

B. Operational Issues

This section discusses components essential to conducting the sexual assault forensic examination: the health care providers conducting the exam, the facilities where exams are performed, the equipment and supplies needed during the exam, and the sexual assault evidence collection kit. It also discusses timing considerations in collecting evidence and evidence integrity during and after the exam.

The following chapters are included:

1. Sexual Assault Forensic Examiners
2. Facilities
3. Equipment and Supplies
4. Sexual Assault Evidence Collection Kit
5. Timing Considerations for Collecting Evidence
6. Evidence Integrity

1. Sexual Assault Forensic Examiners

Recommendations at a glance for jurisdictions to build capacity of examiners to conduct these exams:

- Encourage the development of specific examiner knowledge, skills, and attitudes.
 - Encourage the advanced education and supervised clinical practice of examiners, as well as certification for nurses who are examiners.
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It is critical that health care providers conducting the sexual assault medical forensic exam are committed to providing compassionate and quality health care, collecting evidence in a thorough and appropriate manner, and testifying in court if needed. Their commitment should be grounded both in an understanding that sexual assault is a serious crime that can have profound, negative effects on those victimized and in recognition of the role of advanced education and clinical experience in building competency to perform the exam.

A growing trend across the United States is the use of sexual assault nurse examiners (SANEs) to conduct the exam. SANEs are registered nurses who receive specialized education and fulfill clinical requirements to perform these exams. Some nurses have been certified as SANEs—Adult and Adolescent (SANE–A) through the International Association of Forensic Nurses (IAFN).¹⁰⁴ Others are specially educated and fulfill clinical requirements as forensic nurse examiners (FNEs), enabling them to collect forensic evidence for a variety of crimes. The terms “sexual assault forensic examiner” (SAFE) and “sexual assault examiner” (SAE) are often used more broadly to denote a health care provider (e.g., a physician, physician assistant, nurse, or nurse practitioner) who has been specially educated and completed clinical requirements to perform this exam.

All communities should strive to ensure that victims of a recent sexual assault have access to specially educated and clinically prepared examiners to perform the medical forensic exam. As much as possible, examiners should be permanent rather than on temporary assignment in a jurisdiction. It can be challenging for examiners who are temporary (e.g., at an Indian Health Service facility) to understand needs of victims from the community or to be familiar with jurisdictional policies and procedures. If they move to another job assignment, arranging for them to testify in court can be complicated.¹⁰⁵

Encourage the development of specific knowledge, skills, and attitudes. Conducting a sexual assault medical forensic examination is a complex and time-consuming procedure. It is useful for examiners to have specific knowledge and skills that can guide them as they perform these exams.¹⁰⁶ For example, it is beneficial for them to know about the following:

- The dynamics and impact of sexual victimization;
- Jurisdictional laws related to sexual offenses;
- Coordinated multidisciplinary response, roles of each responding agency, and procedures for communicating with each agency during immediate response;
- The importance of examiner neutrality and objectivity during the examination;
- The broad spectrum of potential evidence and physical findings in these cases;
- The importance of the medical forensic history and other documentation;

¹⁰⁴ Eligibility criteria for IAFN SANE Adult/Adolescent certification includes: registered license as an R.N. in the United States or its Territories, or a license as a first-level general nurse in the jurisdiction of current practice; a minimum of 2 years of practice as an R.N. in the United States or as a first-level general nurse in the country of licensure; successful completion of an adult/adolescent SANE education program that includes either (a) a minimum of 40 continuing education contact hours of classroom instruction, or (b) 3 semester hours (or the equivalent) of academic credit in an accredited school of nursing, and sufficient supervised clinical practice until determined competent in SANE practice. An appropriate clinical authority, as outlined in the adult section of the IAFN *SANE Education Guidelines* (1998) must validate current SANE competency. (Drawn from the *IAFN SANE Certification Brochure*, available at www.iafn.org.)

¹⁰⁵ Most hospitals or medical clinics that physicians or advanced practice nurses are employed by or affiliated with require them to apply for facility privileges. Those requesting privileges usually must agree to provide forwarding addresses when they leave. Also, medical licenses can be tracked to the State or Territory where the health care provider is working.

¹⁰⁶ The next two bulleted sections are adapted from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, pp. 25–26, produced by the California Governor's Office of Criminal Justice Planning. Also see L. Ledray's *SANE Development and Operation Guide*, pp. 54–55, for information on SANE training components.

- Proper evidence collection and preservation procedures;
- Preexisting needs and circumstances of patients that may affect how the exam is conducted;
- Treatment options and procedures for common concerns such as pregnancy, STIs, and HIV infection;
- Equipment, supplies, and medication typically used during the exam;
- Precautions to prevent exposure to potentially infectious materials;¹⁰⁷
- Indications for followup health care and documentation of injuries;
- Applicable laws and protocols regarding performance of medical forensic exams and standardized forms used to document findings;
- Patients' needs for support, crisis intervention, advocacy, information, and referrals during the exam process, local resources for addressing these needs, and procedures for accessing resources;
- The importance of establishing vehicles to ensure the quality of the exam and related documentation;
- Examiner court testimony (what it involves and how examiners can prepare for it); and
- Applicable research findings, technological advances, and promising practices.

