



**ADULT AND CHILD
SEXUAL ASSAULT
PROTOCOLS:**

**INITIAL FORENSIC
PHYSICAL EXAMINATION
2007**

Office of the Attorney General



STATE OF FLORIDA
ATTORNEY GENERAL

Dear Victim Services Provider:

This office is pleased to provide you with the current initial forensic physical examination protocol standards for adult and child victims of sexual assault. The protocol standards were revised through cooperative efforts among experts from the various disciplines that play a role in serving this particular population.

Initial forensic examinations as detailed in the protocols are essential for the purpose of gathering evidence for a potential criminal prosecution. Section 960.28, Florida Statutes, provides in part that no victim of a sexual assault shall be required to pay, directly or indirectly, the cost of an initial forensic examination. The Office of the Attorney General, Bureau of Victim Compensation, will pay up to \$500 for the cost of such examinations. Payments under this provision of law shall be considered by the provider as payment in full. This means that all other collateral sources, including insurance, Medicare and Medicaid, are not applicable to initial forensic examinations. Claims for the expense of forensic examinations must be filed directly with the Bureau using the "Sexual Battery Claim Form" (DVS-201).

With the release of this publication, I ask for your help to inform appropriate health care professionals in your organization of this important law and the protocols. If you have any questions, please call the Attorney General's Victim Services Office at 850-414-3300.

Thank you for your assistance.



ACKNOWLEDGMENTS

The 2007 revision would not have been possible without the dedication and support of many individuals and organizations. The hard work and effort by the workgroup members resulted in standardized, current protocols that will greatly improve the treatment of sexual assault victims in Florida.

Special thanks go to the workgroup members: David J. Rothamer, Staff Attorney, Florida Prosecuting Attorneys Association; Rita Hall, A.R.N.P.; Jodi Yaver, A.R.N.P.; Barry Funk, Chief Forensic Scientist, and Melissa Suddeth, Crime Laboratory Analyst Supervisor, Florida Department of Law Enforcement; Dale Livingston, Technical Leader Toxicology, Florida Department of Law Enforcement; Dr. Randy Alexander, State Medical Director, Children's Medical Services, Florida Department of Health; Beth Knake, Executive Director, Project Help; Captain William Parker, Hillsborough County Sheriff's Office; and Grace Frances, Florida Council Against Sexual Violence. Their dedication to better serving victims is greatly appreciated.

INTRODUCTION

During the 1995 legislative session the Office of the Attorney General was mandated by Florida statute to develop and maintain statewide sexual assault protocols for the initial forensic physical examination of adults and children. In response to this mandate, a workgroup was established to review and revise the Sexual Assault Evidence Collection Protocol developed by this office.

As a result of the dedicated efforts of the workgroup members, the enclosed ADULT and CHILD SEXUAL ASSAULT PROTOCOLS: Initial Forensic Physical Examination has been developed for use throughout the state. These protocols are intended to address issues that are routinely involved in the collection of evidence in sexual battery cases. At the same time, the workgroup was acutely aware that there is no such thing as a routine sexual battery case. Each case and each victim is unique and must be evaluated based on the circumstances and people involved in each situation.

It is the intention of this office that the implementation of sexual assault evidence collection protocols will minimize the trauma to victims of sex crimes, improve the quality and consistency of the evidence that is collected, and increase the successful prosecutions of these crimes.

Dual Purpose of the Forensic Medical Exam Process:

The forensic medical exam process serves two purposes. The first purpose

is to address the needs of individuals disclosing sexual assault. This is accomplished (with their permission) by:

- * Evaluating and treating injuries;
- * Conducting prompt examinations;
- * Providing support, crisis intervention, and advocacy;
- * Providing prophylaxis against sexually transmitted infections;
- * Assessing female patients for pregnancy risk and discussing treatment options, including reproductive health services; and
- * Providing follow-up care for medical and emotional needs.

The other purpose is to address justice system needs. This is accomplished by:

- * Obtaining a history of the assault;
- * Documenting exam findings;
- * Properly collecting, handling, and preserving evidence;
- * Interpreting and analyzing findings (postexam); and
- * Subsequently presenting findings and providing factual and expert opinion related to the exam and evidence collection.

Victim Issues

The impact of sexual assault on the victim is a complex issue. The scope of this protocol is not intended to be a comprehensive presentation of the traumatic and far-reaching consequences these crimes can inflict on victims. This protocol addresses the most basic aspects of victim sensitivity from the perspective of the examination and evidence collection procedure.

It is strongly recommended that any professional working with sexual assault victims or the related evidence have specific training in victim impact and the injuries resulting from these crimes. Such training can provide a better understanding of the immediate and possible long-term effects of these crimes.

Mandatory Reporting

Florida law mandates reporting of abuse and neglect for three specific populations: children, the elderly and persons having disabilities.

