME 04910
207-437-9388
207-437-7022

Bethel

Bethel Family Health Center
32 Railroad Street
P. O. Box 1367
Bethel, ME 04217-1367
824-2193/Fax: 824-3005

Bingham

Bingham Area Health Center
237 Main Street
PO Box 746
Bingham ME 04920
672-4187/Fax: 672-3641

Coopers Mills

Sheepscot Valley Health Center
47 Main Street
PO Box 207
Coopers Mills, ME 04341
207-549-7581

Rangeley

Rangeley Regional Health Center
42 Dallas Hill Road
PO Box 569
Rangeley ME 04970
864-3303/Fax: 864-2969

Portland Public Health (SBHC)
(Includes Casco Bay HS, Deering HS,
Portland HS)

Portland / Casco Bay

Family Health Services
Public Health Division
Health & Human Services Dept.
389 Congress St., Room #307
Portland, ME 04101
756-8052/Fax: (207) 874-8913

PENQUIS

Bangor

Penquis Family Planning
262 Harlow Street
P.O. Box 1162
Bangor, ME 04401
973-3650/Fax: 941-2978

Dexter

Family Planning
311A Corinna Rd
PO Box 45
Dexter, ME 04930
924-7383/Fax: 924-5148

Lincoln

Family Planning
119 Main Street
Lincoln, ME 04457
794-3313/Fax: 794-2894

Planned Parenthood of Northern New England

Biddeford Family Planning

281 Main Street, PO Box 1556
Biddeford, ME 04005-1556
282-6620/282-3401
Fax: 283-4408

Portland

Family Planning
970 Forest Avenue
P.O. Box 1519
Portland, ME 04104-1519
797-8881/Fax: 797-5093

Sanford

Family Planning
886 Main Street, Suite 302
Sanford, ME 04073-0589
324-9385/324-0742
Fax: 324-2818

Brunswick/Topsham

Family Planning
P.O. Box 234 (mailing address)
Brunswick, ME 04011-0234
[Bowdoin Mill Island, Ste. 101,
Topsham, 04086 (physical address)]
725-8264/Fax: 729-6117

Western Maine Community Action Health Services

Lewiston

Family Planning
PO Box 1038
179 Lisbon Street
Lewiston 04240
795-4007/1-800-587-9354

Farmington

Family Planning
193 Front Street Suite 5
Farmington, ME 04938
778-4553/Fax: 778-4257

Rumford

Family Planning
218 Penobscot Street
Rumford, ME 04276
364-3960/Fax: 369-8041

Norway

Family Planning
39 Lower Main Street, PO Box 151
Norway, ME 04268
743-2066/Fax: 743-6086

Porter

Sacopee Valley Health Outreach Clinic
70 Maine Street
Porter, ME 04068
625-8126

DHHS Regional Offices
Office of Adults with Cognitive and Physical Disabilities
(Coordination point for case management for people with MR.)

Regular office hours are 8 AM-5 PM.
For non-business hour crisis, dial 1-888-568-1112 – ask for MR Services.

Augusta ~ 287-2205 or 1-800-232-0944
TTY 1-800-606-0215; FAX 287-7186

Bangor ~ 941-4360 or 1-800- 963-9491
TTY 1-800-606-0215; FAX 941-4389

Caribou ~ 493-4000 or 1-800-432-7366
TTY 1-800-606-0215; FAX 493-4173

Farmington ~ 778-8400 or 1-800-442-6382
TTY 1-800-606-0215; FAX 778-8410

Lewiston ~ 795-4300 or 1-800-482-7517
TTY 1-800-606-0215; FAX 795-4444

Machias ~ 255-1955 or 1-800-606-0215
TTY 1-800-606-0215; FAX 255-1958

Portland ~ 822-0270 or 1-800-269-5208
TTY 1-888-254-0311; FAX 822-0295

Rockland ~ 596-4302 or 1-800-704-8999
TTY 1-800-606-0215; FAX 596-2304

Sanford ~ 490-5400 or 1-800-482-0790
TTY 1-800-606-0215; FAX 490-4619

South Paris ~ 744-1200 or 1-888-593-9775
TTY 1-800-606-0215; FAX 743-1698

Appendix D

Tab

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§2915. Uniform forensic examination kit for evidence collection in alleged cases of gross sexual assault

1. Development of uniform forensic examination kit. The Department of Public Safety shall determine by rule what constitutes a uniform standardized forensic examination kit for evidence collection in alleged cases of gross sexual assault. The rules must define the contents of the kit, instructions for administering the kit and a checklist that examiners must follow and enclose in the completed kit.

