



State of New York

PROTOCOL

for the Acute Care of the
Adult Patient Reporting
Sexual Assault

November 2004

DNA Evidence Collection Revised 10/08

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In 2002, the New York State Department of Health staff collaborated with a workgroup convened to revise the Sexual Offense Evidence Collection Protocol, which has been renamed the *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. The members of the workgroup and other consultants represent various disciplines that are directly involved in addressing the needs of adults who have been sexually assaulted. This newly revised *Protocol* is the result of the combined efforts of those listed below and additional individuals committed to the provision of quality care to adults who have been sexually assaulted. We are grateful to all of these individuals, who spent considerable time and effort working with us to produce a *Protocol* that provides guidance on the most current standards of compassionate and consistent care and evidence collection procedures.

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Information about using this Protocol

In May 2002, the New York State Department of Health issued the revised *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. The revised *Protocol* reflects a more comprehensive view of patient care, one that changes the focus from determining the validity of the patient's claim of rape to the provision of standardized, consistent health care, along with the proper collection and preservation of forensic evidence. The new release of the *Protocol* reflects updates to the standards, including revised requirements for emergency contraception, information about the Forensic Payment Act and HIV post-exposure prophylaxis.

The *Protocol* has been developed to assist health care providers in minimizing the physical and psychological trauma to victims of sexual assault, by ensuring appropriate and consistent treatment in hospital emergency departments. The *Protocol* also facilitates the proper collection and preservation of physical evidence for potential use in the criminal justice system, if there are subsequent legal proceedings. This document includes requirements that are legislatively mandated and set forth in regulation, as well as care that is considered optimum, or "best practice," by experts and practitioners from the various disciplines involved in the care of the patient and the prosecution of the crime.

This document is presented as a guide for the minimum standard of care that a patient reporting sexual assault should receive, taking into consideration current knowledge, equipment, and professional practice. What is considered "standard" in health care is constantly evolving. Standard practice is influenced by advancing technology, published research findings, recommendations promulgated by professional organizations, and current law. Health care professionals serving as examiners are encouraged to supplement information provided here by participating in professional continuing education, reviewing professional literature, and seeking current practice information from their professional associations.

Individuals who have been raped or sexually assaulted may seek care from a variety of health care providers, including hospitals, a primary care provider, gynecologist, or local sexually transmitted disease clinic. **It is most advantageous for all victims of sexual assault to seek health care treatment and evidence collection from a hospital emergency department.** Emergency departments are required to establish and implement policies and procedures for the treatment of rape victims; have procedures in place for contacting rape victim advocates; and, collect and maintain forensic evidence utilizing the New York State standardized evidence collection kits and procedures, including second kits for suspected drug-facilitated rape incidents, when appropriate.

Other providers may offer the necessary health care and evidentiary exam, if they are familiar with the special needs of sexual assault victims; have a sexual offense evidence collection kit and other forensic equipment available; and, are able to ensure access to prophylaxis, and prophylaxis against pregnancy resulting from sexual assault (also known as "emergency contraception" or "the morning after pill"), as needed. When the above expertise, equipment, and medications are not available, the health care provider should refer the patient for comprehensive care at a local emergency department.

Information about using this Protocol

"Rape" and "assault" are legal terms. Providing consistent, comprehensive care and evidence collection must rely on the *patient* reporting that she has been sexually assaulted, rather than the emergency department staff's analysis of the patient's allegations, and whether these allegations constitute assault or rape. **The approach to the patient and subsequent care should be "as if" the patient has been sexually assaulted.**

Section 2805-i of the Public Health Law (see Appendix A) states that sexual assault evidence shall be collected, unless the patient signs a statement directing the hospital not to collect it (for a sample form to be used when the patient directs the hospital not to collect evidence, see Appendix B). **However, reporting sexual assault to a health care provider and consenting to evidence collection does not imply or assume that the patient will report to law enforcement officials.** It simply means that all patients who report sexual assault to a health care provider should receive specific treatment. This document should guide that treatment.

Terminology used in this document should be noted. The person providing care is referred to as "the examiner." An examiner may be a currently licensed or credentialed physician, physician assistant (PA), registered professional nurse, or a nurse practitioner, and may or may not be a sexual assault forensic examiner (a health care professional with extensive specialized training, knowledge, and experience regarding sexual assault care). The term "victim," as opposed to "survivor," is used in this document, since most patients receiving *acute* care for sexual assault are in a state of crisis, and are not yet re-empowered. Throughout this document, the person receiving care is generally referred to as "the patient." To simplify the wording of the text, the patient is referred to with the pronoun "she." The care for male and female patients is comparable, except where noted.

The information in this document is applicable to adult patients reporting sexual assault.

For more information about sexual assault and sexual assault care contact the New York State Department of Health Rape Crisis Program at (518) 474-3664 or via e-mail at BWH@health.state.ny.us. The protocol may also be accessed through the Department's web site at www.health.state.ny.us/nysdoh/sexual-assault/index.htm.

Introduction

Overview

Victims of sexual assault have special and serious needs that must be met promptly, sensitively, and with expertise. The experience of a sexual assault can leave an individual psychologically traumatized and physically injured. Often, the effects remain for months and years. The initial response of a health care provider to a patient reporting sexual assault can have a profound influence on the psychological and physical recovery process.

The responsibility of attending to a sexual assault patient's immediate psychological and physical needs is shared by the examiner, the rape crisis center victim advocate, and other health care providers in hospital emergency departments and other places where victims present for sexual assault exams.

The patient is often the only witness (other than the perpetrator) to a crime of sexual assault. Evidence from sexual assault can sometimes be found in the environment in which the crime occurred and on the patient's clothing. Most often, the patient's body is the only evidence. When immediate and appropriate health care is received and an evidentiary exam is completed, the chances are dramatically increased that some type of physical evidence will be found which can be preserved.

New forensic techniques and a better understanding of injuries caused during an assault make it easier to identify, explain, and document injuries caused by forced sexual activity and can also explain a lack of injuries. In order for the examiner to provide a comprehensive and holistic sexual assault exam, he or she must be well-versed in both the needs of sexual assault patients and in forensic science.

This document is intended to provide guidance to health care providers to assist them in the following:

- Optimizing the psychological and physical health of a patient who reports sexual assault by ensuring appropriate and comprehensive treatment and follow-up; and,
- Collecting and preserving evidence for potential use by the criminal justice system.

General Hospital Requirements

Every hospital in New York State is responsible for ensuring that all victims of rape or sexual assault who present at the hospital are provided with care that is comprehensive and consistent with current standards of practice. Hospitals must also ensure that forensic evidence is properly collected and preserved. Specifically, hospitals have the following responsibilities in meeting the specialized needs of patients who have been sexually assaulted:

- Maintain current protocols regarding the care of patients reporting sexual assault;

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- Ensure that there are trained and qualified staff available to perform sexual assault examinations at all times;
- Promote staff opportunities for continuing education;
- Designate a staff member to coordinate the required care of a victim of rape or sexual assault;
- Assure that each patient has access to a rape crisis counselor or victim advocate who can provide specialized victim assistance;
- Provide for the immediate availability of prophylaxis for sexually transmitted infection, HIV, hepatitis B, and prophylaxis against pregnancy resulting from sexual assault, as needed;
- Implement protocols that provide for the conduct of an evidentiary examination to collect and preserve evidence, in accordance with current forensic techniques and this *Protocol*; and,
- Develop and implement quality improvement activities to monitor performance.

Sexual Assault Forensic Examiner (SAFE) Program Requirements

In New York State, some hospitals and other entities have developed programs known as Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) Programs to provide specialized care to sexual assault patients. Legislation enacted in 2000 in New York State known as the Sexual Assault Reform Act (SARA) mandates that the Department of Health formally designate interested hospitals as the sites of twenty-four hour SAFE programs. Hospitals interested in applying for designation as SAFE Programs must submit applications issued by the Department in January 2003 as part of the NYS SAFE Standards. The Department has developed standards for SAFE programs that were issued in January 2003 and updated in October 2004 as part of the Sexual Assault Reform Act and have been attached to this document as Appendix C.

The primary mission of a SAFE program is to provide immediate, compassionate, culturally sensitive and comprehensive forensic evaluation and treatment by specially trained sexual assault forensic examiners in a private, supportive setting to all victims of sexual assault, regardless of whether or not they choose to report to law enforcement. Specifically, the goals of the SAFE program are to:

- 1) Provide timely, compassionate, patient-centered care in a private setting that provides emotional support and reduces further trauma to the patient;
- 2) Provide quality medical care to the patient who reports sexual assault, including evaluation, treatment, referral and follow-up;
- 3) Ensure the quality of collection, documentation, preservation and custody of physical evidence by utilizing a trained and New York State Department of Health (DOH) certified sexual assault forensic examiner to perform the exam, which may lead to increased rates of identification, prosecution and conviction of sexual assault perpetrators;
- 4) Utilize an interdisciplinary approach by working with rape crisis centers and other service providers, law enforcement and prosecutors' offices to effectively meet

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- the needs of the sexual assault victim and the community;
- 5) Provide expert testimony when needed if the survivor chooses to report the crime to law enforcement; and,
 - 6) Improve and standardize data collection regarding the incidence of sexual assault victims seeking treatment in hospital emergency departments.

A comparison of general hospital and DOH-certified SAFE program responsibilities for the care and treatment of victims of sexual assault is included in Appendix D. Federal Emergency Medical Treatment and Active Labor Act requirements are included in Appendix E.

Sexual Assault Forensic Examiners

Sexual assault examinations require the integration of specialized knowledge of genital anatomy and physiology, human sexual response, common sexual assault injuries, specialized health care treatment, forensic science, and criminal justice.

Because this knowledge transcends basic education in medical and nursing curricula, the New York State Department of Health recommends that each hospital ensures that patients reporting a sexual assault receive the care of a specially trained sexual assault forensic examiner.

In addition, examiners from any discipline providing sexual assault exams should take part in professional continuing education programs. These programs should specifically address medical forensic care for the patient reporting sexual assault.

The Sexual Assault Reform Act also mandates that the Department certify sexual assault forensic examiners for sexual assault examinations. Standards for sexual assault forensic examiners are included in Appendix C.

Didactic training for DOH-certified sexual assault forensic examiners must be provided through a training program that has been approved by the NYS Department of Health. Only training programs which demonstrate to the Department the ability to provide training that meets the minimum standards and requirements and enter into a formal agreement with the Department can provide training related to the Department's issuance of certificates of qualification. The Department has issued standards for sexual assault forensic examiner training programs (Appendix C).

Training of non-DOH certified SAFE examiners can continue to be obtained from training programs not certified by DOH (see Appendix F for training programs in New York State with those certified by DOH so indicated). Most current information may be obtained on the Department's web site at www.health.state.ny.us.

For a list of sexual assault forensic examiner services in New York State, refer to Appendix G. DOH certified SAFE programs are so indicated. See the Department's web site for most current status at www.health.state.ny.us.

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Continuous Quality Improvement

Pursuant to 10 NYCRR 405.9 (c) and 405.19 (see Appendix H), all hospitals are required to establish protocols regarding the care of patients reporting sexual assault, and to maintain evidence. Such protocols must be followed for treatment of the sexual assault patient regardless of where they first present in the hospital. The hospital must designate a staff member to coordinate the required care of a victim of sexual assault. All emergency department (ED) managers should review their sexual assault protocols and procedures to ensure the following are in place:

- Around-the-clock availability of a specially trained sexual assault forensic examiner or other provider trained in the evaluation of sexual assault patients;
- A rape crisis advocate is contacted;
- A setting is provided where all health care needs can be met;
- Immediate availability of appropriate medications (including those for STIs, prophylaxis against pregnancy resulting from sexual assault, HIV prophylaxis, and hepatitis B prophylaxis);
- Necessary forensic equipment (for a list of suggested supplies and equipment, see Appendix I);
- Procedures for securing evidence and maintaining the chain of custody;
- Appropriate medical and forensic documentation;
- Appropriate and safe discharge is provided, including: medical transfer, as necessary; necessary and appropriate follow-up care/referrals; hospital contact person to assist with release or disposal of sexual offense evidence; suitable attire; transportation or other appropriate arrangements as necessary to meet patient needs; and,
- Follow-up services for medical and counseling referrals.

The hospital must develop and implement written policies and procedures establishing an internal quality improvement program to identify, evaluate, resolve, and monitor actual and potential problems in patient care. The following components are recommended for inclusion:

- 1) Chart audit performed periodically on a statistically significant number of sexual assault patient records. Sexual assault patient records and other appropriate information should be periodically reviewed to answer the following:
 - How long did the victim wait from arrival to exam commencement?
 - Were appropriately trained staff available to examine the patient?
 - Were necessary equipment and supplies available?
 - Was a rape crisis advocate called to attend the patient?
 - Did the patient receive appropriate medical treatment, including a recommendation of HIV prophylaxis in cases of significant risk exposure?
 - Was consent obtained from the patient?
 - Did the patient receive appropriate counseling about pregnancy prophylaxis, including the timeframe for effectiveness and the treatment?

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- Did the patient request and receive emergency contraception, unless medically contraindicated?
 - If the patient did not receive emergency contraception, is the reason documented, i.e. refused or already pregnant?
 - Did the patient receive treatment for STIs?
 - Did the patient choose to take advantage of all treatment offered? If not, why?
 - Was a referral made; if so, to whom?
 - Was forensic evidence collected and maintained in a manner which was consistent with laws, regulations and standards, including maintaining the chain of custody?
 - Was the patient provided with self-care information and plans for referral?
 - Was an appropriate psychological and medical follow-up plan developed for the patient?
 - Was the patient provided safe discharge?; and,
 - Was patient confidentiality maintained?
- 2) A system for developing and recommending corrective actions to resolve identified problems;
 - 3) A follow-up process to assure that recommendations and plans of correction are implemented and are effective; and,
 - 4) A system for resolving patient complaints.

It is recommended that emergency departments keep statistics on sexual assaults for community and public health assessment. Keeping accurate data on sexual assault patients and the services provided will assist the examiner and the facility in documenting the extent of the problem, determining the cost of service, identifying gaps in service, planning for growth and expansion, etc.

Data that could be collected include:

- The number of personnel who are certified as sexual assault forensic examiners;
- The number of sexual assault victims who present at the hospital for services;
- The response time of the sexual assault examiner from the time the call was made to the time the examiner arrived;
- The number of sexual assault exams performed by sexual assault forensic examiners;
- The number of sexual assault exams performed by personnel other than sexual assault forensic examiners;
- The number of inpatient admissions resulting from sexual assaults;
- The number of patients served by age, racial/ethnic status, and gender;
- Insurance payer status of victims;
- The number of patients accompanied by a rape crisis advocate;
- The number of patients who refused the services of a rape crisis advocate;
- The number of patients who took HIV prophylaxis;
- The number of patients who refused or were ineligible for HIV prophylaxis;

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- The number of patients who took prophylaxis against pregnancy resulting from sexual assault;
- The number of examinations where the patient chose to report sexual assault to law enforcement;
- The number of examinations where the patient declined to report sexual assault to law enforcement;
- The number of sexual assault evidence collection kits completed for sexual assault forensic examinations;
- The number of those kits released to law enforcement at the time of the exam;
- The number of those kits released to law enforcement after the exam was completed; and,
- The number of victims who refused to have evidence collected.

Note: Some of these data can be collected using SPARCS via consistent use of E-codes entered by ED staff.

Law Enforcement Involvement

When law enforcement officers are the first contact a patient makes after a sexual assault, it is their responsibility to ensure the immediate safety and security of the patient, to obtain basic information about the assault and to transport the patient to a facility for immediate health care.

The responding law enforcement officers may conduct a preliminary, basic interview of the patient to obtain information that may be vital to the apprehension of the assailant. The officers may offer to transport the patient to a local emergency department. At the hospital, the responding officer should give the examiner any information about the assault that may assist in the examination and evidence collection procedures.

If a patient has not contacted law enforcement officers before arriving at a health care facility, she should be informed of the right to report the crime. **Hospital personnel should not call the police and identify a sexual assault patient, absent a legal obligation to do so, or absent a patient's consent. It is the adult patient's choice whether or not to involve law enforcement personnel.** If the patient so chooses, providers should assist her in contacting law enforcement officials.

Pursuant to Penal Law Section 265.25 (see Appendix J), the health care provider in charge of a patient has a legal obligation to report injuries including gunshot wounds or other injuries arising from the discharge of a firearm, or a wound which is likely to result in death and is actually or apparently inflicted by a knife, ice pick, or other sharp instrument.

Pursuant to Penal Law Section 265.26 (see Appendix J), every case of a burn injury or wound where the victim sustained second or third degree burns to five percent or more of the body, and/or any burns to the upper respiratory tract, or laryngeal

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edema due to the inhalation of super-heated air, and every case of a burn injury or wound which is likely to or may result in death, shall be reported at once to the Office of Fire Prevention and Control.

Section 2803-d of the Public Health Law (see Appendix K) requires that health care providers report physical abuse, mistreatment, or neglect of a person receiving care or services in a residential health care facility. Reports of suspected physical abuse, mistreatment, or neglect must be made immediately by telephone and in writing within forty-eight hours to the New York State Department of Health (see Appendix L for patient care hotline numbers).

There is no medical or legal reason to have a law enforcement representative present during the health care exam or the evidence collection process. Doing so against a patient's wishes is a serious violation of the patient's rights.

Intake

Acute care for patients reporting sexual assault is considered an emergency. Although patients may not have immediately recognizable signs of physical injury, they usually suffer from emotional trauma.

Hospital emergency staff should immediately implement the following protocol upon arrival of the patient in the emergency department:

- Provide triage and assessment in a timely manner;
- Assign a trained and qualified individual, preferably a sexual assault forensic examiner, to perform the exam when the patient discloses that she has been sexually assaulted;
- Contact a rape crisis advocate at the same time that contact is made to the sexual assault forensic examiner;
- Be available for consultation and support of the individual providing the exam;
- Assist in obtaining necessary tests and medications; and,
- Assist in arranging referrals and follow-up services.

In addition, the individual performing the exam must have readily available access to medical/surgical back-up as needed, which, in addition to the emergency department, may include: general surgery, obstetrics/gynecology, pediatrics, urology and psychiatry.

To prevent others from hearing privileged and confidential information, a private location within the hospital should be utilized for intake and the preliminary and post-examination consultation, as well as the examination. Once in the exam room, the patient should not be left alone.

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Rape Crisis Center Victim Advocates

The hospital must comply with Public Health Law 2805-i (1)(b) (see Appendix A) regarding contacting a rape crisis or victim advocate organization, if any, providing victim assistance to the geographic area served by the hospital, to establish the coordination of non-medical services to sexual offense victims who request such assistance. The best way to do this is to call the advocate and let the advocate present the services s/he offers to the patient in person. Hospital personnel should call the local Rape Crisis Center (see Appendix M) or the New York State Department of Health Rape Crisis Program at (518) 474-3664 for more information.

The New York State Department of Health has established standards for rape crisis centers in training rape victim advocates. Advocates who complete the training can, by law, provide confidential services to victims of sexual assault (see Subpart 69-5 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, Appendix N).

The Rape Crisis Center victim advocates' primary focus is to provide calm, consistent support to the patient. While advocates do not provide health care or collect evidence, they enhance the efforts of health care staff through the provision of information regarding medical and legal options. They can provide the crisis intervention necessary when patients first arrive for treatment, assist patients in understanding the health care and evidence collection procedures, and counsel family members or friends who may accompany the patient. Rape crisis advocates often provide patient "comfort packs" and a change of clothing.

Advocates are the bridge to the care and services required following the hospital visit. They can assist the patient with the coordination of aftercare, including counseling, compensation, clothing, transportation, and follow-up medical appointments. They can provide advocacy and accompaniment through the legal system. Advocates are the direct link to the array of services and counseling available through the local Rape Crisis Center.

Hospitals can assure the highest level of comprehensive care and continuity of care beyond the ED visit by working with the Rape Crisis Center in their community. The patient is assured immediate crisis intervention and all necessary follow-up - medical, legal, and emotional - when a specially trained rape crisis advocate is part of the initial response team.

The Health Care and Evidentiary Examinations

Overview

When a patient has been sexually assaulted, the primary focus is on assessing the immediate health care needs, and on the collection and preservation of evidence. The patient is often the only witness to the crime, and her body is the crime scene. **A health care assessment and evaluation must be offered to all patients reporting sexual assault, regardless of the length of time which may have elapsed between the assault and the examination.** (If the assault occurred within 96 hours, a New York State Sexual Assault Evidence Collection Kit is used. If it is determined that the assault took place more than 96 hours prior to the examination, the use of an evidence collection kit is generally not necessary.)

Survivors of sexual assault are treated with dignity and sensitivity in a non-judgmental manner. At all times, care should be given in an emotionally supportive and private environment, protecting the patient's right to confidentiality, the right to be informed, the right to consent and refuse to consent, and to participate in treatment decisions and legal choices. Care following a sexual assault should be directed by the goal of healing and restoring control and decision making to the patient.

Patients who have been sexually assaulted will experience psychological trauma to one degree or another. The effects of this trauma may be more difficult to recognize than physical trauma. Every person has her own method of coping with sudden stress. When in crisis, patients can appear calm, indifferent, submissive, jocular, angry, or uncooperative and hostile toward those who are trying to help. It is important for the caregivers to understand that all of these responses are within the range of anticipated normal reactions. A judgment about the validity of the patient's account of the assault based on her demeanor can further traumatize the patient and hinder the collection of complete and objective data.

Some patients perceive the evidentiary exam as an extension of the trauma they have experienced from the assault. It is essential that examiners understand both the practice and philosophy of appropriate care for sexual assault victims, that they acknowledge the potential for further trauma, and that they take measures to mitigate it. The coordination of health care and forensic procedures is crucial to the compassionate care of the patient. Integrating health care and evidence collection (with appropriate consent) minimizes trauma for the patient. For example, whenever possible, the patient should undergo only one venipuncture for diagnostic purposes.

There are some unique considerations when caring for a male who has been sexually assaulted. Anecdotal evidence suggests that males experience an increased use of force and brutality, experience a higher incidence of non-genital trauma and exhibit a higher incidence of anogenital trauma on gross visual examination than females who have been sexually assaulted. Males may complain of rectal pain, bleeding, and rectal discharge. When examining a male patient, examine the anus for tears,

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fissures, bleeding, abrasions, foreign bodies, erythema and tears of the rectal mucosa. The examination should also include palpation of the abdomen for peritoneal signs consistent with rectosigmoid perforation. Additionally, examine the penis, noting any bite marks or lacerations.

Past and current health history and conditions, age, socioeconomic status, physical or mental disability, ethnicity, religion, race, gender, domestic violence, participation in illicit activity, and sexual orientation are important to consider when determining the proper method of conducting an interview, proceeding with a health care and evidentiary assessment, providing psychological support, administering treatment, and providing education and counseling. Information about providing sexual assault services to a diverse patient population is included in Appendix O.

A non-threatening, non-judgmental manner helps to establish rapport with the patient. Asking open-ended questions such as, “What else would you like me to know about you before we proceed?” where possible, allows the patient to share important information and voice concerns.

A patient may have a health history that influences her care. Chronic health conditions, medication allergies, or a current pharmaceutical regimen may influence the plan of care. For example, a patient with human immunodeficiency virus (HIV) may be on an extensive regimen of medications. It is important that the examiner take the patient’s health history into consideration when determining the best plan of care.

Forced sexual contact may result in exposure to HIV, hepatitis, sexually transmitted infections (STIs), and unwanted pregnancy. Care should be provided immediately. **The patient should be tested immediately to determine if there is a pre-existing pregnancy. Results of this test may impact immediate treatment decisions, such as administration of HIV prophylaxis (see below and page 44-45).** If the pregnancy test is negative, see page 41-43 for specific, in-depth recommendations on prophylaxis against pregnancy (emergency contraception) resulting from sexual assault.

The danger of exposure to human immunodeficiency virus (HIV) is real and life-threatening. The examiner should recommend HIV post-exposure prophylaxis (PEP) to patients reporting sexual assault when significant exposure may have occurred, as defined by direct contact of the vagina, anus, or mouth with the semen or blood of the perpetrator, with or without physical injury, tissue damage, or presence of blood at the site of the assault. **Offer PEP as soon as possible following exposure, ideally within 1 hour and not more than 36 hours after exposure.** For specific recommendations, refer to the HIV and Other Viruses section of this *Protocol* (page 44-45). It may be necessary to initiate the pregnancy prophylaxis and the HIV prophylaxis protocols before the commencement of the complete evidentiary exam. The examiner should complete the oral swab and smear first and then dispense prophylaxis against pregnancy and HIV PEP.

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It is important during intake that the examiner assesses the possibility of a **drug-facilitated assault**. For specific information, refer to the Drug-Facilitated Sexual Assault section of this *Protocol* (page 20).

If a patient must void or defecate prior to the collection of the specimens, she should be cautioned that semen or other evidence may be present in the genital area, and to take special care not to wash or wipe away those secretions until after the evidentiary exam has been completed. Likewise, a patient is advised not to remove or change a diaphragm, cervical cap, contraceptive sponge, tampon, menstrual pad, or panty liner. If a patient must urinate prior to the exam, that first urine should be collected in case it is determined that such a sample is needed to test for drug-facilitated sexual assault.

If the assault occurred within 96 hours, an evidence collection kit is used. If it is determined that the assault took place more than 96 hours prior to the examination, the use of an evidence collection kit is generally not necessary. It is unlikely that trace evidence would still be present on the patient. However, evidence may still be gathered by documenting findings obtained during the sexual assault examination (e.g., contusions, lacerations), photographing injuries, taking bite mark impressions, and recording statements about the assault made by the patient. The patient may also be evaluated and treated for STIs and hepatitis B. The patient has the right to direct the hospital not to collect sexual offense evidence (for a Sample Form for Patient Consent/Refusal, see Appendix B).

Patient Consent

All procedures should be fully explained and patient concerns addressed. The entire health care and evidentiary exam is conducted at the patient's discretion. The patient may withdraw consent at any time, or may choose to complete only certain parts of the health care exam, evidentiary exam, or health care treatment.

The patient should be able to understand the following:

- The nature of the proposed examination and treatment, including tests and medications;
- The side effects and risks of the proposed treatment;
- The probability that the treatment will be of benefit;
- Feasible treatment alternatives;
- What will or may happen if the treatment is not received¹; and,
- The forensic significance of evidence collection.

Written, informed consent for medical care and HIV testing must be obtained. In addition, consent must be obtained for collection and storage of sexual offense evidence, including forensic photography. A signed consent for release of

¹ Pharris, M. (February, 1998). Allegations of sexual assault on the inpatient unit: How to respond. *Journal of Emergency Nursing*, 24(1), 98-100.

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information and privileged evidence to law enforcement is required. The patient must also sign a release directing the hospital not to collect and keep privileged evidence, if the patient chooses not to participate in an evidentiary exam. For information about obtaining consent for HIV serum testing, please see page 44.

If a suspected sexual assault patient is unconscious, the hospital should follow established procedures for the care and treatment of the unconscious patient.

Maintaining the Chain of Custody of Evidence

Accurately maintaining and accounting for the chain of custody of sexual offense evidence is essential for the evidence to be useful in a court of law. The "chain of custody" is a legal term describing the movement, location, and succession of people responsible for the evidence. In order to maintain the chain of custody, an evidence collection kit and the specimens it contains must be accounted for from the moment collection begins until the moment it is introduced in court as evidence. Each item of evidence must be labeled with the initials of everyone who handled it, the date, a description and source of the specimen, the name of the examiner, and the name of the patient. Evidence not included in the kit (e.g., clothing, photographs, etc.) must be individually packaged, sealed and labeled with a description of the item. Providers must have specific protocols in place to insure confidentiality and maintain the chain of custody of the evidence. **Never leave the patient alone with the evidence. Under no circumstances is a patient, family member, or support person (e.g., advocate) allowed to handle or transport evidence after it has been collected. Maintaining the chain of custody during the examination is the sole responsibility of the examiner, and requires no outside assistance.**

Sexual Assault Documentation

Interview

It is vital that the examiner create a safe and non-judgmental environment in which a candid history statement can be obtained, and procedures carefully explained. The examination should be gently and patiently conducted, with confidentiality ensured, and autonomy respected. A Rape Crisis Center victim advocate should be present during the interview, with patient approval, to reassure the patient and to provide support. During the interview, when possible, all parties present should be seated. When these measures are taken, the patient can be re-empowered in the early stages of recovery, and is more likely to regain a sense of control over her body.

For many patients (even those with a history of prior sexual activity), this may be the first time that they have had a genital examination. It is important to determine early in the interview whether the patient has ever had such an exam, and to assess the patient's understanding of the examination process. Throughout the interview and examination, the examiner should explain to the patient why questions are being asked, why certain diagnostic and evidentiary tests are undertaken, and what

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treatment may be advisable. Sometimes, a patient may be hesitant about telling an examiner an important fact. By asking the question, "Is there anything else that you would like me to know before the physical exam?" the examiner provides one more opportunity for the patient to share information.

Health Care/Medical Documentation

The medical record must reflect that a sexual assault examination was conducted, and must include physical findings, diagnostic tests performed, treatment provided, patient education, and recommended follow-up care. **Information must be legible and include the name of the person providing the history (document relationship to patient).** Document if an interpreter is used, including name and language.

When recording information, the examiner must be careful not to include any subjective opinions or conclusions as to whether or not a crime occurred. Statements such as, "in no acute distress," "no evidence of rape," or "rule out rape," imply a value judgment and discredit the patient. Using the word "alleges" or "claims" implies that the examiner does not believe an assault occurred. Instead of "patient alleges," use "patient reports." Remember, "rape" is a legal conclusion.

Sexual assault prosecutions may require the presence or testimony of the examiner. When testimony is needed, a thorough and legible medical record, photographs and accompanying body diagrams will assist the examiner in recalling important details. The record should include the following:

- 1) Vital signs and other initial information, such as the date and time of the assault and the examination;
- 2) Significant health history. This includes any allergies, acute or chronic illnesses, current medication, surgery, and any post-assault symptoms, such as bleeding, pain, loss of consciousness, nausea, vomiting, or diarrhea;
- 3) Applicable gynecological history, including the date of the last menstrual period, last consensual intercourse (if in the last 96 hours), and contraception history. For patients who may be pregnant, a pregnancy test should be done, to establish the presence or absence of a pre-existing pregnancy;
- 4) A description of the details of the assault relevant to health care and evidence collection. This description includes any oral, vaginal, or rectal penile penetration; whether the perpetrator(s) penetrated the patient with finger(s) or foreign object(s); whether any oral contact occurred; whether a condom was used; and, whether ejaculation occurred. The patient's account of what happened is recorded in the patient's own words;
- 5) A detailed description of non-genital injuries. Describe areas of tenderness and trauma and the presence of blood and secretions. Common sites of injury include the breasts and upper portion of the inner thighs. Common types of injury include grab or restraining marks on the neck, arms, wrists, or legs, and injuries to or soreness of the scalp, back, or buttocks. The examiner may record patient's response when asked about a specific injury;

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- 6) Detailed findings of the genital examination. An examination protocol that includes colposcopy may be the most reliable means to document and characterize genital findings in sexual assault patients, and to evaluate whether findings may be linked to a reported sexual assault. Common areas for trauma include the posterior fourchette and labia minora. Patients reporting anal assault should be examined with a colposcope and anoscope, and injuries documented. All injuries should be documented in text, on a traumagram (body diagram) and photographically (see Appendix P for Sample Diagrams for Male and Female Patients); and,
- 7) All diagnostic tests conducted, treatment rendered, patient education provided, and the plan for follow-up care.

Injury Documentation

Recognition and documentation of injuries is an essential step in the examination of a sexual assault patient. In many patients, non-genital injuries are more apparent than genital injuries. Although most of these injuries are medically “insignificant,” they can have significant forensic value, and need to be adequately documented.

The written description of the injury should be kept simple and accurate. The following characteristics of the injury should be included:

- 1) Site of injury - the location of the injury should be clearly stated. Correct anatomical terms should be used when possible. Remember to specify whether “right” or “left” when applicable;
- 2) Type of injury - describe the type of injury (e.g., contusion/burn/stab wound);
- 3) Size of injury - record both the width and length of the injury. Use the same unit of measurement (inches or centimeters) throughout your description;
- 4) Shape of injury - if the injury has a specific shape, describe it (circular, curvilinear, linear, triangular, etc.). An injury can have a shape and pattern similar to the object that caused it. This is called a “patterned” injury and can be important to investigators; and,
- 5) Color of injury - in simple terms, describe the color of the injury. It is important to note, however, that the color of an injury is not an accurate estimation of the age of the injury, as color can vary depending on many factors, including depth of injury, skin pigmentation, and ambient light.

Many injuries are difficult to describe, and, as such, words alone may fail to describe the injuries adequately. For this reason, supplementing the written description with “body diagrams” and photographs is essential (see Appendix P).

Body Diagrams

These serve as an adjunct and not as an alternative to the written records. Both anterior (front) and posterior (back) view diagrams should be used (see Appendix P).

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Record the patient's name and date of exam on the body diagram. The person drawing on the body diagram should sign the diagram for future reference. A note should be made in the patient's records that body diagrams were recorded.

Forensic Photography

When injuries are found on physical examination, photography should be undertaken in addition to the written description and body diagrams. This is important for both genital and non-genital injuries. External genital injuries may be photographed using the same techniques as non-genital injuries or using a colposcope with photographic capability, whereas vaginal, cervical, and anal injuries will require use of a colposcope and/or anoscope with photographic capability.

Importance of photography in the acute setting

- 1) Much physical evidence is short-lived, and, if not recorded, may be lost.
- 2) The appearance of injuries can change significantly with time.
- 3) Photographs create a permanent record of the acute injury and reduce subjectivity.
- 4) Photographs serve as an aid to memory.
- 5) They permit the court and jurors to see the evidence "as it was."

Forensic photography - Things to remember:

- 1) Patients must give specific consent for photography. The exceptions to this include: an unconscious patient when "implied consent" applies, and situations where a Court Order has been issued;
- 2) Record in the medical record that photographs were taken, how many, and by whom;
- 3) The person taking the photos should sign and date the back of each picture;
- 4) Photographs are not to be placed into the evidence collection kit. They should be placed in an envelope, stapled to the chart, where they become part of the medical record. Rolls of 35mm film should be turned over to medical personnel for developing in a security-minded photo-lab facility. When retrieved, these photos should reside in a clasped envelope stapled to the inside of the patient's medical record.

Insert your facility's film development procedure on the next page.

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Facility Name _____ Date _____

Procedure for Film Development

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Photography - Suggestions

The following are suggestions on how to maximize the usefulness of the photography.

- 1) First, obtain an identification picture (“ID shot”) of the patient. This should be a frontal view of the patient and should clearly show the patient’s face. It serves to identify the patient, with subsequent photographs of the injuries.
- 2) Next, take an “orientation” photograph of the injury. This photograph is an overview of the injury, and serves primarily to show the location of the injury. Thought should be given to the background of the photo. Unnecessary distractions should be avoided, and metallic objects, which will reflect the flash, should be removed.
- 3) Next, take a photograph of the injury itself. The injury should occupy the center portion of the photograph, and be in focus. If the injury is small, a macro lens may be required. This photograph aims to show the characteristics of the injury as described in the written description and drawn on the body diagrams.
- 4) A tape measure should be displayed in the photo, and, where possible, the date. Without a reference of measure, the size of the image will be unclear, especially in the close-up views. Use the same units of measurement in written description as displayed on the scale to avoid unnecessary confusion.
- 5) The same photo should be taken again but without the tape measure, to confirm that no part of the injury was hidden under the tape or scale.
- 6) A minimum of two views of each injury should be taken, to show the length and width of the injury.
- 7) Photos should be taken at 90 degrees to the surface to avoid distortion of the shape and size.
- 8) If an injury requires specific treatment (e.g., suturing), take a photograph of the injury before and after repair.

Photographs In Court

When a case goes to trial, some evidence, photographs included, may be “admitted into evidence” in the case. This decision rests with the judge. Many factors influence this decision, and include the following:

- 1) It must be verified that the photo is “a true and accurate representation” of the injuries at the time the photo was taken. The person who took the photo, or someone who was present when it was taken, can verify this;
- 2) The photo may not be introduced into evidence if it is deemed to be “inflammatory.” In legal terms, this means that the photo may “inflame” the passions of the jury, making it difficult for them to render a dispassionate verdict. Unnecessary items or objects should be removed for photography, e.g., blood stained gauze or a scalpel. These may deem the photo “objectionable,” and the photographic evidence may be excluded; and,

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- 1) The photos must meet minimum standards. While professional quality images are not expected, the image should be in focus, the injury of interest should be clearly visible, the photograph should not be over-exposed, distorting colors and giving a “washed out” appearance to the picture.

Type of Camera

A wide variety of cameras exist, each with advantages and disadvantages.

Conventional 35mm cameras are preferred for legal work, and 35mm film (ISO 100 or 200) for slides is preferred. These cameras allow the use of interchangeable lenses (e.g., macro) and flashes (e.g., ring flashes), which produce better results for close-up work. The image quality cannot be viewed until a later date because of film development. Many hospitals do not have access to police or other secure photo labs, and patient confidentiality and the chain of custody preclude commercial photo shops from handling such material.

"Instant" cameras are commonly found in emergency departments and clinics where victims are examined. These cameras allow for the viewing of the image immediately, and eliminate concerns about developing images outside the facility. The image quality and color reproduction tends to be less reliable than conventional cameras. Older polaroid-type cameras have limited zoom capability, making close-up work difficult; newer models have addressed this problem. A newer model is recommended, if using a polaroid-type camera.

Most colposcopes can use either polaroid-type or 35mm cameras.

Although digital cameras are widely available, they have not yet been “fully tried and tested” in the legal arena. Prior to a decision regarding whether to use digital photography, seek guidance from the local District Attorney and courts as to the admissibility of digital photographs as evidence in a particular jurisdiction.

Regardless of the exact type of camera, it is important to be familiar with the one in use at the facility where you work. With practice and experience, you will learn how to use the equipment to its maximum potential, and, as such, how to be of most value to your patients.

Local law enforcement agencies can often provide educational programs to emergency department personnel on the subject of photographing injuries.

Bite Mark Evidence

The first step is to recognize the injury as a bite mark. A classic bite mark consists of two opposing arches, which are patterned abraded contusions. In many instances, the bite mark is “incomplete,” and, as such, the pattern is not so obvious. If a patient reports that an injury is a bite mark, the injury should be treated as such, regardless of its appearance.

Documentation of Bite Mark Injuries

Describe the appearance and location of the injury in simple, accurate terms. Record the types of injury seen, e.g., abrasion, contusion, laceration, avulsion. In addition to the narrative description, record the injury on a body diagram. Photographic documentation of the bite mark is essential.

- 1) Photograph the bite mark before any manipulation (e.g., swabbing or cleaning), if possible.
- 2) Photograph the injury at 90 degrees to the surface, to avoid distortion of its size and shape.
- 3) Take several photos of the injury.
- 4) Including a reference measuring scale is essential. Photograph measurements of both the horizontal and vertical dimensions of the injury. The ABFO #2 scale is ideal, as it incorporates both a circular and linear scale. If none is available, a simple tape measure placed beside and in the same plane as the bite mark will suffice.
- 5) For polaroid-type photos, label with the patient’s name, including the date and time the photo was taken. Sign the back of the photo, and record in the medical record that photos were taken.

Collection of Bite Mark Forensic Evidence

In addition to the injury, the perpetrator of a bite mark may have left saliva on the patient, which is important trace evidence. Saliva may contain ABO blood type antigens, and ABO typing from saliva may be helpful in including or excluding suspects. Its greatest potential value lies in the fact that cells from the perpetrator may be recovered from the saliva, allowing DNA profiling if adequate cells are collected.

Procedure:

- 1) Moisten a sterile swab with water.
- 2) Swab the bite mark with the swab, using a circular motion and moderate pressure.
- 3) Allow swab to air dry.

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- 4) When dry, place the swab in the swab box, and place it in the envelope marked “Dried Secretions.” If multiple bite marks are present, each bite mark should be handled separately. The swabs from each should be thoroughly dried and placed in separate paper envelopes.
- 5) The envelope should be labeled with the patient’s name, time of collection, and location of bite.
- 6) The envelope should be sealed, signed by the person collecting the evidence, and submitted into evidence. If additional envelopes are needed, self-sealing envelopes should be used. **Envelopes should never be sealed by licking;** and,
- 7) It should be documented in the patient’s record that bite mark evidence was collected.

Drug-Facilitated Sexual Assault

There has been an increase in the use of some drugs, e.g., (gamma hydroxybutyrate [GHB], Ketamine, flunitrazepam (Rohypnol), Benadryl) to render a person incapacitated and more susceptible to sexual assault. Some of these drugs are available over-the-counter. Ingestion of drugs can result in a loss of consciousness and an inability to resist. Some drugs cause memory loss and incapacitation. Many victims of drug-facilitated sexual assault may not remember the assault itself.

It is important during the interview that the examiner assess the possibility of a drug-facilitated assault. Memory loss, dizziness, drowsiness, confusion, impaired motor skills, impaired judgment, or reduced inhibition during the interview or reported at the time of the assault may indicate the unknowing ingestion of Rohypnol, GHB, or other drugs. Some symptoms may still be present when the patient is speaking to you.

The examiner must recognize the possibility of drug-facilitated sexual assault and act quickly to provide necessary care to the patient and preserve evidence. In November 2003, the New York State Division of Criminal Justice Services (DCJS) announced the availability of a standardized Drug Facilitated Sexual Assault (DFSA) evidence collection kit. The kits are provided free to hospitals in New York State and should be used only in cases where there is a suspicion of drug facilitated sexual assault. The collection must be done within 96 hours of the ingestion of the suspected drug. Permission must be obtained from the victim (a consent form is included in the DFSA kit). The victim’s first urine is critical. Do not use the clean catch method of urine collection and collect as much urine as possible, up to 100 ml.

If your facility does not have any Drug Facilitated Sexual Assault kits available, use two gray top test tubes and a standard sterile urine collection cup to obtain the samples. To obtain DFSA kits, contact the DCJS Violence Against Women Unit at (518) 457-9726. To obtain a copy of the form, “Authorization for Release of Sexual Assault Drug Screen,” either call DCJS or access it on line 24 hours a day at www.criminaljustice.state.ny.us or copy the form attached on page 24. If less than 96 hours has elapsed since the time of the assault, a urine sample should be obtained from the patient immediately but not before the New York State Sexual Assault Evidence Collection Kit is used. Securing blood or urine for testing for drug-facilitated sexual assault should only occur when there seems to be medical indications of

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their use or a statement of their use by the patient. When collected, specimens should be labeled, packaged, and sealed according to the protocol and procedures established at your facility. Do not place these specimens in the evidence collection kit.

Signs that Your Patient May Have Been Drugged

- If the patient remembers taking a drink but cannot remember what happened for a period of time after he/she consumed the drink.
- If the patient feels as though someone had sex with him/her, but cannot recall any or all of the incident.
- If the patient feels a lot more intoxicated than his/her usual response to the amount of alcohol he/she consumed.
- If the patient woke up feeling very hung over or "fuzzy," experiencing memory lapse, and cannot account for a period of time.
- If the patient wakes up in a strange or different location and does not know how he/she got there.
- If the patient's clothes are absent, inside out, disheveled, or not his/hers.
- If the patient has "snapshots" or "cameo memories."

Many drugs are detectable in the urine for at least 96 hours; therefore, the patient should be advised to openly discuss any recent ingestion of prescription or recreational drugs, so that the history will accurately explain the presence of those drugs in her urine toxicology screening. The patient must be counseled that testing her blood or urine for "rape drugs" may also show the presence of prescription or recreational drugs. Specific patient consent must be obtained for this testing.

The procedures for toxicology testing vary depending on the area of the state where the examination takes place. The facility should contact the local crime laboratory beforehand and establish a mutually acceptable protocol for collecting, packaging, storing, and transporting these specimens.

Insert your facility's procedure for toxicology testing on the next page.