As referenced in s. 39.201, F.S., **any person**, including but not limited to members of specified occupations, who knows or has reasonable cause to suspect that a child is abused, abandoned or neglected, **must immediately** make a report to the central abuse hotline (**1-800-962-2873**). As referenced in s. 415.1034, F.S., **any person** who knows or has reasonable suspicion that a vulnerable adult has been or is being abused, neglected or exploited is required to immediately

report such knowledge or suspicion to the central abuse hotline (**1-800-962-2873**).

The Rights of Crime Victims

Since 1984, the laws of Florida have mandated specific rights for victims of crime. Guidelines for the treatment of victims (s. 960.001, F.S.) were adopted to address the rights of victims within the criminal justice system. The victim's rights constitutional amendment, adopted in 1988, guarantees victims the right to be notified, present and heard at all relevant stages of criminal justice proceedings.

Many of the rights afforded to crime victims are applicable only when a case is prosecuted. However, the statute requires that law enforcement personnel provide all victims information that identifies available services and resources. This information includes, but is not limited to, victim compensation, crisis intervention services, the right to the presence of a victim advocate from a certified rape crisis program during the forensic physical exam, support counseling, social services and community-based victim treatment programs. It is important that communities identify and remove barriers to the accessibility of these resources.

Sensitivity to Victim Needs

Every effort should be made to maximize the victim's level of comfort. A victim should never be subjected

to routine triage procedures prior to the examination. Whenever possible, the victim should be taken directly to the examination room or to a separate waiting room. The presence of law enforcement personnel during the examination is unnecessary and is an invasion of privacy. Maintaining the chain of custody during the examination is the responsibility of attending medical personnel. If desired by the victim, victim advocates from a certified rape crisis program should be present to provide support and advocacy during the exam. When family members are present, a medical professional or advocate should speak privately with the victim, prior to the examination, regarding accompaniment in the examination room. This facilitates sensitive and tactful communication with family and friends, while aiding in the restoration of control to the victim.

Treatment of sexual assault victims must be considered a medical emergency. These victims will suffer varying degrees of physical injury. The nature and severity of any physical injury should be the first consideration, before initiating the evidence gathering process. Additionally, victims will experience varying degrees of psychological trauma, although the effects of this trauma may be more difficult to recognize than physical trauma.

Methods of coping with sudden stress vary from person to person. When severely traumatized, victims may appear to be calm, indifferent, submissive, joking, angry or even uncooperative and hostile toward those trying to help. All of these responses,

individually or in combinations, are within the normal range of anticipated reactions. An inappropriate response to information concerning the circumstances surrounding the assault or a misinterpretation of a victim's reaction to the assault may lead to further traumatization, as well as possibly hindering the interview or evidence gathering process.

Special Victim Considerations

While each victim must be evaluated and treated based on the set of circumstances surrounding the individual case, some victims present unique issues that must be considered by everyone involved in the case.

Cultural and Religious Issues

Issues having the most profound impact on victims may, in part, be attributed to their cultural or religious backgrounds. For some victims, problems associated with poverty and discrimination, as well as inadequate access to quality health care, already have resulted in a high incidence of victimization. There may exist a general distrust of medical and law enforcement personnel who play vital roles in the aftermath of sexual assault, particularly if there has been a history of unpleasant or disappointing experiences with these professionals.

In some cultures, the loss of virginity is an issue of paramount importance which may render the victim unacceptable for an honorable marriage. In other cultures, the actual event of the assault

may be a more significant issue of concern for the family than is the victim's loss of virginity.

Some religious doctrines prohibit a female from being disrobed in the presence of a male who is not her husband. A genital examination by a male physician also may be forbidden. These practices are often considered a further violation of the victim, the family or both.

Law enforcement, medical and support professionals must be sensitive to these issues. In areas serving specific cultural or religious populations, procedures sensitive to the particular needs of the population should be developed. In-service training addressing these needs should be conducted on a regular basis.

The Elderly Victim

As with most other victims, elderly victims experience extreme humiliation, shock, disbelief and denial. However, full emotional impact of the assault may not be felt until the victim is alone, well after initial contact with physicians, police, legal and advocacy groups. During this time, elderly victims must deal with having been violated and possibly infected with sexually transmitted diseases. This is also when the elderly become more acutely aware of their physical vulnerability, reduced resilience and mortality. Fear, anger or depression can be especially severe in elderly victims who are isolated, have no confidant or live on meager incomes. Fear of losing independence as a result of family members learning about the sexual assault can be a strong deterrent

to reporting. Recognizing that the offender may be a family member, friend or caretaker is also important.

In general, the elderly are more physically fragile than the young, and injuries from an assault are more likely to be life-threatening. In addition to possible pelvic injury and sexually transmitted diseases, elderly victims may have higher risk for exacerbation of preexisting illness or injury and for other tissue or skeletal damage. Recovery processes for the elderly tend to be more complicated and protracted than for younger victims.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often render the elderly unable to communicate their needs. These factors may contribute to prolonged or inappropriate treatment. It also is not unusual for responders to mistake confusion and distress for senility. Additionally, the acts performed by the assailant may be something the elderly victim has never experienced before, such as oral contact with a penis. It is unlikely that an elderly victim would report an assault component of this type without specific, sensitive questions.