2. Use of uniform forensic examination kit. A licensed hospital or licensed health care practitioner that conducts physical examinations of alleged victims of gross sexual assault shall use the uniform standardized forensic examination kit developed by the Department of Public Safety pursuant to subsection 1. A health care practitioner who conducts physical examinations of alleged victims of gross sexual assault must be trained in the proper evidence collection procedures for conducting a forensic examination.

Evidence collection results may not be excluded as evidence in any proceeding before any court of this State as a result of the examiner's failure to use the standardized evidence collection kit or as a result of the examiner's failure to be trained in the proper procedures for the collection of evidence required by this subsection.

3. Furnishing of uniform forensic examination kit. The Department of Public Safety shall furnish the uniform forensic examination kits to licensed hospitals and licensed health care practitioners that perform forensic examinations of alleged victims of gross sexual assault.

4. Rules. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

§3821. Transportation and storage of forensic examination kits

If an alleged victim of gross sexual assault has a forensic examination and has not reported the alleged offense to a law enforcement agency when the examination is complete, the licensed hospital or licensed health care practitioner that completed the forensic examination shall notify the nearest law enforcement agency. That law enforcement agency shall transport the completed kit, identified only by a tracking number assigned by the hospital or health care practitioner, to its evidence storage facility. The law enforcement agency shall store the kit for at least 90 days from the time of receipt. If during that 90-day period the alleged victim reports the offense to a law enforcement agency, the agency storing the kit shall transport the kit to the Maine State Police Crime Laboratory.

Maine Court Rules

Maine Rules of Evidence

Article VIII. Hearsay

Rule 801. Definitions

The following definitions apply under this article:

- (a) Statement. A “statement” is (1) an oral or written assertion of (2) nonverbal conduct of a person, if it is intended by the person as an assertion.
- (b) Declarant. A “declarant” is a person who makes a statement.
- (c) Hearsay. “Hearsay” is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.
- (d) Statements Which Are Not Hearsay. A statement is not hearsay if:
 - (1). *[omitted]*
 - (2) Admission by Party-Opponent. The statement is offered against a party and is (A) the party’s own statement, in either an individual or a representative capacity or (B) a statement of which the party has manifested an adoption or belief in its truth, or (C) a statement concerning the subject, but not to the principal or employer himself, or (D) a statement by the party’s agent or servant concerning a matter within the scope of the agency or employment, but not to the principal or employer, made during the existence of the relationship, or (E) a statement by a co-conspirator of a party during the course and in furtherance of the conspiracy. The contents of the statement shall be considered, but are not alone sufficient to establish the declarant’s authority under subdivision (C), the agency or employment relationship and scope thereof under subdivision (D), or the existence of the conspiracy and the participation therein of the declarant and the party against whom the statement is offered under subdivision (E).

Rule 803. Hearsay Exceptions; Availability of Declarant Immaterial

The following are not excluded by the hearsay rule, even though the declarant is available as a witness:

- (1) **Present Sense Impression.** A statement describing or explaining an event or condition made while the declarant was perceiving the event or condition, or immediately thereafter.
- (2) Excited Utterance. A statement relating to a startling event or condition made while the declarant was under the stress of excitement caused by the event or condition.
- (3) The Existing Mental, Emotional, or Physical Condition. A statement of the declarant’s then existing state of mind, emotion, sensation, or physical condition such as intent, plan, motive, design, mental feeling, pain, and bodily health, but not including a statement of memory or belief to prove the fact remembered or believed unless it relates to the execution, revocation, identification, or terms of declarant’s will.
- (4) Statements for Purposes of Medical Diagnosis or Treatment. Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment.

Chapter 260: CONSENT OF MINORS FOR HEALTH SERVICES (HEADING: PL 1995, c. 694, Pt. C, @8 (new))

§1501. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

- 1. Health care practitioner.** "Health care practitioner" has the same meaning as set forth in Title 24, section 2502, subsection 1-A.
- 2. Health care provider.** "Health care provider" has the same meaning as set forth in Title 24, section 2502, subsection 2.
- 3. Minor.** "Minor" means a person under 18 years of age.