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Facility Name _____ Date _____

Procedure for Toxicology Testing for the Patient Reporting Sexual Assault

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The following are additional forms for use in collecting possible evidence of a drug-facilitated sexual assault:

- an “Authorization for Release of Drug Facilitated Sexual Assault Screening” form that should be completed but *not* put into the completed and sealed DCJS DFSA kit.
- “Drug Facilitated Sexual Assault Blood and Urine Specimen Collection Instructions” that should be used only in conjunction with the NYS Sexual Offense Evidence Collection Kit.
- a “Drug Facilitated Sexual Assault Laboratory Information Form.”

**STATE OF NEW YORK
DIVISION OF CRIMINAL JUSTICE SERVICES
AUTHORIZATION FOR RELEASE OF
DRUG FACILITATED SEXUAL ASSAULT SCREENING**

I, _____ consent to the taking of blood and urine specimens for the purpose of identifying the presence of drugs as a part of this sexual assault exam. I understand that my samples will be turned over to a law enforcement officer and that information regarding the results of the screening may be released to the defense, prosecution and other law enforcement officials. I understand that testing the specimens may detect drugs that have been ingested voluntarily prior to this sexual assault, including, but not limited to recreational drugs. I understand that the results of this screening will become part of my medical record, and may be admissible as evidence in court.

Signature (Parent/Guardian if applicable)

Witness

Date/Time

Address

Date of Birth

Medical Record#

RECEIPT OF INFORMATION

I certify that I have received one sealed New York State Drug Facilitated Sexual Assault evidence kit.

Print the name of person receiving the kit _____

Signature of person receiving the kit: _____ Date _____ Time _____

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

Person receiving kit is representative of _____

Name of person releasing kit: _____
Printed Name Signature

Distribute: Original to law enforcement
Copy to medical record
Copy to patient

DO NOT PLACE THIS FORM INTO THE SEALED KIT

**Drug Facilitated Sexual Assault
BLOOD AND URINE
SPECIMEN COLLECTION INSTRUCTIONS**

NOTES

- A. This kit is only to be used in conjunction with a NYS Sexual Offense Evidence Collection Kit.
- B. Collect both blood and urine specimens in all cases.
- C. Urine samples should be collected from the victim as soon as possible, but not before the use of the NYS Sexual Offense Evidence Collection Kit. Please note: **the first urine after the drugging is critical**. Every time the victim urinates the chance of detecting a drug, if present, diminishes. Therefore, every effort should be made to obtain the first urine specimen. If a urine sample is taken at the start of the exam for a pregnancy test, the leftover urine should NOT be thrown out.
- D. This kit may be used up to **96 hours after** the ingestion of the suspected drug.

- STEP 1** Remove all components from kit box.
- STEP 2** Have the victim read and sign the *Authorization for Release of Drug Facilitated Sexual Assault Screening* form.
- STEP 3** Fill out all information requested on the *Drug Facilitated Sexual Assault Laboratory Information* form.

Blood Specimen Collection

Blood specimen collection must be performed only by a physician, registered nurse or trained phlebotomist. Note: If blood tubes have expired, use two gray top tubes from the hospital supply.

- STEP 4** Cleanse the blood collection site with the alcohol-free prep pad provided. Following normal hospital/clinic procedure and using the gray top blood tubes provided, withdraw blood specimens from subject, allowing both tubes to fill to maximum volume.

Note: Immediately after blood collection, assure proper mixing of anticoagulant powder by slowly and completely inverting the blood tube several times. Do not shake vigorously!

- STEP 5** Write the patient's name directly on the white label on the blood tube. Fill in the date on two of the three Evidence Seals provided. Then remove backing from the two Evidence Seals. Affix center of seals to the blood tube rubber stoppers, and press ends of seals down sides of the blood tubes, then return both filled and sealed blood tubes to specimen holder.

Urine Specimen Collection

- STEP 6** Have subject void directly into the urine specimen bottle provided. Do not use clean catch method. Collect 100 ml. of urine, or as much urine as possible.
- STEP 7** After specimen is collected, replace cap and tighten down to prevent leakage.
- STEP 8** Fill out information requested on the remaining Evidence Seal. Affix center of seal to the bottle cap and press ends of seal down sides of bottle, then return urine bottle to specimen holder.
- STEP 9** Place specimen holder inside the ziplock bag, then squeeze out excess air and close bag. Place specimen holder in kit box.

Note: Do not remove liquid absorbing sheet from specimen bag.

- STEP 10** Separate pages of *Drug Facilitated Sexual Assault Laboratory Information Form*.

Place original in DFSA kit box and give a copy to investigating officer, a copy to medical records and a copy to the patient.

- STEP 11** Close kit box lid and affix Security Seal where indicated.
- STEP 12** Fill out all information requested on kit box top under "For Hospital Personnel".
- STEP 13** Give sealed kit to the investigating officer. If officer is not present, place sealed kit in a secure and refrigerated area, in accordance with established protocol. Just as it is the responsibility of each facility to properly collect evidence in sexual assault cases, it is also their responsibility to ensure that evidence is properly maintained and secured in a refrigerated area for 30 days, and that the chain of custody is documented.

DRUG FACILITATED SEXUAL ASSAULT LABORATORY INFORMATION FORM

Patient's Name: _____

Patient's Height (approximate): _____ Weight (approximate): _____

Did the patient experience unconsciousness and for how long? _____

Specimen Collection:

Blood (2 gray top tubes): Date: _____ Time: _____

Urine: Date: _____ Time: _____ cc's collected: _____

Since the incident, how many times did the patient void prior to this collection? _____

How much alcohol did the patient consume? _____ Type of alcohol? _____

Please circle "*Hx*" (patient history) or "*Obs*" (observed by examiner). Circle both if appropriate.

Disturbance of Consciousness	Memory Impairment	Neurological	Psycho physiological	GI/GU
Drowsiness Hx Obs	Confusion Hx Obs	Muscle Relaxation Hx Obs	Excitability Hx Obs	Nausea Hx Obs
Sedation Hx Obs	Memory Loss Hx Obs	Dizziness Hx Obs	Aggressive Behavior Hx Obs	Vomiting Hx Obs
Stupor Hx Obs		Weakness Hx Obs	Sexual Stimulation Hx Obs	Diarrhea Hx Obs
Loss of Consciousness Hx Obs		Slurred Speech Hx Obs	Loss of Inhibitions Hx Obs	Incontinence Urine /Feces Hx Obs
		Paralysis Hx Obs	Hallucinations Hx Obs	
		Seizures Hx Obs	Dissociation Hx Obs	
		Pupil Size Hx Obs		

Please list below any drugs taken prior to and after the incident, including recreational, prescription, and OTC drugs.

	Name	Date	Time	Amount
Prior to incident:				
After incident:				

Examiner: _____ **Date:** _____ **Time:** _____

- Distribute: Original in DFSA kit
 Copy to medical record
 Copy to law enforcement
 Copy to patient

Drug-Facilitated Sexual Assault ALERT SHEET

What is it?

Rape or sexual assault facilitated by the use of drugs to incapacitate the victim.

What are the signs?

- | | |
|--|--|
| <ul style="list-style-type: none">▶ memory loss including “snapshots” or “cameo memories”▶ confusion▶ impaired motor skills▶ reduced inhibition | <ul style="list-style-type: none">▶ dizziness▶ drowsiness▶ impaired judgment▶ intoxication disproportionate to the amount of alcohol consumed |
|--|--|

How do I determine if a sexual assault may have been drug-facilitated?

Be aware of the following scenarios that may point to the possibility that the victim was drugged:

- If the victim remembers taking a drink but cannot recall what happened for a period of time after consuming the beverage.
- If the victim feels a lot more intoxicated than her/his usual response to the amount of alcohol consumed or feels intoxicated after drinking a non-alcoholic beverage.
- If the victim woke up feeling “hung over” or “fuzzy,” experiencing memory lapses and unable to account for a period of time.
- If the victim feels as though someone had sex with her/him, but cannot recall any or all of the incident.
- If the victim wakes up in a strange or different location without knowing how she/he got there.
- If the victim’s clothes are absent, inside out, disheveled, or not hers/his.
- If the victim has “snapshots” or “cameo memories.”

What do I do if I recognize the possibility of drug-facilitated sexual assault?

You can use the **Drug Facilitated Sexual Assault (DFSA) Kit**, developed by the NYS Division of Criminal Justice Services (DCJS). **But remember:**

- ▶ The collection must be done within **96 hours** of the ingestion of the suspected drug.
- ▶ You must obtain permission from the victim (a **consent form** is included in the DFSA kit).
- ▶ **The victim’s first urine is critical.** If a pregnancy test is done as part of the routine exam, do not throw out any leftover urine.
- ▶ Do **not** use the clean catch method of urine collection.
- ▶ Collect as much urine as possible, up to 100ml.

- ▶ Be sure to complete the forensic exam using the NYS Sexual Offense Evidence Collection Kit **before using the Drug Facilitated Sexual Assault Kit.**

What if our hospital does not have any Drug Facilitated Sexual Assault Kits available?

Use 2 gray top blood tubes and a standard sterile urine collection cup to obtain the samples. You must also obtain a signed consent from the victim. If your hospital does not have a copy of the *Authorization for Release of Sexual Assault Drug Screen*, you can obtain one by calling the DCJS Violence Against Women Unit at (518) 457-9726, or you can access it 24 hours a day on the website at www.criminaljustice.state.ny.us or copy from page 24 of this document. **Do not include the DFSA samples in the NYS Sexual Offense Evidence Collection Kit used to do the forensic exam.**

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DNA Evidence Collection (rev 10/08)

The following information may enhance the efficacy of the evidence collected by sexual assault examiners.

Using today's DNA identification technology, an individual may be identified with virtual certainty. Of course, as with any scientific method, there may be circumstances that only permit a less precise association. For example, when an evidence stain is degraded or very limited in size, a full analysis may not be able to be performed. This rarely occurs now, because only a trace amount of biological material is required for laboratory analysis that can result in a DNA profile. For example, DNA identification profiles are routinely detectable from saliva recovered from a cigarette butt or a bite mark, or from the cellular material adhering to the root portion of a single hair. A suspect's DNA profile may be determined from blood, semen, saliva, hair, or other body tissue that may be recovered in connection with a criminal incident. In cases involving sexual assault, these kinds of evidentiary material are typically recovered from the body and clothing of the victim.

The DNA profile may be used to identify the perpetrator of the crime, to show evidence of intimate contact between the perpetrator and the victim, or to link crimes that have been committed by the same individual. The technology has been used to clear innocent suspects and to exonerate persons wrongfully convicted of crimes.

All states, including New York, have passed DNA database legislation in recognition of the enormous potential of forensic DNA technology to solve crimes more quickly and to identify the perpetrators of crimes with greater certainty. DNA profiles are obtained not only from designated convicted felons, but from physical evidence recovered from the victim (body and clothing), or at scenes of crimes - presumably from the perpetrator of the crime. DNA profiles are entered into the state data bank, and routinely uploaded to the national data bank. Used effectively, the data banks have the potential to substantially reduce the total hours spent by investigators in eliminating suspects and identifying the offender - especially in cases involving sexual assault. For personal privacy considerations, it is mandated that DNA specimens taken from an offender, and the resulting DNA identification profile, may only be used for identification purposes in connection with a criminal investigation.

The efforts of specially trained sexual assault forensic examiners will assist in ensuring the proper collection and preservation of DNA evidence and increase the likelihood that the perpetrator of a sexual assault will be identified.

The New York State Sexual Offense Evidence Collection Kit

The New York State Department of Health, in conjunction with the New York State Division of Criminal Justice Services and the crime labs in New York State, developed a Sexual Offense Evidence Collection Kit for the collection and preservation of sexual

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assault forensic evidence. While most materials/supplies used in collection of forensic evidence are routinely found in hospital emergency departments, the use of a standardized kit provides the following benefits:

- Standardization of evidence collection procedures across the state;
- At the time of crisis/need, everything needed to perform the exam is “in the box”;
- The knowledge is current and applicable to any hospital in New York State; and,
- Standardization of procedures and materials in evidence collection yields better outcomes for survivors in court.

Although the completion of each appropriate step in the kit is requested, it is acknowledged that the examiner may elect not to complete one or more steps, based upon consideration of the physical and/or emotional well-being and preference of the patient. It must be acknowledged that a patient has the right to refuse one or more of the individual steps without relinquishing the right to have evidence collected.

Kits are provided by the New York State Division of Criminal Justice Services at no cost to hospitals in the state. Call the New York State Division of Criminal Justice Services at (518) 459-9726 for information or visit <http://www.criminaljustice.state.ny.us/ofpa/evidencekit.htm> for further information.

General Guidelines for Using the Kit

If the assault occurred within 96 hours, an evidence collection kit is used. If it is determined that the assault took place more than 96 hours prior to the examination, the use of an evidence collection kit is generally not necessary.

The evidence collection kit contains self-sealing envelopes for storing all samples. If it is necessary to use other than self-sealing envelopes, do not lick the envelopes. It is important to ensure that each envelope used contains all of the requested items and information. Envelopes that are not used should be marked “No” on the line which asks, “Was sample collected?” All sample swabs and smears must be dry before repackaging. They can be air dried at room temperature, or to expedite the drying process, electric swab dryers are available.

Each item of clothing must be allowed to air dry if damp, and placed in a separate paper bag.

Additionally, there may be clothing evidence that is too large to be placed in the kit. That evidence also must be properly collected, placed in large paper bags, and properly stored, while maintaining the chain of custody.

See Appendix Q for a copy of the Sexual Offense Evidence Collection Kit Instruction Sheets, including Patient Information form, Medical Record Sexual Assault form,

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sample envelope covers, sample box cover and a list of items to be included in a sexual offense evidence kit. The evidence collection instructions that follow are derived from those sheets.

Please Note: Blood is no longer drawn for evidentiary purposes. However, it is essential to draw blood immediately to allow timely baseline HIV testing (when the patient is eligible for prophylaxis) and serum blood testing for pregnancy (if serum testing is preferred to urine testing). Blood needed for any other health care diagnostic test should be obtained at this time. In the case of serum for HIV antibody testing, the specimen is held until the patient is able to consent to testing. The patient may be offered rapid HIV testing using Oraquick or another rapid test. If the patient does not consent to HIV antibody testing, the specimen must be discarded. It is important that the patient not be subjected to more than one venipuncture when possible. Collect blood specimens **prior** to beginning Step 1 of evidence collection.

Each step in this kit is designed for one of two purposes. The first is to recover potentially valuable physical evidence that will be useful in any subsequent investigation and legal proceeding to identify the perpetrator of the reported assault (through forensic DNA analysis, for instance) and/or to verify the nature and circumstances of the reported assault. The type of evidence often detected includes saliva, semen, hairs, spermatozoa, blood, fibers, plant material, soil and other debris that may have been transferred from the perpetrator's clothing or personal effects, or from the scene of the reported assault. The other steps are intended to collect evidence that will be used as a reference standard (controls from the victim). Each step is noted as either "*Evidence Collection*" or "*Control Sample*".

The kit contains material sufficient for the collection of evidence from ONE subject (male or female). Use a separate kit for each person. Change gloves for each step.

Step 1

Evidence Collection

► Oral Swabs and Smear

The swabs are not moistened prior to the sample collection. Smears are not stained or chemically fixed. All items are removed from the envelope. Two swabs are used simultaneously to swab the patient's mouth and gum pockets. Both swabs are used to prepare one smear. The swabs and smear are allowed to air dry. When the slide is dry, write Oral on the slide and place in the slide mailer marked Oral. Tape closed on one side only and complete the label on the mailer. The swabs are placed in the swab box marked "Oral." Both the mailer and the swab box are returned to the envelope. The envelope is sealed, and the information requested is completed. **This test is done after obtaining patient consent and often before the interview and physical examination. The patient can then rinse her mouth, receive timely treatment and prophylaxis and participate in the interview with no danger of**

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losing oral evidence.

Rationale/Discussion Steps 1, 12, 13, 14 and 15.

Swabs and Smears

The purpose of obtaining swabs and smears is to allow a forensic analyst to test for DNA evidence or microscopically for the presence of spermatozoa. If no spermatozoa are present, the analyst will then use the swabs to identify the seminal plasma components to confirm the presence of semen.

Depending on the nature of the assault, semen may be detected on the clothing or skin, or in the mouth, vagina, or rectum. Embarrassment, fear, trauma, or lack of understanding of the nature of the assault may cause a patient to be vague or mistaken about the type of sexual contact that actually occurred. For this reason, and because there can be leakage of semen from the vagina or penis onto the anus, it is recommended that patients be encouraged to allow examination of and specimen collection from all three orifices.

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

Spermatozoa and Semen

Historically, health care and law enforcement personnel have placed significant emphasis on the presence of spermatozoa in or on the body or clothing of a sexual assault victim as the most positive indicator of sexual assault. Conversely, when no spermatozoa were found, a shadow of doubt was sometimes cast upon the patient's report of sexual assault, contributing to the misconception that the absence of spermatozoa meant that no sexual assault occurred.

Many sexual assault offenders are sexually dysfunctional and do not ejaculate during the assault. Additionally, offenders may have had a vasectomy, may have used a condom, may have a low sperm count, or may ejaculate somewhere other than in an orifice or on the patient's clothing or body, or may not ejaculate at all if the assault is interrupted. Therefore, a lack of spermatozoa does not prove that an assault did not occur.

Similarly, the lack of semen may mean only that no ejaculation occurred, or that various other factors contributed to its absence in detectable amounts in the specimen. For example, the assailant may have used a condom; there may have been a significant time delay between the assault and the collection of specimens; penetration of the patient may have been made by an inanimate object; the patient may have inadvertently cleaned or washed away the semen; or, the specimen may

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have been improperly collected.

Therefore, although the finding of semen, with or without the presence of spermatozoa, may indicate that sexual contact did take place, its absence does not preclude the possibility of sexual contact.

The finding of spermatozoa is useful for two reasons. It is positive indication that ejaculation occurred and semen is present. Additionally, the presence of spermatozoa allows for the genetic (DNA) profile of the donor of the semen. This profile may also be determined from the cellular material remaining on the swab.

Forensic scientists are also interested in the presence of seminal plasma because it can identify semen in the absence of spermatozoa.

Step 2

Control Sample

▶ Buccal Specimen for Patient DNA Sample

Instruct the patient to rinse the inside of her mouth by vigorously swishing with water. Using the special swab from the envelope marked "Buccal Specimen," collect a specimen by swabbing with a scrubbing motion between the cheek and the gums on both sides of the mouth. To assure a sufficient sample, the swab should be applied in a scrubbing motion for 15 to 20 times. The swabs are allowed to air dry. When dry, the swabs are placed in the box provided. The swab box is returned to the envelope. The envelope is sealed, and all of the information requested is filled out.

Rationale/Discussion Step 2.

Buccal swabs, in lieu of an intravenous blood draw, are less intrusive, less expensive, do not require refrigeration or other special handling, are not subject to possible spillage or breakage (as might a glass tube), and are safer (in terms of pathogenic exposure) to handle than whole blood.

Step 3

Evidence Collection

▶ Trace Evidence

To minimize the loss of evidence, lay a sheet of white paper (use exam table paper) on the floor then lay another piece of exam table paper on top of that. Preferably, in the presence of the examiner, the patient disrobes over the white paper, handing the examiner each piece of clothing as it is removed. This allows trace evidence to collect on the paper. Fill out the requested information on the envelope and then carefully fold the top paper and, place it in the envelope and seal.

► Clothing

The examiner should determine whether the patient is wearing the same clothing that she wore during or immediately following the assault. If the victim has changed clothes after the assault, it is recommended that an investigator go to the victim's residence to obtain clothing worn at the time of the assault. The victim may also be asked to bring the clothing to the investigator at the police station. Clothing should be examined for any apparent foreign material, stains, or damage. An ultraviolet light source, which causes semen and other substances to become fluorescent when illuminated (Wood's lamp), can be used to detect stains on clothing. With patient consent, all items that may contain possible evidence related to the assault should be collected. Additionally, it may be helpful to save any clothing that may corroborate the patient's account of the assault. This may be useful if the matter is later pursued in the legal system.

Clothing is not shaken, as microscopic evidence may be lost.

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

After air drying all items, place each item in a separate bag. Hosiery, slips, and bras should be put into small individual paper bags. When items such as slacks, dresses, blouses, or shirts are to be retained as part of evidence collection, each should be put individually into larger paper bags. Label the bags with the victim's name and type of item; then tape the bag shut.

If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transfer or storage, the labeled and sealed clothing bags should be placed inside a larger plastic bag with the top of the plastic bag left open. A label should be affixed to the outside of the plastic bag, which indicates that wet evidence is present. This will enable the laboratory to remove the clothing promptly to avoid loss of evidence due to putrefaction. Not more than one wet piece of evidence should be placed in each plastic bag (in order to prevent cross-contamination). Bags/containers are labeled and numbered (i.e., 1 of 3; 2 of 3; etc.) to ensure that all items of evidence are transferred to the crime laboratory with the kit. The number of additional containers collected is indicated on the outside of the kit.

The hospital or exam site should arrange to have appropriate clothing and shoes available. **No patient should ever leave the examination site in an examining gown.**

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Rationale/Discussion Step 4

Frequently, clothing contains the most important evidence in a case of sexual assault. The reasons are twofold:

- Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs, and fibers, as well as debris from the crime scene. While foreign matter can be washed off or worn off the body of the patient, the same substances can often be found intact on clothing for a considerable length of time following the assault; and,
- Damaged or torn clothing may be significant. It may be evidence of force, and can also provide laboratory standards for comparing trace evidence with evidence collected from the suspect and/or crime scene.

Step 5

Evidence Collection

▶ Underwear

Wet or damp underwear should be air dried before packaging. The patient's underwear should be collected regardless of whether it was worn at the time of the assault. Fill out all information requested on the envelope; place underwear into the envelope and seal.

Step 6

Evidence Collection

▶ Debris Collection

The patient's body is examined carefully for any foreign material (e.g., leaves, fibers, glass, hair, etc.). Remove and unfold the bindle (paper towel) from the envelope marked Debris Collection. Any foreign material found on the patient's body is placed in the center of the bindle. The bindle is refolded in a manner to retain the debris and is returned to the envelope. The information requested on the envelope is completed and the envelope is sealed.

Step 7

Evidence Collection

▶ Dried Secretions and/or Bite Marks

An ultraviolet light (Wood's lamp) is used to identify areas of dried secretions on the patient's body. When dried secretion stains and/or bite marks are found, two swabs are used to collect the specimen. The swabs are moistened with 1-2 drops of water. Both swabs are held together to swab the area of the stain. It is important that the examiner use two new swabs for each different location on the body. Two complete

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sets of swabs and boxes are provided. If necessary, additional swabs should be obtained from the hospital's supply of standard sterile swabs. The swabs are allowed to air dry. When dry, they are placed in the swab box marked "Dried Secretions and/or Bite Marks," labeled with the site where collected on the body, and the nature of the secretion (if known), and replaced in the envelope. If additional swabs were used place them in a plain white stationary envelope and seal but do not lick the envelope. The information requested is filled in on the envelope and it is sealed.

Rationale/Discussion Step 7.

Semen and blood are the most common secretions deposited on the patient by the assailant. There are also other secretions (e.g., saliva) which can be analyzed by laboratories to aid in the identification of the perpetrator.

► Matted Material in Hair

Where there is evidence of semen or other matted material on pubic or head hair, it may be collected in the same manner as other dried secretions (see Step 7). The swab is then placed in a small paper envelope and labeled "possible secretion sample from head (or pubic) hair." Although the specimen can be collected by cutting off the matted material, it is important to obtain the patient's permission prior to cutting hair.

Step 8

Evidence Collection

► Fingernail Scrapings

It is important to collect evidence from each hand separately. Remove both bindles (paper towels) and scrapers from the envelope. Mark one bindle, Left, and one bindle, Right. One bindle is unfolded and placed on a flat surface. Use the scraper in the kit (an orange wood stick or cuticle stick will also work) to scrape under each nail. Each finger is held over the bindle when scraping, so that any debris present will fall onto the towel. After all fingers on one hand are done, the scraper is placed in the center of the towel. The towel is refolded to retain the debris and the scraper. Repeat steps for other hand. Both bindles are returned to the envelope. The information requested on the envelope is completed and the envelope is sealed.

Rationale/Discussion Step 8

During the course of an assault, the victim will be in contact with the environment and the assailant. Trace materials, such as skin, blood, hairs, soil, and fibers can collect under the fingernails of the victim and may provide useful evidence.

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Step 9

Control Sample

▶ Pulled Head Hairs

Pulled hair standards for evidence collection are considered by many to be very traumatic to the victims of sexual assault. The examiner must use his/her professional judgment regarding whether or not to complete this step, based upon the physical and/or emotional well-being and preference of the victim. Hairs can be pulled at a later date, if needed. The victim should be aware that hair collected at a later date may not be as conclusive as if it were collected at the time of the initial exam. Give victim the option of collecting the sample themselves.

Remove paper bindle from envelope. Using thumb and forefinger, not forceps, PULL, do not cut, 5 hairs from each of the following scalp locations (for a total of 25 hairs): center, front, back, left side, right side. Place pulled hair in center of bindle and refold bindle. Fill out all information requested on the envelope; replace bindle into envelope and seal.

Step 10

Evidence Collection

▶ Pubic Hair Combing

A bindle (paper towel) is placed underneath the patient's pubic hair area. Using the comb provided, the pubic hair is combed in downward strokes, so that any loose hairs or debris will fall onto the bindle. The patient should always be given the option of combing her own pubic hair. The bindle is carefully removed, and the comb is placed in the center. The towel is refolded in a manner to retain the comb and any evidence present. The bindle is returned to the envelope. Fill out information requested on envelope; replace bindle into envelope and seal.

Step 11

Control Sample

▶ Pulled Pubic Hairs

It is recommended that pubic hair standards not be pulled during the initial medical exam. They can be pulled at a later date (if the prosecution requests these samples and the victim consents to the procedure). When the specimen is obtained, fifteen full-length hairs are pulled from various areas of the pubic region (using the gloved thumb and the forefinger - not forceps). When possible, it is advisable to offer the patient the opportunity to pull her own hairs. They are placed in the envelope. The envelope is sealed, and the information requested is completed.

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▶ External Genital Exam

It is important for the examiner to complete a visual examination (including the use of magnification of the external genitalia). The examiner should identify trauma (e.g., laceration or contusion at the posterior fourchette) and document any trauma both by written documentation and forensic photography.

Step 12

Evidence Collection

▶ Perianal and Anal Swabs and Smear

Smears are not stained or chemically fixed. All items are removed from the envelope. Two swabs may be lightly moistened with 1-2 drops of water. Perianal swabs should be taken (even without history of anal contact), as secretions may pool in this area. If both perianal and anal swabs are collected, it is preferable to make the slide from the anal swab.

If only perianal swabs are to be collected, proceed as follows: Using two swabs simultaneously, moisten if necessary with 1 or 2 drops of water, and with a rolling motion carefully swab the perianal area. Using both swabs, prepare one smear on the slide provided and allow to air dry. (*Smear should be confined to the circle area on the slide.*) DO NOT DISCARD EITHER SWAB. When slide is dry, place in the slide mailer marked "Perianal/Anal." Tape closed on one side only and fill out the label on mailer indicating perianal area. Allow both swabs to air dry. When swabs are dry, place in swab box marked "Perianal."

If both perianal and anal swabs are to be collected, proceed as follows: Using two swabs simultaneously, moisten with 1 or 2 drops of water if necessary and with a rolling motion carefully swab the perianal area. Allow to air dry. Using two additional swabs simultaneously, gently swab the anal canal. Using both swabs, prepare one smear on slide provided and allow to air dry. (*Smear should be confined to the circle area on the slide.*) DO NOT DISCARD EITHER SWAB. When slide is dry, place in the slide mailer marked "Perianal/Anal." Tape closed on one side only and fill out label on mailer indicating anal area. When swabs are dry place in appropriate swab boxes marked "Perianal" and "Anal" respectively.

If a patient has been rectally traumatized, she may need to be examined with an anoscope and a colposcope. It is important for the examiner to rule out rectal trauma requiring further medical or surgical evaluation.

Rationale/Discussion Step 12.

It is recommended that anal evidence be collected before conducting the vaginal examination and evidence collection. In this way, contamination of the anal site and possible destruction of dried secretions by the examiner may be avoided.

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Step 13

Evidence Collection

► Vulvar/Penile Swabs and Smears

All items should be removed from the envelope. The swabs are moistened with one to two drops of water. Using both swabs simultaneously, with a rolling motion carefully swab the external genitalia, including along the folds between the labia majora and

labia minora in the female patient. For male patients, swab the penis and scrotum. Prepare one smear on the slide provided and allow to air dry. Do not discard either swab, allow both to air dry. When dry, the swabs are placed in the box marked "Vulvar/Penile." When the slide is dry, it is placed in the slide mailer marked "Vulvar/Penile" and taped closed, on one side only. The label on the mailer is filled out. The mailer and the swab box are replaced in the envelope and sealed. All requested information on the envelope should be filled out, including possible type of secretion.

Step 14

Evidence Collection

► Vaginal Swabs and Smear

Note: Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection. Take special care not to contaminate the patient's vaginal area with any debris from the anal area.

Remove all items from envelope. Using two swabs simultaneously, carefully swab the vaginal vault. Allow both swabs to air dry. When dry, place in swab box marked "Vaginal."

Using two additional swabs, repeat the swabbing procedure of the vaginal vault. Prepare one smear on the slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) DO NOT DISCARD ANY SWABS. When slide is dry, place in the slide mailer marked "vaginal." Tape closed on one side only and fill out label on mailer. When second set of swabs are dry place in second swab box marked "Vaginal." (If a speculum is used for this step, do not remove until next step (step 15) is completed.) Fill out all information on envelope; replace swab boxes and slide mailer into envelope and seal.

After the collection of vaginal specimens, and the completion of any photo-documentation, it is important for the examiner to complete a bimanual exam to assess for cervical motion tenderness. If the patient has cervical motion tenderness, uterine, or adnexal tenderness, she will need further medical assessment.

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Step 15

Evidence Collection

▶ Cervical Swabs and Smear

This step is particularly important if more than 12 hours have passed since the assault. Do not moisten swabs prior to sample collection. **DO NOT COLLECT ON PREPUBERTAL CHILDREN.**

Remove all items from envelope. Using two swabs simultaneously, carefully swab the cervix and cervical os. Allow both swabs to air dry. When dry, place in swab box marked "Cervical." Using two additional swabs, repeat the swabbing procedure of the cervix and os. Prepare one smear on the slide provided and allow to air dry. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD ANY SWABS.** When the slide is dry, place in the slide mailer marked "Cervical." Tape closed on one side only and fill out label on mailer. When swabs are dry, place in swab box marked "Cervical." Fill out all information on envelope; replace swab boxes and slide mailer into envelope and seal.

What to do when the medical evidentiary exam has been completed:

- ▶ Make sure each envelope used contains all requested items and information (see Appendix Q-6 for a list of items to be included).
- ▶ Envelopes which were NOT used should bear a mark in the "NO" box next to the "Was sample collected?" line.
- ▶ Remove the Police Evidence Seal from the box. Return all evidence envelopes and instruction sheet to the kit box. All required information, including the number of additional bags and containers, should then be filled out on the top of the kit just prior to affixing the evidence seal.
- ▶ If photographs were taken, do not include them in the kit. Include photos in the patient's medical record, or release to investigating officer as determined by your institution's policy.
- ▶ Do not include blood or urine in this kit.
- ▶ Sign the Police Evidence Seal and use it to seal the box. Signature must be partly on seal and partly on box.
- ▶ Fill out information requested on top of box in space provided for Hospital Personnel.
- ▶ Give sealed kit and clothing bags to the investigating officer. If officer is not present, place sealed kit in a secure area, in accordance with established protocol. Just as it is the responsibility of each facility to properly collect evidence in sexual assault cases, it is also their responsibility to ensure that evidence is properly maintained, and the chain of custody is documented. New York State Public Health Law 2805-i (Appendix A of the Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault) requires that evidence be secured for 30 days
- ▶ Diagnostic specimens collected for non-evidentiary purposes should not be included in the kit. Placement of these specimens in the kit could delay or prevent diagnostic testing and/or treatment.

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DO NOT INCLUDE THE FOLLOWING IN THE KIT:

- ▶ Patient Photographs
- ▶ Blood or Urine Samples
- ▶ Forms included in the kit for your convenience including: Sample Diagrams for Male and Female Patients (see Appendix P), the Patient Information form and Medical Record Sexual Assault form (see Appendix Q), and the Authorization for Release of Information and Evidence to Law Enforcement Agency form (see Appendix S). Follow the instructions on the forms to determine their distribution.

Procedures for Release of Evidence

If the patient has given her permission, the sealed kit and clothing bags must be given to the investigating officer. If the officer is not present, or the patient has not given permission for the kit to be released, the sealed kit is placed in a secure area, in accordance with established protocol. The evidence must be kept secured for at least thirty days (see Appendix H for regulations).

Non-Authorization of Release

Patients may choose not to authorize release of evidence at the time of examination. Public Health Law 2805-i(2) provides that hospitals must maintain sexual offense evidence in a locked separate and secure area, and the chain of custody for not less than thirty days unless before the expiration of 30 days the patient directs the hospital to surrender it to the police, or for certain kinds of evidence, if the police request its surrender (see Appendix A). Examiners must inform patients of the length of time evidence will be held prior to disposal.

Release of Evidence

Evidence may not be released from a hospital without the written authorization and consent of the informed adult patient, or an authorized third party, if the patient is unable to understand or execute the release. An Authorization for Release of Information and Evidence form (see Appendix S for a sample) must be completed. In addition to obtaining the signature of the patient or authorized third party on this form, signatures must be obtained from the examiner or hospital representative turning over the evidence, and the law enforcement representative who picks up the evidence. The original copy of the release form should be kept in the medical record, and a copy given to the law enforcement representative.

The patient should also be made aware of the State DNA Databank and the potential to identify the assailant, or if the assailant is already known, to link the assailant to evidence recovered from the victims of other sexual assaults. While the patient may be reluctant to proceed with criminal charges based solely on the assault, linkages with DNA evidence recovered from victims of other assaults determined from an analysis of DNA evidence in the case could provide important leads to investigators and, ultimately, result in the solution of those cases in addition to the victim's own case.

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Transportation of Evidence

Under no circumstances should a patient, family member, or support person (e.g., advocate) be allowed to handle or transport evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer physical evidence from the examination site to a crime laboratory.

Additional Health Concerns - Treatment and Testing

Each patient must be assessed and treated as a unique individual. Allergies, current medications, and current health conditions must all be considered in determining the best plan of care. When treatment or prophylaxis is initiated, the patient should be counseled and given written information about the common side effects of the medication. The patient must also understand that the ingestion of antibiotic treatment may make a prescription oral contraceptive less effective.

Pregnancy

For female patients of child-bearing age, there is a risk of unplanned pregnancy as a result of rape. Also, the patient may present with a pre-existing pregnancy. Such patients should be tested immediately to determine if there is a pre-existing pregnancy. Results of this test may affect immediate decisions, such as administration of HIV prophylaxis. If the patient is pregnant and HIV infected, treatment protocols may vary depending on the stage of pregnancy, and an HIV specialist or obstetrician should be consulted.

Prophylaxis Against Pregnancy (Emergency Contraception) Resulting from Sexual Assault

Examiners are expected to adhere to and fully document services provided, consistent with the following standards of professional practice and Section 2805-p of the Public Health Law:

- Counsel female patients about options for prophylaxis against pregnancy resulting from sexual assault (also known as emergency contraception or "morning after" pill) and the importance of timely action. Prophylaxis should be taken as soon as possible after unprotected intercourse and should be taken within 72 hours to be effective, unless medically contraindicated. Optimally, the treatment should be initiated within 12 hours after the assault.
- Ensure that female patients are properly informed of the effectiveness rates, risks, and benefits associated with the provision of emergency contraception to prevent pregnancy resulting from sexual assault.
- Provide female patients with written information prepared or approved by the Department of Health relating to emergency contraception.
- Provide female patients with appropriate information to make an informed choice regarding emergency contraception to prevent pregnancy resulting from sexual assault, and ensure that such services are provided upon request to the patient without delay, unless medically contraindicated.
- No hospital shall be required to provide emergency contraception to a rape survivor who is pregnant.

Any undue delay in making this service available to a patient who elects to receive such treatment would not be consistent with the current standards of care for female victims of rape and sexual assault. As such, hospitals not complying in a timely fashion would not be considered in compliance with department requirements.

Additional Health Concerns - Treatment and Testing

The treatments listed on the following page are intended to prevent pregnancy. The requirements related to administration of prophylaxis against pregnancy (emergency contraception) resulting from sexual assault are consistent with the requirements of 10 NYCRR 405.9(b)(10) which states that:

"No hospital shall be required to admit any patient for the purpose of performing an induced termination of pregnancy, nor shall any hospital be liable for its failure or refusal to participate in such an act, provided that the hospital shall inform the patient of its decision not to participate in such act or acts. The hospital in such an event shall inform the patient of appropriate resources for services or information."

The post-coital methods that are currently recommended for prophylaxis against pregnancy following sexual assault are:

- Progestin-only pills (most effective oral alternative, fewest side effects)
- Combination contraceptive pills.

For emergency contraceptive pills, the treatment schedule is one dose within 72 hours of unprotected intercourse and a second dose 12 hours later. The number of pills per dose varies by brand - see table on page 43. At least 30 minutes before the first dose, administer an anti-emetic - for example, Prochlorperazine (Compazine) 10 mg sustained release capsule PO or 25 mg PR. Repeat dosage every 12 hours as needed.

For further information about prophylaxis against pregnancy, particularly options for women for whom hormonal methods may be problematic, please call 1-888-668-2528, or visit Princeton University's Office of Population Research at <http://ec.princeton.edu/>.

Additional Health Concerns - Treatment and Testing

Contraceptives Packaged Specifically for Emergency Use in the United States

<i>Brand</i>	<i>Manufacture</i>	<i>Pills per Dose</i>	<i>Ethinyl Estradiol per Dose (µg)</i>	<i>Levonorgestrel per Dose (mg)</i>
Plan B	Barr	1 white pill*	0	0.75

Standard Oral Contraceptives – Also Effective For Emergency Use

<i>Brand</i>	<i>Manufacture</i>	<i>Pills per Dose</i>	<i>Ethinyl Estradiol per Dose (µg)</i>	<i>Levonorgestrel per Dose (mg)</i>
Alesse	Wyeth-Ayerst	5 pink pills	100	0.50-
Aviane	Barr	5 orange pills	100	0.50
Cryselle	Barr	4 white pills	120	0.60
Enpresse	Barr	4 orange pills	120	0.50
Lessina	Barr	5 pink pills	100	0.50
Levlen	Berlex	4 light-orange pills	120	0.60
LevLite	Berlex	5 pink pills	100	0.50
Levora	Watson	4 white pills	120	0.60
Lo-Ogestrel	Watson	4 white pills	120	0.60
Lo/Ovral	Wyeth-Ayerst	4 white pills	120	0.60
Nordette	Wyeth-Ayerst	4 light orange pills	120	0.60
Ogestrel	Watson	2 white pills	100	0.50
Ovrette	Wyeth-Ayerst	20 yellow pills	0	0.75
Ovral	Wyeth-Ayerst	2 white pills	100	0.50
Portia	Barr	4 pink pills	120	0.60
Seasonale	Barr	4 pink pills	120	0.60
Triphasil	Wyeth-Ayerst	4 yellow pills	120	0.50
Tri-Levlen	Berlex	4 yellow pills	120	0.50
Trivora	Watson	4 pink pills	120	0.50

*Note: Recent studies indicate that both doses of Plan B can be taken at once, rather than needing to wait 12 hours for the second dose.

Source: Trussel J., Koenig J., Ellerston C., Stewart F. (1997). Preventing unintended pregnancy: the cost-effectiveness of three methods of emergency contraception. American Journal of Public Health 87(6), 932-937.

Additional Health Concerns - Treatment and Testing

The effectiveness of prophylaxis against pregnancy declines as the interval between intercourse and the start of treatment increases. Therefore, treatment should not be delayed. Optimally, treatment should be initiated within 12 hours of the assault. In cases where there has been significant delay in obtaining services, prophylaxis against pregnancy (emergency contraception) could be administered up to five days post-assault, but there is a significant drop in efficacy between 12 and 120 hours post-assault and emergency contraception should be taken within 72 hours if at all possible. All health care providers providing sexual assault examinations must be well-versed in prophylaxis against pregnancy resulting from sexual assault.

Patients should be advised to have a follow-up pregnancy test three weeks after the assault. Patients who have taken prophylaxis against pregnancy resulting from sexual assault must be advised that there is still a 1-2 percent chance of pregnancy despite correct use, or significantly greater, if not able to administer prophylaxis within 72 hours.

HIV and Other Viruses

Exposure to blood and/or body fluids of a carrier can result in HIV, hepatitis B, and hepatitis C in the patient, which can have serious life-threatening consequences. The patient must be offered testing for HIV, hepatitis B, and hepatitis C at the time of the health care and evidentiary exam.

HIV

The HIV testing and prophylaxis recommendations below are current as of July 2004. To check for updated recommendations or other HIV-related guidelines, visit the New York State Department of Health HIV guidelines website (www.hivguidelines.org).

Written, informed consent for HIV testing must be obtained. All patients to be tested for HIV antibodies should be provided with pre- and post-test counseling in compliance with New York State HIV Confidentiality Law (Article 27-F). The examiner should recommend HIV post-exposure prophylaxis (PEP) to patients reporting sexual assault when significant exposure may have occurred, as defined by direct contact of the vagina, anus, or mouth with the semen or blood of the perpetrator, with or without physical injury, tissue damage, or presence of blood at the site of the assault. PEP should be recommended based on the nature of the exposure, and not the likelihood of HIV infection in the assailant or local prevalence of HIV. If the patient is pregnant, treatment protocols may vary depending on the stage of pregnancy, and an HIV specialist should be consulted. If an HIV specialist is not available, consult the HIV Clinical Education Initiatives (CEIs) listed in Appendix T for information on how to reach an HIV specialist. Appendix T contains telephone numbers of specialists who are available for consultation 24 hours a day.

PEP should be offered as soon as possible following exposure, ideally within 1 hour and not more than 36 hours after exposure. Because of the need for early

Additional Health Concerns - Treatment and Testing

administration of HIV prophylaxis, in some instances medication may be administered before the evidence collection process is completed. Blood for baseline HIV serologic testing should be obtained before initiating PEP. The patient may be offered rapid HIV testing, using Oraquick or another rapid test. However, initiation of PEP should not be delayed until results are available. Refusal to undergo baseline testing should not preclude initiation of therapy. PEP should be offered even if the patient refuses baseline testing.

Treatment should be given for 28 days, according to the following regimen:

Zidovudine (ZDV) 300 mg PO bid *plus* Lamivudine (3TC) 150 mg PO bid
(or Combivir 1 tablet bid)
plus
Tenofovir 300 mg PO qd

Note: Recommended HIV regimens are frequently updated. For the most up-to-date regimen, consult the web site at www.hivguidelines.org.

Note: When the source is known to be HIV-infected, past and current antiretroviral therapy experience, viral load data, and genotypic or phenotypic resistance data (if available) may require the use of an alternate PEP regimen. **Consult an HIV Specialist for specific recommendations.** Some anti-retroviral drugs are *not* routinely recommended for post-exposure prophylaxis: for example nevirapine, because it poses a risk of potentially fatal side-effects. Further information about PEP is available from the:

NYS DOH HIV Guidelines Website (www.hivguidelines.org), under: Clinical Guidelines, HIV Post Exposure Prophylaxis Guidelines

The HIV Clinical Education Initiative (CEI) provides 24-hour access to HIV specialists (see Appendix T for a list of HIV Clinical Education Center sites and contact information).