Medical and social services follow-up must be easily accessible, or elder victims may be unable or unwilling to seek or receive assistance. Without encouragement and assistance in locating services, many elderly victims may be reluctant to proceed in the prosecution of their offenders.

See Mandatory Reporting section on page 2.

The Victim with Disabilities

Sexual assault committed against victims with any physical or mental disability also demands specific consideration. Disability is defined as any impairment that substantially limits a major life activity. Victims with disabilities and their families should receive the highest priority, allotting additional time for evaluation, medical examination and evidence collection. Proper accommodation can be facilitated by identifying the nature and severity of any disability at the earliest possible time. Assessing the individual needs of a victim with a disability can be accomplished by simply asking the victim to identify their specific needs.

Persons having mental or developmental disabilities may be confused or frightened, unsure of what occurred, or they may not even understand that they have been exploited and are victims of a crime. In sexual assault cases involving victims with mental or developmental disabilities, using anatomically detailed dolls has proven to be a successful means of communication. Only those specifically trained in their use should use anatomically detailed dolls. In some cases, offenders may be family members, caretakers or friends who inflict repeated abuse because their victims are not able to report the crimes against them.

A victim with physical disabilities may be more vulnerable to a brutalizing assault

and may require special assistance to assume the positions necessary for a complete examination and collection of evidence. Improvising with portions of the standard protocol may be indicated.

Title II of the Americans with Disabilities Act requires that all state and local government entities comply with all aspects of civil rights legislation and incorporates the earlier federal mandates. Under section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and police departments) that directly receives federal assistance or indirectly benefits from such assistance must be prepared to offer a full variety of communication options to ensure that persons with a hearing impairment are provided effective health care services. This variety of options, which must be provided at no cost to the patient, also includes arranging to provide non-familial interpreters who can communicate information accurately and fluently in sign language.

Referrals to specialized support services and detailed reports to law enforcement agencies are vital when working with individuals having a physical or mental impairment. This population may require protection, physical assistance and transportation to attend follow-up treatment and counseling.

See Mandatory Reporting section on page 2.

The Male Victim

It is believed that the number of adult

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

The male victim may have serious concerns regarding his inability to prevent the assault. There also may be confusion about the nature of his role as victim/participant because of a possible involuntary physiological response to the assault, such as stimulation to ejaculation. Male victims need reassurance that they were the victims of a violent crime which was not their fault, and that other sexually assaulted males have survived to function normally in every way.

Significant progress has been made in furthering the public's understanding that sexual assault against either gender is an act of violence. However, there still remains a great reluctance on the part of most male victims to report sexual assault. Referrals to available therapists or advocacy groups having expertise in the area of sexual assault of males are a vital component in the recovery process.

The Child and Adolescent Victim

Children are not small adults either physiologically or emotionally. Just as the physical examination protocol for

children is different from the protocol for adults, the emotional needs of the child are also different. Children require the services of individuals specifically trained to provide the crisis intervention, medical examination and long-term treatment that will surely be needed as a result of acute sexual assault or chronic sexual abuse.

Adolescents are experiencing a transition from childhood to adulthood and show extremely variable reactions which may be a reflection of their individual developmental stage. There is no typical adolescent victim, and the approach to each is a challenge for even the most experienced practitioner. Acquaintance or "date rape" may be the most under-reported type of sexual assault. Clearly, access to long-term treatment by specifically trained individuals is essential for all child and adolescent victims.

See Mandatory Reporting section on page 2.

The Domestic Violence Victim

Sexual assault by a spouse or other familial is a grave indicator of the danger a victim faces and must be taken seriously. Forced sex is a factor in determining the potential for lethality; a woman who is raped by her partner is more likely to die at his hands. Medical personnel must determine whether the victim is a domestic violence victim so proper services and referrals can be provided.

A victim who has been sexually

assaulted by a partner has likely been suffering other forms of violence during the relationship. Many victims keep physical, emotional and sexual abuse hidden from friends and family members for numerous reasons: many religions and cultures prohibit divorce, the victim believes that the abuse is deserved or does not realize a crime has been committed, the victim has no support system, the victim is financially dependent upon the abuser, or the victim fears the abuser will harm or take the children.

When a victim indicates that domestic violence is occurring, the medical provider should refer the victim to a domestic violence counselor. Materials which list resources and explain the cycle of violence are available from law enforcement and state attorney's offices. Providing this information is crucial to the safety of the victim.