§1502. Consent

In addition to the ability to consent to treatment for health services as provided in sections 1823 and 1908 and Title 32, sections 2595, 3292, 3817, 6221 and 7004, a minor may consent to treatment for abuse of alcohol or drugs or for emotional or psychological problems.

§1502-A. Consent to give blood

A minor may consent to give blood if the minor is at least 17 years of age, notwithstanding any other provision of law.

§1503. Authority

A minor may give consent to all medical, mental, dental and other health counseling and services if the minor:

- 1. Living separately; independent of parental support.** Has been living separately from parents or legal guardians for at least 60 days and is independent of parental support;
- 2. Married.** Is or was legally married;
- 3. Armed Forces.** Is or was a member of the Armed Forces of the United States; or
- 4. Emancipated.** Has been emancipated by the court pursuant to Title 15, section 3506-A.

§1504. Good faith reliance on consent

A health care practitioner or health care provider who takes reasonable steps to ascertain that a minor is authorized to consent to health treatment as authorized in section 1503 and who subsequently renders treatment in reliance on that consent is not liable for failing to have secured consent of the minor's parent or guardian prior to providing health care services to the minor.

§1505. Confidentiality; notification

- 1. Confidentiality.** Except as otherwise provided by law, a minor who may consent to health care services, as provided in this chapter or by other provision of law, is entitled to the same confidentiality afforded to adults.
- 2. Parental notification.** A health care practitioner or health care provider may notify the parent or guardian of a minor who has sought health care under this chapter if, in the judgment of the practitioner or provider, failure to inform the parent or guardian would seriously jeopardize the health of the minor or would seriously limit the practitioner's or provider's ability to provide treatment.

§1506. Financial responsibility

Unless the parent or guardian expressly agrees to assume full or partial responsibility, a minor who consents to health care services as provided in this chapter is responsible for the costs of those services. A minor may not be denied benefits or services to which the minor is entitled from a health care practitioner, health care provider, insurer or public agency because the minor has given the consent for those services as provided in this chapter.

§1507. Consent for sexual assault forensic examination

Notwithstanding the limitations set forth in section 1503, a minor may consent to health services associated with a sexual assault forensic examination to collect evidence after an alleged sexual assault.

§1823. Treatment of minors

Any hospital licensed under this chapter or alcohol or drug treatment facility licensed pursuant to section 7801 that provides facilities to a minor in connection with the treatment of that minor for venereal disease or abuse of drugs or alcohol or for the collection of sexual assault evidence through a sexual assault forensic examination is under no obligation to obtain the consent of that minor's parent or guardian or to inform that parent or guardian of the provision of such facilities so long as such facilities have been provided at the direction of the person or persons referred to in Title 32, sections 2595, 3292, 3817, 6221 or 7004. The hospital shall notify and obtain the consent of that minor's parent or guardian if that hospitalization continues for more than 16 hours.

§3477. Persons mandated to report suspected abuse, neglect or exploitation

1. Report required. The following persons immediately shall report or cause a report to be made to the department when the person suspects that an adult has been abused, neglected or exploited and has reasonable cause to suspect that the adult is incapacitated or dependent:

A. While acting in a professional capacity:

- (1) An allopathic or osteopathic physician;
- (2) A medical intern;
- (3) A medical examiner;
- (4) A physician's assistant;
- (5) A dentist;
- (6) A chiropractor;
- (7) A podiatrist;
- (8) A registered or licensed practical nurse;
- (9) A certified nursing assistant;
- (10) A social worker;
- (11) A psychologist;
- (12) A pharmacist;
- (13) A physical therapist;
- (14) A speech therapist;
- (15) An occupational therapist;
- (16) A mental health professional;
- (17) A law enforcement official;

- (18) A coroner;
- (19) Emergency room personnel;
- (20) An ambulance attendant;
- (21) An emergency medical technician; or
- (22) Unlicensed assistive personnel; or
- (23) A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications;

B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the adult, regardless of whether the person receives compensation; and

C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation.

Whenever a person is required to report as a member of the staff of a medical, public or private institution, agency or facility, the staff person immediately shall make a report directly to the department.

2. Reports. Reports regarding abuse, neglect or exploitation shall be made immediately by telephone to the department and shall be followed by a written report within 48 hours if requested by the department. The reports shall contain the name and address of the involved adult; information regarding the nature and extent of the abuse, neglect or exploitation; the source of the report; the person making the report; his occupation; and where he can be contacted. The report may contain any other information which the reporter believes may be helpful.