It is important to emphasize the need for sensitivity of a clinician when sharing a positive HIV test with an individual who has just experienced sexual trauma. A follow-up visit with a primary care physician, HIV clinic, or infectious disease specialist should be scheduled within 24 hours to review decisions, reinforce the need for regimen adherence, and to arrange for follow-up care if the patient has initiated treatment. If HIV PEP is initiated, the patient should be given the name and telephone number of a hospital clinician or service where the patient or her private physician can call for consultation on the management of PEP, including information about drug side effects and alternatives in case of drug toxicity. This information should be recorded on the patient's discharge plan. HIV serologic testing should be repeated at 4 weeks, 12 weeks, and 6 months following the assault.

For additional information about HIV and HIV Post-Exposure Prophylaxis, call the New York State AIDS Institute at (212) 268-6142.

Additional Health Concerns - Treatment and Testing

Hepatitis B and Hepatitis C

The hepatitis B surface antigen (HBsAg) test indicates exposure as early as 1-2 weeks after infection, but may not be detectable until as late as 12 weeks after infection; the hepatitis C antibody is not detected until 8-9 weeks after infection, however an early diagnosis of hepatitis C can be made using PCR (polymerase chain reaction) testing two to four weeks after exposure. As a result, the patient will not know immediately if she has been infected with these viruses during the assault.

If the patient has been previously vaccinated against hepatitis B and has a known response, generally no treatment is indicated. If the patient has not been previously vaccinated or has not completed the series, then the hepatitis vaccination series should be initiated. To assess whether the patient is already Hep-B immune (either from successful vaccination or previous infection), check Hepatitis B surface antibody (Anti-HBs) titre.

Management of the exposed person depends on the HBsAg status of the source, and the vaccination and anti-HBs response status of the exposed person. Recommended postexposure prophylaxis is described on the table below.

Recommended Postexposure Prophylaxis for Exposure to Hepatitis B Virus

Vaccination and antibody status of exposed person*		Treatment		
		Source HBsAg** Positive	Source HBsAg** Negative	Source Unknown or not available for testing
Unvaccinated		HBIG ^o X 1 and initiate HB vaccine series	Initiate HB vaccine series	Initiate HB vaccine series
Previously Vaccinated	Known Responder ¹	No treatment	No treatment	No treatment
	Known Nonresponder ²	HBIG X 1 and initiate revaccination or HBIG X 2 ³	No treatment	Treat as if source were HBsAg positive (HBIG X 1 and initiate revaccination or HBIG X 2 ³)
	Antibody response unknown	Test exposed person for anti-HBs ^a - If adequate ¹ , no treatment is necessary - If inadequate ² , administer HBIG X 1 and vaccine booster	No treatment	Test exposed person for anti-HBs - If adequate ¹ , no treatment is necessary - If inadequate ² , administer HBIG X 1 and vaccine booster and re-check titer in 1-2 months

* Persons who have previously been infected with HBV are immune to reinfections and do not require post exposure prophylaxis

** Hepatitis B surface antigen

^o Hepatitis B immune globulin, dose is 0.06 mL/kg and administered intramuscularly

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- ¹ A responder is a person with adequate levels of serum antibody to HBsAg (i.e. anti HBs \geq 10mIU/mL)
 - ² A nonresponder is a person with inadequate response to vaccination (i.e. serum anti HBs $<$ 10mIU/mL)
 - ³ The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.
- ^a Antibody to HBsAg.

Source: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Atkinson W, Hamborsky J, Wolfe S, eds. 8th ed. Washington DC: Public Health Foundation, 2004.

If the patient has begun the vaccination series and the baseline hepatitis B test shows pre-existing hepatitis B disease or evidence of previous vaccination, the vaccination series should be discontinued. Patients receiving the hepatitis vaccination series should have post-vaccination testing done 1-2 months after their vaccine series is completed.

The patient should also have baseline hepatitis C serology and serum ALT (alanine aminotransferase) obtained at the time of exam for sexual assault and repeated at four to six months post-exposure. Limited data indicates the treatment of hepatitis C might be most beneficial when started early in the course of hepatitis C infection. When hepatitis C infection is identified early, the individual should be referred for medical management to a specialist knowledgeable in this disease. There is currently no effective prophylaxis for hepatitis C. Immunoglobulin and antiviral agents are not recommended at this time for hepatitis C PEP.

The patient must be advised that until blood-borne disease acquisition is ruled out, condoms should be used when engaging in sexual contact, in order to decrease the possibility of exposing a sexual partner.

The most up to date guidelines may be accessed through the Centers for Disease Control and Prevention web site at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a.htm>.

Sexually Transmissible Infections (STIs)

The risk of contracting a sexually transmissible infection as a consequence of a sexual assault is unknown, but many STIs are preventable by prophylactic use of antibiotics. Chlamydia and gonorrhea are the two most common STIs, and because they can cause sterility and (rarely) life-threatening complications, all patients are given medication to prevent infection by these organisms. Trichomonas and bacterial vaginosis can be diagnosed or ruled out by a wet prep done in the emergency department, and treatment provided if positive. If a microscope is not available in the emergency department, the patient should be treated empirically. Because compliance failure may cause treatment failure, one-dose regimens are preferable.

Additional Health Concerns - Treatment and Testing

The standard protocol for antibiotic prophylaxis following sexual assault is:

- Ceftriaxone 125 mg IM* in a single dose; plus
- Azithromycin 1 g orally in a single dose, or Doxycycline 100 mg orally twice a day for 7 days; plus
- Metronidazole 2 g orally in a single dose (if indicated).

*Alternatives to Ceftriaxone 125 mg IM, approved by the CDC for treatment of uncomplicated gonorrhea infections are:

- Cefixime 400 mg orally in a single dose, or
- Ciprofloxacin 500 mg orally in a single dose, or
- Ofloxacin 400 mg orally in a single dose.

With the increase in resistant strains, it may be wise to avoid quinolones (ciprofloxacin and ofloxacin) for use in these individuals. In addition, while the risk from a one-time dose is low, quinolones should not be used in a person less than 17 years old due to a potential risk for damage to cartilage. The same is true for pregnant women or breast-feeding women due to similar potential effects of quinolones on cartilage in the developing fetus and infant.

Finally, in areas with high rates of syphilis, clinicians may wish to use a ceftriaxone single dose of 250 mg IM rather than the 125 mg as the higher dose combined with azithromycin is more effective against incubating syphilis.

Syphilis prophylaxis is not necessary at the initial exam. Testing should be done at a follow-up appointment, and treatment given if positive.

For an example of standing orders for a patient reporting sexual assault, see Appendix U.

Discussion/Rationale

Routine testing for gonorrhea, Chlamydia, and syphilis is not recommended for the following reasons. Testing for sexually transmissible infections at the time of initial exam usually ascertains whether a patient had an STD before the assault. Prior exposure to a sexually transmissible infection can be used to bias a jury against a patient in court. All patients are offered medication, as if infected, so testing a patient does not change the course of treatment. If the patient has symptoms of a sexually transmissible infection or clinical findings are questionable, testing is advised.

Examiners must inform patients of the possible risks of contracting a sexually transmissible infection, and provide them the information with which to make informed decisions regarding testing and treatment; antibiotic prophylaxis is standard care. Even when antibiotic prophylaxis is given, the patient should be counseled about the symptoms of STIs, and advised that if she develops symptoms, she should seek prompt follow-up care from her primary care provider, gynecologist, or local STD clinic. The patient must be counseled that until STD prophylaxis is completed,

Additional Health Concerns - Treatment and Testing

abstinence is advised, as sexual contact can lead to transmitting infection to a sexual partner. If sexual contact has occurred after the assault and before treatment, the patient must be advised that her partner should seek health care for STD evaluation.

Post-Assault Care and Patient Discharge

After the patient has had the health care and evidentiary exam, and has received all necessary treatment, she should be offered the opportunity to shower and brush her teeth. Necessary items for showering, oral hygiene, and clothing are often provided by hospital and community volunteer organizations or the local Rape Crisis Center. She may also need information and specific instructions on any or all of the following:

- Cleaning and treating abrasions/lacerations,
- Tetanus vaccination,
- HIV care and treatment,
- Hepatitis B vaccination, and,
- Counseling.

Prior to discharge, the patient must be provided written documentation of diagnostic testing, treatment, and follow-up health care recommendations, including information on available community resources that might be needed. The patient should be provided with necessary follow-up appointments, prescriptions and referrals.

The local Rape Crisis Center can assist the patient with access to much of the physical and psychological post-assault care. A list of Rape Crisis Centers is included in Appendix M.

The examiner must inform the patient of the institution's policy regarding the release or disposal of sexual offense evidence. The patient should receive the name and phone number of a staff person who can assist the patient as necessary. Any further contact with the patient must be carried out in a discreet manner. The name and number of a contact person (associated with the health care provider) is included on the patient information form (see Appendix Q).

Arrangements must be made to ensure that no patient has to leave the examination site in a patient gown.

The hospital must provide each patient with an appropriate and safe discharge, including: medical transfer, as necessary, necessary and appropriate follow-up care/referrals, hospital contact person to assist with release or disposal of sexual offense evidence, suitable attire, transportation or appropriate arrangement, etc., as necessary to meet patient needs.

To ensure that all steps have been taken, a sample checklist has been provided for your use (see Appendix R).

Testifying

Examiners must be prepared to testify at grand jury or trial about findings during the health care and evidentiary exams and about statements the patient made at the time of examination. Sexual assault forensic examiners who have completed SAFE training that is consistent with the standards established by the New York State Department Health or are NYS DOH-certified Sexual Assault Forensic Examiners will have received training on court testimony.

Often the time delay between when the examiner treats the patient and the time they may be called to testify at trial, as well as the number of patients they will see during that interval, make it very difficult for the examiner to recall the details of any particular case by the time they testify. Therefore, it is necessary to document all findings in detail, and document the patient's statements verbatim regarding the sexual assault.

Although the examiner may be familiar with the court process, and may have testified in a number of other cases, it is still necessary for the examiner to meet with the particular Assistant District Attorney prosecuting the case prior to trial. At this meeting the Assistant District Attorney will, among other things, go over the patient's medical records with the examiner, in order to fully refresh the examiner's memory prior to his or her testifying; show the examiner the physical exhibits that will be shown to them on the witness stand; and, otherwise prepare the examiner for the issues the Assistant District Attorney believes will arise in this particular case during trial. The Assistant District Attorney will also go over both what he or she expects to ask the examiner on the witness stand, as well as what he or she expects the defense attorney may ask.

Because the examiner serves as a witness in the trial or may be asked to present expert testimony, he or she must maintain an objective demeanor, and not appear to the jury to be a victim advocate. It may be helpful for the Rape Crisis Center victim advocate to explain to the patient that she can expect that the examiner will not engage in social conversation at the courthouse.

Traditionally, the successful prosecution of sexual assault cases has been difficult. With advanced techniques to document injuries and identify perpetrators of sexual assault, and examiners who detect and document sexual assault injuries, both patients reporting sexual assault and the public are better served.

Additional Resources

Brief Glossary of Anatomic and Forensic Terminology

<i>abrasion</i>	A scraping away of the surface, as in a skinned knee
<i>anoscope</i>	A piece of health care equipment used to assess injury to the anus and rectum
<i>chain of custody</i>	<p>A legal term which means the movement and location of evidence from the time it is obtained to the time it is presented in court. Chain of custody requires testimony of continuous possession by each individual having possession, together with testimony by each that the object remained in substantially the same condition during its presence in his possession (Black's Law Dictionary, 222. 7th ed., 1999).</p> <p>If the evidence cannot be accounted for at all times since its collection, there exists the possibility that someone may have tampered with it. It is difficult for evidence to be admitted if the chain of custody is not intact.</p>
<i>colposcope</i>	An instrument used to magnify the perineum and vagina, using an optimal illumination source. Colposcopes usually have attachments to accommodate a 35mm camera or a video camera.
<i>contusion</i>	Bruise
<i>fossa navicularis</i>	The internal area between the external entryway to the vagina and the hymen
<i>hymen</i>	A fold of tissue in the lower segment of the vagina
<i>labia majora</i>	The outer lips external to the vagina
<i>labia minora</i>	The inner lips external to the vagina
<i>laceration</i>	Tear, cut
<i>perineum</i>	The area dorsal to the pubic arch and ventral to the coccyx

Additional Resources

<i>posterior fourchette</i>	The tissue connecting the posterior labia minora, a common area of sexual assault injury
<i>sexual assault examiner or sexual assault forensic examiner</i>	A health care professional (physician, physician assistant, registered professional nurse, nurse practitioner) with specific sexual assault and forensic training, who examines and treats patients reporting sexual assault and testifies as needed. Note: certified sexual assault forensic examiners are those that have received training in NYS DOH-approved training programs, and have been certified by the NYS DOH as meeting all training and qualifications as a SAFE.
<i>swab</i>	Most often, a wooden stick with a cotton tip, used for the collection of biological material
<i>swab dryer</i>	An electric machine which expedites the process of drying swabs
<i>smear</i>	A glass slide, prepared with swabs and saturated with biological material
<i>Toluidine Blue dye</i>	A dye used to assist sexual assault examiners with identification and photodocumentation of injuries
<i>vagina</i>	Birth canal
<i>Wood's lamp</i>	An ultraviolet light source used to detect the presence of semen and other substances

APPENDIX A

New York State Public Health Law; Section 2805-i;
Treatment of sexual offense patients and maintenance of
evidence in a sexual offense, including Sections 2805-i (4-
b) and 2805-i (5);

Establishment of hospital-based
Sexual Assault Forensic Examiner Programs
And

New York State Public Health Law; Section 2805-p;
“Emergency treatment of rape survivors.”

Appendix A

New York State Public Health Law; Section 2805-i; "Treatment of sexual offense patients and maintenance of evidence in a sexual offense, including Sections 2805-i (4-b) and 2805-i (5); Establishment of hospital-based Sexual Assault Forensic Examiner Programs"

And

New York State Public Health Law; Section 2805-p; "Emergency treatment of rape survivors"

2805-i. Treatment of sexual offense victims and maintenance of evidence in a sexual offense.

1. Every hospital providing treatment to alleged victims of a sexual offense shall be responsible for:
 - 1-a. maintaining sexual offense evidence and the chain of custody as provided in subdivision two of this section.
 - 1-b. contacting a rape crisis or victim assistance organization, if any, providing victim assistance to the geographic area served by that hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services.

2. The sexual offense evidence shall be collected and kept in a locked, separate and secure area for not less than thirty days unless:
 - 2-a. such evidence is not privileged and the police request its surrender before that time, which request shall be complied with; or
 - 2-b. such evidence is privileged and
 - 2-b (i) the alleged sexual offense victim nevertheless gives permission to turn such privileged evidence over to the police before that time, or
 - 2-b (ii) the alleged sexual offense victim signs a statement directing the hospital to not collect and keep such privileged evidence, which direction shall be complied with. The sexual offense evidence shall include, but not be limited to, slides, cotton swabs, clothing and other items. Where appropriate such items must be refrigerated and the clothes and swabs must be dried, stored in paper bags and labeled. Each item of evidence shall be marked and logged with a code number corresponding to the patient's medical record. The alleged sexual offense victim shall be notified that after thirty days, the refrigerated evidence will be discarded in compliance with state and local health codes and the alleged sexual offense victim's clothes will be returned to the alleged sexual offense victim upon request.

3. Upon admittance or commencement of treatment of the alleged sexual offense victim, the hospital shall advise the victim of the availability of the services of a local rape crisis or victim assistance organization, if any, to accompany the victim through the sexual offense examination. If after receiving such advice the sexual offense victim wishes the presence of a rape crisis or victim assistance advocate, the hospital shall contact the appropriate organization and request that one be provided, provided, however, that if in the professional judgment of the treating practitioner a delay in treatment is detrimental to the provision of medical treatment, then examination or treatment need not be delayed pending the arrival of such advocate and further provided that the presence or continued presence of such advocate does not interfere with the provision of necessary medical care to the victim.

4. No hospital or treating practitioner shall be liable in civil damages for failing to comply with the requirements of subdivision one, two or three of this section or acting in good faith to provide treatment as provided in subdivision three of this section.
 - 4-a. On and after April first, two thousand one, a hospital providing treatment to alleged victims of sexual offenses shall be eligible to receive from the division of criminal justice services, at no cost, sexual offense evidence collection kits.
 - 4-b. (a) The commissioner shall, with the consent of the directors of interested hospitals in the

state and in consultation with the commissioner of the division of criminal justice services, designate hospitals in the state as the sites of a twenty-four hour sexual assault forensic examiner program. The hospital sites shall be designated in urban, suburban and rural areas to give as many state residents as possible ready access to the sexual assault forensic examiner program. The commissioner, in consultation with the commissioner of the division of criminal justice services, shall consider the following criteria when designating these sexual assault forensic examiner program sites:

- (1) the location of the hospital;
- (2) the hospital's capacity to provide on-site comprehensive medical services to victims of sexual offenses;
- (3) the capacity of the hospital site to coordinate services for victims of sexual offenses including medical treatment, rape crisis counseling, psychological support, law enforcement assistance and forensic evidence collection;
- (4) the hospital's capacity to provide access to the sexual assault forensic examiner site for disabled victims;
- (5) the hospital's existing services for victims of sexual offenses;
- (6) the capacity of the hospital site to collect uniform data and insure confidentiality of such data; and
- (7) the hospital's compliance with state and federally mandated standards of medical care.

4-b. (b) Each sexual assault forensic examiner program site designated pursuant to this subdivision shall comply with the requirements of subdivisions one, two and three of this section, and shall also provide treatment to the victim as follows:

(1) The victim shall, absent exigent circumstances, be met by a sexual assault forensic examiner within sixty minutes of arriving at the hospital, who shall be a nurse practitioner, registered nurse or physician specially trained in forensic examination of sexual offense victims and the preservation of forensic evidence in such cases and certified as qualified to provide such services pursuant to regulations promulgated by the commissioner. Such program shall assure that such a specially trained forensic examiner is on-call and available on a twenty-four hour a day basis every day of the year.

(2) An examination of the victim shall be performed promptly by such forensic examiner in a private room designated for such examinations. An obstetrician/gynecologist or other appropriate medical doctor shall be readily available to the forensic examiner if there is a need for more specialized medical evaluation or treatment.

(3) Promptly after the examination is completed, the victim shall be permitted to shower, be provided with a change of clothing, and receive follow-up information, counseling, medical treatment and referrals for same.

(c) Nothing in this subdivision shall affect the existence or continued existence of any program in this state through which a trained nurse practitioner, registered nurse or physician is providing appropriate forensic examinations and related services to survivors of sexual assault.

5. The commissioner shall promulgate such rules and regulations as may be necessary and proper to carry out effectively the provisions of this section. Prior to promulgating such rules and regulations, the commissioner shall consult with relevant police agencies, forensic laboratories, rape crisis centers, hospitals, and other such persons as the commissioner deems necessary. Such rules and regulations shall identify the offenses subject to the provisions of this section, provide a specific definition of sexual offense evidence and require each hospital to contact its local police agency and forensic laboratory to determine their specific needs or requirements.

6. On or before November thirtieth, two thousand two, the commissioner shall make a report to the governor, the temporary president of the senate and the speaker of the assembly concerning the sexual assault forensic examiner program established under subdivision four-b of this section.

Such report shall include an evaluation of the efficacy of such program in obtaining useful forensic evidence in sexual offense cases and assuring quality treatment to sex offense victims. Such report shall also recommend whether this program should be expanded and shall estimate the financial cost, if any, of such expansion.

S 2805-p. Emergency treatment of rape survivors.

1. As used in this section:

1-a. "Emergency Contraception" shall mean one or more prescription drugs used separately or in combination to be administered or self-administered by a patient to prevent pregnancy within a medically recommended amount of time after sexual intercourse and dispensed for that purpose in accordance with professional standards of practice and determined by the United States Food and Drug Administration to be safe.

1-b. "Emergency Treatment" shall mean any medical examination or treatment provided by a hospital to a rape survivor following an alleged rape.

1-c. "Rape" shall mean any act defined in Section 130.25, 130.30 or 130.35 of the penal law.

1-d. "Rape Survivor" or "Survivor" shall mean any female person who alleges or is alleged to have been raped and who presents as a patient.

2. Every hospital providing emergency treatment to a rape survivor shall promptly:

2-a. Provide such survivor with written information prepared or approved, pursuant to subdivision three of this section, relating to emergency contraception.

2-b. Orally inform such survivor of the availability of emergency contraception, its use and efficacy; and

2-c. Provide emergency contraception to such survivor, unless contraindicated, upon her request. No hospital may be required to provide emergency contraception to a rape survivor who is pregnant.

3. The Commissioner shall develop, prepare and produce informational materials relating to emergency contraception for distribution to and use in all hospitals in the state, in quantities sufficient to comply with the requirements of this section. The Commissioner may also approve informational materials from medically recognized sources for the purposes of this section. Such informational material shall be in clear and concise language, readily comprehensible, in such varieties and forms as the Commissioner shall deem necessary to inform survivors in English and languages other than English. Such materials shall explain the nature of emergency contraception including its use and efficacy.

4. The Commissioner shall promulgate all such rules and regulations as may be necessary and proper to implement the provisions of this section.

S3. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided that the Commissioner of Health is authorized and directed to promulgate any rules and regulations and develop, produce and distribute any materials necessary to implement the provisions of this act on or before such date.

APPENDIX B

Sample Form for Patient Consent/Refusal and Evidentiary Log

APPENDIX B
SAMPLE FORM FOR PATIENT CONSENT/REFUSAL AND EVIDENTIARY LOG

Date: _____

Patient Name: _____ Contact No.: _____

*S.A.F.E 1) _____ Contact No.: _____

Examiner(s):
 2) _____ Contact No.: _____

Provider: _____ Dept: _____ Contact No.: _____

(If not a *S.A.F.E. Examiner)

*Sexual Assault Forensic Examiner

PATIENT CONSENT/REFUSAL

I understand that if I consent, an examination for evidence of sexual assault and collection of possible evidence will be conducted. I understand that I may refuse to consent, or I may withdraw consent at any time for any portion of the examination. I understand that the collection of evidence may include photographing injuries, which may include injuries to the genital area. I understand that if I consent, such evidence will be released to the police at this time. If I do not consent to release of evidence at this time, such evidence will be preserved at the Hospital for not less than 30 days and I may consent to its release or destruction at any time during this 30-day period.

I consent to:

- | | | |
|---|------------------------------|-----------------------------|
| Physical Examination: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Photographing of Injuries: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Collection of Evidence: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Release of Evidence to Police: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Verbal Communication by Hospital Personnel with Prosecutorial Agency: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Print Name of Witness _____

LOG OF ITEMS TAKEN FROM PATIENT FOR EVIDENCE

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

APPENDIX C

Sexual Assault Forensic Examiner (SAFE) Program Standards, Sexual Assault Forensic Examiner (SAFE) Standards and Sexual Assault Forensic Examiner (SAFE) Training Program Standards, Requirements and Applications

SEXUAL ASSAULT FORENSIC EXAMINER (SAFE) PROGRAM
STANDARDS AND REQUIREMENTS

INTRODUCTION

The goals of the SAFE program are to:

1. Provide timely, compassionate, patient-centered care in a private setting that provides emotional support and reduces further trauma to the patient;
2. Provide quality medical care to the patient who reports sexual assault, including evaluation, treatment, referral and follow-up;
3. Ensure the quality of collection, documentation, preservation and custody of physical evidence by utilizing a trained and New York State Department of Health (DOH) certified sexual assault forensic examiner to perform the exam;
4. Utilize an interdisciplinary approach by working with rape crisis centers and other service providers, law enforcement and prosecutors' offices to effectively meet the needs of the sexual assault victim and the community;
5. Provide expert testimony when needed if the patient chooses to report the crime to law enforcement; and,
6. Improve and standardize data regarding the incidence of sexual assault victims seeking treatment in hospital emergency departments.

A comparison of general hospital and SAFE program responsibilities for the care and treatment of victims of sexual assault is included in Appendix D.

SAFE PROGRAM MODELS

The SAFE Program may be housed within the emergency department or in an easily accessible area nearby. Increasingly, hospitals provide a separate sexual assault medical/forensic unit, in an easily accessible area near, but not necessarily within, the emergency department.

Some hospitals may develop a self-contained SAFE program that utilizes hospital staff trained as sexual assault forensic examiners. A self-contained hospital SAFE program will retain responsibility for recruiting, ensuring training and clinical competence of and maintaining call rosters for SAFE staff. Hospitals may use a variety of methods to do this. For example, the hospital may elect to have emergency department staff trained as sexual assault forensic examiners available on each shift. The hospital may need to have another employee on-call to take over the usual duties of the examiner at the time the examiner assumes responsibility for the care of a sexual assault patient. Alternatively, the examiner may be an employee of the hospital, listed on an "on-call" schedule at times when s/he is not on duty. The sexual assault forensic examiner is called in to care exclusively for the sexual assault patient.

The Department will consider alternative program models that demonstrate clear accountability and oversight for the program and comply with relevant laws, regulations and program standards and requirements for SAFE programs. For example, hospitals with a low volume of sexual assault patients may wish to participate in a regional network system. Under the network program, regionally-based, trained examiners will be available to provide sexual assault exams at several hospitals in a region. The examiners are employees of an outside group (e.g., another hospital, a

Visiting Nurse Service (VNS) or a private practice). The group serves one or more hospitals and travels to the location of the sexual assault patient. In this model, the hospitals which apply for SAFE programs have examiners from this outside group on-call. The SAFE program must ensure that sexual assault forensic examiners who are on call from an outside group have been appropriately certified by the Department of Health and have been credentialed by the SAFE program hospital.

A hospital must agree to ensure that the following minimum requirements are met throughout its designation as a SAFE program.

1. Appropriate administrative and clinical oversight is provided to the program;
2. SAFE programs are affiliated with and integrated into the policies and procedures and operations of the hospital, particularly the emergency department;
3. Initial and ongoing assessment of competency and credentialing of SAFE staff, including certification of sexual assault forensic examiners by the Department (see Specialized Staff Training and Availability, further on in this appendix);
4. A well-functioning system to provide triage and assessment;
5. A well-functioning on-call and back-up call schedule has been developed so that the patient is met by an examiner within 60 minutes of the patient's arrival in the hospital, except when the patient does not disclose a sexual assault at the time of triage, or under exigent circumstances;
6. The rape crisis center is contacted immediately to ensure that a rape crisis advocate is available to offer services to the patient;
7. Medical/surgical backup is readily available to the sexual assault forensic examiner;
8. An appropriately equipped, private, designated room that can accommodate disabled patients and with access to a shower is available when needed for sexual assault exams;
9. Medical treatment and forensic examination of sexual assault survivors is provided in compliance with all relevant laws and regulations and consistent with generally accepted standards of care, including the Department's *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*;
10. Prophylaxis for sexually transmitted infections, HIV and hepatitis B, and prophylaxis against pregnancy resulting from a sexual assault (emergency contraception) is provided on site;
11. The New York State Sexual Offense Evidence Collection Kit is used unless a patient refuses to have evidence collected and evidence is maintained and collected as required by PHL 2805-i;
12. The Drug Facilitated Sexual Assault kit is used when applicable;
13. Replacement clothing is provided to the patient before leaving the hospital;
14. Referral and follow-up regarding medical treatment is provided;
15. Patient is referred to counseling and support and other needed services;
16. Safe discharge is assured for the patient;
17. Medical and forensic SAFE services are appropriately documented;
18. Information is collected related to the provision of services to victims of sexual assault and confidentiality of the data is ensured; and,
19. An effective system of continuous quality improvement is established to ensure SAFE medical and forensic services are in compliance with generally accepted standards of care.

In all models, the hospital's obligation to provide medical screening and emergency treatment or transfer per the US Emergency Medical Treatment and Labor Act

(EMTALA) 42 USC 1395 (dd) remains the same. For all sexual assault patients who require medical transfer, forensic evidence collection should be done at the hospital accepting the transferred patient.

SAFE services do not replace the care that would normally be provided to patients in an emergency department. Sexual assault patients will receive the same intake and screening that any patient would receive in any emergency department. However, under the SAFE Program, sexual assault patients will be accorded a high priority in the emergency department and can be transferred to the SAFE program as soon as is medically feasible.

Hospital emergency staff should immediately implement the following protocol upon arrival of the patient in the emergency department:

- Provide triage and assessment in a timely manner (See Attachment V for an example of a standardized assessment tool for sexual assault patients. SAFE Programs should take into account local protocols and interdisciplinary requirements when developing a standardized assessment tool);
- Contact the sexual assault forensic examiner when the patient discloses that s/he has been sexually assaulted;
- Contact a rape crisis advocate at the same time that contact is made to the sexual assault forensic examiner;
- Be available for consultation and support of the SAFE program and sexual assault forensic examiner;
- Assist in obtaining necessary tests and medications; and,
- Assist in arranging referrals and follow-up services.

In addition, the SAFE program and the examiner must have readily available access to medical/surgical back-up as needed, which, in addition to the emergency department, may include: general surgery, obstetrics/gynecology, pediatrics, urology and psychiatry.

INTERDISCIPLINARY MODEL

SAFE programs are required to participate in an interdisciplinary/community task force. The task force should be formalized through a Memorandum of Understanding. The task force should include representation from the following: the hospital SAFE program, the emergency department, local colleges (including security and health services), hospital administration, the local Rape Crisis Center, law enforcement, prosecuting attorneys (including a special sex crimes unit, where available), emergency medical services and other health and human service agencies that may provide follow-up services to victims of sexual assault. This task force should be actively engaged in assessing community need and in developing new SAFE programs and should convene on an ongoing basis to ensure coordination and resolution of issues related to existing programs. The task force can also assist with outreach and education efforts and can provide follow-up services for victims of sexual assault.

Hospitals already participating in a sexual assault task force whose mission or goal is consistent with the above will be considered to meet this requirement. If there is a sexual assault task force already serving the community, it is not recommended that hospitals establish a new task force. In areas where there is a regional network system, a single task force involving several hospitals, the provider of sexual assault

examiner services, the rape crisis center(s), as well as other appropriate organizations, may be sufficient for program development and ongoing coordination.

Public Health Law requires hospitals to inform survivors of rape crisis services available within the geographic area and to contact the Rape Crisis Center to provide the services of a rape crisis advocate. This works most effectively when the advocate is called at the same time the sexual assault examiner is contacted and offers to provide services directly to the patient. Hospitals applying for SAFE program status must have a cooperative agreement(s) with a local Rape Crisis Center(s) to ensure that all survivors are offered the assistance of a rape crisis advocate. The New York State Department of Health Rape Crisis Program funds over 50 Rape Crisis Centers providing services at over 75 sites. A list of these programs is appended (Appendix M).

The Department has established standards for Rape Crisis Centers in training rape victim advocates. Advocates who complete the training can, by law, provide confidential services to victims of sexual assault. Rape Crisis Center victim advocates' primary focus is to provide calm, consistent support to the patient. While advocates do not provide health care or collect evidence, they enhance the efforts of health care staff through the provision of information regarding medical and legal options. They can provide the intervention necessary when patients first arrive for treatment; assist patients in understanding the health care and evidence collection procedures; and, counsel family members or friends who may accompany the patient. Advocates are the bridge to the care and services required following the hospital visit.

ORGANIZATION/STAFFING

The hospital must ensure administrative as well as clinical oversight for the SAFE program to ensure that care provided to rape victims is consistent with generally accepted standards of care. SAFE programs must have a Program Director designated to provide oversight and coordination related to the program. If the Program Director is a clinician, s/he may also directly provide SAFE examination services, however the Director's role in directly providing care should be limited in light of other duties.

The Program Director's position must be integrated within the hospital administrative structure, reporting to the director of the emergency department or the director of nursing, or other appropriate area. The Program Director will be the liaison with other areas of the hospital and with members of the interdisciplinary/community task force.

For some existing SAFE programs, a Program Director has been designated who has been hired through some other community-based agency, such as a Rape Crisis Center. In those cases, an individual employed by or affiliated with the hospital(s) where SAFE services are provided must be designated to coordinate SAFE activities in the hospital setting in conjunction with the community-based program.

The Program Director coordinates SAFE staffing, either directly, in a self-contained hospital model, or indirectly through another agency, such as the Visiting Nurse Service in a regional network model. This includes recruiting, education and continuing education, preceptorships, certification and re-certification, and establishing on-call and back-up schedules for examiners. The Program Director works with the interdisciplinary/community task force in developing a community outreach and education plan for the SAFE program.

A medical director for the program is recommended but not required. If there is no medical director for the program, the hospital must ensure that the SAFE program is integrated within the hospital's clinical oversight and quality improvement structure. The hospital must also ensure that physicians and other qualified staff in the hospital emergency department are readily available to write prescriptions, order tests, and perform other functions appropriate as defined within their professional scope of practice.

SPECIALIZED STAFF TRAINING AND QUALIFICATIONS

The key component of the SAFE program is a cohort of specially trained individuals who have been prepared through an intensive classroom and preceptor training program to conduct complete sexual assault medical-forensic examinations, collect and preserve evidence and present testimony in the prosecution of sexual assault cases. Every DOH-approved SAFE program is required to have specially trained examiners who are certified by the Department of Health and credentialed according to the individual institution's procedures to provide forensic examinations to sexual assault victims.

Qualifications

The Department of Health has developed standards for sexual assault forensic examiners (Appendix C - Section II). The Department will certify individual sexual assault forensic examiners who meet these standards (see Attachment III for certification application). These standards apply to registered nurses, nurse practitioners, physician assistants, and physicians who complete special training in the areas of sexual assault and forensic evidence collection

An individual requesting certification by the NYS Department of Health as a sexual assault forensic examiner must perform within the scope of practice of the discipline in which s/he holds a license and certify on the required form and provide evidence to the NYS Department of Health that s/he:

1. Holds a current license to practice as a registered nurse, nurse practitioner, physician assistant or physician in the State of New York; and,
2. Has a minimum of one year, full-time clinical post-graduate experience; and,
3. Has successfully completed at least a 40 hour didactic and clinical training course approved by the New York State Department of Health. Individuals who can demonstrate competence in some or all of the course objectives required for DOH approval may be eligible for exemption from those components of the course; (See Training Requirements) and,
4. Has completed a competency-based post-course preceptorship; and,
5. Has successfully demonstrated all key didactic and clinical competencies to a NYSDOH-approved training program; and,
6. Has a signed letter from the SAFE Program or other provider or institution ensuring qualified medical oversight of the sexual assault forensic examiner; or,

7. Has certification as a sexual assault nurse examiner-adult/adolescent (SANE-A) from the International Association of Forensic Nurses (IAFN) and has a signed letter from the SAFE Program or other provider or institution ensuring qualified medical oversight of the sexual assault forensic examiner.

The Department will also re-certify a sexual assault forensic examiner every three years. An individual who is requesting re-certification by the NYS Department of Health as a sexual assault forensic examiner must certify on the required form and provide evidence to the NYS Department of Health that s/he:

1. Completed of a minimum of fifteen (15) hours of continuing education in the field of forensic science in the past three years;
2. Maintained competency in providing sexual assault examinations. Based upon the examiner's performance of sexual assault examinations during the preceding year, the medical director of the SAFE program or other appropriate institution shall attest to the examiner's continuing competency. If the examiner has had more than a one year lapse in service during the three year period, the medical director should explain how competency was maintained or updated, i.e., via repeating training or by other means;
3. Will be provided with qualified clinical oversight as a sexual assault forensic examiner. A signed letter from the SAFE Program or other provider or institution will satisfy this requirement.

Didactic training must be provided through a training program that has been approved by the NYS Department of Health. Only training programs which demonstrate to the Department the ability to provide training that meets the minimum standards and requirements and enter into a formal agreement with the Department can provide training related to the Department's issuance of certificates of qualification. (See Attachment IV for Training Program Agreement, Appendix C - Section III for Training Program Standards, and Attachment VI for Training Program Application.)

TREATMENT PROTOCOL/STANDARD OF CARE

The Sexual Assault Reform Act (SARA) requires that, absent exigent circumstances, or unless the patient does not disclose a sexual assault at the time of triage, the sexual assault forensic examiner must meet the patient within 60 minutes of arriving at the hospital. In those rare circumstances when a SAFE program does not have a sexual assault examiner available to perform the examination of the sexual assault patient, the hospital must ensure that the examination and associated treatment is provided in a manner that is consistent with Department standards as described below. An on-call schedule consistent with services available should be established. The Department may review a hospital's compliance with SAFE Program standards and rescind a hospital's designation when standards are not being met, e.g., if on-call coverage in a SAFE program falls below an acceptable limit.

Services must comply with all applicable state and federal laws, regulations and standards, including, but not limited to:

APPENDIX C - SECTION I

- NYS Public Health Law Section 2805-j, Treatment of sexual offense patients and maintenance of evidence in a sexual offense;
- NYS Public Health Law Section 2805-p, Emergency Treatment of rape survivors;
- Regulations Title 10 NYCRR 405.9(c) and 405.19(c)(4), Establishment of hospital protocols and maintenance of sexual offense evidence;
- The Department of Health *HIV Prophylaxis Following Sexual Assault: Guidelines for Adults and Adolescents*;
- The Department of Health *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*; and
- The Sexual Assault Reform Act (SARA), Chapter 1 of the Laws of 2000.

The New York State Department of Health has issued the *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, to provide a standard of care to ensure appropriate, consistent and compassionate medical care and forensic evidence collection. SAFE programs, as well as other hospital providers of services to victims of sexual assault, must follow the protocol for treatment and evidence collection as described in the *Protocol*. The *Protocol* correlates with the New York State Sexual Offense Evidence Collection Kit. Hospitals designated as SAFE programs must use the New York State standardized evidence collection kit and instructions. For information regarding treatment of suspected child sexual abuse victims, see Attachment VII.

FACILITIES/ EQUIPMENT

SAFE programs are required to have a private, designated room for the performance of exams. The exam room must have access to a shower and must be accessible to the disabled. If possible, there should be a separate waiting area available to the family or friends of the survivor. Required equipment and supplies include the following:

- A universally accessible exam table
- A dedicated colposcope, with the ability to photo document
- An anoscope
- A camera and film
- An ultraviolet light source and bulbs
- A swab dryer
- Specula in different sizes, preferably with light illumination
- A supply cart and all necessary supplies
- Portable stand for setting up equipment and supplies
- Locked storage, if needed
- Beepers and/or cell phones as needed
- Phlebotomy equipment
- Other necessary medical supplies
- Other necessary forensic supplies, including brown paper bags, plain labels and envelopes, toluidine blue stain, tape, white paper for collecting trace evidence, forensic urine collection containers
- Office supplies for the SAFE Program Director
- Replacement clothing for patients to leave the hospital
- New York State Sexual Offense Evidence Collection Kits
- Drug Facilitated Sexual Assault kits (available through DCJS)

- Sexual assault patient literature for patient information and resources
- Comprehensive sexual assault assessment forms (see Appendix V for sample assessment form)
- Crime Victim's Board (CVB) claim forms and information, and
- Copy(ies) of the *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*.
- Emergency contraception brochure for patients either from DOH or approved by DOH.

DATA/EVALUATION

SAFE programs are required to keep data related to their activities. These data will enable the SAFE program and the hospital to document the extent of the problem, the level of service, determine the cost of the service and provide information for program planning, quality improvement and evaluation purposes. These data must be provided to the Department of Health and the Division of Criminal Justice Services (if funded by them) on a quarterly and annual basis for use in program monitoring and public health and criminal justice planning. Only aggregate, de-identified data will be provided to these state agencies. The Department may require additional information for program monitoring or statutory or other reporting purposes. At a minimum, hospital SAFE programs approved by the Department will be required to collect the following data on a quarterly and annual basis:

- The number of personnel who are certified as sexual assault forensic examiners;
- The number of sexual assault victims who present at the hospital for services;
- The response time of the sexual assault examiner from the time the call was made to the time the examiner arrived;
- The number of sexual assault exams performed by DOH certified sexual assault forensic examiners;
- The number of sexual assault exams performed by personnel other than DOH certified sexual assault forensic examiners;
- The number of victims seeking services who could not be served;
- The number of inpatient admissions resulting from sexual assaults;
- The number of patients served by age, racial/ethnic status and gender;
- Insurance payer status of victims;
- The number of patients accompanied by a rape crisis advocate;
- The number of patients who refused the services of a rape crisis advocate;
- The number of patients who took HIV prophylaxis;
- The number of patients who refused or were ineligible for HIV prophylaxis;
- The number of patients who took prophylaxis against pregnancy related to a sexual assault (emergency contraception);
- The number of examinations where the patient chose to report sexual assault to law enforcement;
- The number of examinations where the patient declined to report sexual assault to law enforcement;
- The number of sexual assault evidence collection kits completed for sexual assault forensic examinations;
- The number of drug facilitated sexual assault kits completed;

- The number of those kits released to law enforcement at the time of the exam;
- The number of those kits released to law enforcement after the exam was completed;
- The number of victims who refuse to have evidence collected; and
- In collaboration with the interdisciplinary task force, the number of sexual assault case dispositions by SAFE and non-SAFE staff to the extent possible, including:
 - the number of arrests
 - number of cases referred to prosecution
 - number of convictions by plea bargaining
 - number of convictions by trial
 - number of cases dropped.

Additional data requirements may be identified by the Department.

NOTE: All hospitals will be required to fill out ICD-CM E-codes (external cause of injury codes) for emergency room patients reporting rape or sexual assault (E960.1) when the SPARCS system is initiated for emergency rooms. This will permit the Department to compare SAFE program hospitals to other institutions in terms of the numbers of these patients treated in SAFE programs compared to hospitals without SAFE programs.

CONTINUOUS QUALITY IMPROVEMENT

Pursuant to 10 NYCRR 405.9 and 405.19, hospitals are required to establish protocols regarding the care of patients reporting sexual assault, and to maintain evidence. These protocols apply to all units in which sexual assault victims are treated; including but not limited to medicine, surgery, emergency, obstetric and gynecology, pediatric, mental health, outpatient and inpatient services, and the range of subspecialty services appropriate for victims of sexual assault.

Each hospital must develop and implement written policies and procedures establishing an internal quality improvement program to identify, evaluate, resolve and monitor actual and potential problems in patient care. SAFE programs should be integrated within the hospital's overall quality improvement plan. For SAFE programs quality improvement components shall include, but not be limited to the following:

1. Chart audit performed periodically on a statistically significant number of sexual assault patient records. The hospital must designate an individual(s) to periodically review sexual assault patient records, along with other appropriate information, to determine the following:
 - How long did the patient wait from arrival to exam commencement?
 - Were appropriately trained staff available to examine the patient?
 - Was all of the necessary equipment available?
 - Was a rape crisis program advocate called to accompany the patient?
 - Was consent appropriately obtained from the patient?
 - Did the patient receive appropriate medical treatment?
 - Was HIV prophylaxis recommended in all cases, where appropriate, per DOH protocol?
 - Was HIV prophylaxis made available on-site to all clients requesting this preventive measure?

- Did the patient receive appropriate counseling related to pregnancy prophylaxis?
 - Did the patient receive on-site pregnancy prophylaxis, if requested?
 - Did the patient receive treatment for STIs?
 - Was forensic evidence collected in a manner that was consistent with law, regulations and standards, including maintenance of the chain of custody?
 - Was an appropriate medical and psychosocial referral and follow-up plan developed for the patient?
 - Was safe discharge assured for the patient?
 - Was confidentiality maintained?
2. A system for developing and recommending corrective actions to resolve identified problems; and
 3. A follow-up process to assure that recommendations and plans of correction are implemented and are effective.

Hospitals designated as SAFE programs are encouraged to work with other area hospitals that have not established SAFE programs to improve the quality of their response to sexual assault patients.

RESOURCE INFORMATION

The following resources are available for hospitals wishing to develop SAFE programs:

- The New York State Department of Health has issued a *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. The *Protocol* has been revised to provide a standard of care that ensures appropriate, consistent and compassionate medical care and forensic evidence collection. Copies of the *Protocol* will be provided to all hospital emergency departments. Additional copies of the *Protocol* can be obtained by contacting the New York State Department of Health, Bureau of Women’s Health Rape Crisis Program at (518) 474-3664.
- The federal Office for Victims of Crime has developed a “SANE Development and Operation Guide” through the national Sexual Assault Resource Service in Minneapolis, Minnesota. Copies of the guide can be obtained by calling or through the website, www.SANE-SART.com.
- The New York State Coalition Against Sexual Assault (NYSCASA) provides technical assistance to individual programs and coordinates trainings that include Sexual Assault Examiners as well as criminal justice personnel, college security personnel, and Rape Crisis Center advocates. For more information, call NYSCASA at (518) 482-4222.
- The New York City Alliance Against Sexual Assault’s Forensic Healthcare Program (FHP) supports the development of Sexual Assault Examiner Programs in New York City by offering ongoing forums for service providers to share information, by organizing an interdisciplinary committee for healthcare providers, rape crisis programs, law enforcement and criminal justice personnel, and through provision of technical assistance to individual programs. For additional information or copies of publications, please call the FHP at (212) 523-5344.