The Homosexual Victim

Homosexual male and lesbian victims are often reluctant to seek services for a number of reasons. There is concern of encountering barriers of prejudice or homophobia, as well as fears that the assault will not be taken seriously or even perceived as a crime. Many times the homosexual community in a given area is small; this results in limited access to qualified service providers, and the fear that the entire community will find out about the attack. Another consideration is that the victim's family, friends or co-workers may not be aware of the victim's sexual orientation. Fears of ostracism by peers and family can be more traumatizing for the victim than the

attack.

Bisexual and transgender victims are also at high risk for encountering prejudice and ridicule as a result of reporting sexual assault. Recognizing that sexual assault is always a crime and knowing appropriate referrals for victims who are not heterosexual is essential for all first responders and service providers.

Victimization Involving Alcohol/ Drugs

Alcohol is the drug most frequently used to facilitate sexual assault. Victims often believe that because they voluntarily consumed alcohol, ecstasy or some other drug, they are to blame for the assault. It is important for service providers to help victims understand that intoxication and the resulting diminished abilities are not causes of sexual assault; they are tools used to aid in commission of this crime.

Victims who have ingested a drug or combination of drugs may not be aware that they have been sexually assaulted. Victims may experience unexplainable soreness or injuries or a disheveled appearance. Events described as "dreamlike" or that cannot be remembered at all are strong indicators that toxicology screens are warranted and should be discussed. Victims must be informed of the broad scope of screening detection parameters and of the time constraints involved.

Pregnancy and Sexually Transmitted Disease Issues

All victims must be offered emergency medical treatment. Offering counseling to female victims about pregnancy prevention and the importance of timely action is also necessary. Optimally, said treatment should be initiated within 12 hours after the assault. Health care facilities or physicians that do not offer these services or choose not to provide emergency contraception as a treatment option following the completion of a rape examination must immediately provide the victim a referral to another facility that does provide this treatment option. The type and dosage of any medication administered or prescribed and any

referral arrangements must be recorded in the medical chart and also be provided to the victim. Readily available information regarding STD's, including HIV screening, and the importance of follow up medical treatment/counseling is also vital. An informational form or brochure explaining the feelings and reactions the victim may experience as a result of the rape and additional services that are available must also be provided. This printed material needs to include contact information for these service agencies.



ADULT SEXUAL ASSAULT PROTOCOL:

Initial Forensic Physical Examination

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The documentation of injuries and collection of evidence is enhanced by performing the examination as quickly as possible following the incident.

Photographs should not be taken by law enforcement, but injuries may be documented by the forensic examiner using a colposcope or digital camera.

As a precautionary measure, it is recommended that medical care and complete forensic services be provided to victims who may not have been vaginally or anally penetrated with a penis or who may be uncertain of the assault details. Forensic labs routinely find DNA evidence from saliva, seminal fluid, sweat, and blood that corroborate the victim's assault history regardless of penetration.

As of July 1, 2007, sexual assault victims are not required to report the assault to law enforcement in order to receive a forensic physical examination. Examiners should use this protocol in the same manner, providing a forensic physical exam within the same timeframe, for both reporting and initially non-reporting victims of sexual assault.

The examiner may modify, omit or add to this protocol based on the history, age of the victim, or physical findings. Modifications should be documented. An adult with a developmental disability may be better served by a practitioner who is skilled in working with people

with communication or intellectual disabilities.

1. VICTIM CONSENT FORM

A Victim Consent Form should explain the examination procedures, give consent to perform the evidence gathering exam, and be dated and signed by the victim and witnessed by a medical professional, as defined in Florida Statute. If the victim chooses to make a report to law enforcement, a separate form authorizing the release of collected evidence and report to law enforcement should be dated and signed by the victim and witnessed by a medical professional as defined by Florida Statute. The victim should be informed of the right to refuse all or part of the forensic evidence examination at any time. In the event that the victim is an adult who lacks the capacity to give consent, the victim's legal representative should sign the consent forms.

2. CLOTHING EVIDENCE

Clothing is retained for the presence of hairs, fibers, and body fluids and is one of the most important sources of evidence in a sexual battery case. Disrobing should be done over a sheet of clean, white table paper. If patient cannot undress, clothing may be cut off. Be sure not to cut through existing rips, tears, or stains. Handle each item as little as possible and only when wearing gloves. Underwear must be packaged separately in a small paper bag. Other clothing items may be packaged together in a paper bag. Any clothing with wet stains, such as blood or semen, should be allowed to dry, folded inward and then placed into paper bags. If excessive moisture is

still present, place in an unsealed plastic bag, then into a paper bag and alert the law enforcement officer. It is the responsibility of law enforcement to dry the item(s) as soon as possible before taking to the crime lab. Labels should be affixed to the outside of the paper bag to alert law enforcement that wet evidence is present. Each item, including the paper over which the victim disrobed, is then labeled with the victim's name and date and sealed with evidence tape. The examiner's initials should cover both the tape and the bag.