3. Confidentiality in case of treatment. This section does not require any person acting in their professional capacity to report when:

A. The factual basis for knowing or suspecting abuse, neglect or exploitation of an adult covered under this subchapter derives from the professional's treatment of the individual suspected of causing the abuse, neglect or exploitation;

B. The treatment was sought by the individual for a problem relating to the abuse, neglect or exploitation; and

C. In the opinion of the person required to report, the abused, neglected or exploited adult's life or health is not immediately threatened.

§4011-A. Reporting of suspected abuse or neglect

1. Required report to department. The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected:

A. When acting in a professional capacity:

- (1) An allopathic or osteopathic physician, resident or intern;
- (2) An emergency medical services person;
- (3) A medical examiner;
- (4) A physician's assistant;
- (5) A dentist;
- (6) A dental hygienist;
- (7) A dental assistant;
- (8) A chiropractor;
- (9) A podiatrist;

- (10) A registered or licensed practical nurse;
- (11) A teacher;
- (12) A guidance counselor;
- (13) A school official;
- (14) A children's summer camp administrator or counselor;
- (15) A social worker;
- (16) A court-appointed special advocate or guardian ad litem for the child;
- (17) A homemaker;
- (18) A home health aide;
- (19) A medical or social service worker;
- (20) A psychologist;
- (21) Child care personnel;
- (22) A mental health professional;
- (23) A law enforcement official;
- (24) A state or municipal fire inspector;
- (25) A municipal code enforcement official;
- (26) A commercial film and photographic print processor;
- (27) A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications; or
- (28) A chair of a professional licensing board that has jurisdiction over mandated reporters; or

B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the child, *regardless of* whether the person receives compensation; and

C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation.

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department.

2. Required report to district attorney. When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney's office.

3. Optional report. Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

4. Mental health treatment. When a licensed mental health professional is required to report under subsection 1 and the knowledge or reasonable cause to suspect that a child has been or is likely to be abused or neglected comes from treatment of a person responsible for the abuse or neglect, the licensed mental health professional shall report to the department in accordance with subsection 1 and under the following conditions.

Maine Office of the Attorney General
6 State House Station
AUGUSTA, ME 04333
(207) 626-8800

To: Polly Campbell, R.N., Director, Sexual Assault Forensic Examiner Program
From: Janice S. Stuver, A.A.G., Chief, Child Protection Division
Date: February 26, 2005
Re: Reporting of Child Abuse and Neglect

Below is a brief outline of Maine's child abuse and neglect reporting law. I am hopeful that this outline will help clear up some confusion about reporting obligations. The full text of the law is contained at 22 M.R.S.A. §4011-A – §4018, and may be reviewed at: <http://janus.state.me.us/legis/statutes/22/title22ch1071sec0.html>.

Standard For Making A Report

Those required to report (see mandated reporting section below) must make a child abuse / neglect report to the appropriate agency **“when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.”** 22 M.R.S.A. §4011-A(1).

Those required to report must also make a prenatal exposure to drugs report **“when a health care provider involved in the delivery or care of an infant who the provider knows or has reasonable cause to suspect has been born affected by illegal substance abuse or is suffering from withdrawal symptoms resulting from prenatal drug exposure, whether or not the prenatal exposure was to legal or illegal drugs.”** 22 M.R.S.A. §4011-B

Note that “reasonable cause to suspect” is enough to trigger the reporting obligation; proof or personal knowledge is not required. Also note that the reporting obligation extends to abuse that may occur in the future, and is not limited solely to abuse that has already occurred.

Definition of Child

The Child Protection Code defines **“child”** as *any person under age 18.*

“Abuse or Neglect” is defined as a *“threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these, by a person responsible for the child.”*

“Person responsible for the child” is defined as *“a person with responsibility for a child’s health or welfare, whether in the child’s home or another home or a facility which, as part of its function, provides for care of the child. It includes the child’s custodian.”* The definition of Person responsible for the child is very broad and can include anyone who explicitly or implicitly has been given or assumed responsibility for a child. This includes, but is not necessarily limited to, parents, adult members of the household, day care providers, babysitters, siblings, adult family members who frequent the home, school staff, or residential staff.

There is no definition in the code for “sexual abuse or exploitation.”

There are also no distinctions made in the Child Welfare Code about the comparative ages of the perpetrator and victim, the mental capacity of the victim, or the consensual or non-consensual nature of the sexual relations.