New York State Department of Health (NYSDOH) Standards for the Sexual Assault Forensic Examiner

A. INTRODUCTION

The initial response a victim of rape or sexual assault receives when seeking health care or reporting the crime has a profound influence on that individual's subsequent recovery. The treatment of sexual assault victims by health care providers and the criminal justice system has not been universally adequate. In response to a lack of consistent, adequate and sensitive care, across the nation there has been an emergence and use of health care practitioners known as Sexual Assault Examiners (SAE), Sexual Assault Nurse Examiners (SANE), and Sexual Assault Forensic Examiners (SAFE). These terms are often used interchangeably, but the term SAFE will be used throughout this document. The NYSDOH will certify all appropriately qualified individuals as Sexual Assault Forensic Examiners (SAFEs).

In New York State, comprehensive and high quality medical care, collection of forensic evidence, and respectful and sensitive treatment comprise the standard of care for rape and sexual assault victims presenting at health care settings. The Department of Health recommends the use of SAFEs in all hospitals to assist in meeting this standard. The use of DOH-certified SAFEs is required in hospitals seeking SAFE designation.

These practitioners are committed to ensuring the best medical, legal, and psychological outcomes for the adult victim of sexual assault. They are specially trained to provide care to victims of sexual assault. They are skilled in collecting and preserving forensic evidence to support prosecution and are prepared to provide testimony in a court of law, if the victim decides to report the crime to law enforcement. They provide compassionate emotional support to the victim of sexual assault.

In New York State, sexual assault forensic examiners should work closely with rape crisis victim advocates, other health care providers, police, and prosecutors to form an interdisciplinary team which effectively and compassionately responds to the victim's needs. The results of this interdisciplinary approach are tangible: better outcomes for the victim; comprehensive and high quality health assessment and treatment, better collection and preservation of evidence; and, an increased chance of arrest and conviction of the perpetrator of the crime, if the victim chooses to report the crime. As a member of that team, the sexual assault forensic examiner is responsible for maintaining the highest level of confidentiality, as the needs of the victim are addressed.

The health care setting is often the first institutional contact for the rape victim. Therefore, the Department has developed the following standards associated with the use of sexual assault forensic examiners in the health care setting.

The Department will certify SAFEs based upon these standards. The standards include the qualifications, roles and responsibilities, training and continuing education necessary to be a sexual assault forensic examiner in New York State. These standards are consistent with existing New York State Department of Health laws, regulations and protocols.

B. QUALIFICATIONS

An individual who requesting certification by the NYS Department of Health as a sexual assault forensic examiner must certify on the required form and provide evidence to the NYS Department of Health that s/he:

1. Holds a current license to practice as a registered nurse, nurse practitioner, physician assistant or physician in the State of New York; and,
2. Performs within the scope of practice of the discipline in which s/he holds a license; and,
3. Has a minimum of one year, full-time clinical post-graduate experience; and,
4. Has successfully completed at least a 40 hour didactic and clinical training course approved by the New York State Department of Health. Individuals who can demonstrate competence in some or all of the course objectives required for DOH approval may be eligible for exemption from those components of the course; (See Training Requirements) and,
5. Has completed a competency-based post-course preceptorship. Under the supervision of a preceptor, the individual is provided with the opportunity to refine skills in performing pelvic exams, identifying injuries, using specialized equipment, collecting evidence and documenting injuries. In addition, during the preceptorship, opportunities should be provided to give the examiner the opportunity to understand the roles and responsibilities of the other professionals that interact with sexual assault survivors. For example, the examiner may observe the work of a rape crisis center, law enforcement agency, including the crime lab, the district attorney's office and a courtroom; and,
6. Has successfully demonstrated all key didactic and clinical competencies to a NYSDOH-approved training program; and,
7. Has a signed letter from the SAFE Program or other provider or institution ensuring qualified medical oversight of the sexual assault forensic examiner; or,
8. Has certification as a sexual assault nurse examiner-adult/adolescent (SANE-A) from the International Association of Forensic Nurses (IAFN) and has a signed letter from the SAFE Program or other provider or institution ensuring qualified medical oversight of the sexual assault forensic examiner.

The Department will also recertify a sexual assault forensic examiner every three years. An individual who is requesting recertification by the NYS Department of

Health as a sexual assault forensic examiner must certify on the required form and provide evidence to the NYS Department of Health that s/he:

1. Completed of a minimum of fifteen (15) hours of continuing education in the field of forensic science in the past three years;
2. Maintained competency in providing sexual assault examinations. Based upon the examiner's performance of sexual assault examinations during the preceding year, the medical director of the SAFE program or other appropriate institution shall attest to the examiner's continuing competency. If the examiner has had more than a one year lapse in service during the three year period, the medical director should explain how competency was maintained or updated, i.e., via repeating training or by other means; and,
3. Will be provided with qualified clinical oversight as a sexual assault forensic examiner. A signed letter from the SAFE Program or other provider or institution will satisfy this requirement.

C. ROLES & RESPONSIBILITIES

The roles of the sexual assault forensic examiner are to:

1. Ensure that the services of a trained rape crisis advocate have been offered to the patient prior to treatment, and work with the advocate to ensure victim needs are met;
2. Maintain patient confidentiality;
3. Provide the sexual assault patient with victim-centered, sensitive care which includes a comprehensive medical assessment and evaluation, including a thorough medical examination;
4. Document injuries;
5. Collect and preserve quality forensic evidence using the New York State Sexual Offense Evidence Collection Kit and Drug Facilitated Sexual Assault Kit where appropriate and maintain the chain of custody;
6. Provide prophylaxis for STIs, HIV and pregnancy prevention if the patient so desires;
7. Refer the patient to follow-up medical and psychological care;
8. Refer the patient to other emergency medical services as needed;
9. Provide testimony as to findings when needed, if the patient reports the crime, and the case is prosecuted; and,
10. Testify as an expert witness.

The sexual assault forensic examiner is not to be considered the victim's advocate; to do so would be a conflict in roles and could compromise the sexual assault forensic examiner's position in the courtroom. The role of the rape crisis advocate is to provide the victim with emotional support, advocacy, information, counseling, and accompaniment services, and to facilitate informed decision-making at a time when the victim may be in crisis.

In order to maintain the sexual assault forensic examiner's status as an objective and expert witness, it is recommended that the following information be provided by a Rape Crisis Advocate. In the absence of the Rape Crisis Advocate, the sexual assault forensic examiner may provide information about:

1. Civil and criminal court proceedings and availability of accompaniment and support throughout the legal process;
2. Availability of crime victims' compensation benefits; and,
3. Availability of crisis intervention, telephone and in-person counseling services.

Sexual assault forensic examiner services must comply with all applicable state and federal laws, regulations, standards and protocols listed below.

- NYS Public Health Law Section 2805-i, Treatment of sexual offense patients and maintenance of evidence in a sexual offense;
- NYS Public Health Law Section 2805-p, Emergency Treatment of rape survivors;
- Regulations Title 10 NYCRR 405.9(c) and 405.19(c)(4), Establishment of hospital protocols and maintenance of sexual offense evidence;
- The Department of Health *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*;
- The Department of Health *HIV Prophylaxis Following Sexual Assault: Guidelines for Adults and Adolescents*;
- The Sexual Assault Reform Act (SARA), Chapter 1 of the Laws of 2000

D. QUALITY ASSURANCE

The sexual assault forensic examiner is required to participate in and comply with the quality assurance/improvement programs of the facility in which (s)he works. This includes, but is not limited to participating in training; demonstrating competence to provide appropriate care and treatment of patients who have been sexually assaulted, and updating that competence when new procedures/techniques are introduced. It also includes participating in efforts to identify, evaluate, resolve and monitor actual and potential problems in patient care.

New York State Department of Health (NYSDOH)
Standards for the Sexual Assault
Forensic Examiner Training Programs

Programs that can provide SAFE training:

- ▶ Accredited college or university;
- ▶ School of Nursing or Medicine;
- ▶ Hospital continuing education program;
- ▶ Other institutions able to meet DOH training standards.

Any training program must be able to provide continuing education credits, course credits or contact hours.

Training should be conducted by:

- ▶ Instructors who have demonstrated training experience and expertise in the field of forensic science and sexual assault; and,
- ▶ At least one faculty member must be an active DOH certified sexual assault forensic examiner.

Training Standards

Training should be conducted that is consistent with:

- ▶ New York State Department of Health *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*;
- ▶ New York State Department of Health Standards for Sexual Assault Forensic Examiners (Appendix C - Section III);
- ▶ New York State Department of Health Standards for Sexual Assault Forensic Examiner Programs (Appendix C - Section I);
- ▶ New York State laws and regulations promulgated in relation to the treatment of sexual assault;
- ▶ Any standards developed by the International Association of Forensic Nurses and other such standards developed nationally, as appropriate; and
- ▶ Such other requirements as the Department of Health determines are necessary to ensure that certified SAFE examiners have been trained in a manner which is consistent with applicable laws, rules, regulation, protocols, current standards of care, and the goals of the SAFE program set forth in the program standards and requirements for Sexual Assault Forensic Examiner Programs.

Other training requirements:

Programs must:

- ▶ Have a formalized, 40 hour curriculum, inclusive of a clinical component;
- ▶ The curriculum, course schedule and teaching strategies shall be submitted to the Department for prior approval. Such materials shall be designed to ensure that individuals completing the course have the training and experience necessary to provide services in a manner which is consistent with all applicable laws, rules,

regulations, protocols, current standards of care, and goals of the SAFE program set forth in the program standards and requirements for Sexual Assault Forensic Examiner Programs (see Attachment III) and at a minimum shall include:

- a. Comprehensive training in the dynamics of sexual assault, types of sexual assaults, myths and facts about sexual assault, post traumatic stress and rape trauma syndrome, reactions of survivors and significant others, and the importance of a victim-centered, cooperative, interdisciplinary approach in the treatment of sexual assault survivors;
 - b. The roles and responsibilities of the sexual assault forensic examiner;
 - c. Identifying the components of crisis intervention and supportive techniques to be used with sexual assault survivors;
 - d. Cultural/community considerations;
 - e. Providing services to individuals with disabilities;
 - f. Injury detection and documentation;
 - g. Identifying the elements of physical assessment and evaluation of the patient reporting sexual assault;
 - h. The collection and handling of forensic evidence;
 - i. Documentation procedures;
 - j. Testing for and treatment of sexually transmitted diseases (syphilis, gonorrhea, chlamydia);
 - k. Testing for and treatment of blood-borne diseases (e.g., HIV, hepatitis B, hepatitis C);
 - l. Pregnancy risk assessment, pregnancy testing, and provision of emergency contraception;
 - m. Use of specialized equipment (colposcope, camera, imaging, photography);
 - n. Observing and practicing the clinical skills in completing the exam;
 - o. Judicial processes and providing courtroom testimony;
 - p. Adolescents: parental rights/patient rights;
 - q. Confidentiality and consent;
 - r. Relevant laws, regulations and NYS standards;
 - s. Drug facilitated sexual assault;
 - t. Interviewing skills;
 - u. Ethical issues;
 - v. Long term effects of sexual assault; and,
 - w. Follow-up, referral.
- ▶ The curriculum and associated materials must be updated as needed to reflect new medical and forensic standards for the treatment of victims of sexual assault;
 - ▶ Provide sufficient clinical preceptorship and training experiences for students under qualified supervision;

Training programs must:

- ▶ Keep an accurate record of attendance for each segment of the course;
- ▶ Have regular course evaluation and pre- and post-testing of recipients;
- ▶ Issue documentation of completion to each participant who has successfully demonstrated mastery of all key didactic and clinical competencies required for certified sexual assault forensic examiners;

- ▶ Report to the Department of Health the successful completion of demonstrated mastery of all key didactic and clinical competencies for each participant; and,
- ▶ Collect data as specified by the Department of Health regarding the number of individuals trained, as well as other required data, for the submission to the Department, as needed.

**NEW YORK STATE DEPARTMENT OF HEALTH
SEXUAL ASSAULT FORENSIC EXAMINER (SAFE) PROGRAM
PROVIDER AGREEMENT**

THIS AGREEMENT, made this _____ day of _____, 20____, by and between THE PEOPLE OF THE STATE OF NEW YORK, acting by and through the Commissioner of Health (hereinafter referred to as the STATE) Party of the First Part, and the

a facility licensed pursuant to Public Health Law, Article 28, hereinafter referred to as the PROVIDER, Party of the Second Part;

W I T N E S S E T H:

Whereas, under of the provisions of Article 28 of the New York State Public Health Law, the STATE has general responsibility and jurisdiction over matters related to care provided in hospitals;

Whereas, the care to survivors of rape and sexual assault is a vital component of health care for the residents of New York; and,

Whereas, the New York State Legislature has authorized the Commissioner of Health to set standards and designate hospitals as Sexual Assault Forensic Examiner (SAFE) Programs through enactment of the Sexual Assault Reform Act; and

Whereas, the New York State Department of Health has established standards for comprehensive sexual assault forensic examination services and programs; and,

NOW, THEREFORE, for and in consideration of the mutual promises and covenants herein set forth, the parties agree as follows:

1. The PROVIDER shall provide comprehensive services to victims of rape and sexual assault in accordance with generally accepted standards of practice and patient services and the minimum requirements set forth by the Department. Comprehensive SAFE services shall, at a minimum, include the components of patient care described in the Department's *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*, and the Department's Sexual Assault Forensic Examiner Program

- Standards and Requirements, which are attached hereto and hereby made a part of this AGREEMENT.
2. The PROVIDER shall comply with the Codes, Rules and Regulations of the New York State Department of Health, with appropriate articles of the Public Health Law, and with all other pertinent Federal, State and local laws and regulations.
 3. The PROVIDER shall notify the STATE of circumstances resulting in the inability of the PROVIDER to perform activities and services required under this AGREEMENT.
 4. The STATE, its employees, representatives, and designees shall have the responsibility for determining adherence to this AGREEMENT, as well as the quality of services being provided. The STATE shall conduct such site visits and program reviews as it deems necessary to assess the quality of services being provided and performance under this AGREEMENT.
 5. The PROVIDER shall assure the STATE and its authorized representatives have ready access to all project sites and all financial, clinical and other records and reports relating to the project. The STATE shall have full access to all patient medical records consistent with all legal requirements regarding patient privacy and confidentiality.
 6. The PROVIDER shall make available to the STATE upon request any technical data, information or materials developed for and related to the activities required under this AGREEMENT. This includes, but is not limited to, copies of studies, reports, surveys, proposals, plans, patient charts, schedules and exhibits as may be required and appropriate to the monitoring and evaluation of activities and services required under this AGREEMENT.
 7. The PROVIDER shall maintain program reports including financial, administrative, utilization and patient care data in such a manner as to allow the identification of expenditure, revenue and utilization data associated with health care provided under this AGREEMENT. Records containing the information as described in this paragraph, including patient-specific records, shall be available at all times to the STATE upon request and shall be subject to audit. Patient records shall be held by the STATE in strict confidence, and patients' rights to privacy shall not be abrogated, in accordance with Article 27F of the Public Health Law and 10 NYCRR Part 63.
 8. The PROVIDER shall provide the STATE with reports and data, as required by the Department. All required reports and data shall be completed in a manner satisfactory and acceptable to the STATE.
 9. The PROVIDER shall indemnify and hold the STATE harmless from and against any and all claims, costs, expenses (including attorney's fees), losses and liabilities of whatsoever nature arising out of, occasioned by, or in connection with the PROVIDER'S performance under this AGREEMENT. This clause shall survive the termination of this agreement howsoever caused.

- 10. The STATE may cancel this AGREEMENT at any time giving to the PROVIDER not less than thirty (30) days written notice that on or after a date therein specified, this AGREEMENT shall be deemed terminated and cancelled. Cause for cancellation of this AGREEMENT shall include but not be limited to failure of the PROVIDER to comply with the terms of this AGREEMENT, including but not limited to, failure to provide care consistent with law, regulations and requirements related to SAFE programs; failure to provide the Department with accurate and timely reporting, including program data; and, failure to permit appropriate Department access to perform program and patient record reviews.
- 11. The PROVIDER may request cancellation of this AGREEMENT with 90 days notice to the STATE, and with submission of an acceptable transition plan, when there are extenuating circumstances adversely affecting the PROVIDER. Such cancellation must be requested in writing and include a description of the basis for the request, and shall require approval by the STATE. Such approval shall not be unreasonably withheld. The PROVIDER will continue to be responsible for providing services to patients consistent with requirements for all hospitals.
- 12. This AGREEMENT shall be effective for the period beginning _____ and may continue in effect thereafter with the consent of both parties.

PROVIDER

By: _____
(Signature of CEO)

(Print Name)

(Title)

(Facility Name)

Article 28 Operating Certificate Number

THE PEOPLE OF THE STATE OF
NEW YORK

By: _____
Division of Family Health

Sexual Assault Forensic Examiner Program (SAFE) Hospital Application

INSTRUCTIONS TO FACILITY

Article 28 Hospitals interested in DOH certification as a Sexual Assault Forensic Examiner (SAFE) center of excellence **must** complete this application.

This is a survey of your hospital's capacity to provide SAFE Program services as required by the Sexual Assault Reform Act (SARA), which became effective February 1, 2001. Your response to the questions in this application will be used to measure your facility's compliance with SAFE standards.

Please print or type responses and number all attachments sequentially. Return the completed questionnaire to:

Rape Crisis Program
Bureau of Women's Health
New York State Department of Health
Governor Nelson Rockefeller Empire State Plaza
Corning Tower, Room 1805
Albany, New York 12237-0621

Facility Information

Permanent Facility Identifier Operating Certificate Number

Name of Facility _____

No. and Street _____

City _____ State _____ Zip Code _____

Telephone Number _____ County _____

Institutional Contact Person: (please print)

Telephone First MI Ext. Last

Certification of Information

NOTE: All Article 28 hospitals applying must complete this section.

I, _____,
(please print CEO's name and title)

having legal custody of the information contained herein, do hereby attest that the attached information is true and correct.

Name of Facility Signature of CEO of facility

In the county of _____ Address _____

Mo. Day Year

Section A. Service Data

Please complete the following using the most recent calendar year of data available. Indicate year for which data are provided (____) and the source of the data (_____).

Estimated number of sexual assault patients seen in the hospital in the year indicated.

Section B. Organization and Staffing

In a narrative not to exceed five pages, describe the proposed organization and staffing of the program, including the following:

1. Administrative oversight of the program, including:
 - Name and title of the Program Director;
 - Percent of time the Program Director will be dedicated to the program;
 - A copy of an organization chart and a description of reporting relationships for the SAFE program;
 - A description of the Program Director's role in administering the program, including the percent of time the Director will provide direct care (if any);
2. Clinical oversight for the SAFE Program;
 - Describe how clinical oversight for the program will be provided; if there is no medical director for the program, describe how day-to-day clinical oversight will be ensured and ordering of tests, writing prescriptions, etc., will be handled;
3. Describe how the hospital's emergency department will coordinate with and support the activities of the SAFE program and sexual assault forensic examiners; and,
4. Describe how the hospital will ensure initial and ongoing competency and credentialing of SAFE staff, including certification of sexual assault forensic examiners by the Department.

Section C. Hospital Service Model

1. Is the proposed SAFE program to be (check only one):

self-contained
 regional network model
 other (specify) _____

2. Describe the model and how it will operate in a narrative not to exceed one page. For regional network models, the narrative should describe the hospitals participating in the network, the agency providing sexual assault forensic examiner services, the organization and coordination of services within the network, etc.

3. SAFE services are proposed to be provided:

in the hospital emergency department
 in the hospital in a location near the emergency department
 other (specify) _____

4. Is there a program similar to the proposed DOH certified SAFE program currently in operation in your facility? Yes No

5. In a narrative not to exceed five pages, applicants must provide a description of services offered or proposed under the SAFE model. The description must include how the hospital will ensure:
 - a. Appropriate administrative and clinical oversight is provided to the program;
 - b. SAFE programs are affiliated with and integrated into the policies and procedures and operations of the hospital, particularly the emergency department;
 - c. Initial and ongoing assessment of competency and credentialing of SAFE staff, including certification of sexual assault forensic examiners by the Department (see Specialized Staff Training and Availability, SAFE Program Standards and Requirements; also, see Sexual Assault Forensic Examiner Standards.)
 - d. A well-functioning system to provide triage and assessment;
 - e. A well-functioning on-call and back-up call schedule has been developed so that the patient is met by an examiner within 60 minutes of the patient's arrival in the hospital, except when the patient does not disclose a sexual assault at the time of triage, or under exigent circumstances;
 - f. The rape crisis center is contacted immediately to ensure that a rape crisis advocate is available to offer services to the patient;
 - g. Medical/surgical backup is readily available to the sexual assault forensic examiner;
 - h. An appropriately equipped, private, designated room that can accommodate disabled patients and with access to a shower is available when needed for sexual assault exams;
 - i. Medical treatment and forensic examination of sexual assault survivors is provided in compliance with all relevant laws and regulations and consistent with generally accepted standards of care, including the Department's *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*;
 - j. Prophylaxis for sexually transmitted diseases, HIV and hepatitis B, and prophylaxis against pregnancy resulting from a sexual assault (emergency contraception) is provided on site;
 - k. The New York State Sexual Offense Evidence Collection Kit is used unless a patient refuses to have evidence collected, and evidence is maintained and collected as required by PHL 2805-i;
 - l. The Drug Facilitated Sexual Assault Kit is used as appropriate;
 - m. Replacement clothing is provided to the patient before leaving the hospital;
 - n. Referral and follow-up regarding medical treatment is provided;
 - o. Patient is referred to counseling and support and other needed services;
 - p. Safe discharge is assured for the patient;
 - q. Medical and forensic SAFE services are appropriately documented;
 - r. Information is collected related to the provision of services to victims of sexual assault and confidentiality of the data is ensured; and,
 - s. An effective system of continuous quality improvement is established to ensure SAFE medical and forensic services are in compliance with generally accepted standards of care.

Section D. Interdisciplinary Task Force

In a narrative not to exceed one page, describe the proposed interdisciplinary task force and how this task force will be utilized to develop, maintain and coordinate the SAFE program. See

the SAFE standards for a description of the purpose of the task force and recommended membership.

Section E. Facilities/Equipment

1. In a narrative not to exceed one page, describe the private, designated room and equipment to be used for the SAFE program, including arrangements for individuals with physical disabilities.
2. Indicate the equipment and supplies that will be available to the SAFE program by checking the items below:
 - a. ___ A universally accessible examining table;
 - b. ___ A dedicated colposcope with the ability to photo document;
 - c. ___ An anoscope;
 - d. ___ A camera and film;
 - e. ___ An ultraviolet light source and bulbs;
 - f. ___ A swab dryer;
 - g. ___ Specula in different sizes, preferably with light illumination;
 - h. ___ A supply cart and all necessary supplies;
 - i. ___ Locked storage;
 - j. ___ Beepers and/or cell phones;
 - k. ___ Phlebotomy equipment;
 - l. ___ Other necessary medical supplies;
 - m. ___ Other necessary forensic supplies, including brown paper bags, plain labels and envelopes, toluidine blue stain, tape, white paper for collecting trace evidence, forensic urine collection containers;
 - n. ___ Office supplies for the SAFE Program Director;
 - o. ___ Replacement clothing for patients to wear when leaving the hospital;
 - p. ___ New York State Sexual Offense Evidence Collection Kits;
 - q. ___ Drug Facilitated Sexual Assault kits (available through DCJS);
 - r. ___ Comprehensive sexual assault assessment forms;
 - s. ___ Crime Victims' Board (CVB) claim forms and information;
 - t. ___ Copy(ies) of the *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*;
 - u. ___ Sexual assault patient literature; and,
 - v. ___ Emergency contraception brochures for patients (from DOH or approved by DOH).

Section F. Data and Evaluation

In a narrative not to exceed one page, indicate the hospital's willingness to collect SAFE program data as described in the "SAFE Program Standards and Requirements". Describe how data will be collected and the plan for utilizing the data for program planning, continuous quality improvement and evaluation.

Section G. Continuous Quality Improvement

In a narrative not to exceed two pages, describe the hospital's quality improvement plan to ensure medical and forensic SAFE program services are consistent with laws and regulations

and with generally accepted standards of care, including the NYSDOH *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* and "SAFE Program Standards and Requirements".

Hospitals designated as SAFE programs are encouraged to work with other area hospitals that have not established SAFE programs to improve the quality of their response to sexual assault patients.

Application for New York State Department of Health
Certification for Sexual Assault Forensic Examiner (SAFE)

Applicant Information

Name: _____ Date: _____
Last First MI Mo. Day Year

Address: _____
Street Apt# City State Zip

Telephone: _____ E-Mail: _____

Fax: _____ County(ies) of Practice: _____

Applicant Type: Registered Nurse Physician
(check only one) Nurse Practitioner Physician Assistant

License Number: _____

IAFN SANE-A certified: Yes No

Type of Certification Requested:
 Initial Re-certification

For DOH use only:

- All checklist documentation provided
- Documentation missing: _____
- Qualifications reviewed. Comments: _____

- Status: _____
- Certification granted. Effective dates: _____ to _____
- Entered into database: _____
Date

CHECKLIST OF ATTACHED DOCUMENTATION

Initial Certification

- Copy of current license
 - Proof of a minimum of one year, full-time clinical experience post-graduate
 - A signed letter (of agreement) from the SAFE Program or other provider or institution that will provide qualified medical oversight. The name of the program is:

 - Proof of successful completion of at least a 40 hour didactic and clinical training program conducted by a Department of Health-approved Sexual Assault Forensic Examiner training program, including documentation by the training program that mastery of all key didactic and clinical competencies has been demonstrated
 - Proof of successful completion of a competency-based preceptorship.
- OR**
- IAFN Certification (attach certificate) and has a signed letter (of agreement) from the SAFE Program or other provider or institution that will provide qualified medical oversight. The name of the program is:

(Refer to Standards for DOH Certified Sexual Assault Forensic Examiners)

For Re-certification Only

- Documentation of successful completion of 15 hours of continuing education in forensic science during the previous three years
- Proof that competency in providing sexual assault examinations has been maintained.
- A signed letter (of agreement) from the approved health service facilities or sexual assault forensic examiner program, as appropriate, affirming that qualified clinical oversight will continue to be provided.

Signature of Applicant _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
SEXUAL ASSAULT FORENSIC EXAMINER (SAFE)
TRAINING PROGRAM PROVIDER AGREEMENT

THIS AGREEMENT, made this _____ day of _____ 20____, by and between THE PEOPLE OF THE STATE OF NEW YORK, acting by and through the Commissioner of Health (hereinafter referred to as the DEPARTMENT) Party of the First Part, and the

hereinafter referred to as the PROGRAM, Party of the Second Part;

W I T N E S S E T H:

Whereas, under of the provisions of Article 28 of the New York State Public Health Law, the DEPARTMENT has general responsibility and jurisdiction over matters related to care provided in hospitals; and

Whereas, the care to survivors of rape and sexual assault is a vital component of health care for the residents of New York; and

Whereas, the New York State Legislature has authorized the Commissioner of Health to set standards and designate hospitals as Sexual Assault Forensic Examination (SAFE programs), as well as to certify sexual assault forensic examiners through enactment of the Sexual Assault Reform Act; and

Whereas, the New York State Department of Health has established standards for comprehensive sexual assault forensic examination services and for certification of sexual assault forensic examiners; and

Whereas, the New York State Department of Health has established minimum standards for didactic and clinical training for certified sexual assault forensic examiners and requires that such training occur in a program approved by the Department; and

Whereas, the PROGRAM plans to offer didactic and clinical training programs for certified sexual assault forensic examiners and has expressed an interest in being approved by the Department as a program which meets the minimum standards for didactic and clinical training for certified sexual assault forensic examiners;

NOW, THEREFORE, for and in consideration of the mutual promises and covenants herein set forth, the parties agree as follows:

1. The PROGRAM agrees to provide comprehensive training to individuals

consistent with the curriculum, course schedule, teaching strategies and other material submitted to, and approved by, the Department, as well as all standards and course content which are appended hereto and made a part of this agreement;

2. The PROGRAM agrees to utilize instructors who have demonstrated training experience and expertise in the field of forensic science and sexual assault. At least one faculty member must be an active DOH certified sexual assault forensic examiner;
3. The PROGRAM agrees to update the curriculum and associated materials as needed to reflect new medical and forensic standards for the care and treatment of victims of sexual assault, and agrees to provide such curriculum changes and associated materials to the DEPARTMENT for review, on request;
4. The PROGRAM agrees to keep an accurate record of attendance for each segment of the course, utilize regular evaluation, including pre- and post-testing of participants, and issue documentation of completion to each participant who has satisfactorily demonstrated mastery of the didactic and clinical training for certified sexual assault forensic examiners;
5. The PROGRAM agrees to provide documentation to those individuals who have demonstrated mastery of the didactic and clinical training for certified sexual assault forensic examiners. This documentation will also be provided to the DEPARTMENT in a timely manner;
6. The PROGRAM agrees to provide the DEPARTMENT with ready access to any and all training sites while training is being conducted and to any and all written curricula, course schedules, faculty credentials and related information, records, reports, and other relevant materials;
7. The PROGRAM shall notify the DEPARTMENT of circumstances resulting in the inability of the PROGRAM to perform activities and services required under the AGREEMENT;
8. The PROGRAM shall make available to the DEPARTMENT upon request any technical or course evaluation data, including, but not limited to, the number of individuals trained or the results of pre- and post-training testing related to the training program;
9. The PROGRAM shall indemnify and hold the DEPARTMENT harmless from and against any and all claims, costs, expenses (including attorney's fees), losses and liabilities of whatsoever nature arising out of, occasioned by, or in connection with the PROGRAM performance under this AGREEMENT. This clause shall survive the termination of this agreement howsoever caused.
10. Upon approval of the submitted course curriculum, course schedule, teaching strategies and other required materials, satisfactory demonstration of the PROGRAM's ability to comply with all requirements of this agreement, and execution of this agreement by both parties, the DEPARTMENT agrees to provide Program with a certificate stating that the training program meets the minimum standards and requirements for didactic and clinical training for certified sexual assault forensic examiners;

- 11. The PROVIDER agrees to provide oversight of any preceptorships of candidates seeking SAFE Examiner Certification within the program, which shall include, but not be limited to, ensuring experienced certified sexual assault forensic examiners directly oversee examinations and procedures performed by candidates on sexual assault survivors and provide guidance and evaluation as necessary until the program determines the candidate has the training and experience necessary to perform such examinations and procedures in a manner that is consistent with SAFE standards, sexual assault protocols and any other applicable standards of care.
- 12. The DEPARTMENT, its employees, representatives and designees shall have the responsibility for determining adherence to this and may require immediate remedial action to ensure that such PROGRAM is provided in a manner which is consistent with this agreement;
- 13. The DEPARTMENT may cancel this AGREEMENT at any time giving to the PROVIDER not less than thirty (30) days written notice that on or after a date therein specified, this AGREEMENT shall be deemed terminated and cancelled. Cause for cancellation of this AGREEMENT shall include but not be limited to failure of the PROGRAM to comply with the terms of this AGREEMENT, including but not limited to failure to provide training consistent with standards and failure to provide program data as specified in No. 8 above;
- 14. The PROGRAM may request cancellation of this AGREEMENT when there are extenuating circumstances adversely affecting the PROGRAM. Such cancellation must be requested in writing and include a description of the basis for the request, and shall require approval by the DEPARTMENT. Such approval shall not be unreasonably withheld.

This AGREEMENT shall be effective for the period beginning _____ and may continue in effect thereafter with the consent of both parties.

PROVIDER

By: _____
(Signature)

(Print Name)

(Title)

(Facility Name)

THE PEOPLE OF THE STATE OF NEW YORK

By: _____
Division of Family Health

Appendix C - Attachment V*

Sample Form For Consent/Refusal and Evidentiary Log

*Adapted from a form developed by St. Luke's-Roosevelt Hospital Center

Date: _____ Time of Exam: _____ AM/PM

Patient Name: _____ Contact No.: _____

S.A.F.E ** 1) _____ Contact No.: _____

Examiner(s) 2) _____ Contact No.: _____

Provider: _____ Dept.: _____ Contact No.: _____

(If not a S.A.F.E.** Examiner)

**Sexual Assault Forensic Examiner

Patient Consent/Refusal

I understand that if I consent, an examination for evidence of sexual assault and collection of possible evidence will be conducted. I understand that I may refuse to consent, or I may withdraw consent at any time for any portion of the examination. I understand that the collection of evidence may include photographing injuries, which may include injuries to the genital area. I understand that if I consent, such evidence will be released to the police at this time. If I do not consent to release of evidence at this time, such evidence will be preserved at the Hospital for not less than 30 days.

I consent to:

- | | | |
|--|-----------|----------|
| Physical Examination: | _____ Yes | _____ No |
| Photographing of Injuries: | _____ Yes | _____ No |
| Collection of Evidence: | _____ Yes | _____ No |
| Release of Evidence to Police: | _____ Yes | _____ No |
| Verbal Communications by
Hospital Personnel with
Prosecutorial Agency: | _____ Yes | _____ No |

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Print Name of Witness _____

LOG OF ITEMS TAKEN FROM PATIENT FOR EVIDENCE

-
- | | |
|----|----|
| 1) | 4) |
| 2) | 5) |
| 3) | 6) |

Appendix C - Attachment V

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM

PLEASE PRINT CLEARLY

1. INITIAL ASSESSMENT

Date of Birth: _____ Male _____ Female

__African Descent __Asian/Pacific Islander __Caucasian __Hispanic Other _____

Physical Disability: __Yes __No If Yes describe _____

Primary Language if not English _____ Was interpreter used _____

2. PERTINENT PAST MEDICAL HISTORY

LMP: _____ Allergies _____

Medications: _____

Last Tetanus Immunization: _____ Hepatitis B Immunization Yes No If yes date _____

3. SEXUAL ASSAULT HISTORY

Date of Sexual Assault: _____ Time of Sexual Assault: _____ AM/PM

Time Elapsed between Assault and Exam: _____ days _____ hours

Location of Sexual Assault (include exact address if known): _____

Type of Violations Perpetrated against Survivor during Sexual Assault:

Vaginal Contact	Yes	No	Unsure	Oral Contact (offender to survivor)	Yes	No	Unsure
Anal Contact	Yes	No	Unsure	Oral Contact (survivor to offender)	Yes	No	Unsure
Condom Used	Yes	No	Unsure				
Use of Foreign Object	Yes	No	Unsure	If Yes describe	_____		
Foam/Jelly/Lubricant	Yes	No	Unsure	If Yes describe	_____		
Use of Weapon	Yes	No	Unsure	If Yes describe	_____		
Other:	_____						

Brief Narrative of Assault (optional) _____

Actions Before or After Assault

Has the survivor had consensual sex within the last 72 hours? Yes No Unsure If Yes when: _____

After the sexual assault, has the survivor:

Urinated?	Yes	No	Bathed/showered?	Yes	No	Changed underwear?	Yes	No
Defecated?	Yes	No	Douched?	Yes	No	Changed clothes?	Yes	No
Vomited?	Yes	No	Brushed teeth?	Yes	No	Changed sanitary product?	Yes	No
			Used mouthwash?	Yes	No	Other:	_____	

Appendix C - Attachment V
COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM
 PLEASE PRINT CLEARLY

4. PHYSICAL EXAMINATION General Appearance

General Medical Examination (use Traumagram on pages 6,7,8 as appropriate)

Colposcopic Examination – to be completed prior to pelvic exam and forensic evidence collection
 (use Traumagram on pages 6,7,8 as appropriate)

Female

Labia majora _____	Vagina _____
Labia minora _____	Hymen _____
Clitoris _____	Cervix _____
Posterior fourchette _____	Perineum _____
Fossa navicularis _____	Anus _____
Periurethral _____	Rectum _____
Vestibule _____	Other _____

Male

Penis _____	Rectum _____
Perineum _____	Scrotum _____
Anus _____	Other _____

Pelvic/Genital Examination

Female

Labia majora _____	Vagina _____
Labia minora _____	Hymen _____
Clitoris _____	Cervix _____
Posterior fourchette _____	Perineum _____
Fossa navicularis _____	Anus _____
Periurethral _____	Rectum _____
Vestibule _____	Other _____

Male

Penis _____	Rectum _____
Perineum _____	Scrotum _____
Anus _____	Other _____

Appendix C - Attachment V
COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM
 PLEASE PRINT CLEARLY

5. EXAMINATION TECHNIQUES

Direct Visualization	Yes	No	Evidence Kit Collected	Yes	No	
Bimanual Exam	Yes	No	Photos Taken	Yes	No	If Yes How many? _____
Speculum Exam	Yes	No	Area(s) of Body Photographed:	_____		
Colposcopic Exam	Yes	No	_____			
Toluidene Blue	Yes	No	_____			
Wood's Lamp	Yes	No	_____			
Anoscope	Yes	No	_____			

6. DIAGNOSTIC TESTS

Pregnancy Test	Yes	No	Chlamydia	Yes	No
Gonorrhea: Cervical	Yes	No	VDRL	Yes	No
Urethral	Yes	No	Hepatitis B Serologies	Yes	No
Rectal	Yes	No	Specimens (urine and/or blood for diagnosis of drug-facilitated sexual assault)	Yes	No
Pharyngeal	Yes	No			

7. STI PROPHYLAXIS

Gonorrhea	Yes	No	Chlamydia	Yes	No	Trichomonas/BV	Yes	No	Hepatitis B	Yes	No
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8. HIV POST-EXPOSURE PROPHYLAXIS

Referral Sheet Completed (see next page) Yes No

9. POST-COITAL CONTRACEPTION

Yes No

10. REFERRALS GIVEN

Rape Crisis or Crime Victims Treatment Center ____ Gyn Clinic ____ Patient's Primary Care MD ____

11. CHAIN OF CUSTODY

Name of Person Receiving Evidence _____
 ID#/Shield# _____
 Agency _____

ADDITIONAL NOTES OR COMMENTS

PROVIDER SIGNATURE

Appendix C - Attachment V

SAMPLE SEXUAL ASSAULT PATIENT HIV PEP: REFERRAL SHEET

PLEASE PRINT
CLEARLY

Patient Name: _____

Patient MR#: _____ Age of Patient: _____

Date of Assault: _____ Time of Assault: _____

Date of Emergency Department Visit: _____

Date of Patient's Follow-up Appointment: _____

Time 1st Dose of PEP Given: _____ Date (if different from ED Visit): _____

PEP Medications Given: _____

Labs Sent: CBC Yes No Chem 18 (Admission Panel) Yes No
Hepatitis B serology Yes No
Hepatitis C serology Yes No
Urine pregnancy test result: Positive Negative

Patient Rx'ed for GC, Chlamydia and Syphilis: Yes No Hep B Vaccine: Yes No

Emergency Contraception Provided: Yes No

Check here if patient requests **HIV testing only** (without HIV PEP):

Provider Name: _____ MD PA NP RN
(Please print)

NOTE: Arrange for timely referral to clinic or provider for HIV PEP management.

Referral made to: _____

APPLICATION FOR SEXUAL ASSAULT FORENSIC EXAMINER TRAINING
PROGRAM ACCREDITATION
NEW YORK STATE DEPARTMENT OF HEALTH

Any entity interested in applying for accreditation as a DOH Sexual Assault Forensic Examiner (SAFE) training program **must** complete this application.

Please print or type responses and number all attachments sequentially. Return the completed questionnaire to:

Rape Crisis Program
Bureau of Women's Health
New York State Department of Health
Governor Nelson Rockefeller Empire State Plaza
Corning Tower, Room 1805
Albany, NY 12237-0621

Applicant Information

Permanent Facility Identifier Operating Certificate Number _____
(if appropriate) (if appropriate)

Name of Facility _____

No. and Street _____

City _____ State _____ Zip Code _____

Telephone Number _____ County _____

Training Program Contact Person: (please print)

_____ First MI Last

Telephone Ext.

If not an academic institution, academic affiliation if any: _____

- Type of Entity to Provide SAFE Training:
- College or University
 - School of Nursing or Medicine
 - Hospital Continuing Education Program
 - Other _____
(specify)

Section A. Training Program Staffing

Number of staff who will be providing SAFE training

For each SAFE program faculty, including the Director, submit the following, as appropriate:

1. Name and title of SAFE program faculty member
2. Degrees and licenses/certifications held, and awarding institutions
3. Percent of time or number of hours per week that will be devoted to SAFE training program
4. Proposed role in training program
5. Number of years of training experience
6. Number of years of experience as a sexual assault forensic examiner (if none, so state)
7. Number of SAFE exams completed
8. Year in which last active as a SAFE examiner

Submit an organizational chart that will show the SAFE training program staff, and their relationship to the overall agency.

If your facility provides training in cooperation with other institutions, make sure that the roles and responsibilities of each institution are clearly delineated.

Section B. Indications of Need for Training Program

In a narrative not to exceed one page, describe:

1. The basis on which you judge there to be a need for an additional SAFE training program;
2. Evidence of any community support for this program, and
3. A description of the intended area from which applicants to the program will be drawn.

Section C. Training Curriculum

Number of hours of training in curriculum, of which ____ are clinical.

Submit a copy of your training curriculum, course schedule and related materials, and check below all components of training that are covered in the curriculum:

- Comprehensive training in the dynamics of sexual assault, types of sexual assaults, myths and facts about sexual assault, post traumatic stress and rape trauma syndrome, reactions of survivors and significant others, and the importance of a victim-centered, cooperative, interdisciplinary approach in the treatment of sexual assault survivors;
- The roles and responsibilities of the sexual assault forensic examiner;
- Identifying the components of crisis intervention and supportive techniques to be used with sexual assault survivors;
- Cultural/community considerations;

- Providing services to individuals with disabilities;
- Injury detection and documentation;
- Identifying the elements of physical assessment and evaluation of the patient reporting sexual assault;
- The collection and handling of forensic evidence;
- Documentation procedures;
- Testing for and treatment of sexually transmitted infections (syphilis, gonorrhea, chlamydia);
- Testing for and treatment of blood-borne diseases (e.g. HIV, hepatitis B, hepatitis C);
- Pregnancy risk assessment, pregnancy testing, and provision of emergency contraception;
- Use of specialized equipment (colposcope, camera, imaging, photography);
- Observing and practicing the clinical skills in completing the exam;
- Relevant laws, regulations and NYS standards;
- Judicial processes and providing courtroom testimony;
- Adolescents: parental rights/patient rights;
- Confidentiality and consent;
- Drug facilitated sexual assault;
- Interviewing skills;
- Ethical issues;
- Long term effects of sexual assault; and,
- Follow-up, referral.

In a narrative not to exceed 3 pages, describe:

1. The course goals and objectives;
2. Testing requirements and pass/fail criteria;
3. Attendance requirements and make-up procedure;
4. The course schedule and teaching strategies that are employed in the training program;
5. The didactic materials that are used;
6. The frequency and methods used to update the curriculum to conform to the latest forensic and medical standards;
7. Course evaluation methods; and
8. Pre- and post-testing of students.
9. If not already included in the curriculum, provide:
 - a. the number of clinical forensic exams to be observed,
 - b. the number conducted under close supervision, and
 - c. the number of forensic exams conducted by each student under general preceptorship.

Describe how the agency will ensure initial and ongoing competency and credentialing of SAFE program training staff, including standards for assessing ongoing competency of staff in providing SAFE services.