3. PUBIC HAIR EVIDENCE COLLECTION/COMBING

Pubic hair combing is routinely collected. Pubic area should be combed over a clean piece of paper using the wide tooth end of comb to collect all loose hairs and any fibers. Comb the entire hair area. If there is no pubic hair, the area is still examined, and any loose material or hair should be collected. Place comb on paper and fold with comb inside. Place in paper envelope and mark "pubic hair combing," label and seal. Absence of pubic hair should be noted.

NOTE: Do NOT Take Pulled Hair Standards

4. ORAL SWABS

Oral swabs are collected when it is believed that a penis penetrated the mouth. Using two (2) sterile cotton tipped applicators, swab inside the mouth along the gum line, inner cheek and by the tonsils. Optional: If an

examiner wishes to observe specimen under microscope, a separate slide is made. NOTE: FDLE no longer suggests the preparation of microscope slides. The SAVE kit provided by FDLE no longer includes microscope slides as part of the kit.

Allow swabs to air dry. The swabs are then placed in the end paper from the cotton tipped applicator package and then into a small envelope. Label and seal.

5. VAGINAL SWABS

Inspect external genitalia (perineum and hymen) for trauma, stains, and debris. Collect debris, place in evidence envelope, label and seal. Use Wood's lamp to fluoresce seminal fluid.

Vaginal swabs are collected when a penis is believed to have penetrated the vagina. The vaginal swabs are collected prior to the bimanual or cervical examination, by placing four (4) sterile cotton tipped applicators in the vaginal fornix. If there is a pool of fluid, the applicators can sit in the pool while collecting the cervical swabs. Optional: Make wet slides for microscope at the same time.

Allow swabs to air dry. The swabs are placed in the end paper from the applicators and into a small envelope. It is important not to aspirate the vaginal orifice or to dilute the secretions in any way before the swabs are taken. If the victim has douched, be sure to swab behind the cervix and along the vaginal walls.

6. CERVICAL SWABS

Cervical swabs are taken whenever vaginal swabs are taken. Using two (2) sterile cotton tipped applicators, swab inside the cervix. The applicators may be moistened with sterile water or sterile saline solution.

The cervical swabs are air dried and placed in an end wrapper. These swabs may be placed in the same small evidence envelope as the vaginal swabs, provided both are well labeled as to the source.

Optional: In acute cases, paint the perineum with toluidine blue and wipe area with KY jelly to highlight micro lacerations. Use of the magnifying light is helpful in some cases as well.

7. PENILE SWABS

Penile swabs are taken when looking for semen or saliva. Slightly moisten two (2) sterile cotton tipped applicators with sterile saline solution or sterile water. Swab the external surface of the penile shaft and glans and scrotum, as appropriate. Dry, label and seal in the same manner as other swabs.

8. RECTAL SWABS

Rectal swabs are collected prior to the rectal examination, when a penis is believed to have penetrated the anus. Look for the presence of fluid. If fluid is observed, swab the fluid with two (2) sterile cotton tipped applicators. To minimize discomfort, the applicators may be pre-moistened with sterile saline solution or sterile water. **Optional:** A glass slide for the microscope may be

prepared at this time. Allow the swabs to air dry. Label, remembering to include source of specimen. Applicators are placed in end wrapper and then placed in a small envelope labeled "rectal swabs" and sealed.

9. DRIED FLUIDS EVIDENCE COLLECTION

Collect foreign materials and swabs from the surface of the body. Carefully inspect the body, including head, hair, and scalp, for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat, and saliva) and other foreign material. Use an alternate light source to assist in identifying evidence. Obtain swabs from any area that may bear a dry secretion or stain, any moist secretion, any area that fluoresces with long-wave ultraviolet light ("Woods lamp"), and any area for which patient relates a history or suspicion of bodily fluid transfer (e.g., licking, kissing, biting, splashed semen, or suction injury). Also collect swabs from potentially high-yield areas (e.g., neck, breasts, or external genitalia) if the history is absent or incomplete.

- * Flake off dried secretions and/or moisten two (2) sterile cotton tipped applicators with sterile saline solution or sterile water. Swab the area. Repeat the process with two (2) dry sterile cotton tipped applicators. Separate swabs should be used for every sample area collected.
- * Swab bite marks.
- * Cut matted head, facial, or pubic hairs bearing crusted material (or

flake off material if possible) and place in an envelope.

- * After air drying, the wet applicators are placed in an end wrapper and marked wet. The dry applicators are placed in an end wrapper and marked dry. Both sets may be placed in one envelope. Mark the envelope with title of suspected type of fluid, making sure to include the source of specimen(s).
- * If teeth are flossed prior to oral swab collection, package used floss, label, seal, and initial the seal.

10. FINGERNAIL CRAPINGS EVIDENCE COLLECTION

Fingernail scrapings are collected whenever the circumstances warrant, such as when the victim scratched the assailant. Scrapings are not a routine part of evidence collection.

Do not be overly vigorous in scraping as enough DNA may be obtained from the victim to over ride what is contained in the specimen. Broken or torn fingernails may require cutting. Nail scrapings or cuttings must be taken using a separate clean sheet of paper for each hand. Each paper should be folded around specimen and placed in separate envelopes, labeled to identify the source of evidence.