In short, reporting is required whenever a professional listed below has “reasonable cause to suspect” that a person under age 18 has been or is likely to be abused or neglected, which includes either an act of sexual abuse or exploitation upon that child, or the failure to protect the child from such acts, by a person responsible for him/her.

Subsequent questions about whether a crime has been committed, whether sufficient evidence exists to prosecute, whether child protective steps will be taken, and other considerations must be left to the appropriate D.H.S. and law enforcement authorities, **after** the mandated report has been made.

Optional and Mandated Reporting – Who May Report; Who Must Report

The mandated reporting law lists approximately 29 categories of professionals and lay people who are mandated by law to report reasonable suspicions of abuse or neglect. In addition to those listed, the law also obligates “any other person who has assumed full, intermittent or occasional responsibility for the care or custody of [a] child, whether or not the person receives compensation” to file a report if his/her information meets the standard outlined above.

The full list of mandated reporters is available at <http://janus.state.me.us/legis/statutes/22/title22sec4011-A.html>

A person who is not listed as a mandated reporter but who has information meeting the reporting standard may still make an optional report.

Where to Report

Reports of suspected child abuse or neglect by a person responsible for the child must be made by telephone with the **Maine Department of Human Services Central Intake: 1-800-452-1999**.

In those cases where the suspected perpetrator of abuse is an individual who is not responsible for the child, then **the report** must be made to the appropriate **District Attorney's Office**:

| | | |
|----------------|--|----------|
| District I— | York Co. | 324-8001 |
| District II— | Cumberland Co. | 871-8384 |
| District III— | Androscoggin, Franklin, Oxford Cos. | 784-1397 |
| District IV— | Kennebec, Somerset Cos. | 623-1156 |
| District V— | Penobscot, Piscataquis | 942-8552 |
| District VI— | Knox, Waldo, Sagadahoc, Lincoln Cos. | 594-0424 |
| District VII— | Hancock, Washington | 667-4621 |
| District VIII— | Aroostook Co. | 498-2557 |

Privileged Or Confidential Communications

The privileged and confidential nature of many communications are temporarily suspended (“abrogated”) for purposes of required reporting, cooperating with the Department or a guardian ad litem in an investigation, or giving evidence in a child protection proceeding. 22 M.R.S.A. §4015.

<http://janus.state.me.us/legis/statutes/22/title22sec4015.html>. Among other examples listed in the statute, this includes the abrogation of the physician-patient privilege, the psychotherapist-patient privilege, the confidential nature of communication to a sexual assault counselor under 16 M.R.S.A. §53-B, and the confidential nature of communication to a social worker under 32 M.R.S.A. §7005. (*Please consult the*

language of the statute and legal counsel for a full list and an explanation of the effect of abrogation).

The privileged and confidential nature of many communications as afforded by the HIPAA Privacy Rule are also suspended. The federal regulations for the HIPAA Privacy Rule provide that a provision of state law that provides for the reporting of child abuse will take precedence over contrary provisions of the HIPAA Privacy Rule. 45 C.F.R. §160.203(2)(c). Hence, State of Maine statutory provisions mandating reporting of suspected child abuse or prenatal exposure to drugs take precedence over the general HIPAA Privacy rule requirement of a written authorization for the disclosure. In other words, the reporting to the Department is mandated, even in the absence of a written authorization by the parent or guardian, without violating the HIPAA Privacy Rule.

Memorandum Provided For Informational Purposes

The information in this memorandum is for informational purposes, and indicates the position of the Attorney General's Office with regard to mandated and optional reporting. However, the Maine Attorney General's Office cannot give legal advice to private citizens or agencies. Individuals or agencies should seek advice and guidance from independent legal counsel if they have questions about their obligations under these laws. The Child and Family Services and Child Protection Act also contains other important provisions regarding mandated reporting. The full text of the statute should be reviewed, with questions directed to legal counsel.

For More Information

In 2002, *Keeping Children Safe Downeast*, in collaboration with the Maine Department of Human Services produced "***Recognizing and Reporting Child Abuse and Neglect, A Guide For Mandated Reporters.***" Copies are available from the D.H.S. Central Office at 207-287-5060.