Section D. Program Resources

In a narrative not to exceed three pages, describe the following:

1. Classrooms, laboratories, administrative offices, and how these spaces are sufficient to accommodate the number of proposed students;
2. Equipment and supplies sufficient to accommodate the number of proposed students;
3. Library resources related to the curriculum as needed, and readily accessible to the students;
4. Clinical field experiences and supervised preceptorship opportunities, objectives, evaluation methods, including:
 - a. All clinical sites to be used
 - b. Indications of signed clinical affiliation agreements, as appropriate
 - c. List of clinical preceptors, qualifications, and contact telephone numbers
 - d. Description of method of selection/orientation/supervision of preceptors.

Section E. Attestations

Check the following boxes if you attest to each of the statements below:

- The proposed training program will assume responsibility for assessing that each student has mastered all key didactic and clinical competencies and can perform a sexual assault exam per New York State guidelines and current standards of practice, and will issue documentation to the student attesting to this. A duplicate of this document will be sent to the Department of Health. A copy of this document will be submitted by students along with their application as a NYSDOH Certified Sexual Assault Forensic Examiner.
- The proposed training program will keep an accurate record of attendance for each segment of the course, and have regular course evaluation and pre- and post-testing of recipients.
- Student files will be available for examination by the State as needed, and will be kept for a minimum of five years, inclusive of attendance records, interim examination results, practical skills examination results, clinical experience documentation, preceptorship notes, counseling notes, and any student correspondence.
- Students will be asked during the application process to this program to attest to the fact that he or she is not currently charged with a crime and has no criminal conviction of any type. Students with charges pending or previous convictions will not be accepted into the training program. This attestation form will be kept in the student's file for a period of five years.

Assurances

I, _____, _____
Name (please print) Title

as the authorized signatory for _____
Name of Training Agency

located at _____, the applicant for
Address

certification as a New York State DOH certified SAFE training facility, do hereby attest that the information submitted on this form and attached hereto is complete and correct.

Signed:

--	--	--	--	--	--

Month Day Year Signature (Authorized Signatory of Training Agency)

Care for Suspected Child Abuse Victims

The NYS Child and Adolescent Sexual Offense Medical Protocol, distributed in 1997, was developed to serve as a resource to practitioners who have experience in the area of child sexual abuse. The Protocol is currently under revision. For additional information or copies of the current document, please call the NYS Rape Crisis Program at 518-474-3664.

In addition, the New York State Department of Health has awarded funding to the Child Abuse Referral and Evaluation (CARE) Program in the SUNY Health Science Center at Syracuse to develop the Child Abuse Medical Provider (CHAMP) network. CHAMP is a statewide network of medical providers specially trained to examine pediatric patients suspected of being sexually abused. The goal of CHAMP is to improve access to quality medical care for suspected child abuse victims by providing physicians, physician's assistants and nurse practitioners with the assessment and diagnostic skills to treat these children. The network has increased the number of accessible expert child sexual abuse medical providers. It is intended that providers will be available within each region within a practical traveling distance for children and families.

For more information about the CHAMP Network, contact:

Dr. Ann Botash
Director of the Child Abuse Referral and Evaluation (CARE) Program
Department of Pediatrics
University Health Care Center
90 Presidential Plaza
Syracuse, New York 13202.

Phone number: (315) 464-5831

Email: botash@upstate.edu

Web site: <http://www.upstate.edu/peds/care>

APPENDIX D

Responsibilities of Hospitals with a DOH-Certified SAFE Program Compared to Hospitals without a SAFE Program Related to the Treatment of Victims of Sexual Assault

Responsibilities of Hospitals with a SAFE Program Compared to Hospitals without a SAFE Program Related to the Treatment of Victims of Sexual Assault

The following compares the responsibilities of hospitals with a DOH-approved Sexual Assault Forensic Examiner (SAFE) Program compared to hospitals without a DOH-approved SAFE program.

<i>Service Component</i>	<i>SAFE PROGRAM</i>	<i>HOSPITALS without a SAFE Program</i>
Provide timely, compassionate, victim-centered care that meets the health care needs of victims, provides emotional support and reduces further trauma to the victim.	Yes	Yes
Provide quality medical care to the patient who reports sexual assault, including screening, evaluation and treatment.	Yes	Yes
Provide services in compliance with Federal EMTALA requirements for all patients presenting for emergency care.	Yes	Yes
Maintain current protocols regarding the care of patients reporting sexual assault and for the collection and storage of sexual offense evidence.	Yes	Yes
Advise the victim of the availability of services provided by a local rape crisis or victim assistance organization, and, secure such services as requested by the patient.	Yes	Yes
Seek the sexual offense victim's consent for collection and storage of privileged sexual offense evidence.	Yes	Yes
Consistent with hospital protocols, conduct an evidentiary examination to collect and preserve evidence, in accordance with current forensic techniques and consistent with the Department's <i>Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault</i> .	Yes	Yes
Ensure the quality of the collection, documentation and preservation of sexual offense evidence.	Yes	Yes
Discuss with the patient the option of reporting the sexual offense to the police, and, upon the request of the patient, report event to the local law enforcement agency.	Yes	Yes
Promote staff opportunities for continuing education.	Yes	Yes
Ensure and monitor for quality, conduct ongoing review and oversight of services provided through the hospital-wide quality assurance program for quality improvement purposes.	Yes	Yes
Maintain a designated and appropriately equipped, private room in or near the hospital's emergency department to meet the specialized needs of sexual assault patients. Accommodations must include access to a shower and be handicapped accessible.	Yes	Recommended

<i>Service Component</i>	<i>SAFE PROGRAM</i>	<i>HOSPITALS without a SAFE Program</i>
Ensure that prophylaxis against pregnancy (emergency contraception) resulting from sexual assault is provided to the patient upon request without delay, unless the patient is already pregnant or the treatment is otherwise medically contraindicated.	Yes	Yes
Provide each patient with an appropriate and safe discharge, including: medical transfer, as necessary, necessary and appropriate follow-up care/referrals, hospital contact person to assist with release or disposal of sexual offense evidence, suitable attire, transportation or appropriate arrangement, etc., as necessary to meet patient needs.	Yes	Yes
Collect required data in accordance with statewide data collection activities (*hospitals without SAFE programs must comply with use of E-codes in ER SPARCS data; SAFE programs must comply with all data submission requirements.)	Yes	Yes*
Maintain a supply and provide to patients, as medically indicated, prophylaxis for sexually transmitted diseases and hepatitis B.	Yes	Yes
Maintain a supply of and provide an initial supply to patients, as medically indicated, of prophylaxis for HIV.	Yes	Yes
Establish an organized program/service specifically to carry out and oversee the provision of sexual assault services. This would include the development and implementation of policies and procedures, detailing staffing requirements, initiating and conducting community outreach programs, participating in an organized data collection system, and routinely following-up with patients/law enforcement officials and crime laboratory personnel regarding evidence collection activities.	Yes	Recommended
Designate a program coordinator to exercise administrative and clinical oversight for the program.	Yes	Recommended
Ensure that the program includes a cohort of specially trained individuals (SAFEs) who have been prepared through an intensive classroom and preceptor training program and have been certified by NYSDOH to conduct sexual assault exams (see attached SAFE Standards for individual providers).	Yes	Recommended
Establish/participate in an interdisciplinary task force that includes local Rape Crisis Centers and other service agencies, and law enforcement representatives/ local prosecutors to develop services that meet community need and to ensure that quality victim services are available.	Yes	Recommended
Sexual Assault Forensic Examiners on-site or on-call available to the patient within 60 minutes of arriving at the hospital, except under exigent circumstances.	Yes	Recommended

<i>Service Component</i>	<i>SAFE PROGRAM</i>	<i>HOSPITALS without a SAFE Program</i>
Routinely use the New York State Evidence Collection Kit, if the patient consents to have evidence collected. Use the drug facilitated sexual assault kit, where appropriate.	Yes	Yes
Coordinate outreach activities in the community and with other hospitals to share best practices, provide training opportunities and promote the availability of the program, to the extent feasible.	Yes	Recommended
Participate in regional and statewide quality assurance initiatives designed to measure program effectiveness and meet reporting requirements.	Yes	Recommended

APPENDIX E

**United States Emergency Medical Treatment
and Active Labor Act;
42 U.S.C. Section 1395dd;
Examination and treatment for
emergency medical conditions and
women in active labor.**

United States Emergency Medical Treatment and Active Labor Act;
42 U.S.C. Section 1395dd; Examination and treatment for emergency
medical conditions and women in active labor.

*Sec. 1395dd. Examination and treatment for emergency medical conditions and
women in labor*

(a) Medical screening requirement.

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either -

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph

(1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer a hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized.

(1) Rule If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless -

(A) (i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that [1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical

APPENDIX E

treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer -

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility -

(i) has available space and qualified personnel for the treatment of the individual, and
(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than \$50,000 (or not more than \$25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section, is subject to a civil money penalty of not more than \$50,000 for each such violation and, if the violation is is[2] gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second

APPENDIX E

sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1), the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review.

(e) Definitions In this section:

(1) The term "emergency medical condition" means -

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women [3] who is having contractions - [3] So in original. Probably should be "woman".

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may

APPENDIX E

be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

Footnotes

[1] So in original. Probably should be followed by a comma.

[2] So in original. Probably should be "woman".

APPENDIX F

Forensic Education Programs in New York State and Status of New York State Department of Health Certification of Sexual Assault Forensic Examiner Training Programs

The following organizations provide education on the subject of forensics. For more information, contact the organization directly.

Organization	DOH Certified
Crisis Services Jeanine Fleming Schnell RN, SANE-A, NYSAFE SAFE Program Coordinator Crisis Services 2969 Main Street Buffalo, NY 14214 (716) 834-2310 Ext. 142 (716) 834-9881 fax jschnell@crisisservices.org	
Family Services, Inc. Erin Ptak, RN, CEN, SANE-A, NYSAFE 29 North Hamilton Street Poughkeepsie, NY 12601 (845) 452-1110 Ext. 3407phone (845) 452-7298 fax eptak@familyservicesny.org	Certified on 4/14/05
Forensic Healthcare Program New York City Alliance Against Sexual Assault Tamara Pollak, RN, MPH, Director 27 Christopher Street, 3 rd Floor New York, New York 10014 (212) 229-0345 phone (212) 229-0676 fax tpollak@nycagainstrape.org	Certified on 8/5/04
Sexual Assault Forensic Examiner Training Program Samaritan Hospital 2215 Burdett Avenue Troy, NY 12180 (518) 447-3517 phone	Application submitted to DOH and under review

Organization	DOH Certified
University of Rochester National Forensic Nursing Institute Dolores Krebs, MS, FNP, SANE-A, PhD Candidate 601 Elmwood Avenue Rochester, NY 14642 (585) 220-7222 pager (585) 442-4663 fax Dolores_Krebs@URMC.Rochester.edu	Application submitted to DOH and under review
Onondaga County SANE Program Anne Galloway, RN, SANE-A, NYSAFE 611 Skyview Terrace Syracuse, NY 13219 (315) 464-2037 phone (315) 464-2051 fax gallowaa@upstate.edu	
Donna Gaffney, RN, DNSc, FAAN, SANE-A, NYSAFE Seton Hall University 57 Winchip Road Summit, NJ 07901 (908) 464-7328 dag1@comcast.net	Application submitted to DOH and under review

APPENDIX G

Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Nurse Examiner (SANE) Services in New York State and Status of Department of Health Certification

County	Coordinator	DOH Certified
Albany	Mara McErlean, MD Albany Medical Ctr. Dept of Emergency Medicine 47 New Scotland Avenue Albany, NY 12208 (518) 262-3773	
Allegany		
Bronx	<p>Elaine Garbaty, LCSW Sexual Assault Treatment Program Coordinator North Central Bronx Hospital 3424 Kossuth Avenue, Room 14A03A Bronx, NY 10467 (718) 519-5722 phone (718) 519-3634 fax Elaine.garbaty@nbhn.net</p> <p>Mary Ryan, MD Lincoln Medical and Mental Health Center 234 East 149th Street Bronx, NY 10451 (718) 579-6011 phone maryryanmd@aol.com</p> <p>Regina Riolo, LCSW Jacobi Medical Center 1400 Pelham Parkway Bronx, NY 10461 (718) 918-5834 phone (718) 918-3480 fax regina.riolo@nbhn.net</p>	<p>Certified 1/7/04</p> <p>Certified on 6/15/05</p> <p>Application Submitted to DOH and Under Review</p>
Broome	<p>Maria Berry Crime Victims Assistance Center Our Lady of Lourdes Hospital 377 Robinson Street Binghamton, NY 13904 (607) 779-3342 pager (607) 773-8370 fax mberry@lourdes.com</p> <p>Barbara Musok UHS - Wilson Hosp. Division P.O. Box 836 Binghamton, NY 13902 (607) 723-3200 phone (607) 773-8370 fax</p>	
Cattaraugus		

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County	Coordinator	DOH Certified
Cayuga	Sue McKelvey, RN Cayuga Medical Center Emergency Department 101 Dates Drive Ithaca, NY 14850 (607) 274-4411 phone (607) 274-4132 fax smckelvey@cayugamed.org	
Chatauqua	Maureen Kohl WCA Hospital Attention : Emergency Room PO Box 840 Jamestown, NY 14702 (716) 664-8120	
Chemung		
Chenango		
Clinton	Evelyn Hammack, LNP Champlain Valley Physicians Hospital 75 Beekman Street Plattsburgh, NY 12901 (518) 562-7370 phone (518) 562-7950 fax ehammack@cvph.org	
Columbia	Jennifer Clark, RN, SANE-A, NYSAFE The R.E.A.C.H. Center 542 Warren Street Hudson, NY 12534 (518) 828-5556 phone (518) 822-9264 fax saneclark@hotmail.com Mary Daggett, RN Columbia Memorial Hospital 1 Prospect Avenue Hudson, NY 12534 518-828-8013	Certified on 8/11/05
Cortland	Rita Wright, Director Aid to Victims of Violence Program YWCA-Cortland 14 Clayton Avenue Cortland, NY 13045 (607) 753-3639 phone (607) 753-8774 fax wright@cortlandywca.org	
Dutchess	Erin Ptak, RN, CEN, CEN, SANE-A Family Services, Inc. 29 North Hamilton Street Poughkeepsie, NY 12601 (845) 452-1110 x. 3407 phone (845) 452-7298 fax eptak@familyservicesny.org	

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County	Coordinator	DOH Certified
Dutchess (continued)	<p>Lisa Corcoran Saint Francis Hospital 241 North Road Poughkeepsie, NY 12601 (845) 483-5073</p> <p>Brenda Lynch Vassar Brothers Medical Center 45 Reade Place Poughkeepsie, NY 12601 (845) 437-3035</p>	<p>Application Submitted to DOH and Under Review</p> <p>Application Submitted to DOH and Under Review</p>
Erie	<p>Bonnie Ann Glica, RN Interim Director of Nursing Erie County Medical Center 462 Grider Street Buffalo, NY 14215 (716) 898-3623 phone</p> <p>Rebecca Roloff, RN, BSN, SANE-A, NYSAFE Women and Children’s Hospital of Buffalo 219 Bryant Street Buffalo, NY 14222 (716) 878-7000</p> <p>Jessica Pirro Suicide Prevention and Crisis Service, Inc. 2969 Main Street Buffalo, NY 14214 (716) 834-2310</p>	<p>Certified 8/16/04</p> <p>Application Submitted to DOH and Under Review</p>
Essex	<p>Sharon St. Louis, RN SANE Coordinator Adirondack Medical Center PO Box 471 Lake Colby Drive Saranac Lake, NY 12983 (518) 897-2316 phone (518) 891-7044 fax sstlouis@amccares.org</p> <p>Pat Chamberlain, RN Moses Luddington Hospital 1019 Wicker Street Ticonderoga, NY 12883 (518) 585-2831 phone (518) 585-3875 fax pchamberlain@mlh.aanet.org</p> <p>Meredith King Elizabethtown Community Hosp. PO Box 277 75 Park Street Elizabethtown, NY 12932 (518) 873-3068 phone (518) 873-3075 fax mking@ech.org</p>	

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County	Coordinator	DOH Certified
Franklin, Fulton, Genesee, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison	<p>Deborah LaFlesh ER Nurse Manager/SANE Coordinator Alice Hyde Medical Center 133 Park Street Malone, NY 12953 (518) 483-3000 X626 phone dlaflesh@alicehyde.com</p> <p>Megan Murphy Adirondack Medical Center Lake Colby Drive PO Box 471 Saranac Lake, NY 12983 (518) 897-2439</p>	
Kings	<p>Acquilles Yago Woodhull Medical and Mental Health Center 760 Broadway Brooklyn, NY 11206 (718) 963-6860 phone (718) 630-3045 fax Acquilles.Yago@Woodhullhc.nychhc.org</p> <p>Maria Schaefer Director of Domestic Violence and Sexual Assault Department of Emergency Medicine Kings County Hospital Center 451 Clarkson Avenue Brooklyn, NY 11203 (718) 613-8113 phone (718) 245-2887 fax schafem@nychhc.org</p> <p>Lillian Tsai Long Island College Hospital 339 Hicks Street Brooklyn, NY 11201 (718) 780-1459 phone (718) 780-2942 fax Ltsai@chpnet.org</p> <p>Marie Longo, RN, BSN, MA, NY SAFE Coney Island Hospital 2601 Ocean Parkway Brooklyn, NY 11235 (718) 616-4349 phone (718) 616-4388 fax</p>	<p>Certified 12/31/04</p> <p>Certified 9/1/04</p> <p>Certified 12/31/04</p> <p>Application Submitted to DOH and Under Review</p>
Monroe	<p>Anna Potter, RCC Director PP Rochester/Syracuse Region 114 University Avenue Rochester, NY 14605 (585) 546-2777 phone (585) 454-7001 fax apotter@pprsr.org</p>	

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County	Coordinator	DOH Certified
Monroe (continued)	Dolores Krebs, MS, FNP, SANE-A, PhD Candidate Strong Memorial Hospital 601 Elmwood Avenue Rochester, NY 14642 (585) 220-7222 pager (585) 442-4663 fax dolores_krebs@urmc.rochester.edu	
Montgomery		
Nassau	<p>Ann Wilson-Rizk, Director Coordinator, CASC Emergency Patient Care North Shore University Hospital 300 Community Drive Manhasset, NY 10030 (516) 562-4125 phone (516) 562-2871 fax arizk@nshs.edu</p> <p>Janine Sadowski, CSW, CASC SANE Coordinator Nassau County Coalition Against Domestic Violence Third Floor, 250 Fulton Ave. Hempstead, NY 11550 (516) 572-0700 phone (516) 572-0715 fax jsadowski@cadvnc.org</p> <p>Eileen Mascia Nassau County District Attorney's Office 262 Old Country Road Mineola, NY 11501 (516) 571-3786</p>	Certified 8/11/05
New York	<p>Lorraine Giordano, MD St. Luke's-Roosevelt Hospital 411 West 114th Street 2C New York, NY 10025 (212) 523-5659 phone (212) 523-8000 fax</p> <p>Kerry Stout, LMSW Emergency Department Beth Israel Medical Center 1st Avenue and 16th Street New York, NY 10003 (212) 420-2832 phone (212) 420-2863 fax kstout@bethisraelny.org</p> <p>Jenny Castillo, MD SAFE Program Medical Director Harlem Hospital Center 506 Lenox Avenue New York, NY 10037 (212) 939-2253 phone (212) 939-2136 fax</p>	<p>Certified 5/12/04</p> <p>Certified on 8/10/04</p> <p>Application Submitted to DOH and Under Review</p>

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County	Coordinator	DOH Certified
New York (continued)	<p>Carla Brekke, LMSW SAFE Program Director Bellevue Hospital Center 462 First Avenue New York, NY 10016 (212) 562-3435 phone carla.brekke@bellevue.nychhc.org</p> <p>Mona Singh, MD SAFE Program Medical Director Metropolitan Hospital Center 1901 First Avenue New York, NY 10029 (212) 423-6464 phone (212) 423-6383 fax mona_m_singh@yahoo.com</p> <p>George Lewert, LMSW SAFE Program Manager New York Presbyterian Hospital Columbia University Medical Center (212) 305-5130 phone (212) 305-6196 fax gel9002@nyp.org</p> <p>Barbara Richardson, MD, NYSAFE SAFE Medical Director Mount Sinai Medical Center Department of Emergency Medicine Box 1620, One Gustave L. Levy Place New York, NY 10029-6574 (212) 659-1660 phone (212) 426-1946 fax Barbara.richardson@mssm.edu</p>	<p>Certified 8/11/05</p> <p>Application Submitted to DOH and Under Review</p> <p>Certified 8/11/05</p>
Niagara	<p>Ginny Klonowski, RN, MS, SANE-A Lockport Memorial Hospital 521 East Avenue Lockport, NY 14094 (716) 514-5683 phone (716) 514-5783 ginnyk@localnet.com</p> <p>Desiree Korbs, RN Safe Program Coordinator Niagara Falls Memorial Medical Center 621 Tenth Street Niagara Falls, NY 14302 (716) 278-4163 phone (716) 278-4693 fax desiree.korbs@nfmcc.org</p>	<p>Application Submitted to DOH and Under Review</p> <p>Application Submitted to DOH and Under Review</p>
Oneida		

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County	Coordinator	DOH Certified
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Ontario	<p>Virginia Hebda, RN, MS, CEN F.F. Thompson Foundation, Inc. 350 Parrish Street Canandaigua, NY 14424 (585) 396-6607 phone (585) 396-6154 fax Virginia.hebda@thompsonhealth.com</p>	Application Submitted to DOH and Under Review
Orange	<p>Angel Henze, SANE Coordinator Mental Health Association In Orange County 20 Walter Street Goshen, NY 10924 (845) 294-7411 x. 250 phone (845) 294-7348 fax ahenze@mharoganeny.com</p>	
Orleans		
Oswego		
Otsego	<p>Debra Harvey-Baldo, RN, Director of Nursing Emergency Room A.O. Fox Hospital 1 Norton Avenue Oneonta, NY 13820 (607) 431-5207 phone (607) 431-5007 fax dharvey@foxcarenetwork.com</p>	
Putnam	<p>Marsha Perlman, MSW Putnam/Northern Westchester Women's Resource Center 935 S. Lake Blvd., Suite #2 Mahopac, NY 10541 (845) 628-9284 phone (845) 628-9272 fax marshaperlman@rcn.com or pnwwrc@suscom.net</p>	

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County	Coordinator	DOH Certified
Queens	<p>Rebecca Carman, CSW City Hospital Center at Elmhurst 79-01 Broadway Elmhurst, NY 11373 (718) 334-2732 phone (718) 334-2664 carmanr@nychhc.org</p>	Certified 12/31/04
	<p>Kashif Creary Queens Hospital Center 82-68 164th Street Jamaica, NY 11432 (718) 883-3504 phone (718) 883-6115 fax</p>	Application submitted to DOH and under review
	<p>Kiran Sharma, MD SAFE Program Medical Director Saint Vincent Catholic Medical Centers Mary Immaculate Hospital 152-11 89th Avenue Jamaica, NY 11432 (718) 558-2404 phone (718) 558-9571 fax ksharma@svcmcnyc.org</p>	Application Submitted to DOH and Under Review
Rensselaer	<p>Samaritan Hospital 2215 Burdett Avenue Troy, NY 12180 (518) 271-3638 voice mail</p>	Certified 2/1/05
Richmond	<p>Jean Gordon, RN Staten Island University Hospital 355 Bard Avenue Staten Island, NY 10310 (718) 818-2054 phone (718) 818-2112 fax jgordon@svcmcnyc.org</p>	
Rockland	<p>Tara Healy Coordinator of SAFE Program Rockland Family Shelter 2 Congers Road New City, NY 10956 (845) 634-3391 phone (845) 634-3396 fax thealy@rocklandfamilyshelter.org</p>	
	<p>Erica DiMaio, RN SAFE Program Coordinator Nyack Hospital 160 North Midland Avenue Nyack, NY 10960 (845) 348-2345 phone (845) 348-6899 fax</p>	Application to DOH - Inactive

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County	Coordinator	DOH Certified
Rockland (continued)	<p>Cathy Fogarty Good Samaritan Hospital 255 Lafayette Street Suffern, New York (845) 368-5000 X 5505 phone (845) 368-5347 fax cfogarty@tshs.org</p> <p>Anita Conklin Rockland County District Attorney's Office 1 South Main Street, Suite 500 New City, NY 10956 (845) 638-5351</p>	Application Submitted to DOH and Under Review
St. Lawrence	<p>Judy Markell, RN, MA Massena Memorial Hospital One Hospital Drive Massena, NY 13662 (315) 769-4263 phone (315) 769-4278 fax jmarkell@massenahospital.org</p> <p>Jan Knickerbocker, RN Canton Potsdam Hospital 50 Leroy Street Potsdam, NY 13676 (315) 261-5910 phone jknickerbocker@cphospital.net</p> <p>Jenny Flanagan, RN Claxton-Hepburn Medical Center 214 King Street Ogdensburg, NY 13669 (315) 393-8880 X5120 phone jflanagan@chmed.org</p> <p>Carrie Whalen Citizens Against Violent Acts, Inc. 20 East Main Street Canton, NY 13617 (315) 386-2761</p>	<p>Certified 7/29/05</p> <p>Certified 7/29/05</p> <p>Certified 7/29/05</p>
Saratoga	<p>Judy Sleater Director of Nursing Saratoga Hospital 211 Church Street Saratoga Springs, NY 12866 (518) 583-8313 phone (518) 580-2541 fax jsleater@saratogacare.org</p> <p>Maggie Fronk Domestic Violence & Rape Crisis Services 480 Broadway LL-20 Saratoga Springs, NY 12866 (518) 583-0280</p>	

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County	Coordinator	DOH Certified
Schenectady	<p>Ellis Hospital Emergency Department 1101 Nott Street Schenectady, NY 12305 (518) 243-4121 phone (518) 423-4340 fax</p> <p>Janine Pustolka Planned Parenthood Mohawk Hudson, Inc. 414 Union Street Schenectady, NY 12305 (518) 374-5353</p>	Application to DOH - Inactive
Schoharie		
Schuyler		
Seneca	<p>Jaimi Schoemaker SAFE Director Rape & Abuse Crisis Services of the Finger Lakes P.O. Box 624 Penn Yan, NY 14527 (315) 536-9654 phone (315) 536-0637 fax Yates@racsfl.org</p>	
Steuben	<p>Betsy Fusco, NYSAFE Ira Davenport Memorial Hospital 7571 Route 54 Bath, New York 14810 (607) 776-8564 phone (607) 776-8817 fax edubsf@idmh.org</p> <p>Sarah Chapman Steuben County District Attorney's Office 3 East Pulteney Square Bath, NY 14810 (607) 776-9631</p>	Application Submitted to DOH and Under Review
Suffolk	<p>Allison Ryan Coordinator of Community Education & SANE Victims Information Bureau of Suffolk County PO Box 5483 Happauge, NY 11788 (631) 360-3730 phone (631) 360-0089 fax sane@vibs.org</p> <p>Central Suffolk Hospital 1300 Roanoke Avenue Riverhead, NY 11901 (631) 548-6000 phone (631) 727-8890 fax</p>	Certified 8/11/05

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County	Coordinator	DOH Certified
Suffolk (continued)	<p>Mitchell Pollack, MD SAFE Medical Director John T. Mather Memorial Hospital 75 North Country Road Port Jefferson, NY 11777-2190 (631) 473-1320 phone (631) 474-4667 fax mpollack@matherhospital.org</p> <p>James Golbin Suffolk County Probation Department Yaphank Avenue PO Box 188 Yaphank, NY 11980-0188 (631) 852-5105</p>	Certified 8/11/05
Sullivan		
Tioga		
Tompkins	<p>Louise Miller, Program Director The Advocacy Center PO Box 164 Ithaca, NY 14851 (607) 277-4003 phone (607) 277-4003 fax lmiller@odyssey.net</p> <p>Kathy Schlather Tompkins County Department of Social Services 320 West State Street Ithaca, NY 14850 (607) 274-5678</p>	
Ulster		
Warren	<p>Ann Marie Cross, SANE Coordinator Glens Falls Hospital 100 Park Street Glens Falls, NY 12801 (518) 926-4263 phone (518) 926-3110 fax amcross@glensfallshosp.org</p> <p>Janine Pustolka Planned Parenthood Mohawk Hudson, Inc. 414 Union Street Schenectady, NY 12305 (518) 374-5353 phone</p>	
Washington		

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County	Coordinator	DOH Certified
Wayne	<p>Cynthia Witter, RNC, BSN, SANE-A Nurse Manager of Women's Care Newark-Wayne Community Hospital, Inc. PO Box 111 Driving Park Avenue Newark, NY 14513 (315) 332-2280 phone (315) 332-2790 fax cindy.witter@viahealth.org</p> <p>Emilie Sisson Wayne County Rural Health Network Driving Park Avenue, PO Box 111 Newark, NY 14513 (315) 483-3266 phone</p>	
Westchester	<p>Victims Assistance Services Westchester Community Opportunities Program 2269 Sawmill River road, Building 3 Elmsford, NY 10523-3833 (914) 345-3113 phone (914) 345-3515 fax</p>	
Wyoming		
Yates	<p>Jaimi Shoemaker Rape & Abuse Crisis Services of the Finger Lakes, Inc. PO Box 624 Penn Yan, NY 14527 (315) 536-9654</p>	

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**10 NYCRR 405.9 (c) and 405.19;
Establishment of hospital protocols
and maintenance of
sexual offense evidence.**

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10 NYCRR 405.9 (c) and 405.19; Establishment of hospital protocols and maintenance of sexual offense evidence.

Section 405.9 (c) Sexual offense evidence. The hospital shall provide for the maintenance of evidence of sexual offenses. The hospital shall establish and implement written policies and procedures which are consistent with requirements of this section and which shall apply to all service units of the hospital which treat victims of sexual offenses, including but not limited to medicine, surgery, emergency, pediatric and outpatient services.

(1) The sexual offenses subject to the provisions of this subdivision shall be sexual misconduct, rape, sodomy, sexual abuse and aggravated sexual abuse.

(2) The sexual offense evidence shall include, as appropriate to the injuries sustained in each case, slides, cotton swabs, clothing, hair combings, fingernail scrapings, photographs, and other items as may be specified by the local police agency and forensic laboratory.

(3) The hospital shall refrigerate items of sexual offense evidence where necessary for preservation and ensure that clothes and swabs are dried, stored in paper bags and labeled, and shall mark and log each item of evidence with a code number corresponding to the patient's medical record.

(4) Privileged sexual offense evidence shall mean evidence which is associated with the hospital's treatment of injuries sustained as a result of a sexual offense.

(5) Sexual offense evidence that is not privileged shall mean that which is obtained from victims of suspected child abuse or maltreatment, and that derived from other alleged crimes, attendant to or committed simultaneously with the sexual offense, which are required to be reported to a police agency, such as bullet or gunshot wounds, powder burns or other injury arising from or caused by the discharge of a gun or firearm, or wounds which may result in death and which are inflicted by a knife, ice pick or other sharp or pointed instrument. Nothing in this paragraph shall prevent the reporting of diseases or medical condition required by law to be reported to health authorities.

(6) Upon admission of a patient who is an alleged sexual offense victim, the hospital shall seek patient consent for collection and storage of the sexual offense evidence and explain the specific rights of the patient and obligations of the hospitals as outlined in this paragraph. The hospital shall store the sexual offense evidence in a locked, separate and secure area for not less than thirty days unless:

(i) the patient signs a statement directing the hospital not to collect and keep privileged evidence;

(ii) such evidence is privileged and the patient signs a statement directing the hospital to surrender the evidence to the police before thirty days has expired;

(iii) the evidence is not privileged and the police request its surrender before thirty days has expired;

(7) After thirty days from commencement of treatment, the refrigerated evidence shall be discarded and the clothes shall be returned upon the patient's request.

(8) The hospital shall designate a staff member to coordinate the required actions and to contact the local police agency and forensic laboratory to determine their specific needs and requirements for the maintenance of sexual offense evidence.

Section 405.19 - Emergency services

(a) General.

(1) Emergency services shall be provided in accordance with this subdivision or subdivisions (b) through (e) of this section as appropriate.

(2) If emergency services are not provided as an organized service of the hospital, the governing body and the medical staff shall assure:

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- (i) prompt physician evaluation of patients presenting emergencies;
- (ii) initial treatment and stabilization or management; and
- (iii) transfer, where indicated, of patients to an appropriate receiving hospital.

(b) Organization.

(1) The medical staff shall develop and implement written policies and procedures approved by the governing body that shall specify:

(i) the responsibility of the emergency services to evaluate, initially manage and treat, or admit or recommend admission, or transfer patients to another facility that can provide definitive treatment;

(ii) the organizational structure of the emergency service, including the specification of authority and accountability for services; and

(iii) explicit prohibition on transfer of patients based on their ability or inability to pay for services.

(2) The emergency service shall be directed by a licensed and currently registered physician who is board-certified or board-admissible for a period not to exceed five years after the physician first attained board admissibility in emergency medicine, surgery, internal medicine, pediatrics or family practice, and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-certified or board-admissible in psychiatry for a period not to exceed five years after the physician first attained board-admissibility, in psychiatry may serve as psychiatrist director of a separately operated psychiatric emergency service. Directors of separately operated psychiatric emergency services need not be qualified to perform ACLS and ATLS.

(3) An emergency service shall have laboratory and X-ray capability, including both fixed and mobile equipment, available 24 hours a day, seven days a week, to provide test results to the service within a time considered reasonable by accepted emergency medical standards.

(c) General policies and procedures.

(1) The location and telephone number of the State Department of Health-designated poison control center, shall be maintained at the telephone switchboard and in the emergency service.

(2) All cases of suspected child abuse or neglect shall be treated and reported immediately to the New York State Central Register of Child Abuse and Maltreatment pursuant to procedures set forth in article 6, title 6 of the Social Services Law.

(3) Domestic violence. The emergency service shall develop and implement policies and procedures which provide for the management of cases of suspected or confirmed domestic violence victims in accordance with the requirements of section 405.9(e) of this Part.

(4) The emergency service shall establish and implement written policies and procedures for the maintenance of sexual offense evidence as part of the hospital-wide provisions required by this Part. An organized protocol for victims of sexual offense, including medical and psychological care shall be incorporated into such policies and procedures.

(5) The emergency service, in conjunction with the discharge planning program of the hospital, shall establish and implement written criteria and guidelines specifying the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services but not in need of inpatient hospital care;

(6) An admission and discharge register shall be current and shall include at least the following information for every individual seeking care:

- (i) date, name, age, gender, ZIP code;
- (ii) expected source of payment;

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(iii) time and means of arrival, including name of ambulance service for patients arriving by ambulance;

(iv) complaint and disposition of the case; and

(v) time and means of departure, including name of ambulance service for patients transferred by ambulance.

(7) There shall be a medical record that meets the medical record requirements of this Part for every patient seen in the emergency service. Medical records shall be integrated or cross-referenced with the inpatient and outpatient medical records system to assure the timely availability of previous patient care information and shall contain the prehospital care report or equivalent report for patients who arrive by ambulance.

(8) Review of the hospital emergency service shall be conducted at least four times a year as a part of the hospital's overall quality assurance program. Receiving hospitals shall report to sending hospitals and emergency medical systems, as appropriate, all patients that die unexpectedly within 24 hours upon arrival at the receiving hospitals. These patient mortalities shall be included in both hospitals' quality assurance review.

(d) Staffing. The following requirements are applicable to all organized emergency services:

(1) Emergency Service physician services shall meet the following requirements:

(i) The emergency services attending physician shall meet the minimum qualifications set forth in either clause (a) or clause (b) of this subparagraph.

(a) The emergency services attending physician shall be a licensed and currently registered physician who is board-certified in emergency medicine, surgery, internal medicine, pediatrics or family practice and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-certified in psychiatry may serve as psychiatrist attending in a separately operated psychiatric emergency service. A licensed and currently registered physician who is board-admissible in one of these specialty areas and is currently certified in ATLS or who has training and experience equivalent to ATLS and has successfully completed a course in ACLS or has had training and experience equivalent to ACLS may be designated as attending physician for a period not to exceed five years after the physician has first attained board-admissibility except that the requirement to be qualified to perform ATLS and ACLS shall not be applicable to qualified psychiatrist attendings in a separately operated psychiatric emergency service. Physicians who are board-certified or admissible, for a period not to exceed five years after the physician first attained board-admissibility, in other specialty areas may be designated as attending physicians for patients requiring their expertise.

(b) The emergency services attending physician shall meet the following minimum standards. The physician:

(1) is licensed and currently registered;

(2) has successfully completed one year of post-graduate training;

(3) has, within the past five years accumulated 7,000 documented patient contact hours or hours of teaching medical students, physicians-in-training, or physicians in emergency medicine. Up to 3,500 hours of documented experience in hospital-based settings or other settings in the specialties of internal medicine, family practice, surgery or pediatrics may be substituted for the required hours of emergency medicine experience on an hour-for-hour basis;

(4) has acquired in each of the last three years, an average of fifty hours or more per year of continuing medical education pertinent to emergency medicine or to the specialties of practice which contributed to meeting the 7,000 hours requirement specified in subclause (3) of this clause;

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(5) is currently certified in ATLS or has training and experience equivalent to ATLS; and
(6) has successfully completed a course in advanced cardiac life support (ACLS) or has had training and experience equivalent to ACLS.

(ii) There shall be at least one emergency service attending physician on duty 24 hours a day, seven days a week. For hospitals that exceed 15,000 unscheduled visits annually, the attending physician shall be present and available to provide patient care and supervision in the emergency service. As necessitated by patient care needs, additional attending physicians shall be present and available to provide patient care and supervision. Appropriate subspecialty availability as demanded by the case mix shall be provided promptly in accordance with patient needs. For hospitals with less than 15,000 unscheduled emergency visits per year, the supervising or an attending physician need not be present but shall be available within twenty minutes;

(iii) Other medical staff practitioner services provided in the emergency service shall be in accordance with the privileges granted the individual; and

(iv) Every medical-surgical specialty on the hospital's medical staff which is organized as a department or clinical service and where practitioner staffing is sufficient, shall have a schedule to provide coverage to the emergency service by attending physicians in a timely manner, 24 hours a day, seven days a week, in accordance with patient needs.

(2) Nursing services:

(i) There shall be at least one supervising emergency services registered professional nurse present and available to provide patient care services in the emergency service 24 hours a day, seven days a week;

(ii) Emergency services supervising nurses shall be licensed and currently registered and possess current, comprehensive knowledge and skills in emergency health care. They shall have at least one year of clinical experience, be able to demonstrate skills and knowledge necessary to perform basic life support measures, have successfully completed a course in ACLS or have had training and experience equivalent to ACLS and maintain current competence in ACLS as determined by the hospital;

(iii) Registered professional nurses in the emergency service shall be licensed and currently registered professional nurses who possess current, comprehensive knowledge and skills in emergency health care. They shall have at least one year of clinical experience, have successfully completed an emergency nursing orientation program and be able to demonstrate skills and knowledge necessary to perform basic life support measures. Within one year of assignment to the emergency service, each emergency service nurse shall have successfully completed a course in ACLS or have had training and experience equivalent to ACLS and shall maintain current competence in ACLS as determined by the hospital.

(iv) Additional registered professional nurses and nursing staff shall be assigned to the emergency service in accordance with patient needs. If, on average:

(a) the volume of patients per eight-hour shift is under 25, an additional registered professional nurse shall be available as needed to assist the supervising registered professional nurse with delivery of direct patient care; or

(b) the volume of patients per eight-hour shift is over 25, there shall be a minimum of two registered professional nurses per shift assigned to provide direct patient care. As patient volume and intensity increases, the total number of available registered professional nurses shall also be increased to meet patient care needs;

(3) Registered physician's assistants and nurse practitioners:

(i) patient care services provided by registered physician's assistants shall be in accordance with section 405.4 of this Part;

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(ii) patient care services provided by certified nurse practitioners shall be in collaboration with a licensed physician whose professional privileges include approval to work in the emergency service and in accordance with written practice protocols for these services; and

(iii) the registered physician assistants and the nurse practitioners shall meet the following standards:

(a) The registered physician assistants and the nurse practitioners in the emergency service shall have successfully completed a course in ACLS or have had training and experience equivalent to ACLS when determined necessary by the hospital to meet anticipated patient needs or when a physician assistant or nurse practitioner is serving as the sole practitioner on duty in a hospital with less than 15,000 unscheduled emergency visits per year;

(b) Registered physician assistants and nurse practitioners in the emergency service shall have had training and experience equivalent to ATLS when determined necessary by the hospital to meet anticipated patient needs or when a physician assistant or nurse practitioner is serving as the sole practitioner on duty in a hospital with less than 15,000 unscheduled emergency visits per year.

(4) Support personnel. There shall be sufficient support personnel assigned to the emergency service to perform the following duties on a timely basis: patient registration, reception, messenger service, acquisition of supplies, equipment, delivery and labeling of laboratory specimens, responsible for the timely retrieval of laboratory reports, obtaining records, patient transport and other services as required.

(e) Patient care.

(1) The hospital shall assure that all persons arriving at the emergency service for treatment receive emergency health care that meets generally accepted standards of medical care.

(2) Every person arriving at the emergency service for care shall be promptly examined, diagnosed and appropriately treated in accordance with triage policies and protocols adopted by the emergency service and approved by the hospital. All patient care services shall be provided under the direction and control of the emergency services director or attending physician. In no event shall a patient be discharged unless evaluated and treated as necessary by an appropriately privileged physician, physician's assistant, or nurse practitioner. Hospitals which elect to use physician's assistants or nurse practitioners shall develop and implement written policies and treatment protocols subject to approval by the governing body that specify patient conditions that may be treated by a registered physician's assistant or nurse practitioner without direct visual supervision of the emergency services attending physician.

(3) Hospitals that have limited capability for receiving and treating patients in need of specialized emergency care shall develop and implement standard descriptions of such patients, and have triage protocols and formal written transfer agreements with hospitals that are designated as being able to receive and provide definitive care for such patients. Patients in need of specialized emergency care shall include, but not be limited to:

(i) trauma patients and multiple injury patients;

(ii) burn patients with burns ranging from moderate uncomplicated to major burns as determined by use of generally acceptable methods for estimating total body surface area;

(iii) high risk maternity patients or neonates or pediatric patients in need of intensive care;

(iv) head-injured or spinal-cord injured patients;

(v) acute psychiatric patients;

(vi) replantation patients; and

(vii) dialysis patients.

APPENDIX H

(4) Hospitals shall verbally request ambulance dispatcher services to divert patients with life threatening conditions to other hospitals only when the chief executive officer or designee appointed in writing, determines that acceptance of an additional critical patient would endanger the life of that patient or another patient. Request for diversion shall be documented in writing and, if warranted, renewed at the beginning of each shift.

(5) Where observation beds are used, they shall be for observation and stabilization and they shall not be used for longer than eight hours duration. Patients in these beds shall be cared for by sufficient staff assigned to meet the patients needs. At the end of eight hours observation or treatment the patient must be admitted to the inpatient service, be transferred in accordance with paragraph (6) of this subdivision, or be discharged to self-care or the care of a physician or other appropriate follow-up service.

(6) Patients shall be transferred to another hospital only when:

- (i) the patient's condition is stable or being managed;
- (ii) the attending practitioner has authorized the transfer; and
- (iii) administration of the receiving hospital is informed and can provide the necessary resources to care for the patient; or
- (iv) when pursuant to paragraph (2) of this subdivision, the patient is in need of specialized emergency care at a hospital designated to receive and provide definitive care for such patients.

(7) Hospitals located within a city with a population of one million or more persons shall apply and, if accepted, participate to the full extent of their capability in the emergency medical service which is operated by such city or such city's health and hospitals corporation.

(f) Quality assurance. Quality assurance activities of the emergency service shall be integrated with the hospital-wide quality assurance program and shall include review of:

- (1) arrangements for medical control and direction of prehospital emergency medical services;
- (2) provisions for triage of persons in need of specialized emergency care to hospitals designated as capable of treating those patients;
- (3) emergency care provided to hospital patients, to be conducted at least four times a year, and to include prehospital care providers, emergency services personnel and emergency service physicians; and
- (4) adequacy of staff training and continuing education.