11. BITE MARKS EVIDENCE COLLECTION

Specimens from bite marks are collected in the same manner as for "dried fluids." Bite marks should be photographed or depicted in a drawing, placing an

L-shaped ruler adjacent to but not covering the mark.

12. BUCCAL SWAB COLLECTION

Victim should not smoke, eat or drink for at least 30 minutes prior to the examination. If oral swabs were collected, have the victim rinse the mouth and wait 15 minutes before obtaining this sample. Using two (2) sterile cotton tipped applicators from the envelope, rub the inside of the cheek ten (10) times, with an up and down motion. When dry, place the applicators back in the envelope. Seal and label appropriately.

13. WHOLE BLOOD SPECIMEN

If blood is needed for the STD/RPR, pregnancy testing or toxicology, it should be drawn at this time. Collect 5 ml in a red top tube. Refrigerate (DO NOT FREEZE). Blood in red top tube is not to be included in the kit.

14. TOXICOLOGY SCREENING

If a toxicology screening is requested by the victim, or by the detective with the victim's knowledge that it will be used as evidence, obtain the following:

- * An additional 20 ml of blood placed in two (2) grey top (sodium fluoride) tubes; and
- * At least 30 ml of urine placed in a leak proof container.

Label with patient's name and date. Package samples separately from other refrigerated evidence. If supplemental information is needed by medical

practitioner, additional samples should be drawn at this time.

15. WET SLIDE EXAMINATION

If a microscope is readily available, examine the wet slides for motile or nonmotile spermatozoa, then record findings on examination forms. Observe for trichomoniasis, etc., and note findings on examination forms.

16. SECURING EVIDENCE

All specimens must be identified with victim identification or a case number, the date of collection, source of the specimen and the examiner's initials. Each item should be secured with tape to prevent loss of specimen. Place all items in a large evidence envelope. If refrigeration is required, mark the envelope to indicate refrigeration is needed. Seal with evidence tape, sign and date, making certain to write on either side of and across the tape.

If evidence is not immediately turned over to law enforcement, place the completed evidence packet into a locked refrigerator.

17. INFORMATION FOR CRIME LAB

Complete existing forensic report form, which must include:

- * Date and time of assault
- * Number, race and gender of assailants
- * Age, race and gender of victim

- * Activity of the victim since the assault
- * Injuries
- * Date and time of the examination
- * Date of last voluntary intercourse
- * Areas penetrated and by what
- * Items of clothing
- * Stains, rips or tears on clothing
- * Has victim had any previous contact with assailant?

Information Not Necessary For Crime Lab:

- * Copy of complete medical record
- * Diagrams
- * Medical history
- * GYN history
- * Allergies
- * Cultures

18. PATIENT MEDICAL RECORD SHOULD INCLUDE:

- * Contraception/menstruation information
- * Past medical problems

- * GYN history (miscarriage, abortion, pregnancy, hysterectomy, tubal ligation)
- * History of battery
- * Physical examination
- * Body diagrams and photographs
- * Drawing: male/female, adult/child (genitalia for both)
- * Written description of trauma
- * Date of last voluntary intercourse
- * Toxicology blood/urine screen
- * Copy of forensic report form
- * Documentation of contraceptive information/treatment or emergency referral



CHILD SEXUAL ASSAULT PROTOCOL:

Initial Forensic Physical Examination

2007

CHILD SEXUAL ASSAULT PROTOCOL: Initial Forensic Physical Examination

The examiner may modify, omit or add to this protocol based on the history, age of the victim, or physical findings. Modifications should be documented. A child is defined as a person under 18 years of age or with a developmental age of less than 18 years.

FEMALE EVIDENCE COLLECTION PROCEDURE

1. CLOTHING EVIDENCE

If the child has not changed clothes, have the child undress over a sheet of clean, white table paper. It is important to remember that evidence in child cases is most likely to be found on clothing, diapers or bedclothes rather than on the child. Underwear must be packaged separately in a small paper bag. Other clothing items may be packaged together in a paper bag. **Handle each item as little as possible and only when wearing gloves.** Observe for tears, stains, or foreign material as each item is placed into its bag. If patient cannot undress, clothing may be cut off. Be sure not to cut through existing rips, tears, or stains. Document these findings. Any clothing with wet stains, such as blood or semen should be allowed to dry, folded inward and then placed into paper bags. If excessive moisture is still present, place in an unsealed plastic bag, then into a paper bag and alert the law enforcement officer. It is the responsibility of law

enforcement to dry the item(s) as soon as possible before taking to the crime lab. Labels should be affixed to the outside of the paper bag to alert law enforcement that wet evidence is present. Each item, including the paper over which the victim disrobed, is then labeled with the victim's name and date and sealed with evidence tape. Initial evidence bag so that initials cover both the tape and the bag.