State of Maine

OFFICE OF THE ATTORNEY GENERAL

To: Sexual Assault Forensic Examiners, SAFEs-in-Training, Emergency Department Medical Directors and Nurse Managers, Maine Prosecutors Association, Maine Hospital Association, Maine State Nurses Association, Maine Emergency Nurses Association, Maine Coalition Against Sexual Assault

From: Polly Campbell, Director
Sexual Assault Forensic Examiner Program

Melissa Reynolds O’Dea, Assistant Attorney General
Chair, Sexual Assault Forensic Examiner Advisory Board

Date: July 10, 2006

Subject: Collection of Forensic Evidence from an Unconscious Patient

This memo is to inform you of a new law that goes into effect on August 23, 2006, and to provide you with a copy of the law. Following are some of its highpoints that relate to hospitals and health care practitioners:

- If an unconscious patient presents as a possible victim of a sexual assault, a licensed hospital or health care provider may perform a sexual assault medical/forensic examination without the patient’s consent if it is reasonable to believe that evidence would be lost or destroyed if the examination were not conducted immediately. The provider should document in the medical record the findings that form the basis for believing that the patient was possibly sexually assaulted.
- The examiner/health care provider must handle the sex crimes kit in such a way as to preserve the patient’s anonymity.
- If a patient does not regain consciousness within 60 days, there are certain procedures that law enforcement must follow to preserve the collected evidence.
- Hospitals and health care practitioners who perform sexual assault forensic examinations with due care and in accordance with the Maine Health Security Act are free from legal liability in performing those exams.

If there are any questions please contact either Polly Campbell (626-8806) or Melissa Reynolds O’Dea (626-8552).

CHAPTER 538

H.P. 1313 - L.D. 1873

An Act Regarding Sexual Assault Forensic Examinations

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2986, sub-§3, as enacted by PL 1999, c. 719, §2 and affected by §11, is amended to read:

3. Completed kit. If the alleged victim has not reported the alleged offense to a law enforcement agency when the examination is complete, the hospital or health care practitioner shall then notify the nearest law enforcement agency, which shall transport and store the completed forensic examination kit for at least 90 days. The completed kit may be identified only by the tracking number. If during that 90-day period an alleged victim decides to report the alleged offense to a law enforcement agency, the alleged victim may contact the hospital or health care practitioner to determine the tracking number. The hospital or health care practitioner shall provide the alleged victim with the tracking number on the forensic examination kit and shall inform the alleged victim which law enforcement agency is storing the kit.

If the alleged victim reports the alleged offense to a law enforcement agency by the time the examination is complete, the investigating law enforcement agency shall transport the forensic examination kit directly to the Maine State Police Crime Laboratory.

If an examination is performed under subsection 5 and the alleged victim does not, within 60 days, regain a state of consciousness adequate to decide whether or not to report the alleged offense, the State may file a motion in the District Court relating to storing or processing the forensic examination kit. Upon finding good cause and after considering factors, including, but not limited to, the possible benefits to public safety in processing the kit and the likelihood of the alleged victim's regaining a state of consciousness adequate to decide whether or not to report the alleged offense in a reasonable time, the District Court may order either that the kit be stored for additional time or that the kit be transported to the Maine State Police Crime Laboratory for processing, or such other disposition that the court determines just. In the interests of justice or upon motion by the State, the District Court may conduct hearings required under this paragraph confidentially and in camera and may impound pleadings and other records related to them.

Sec. 2. 24 MRSA §2986, sub-§§5 and 6 are enacted to read:

5. Implied consent. If an alleged victim of gross sexual assault is unconscious and a reasonable person would conclude that exigent circumstances justify conducting a forensic examination, a licensed hospital or licensed health care practitioner may perform an examination in accordance with the provisions of this section.

A forensic examination kit completed in accordance with this subsection must be treated in accordance with Title 25, section 3821 and must preserve the alleged victim's anonymity. In addition, the law enforcement agency shall immediately report to the district attorney for the district in which the hospital or health care practitioner is located that such a forensic examination has been performed and a forensic examination kit has been completed under this subsection.

6. Liability. A licensed hospital or licensed health care practitioner in the exercise of due care is not liable for an act done or omitted in performing a sexual assault forensic examination under this section.

Sec. 3. 25 MRSA §3821, as enacted by PL 1999, c. 719, §4 and affected by §11, is amended by adding at the end a new paragraph to read:

In the case of a forensic examination performed under Title 24, section 2986, subsection 5, the law enforcement agency must immediately notify the district attorney for the district in which the hospital or health care practitioner is located that such a forensic examination has been performed and a forensic examination kit has been completed under Title 24, section 2986, subsection 5.

Appendix E

Tab

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