APPENDIX I

Suggested Supplies and Equipment for Sexual Assault Evaluations

APPENDIX I

Suggested Supplies and Equipment for Sexual Assault Evaluations

Anoscopes
Beeper or cell phone as needed
Camera and film
Crime Victims Board (CVB) claim forms and information
Dedicated colposcope, with ability to photo document
Forensic urine container
Gray top tubes for blood toxicology screening
Locked storage, if needed
Medical supplies
New York State Department of Health *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*
New York State Sexual Offense Evidence Collection Kits
Drug Facilitated Sexual Assault Kits
Office supplies for SAFE Program Director
Other forensic supplies, including brown paper bags, roll of exam paper, plain labels and envelopes, toluidine blue stain, tape
Phlebotomy equipment
Portable stand for setting up equipment and instruments
Replacement clothing for patients to leave hospital
Sexual assault patient literature
Specula, various sizes, preferably with light illumination
Supply cart and necessary supplies
Swab dryer
Ultraviolet light source and bulbs
Universally accessible examining table

APPENDIX J

New York State Penal Law; Section 265.25;
Certain wounds to be reported.

New York State Penal Law; Section 265.26;
Burn injury and wounds to be reported.

APPENDIX J

New York State Penal Law; Section 265.25; Certain wounds to be reported.

Sec. 265.25 Certain wounds to be reported.

Every case of a bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun or firearm, and every case of a wound which is likely to or may result in death and is actually or apparently inflicted by a knife, icepick or other sharp or pointed instrument, shall be reported at once to the police authorities of the city, town or village where the person reporting is located by:

- (a) the physician attending or treating the case; or
- (b) the manager, superintendent or other person in charge, whenever such case is treated in a hospital, sanitarium or other institution.

Failure to make such report is a class A misdemeanor. This subdivision shall not apply to such wounds, burns or injuries received by a member of the armed forces of the United States or the state of New York while engaged in the actual performance of duty.

New York State Penal Law; Section 265.26: Burn injury and wounds to be reported.

§ 265.26 Burn injury and wounds to be reported.

Every case of a burn injury or wound, where the victim sustained second or third degree burns to five percent or more of the body and/or any burns to the upper respiratory tract or laryngeal edema due to the inhalation of super-heated air, and every case of a burn injury or wound which is likely to or may result in death, shall be reported at once to the office of fire prevention and control. The state fire administrator shall accept the report and notify the proper investigatory agency. A written report shall also be provided to the office of fire prevention and control within seventy-two hours. The report shall be made by (a) the physician attending or treating the case; or (b) the manager, superintendent or other person in charge, whenever such case is treated in a hospital, sanitarium, institution or other medical facility. The intentional failure to make such report is a class A misdemeanor.

Article 130 of the State Penal Code - *Sexual Offenses* may be obtained at <http://public.leginfo.state.ny.us>. Select "Laws of New York" and then select "Penal Code".

APPENDIX K

**New York State Public Health Law; Section 2803-d;
Reporting abuses of persons receiving care or services in
residential health care facilities.**

**New York State Penal Law; Section 130.05; Sex offenses; lack
of consent.**

New York State Public Health Law; Section 2803-d;
Reporting abuses of persons receiving care or services in
residential health care facilities.

§ 2803-d. Reporting abuses of persons receiving care or services in residential health care facilities.

1. The following persons are required to report in accordance with this section when they have reasonable cause to believe that a person receiving care or services in a residential health care facility has been physically abused, mistreated or neglected by other than a person receiving care or services in the facility: any operator or employee of such facility, any person who, or employee of any corporation, partnership, organization or other entity which, is under contract to provide patient care services in such facility, and any nursing home administrator, physician, medical examiner, coroner, physician's associate, specialist's assistant, osteopath, chiropractor, physical therapist, occupational therapist, registered professional nurse, licensed practical nurse, dentist, podiatrist, optometrist, pharmacist, psychologist, certified social worker, speech pathologist and audiologist.
2. In addition to those persons required to report suspected physical abuse, mistreatment or neglect of persons receiving care or services in residential health care facilities, any other person may make such a report if he or she has reasonable cause to believe that a person receiving care or services has been physically abused, mistreated or neglected in the facility.
3. Reports of suspected physical abuse, mistreatment or neglect made pursuant to this section shall be made immediately by telephone and in writing within forty-eight hours to the department. Written reports shall be made on forms supplied by the commissioner and shall include the following information: the identity of the person making the report and where he can be found; the name and address of the residential health care facility; the names of the operator and administrator of the facility, if known; the name of the subject of the alleged physical abuse, mistreatment or neglect, if known; the nature and extent of the physical abuse, mistreatment or neglect; the date, time and specific location of the occurrence; the names of next of kin or sponsors of the subject of the alleged physical abuse, mistreatment or neglect, if known; and any other information which the person making the report believes would be helpful to further the purposes of this section. Such written reports shall be admissible in evidence, consistent with the provisions of paragraph (f) of subdivision six of this section, in any actions or proceedings relating to physical abuse, mistreatment or neglect of persons receiving care or services in residential health care facilities. Written reports made other than on forms supplied by the commissioner which contain the information required herein shall be treated as if made on such forms.
4. Any person who in good faith makes a report pursuant to this section shall have immunity from any liability, civil or criminal, for having made such a report. For the purpose of any proceeding, civil or criminal, the good faith of any person required to report instances of physical abuse, mistreatment or neglect of persons receiving care or services in residential health care facilities shall be presumed.
5. Notwithstanding the provisions of section two hundred thirty of this chapter, any licensed person who commits an act of physical abuse, mistreatment or neglect of a person receiving care or services in a residential health care facility and any licensed person required by this section to report an instance of suspected physical abuse, mistreatment or neglect of a person receiving care or services in a residential health care facility who fails to do so shall be guilty of unprofessional conduct in the practice of his or her profession.

6. (a) Upon receipt of a report made pursuant to this section, the commissioner shall cause an investigation to be made of the allegations contained in the report. Notification of the receipt of a report shall be made immediately by the department to the appropriate district attorney if a prior request in writing has been made to the department by the district attorney. Prior to the completion of the investigation by the department, every reasonable effort shall be made to notify, personally or by certified mail, any person under investigation for having committed an act of physical abuse, mistreatment or neglect. The commissioner shall make a written determination, based on the findings of the investigation, of whether or not sufficient credible evidence exists to sustain the allegations contained in the report or would support a conclusion that a person not named in such report has committed an act of physical abuse, neglect or mistreatment. A copy of such written determination, together with a notice of the right to a hearing as provided in this subdivision, shall be sent by registered or certified mail to each person who the commissioner has determined has committed an act of physical abuse, neglect or mistreatment. A letter shall be sent to any other person alleged in such report to have committed such an act stating that a determination has been made that there is not sufficient evidence to sustain the allegations relating to such person. A copy of each such determination and letter shall be sent to the facility in which the alleged incident occurred.

(b) The commissioner may make a written determination, based on the findings of the investigation, that sufficient credible evidence exists to support a conclusion that a person required by this section to report suspected physical abuse, mistreatment or neglect had reasonable cause to believe that such an incident occurred and failed to report such incident. A copy of such written determination, together with a notice of the right to a hearing as provided in this subdivision, shall be sent by registered or certified mail to each person who the commissioner has determined has failed to report as required by this section.

(c) All information relating to any allegation which the commissioner has determined would not be sustained shall be expunged one hundred twenty days following notification of such determination to the person who made the report pursuant to this section, unless a proceeding pertaining to such allegation is pending pursuant to article seventy-eight of the civil practice law and rules. Whenever information is expunged, the commissioner shall notify any official notified pursuant to paragraph (a) of this subdivision that the information has been expunged.

(d) At any time within thirty days of the receipt of a copy of a determination made pursuant to this section, a person named in such determination as having committed an act of physical abuse, neglect or mistreatment, or as having failed to report such an incident, may request in writing that the commissioner amend or expunge the record of such report, to the extent such report applies to such person, or such written determination. If the commissioner does not comply with such request within thirty days, such person shall have the right to a fair hearing to determine whether the record of the report or the written determination should be amended or expunged on the grounds that the record is inaccurate or the determination is not supported by the evidence. The burden of proof in such hearing shall be on the department. Whenever information is expunged, the commissioner shall notify any official notified pursuant to paragraph (c) of this subdivision that the information has been expunged.

(e) Except as hereinafter provided, any report, record of the investigation of such report and all other information related to such report shall be confidential and shall be exempt from disclosure under article six of the public officers law.

(f) Information relating to a report made pursuant to this section shall be disclosed under any of the following conditions:

(i) pursuant to article six of the public officers law after expungement or amendment, if any, is made in accordance with a hearing conducted pursuant to this section, or at least forty-five days after a written determination is made by the commissioner concerning such report, whichever is later; provided, however, that the identity of the person who made the report, the victim, or any other person named, except a person who the commissioner has determined committed an act of physical abuse, neglect or mistreatment, shall not be disclosed unless such person authorizes such disclosure;

(ii) as may be required by the penal law or any lawful order or warrant issued pursuant to the criminal procedure law; or

(iii) to a person who has requested a hearing pursuant to this section, information relating to the determination upon which the hearing is to be conducted; provided, however, that the identity of the person who made the report or any other person who provided information in an investigation of the report shall not be disclosed unless such person authorizes such disclosure.

(g) Where appropriate, the commissioner shall report instances of physical abuse, mistreatment or neglect or the failure to report as required by this section, to the appropriate committee on professional conduct for the professions enumerated in subdivision one of this section when a determination has been made after the commissioner has provided an opportunity to be heard. The commissioner shall report instances of physical abuse, mistreatment, neglect or misappropriation of resident property by a nurse aide or other unlicensed individual and any brief statement by the nurse aide or other unlicensed individual disputing the finding to the nursing home nurse aide registry established pursuant to section twenty-eight hundred three-j of this article when a determination has been made after the commissioner has provided an opportunity to be heard.

7. In addition to any other penalties prescribed by law, any person who commits an act of physical abuse, neglect or mistreatment, or who fails to report such an act as provided in this section, shall be deemed to have violated this section and shall be liable for a penalty pursuant to section twelve of this chapter after an opportunity to be heard pursuant to this section.

8. No residential health care facility or officer or employee thereof shall discharge or in any manner discriminate or retaliate against any person in any residential health care facility, or any relative, or sponsor thereof, or against any employee of the facility, or against any other person because such person, relative, legal representative, sponsor or employee has made, or is about to make, a report pursuant to this section, or has testified, or is about to testify, in any proceeding relating to physical abuse, mistreatment or neglect of a person receiving care or services in a residential health care facility. The supreme court may grant injunctive relief to any person subject to such retaliation or discrimination. Any violation of this subdivision shall be punishable pursuant to section twelve of this chapter.

9. No later than March fifteenth of every year the commissioner shall prepare and transmit to the governor and the legislature a report on the incidents of physical abuse, mistreatment and neglect of persons receiving care or services in residential health care facilities. No information concerning any individual or facility shall be disclosed in a report made pursuant to this subdivision, or in any other report, except information which would be available pursuant to article six of the public officers law as provided in this section. Nothing in this section shall be construed to prohibit the maintenance or disclosure of, or require the expungement of, statistical data which would not reveal the identity of any person or facility.

10. An investigation shall be made of each incident reported pursuant to this section, but only the provisions of paragraphs (e) and (f) of subdivision six, and subdivisions two, four, eight and nine shall apply to physical abuse by persons receiving care or services in residential health care facilities.

11. The commissioner shall adopt rules and regulations necessary to implement this section.

[New York State Penal Law; Section 130.05; Sex offenses; lack of consent.](#)

[§ 130.05 Sex offenses; lack of consent.](#)

1. Whether or not specifically stated, it is an element of every offense defined in this article that the sexual act was committed without consent of the victim.

2. Lack of consent results from:

(a) Forcible compulsion; or

(b) Incapacity to consent; or

(c) Where the offense charged is sexual abuse or forcible touching, any circumstances, in addition to forcible compulsion or incapacity to consent, in which the victim does not expressly or impliedly acquiesce in the actor's conduct; or

(d) Where the offense charged is rape in the third degree as defined in subdivision three of section 130.25, or criminal sexual act in the third degree as defined in subdivision three of section 130.40, in addition to forcible compulsion, circumstances under which, at the time of the act of intercourse, oral sexual conduct or anal sexual conduct, the victim clearly expressed that he or she did not consent to engage in such act, and a reasonable person in the actor's situation would have understood such person's words and acts as an expression of lack of consent to such act under all the circumstances.

3. A person is deemed incapable of consent when he or she is:

(a) less than seventeen years old; or

(b) mentally disabled; or

(c) mentally incapacitated; or

(d) physically helpless; or

(e) committed to the care and custody of the state department of correctional services or hospital, as such term is defined in subdivision two of section four hundred of the correction law, and the actor is an employee, not married to such person, who knows or reasonably should know that such person is committed to the care and custody of such department or hospital. For purposes of this paragraph, "employee" means

(i) an employee of the state department of correctional services who performs professional duties in a state correctional facility consisting of providing custody, medical or mental health services, counseling services, educational programs, or vocational training for inmates;

(ii) an employee of the division of parole who performs professional duties in a state correctional facility and who provides institutional parole services pursuant to section two hundred fifty-nine-e of the executive law; or

(iii) an employee of the office of mental health who performs professional duties in a state correctional facility or hospital, as such term is defined in subdivision two of section four hundred of the correction law, consisting of providing custody, or medical or mental health services for such inmates; or

(f) committed to the care and custody of a local correctional facility, as such term is defined in subdivision two of section forty of the correction law, and the actor is an employee, not married to such person, who knows or reasonably should know that such person is committed to the care and custody of such facility. For purposes of this paragraph, "employee" means an employee of the local correctional facility where the

person is committed who performs professional duties consisting of providing custody, medical or mental health services, counseling services, educational services, or vocational training for inmates; or

(g) committed to or placed with the office of children and family services and in residential care, and the actor is an employee, not married to such person, who knows or reasonably should know that such person is committed to or placed with such office of children and family services and in residential care. For purposes of this paragraph, "employee" means an employee of the office of children and family services or of a residential facility who performs duties consisting of providing custody, medical or mental health services, counseling services, educational services, or vocational training for persons committed to or placed with the office of children and family services and in residential care; or

(h) a client or patient and the actor is a health care provider or mental health care provider charged with rape in the third degree as defined in section 130.25, criminal sexual act in the third degree as defined in section 130.40, aggravated sexual abuse in the fourth degree as defined in section 130.65-a, or sexual abuse in the third degree as defined in section 130.55, and the act of sexual conduct occurs during a treatment session, consultation, interview, or examination.

APPENDIX L

**Department of Health
Patient Care Hotline Numbers**

APPENDIX L

Department of Health Patient Care Hotline Numbers

The Patient Care Hotlines may be used 24 hours a day, seven days a week, to report situations requiring immediate action.

During normal business hours (Monday - Friday, 8:30 am - 4:30pm), you may also contact or write to the Health Department office in your region at the address and telephone number listed below.

Office	Patient Care Hotline (after hours, weekends and to report patient abuse at any time)	General Information
Capital District Field Office Frear Building - 2 nd Floor 2 Third Street Troy, New York 12180	800-220-7184	(518) 408-5300
Western Regional Office (Buffalo) 584 Delaware Avenue Buffalo, New York 14202	800-425-0314	(716) 847-4320
Western Regional Office (Rochester) Triangle Building 335 East Main Street Rochester, New York 14604	800-837-9018	(585) 423-8104
Central Field Office (Syracuse) 217 South Salina Street Syracuse, New York 13202	800-425-0319	(315) 426-7666
New York Metropolitan Area Regional Office (New York City Office) 5 Penn Plaza New York, New York 10001	800-425-0316	(212) 268-6689
New York Metropolitan Area Regional Office (New Rochelle Office) 145 Huguenot Street - 6 th Floor New Rochelle, New York 10801	800-425-0320	(914) 654-7058
New York Metropolitan Area Regional Office (Hauppauge Office) 300 Motor Parkway Hauppauge, New York 11788	800-425-0323	(631) 231-1880

APPENDIX M

Directory of Rape Crisis Providers

Rape Crisis Providers Report

County	Project Contact	Agency/Program	Address	Contact Information
Albany	Jane McEwen Executive Director	NYS Coalition Against Sexual Assault NYS Statewide Coalition	28 Essex St. Albany NY 12206	Phone 518) 482-4222 Hotline None Fax (518) 482-4248 Email jmcewen@nyscasa.org
Albany	Elizabeth Martin Director	Albany County Crime Victims & Sexual Violence Center	112 State St. Room 1100 Albany NY 12207	Phone (518) 447-5500 Hotline (518) 447-7716 Fax (518) 447-7102 Email cvsvc@albanycounty.com
Allegany	Crystal Vossler Victim Services	Community Action, Inc. Rape Crisis Program	85 N. Main St. Wellsville NY 14895	Phone (585) 593-4685 Hotline (888) 945-3970 Fax (585) 593-4603 Email cvossler@ccaction.org
Bronx	Christine Marr Director	Kingsbridge Heights Comm. Ctr. Child Sexual Abuse Program Director	3101 Kingsbridge Terrace Bronx NY 10463	Phone (718) 884-0700 Hotline (718) 884-0700 Fax (718) 884-0858 Email cmarr@khcc-nyc.org
Bronx	BethAnn Holzhay Project Director	Bronx DAs Office Crime Victims Assistance Unit	198 East 161st Street 5th Floor Bronx NY 10451	Phone (718) 590-2114 Hotline (800) 862-2637 Fax (718) 590-2532 Email holzhayb@bronxda.nyc.gov
Bronx	Rocio Gilman Rape Crisis Counselor	SAFE HORIZON Bronx Community Program	2530 Grand Concourse 7th Floor Bronx NY 10458	Phone (718) 933-1000 Hotline (212) 227-3000 Fax (718) 584-5307 Email rgilman@safehorizon.org
Broome	Suzanne Rauscher Clinical Coordinator	Crime Victims Assistance Center, Inc.	377 Robinson Street Binghamton NY 13904	Phone (607) 723-3200 Hotline (607) 722-4256 Fax (607) 773-8370 Email suzanne@cvac.us
Cattaraugus	Amy Maitland Division Director, VSP	Cattaraugus Community Action, Inc. Rape Crisis Program	25 Jefferson St. PO Box 308 Salamanca NY 14779	Phone (716) 945-1041 X19 Hotline (888) 945-3970 Fax (716) 945-1301 Email amaitland@ccaction.org
Cayuga	Heather Petrus Program Supervisor	Cayuga Counseling Services SAVAR	17 E Genesee St Auburn NY 13021	Phone (315) 253-9795 Hotline (315) 252-2112 Fax (315) 253-3255 Email ccsinc@baldcom.net
Chautaugua	Stacey Tanner Director, DV/RC	The Salvation Army Rape Crisis Services	P.O. Box 368 Jamestown NY 14702	Phone (716) 664-6567 Hotline (800) 252-8748 Fax (716) 484-2793 Email stanner@USE.salvationarmy.org

County	Project Contact	Agency/Program	Address	Contact Information
Chemung	Denise Townley Program Coordinator	PP of the Southern Finger Lakes, formerly Rape Crisis of the Southern Finger Lakes	155 E. Church St. Elmira NY 14901	Phone (607) 796-0220 Hotline (888) 810-0093 Fax (607) 796-0337 Email denise.townley@ppfa.org
Chenango	Jim M. Sereno Program Director	Chenango County Catholic Charities Domestic Violence/Crime Victims Program	3 O'Hara Dr. Norwich NY 13815	Phone (607) 334-3532 Hotline (607) 336-1101 Fax (607) 336-5779 Email jsereno@ccofcc.com
Clinton	Jennifer Belli, MS, NCC, CV/SA Coordinator	Crisis Center of CEF	36 Brinkerhoff Street Plattsburgh NY 12901	Phone (518) 561-2699 Ext 107 Hotline (800) 342-5767 Fax (518) 561-1813 Email jenniferb@crisiscentermny.org
Columbia	Pamela Sackett Executive Director	The REACH Center	542 Warren Street Hudson NY 12534	Phone (518) 828-5556 Hotline (888) 943-2472 Fax (518) 822-9264 Email psackett@valstar.net
Cortland	Rita Wright Director	YWCA-Cortland Aid to Victims of Violence Program	14 Clayton Avenue Cortland NY 13045	Phone (607) 753-3639 Hotline (607) 756-6363 Fax (607) 753-8774 Email wright@cortlandywca.org
Delaware	Dorothy Strachman Program Coordinator	Delaware Opportunities, Inc. SAFE Against Violence	47 Main Street Delhi NY 13753	Phone (607) 746-2165 Hotline (607) 746-6278 or 866 457-7233 Fax (607) 746-6269 Email do_sav@hotmail.com
Dutchess	Aaron Ptak Rape Crisis Coordinator	Family Services, Inc. Sexual Trauma & Recovery Services	29 North Hamilton Street Poughkeepsie NY 12601	Phone (845) 452-1110 Hotline (845) 452-7272 Fax (845) 452-7298 Email eptak@familyservicesny.org
Erie	Jessica Pirro-Benigni Project Director	Suicide Prevention & Crisis Services Inc.	2969 Main Street Buffalo NY 14214	Phone (716) 834-2310 Hotline (716) 834-3131 Fax (716) 834-9881 Email jpirro@crisiservices.org
Essex	Erin Ganter Manager/Counselor	Crisis Center of CEF	PO Box 566 Elizabethtown NY 12932	Phone (518) 873-6514 Hotline (800) 342-5767 Fax (518) 873-6539 Email ering@crisiscentermny.org
Franklin	Erin Gantner Manager/Counselor	Crisis Center of CEF	566 E. Main St. PO Box 611 Malone NY 12953	Phone (518) 483-8211 Hotline (800) 342-5767 Fax (518) 481-5222 Email ering@crisiscentermny.org
Fulton	Pamela Hyde Coordinator for Fulton Co.	PP Mohawk Hudson, Inc Rape Crisis Service	40 N. Main St. Suite 8 Gloversville NY 12078	Phone (518) 773-0040 Hotline (518) 843-4367 Fax (518) 725-8307 Email phyde@nycap.rr.com

County	Project Contact	Agency/Program	Address	Contact Information
Genesee	Theresa Asmus Staff Counselor	PP Rochester/Syracuse Region, Inc. Rape Crisis Service of Genesee Co.	222 W. Main St. Batavia NY 14020	Phone (585) 344-0541 Hotline (800) 527-1757 Fax (585) 344-2831 Email tasmus@pprsr.org
Greene	Pamela Sackett Director	The REACH Center	542 Warren Street Hudson NY 12534	Phone (518) 943-4482 Hotline (888) 943-2472 Fax (518) 822-9264 Email cgrcc@taconic.net
Hamilton	Rosemary Vennero Co-Director	YWCA of the Mohawk Valley Hamilton-YWCA - Utica	1000 Cornelia Street Utica NY 13502	Phone (315) 866-6738 Hotline (800) 342-5767 Fax None Email rvennero@ywcamv.org
Hamilton	Leigh Ann Healy Coordinator	PP Mohawk Hudson, Inc. Hamilton-PP Mohawk Hudson, Inc.	414 Union Street Schenectady NY 12305	Phone (518) 792-4305 Hotline (866) 307-4086 Fax (518) 792-3791 Email lahealy@nycap.rr.com
Hamilton	Erin Gantner Manager/Counselor	Crisis Center of CEF Hamilton-CEF	PO Box 566 Elizabethtown NY 12932	Phone (518) 873-6514 Hotline (800) 342-5767 Fax Email ering@crisiscenternny.org
Herkimer	Wendy Bazan Project Director	YWCA of the Mohawk Valley Sexual Violence Services	205 N. Washington Herkimer NY 13350	Phone (315) 866-0748 Hotline (315) 866-4120 Fax (315) 866-0852 Email wbazan@ywcamv.org
Jefferson	Roland Charlton III Sr. Direct Services	Victims Assistance Center of Jefferson County	120 Arcade St. Watertown NY 13601	Phone (315) 782-1823 Hotline (315) 782-1855 Fax (315) 782- 3760 Email victimsasstctr@hotmail.com
Kings	Michelle Vigeant, EdM, Director of Sexual Assault	SAFE HORIZON - ADMINISTRATIVE SAFE HORIZON - ADMINISTRATIVE	180 Livingston Street Suite 305 Brooklyn NY 11201	Phone (718) 928-6952 Hotline Fax (718) 928-6951 Email mvigeant@safehorizon.org
Kings	Lillian Tsai Director	Long Island College Hospital RC Intervention Program	339 Hicks Street Brooklyn NY 11201	Phone (718)780-1459 Hotline (718) 780-1459 Fax (718) 780-2942 Email ltsai@chpnet.org
Kings	Joanna Johnson Rape Crisis Counselor	SAFE HORIZON Brooklyn Community Program	180 Livingston St. Suite 305 Brooklyn NY 11201	Phone (718) 928-6929 Hotline (800) 621-4673 Fax (718) 928-6952 Email jsjohnson@safehorizon.org
Kings	Jackie Winston Director	SAFE HORIZON Brooklyn Child Advocacy Ctr	320 Schemerhorn St. 1st Floor Brooklyn NY 11217	Phone (718) 330-5405 Hotline (212) 577-7777 Fax (718) 330-5648 Email jwinston@safehorizon.org

County	Project Contact	Agency/Program	Address	Contact Information
Kings	Marie Thermidor Rape Crisis Coordinator	Church Avenue Merchants Block Association, Rape Crisis Program	885 Flatbush Avenue Brooklyn NY 11226	Phone (718) 282-5575 Hotline (800) 310-2449 Fax (718) 282-5997 Email mariet@camba.org
Lewis	Kathleen Purington Director of DV/RC	Lewis County Opportunities, Inc. HELP Hotline	8265 State Route 812 Lowville NY 13367	Phone (315) 376-8202 Hotline (315) 376-4357 Fax (315) 376-8421 Email dvrcdir@lcopps.org
Livingston	Donna Rivers Counselor	PP Rochester/Syracuse Region, Inc. Rape Crisis Service of Livingston Co.	116 Main Street Mt. Morris NY 14510	Phone (585) 658-2370 Hotline 1-800-527-1757 Fax (585) 658-2909 Email drivers@pprsr.org
Madison	Cheryl Matzke Project Director	Liberty Resources Victims of Violence	218 Liberty St. Oneida NY 13421	Phone (315) 363-0048 Hotline (315) 366-5000 Fax (315) 363-0052 Email cmatzke@liberty-resources.org
Monroe	Anna Potter Coordinator	PP Rochester/Syracuse Region, Inc. Rape Crisis Service	114 University Avenue Rochester NY 14605	Phone (585) 546-2777 Hotline (585) 546-2777 Fax (585) 454-7001 Email apotter@pprsr.org
Montgomery	Veronica Parks County Coordinator	PP Mohawk Hudson, Inc Rape Crisis Service	Amsterdam Memorial Hospital Route 30 - North Amsterdam NY 12010	Phone (518) 843-0945 Hotline (518) 843-4367 Fax (518) 843-0595 Email vgparks@nycap.rr.com
Nassau	Liza Papazian MS CSW Director	Nassau County CADV Inc. Center for Rape/ Sexual Assault Services	250 Fulton Avenue 3rd Floor Hempstead NY 11550	Phone (516) 572-0700 Hotline (516) 222-2293 Fax (516) 572-0715 Email lpapazian@cadvnc.org
New York	Harriet Lessel Director	NYC Alliance Against Sexual Assault New York City Coalition	411 West 114th St. Suite 6D New York NY 10025	Phone (212) 523-4185 Hotline None Fax (212) 523-4429 Email hlessel@nycagainstrape.org
New York	Jeanette Kossuth Rape and Sexual Assault	NYC Gay & Lesbian Anti-Violence Project Domestic Violence & Sexual Assault Program	240 West 35th Street Suite 200 New York NY 10001	Phone (212) 714-1184-Ext.23 Hotline (212) 714-1141 Fax (212) 714-2627 Email jkossuth@avp.org
New York	George Lewert, CSW Social Work Manager	New York Presbyterian Hospital DOVE Program	622 West 168th St New York NY 10032	Phone (212) 305-5130 Hotline (212) 523-4728 Fax None Email gel9002@nyp.org
New York	Kerry Stout SAFE Coordinator	St Luke's Roosevelt Hospital Crime Victims Treatment Center	411 West 114th St. Suite 2C New York NY 10025	Phone (212) 523-4727 Hotline (212) 523-4728 Fax (212) 523-4781 Email kstout@cvtc-sl.org

County	Project Contact	Agency/Program	Address	Contact Information
New York	Carla Brekke Rape Crisis Coordinator	Bellevue Hospital Center Rape Crisis Program	First Avenue & 27th Street C&D Bldg., Room New York NY 10016	Phone (212) 562-3435 Hotline (212) 562-3435 Fax (212) 562-6103 Email carla.brekke@bellevue.nychhc.org
New York	Christine Fowley Director	St. Vincent's Hospital & Med. Center Rape Crisis Program	41-51 E. 11th Street 9th Floor New York NY 10013	Phone (212) 604-8068 Hotline None Fax (212) 604-7627 Email rcp@svcmcnny.org
New York	Carole Sher Coordinator of Victim	Beth Israel Medical Center RC Intervention Program	First Avenue at 16th Street New York NY 10003	Phone (212) 420-4516 Hotline (212) 420-4516 Fax (212) 420-2012 Email csher@bethisraelny.org
New York	Gail Murtha Program Coordinator	Mt. Sinai Adolescent Health Center Rape Crisis Intervention and Prev. Prog	320 E. 94th Street New York NY 10128	Phone (212) 423-2981 Hotline (212) 423-2833 Fax (212) 423-2920 Email gail.murtha@mountsinai.org
New York	Sharwon Boateng SAFE Coordinator	Mt. Sinai Medical Center Sexual Assault Violence Intervention	Box 1670 1 Gustave L. Levy New York NY 10029	Phone (212) 423-2140Ext 29 Hotline (212) 227-3000 Fax (212) 423-1021 Email Sharwon.Boateng@mssm.edu
Niagara	Carol Bateman Program Coordinator	Niagara County Mental Health Niagara Co. Rape Crisis Services	Trott Access Building 1001 11th St. Niagara Falls NY 14301	Phone (716) 278-1940 Hotline (716) 285-3518 Fax (716) 278-1943 Email carol.bateman@niagaracounty.com
Oneida	Rosemary Vennero Co-Director	YWCA of the Mohawk Valley YWCA - Utica	1000 Cornelia Street Utica NY 13502	Phone (315) 732-2159 Hotline (315) 797-7740 Fax (315) 732-8760 Email rvennero@ywcamv.org
Onondaga	Ellen Ford Clinical Supervisor	Rape Crisis Center of Syracuse	1065 James Street Syracuse NY 13203	Phone (315) 422-7273 Hotline (315) 422-7273 Fax (315) 422-7992 Email RCCofSyr@aol.com
Ontario	Edith Mann Director	Rape and Abuse Crisis Service of the Finger	150 Castle Street Geneva NY 14456	Phone (315) 781-1093 Hotline (800) 247-7273 Fax (315) 781-1093 Email yates@racsfl.org
Orange	Vanessa Green Director of Crisis Services	Mental Health Association in Orange Co., Inc. Orange County Rape Crisis Svcs.	20 Walker St. Goshen NY 10924	Phone (845) 294-7411 Hotline (800) 832-1200 (within Orange) Fax (845) 294-7348 Email vgreen@mhaorangeny.com
Orleans	Terrissa Drennan Staff Counselor	PP Rochester/Syracuse Region, Inc. Rape Crisis Service of Orleans Co.	243 South Main Suite 250 Albion NY 14411	Phone (585) 589-1312 Hotline (800) 527-1757 Fax (585) 589-1613 Email "Drennan, Terri " tchampeny@pprsr.org

County	Project Contact	Agency/Program	Address	Contact Information
Oswego	Robin Braunstein Victim Services	Services to Aid Families SAF Rape Crisis Program	Midtown Plaza Oswego NY 13126	Phone (315) 342-1544 Hotline (315) 342-1600 Fax (315) 342-7554 Email saf@dreamscape.com
Otsego	Nancy Court Victims Services	Opportunities for Otsego Violence Intervention Program	3 West Broadway Oneonta NY 13820	Phone (607) 433-8038 Hotline (607) 432-4855 Fax (607) 433-8029 Email ncourt@ofoinc.org
Putnam	Dorinda Cataldo, Clinical Director/SANE	Putnam-Northern Westchester Women's	935 S. Lake Blvd. Suite #2 Mahopac NY 10541	Phone (845) 628-9284 Hotline (845) 628-2166 Fax (845)-628-9272 Email pnwwrc@rcn.com
Queens	Hilda Castillo Rape Crisis Counselor	SAFE HORIZON Queens Community Program	74-09 37th Avenue Room 412 Jackson Heights NY 11372	Phone (718) 899-1233 Hotline (212) 227-3000 Fax (718) 457-6071 Email hcastillo@safehorizon.org
Queens	Indira Parmar, CSW Director of Social Work	Wyckoff Heights Medical Center	374 Stockholm St Brooklyn NY 11237	Phone (718) 963-7221 Hotline (866) wyckoff Fax (718) 302-8543 Email INP9001@nyp.org
Queens	Cynthia Roman- Queens Coordinator	Mt. Sinai Medical Center SAVI @ Queens	PO Box 1670 1 Gustave L. Levy New York NY 10128	Phone (718) 334-1418 Hotline (212) 227-3000 Fax (718) 334-1325 Email cynthia.roman-hernandez@mssm.edu
Rensselaer	Lisa Smith Director	Samaritan Hospital Sexual Assault & Crime Victims Assistance	2215 Burdett Avenue Troy NY 12180	Phone (518) 271-3445 Hotline (518) 271-3257 Fax (518) 271-3163 Email smithlisa@nehealth.com
Richmond	Christine Vargo Rape Crisis Counselor of	SAFE HORIZON Staten Island Community Program & Rape	358 St. Mark's Place 5th Floor Staten Island NY 10301	Phone (718) 720-2591 Hotline (212) 227-3000 Fax (718) 442-2913 Email cevargo@safehorizon.org
Rockland	May Krukiel Director	Rockland Family Shelter Sexual Trauma Services	2 Congers Road New City NY 10956	Phone (845) 634-3391 Hotline (845) 634-3344 Fax (845) 634-3396 Email mkrukiel@rocklandfamilyshelter.org
Saint Lawrence	Carrie Whalen Program Coordinator	Citizens Against Violent Acts	20 E. Main St. Canton NY 13617	Phone (315) 386-2761 Hotline (315) 386-3777 Fax (315) 379-0656 Email 41432@nnyemail.com
Saratoga	Amy Wise Coordinator	Saratoga Domestic Violence Services	480 Broadway Suite LL-20 Saratoga Springs NY 12866	Phone (518) 583-0280 Hotline (518) 587-2336 Fax (518) 583- 2215 Email dvrc@crisny.org

County	Project Contact	Agency/Program	Address	Contact Information
Schenectady	Janine Pustolka Coordinator	PP Mohawk Hudson, Inc. Rape Crisis Service	414 Union Street Schenectady NY 12305	Phone (518) 374-5353 Hotline (518) 346-2266 Fax (518) 347-1413 Email jpustolka@netscape.net
Schoharie	Janine Pustolka Coordinator	PP Mohawk Hudson, Inc. Rape Crisis/Sexual Assault Support Services	P.O. Box 170 560-2 Main St. Cobleskill NY 12043	Phone (518) 374-5353 Ext.3216 Hotline (518) 234-4949 Fax (518) 234-3316 Email jpustolka@netscape.net
Schuyler	Denise Townley Senior Counselor	PP of the Southern Finger Lakes, formerly Rape Crisis of the Southern Finger Lakes	PO Box 356 Montour Falls NY 14865	Phone (607) 535-6744 Hotline (888) 810-0093 Fax (607) 535- 3190 Email denise.townley@ppfa.org
Seneca	Ann Chidsey Assistant Director	Rape & Abuse Crisis Service of the Finger	12 N. Park St. Academy Sq Seneca Falls NY 13148	Phone (315) 568-4200 Hotline 800)247-7273 Fax (315) 568-4242 Email yates@racsfl.org
Steuben	Denise Townley Senior	PP of the Southern Finger Lakes, formerly Rape Crisis of the Southern Finger Lakes	135 Walnut St. Corning NY 14830	Phone (607) 962-4686 Hotline (888) 810-0093 Fax (607) 962-7520 Email denise.townley@ppfa.org
Suffolk	Joanne Della Valle, Program Director	Victims Information Bureau of Suffolk Co.,	P.O. Box 5483 Hauppauge NY 11788	Phone (631) 360-3730 Hotline (631) 360-3606 Fax (631) 360-0089 Email sane@vibs.org
Sullivan	Cindy Zingher Coordinator	PP of Mid-Hudson Valley, Inc. R.I.S.E.	P.O. Box 1012 Monticello NY 12701	Phone (845) 791-5308 Hotline (845) 791-9595, (877) 791-9595 Fax (845) 796-3673 Email cindy.zingher@ppfa.org
Tioga	Fran Bailey Program Coordinator	A New Hope Center	20 Church Street Owego NY 13827	Phone (607) 687-6887 Hotline (607) 687-6866 or (800)696- Fax (607) 687-6119 Email anhc@att.net
Tompkins	Bonnie Georgia Adult Services Program	The Advocacy Center of Tompkins Co. Domestic Violence & Sexual Abuse	PO Box 164 Ithaca NY 14851	Phone (607) 277-3203 Hotline (607) 277-5000 Fax (607) 277-4003 Email bonni@odyssey.net
Ulster	Laura Wells Sr. Crime Victim	Ulster County Probation Ulster Co. Crime Victims Assistance	5 Pearl Street Kingston NY 12401	Phone (845) 340-3213 Hotline (845)340-3442 Fax (845)340-3223 Email lwes@co.ulster.ny.us
Warren	Leigh Ann Healy Coordinator	PP Mohawk Hudson, Inc. Warren Co Sexual Assault Support Services	21 Bay St. Suite 314 Glens Falls NY 12801	Phone (518) 792-4305 Hotline (866) 307-4086 Fax (518) 792-3791 Email lahealy@nycap.rr.com

County	Project Contact	Agency/Program	Address	Contact Information
Washington	Jan Wolski Coordinator	Upper Hudson Primary Care Sexual Trauma & Recovery Services	1 Broad St PO Box 3253 Glens Falls NY 12801	Phone (518) 747-8849 Hotline (800)225-7114 Fax (518) 747-1457 Email starsjan@adelphia.net
Wayne	Tracy Featherly Sexual Assault Counselor	Victim Resource Center of Finger Lakes, Inc.	132 Harrison St. Newark NY 14513-	Phone (315) 331-1171 Hotline (800) 456-1172 Fax (315) 331- 1189 Email vrc132@verizon.net
Westchester	Karen Coleman SANE Coordinator	Westchester Community Opportunities Victims Assistance Services	2269 Saw Mill River Rd. Bldg 3 Elmsford NY 10523	Phone (914) 345-3113 Hotline (800) 726-4041 Fax (914) 345-3513 Email karen@victimassist.org
Wyoming	Amanda Pasquale Rape Crisis Counselor	PP Rochester/Syracuse Region, Inc. Rape Crisis Counselor	4 Buffalo Street Suite A3 Warsaw NY 14569	Phone (585) 786-5450 Hotline (800) 527-1757 Fax (585) 786-5084 Email apasquale@pprsr.org
Yates	Edith Mann Director	Rape & Abuse Crisis Service of the Finger	PO Box 624 Penn Yan NY 14527	Phone (315) 536-9654 Hotline (315) 536-2897 Fax (315) 536-0637 Email yates@racsfl.org

APPENDIX N

**Title 10 (Health) NYCRR SubPart 69-5;
Approval of rape crisis programs for the purpose of
rape crisis counselor certification.**

Title 10 (Health) NYCRR SubPart 69-5;
Approval of rape crisis programs for the purpose of
rape crisis counselor certification.

Effective Date: 07/27/94

Title: SubPart 69-5 - Approval of rape crisis programs for the purpose of rape crisis counselor certification

SUBPART 69-5
APPROVAL OF RAPE CRISIS PROGRAMS FOR THE PURPOSE
OF RAPE CRISIS COUNSELOR CERTIFICATION
(Statutory Authority: Public Health Law, section 206(15))

SEC.

- 69-5.1 Definitions
- 69-5.2 Eligibility for rape crisis program approval
- 69-5.3 Minimum training standards
- 69-5.4 Application/reapplication for rape crisis program approval
- 69-5.5 Granting of approval
- 69-5.6 Certification of rape crisis counselors
- 69-5.7 Technical assistance
- 69-5.8 Periodic review

Section 69-5.1 Definitions. As used in this Part:

(a) Client means any person seeking or receiving the services of a rape crisis counselor for the purpose of securing counseling or assistance concerning any sexual offense, sexual abuse, incest or attempt to commit a sexual offense, sexual abuse, or incest, as defined in the Penal Law.

(b) Governing authority means the entity or individual responsible for the quality of services and the operation of the rape crisis program.

(c) Rape crisis counselor means any person certified by an approved rape crisis program as having satisfied the training standards set forth in section 206 of the Public Health Law, and who is acting under the direction and supervision of an approved rape crisis program.

(d) Rape crisis program means any office, institution or center, which has been approved, pursuant to subdivision 15 of section 206 of the Public Health Law, to offer counseling and assistance to clients concerning sexual offenses, sexual abuse or incest.

(e) Training coordinator means the individual, designated by the governing authority who is responsible for overseeing the training and certification of rape crisis counselors.

Section 69-5.2 - Eligibility for rape crisis program approval

To be eligible for approval:

(a) The program must provide services to alleviate the immediate and long term negative physical and emotional effects of sexual assault and abuse. Services shall be accessible, confidential, provided without coercion, and available to individuals regardless of age, gender, race, ethnicity, sexual orientation, disability status, or ability to pay. Nothing herein, however, shall prevent the operation of a program formed to meet the special needs of persons from a particular community or group, provided that the program gives the department a written assurance that it will not refuse to provide services to any person who

seeks assistance from the program who is not a member of the target community or group that the program serves. These services must include but need not be limited to:

(1) twenty-four hour access to crisis intervention services including telephone hotline and phone counseling capabilities;

(2) in-person individual or group counseling;

(3) community prevention education programs;

(4) training of professionals concerning sexual assault issues;

(5) accompaniment of victims to medical facilities;

(6) advocacy on behalf of victims within the criminal justice system; and

(7) information and referral services, based on established relationships with human service providers, medical personnel, and law enforcement officials.

(b) The program must provide information to victims of sexual offenses, sexual abuse or incest that is designed to enable them to make informed decisions regarding medical and legal options and support services. Information must be provided regarding:

(1) sexually transmitted diseases;

(2) HIV/AIDS counseling and testing options;

(3) post-coital contraception;

(4) options regarding any pregnancy that may occur as a result of sexual assault or rape;

(5) evidence collection policies and procedures;

(6) civil and criminal court proceedings and availability of accompaniment and support throughout the legal process;

(7) availability of crime victims' compensation benefits; and

(8) availability of crisis intervention, telephone and in-person counseling services.

(c) Programs must have a written policy regarding client confidentiality and a protocol for obtaining an agreement signed by each counselor to adhere to that policy.

(d) Programs must be responsive to the cultural and language needs of the population served.

(e) The governing authority of the rape crisis program shall designate a training coordinator, whose training and/or experience is relevant to the services provided at the program and who shall have the authority and responsibility to oversee the training and certification of the program's rape crisis counselors.

(f) Programs must have a system in place to ensure that the minimum training standards set forth in this section are consistently met.

(g) The rape crisis program shall permit on-site program review by representatives of the Department of Health and, upon request, shall make available to such representatives any records and reports related to department approval of the rape crisis program.

(h) Nothing contained in this section shall prohibit a program, with approval of the Department of Health, from subcontracting for, or otherwise ensuring that the required services are available.