2. GENERAL BODY SURFACE EVIDENCE COLLECTION

Inspect all body surfaces for trauma and debris, including hair and fingernails. Place specimens in evidence envelopes, label and seal.

3. PUBIC HAIR EVIDENCE COLLECTION/COMBING

If pubic hair is present, gently comb through the pubic hair over a paper towel. Wrap comb and hairs/fibers in paper towel and place in an evidence envelope, label and seal.

4. ORAL SWABS

Examine the oral cavity if penetration is believed to have occurred. Swab the gum line, inner cheeks, and tonsillar areas, using two (2) sterile cotton tipped applicators. **Optional:** Make a wet slide if a microscope is readily available. Using the appropriate culture media, collect a gonorrhea specimen from the tonsillar area. Air dry the swabs. Place the dried swabs in the end paper from the cotton tipped applicator package. Place the applicators in an evidence envelope, label and seal. Label the swabs with the child's name, date, origin of specimen, and examiner's initials.

5. VAGINAL SWABS

Inspect external genitalia (perineum and hymen) for trauma, stains, and debris. Collect debris, place in evidence envelope, label and seal. Use Wood's lamp to fluoresce seminal fluid. Swab with sterile cotton swabs, moistened with sterile saline solution, for possible semen. Air dry, place in evidence envelope, label and seal.

Optional: In acute cases, paint the perineum with toluidine blue and wipe area with KY jelly to highlight micro lacerations. Use of the magnifying light is helpful in some cases as well.

In post-pubertal children, and when medically appropriate, use a total of four (4) sterile cotton tipped applicators to obtain fluid from the posterior vaginal fornix. Air dry, and place the swabs in a small evidence envelope, label and seal. **Optional:** Make a wet slide if a microscope is readily available, and label.

6. CERVICAL SWABS

If the age of the child is appropriate and penetration is believed to have occurred, a cervical sample may be taken. Specimens are handled in the same manner as the vaginal specimen. In adolescents, using the appropriate culture media, collect a gonorrhea specimen from the cervical os. The crime lab needs only two (2) swabs from this area. Air dry and place the swabs in a small evidence envelope, label and seal. **Optional:** Make a wet slide if a microscope is readily available, and label.

7. RECTAL SWABS

Visually inspect the anal area for signs of trauma or penetration, and if present, collect two (2) sterile cotton tipped applicators. Air dry, place swabs in an evidence envelope, label and seal. If penetration or any other trauma has occurred and no blood is visible, perform a stool guaiac and note results. Using the appropriate culture media, collect a gonorrhea specimen from adolescents in all such cases. **Optional:** Make a wet slide if a microscope is readily available, and label. A rectal exam with finger should be done, if clinically indicated.

8. DRIED FLUIDS EVIDENCE COLLECTION

Collect foreign materials and swabs from the surface of the body. Carefully inspect the body, including head, hair, and scalp, for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat, and saliva) and other foreign material. Use an alternate light source to assist in identifying evidence. Obtain swabs from any area that may bear a dry secretion or stain, any moist secretion, any area that fluoresces with long-wave ultraviolet light ("Woods lamp"), and any area for which patient relates a history or suspicion of bodily fluid transfer (e.g., licking, kissing, biting, splashed semen, or suction injury). Also collect swabs from potentially high-yield areas (e.g., neck, breasts, or external genitalia) if the history is absent or incomplete.

- * Flake off dried secretions and/or moisten two (2) sterile cotton tipped applicators with sterile saline solution or sterile water. Swab

the area. Repeat the process with two (2) dry sterile cotton tipped applicators. Separate swabs should be used for every sample area collected.

- * Swab bite marks.
- * Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.
- * After air drying, the wet applicators are placed in an end wrapper and marked wet. The dry applicators are placed in an end wrapper and marked dry. Both sets may be placed in one envelope. Mark the envelope with title of suspected type of fluid, making sure to include the source of specimen(s).
- * If teeth are flossed prior to oral swab collection, package used floss, label, seal, and initial the seal.

9. BITE MARKS EVIDENCE COLLECTION

Specimens from bite marks are collected in the same manner as for "dried fluids." Bite marks should be photographed or depicted in a drawing, placing an L-shaped ruler adjacent to but not covering the mark.

10. BUCCAL SWAB COLLECTION

Victim should not smoke, eat or drink for at least 30 minutes prior to the examination. If oral swabs were collected, have the victim rinse the mouth and wait 15 minutes before obtaining this sample. Using two (2)

sterile cotton tipped applicators from the envelope, rub the inside of the cheek ten (10) times, with an up and down motion. When dry, place the applicators back in the envelope. Seal and label appropriately.

11. TOXICOLOGY SCREENING

IN ADOLESCENTS, if a toxicology screening is requested by the victim or by the detective with the victim's knowledge that it will be used as evidence, obtain the following:

- * An additional 3-5 ml of blood placed in a grey top (sodium fluoride) tube; and
- * At least 30 ml of urine placed in a leak proof container.

