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,

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 received[1]; 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.

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

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;

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).

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

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,

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.

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

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 then 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 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?

- memory loss including "snapshots" or "cameo memories"
- confusion
- impaired motor skills
- reduced inhibition
- 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.**

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

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) 457-3776 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,

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**

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

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.

Step 4 Evidence Collection

► *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.**

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

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.

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 Combings*

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.

► *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.

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.

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.

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.

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.