Section 69-5.3 - Minimum training standards

Rape crisis counselors must have at least 40 hours of training, at least 30 hours of which must have been completed prior to certification and the remainder of which must be completed within one year from the date of certification. This training shall include, but need not be limited to, instruction in the following:

(a) the dynamics of sexual offenses, sexual abuse and incest;

(b) crisis intervention techniques;

(c) client-counselor confidentiality requirements;

(d) communication skills and intervention techniques;

(e) an overview of the state criminal justice system;

(f) an update and review of state laws on sexual offenses, sexual abuse and incest;

- (g) the availability of state and community resources for clients;
 - (h) working with a diverse population;
 - (i) an overview of child abuse and maltreatment identification and reporting responsibilities;
- and
- (j) information on the availability of medical and legal assistance for such clients.

Section 69-5.4 - Application/reapplication for rape crisis program approval

(a) Application for approval shall be made on forms provided by the department. Information required from the applicant shall include:

- (1) a description of services provided to victims of sexual offenses, sexual abuse or incest;
 - (2) a description of the program's community prevention education, training of professionals and outreach services;
 - (3) the program's curriculum for training rape crisis counselors, or confirmation of intent to use a curriculum approved by the department;
 - (4) a description of the program's training program, referred to in section 69-5.3 above;
- and
- (5) a description of the program's procedures to evaluate and monitor program services, including the performance of rape crisis counselors.

Section 69-5.5 - Granting of approval.

(a) Within forty-five (45) days of receipt of a complete application, the department shall issue to each rape crisis program that meets the requirements of this Subpart, approval to certify its rape crisis counselors for the confidentiality privilege.

(b) Approval obtained pursuant to subdivision (a) of this section shall continue for three years from the date of notification by the commissioner of approval of the application submitted by the rape crisis program until receipt by the organization of written notice, from the commissioner, terminating approval of the program, whichever occurs first. The commissioner may extend approval of the program for additional three-year periods if the organization has complied with all requirements of these sections during the prior period of approval.

(c) If a program submits an application that does not meet the requirements of this Subpart, the department will provide the applicant with written comments regarding the required modifications needed to obtain approval.

Section 69-5.6 - Certification of rape crisis counselors.

(a) Rape crisis programs shall certify that rape crisis counselors have met the training requirements set forth in section 69-5.3 of this Subpart and shall keep records regarding certified rape crisis counselors consisting of the following:

- (1) documentation of training received on the provision of services to victims of sexual offenses, sexual abuse or incest;
- (2) for rape crisis counselors with less than 40 hours of training, a plan for completing the training requirements within one year from the date of certification;
- (3) documentation of ongoing education and training;
- (4) an agreement signed by each counselor to adhere to the program's client confidentiality policy;
- (5) annual performance evaluation reports;
- (6) an attestation signed by the training coordinator that the rape crisis counselor meets the minimum training requirements for certification; and
- (7) an attestation signed by the training coordinator that the rape crisis counselor has completed the 40 hours of required training.

(b) The governing authority of each rape crisis program approved under this Subpart must provide the department with a list of its certified rape crisis counselors semi-annually, beginning thirty days from the date of department approval of the program.

Section 69-5.7 - Technical assistance

The Department of Health shall provide technical assistance to approved rape crisis programs to implement training programs in accordance with the minimum standards set forth in this Subpart.

Section 69-5.8 - Periodic review

For each approved rape crisis program, the Department of Health shall perform on-site visits, review records or reports related to the program, and/or observe the training of rape crisis counselors as necessary to ensure compliance with the requirements of this Subpart.

APPENDIX O

Special Considerations for Caring for
Diverse Populations
*Domestic Violence Intervention:
A Guide for Health Care Professionals**

Special Considerations for Caring for Diverse Populations

Many factors about an individual's life circumstances may influence their ability to seek help and reap the most positive benefits from the help that is offered. The following information may provide some guidance in dealing with the diversity of the patients you may encounter.

Race/Ethnicity/Culture/Religion

Race/ethnicity may create challenges to service. Commonly held stereotypes about people of color may affect the care they are offered. At the same time, pressure from the racial/ethnic community to be loyal to and protect the image of the community may deter some from seeking care. For non-English speaking patients, an interpreter should be made available so that the patient does not have to rely on a family member to interpret in this sensitive situation. The patient's culture may place restrictions on discussing sexual issues with or being examined by a health care provider of the opposite gender. In some cultures, non-marital sexual contact, even when perpetrated by force, may render a victim unacceptable for an honorable marriage.

In some cultures, female circumcision is practiced. Females who are circumcised and/or infibulated may have perceived reactions of shock or repulsion by health care providers in the past. Depending on the extent of circumcision or infibulation and subsequent healing, sexual assault may cause severe trauma - both physical injury to the perineum and psychological trauma (e.g., reliving the genital mutilation).

As with race/ethnicity and culture, religion may create challenges to service delivery. Religious doctrines may prohibit a female from being disrobed in the presence of a male who is not her husband, or forbid a genital exam by a male. Such practices are considered a further violation. Female care providers should be made available for patients who request them.

Some people are fearful or distrustful of law enforcement officials and health care providers. It is essential that the examiner not make assumptions. The examiner should express a desire to provide what the patient wants and needs and should inquire about the patient's expectations.

As part of professional continuing education, community leaders of local ethnic groups should be invited to present information to examiners on cultural differences and to define the services that are important for their community. The local Rape Crisis Center can assist in providing outreach and educational presentations (see Appendix M). Every effort should be made for the examiners to understand and accommodate the ethnic, cultural and religious needs of the patient.

Gender

Male patients reporting sexual assault often fear that they will be viewed as weak or unmasculine. Heterosexual male patients may fear that they will be viewed as homosexual, if the perpetrator was male.

Female patients may have concerns that the assault will result in pregnancy, or will adversely affect a current or future pregnancy.

Intersexual patients are people born with both male and female physical characteristics. Transgendered patients are people who are living as the opposite of their birth-assigned gender, sometimes with the assistance of surgery and/or hormonal therapy. Both intersexual and transgendered patients often experience discrimination and mockery in our society. Fear of inadequate or harmful health care may make these individuals reluctant to seek care. When an individual is identified as an intersexual or transgendered person, clarify what pronoun the patient uses to describe themselves. Demonstrating sensitivity to correct terminology, and asking open-ended questions allows patients the opportunity to share additional information about themselves.

The Adolescent Patient

Adolescents often know their perpetrators prior to the assault. Adolescents are most often raped by their peers; many of these patients have faced multiple assailants.

For some adolescents, the assault may be their first sexual contact. Because sexual identity and body image are rapidly changing, the effects of a sexual assault can be particularly devastating. The adolescent patient may view the assault as a sexual encounter, rather than an act of violence, thereby distorting the image of a healthy sexual relationship.

The psychological reactions of adolescent rape survivors are in many ways similar to those of adult survivors. However, these reactions may be intensified in the adolescent due to developmental concerns. Some of the critical effects may be:

- A destructive influence on emerging sexuality and sexual awareness;
- Self-blame and guilt over the risk-taking behavior which may be perceived as having contributed to the victimization;
- Fear of disclosure and repercussions, especially from family and peers;
- Damage to sense of identity and self-esteem (e.g., self-doubt, loss of trust in one's own judgment, peer stigmatization);
- Loss of autonomy and independence as a result of the assault (e.g., imposed curfew or other perceived punishment, family over-protectiveness); and,
- Distrust of the protective nature of authority.

It is important to note that sexual assault of an adolescent may represent incest or sexual abuse by a family member. New York State Social Service Law, Section 413 requires that health care professionals report any incident of suspected or actual child sexual abuse to the State Central Register of Child Abuse and Maltreatment. If the examiner has cause to suspect

that the adolescent may be an abused or maltreated child, the professional should refer to the facility's protocol for dealing with such cases.

Domestic Violence

Sexual assault victims may be in a violent domestic relationship. Victims of domestic violence have the additional trauma of long-term, repetitive assault, with the possibility that the violence will continue, escalate, and even end in death. It is, therefore, important that examiners avoid making the assumption that the victim does not know, and is not in an intimate relationship with the assailant. One study found that 33%- 46% of women in an emergency department population who were physically assaulted by their partners were also sexually assaulted.

Domestic violence should be addressed when treating every patient. If the patient discloses that she is a victim of domestic violence or if the examiner suspects domestic violence, the examiner should provide the patient with an additional referral to domestic violence services after sexual assault treatment and evidence collection are completed. It is important to remember that many women in New York State are not aware that marital rape is a crime. This information must be conveyed to the patient. Rape within the context of marriage or a domestic relationship may be additionally traumatic for the patient who may be emotionally and economically dependent on her assailant. For more information regarding the treatment of patients who are victims of domestic violence, refer to *Domestic Violence Intervention: A Guide for Health Care Professionals*, included in this Appendix. For further information, call the New York State Office for the Prevention of Domestic Violence at (518) 486-8462.

The Elderly Patient

As with other patients, the elderly patient may experience extreme humiliation, shock, disbelief, and denial. Sexual violence may intensify feelings of physical vulnerability, diminished resilience, and mortality. Fear, anger, or depression can be especially severe in older patients who are isolated, lack a support system, or live on a limited income.¹Forster, G. and Skinner, C. J. (1995). The coexistence of physical and sexual assault. American Journal of Obstetrics and Gynecology, 172, 1644-1645.

In general, the elderly are physically more vulnerable than younger adults, and injuries from an assault are more likely to be life-threatening. In addition to possible pelvic injury and sexually transmissible diseases (STDs), the older patient may be more at risk for other tissue or skeletal damage and exacerbation of existing illnesses. Hearing impairment and other physical conditions associated with advancing age, coupled with the initial reaction to the crime, may render the elderly patient unable to make his or her needs known, which may result in prolonged or inappropriate treatment. Also, it is not unusual for first-responders or care providers to mistake this confusion and distress for dementia.

Medical and social follow-up services must be made easily accessible to older patients, as they may not otherwise seek assistance. Without encouragement and assistance in locating services, many older patients may be hampered in their ability to recover.

The Patient with a Disability

Some patients have physical or mental disabilities which require adapting an exam to the patient's needs (e.g., a person with quadriplegia may require extra pillows or cushions to provide adequate support; a hearing impaired person may require the assistance of a translator; a person having schizophrenic hallucinations may require a mental health professional as part of the team providing care).

Adults who are particularly vulnerable to sexual assault include individuals who have communication impairments, an altered level of consciousness (e.g., the victim who is comatose), or individuals who are impaired by mental illness, developmental disability, substance abuse, disease (e.g., Alzheimer's disease), or medication.

When an individual is assaulted in an institution or group home (e.g., while a resident of a nursing home), the institution should ensure that the victim is offered a health care and evidentiary exam for several reasons. The appropriate attention of an examiner documents that the institution administered appropriate treatment to the victim. The evidence can later serve in the prosecution of the offender. In a case in which an employee is suspect, and the patient is not able to confirm or deny the suspicion, the evidence may be the standing stone on which the employee is found to be guilty or innocent.²

When a patient is not legally able to give consent (e.g., a person with Alzheimer's disease), or a patient who does not have the ability to consent (e.g., a comatose patient), permission should be sought from a person legally authorized to consent for the patient, such as a legal guardian.

Section 2803-d of the Public Health Law (see Appendix K) requires that health care providers report physical abuse, mistreatment, or neglect of a person receiving care or services in a residential health care facility. Reports of suspected physical abuse, mistreatment, or neglect must be made immediately by telephone and in writing within forty-eight hours to the New York State Department of Health (see Appendix L for patient care hotline numbers).

A health care exam and collection of evidence, regardless of the consenting party, must never be undertaken against the will of the patient. Health care providers should ensure that the patient totally understands the scope of injury, disease and other sequelae that could result from a sexual assault in attempting to secure patient cooperation and consent.

The Homeless Patient

For some homeless patients, the problems of poverty and discrimination have already resulted in a high incidence of victimization, as well as inadequate access to quality health care. There may be a mistrust of health care and law enforcement personnel, particularly if there has been a history of unpleasant or disappointing experiences with such professionals.

The Patient who is an Undocumented Alien

Individuals who are in this country illegally, may be reluctant to seek health care or notify law enforcement officials when they have been sexually assaulted.

The Patient Engaged in Illegal Activity

Individuals who engage in illegal activities, such as drug use or prostitution, may be reluctant to seek health care or notify law enforcement officials when they have been sexually assaulted. Such a patient may believe herself responsible because she was in a vulnerable state or environment, or she may be fearful of her own arrest. It is important, as with all other patients, that the health care provider maintains a non-judgmental attitude.

Sexual Orientation

The sexual orientation of a patient can be a relevant factor in his or her reactions to the sexual assault and subsequent interaction with the health care and criminal justice systems. Lesbians and gay men, when targeted in hate crimes, may be subject to sexual assaults specifically because of their sexual orientation. As with all other victims, fear may cause reluctance to disclose important information about the assault.

Assumptions on the part of the examiner about the sexual orientation of a victim may lead to failure to identify specific needs of lesbians or gay male patients and compromise medical or legal interactions. Taking care to avoid assumptions about the sexual orientation of the patient, and knowing lesbian and gay-identified referral resources, will greatly enhance the quality of services that can be provided to gay and lesbian patients.

It is recommended that health care facilities serving specific populations seek the assistance of community members to help develop procedures that will reflect the special needs of those populations.

- 1 Forster, G. and Skinner, C.J. (1995). The coexistence of physical and sexual assault. *American Journal of Obstetrics and Gynecology*, 172, 1644-1645.
- 2 Pharris, M. (February, 1998). Allegations of sexual assault on the inpatient unit: how to respond. *Journal of Emergency Nursing*, 24(1), 98-100.

Medical and Legal Protocol for Dealing with Victims of Domestic Violence

New York State Office for the Prevention of Domestic Violence
80 Wolf Road
Albany, NY 12205
2004

Medical and Legal Protocol for Dealing with Victims of Domestic ViolenceTable of Contents

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A note about our use of gender specific language: Because the vast majority of victims of adult domestic violence are women who are abused by their male partners, the content of the protocol refers to victims as female and abusers as male. However, the majority of the content in this protocol will apply to all victims regardless of their gender of their partner including gays, lesbians, transgender people and men who are physically abused by their female partners.

Medical and Legal Protocol for Dealing with Victims of Domestic Violence

Overview

Introduction Domestic violence is a health care problem of pandemic proportion with far reaching implications. Women in the US make close to 700,000 visits to the health care system per year as a result of injuries due to physical assault.¹ This number does not reflect the visits made for numerous chronic health problems exacerbated by domestic violence such as depression, substance abuse and hypertension.

Many patients are discharged with only the presenting symptoms or injuries having been treated, leaving the underlying cause of the problem, domestic violence, unaddressed. Failing to identify domestic violence can result in incorrect diagnosis, costly unnecessary testing, and increased utilization of health care services and hospitalizations.

Domestic Violence Domestic violence is a pattern of coercive tactics that can include physical, psychological, sexual, economic and emotional abuse perpetrated by one person against an adult intimate partner, with the goal of establishing and maintaining power and control over the victim.²

Domestic violence occurs in all ethnic, religious, socio-economic, sexual preference and age groups.

Domestic Violence Myths

The following are often blamed as a “cause” for domestic violence:

- Alcohol/substance abuse
- Stress
- Socio-economic factors
- Anger/loss of control
- Another person’s behavior

While these factors may be contributing, they are not causal. Many people experience the above factors and do not abuse their partners.

¹ Family Violence Prevention Fund, “Health Care Public Policy and Domestic Violence,” available from <http://endabuse.org/programs/printable/display.php3?DocID=209> ; Internet; accessed 12 April 2004.

² Model Domestic Violence Policy for Counties (New York: NYSOPDV, January 1998) p 1.

Tactics & Clinical Cues

Tactics of control may manifest in the following ways:

Tactics	Health Care Manifestations
<p><u>Physical Abuse</u></p> <ul style="list-style-type: none"> • Biting • Grabbing • Punching • Shoving • Kicking • Slapping • Shooting • Stabbing, etc. • Withholding medication, medical care, medical equipment, nutrition • Forcing use of alcohol or other drugs 	<ul style="list-style-type: none"> • Ecchymosis (bruises) • Lacerations, often to arms & face • Headaches • Anxiety • Hyperventilation • Hypertension • Chest pains • Chronic pain • During pregnancy <ul style="list-style-type: none"> – Injury to abdomen, breasts, genitalia – Hemorrhaging, including placental separation – Uterine rupture – Miscarriage/stillbirth – Pre-term labor – Premature rupture of membranes • Delay in seeking prenatal care • Frequently missed appointments • Lack of attendance to prenatal education • Poor nutrition • Continued use of cigarettes, drugs and/or alcohol during pregnancy

Continued on next page

Tactics & Clinical Cues

Tactics	Health Care Manifestations
<p><u>Psychological Abuse</u></p> <ul style="list-style-type: none"> • Instilling, or attempting to instill fear through ridiculing or humiliating the victim • Destroying property • Threatening to harm self or victim • Blaming abuse on victim • Injuring, killing, or threatening to injure or kill pets 	<ul style="list-style-type: none"> • Depression • Anxiety • Hypertension • Chronic muscle tension • Psychosomatic illness • Suicidal ideation • Homicidal ideation • Substance abuse
<p><u>Sexual Abuse</u></p> <ul style="list-style-type: none"> • Coercing, or attempting to coerce any sexual activity without consent <ul style="list-style-type: none"> – Rape, sodomy, attacks on sexual parts of the body – Unprotected sex – Sex with others – Forced prostitution – Degrading, sexually explicit behavior toward victim – Taking/showing sexually explicit film or photos and using them against the victim • Attempts to undermine a person's sexuality <ul style="list-style-type: none"> – Treating partner in a sexually derogatory manner – Criticizing sexual performance and desirability – Accusations of infidelity – Withholding sex 	<ul style="list-style-type: none"> • STD's • HIV • Multiple pregnancies • Pregnancy-related injuries, usually around abdomen, breast and genitalia • Spontaneous abortion • Sexual assault injuries • Depression • Anxiety

Continued on next page

Tactics & Clinical Cues

Tactics	Health Care Manifestations
<p><u>Economic Abuse</u></p> <ul style="list-style-type: none"> • Making, or attempting to make a person financially dependent 	<ul style="list-style-type: none"> • Depression • Anxiety • Migraines/headaches • Reluctance to schedule additional tests, or accept needed prescriptions
<p><u>Emotional Abuse</u></p> <ul style="list-style-type: none"> • Undermining, or attempting to undermine, a person’s self-worth <ul style="list-style-type: none"> – Constant criticism – Put downs – Insults – Name calling – Silent treatment – Manipulating feelings/emotions – Repeatedly making and breaking promises – Subverting partner’s parenting and/or relationship with children – Threatening to harm, kill or abduct children – Using child visitation to harass victim 	<ul style="list-style-type: none"> • Depression • Anxiety • Hypertension • Chronic muscle tension • Substance abuse • Suicidal ideation • Homicidal ideations • Psychosomatic illness <p>***NOTE: Any pre-existing conditions can be exacerbated by domestic violence</p>

Identification & Guidelines

Identification To achieve early identification of domestic violence, private routine screening is recommended for all female patients over the age of 16. In addition, men and women in gay and lesbian relationships are also at risk for domestic violence and should be routinely screened. (Please review NYSDOH Guidelines for Integrating Domestic Violence Screening in Relation to HIV Counseling, Testing, Referral and Partner Notification found at <http://www.health.state.ny.us/nysdoh/rfa/hiv/protocol.htm>)

Patients receiving care in the emergency department, and surgical, primary care, pediatric, prenatal, substance abuse and mental health settings should be informed that “**Because intimate partner violence and abuse are so common, we screen for it routinely.**” This gender-neutral statement communicates to the patient that the physician is knowledgeable about domestic violence and does not assume that everyone is heterosexual.

If the patient does not disclose abuse, consider domestic violence if any of the following is observed:

- Injuries to face, neck, throat, chest, abdomen or genitals
- Evidence of sexual assault; vaginal/anal injuries
- Bilateral or patterned injuries
- Injuries during pregnancy
- Delay between injury and treatment
- Multiple injuries in various stages of healing
- Injury inconsistent with patient’s explanation
- Frequent use of emergency department services
- History of trauma related injury
- Chronic pain symptoms with no apparent etiology
- Repeated psychosomatic or emotional complaints
- Suicidal ideation or attempts
- An overly attentive or aggressive partner accompanying the patient
- Patient appears fearful of partner

Continued on next page

Identification & Guidelines

Guidelines

The following guidelines are designed to assist medical personnel in treating victims of domestic violence.

1. Interview the patient in private. Ask any accompanying spouse, friend or family member to leave the treatment area. Questioning the patient about domestic violence in the presence of the abuser, suspected abuser or other family members may put the patient in extreme danger.
2. Convey an attitude of concern and respect for the patient and assure the confidentiality of any information provided.
3. Inform the patient of routine domestic violence screening policy and ask the patient directly if the injuries or complaints are the result of abuse by someone they know.
4. If domestic violence is disclosed, communicate to the victim that they are not alone, they are not to blame for the abuse, and that help is available.
5. Take the patient's history and conduct a thorough medical examination, with appropriate laboratory tests and x-rays. If the extent or type of injury is not consistent with the explanation the patient gives, note this in the medical record. A question to elicit information about site and cause of injury that might indicate domestic violence should be asked. Ask for specifics and document using the patient's own words.

“She threw a cup of coffee at me” is better than “We were arguing and things got out of hand.”

“Patient states that her husband, Joseph Smith, hit her with his belt” is better than “Patient has been abused.”

All emergency department logs should include a code for domestic violence.

Continued on next page

Identification & Guidelines

Guidelines (continued)

6. Preserve physical evidence. Bag torn or blood stained clothing and/or weapon. Mark bag with patient's name, date and name of person who collected evidence. Keep evidence under lock until it is turned over to the police, prosecutor or patient's lawyer. Refer to your facility's sexual assault protocol for evidence collection information.
7. Help the victim assess their immediate safety and safety of the children. Respect and accept the victim's evaluation of the situation. Talk with your local domestic violence program staff for further information on safety assessment and safety plans. Offer to contact the local domestic violence service provider. If appropriate, offer to call the police. Tell the patient that battering is a crime and help is available. Support the patient's decision.
8. Offer to photograph the patient's injuries. See your facility's sexual assault protocol for further information.
9. Encourage the patient to call a local domestic violence program or the toll-free statewide [Domestic Violence Hotline \(English 1-800-942-6906 or Spanish 1-800-942-6908\)](tel:18009426906). Ensure access to a private telephone.
10. If you are working in a hospital or diagnostic and treatment center, The Family Protection and Domestic Violence Intervention Act of 1994 requires that you provide a copy of "The Victims Rights Notice" to all suspected or confirmed victims of domestic violence. A copy of this notice can be found at www.health.state.ny.us/nysdoh/provider/women.htm In addition, Chapter 217 of the Laws of 1997 mandates that hospitals providing maternity/newborn services and diagnostic and treatment centers that offer prenatal care services must distribute a notice regarding family violence to all patients at prenatal visits or at post-partum visit. This notice, "Are You And Your Baby Safe?" can be ordered from www.health.state.ny.us/nysdoh/publication_catalog/index.htm Provide additional information and referrals for counseling, shelter, support groups and legal assistance in the community. Assure confidentiality.

Continued on next page

Identification & Guidelines

Guidelines
(continued)

-
11. Make safety the primary goal of all interventions. Victims are likely to be the best judge of what is safe for them. If it is necessary to follow-up with medical appointments, laboratory tests or prescriptions, ask directly if the victim can safely do so, or what could be done to make it possible for her to meet follow-up care needs.
-

Sample Assessment Questions

-
- Notification of Routine Screening** Let your patients know that you ask everyone about domestic violence.
- “Because intimate partner violence and abuse are so common, we screen for it routinely.”
-

Assessment Questions Avoid asking patients questions using the term “domestic violence.” Most victims do not initially identify with the term, and their understanding of the term varies greatly.

Tailor the following questions to your practice:

Questions that tell victims they are not alone:

- Many patients tell me their partners have hurt them. Is this happening to you?

Questions based on observation:

- You seemed frightened of your partner. Has he ever hurt you?
- Your partner seemed not to want to let me speak with you alone. I’m concerned that he might want to control what you tell me. Do you think that is happening?
- I noticed you check with your partner before you answer any questions. Are you afraid you might get hurt if you say the “wrong” thing?

Questions about physical abuse:

- Are you in a relationship where you get hit, punched, kicked or hurt in any way?
- Do arguments ever end in your partner pushing, shoving or slapping you?
- Has your partner ever used a fist or weapon to hurt or threaten you?

Questions about sexual abuse:

- Does your partner force you to engage in sex that makes you uncomfortable?
 - Does your partner ignore your decisions regarding safe sex or contraceptives?
-

Continued on next page

Sample Assessment Questions

Assessment Questions *(continued)*

Questions about emotional abuse, threats or intimidation:

- Does your partner ever call you names or put you down?
 - When your partner gets angry, does he throw things? Hurt your pet?
 - Does your partner accuse you of having affairs? Check up on you?
 - Do you have to ask your partner's permission to do things you want to do?
-

Avoid These Questions

Avoid the following:

Labeling questions:

- Are you a victim of domestic violence?
- Are you battered?...abused?

Blaming questions:

- Why didn't you come to the hospital sooner?
- Why didn't you leave the first time he hit you?
- Why didn't you call the police?

Be cautious about giving advice (go to a shelter, leave your partner). Your advice may have safety implications of which you are unaware, while providing information about available resources may be helpful.

Referrals

Domestic Violence Service Providers

A domestic violence service provider is located in every county in New York State. These programs offer both residential and non-residential services.

Services can include:

- Emergency shelter
- 24 hour hotline
- Information and referral services
- Advocacy
- Counseling
- Children’s services
- Medical services
- Transportation
- Support groups
- Follow-up
- Community education/outreach

To locate the provider in your county, go to www.ocfs.state.ny.us and click on Domestic Violence Service Providers.

Counseling & Therapy

When appropriate, the victim and children may be referred to counseling to assist them in processing the abuse and the possible transition of the family.

Under no circumstances should family therapy or couples counseling be recommended. These forms of treatment assume a balance of power that does not exist when domestic violence is present and could put the victim’s safety at risk.

Legal Overview

The Family Protection and Domestic Violence Intervention Act

The Family Protection and Domestic Violence Intervention Act of 1994 requires that hospital and diagnostic and treatment center staff provide the Victim's Rights Notice to all suspected and confirmed victims of domestic violence. While not required by law, other health care providers are encouraged to provide victims with this notice. See Appendix A.

The Victim's Rights Notice can also be found at www.health.state.ny.us/nyhdoh/provider/women.htm

New York State Department of Health Regulatory Codes

CHAPTER V MEDICAL FACILITIES/SUBCHAPTER C STATE HOSPITAL CODE
ARTICLE 6 TREATMENT CENTER AND DIAGNOSTIC CENTER OPERATION

Section 751.5 Operating policies and procedures.

The operator shall ensure:

- a. The development and implementation of policies and procedures written in accordance with prevailing standards of professional practice which include but are not limited to:
 8. the identification, assessment, reporting and referral of cases of suspected child abuse or maltreatment and identification and treatment of domestic violence;
 9. the identification of patient's medically related, personal and social problems which may interfere with the patient's treatment, recovery or rehabilitation;
 10. the establishment and implementation, in conjunction with a qualified social worker, of a plan, consistent with available community and center resources, to provide or arrange for the provision of social work, psychological and health educational services that may be necessary to meet the treatment goals of its patients;

Section 751.6 Personnel

The operator shall ensure:

- k. that each employee, as applicable, receives on-the-job training necessary to perform his/her duties;
- l. that all staff receive education in the identification, assessment, reporting and referral of cases of suspected child abuse, maltreatment, and identification and treatment of domestic violence;

Continued on next page

Legal Overview

New York
State
Department of
Health
Regulatory
Codes
(continued)

CHAPTER V MEDICAL FACILITIES SUBCHAPTER A - MEDICAL FACILITIES -
MINIMUM STANDARDS / ARTICLE 2 HOSPITALS/ PART 405 HOSPITALS -
MINIMUM STANDARDS (STATUTORY AUTHORITY: PUBLIC HEALTH LAW 2803,
2805 - k, 2805 - l, 2805-m and 4351)

- e. Domestic Violence. The hospital shall provide for the identification, assessment, treatment and appropriate referral of cases of suspected or confirmed domestic violence. The hospital shall establish and implement written policies and procedures consistent with the requirements of this section, which shall apply to all service units of the hospital.

Emergency Services

- 3. Domestic Violence. The emergency services shall develop and implement policies and procedures that provide for the management of cases of suspected or confirmed domestic violence victims in accordance with the requirements of subdivision (e) of Section 405.9 of this Part.

Chapter 217
Laws of 1997

Chapter 217 of the Laws of 1997 mandates that hospitals that have maternity/newborn services and diagnostic and treatment centers that offer prenatal care services distribute a notice regarding family violence to all patients at prenatal visits or at the post-partum visit. This notice, "Are You And Your Baby Safe?" provides information about the effects of child abuse/maltreatment and domestic violence and services available to adult victims.

Copies of "Are You And Your Baby Safe?" can be obtained from the NYS Department of Health. To order, call (518) 474-5370, or go to www.health.state.ny.us/nysdoh/publication_catalog/index.htm.

Appendix A - Victim's Rights Notice

The Victim's Rights Notice was prepared to inform victims of domestic violence of their legal rights and remedies available under the law. If you are a victim of domestic violence you are encouraged to speak privately with a social worker or someone who can help you. You should be interviewed privately out of eyesight or earshot of anyone who accompanies you. Your rights as a patient will be violated if hospital staff asks if you are a victim of domestic violence in front of any accompanying partner or family member.

IF YOU ARE A VICTIM OF DOMESTIC VIOLENCE:

The police can help you:

- Get to a safe place away from the violence.
- Get information on how the court can help protect you against the violence.
- Get medical care for injuries you or your children may have.
- Get necessary belongings from your home for you and your children.
- Get copies of police reports about the violence.
- File a complaint in criminal court, and tell you where your local criminal and family courts are located.

The courts can help:

- If the person who harmed or threatened you is a family member or someone you've had a child with, then you have the right to take your case to the criminal courts, family court or both.
- If you and the abuser aren't related, weren't ever married or don't have a child in common, then your case can be heard only in criminal court.
- The forms you need are available from the family court and the criminal court.
- The courts can decide to provide a temporary order of protection for you, your children and any witnesses who may request one.
- The family court may appoint a lawyer to help you in court if it is found that you cannot afford one.
- The family court may order temporary child support and temporary custody of your children.

Continued on next page

Appendix A - Victim's Rights Notice

New York state Law states: "If you are the victim of domestic violence, you may request that the officer assist in providing for your safety and that of your children, including providing information on how to obtain a temporary order of protection. You may also request that the officer assist you in obtaining your essential personal effects and locating and taking you, or assist in making arrangements to take you and your children to a safe place within such officer's jurisdiction, including but not limited to a domestic violence program, a family member's or a friend's residence, or a similar place of safety. When the officer's jurisdiction is more than a single county, you may ask the officer to take you or make arrangements to take you and your children to a place of safety in the county where the incident occurred. If you or your children are in need of medical treatment, you have the right to request that the officer assist you in obtaining such medical treatment. You may request a copy of any incident reports at no cost from the law enforcement agency."

"You have the right to seek legal counsel of your own choosing and if you proceed in family court and if it is determined that you cannot afford an attorney, one must be appointed to represent you without cost to you. You may ask the district attorney or a law enforcement officer to file a criminal complaint. You also have the right to file a petition in the family court when a family offense has been committed against you. You have the right to have your petition and request for an order of protection filed on the same day you appear in court, and such request must be heard that same day or the next day court is in session. Either court may issue an order of protection from conduct constituting a family offense which would include, among other provisions, an order for the respondent or defendant to stay away from you and your children. The family court may also order the payment of temporary child support and award temporary custody of your children. If the family court is not in session you may seek immediate assistance from the criminal court in obtaining an order of protection. The forms you need to obtain an order of protection are available from the family court and the local criminal court. Calling the following 800 numbers can access the resources available in this community for information relating to domestic violence, treatment of injuries, and places of safety and shelters. Filing a criminal complaint or a family court petition containing allegations that are knowingly false is a crime." [CPL 530.011(6)]

GET HELP NOW

GET SAFE

STAY SAFE

1-800-942-6909 (English)

1-800-942-6908 (Spanish)

or call your local Domestic Violence Program

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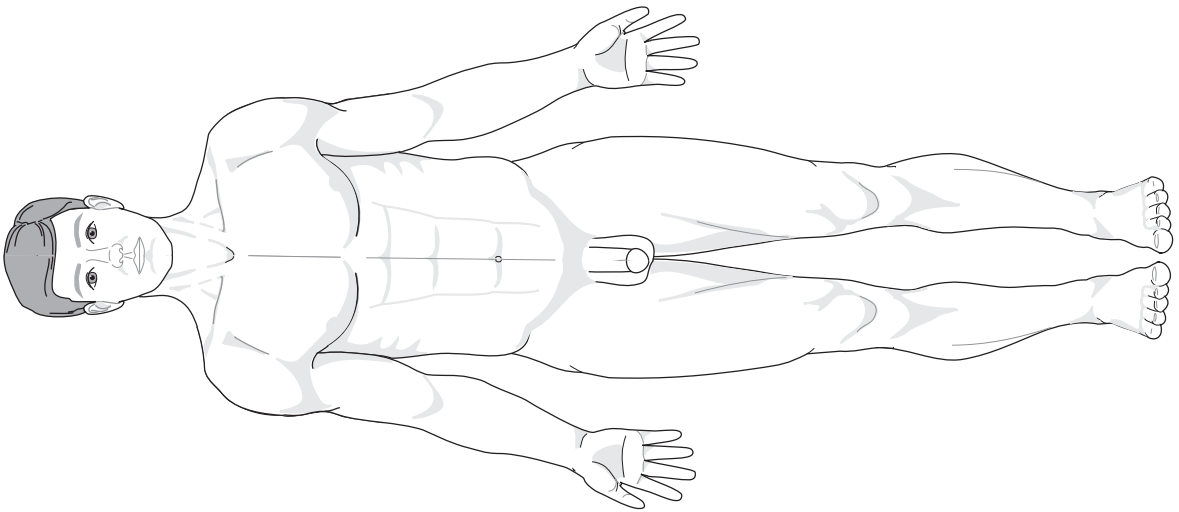
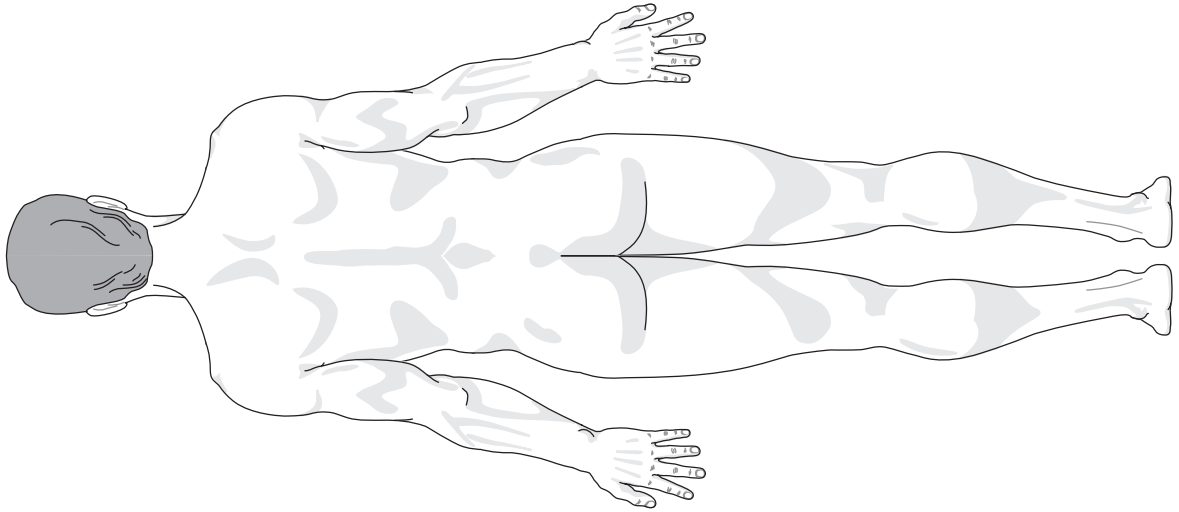
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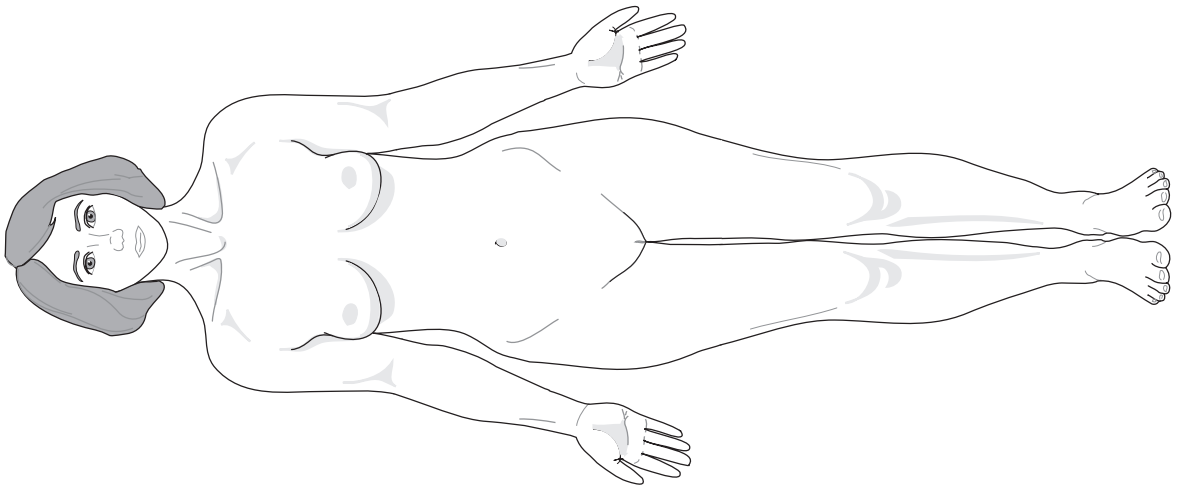
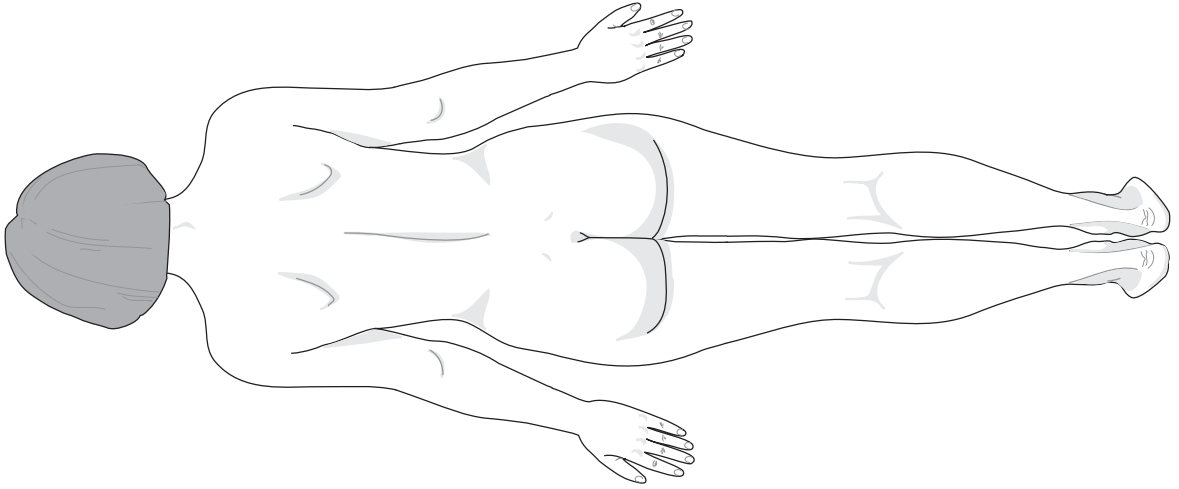
APPENDIX P

Sample Diagrams for Male and Female Patients

APPENDIX P

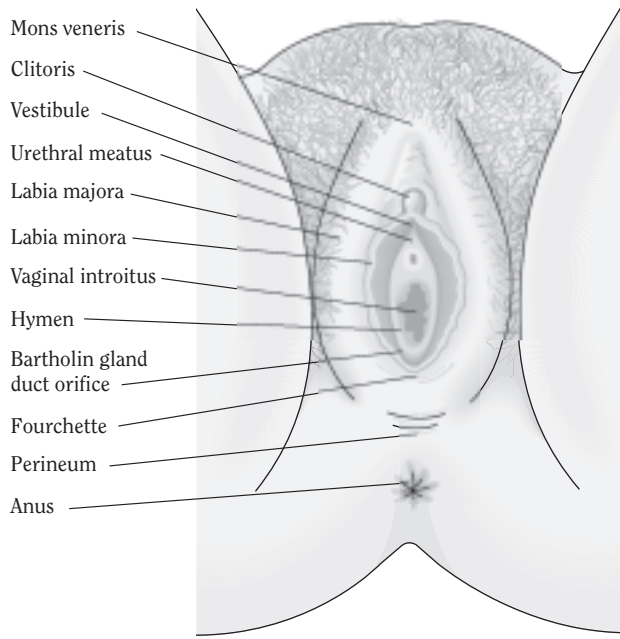


APPENDIX P

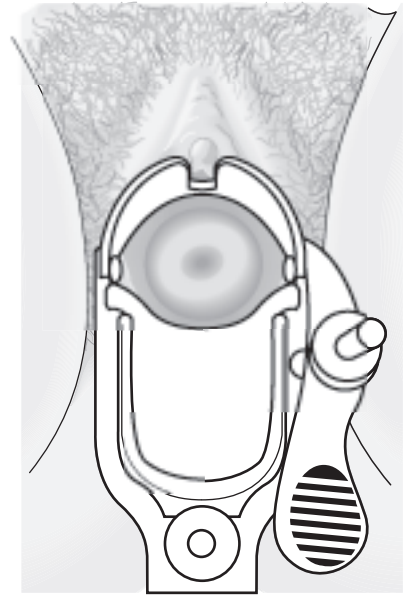


Traumagram – Genital

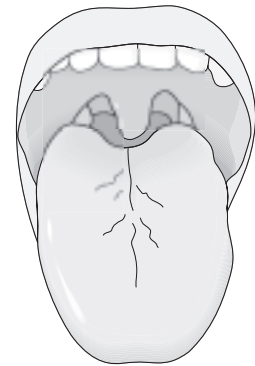
Female genitalia



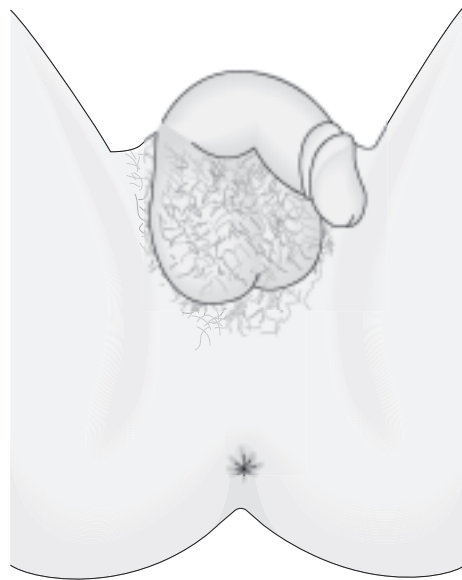
Cervical observation



Oral



Male genitalia



Anal



Appendix Q

Q-1 Sexual Offense Evidence Collection Kit Instruction Sheets

Q-2 Patient Information Form

Q-3 Medical Record Sexual Assault Form

Q-4 Sample Envelopes including:

Step 1 - Oral Swabs and Smear;

Step 2 - Buccal Specimen;

Step 3 - Trace Evidence;

Step 4 - Clothing (Instructions only);

Step 5 - Underwear;

Step 6 - Debris Collection;

Step 7 - Dried Secretions and/or Bite Marks;

Step 8 - Fingernail Scrapings;

Step 9 - Pulled Head Hairs;

Step 10 - Pubic Hair Combing;

Step 11 - Pulled Pubic Hair;

Step 12 - Perianal and Anal Swabs and Smear;

Step 13 - Vulvar or Penile Swabs and Smear;

Step 14 - Vaginal Swabs and Smear;

Step 15 - Cervical Swabs and Smear, and;

Final Instructions

Q-5 Sample Box Cover Information for Sexual Offense Evidence Collection Kit



240 O'Connor Street Wellsville, NY 14895 585-593-6645 ext. 321

**SEXUAL OFFENSE EVIDENCE COLLECTION KIT
INSTRUCTION SHEET**

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*First revision September 2000, second revision February 2002, third revision April 2005, fourth revision September 2008.