Label with child's name and date. Package samples separately from other refrigerated evidence.

12. WET SLIDE EXAMINATION

Examine the wet slides for motile or nonmotile spermatozoa, then record findings on examination forms. Observe for trichomoniasis, etc., and note findings on examination forms.

13. SECURING EVIDENCE

Inspect and initial all evidence packets. Place them in a large evidence envelope, along with a copy of the examination or general information sheet. Seal with evidence tape and sign the tape.

If evidence is not immediately turned over to law enforcement, place the completed evidence packet in locked refrigerator.

14. EVIDENCE PACKETS, AS CASE APPROPRIATE, MUST INCLUDE:

- * Pink copy of the examination form
- * Clothing (underpants to be refrigerated)
- * Combing of pubic hair
- * Fingernail scrapings
- * Saliva specimen
- * Dry swabs of stains
- * Foreign materials
- * Urine container for toxicology
- * Grey top (sodium fluoride) tube for toxicology

15. PATIENT MEDICAL RECORD SHOULD INCLUDE, AS AGE APPROPRIATE:

- * Date/time of collection
- * Date/time of the battery
- * Gender, number and race of offenders
- * Child's emotional status
- * Activity of victim (since the battery)
- * Drug allergies

- * Contraception/menstruation information
- * Past medical problems
- * GYN history (miscarriage, abortion, pregnancy, hysterectomy, tubal ligation)
- * History of battery
- * Physical examination
- * Body diagrams and photographs
- * Drawing: male/female, adult/child (Genitalia for both)
- * Written description of trauma
- * Date of last voluntary intercourse
- * Copy of forensic report form
- * Toxicology blood/urine screen

MALE EVIDENCE COLLECTION PROCEDURE:

1. CLOTHING EVIDENCE

If the child has not changed clothes, have the child undress over a sheet of clean, white table paper. It is important to remember that evidence in child cases is most likely to be found on clothing, diapers or bedclothes rather than on the child. Underwear must be packaged separately in a small paper bag. Other clothing items may be packaged together in a paper bag. Handle each item as

little as possible and only when wearing gloves. Observe for tears, stains, or foreign material as each item is placed into its bag. If patient cannot undress, clothing may be cut off. Be sure not to cut through existing rips, tears, or stains. Document these findings. Any clothing with wet stains, such as blood or semen should be allowed to dry, folded inward and then placed into paper bags. If excessive moisture is still present, place in an unsealed plastic bag, then into a paper bag and alert the law enforcement officer. It is the responsibility of law enforcement to dry the item(s) as soon as possible before taking to the crime lab. Labels should be affixed to the outside of the paper bag to alert law enforcement that wet evidence is present. Each item, including the paper over which the victim disrobed, is then labeled with the victim's name and date and sealed with evidence tape. Initial evidence bag so that initials cover both the tape and the bag.

2. GENERAL BODY SURFACE EVIDENCE COLLECTION

Inspect all body surfaces for trauma and debris, including hair and fingernails. Place specimens in evidence envelopes, label and seal.

3. PUBLIC HAIR EVIDENCE COLLECTION/COMBING

If pubic hair is present, gently comb through the pubic hair over a paper towel. Wrap comb and hairs/fibers in paper towel and place in an evidence envelope, label and seal.

4. ORAL SWABS

Examine the oral cavity if penetration is believed to have occurred. Swab the gum line, inner cheeks, and tonsillar areas, using two (2) sterile cotton tipped applicators. **Optional:** Make a wet slide if a microscope is readily available. Using the appropriate culture media, collect a gonorrhea specimen from the tonsillar area. Air dry the swabs. Place the dried swabs in the end paper from the cotton tipped applicator package. Place the applicators in an evidence envelope, label and seal. Label the swabs with the child's name, date, origin of specimen, and examiner's initials.

5. PENILE SWABS

Slightly moisten two (2) sterile cotton tipped applicators with sterile saline solution and thoroughly swab the external surface of the penile shaft and glans. All outer areas should be swabbed. Allow the swabs to dry. Place the dried applicators into the evidence envelope, label and seal.

6. RECTAL SWABS

Visually inspect the anal area for signs of trauma or penetration, and if present, collect two (2) sterile cotton tipped applicators. Air dry, place swabs in an evidence envelope, label and seal. If penetration or any other trauma has occurred and no blood is visible, perform a stool guaiac and note results. Using the appropriate culture media, collect a gonorrhea specimen from adolescents in all such cases. **Optional:** Make a wet slide if a microscope is readily available, and label. A rectal exam with finger should be done, if clinically indicated.

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- * Flake off dried secretions and/or moisten two (2) sterile cotton tipped applicators with sterile saline solution or sterile water. Swab the area. Repeat the process with two (2) dry sterile cotton tipped applicators. Separate swabs should be used for every sample area collected.
- * Swab bite marks.
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