Refer to NYS Department of Health Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault for further information concerning the examination of victims of sexual assault at:
http://www.health.state.ny.us/professionals/protocols_and_guidelines/sexual_assault/index.htm.

Refer to the National Protocol for Sexual Assault Medical Forensic Examinations for further information at:
<http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>.

NOTE: This kit is designed to assist in the uniform collection of evidentiary specimens in any case in which the crime/incident involved is a sexual assault. Although the completion of each appropriate step is requested, it is acknowledged that the examiner may elect not to complete one or more steps, based upon a consideration of the physical and/or emotional well-being and preference of the patient. **It must be acknowledged that a patient has the right to refuse one or more of the individual steps without relinquishing the right to have evidence collected.**

Each step in this kit is designed for one of two purposes. The first is to recover potentially valuable physical evidence that will be useful in any subsequent investigation and legal proceeding to identify the perpetrator of the reported assault (through forensic DNA analysis, for instance) and/or to verify the nature and circumstances of the reported assault. The type of evidence often detected includes saliva, semen, hairs, spermatozoa, blood, fibers, plant material, soil and other debris that may have been transferred from the perpetrator's clothing or personal effects, or from the scene of the reported assault. The other steps are intended to collect evidence that will be used as a reference standard (controls from the victim). Each step is noted as either "*Evidence Collection*" or "*Control Sample*".

This kit contains material sufficient for the collection of evidence from ONE subject (male or female). Use a separate kit for each person. **Change gloves for each step.**

The hospital is requested not to analyze any of the specimens/evidence collected in this kit.

In order to locate alternative witnesses years later in the event of a DNA hit and/or arrest, please ensure that the names of other hospital personnel present during the exam are clearly recorded in the medical records.

Included in this kit are the Medical Record Sexual Assault form, Body Diagrams, Authorization for Release of Information and Evidence to Law Enforcement form, and Patient Information form as provided by NYS Department of Health. **The forms are provided for hospital records if desired and are NOT to be included in the completed, sealed kit.** Follow the instructions on the forms to determine distribution. In addition, enclosed in the kit are two forms from the NYS Crime Victims Board. One is a claim form for the victim and one is a claim form for the Medical Provider. **Do not include either Claim Form in the sealed kit.**

INSTRUCTIONS

STEP 1 ORAL SWABS AND SMEAR

Evidence Collection

NOTE: This step is to collect possible perpetrator DNA. Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection. Upon completion of this step, ask patient to thoroughly rinse mouth with water.

1. Remove all items from envelope. Using **both swabs simultaneously**, carefully swab the patient's mouth and gum pockets. **Using both swabs**, prepare one smear. (*Smear should be confined to the circle area on the slide.*)

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Allow both swabs and smear to AIR DRY. **DO NOT DISCARD EITHER SWAB.** Place swabs in swab box marked "Oral".

2. When slide is dry, write "oral" on slide and place slide in slide mailer marked "Oral". Tape closed on one side only and fill out label on mailer.
3. Fill out all information requested on envelope; replace both slide mailer and swab box into envelope and seal.

STEP 2 BUCCAL SPECIMEN

Control Sample

NOTE: This step **MUST** be completed for DNA control sample of patient.

1. Instruct the patient to rinse the inside of mouth with water, using vigorous swishing.
2. Using the special swab from the envelope marked "Buccal Specimen", collect a specimen by vigorously swabbing the inside mid-section of the cheek 15 – 20 times.
3. Allow the swab to AIR DRY. When dry, place swab in box provided.
4. Fill out all information requested on the envelope; replace the swab box into envelope and seal.

STEP 3 TRACE EVIDENCE

Evidence Collection

1. To minimize the loss of evidence, place one sheet of exam table paper on the floor and then place another piece of exam table paper on top of that. The patient should disrobe over the top exam table paper, preferably in the presence of the examiner.
2. Fill out all information requested on the envelope; carefully fold only top exam table paper and place into envelope and seal.
3. Discard bottom exam table paper.

STEP 4 CLOTHING (collect all clothing unless patient objects)

Evidence Collection

NOTE: Wet or damp clothing should be **air dried** before packaging. Do not cut through any existing holes, rips, or stains in patient's clothing. Underwear is collected in next step; do not include underwear in this step.

1. **Clothing worn at the time of the assault** should be assessed carefully for potential evidentiary value such as stains, tears, debris or foreign matter. If you are collecting patient's clothing **ensure** she/he has access to other clothes.
2. Do not shake clothing as microscopic evidence may be lost. **Place each item into a SEPARATE PAPER bag (not provided).** Each bag should be labeled **before** article of clothing is placed in bag, seal bag and initial by examiner. Individual bags can then be put into one bag. Label with patient's name and type of items and tape bag closed.
3. If patient has changed clothes after assault and intends to release the kit to law enforcement, ask if it is possible for the patient to bring the clothing to the law enforcement agency handling the investigation. Patient should be instructed to package each piece of clothing individually into paper bags.

STEP 5 UNDERWEAR

Evidence Collection

NOTE: Wet or damp underwear should be **air dried** before packaging.

1. Patient's underwear should be collected regardless if it was worn at time of assault.
2. Fill out all information requested on envelope; place underwear into envelope and seal.
3. Ensure underwear envelope is put in kit.

STEP 6 DEBRIS COLLECTION

Evidence Collection

1. Remove paper bindle from Debris Collection envelope. Unfold and place on a flat surface. Collect any foreign material found on patient's body (leaves, fibers, glass, hair etc.), and place in center of bindle. Refold in a manner to retain debris.
2. Fill out all information requested on envelope; replace bindle into envelope and seal.

STEP 7 DRIED SECRETIONS AND/OR BITE MARKS

Evidence Collection

1. If dried secretion and/or bite marks are found or suspected, moisten **both swabs** with 1-2 drops of water. **Using both swabs simultaneously**, with a rolling motion carefully swab the area. Allow both swabs to AIR DRY.

APPENDIX Q - 1

2. When dry, place both swabs in swab box marked “**Dried Secretions and/or Bite Marks**”. **Label box indicating area of the body swabbed and possible type of secretion.** If additional dried secretion specimens are collected, use the second set of swabs and box provided. If still more swabs and boxes are needed, you may use standard hospital swabs and plain white stationery envelopes in lieu of the boxes.
3. Fill out all information requested on the envelope; replace swab boxes into envelope and seal.

STEP 8 FINGERNAIL SCRAPINGS

Evidence Collection

1. Remove both paper bindles and scrapers from envelope. Mark one bindle Left and one Right.
2. **Left hand** - Unfold one bindle and place on flat surface. Hold each finger over bindle while scraping gently under each nail with the stick provided so that any debris present will fall onto it. After all fingers on left hand are done, place scraper in center of bindle, refold to retain debris and scraper.
3. **Right hand** - Follow same procedure used for left hand.
4. Fill out all information requested on envelope; replace both bindles into envelope and seal.

NOTE: Pulled Hair Samples [from the National Protocol for Sexual Assault Medical Forensic Examinations]

[Follow jurisdictional policy for collection of hair reference samples. Many jurisdictions do not collect pubic hair reference samples routinely and some do not collect head hair reference samples routinely during the exam. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients. Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial exam, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as if it is collected at the time of the initial exam (e.g., due to fact that hair characteristics can change over time). When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed.] **Many of the hairs needed for evidence comparison can be collected by gently combing pubic or scalp region with fingers, followed with light pulling so the looser hairs close to natural shedding are removed. Give patients the option of collecting sample themselves.**

STEP 9 PULLED HEAD HAIRS

Control Sample

1. Remove paper bindle from envelope. Using thumb and forefinger, not forceps, **PULL, do not cut**, 5 hairs from each of the following scalp locations (for a total of 25 hairs): center, front, back, left side, right side. Place pulled hair in center of bindle and refold bindle.
2. Fill out all information requested on the envelope; replace bindle into envelope and seal.

STEP 10 PUBIC HAIR COMBINGS

Evidence Collection

1. Remove paper bindle from envelope and place beneath patient's genital area. Using the comb provided, comb pubic hair in downward strokes so that any loose hairs/debris will fall onto bindle. To reduce embarrassment and increase their sense of control, the patient may prefer to do the combing.
2. Carefully remove bindle. Place comb in center and refold in manner to retain comb and any evidence present.
3. Fill out information requested on envelope; replace bindle into envelope and seal.

STEP 11 PULLED PUBIC HAIRS

Control Sample

1. Remove paper bindle from envelope. Using thumb and forefinger, not forceps, **PULL, do not cut**, 15 full length hairs from various areas of the pubic region and place pulled pubic hair in center of bindle and refold bindle.
2. Fill out all information requested on envelope; replace bindle into envelope and seal.

STEP 12 PERIANAL AND ANAL SWABS AND SMEAR

Evidence Collection

NOTE: Do not stain or chemically fix smear. Swabs may be moistened with 1 or 2 drops of water prior to collection. Take special care not to contaminate the patient's anal area with debris from the vaginal area. **Perianal swabs should be taken (even without history of anal contact) as secretions may pool in this area. If both sets of swabs are collected (perianal and anal), it is preferable to make the slide from the anal swabs.**

1. Remove all items from envelope. Follow either 2a or 2b below as needed.
- 2a. **If only perianal swabs are to be collected**, proceed as follows: Using two swabs simultaneously, moisten if necessary with 1 or 2 drops of water and with a rolling motion carefully swab the perianal area. Using both swabs, prepare one smear on slide provided and allow to **AIR DRY**. (*Smear should be confined to the*

circle area on the slide.) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "Perianal/Anal". Tape closed on one side only and fill out label on mailer indicating perianal area. Allow both swabs to AIR DRY. When swabs are dry, place in swab box marked "Perianal".

- 2b. **If both perianal and anal swabs are to be collected**, proceed as follows: Using two additional swabs simultaneously, moisten with 1 or 2 drops of water if necessary and with a rolling motion carefully swab the perianal area. Allow to air dry. Using two additional swabs simultaneously, gently swab the anal canal. Using both swabs, prepare one smear on slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "Perianal/Anal". Tape closed on one side only and fill out label on mailer indicating anal area. When swabs are dry place in appropriate swab box marked "Perianal" or "Anal".
3. Fill out all information requested on the envelope; replace swab boxes and slide mailer into envelope and seal.

STEP 13 VULVAR OR PENILE SWABS AND SMEAR

Evidence Collection

1. Remove all items from envelope. Moisten swabs with 1-2 drops of water. **Using both swabs simultaneously**, with a rolling motion carefully swab the external genitalia including along the folds between the labia majora and labia minora in the female patient. For male patients, swab the penis and scrotum. Prepare one smear on the slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** Allow both swabs to AIR DRY.
2. When swabs and slide are dry, place swabs in box marked "Vulvar/Penile". Place slide in slide mailer marked "Vulvar/Penile". Tape closed on one side only and fill out label on mailer. Circle appropriate collection area on swab box and slide mailer.
3. Fill out all information on envelope to include possible type of secretion; replace swab box and slide mailer into envelope and seal.

STEP 14 VAGINAL SWABS AND SMEAR

Evidence Collection

NOTE: Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection. Take special care not to contaminate the patient's vaginal area with any debris from the anal area.

It is generally unnecessary to use a speculum when evaluating injuries and collecting specimens in a prepubescent or young adolescent female. **NEVER USE AN ADULT SIZE SPECULUM WHEN EXAMINING THESE PATIENTS.** Even a pediatric speculum may cause further trauma. Specimens for culture and forensic analysis may be obtained by using a cotton-tipped applicator. In prepubescent children, a vaginal (not cervical) specimen is appropriate for STD culture. In cases where extensive injury or foreign bodies cannot be ruled out, or if the exam might cause further trauma to the child, or the child is too distressed to cooperate for the exam, an Examination Under Anesthesia (EUA) is recommended.

1. Remove all items from envelope. Using two swabs simultaneously, carefully swab the vaginal vault. Allow both swabs to AIR DRY. When dry, place in swab box marked "Vaginal".
2. Using two additional swabs, repeat the swabbing procedure of the vaginal vault. Prepare one smear on the slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "vaginal". Tape closed on one side only and fill out label on mailer. When swabs are dry place in swab box marked "Vaginal". **(If a speculum is used for this step, do not remove until next step is completed.)**
3. Fill out all information on envelope; replace swab boxes and slide mailer into envelope and seal.

STEP 15 CERVICAL SWABS AND SMEAR

Evidence Collection

NOTE: This step is particularly important if more than 12 hours have passed since the assault. Do not moisten swabs prior to sample collection. **DO NOT COLLECT ON PREPUBERTAL CHILDREN.**

1. Remove all items from envelope. Using two swabs simultaneously, carefully swab the cervix and cervical os. Allow both swabs to AIR DRY. When dry, place in swab box marked "Cervical".
2. Using two additional swabs, repeat the swabbing procedure of the cervix and os. Prepare one smear on the slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "Cervical". Tape closed on one side only and fill out label on mailer. When swabs are dry, place in swab box marked "Cervical".

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3. Fill out all information on envelope; replace swab boxes and slide mailer into envelope and seal.

FINAL INSTRUCTIONS

1. Make sure each envelope used contains all requested items and information. **Envelopes which were NOT used should bear a mark in the "NO" box next to the "Was sample collected?" line.**
2. Remove the Police Evidence Seal from the box. Return all evidence envelopes and instruction sheet to the kit box. **If photographs were taken, do not include them in the kit.** Include photos in the patient's medical record, or release to investigating officer as determined by your institution's policy.
3. **Do not include blood or urine in this kit.** Sign the Police Evidence Seal and use it to seal the box.
4. Fill out information requested on top of box in space provided for Hospital Personnel.
5. Give sealed kit and clothing bags to the investigating officer. If officer is not present, place sealed kit in a secure area, in accordance with established protocol. Just as it is the responsibility of each facility to properly collect evidence in sexual assault cases, it is also their responsibility to ensure that evidence is properly maintained, and the chain of custody is documented. New York State Public Health Law 2805-i (Appendix A of the Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault) requires that evidence be secured for 30 days.

**Patient information form
Formulario de informacion sobre el paciente**

Patient Name/Nombre y apellido del paciente : _____

Hospital Name/Nombre del hospital : _____

Date of Examination/Fecha del examen: _____

Examining Practitioner/Médico que practicó el examen: _____

With your consent, a number of specimens were collected from you to provide evidence in court should the case be prosecuted. You may call _____ at _____ to discuss the release of disposition of the sexual offense evidence collected today. Additional tests were conducted as follows:

Usted dio su autorización para que le sacaran muestras de laboratorio que, en caso de juicio, se presentarán como prueba ante los tribunales. Usted puede llamar a _____ al _____ para hablar sobre la presentación o entrega de la muestra que le sacaron hoy como prueba del delito sexual. Además, le hicieron las siguientes pruebas :

	Yes/Si	No
1. A blood test for syphilis/Análisis de sangre para detectar sífilis	<input type="checkbox"/>	<input type="checkbox"/>
2. A blood test for Hepatitis B/Análisis de sangre para detectar hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
3. Smear and culture for:/Frotis y cultivo de:		
Gonorrhea/Gonorrea	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia/Clamidia	<input type="checkbox"/>	<input type="checkbox"/>
Trichomonas/Tricomonas	<input type="checkbox"/>	<input type="checkbox"/>
4. Other (specify)/Otras pruebas (indicar) _____		

You were given medication as follows:/Le dieron los siguientes medicamentos:

Name of medication/Nombre del medicamento	Dosage/Dosis	For/Por
_____	_____	_____
_____	_____	_____
_____	_____	_____

Remarks:/Observaciones: _____

You were not given any treatment medication because/No le hicieron tratamiento con medicamentos porque:

You were given information/referrals for the following:/Le dieron la siguiente información/referencias:

	Agency/Agencia	Number/Numero
Rape Crisis Counseling/Apoyo psicológico por violación	_____	_____
HIV/AIDS counseling and Testing/Apoyo psicológico y Para detectar el VIH/SIDA	_____	_____
Crime Victims Compensation/Compensación a las Víctimas de crímenes	_____	_____
Other/Otras agencies	_____	_____

An appointment was made for you at this hospital for follow-up medical treatment on _____ (date).
Le dieron una hora en este hospital para el tratamiento médico subsiguiente el _____ (fecha).

An appointment was made for you at this hospital for follow-up counseling on _____ (date).
Le dieron una hora en este hospital para la sesión de apoyo psicológico subsiguiente el _____ (fecha).

(Health Practitioner Signature)/(Firma del profesional de la salud)

I have received this Patient Information Form/He recibido este formulario de información sobre el paciente.

(Patient/Parent/Guardian Signature)/(Firma del paciente/padre/madre/tutor)

I do not wish to receive this form./No deseo recibir este formulario.

(Patient/Parent/Guardian Signature)/(Firma del paciente/padre/madre/tutor)

Distribute one copy to patient/Entregue una copia al paciente.

File one copy in Medical Record/Archive una copia en la historia clínica

APPENDIX Q - 3

Print Name or Use Patient Plate

MEDICAL RECORD SEXUAL ASSAULT FORM

I. HISTORY DATE OF VISIT TIME

Significant past medical history:

Approximate Time of Attack Is patient pregnant? LMP Medications

Allergies

Date of Attack Usual form of birth control

Is patient bleeding from an injury? Yes No

If yes, describe location:

II. PHYSICAL EXAMINATION (Note all evidence/details of trauma):

III. PELVIC/GENITOURINARY EXAM

Ext/BUS/Hymen Cervix Adnexae Vagina Uterus Rectal Penis Scrotum

IV. DIAGNOSTIC TESTS

Pregnancy test GC Cultures (Pharyngeal Cervical Urethral Rectal) VDRL Chlamydia Hepatitis B Other

V. TREATMENT

Tetanus Toxoid Pregnancy Prevention STI Prophylaxis Other

VI. EVIDENCE COLLECTION

Evidence collected? Y N Evidence kit released to law enforcement? Y N

Written consent? Y N

VII. FOLLOW UP APPOINTMENT

1. Medical: (Adults should be seen within 2 weeks) 2. Counseling:

Examining Health Practitioner:

Health Practitioner:

Signature

Signature

Print Name

Print Name

USE FRESH GLOVES FOR EACH STEP

STEP 1

(Evidence Collection)

ORAL SWABS AND SMEAR

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: This step is to collect possible perpetrator DNA. Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection.

1. Using **both** swabs simultaneously, carefully swab the patient's mouth and gum pockets. **Using both swabs**, prepare one smear. (*Smear should be confined to the circle area on the slide.*) Allow **both** swabs and slide to AIR DRY. **DO NOT DISCARD EITHER SWAB.**
2. When slide is dry, write "oral" on slide and place slide in slide mailer marked "Oral". Tape closed on one side only and fill out label on mailer. When swabs are dry, place in swab box marked "Oral".
3. Fill out all information requested on envelope, replace slide mailer and swab box into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 2

(Control Sample)

BUCCAL SPECIMEN

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
 PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: This step MUST be completed for DNA control sample of patient.

1. Instruct the patient to rinse the inside of mouth with water, using vigorous swishing.
2. Using the special swab from the envelope marked "Buccal Specimen", collect a specimen by vigorously swabbing the inside mid-section of the cheek 15-20 times.
3. Allow the swab to AIR DRY. When dry, place swab in box marked "Buccal Specimen".
4. Fill out all information requested on the envelope; replace swab box into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 3

(Evidence Collection)

TRACE EVIDENCE

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
 PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

1. To minimize the loss of evidence, place one sheet of exam table paper on the floor and then place another piece of exam table paper on top of that. The patient should disrobe over the top exam table paper, preferably in the presence of the examiner.
2. Fill out all information requested on envelope, carefully fold **only** top exam table paper and place into envelope and seal.
3. Discard bottom exam table paper.

NO ENVELOPE FOR THIS STEP – INSTRUCTIONS ONLY**STEP 4*****(Evidence Collection)*****CLOTHING**

NOTE: Wet or damp clothing should be **air dried** before packaging. Do not cut through any existing holes, rips, or stains in patient's clothing. Underwear is collected in next step; do not include underwear in this step.

1. Clothing worn at the time of the assault should be assessed carefully for potential evidentiary value such as stains, tears, debris or foreign matter. If you are collecting patient's clothing ensure she/he has access to other clothes.
2. Do not shake clothing as microscopic evidence may be lost. **Place each item into a SEPARATE PAPER bag (not provided).** Each bag should be labeled **before** article of clothing is placed in bag, seal bag and initial by examiner. Individual bags can then be put into one bag. Label with patient's name and type of items and tape bag closed.
3. If patient has changed clothes after assault and intends to release the kit to law enforcement, ask if it is possible for the patient to bring the clothing to the law enforcement agency handling the investigation. Patient should be instructed to package each piece of clothing individually into paper bags.

USE FRESH GLOVES FOR EACH STEP

STEP 5

(Evidence Collection)

UNDERWEAR

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: Wet or damp underwear should be AIR DRIED before packaging. Do not cut through existing holes, rips, or stains in patient's underwear.

1. Patient's underwear should be collected regardless if it was worn at time of assault.
2. Fill out all information requested on envelope; place underwear into envelope and seal.
Ensure underwear envelope is put into kit.

USE FRESH GLOVES FOR EACH STEP

STEP 6

(Evidence Collection)

DEBRIS COLLECTION

WAS SAMPLE COLLECTED? _____ YES _____ NO

IF YES, **MUST** DESCRIBE AREA(S) OF BODY COLLECTED FROM AND TYPE OF DEBRIS

Area(s) of body: _____

Type of Debris: hair biological sample unknown other _____

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

1. Remove and unfold paper bindle from Debris Collection envelope. Collect any foreign material found on patient's body (leaves, fibers, glass, hair, etc.), and place in center of bindle. Refold in a manner to retain debris.
2. Fill out all information requested on envelope; replace bindle into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 7 (Evidence Collection) DRIED SECRETIONS AND/OR BITE MARKS

WAS SAMPLE COLLECTED? _____ YES _____ NO

IF YES, **MUST** DESCRIBE AREA(S) OF BODY & POSSIBLE TYPE OF SECRETION:

Area(s) of Body: _____

Type of Secretion: saliva semen other unknown _____

Attach Patient's Identification Label here, or enter
 PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

1. If dried secretion and/or bite marks are found or suspected, moisten both swabs with 1-2 drops of water. **Using both swabs simultaneously**, with a rolling motion carefully swab the area.
2. Allow both swabs to AIR DRY. When dry, place in swab box marked "Dried Secretions and/or Bite Marks".
3. Label outside of box indicating area of body swabbed and possible type of secretion.
4. If additional dried secretion specimens are collected, use the second set of swabs and box provided and follow the procedure above; include the specimen in the kit. *(Standard hospital swabs and white envelopes may be used as needed.)*
5. Fill out all information requested on envelope, replace swab boxes into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 8

(Evidence Collection)

FINGERNAIL SCRAPINGS

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
 PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

BEFORE STARTING, MARK ONE BINDLE "LEFT" AND ONE "RIGHT"

1. **Left hand** – Unfold one bindle and place on flat surface. Hold patient's left hand over it while scraping under nails so that debris will fall onto bindle.
2. When all fingers on left hand are done, place scraper in center of bindle. Refold to retain debris and scraper.
3. **Right hand** – Follow same procedure used for left hand.
4. Fill out information requested on envelope; replace both bindles into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 9

(Control Sample)

PULLED HEAD HAIRS

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: Pulled Hair Samples Follow jurisdictional policy for collection of hair reference samples. Many jurisdictions do not collect pubic hair reference samples routinely and some do not collect head hair reference samples routinely during the exam. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients. Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial exam, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as if it is collected at the time of the initial exam (e.g., due to fact that hair characteristics can change over time). When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. **To alleviate any physical and emotional discomfort; many of the hairs needed for evidence comparison can be collected by gently combing scalp region with fingers, followed with light pulling so the looser hairs close to natural shedding are removed. Give patients the option of collecting sample themselves.**

1. Remove paper bindle from envelope. Using thumb and forefinger, not forceps, **PULL, do not cut**, 5 hairs from each of the following scalp locations (for a total of 25 hairs): center, front, back, left side, right side and place pulled hair in center of bindle and refold bindle.
2. Fill out all information requested on the envelope; replace bindle into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 10

(Evidence Collection)

PUBIC HAIR COMBINGS

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
 PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

1. Remove paper bindle from envelope and place beneath patient's genital area. Using the comb provided, comb pubic hair in downward strokes so that any loose hairs or debris will fall onto bindle. To reduce embarrassment, and increase their sense of control, the patient may prefer to do the combing.
2. Carefully remove bindle. Place comb in center and refold in manner to retain comb and any evidence present.
3. Fill out all information requested on envelope; replace bindle into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 11

(Control Sample)

PULLED PUBIC HAIRS

WAS SAMPLE COLLECTED? _____ YES _____ NO _____ N/A (*No pubic hair*)

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: Pulled Hair Samples Follow jurisdictional policy for collection of hair reference samples. Many jurisdictions do not collect pubic hair reference samples routinely and some do not collect head hair reference samples routinely during the exam. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients. Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial exam, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as if it is collected at the time of the initial exam (e.g., due to fact that hair characteristics can change over time). When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. **To alleviate any physical and emotional discomfort; many of the hairs needed for evidence comparison can be collected by gently combing the pubic region with fingers, followed with light pulling so the looser hairs close to natural shedding are removed. Give patients the option of collection sample themselves.**

1. Remove paper bindle from envelope. Using thumb and forefinger, not forceps, PULL, do not cut, 15 full length hairs from various areas of the pubic region and place pulled pubic hair in center of bindle and refold bindle.
2. Fill out all information requested on the envelope; replace bindle into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 12 *(Evidence Collection)*

PERIANAL AND ANAL SWABS & SMEAR

WAS PERIANAL SAMPLE COLLECTED? _____ YES _____ NO

WAS ANAL SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: Do not stain or chemically fix smear. Swabs may be moistened with 1 or 2 drops of water prior to collection. Take special care not to contaminate the patient's anal area with debris from the vaginal area. **Perianal swabs should be taken (even without history of anal contact) as secretions may pool in this area. If both sets of swabs are collected (perianal and anal), it is preferable to make the slide from the anal swabs.**

1. Remove all items from envelope. Follow either 2a or 2b below as needed.
- 2a. **If only perianal swabs are to be collected**, proceed as follows: Using two swabs simultaneously, moisten if necessary with 1 or 2 drops of water and with a rolling motion carefully swab the perianal area. Using both swabs, prepare one smear on slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "Perianal/Anal". Tape closed on one side only and fill out label on mailer indicating perianal area. Allow both swabs to AIR DRY. When swabs are dry, place in swab box marked "Perianal".
- 2b. **If both perianal and anal swabs are to be collected**, proceed as follows: Using two additional swabs simultaneously, moisten with 1 or 2 drops of water if necessary and with a rolling motion carefully swab the perianal area. Allow to air dry. Using two additional swabs simultaneously, gently swab the anal canal. Using both swabs, prepare one smear on slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "Perianal/Anal". Tape closed on one side only and fill out label on mailer indicating anal area. When swabs are dry place in appropriate swab box marked "Perianal" or "Anal".
3. Fill out all information requested on the envelope; replace swab boxes and slide mailer into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 13 (Evidence Collection) VULVAR OR PENILE SWABS & SMEAR

WAS SAMPLE COLLECTED? _____ YES _____ NO

Type of possible collection: saliva semen other unknown_____

Attach Patient's Identification Label here, or enter
 PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

1. Moisten swabs with 1-2 drops of water. **Using both swabs simultaneously**, with a rolling motion swab the external genitalia including along the folds between the labia majora and labia minora in the female patient. For male patients, swab the penis and scrotum. Prepare one smear on the slide provided and AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** Allow both swabs to AIR DRY.
2. When swabs and slide are dry, place both swabs in box marked "Vulvar/Penile." Place slide in slide mailer marked "Vulvar/Penile". Tape closed on one side only and fill out label on mailer. Circle appropriate collection; e.g. vulvar or penile area on swab box and slide mailer.
3. Fill out all information requested on the envelope; replace swab box and slide mailer into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 14

(Evidence Collection)

VAGINAL SWABS AND SMEAR

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection. *It is generally unnecessary to use a speculum when evaluating injuries and collecting specimens in a prepubescent or young adolescent female. **Never use an adult size speculum when examining these patients.** See instruction for more detail.* Take special care not to contaminate the patient's vaginal area with any debris from the anal area.

1. Remove all items from envelope. **Using two swabs simultaneously**, carefully swab the vaginal vault. Allow **BOTH** swabs to AIR DRY. When dry, place swabs in swab box marked "Vaginal".
2. Using the two additional swabs provided, repeat the swabbing procedure of the vaginal vault. Prepare one smear on the slide provided and AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in slide mailer marked "Vaginal". Tape closed on one side only and fill out label on mailer. When swabs are dry, place in swab box marked "Vaginal". (***If a Speculum is used for this step, do not remove until next step is completed.***)
3. Fill out all information requested on the envelope; replace swab boxes and slide mailer into envelope and seal.

USE FRESH GLOVES FOR EACH STEP

STEP 15

(Evidence Collection)

CERVICAL SWABS AND SMEAR

WAS SAMPLE COLLECTED? _____ YES _____ NO

Attach Patient's Identification Label here, or enter
PATIENT'S NAME:

DATE COLLECTED: _____

TIME: _____

COLLECTED BY: _____

NOTE: This step is particularly important if more than 12 hours have passed since the assault. Do not moisten swabs prior to sample collection. **DO NOT COLLECT ON PREPUBERTAL CHILDREN**

1. Remove all items from envelope. Using two swabs simultaneously, swab the cervix and cervical os. Allow both swabs to AIR DRY. When dry, place in swab box marked "Cervical".
2. Using two additional swabs, repeat the swabbing procedure of the cervix and cervical os. Prepare one smear on the slide provided and allow to AIR DRY. (*Smear should be confined to the circle area on the slide.*) **DO NOT DISCARD EITHER SWAB.** When slide is dry, place in the slide mailer marked "Cervical". Tape closed on one side only and fill out label on mailer. When swabs are dry, place in swab box marked "Cervical".
3. Fill out all information requested on envelope; replace swab boxes and slide mailer into envelope and seal.

FINAL INSTRUCTIONS

1. Make sure each envelope used contains all requested items and information. **Envelopes which were NOT used should bear a mark on the “NO” box next to the “Was sample collected?” line.**
2. Remove the Police Evidence Seal from the box. Return **all** evidence envelopes and instruction sheet to the kit box. **If photographs were taken, do not include them in the kit.** Include photos in the patient’s medical record, or release to investigating officer as determined by your institution’s policy.
3. Do not include blood or urine in this kit.
4. Sign the Police Evidence Seal and use it to seal the box.
5. Fill out information requested on top of box in space provided for Hospital Personnel.
6. Give sealed kit and clothing bags to the investigation officer. If officer is not present, place sealed kit in a secure area, in accordance with established protocol. Just as it is the responsibility of each facility to properly collect evidence in sexual assault cases, it is also their responsibility to ensure that evidence is properly maintained, and the chain of custody is documented. New York State Public Health Law 2805-i (Appendix A of the Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault) requires that evidence be secured for 30 days.

A health care assessment and evaluation must be offered to all patients reporting sexual assault, regardless of the length of time which may have elapsed between the assault and the examination. (If the assault occurred within 96 hours, a New York State Sexual Assault Evidence Collection Kit is used. If it is determined that the assault took place more than 96 hours prior to the examination, the use of an evidence collection kit is generally not necessary.)



Sexual Offense Evidence Collection Kit

Mfg.

By: 240 O'Conner Street
Wellsville, NY 14895
585-593-6645 ext. 321

FOR HOSPITAL PERSONNEL

*This kit may be ordered for VICTIM Evidence Collection at this website:
<http://www.criminaljustice.state.ny.us/ofpa/evidencekit.htm> or by calling 518-457-9726
This kit can be purchased at PWI directly for SUSPECT Evidence Collection.*

PATIENT'S NAME: _____

FEMALE _____ **MALE** _____ **DOB:** _____

HOSPITAL NAME: _____

Evidence Secured By: _____ **Date:** _____

Time Kit Opened: _____ am/pm

Kit Sealed by: _____ **Date:** _____

Time Kit Sealed: _____ am/pm

OTHER EVIDENCE TAKEN: YES _____ **NO** _____ **# OF PARCELS:** _____

PLACE KIT IN SECURED AREA AFTER USE

**FOR ALL WHO HANDLE KIT
CHAIN OF CUSTODY**

RECEIVED BY _____ DATE _____ TIME _____ AM PM

RECEIVED BY _____ DATE _____ TIME _____ AM PM

RECEIVED BY _____ DATE _____ TIME _____ AM PM

RECEIVED BY _____ DATE _____ TIME _____ AM PM

DELIVER TO CRIME LAB AS SOON AS POSSIBLE

FOR FORENSIC LAB PERSONNEL ONLY

LAB CASE NUMBER _____

POLICE CASE NUMBER _____

**IF THIS SEAL IS BROKEN
THE KIT MAY STILL BE USED IF
CONTENT BAG IS STILL INTACT.**

**NO BLOOD OR URINE SHOULD BE
INCLUDED IN THIS KIT**

APPENDIX R

Sample Checklist for Sexual Assault Care

APPENDIX R

Sample Checklist for Sexual Assault Care

The following list is provided to assist examiners in providing comprehensive care. Some patients may not require all of the interventions; for others, the list is not exhaustive. Examiners must use their clinical judgment to implement the following interventions as necessary.

- Rape Crisis Center victim advocate services
- Consent for care and treatment
- Consent for release of sexual offense evidence collection kit
- Consent for use of the drug facilitated sexual assault kit, if applicable
- Consent for HIV testing
- Consent for photo documentation of injuries
- HIV testing
- Hepatitis B testing
- Hepatitis C testing
- HIV prophylaxis
- Hepatitis B prophylaxis
- STI prophylaxis for gonorrhea, chlamydia, bacterial vaginosis, and trichomonas, if indicated
- Prophylaxis against pregnancy resulting from sexual assault
- Sexual Offense Evidence Collection Kit
- Drug Facilitated Sexual Assault Kit, if applicable
- Photographs of injuries
- Patient education and recommendations for follow-up care
- Patient provided with name and phone number of hospital contact for release of information
- Written documentation to patient of testing, treatment, and referral

APPENDIX S

**Authorization for Release of
Information and evidence
to Law Enforcement Agency**

APPENDIX S

Authorization for Release of Information and Evidence to Law Enforcement Agency

Patients Name:
Date of Birth:
Hospital Number:
I hereby authorize:
(Name of Hospital)
to release the following information covering treatment

Attach Ferrington Tab Identification Here or Enter Patient's Name

given to me on month day year to (Name of law enforcement agency)

AUTHORIZED FOR RELEASE NOT AUTHORIZED FOR RELEASE (Check those which apply)

- 1. One sealed evidence kit, including specimens Collected
2. X-rays or copies of X-rays taken in connection with examination
3. Photographs
4. Clothing
Other

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

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

Signature of person authorizing release of information:

RECEIPT OF INFORMATION

I certify that I have received the following items (check those which apply): One sealed evidence kit X-rays or copies of X-rays Photographs Sealed clothing bag(s) (if more than one sealed clothing bag, please note):

Print name of person receiving information and articles

Signature of person receiving Information and/or articles: Date Time

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

Person receiving articles is a representative of

Name of person releasing articles: Printed Name Signature

Distribute: One copy to patient One copy to medical records One copy to law enforcement agency

Appendix T

HIV Clinical Education Centers
for consultation on
HIV Antiretroviral Prophylaxis
Following Sexual Assault

HIV Clinical Education Centers for consultation on
HIV antiretroviral prophylaxis following sexual assault
(Dated: November 2003)

New York City Area

Bronx:

Bronx-Lebanon Hospital Center HIV AIDS Clinical Education & Training Program
(Bronx)
(718) 901-8538 (8am-5pm)
(718) 590-1800 (after hours) - - ask for infectious disease consult on call

Brooklyn:

SUNY Downstate Medical Center (Brooklyn & Staten Island)
For adults: (718) 270-2121 (all hours - ask for STAR clinician on call)
For pediatrics: (800) 921-5617 (all hours - ask for pediatric infectious disease
physician on call)

Manhattan:

St. Vincent's Catholic Medical Center - St. Vincent's Manhattan (Boroughs of
Manhattan)
For adults: (212) 604-2980 (work hours), (212) 604-8006 (ER) (after hours)
For pediatrics: (212) 604-1545 (work hours), (212) 604-8052 (after hours)

Queens:

New York Hospital Medical Center (Queens)
(718) 670-1231 (all hours), press "O" for an operator & ask for infectious disease
physician on call

Long Island:

Nassau University Medical Center AIDS Program (Nassau & Suffolk Counties)
(516) 572-5210 (all hours)

Upstate Area

Albany Medical Center, Division of HIV Medicine (Albany, Columbia, Delaware,
Dutchess, Greene, Montgomery, Ostego, Schenectady, Rensselaer, Schoharie &
Ulster Counties)

For adults: (518) 262-4043 (M-F, 8am-4pm), after hours emergency, ask for AIDS
Treatment Center doctor on call

For pediatrics: Division of Pediatrics, (518) 262-6888 (M-F, 8:30am-4:30pm), all other
hours ask for pediatric infectious disease physician on call

Erie County Medical Center AIDS Center (Allegany, Cattaraugus, Chautauqua, Erie,
Genesee, Niagara, Orleans and Wyoming Counties)

(718) 898-4119 (M-F, 8:30am-4:30pm)

(716) 898-4167 (ER) (all other others)

University of Rochester/Strong Memorial Hospital (Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Tioga, Wayne & Yates Counties)

For adults: AIDS Center (585) 275-8418, ask for ID Team II

For pediatrics: (585) 275-5944 (8am-4pm), (585) 275-2222 (all other hours), ask for pediatric infectious disease physician on call

SUNY Upstate Medical University, Syracuse, Department of Medicine (Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Tompkins & St. Lawrence Counties)

For adults: (315) 464-5533 (M-F, 8:30am-4pm), (315) 464-5540 (all other hours), ask for infectious disease physician on call

For pediatrics: (315) 464-6331 (M-F, 8:30am-4pm), (315) 701-7190 (after hours) ask for pediatric infectious disease physician on call

Upper Hudson Primary Care Consortium (Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, Warren & Washington Counties)

(518) 748-0162 (beeper - all hours)

Westchester Medical Center AIDS Care Center (Orange, Putnam, Rockland, Sullivan & Westchester Counties)

For adults: (914) 450-3016 (all hours)

For pediatrics: (914) 493-7307 (ER) (all other hours)

APPENDIX U

Sample Standing Orders for a Patient Reporting Sexual Assault

Sample Standing Orders for a Patient
Reporting Sexual Assault

Standing Orders for a Patient Reporting Sexual Assault		
Date	Time	
		Beta HCG (blood or urine)
		Hepatitis B surface antigen (Anti-HBs) titre
		Plan B 1 pill x 2 q12h (or see page 45 for list of emergency contraception medications) [<i>pregnancy prevention</i>]
		Azithromycin 1 g PO x 1 now [<i>chlamydia coverage</i>]
		Ofloxacin 400 mg PO x 1 now [<i>gonorrhea coverage</i>]
		Prochlorperazine 10 mg sustained release capsule PO q12h prn for nausea
		Metronidazole 2 g PO
		If the patient is not previously vaccinated for hepatitis B and is HBsAg negative, initiate hepatitis B vaccine series [<i>hepatitis B prophylaxis</i>]
		And, if perpetrator is known hepatitis B-positive, administer HBIG (0.06 mL/ kg) (Hepatitis B prophylaxis)
		HIV testing (refusal and/or delay of testing should not preclude Initiation of HIV PEP)
		If the patient meets the criteria for HIV post-exposure prophylaxis, then proceed with regimen below:
		ZDV 300 mg PO bid x 28 days [<i>HIV post-exposure prophylaxis</i>] PLUS
		Lamivudine 150 mg PO bid x 28 days (or combivir 1 bid - instead of ZDV and Lamivudine) [<i>HIV post-exposure prophylaxis</i>] PLUS
		Tenofovir 300 mg PO qd [<i>HIV post-exposure prophylaxis</i>]

APPENDIX V

Crime Victims Board Reimbursement For Services Provided to Victims of Sexual Assault

Crime Victims Board Reimbursement for Services
Provided to Victims of Sexual Assault

Introduction

New legislation signed into law in 2003 will provide for direct reimbursement by the Crime Victims Board (CVB) to providers of forensic health care examination services. This reimbursement will ensure that sexual assault survivors are not billed for any forensic health care examination services. The reimbursement fee will cover the examiner's services, related facilities' costs, and basic laboratory tests and pharmaceuticals. The fee will be \$800, and this fee will be reviewed and, may, if appropriate, adjusted annually by CVB and the Department of Health. The statute becomes effective as of April 1, 2005. More information about this new forensic reimbursement will be issued prior to the effective date.

Follow-up HIV post-exposure prophylaxis costs and the costs of any other long-term pharmaceuticals will continue to be reimbursed according to previously established CVB procedure.

Survivors may also voluntarily assign private insurance benefits to cover the forensic exam in which case the hospital or health care institution may not bill the CVB.

CVB reimbursement for sexual assault survivors until March 31, 2005

Eligible sexual assault victims may obtain compensation in one of two ways, depending on their needs. Individuals in need of more information may contact an office of the CVB at the following telephone numbers:

- Albany (518) 457-8727
- Buffalo (716) 847-7992
- Brooklyn (718) 923-4325.

Victims may also contact a Rape Crisis Center or Victims Services Agency in their county or region. A list of the Rape Crisis Services by county is in Appendix M of this *Protocol*. Many have 24-hour hotlines. These programs may be able to assist individuals in filing claims with CVB, particularly when emergency assistance is needed. These agencies can often provide immediate assistance to victims. CVB also has a resource directory available on its website (www.cvb.state.ny.us) which includes a listing of victim service programs in different areas of the state.

Standard Reimbursement Method

Some sexual assault victims may be able to pay for medication at the time of treatment. These individuals should use the standard procedure for filing a claim with the CVB to receive compensation for unreimbursed medical expenses (see above information regarding filing a CVB claim).

Emergency Reimbursement Method

Victims who suffer undue hardship as a result of expenses resulting from the sexual assault, including medical expenses, are eligible to apply for a CVB emergency award. The amount of each emergency award cannot exceed \$500, and there is a maximum total of emergency awards of \$1,500. The total amount of the emergency awards will be deducted from any final award made to the claimant. The CVB has also developed special procedures to ensure the availability of post-exposure prophylactic HIV treatment for sexual assault victims. CVB will contact the prescription provider to attempt to facilitate availability of needed drugs, if requested to do so, and will directly reimburse pharmacy providers.

The Board prior to the issuing of an emergency award must receive a claim, including a completed and signed affidavit. The Board funds programs in every county of the state which can help with the processing of claims and which can forward the claims by fax to the main office of the Board for immediate consideration for an emergency award.

Emergency award checks are issued only in the CVB offices in Albany, New York City, and Buffalo. Arrangements can be made for checks to be forwarded to the local crime victim service programs, but such forwarding will add to the time required to get a check to the claimant.

Reimbursement for HIV Prophylaxis

Various reimbursement methods may be available for prophylaxis, including Medicaid, Medicare, Crime Victims Compensation, or third-party reimbursement, if the individual has prescription drug coverage. In cases where the facility does not receive reimbursement for these services, such expenses shall be included in their annual Institutional Cost Report as part of indigent care costs.