It is useful for examiners to be able to:

- Preserve their neutrality and objectivity in each case;
- Assess patients' clinical condition (physical and psychological assessment¹⁰⁸) and provide appropriate treatment and medical referrals (e.g., to a surgeon);
- Adapt exam procedures to address patients' needs and circumstances as much as possible;
- Take measures during the exam process to reduce the likelihood of patients' retraumatization;
- Take precautions according to facility policy to prevent exposure to potentially infectious materials;
- Contact advocates upon initial contact with patients (where available) so they can offer patients support, crisis intervention, advocacy, information, and community referrals before, during, and after the exam;¹⁰⁹
- Gather information sensitively from patients for a medical forensic history and use the history as a guide when performing an exam;
- Explain to patients what items need to be collected for evidence and for what purposes;
- If patients want to report, promptly involve law enforcement representatives and work with them to maximize the collection of evidence from patients and from crime scenes;
- Identify and describe pertinent genital and anorectal anatomical structures and external landmarks;
- Identify and document injuries and interpret physical findings;
- Use enhancement techniques for detection and documentation of findings;
- Collect and preserve evidence for analysis by the crime laboratory;
- Collect and preserve toxicology samples in suspected drug-facilitated sexual assault cases;
- Maintain and document the chain of custody for evidence;
- Maintain the integrity of the evidence to ensure that optimal lab results are obtained;
- Evaluate the possibility of STIs and HIV infection and provide prophylactics and/or treatment;

¹⁰⁷ See the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) for its Bloodborne Pathogens Standard (CFR 1910.1030). It may be accessed at www.osha.gov or by calling 800-321-OSHA. According to this standard, bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans. Among other things, the standard requires employers who have employees at risk for occupational exposure to bloodborne pathogens and other potentially infectious materials to develop plans to eliminate or minimize employee exposure. It also advises universal precautions that should be observed to prevent contact with blood or other potentially infectious materials (this approach treats all human blood and certain human body fluids as if they are known to be infectious). In addition, the standard requires employers to ensure that all employees at risk participate in a training program to inform them of risks, related facility policies, and necessary precautions. Employers must also establish and maintain a record for each employee with occupational exposure.

¹⁰⁸ Examiners typically assess patients' psychological functioning to determine whether there is a risk for suicide and whether patients are oriented to person, place, and time. They may request a mental health evaluation for patients, if necessary.

¹⁰⁹ It is helpful if jurisdictions clarify the specific roles of advocates and examiners during the exam process. In the absence of advocates or other victim service providers, examiners may be responsible for providing crisis intervention and support to patients. In situations where examiners are both collectors of evidence and crisis counselors, it is important to understand whether these dual roles affect their ability to testify in an unbiased manner.

- Assess pregnancy risk and discuss treatment options with the patient, including reproductive health services;
- Ensure that patients' immediate medical needs and concerns are addressed and appropriate medical referrals are provided prior to discharge;
- Recognize evidence-based conclusions and limitations in the analysis of findings;
- Complete standard forms for documenting the medical forensic results of the exam;
- Discuss evidentiary findings with investigators, prosecutors, and defense attorneys as requested (according to jurisdictional policy); and
- Testify in court if needed.

Encourage a minimum standard for advanced education and supervised clinical practice for health care personnel conducting the exam, as well as certification for nurse examiners. Such a standard must speak to specific education and supervision needs of involved disciplines. For example, nonphysician examiners may require medical supervision and backup, in addition to completing necessary training and clinical requirements. Certification through the IAFN is currently available only to nurses trained as SANEs. When designing classroom education for examiners, make sure the examiners understand the importance of a multidisciplinary response during the exam process. Consider involving trainers from health care, advocacy, law enforcement, prosecution, judiciary, and crime laboratories.

Standardized curricula on sexual assault exams in medical school, nursing and nurse practitioner programs, and physician assistant programs are recommended. Consideration must be given to how to systematically secure, supervise, and retain examiners in/for poor, rural, or remote areas, institutional settings,¹¹⁰ military bases, college campuses, tribal lands, migrant farm worker communities, and other areas needing increased victim outreach. Examiners need to know how to respond in a respectful manner to various populations within their community (e.g., local tribal victim service providers may be able to provide training on cultural beliefs and practices that might be relevant in sexual assault cases).

In addition, other health care providers who come into contact with patients who disclose a recent assault need information on procedures for obtaining immediate patient assistance and caring for patients prior to their arrival at the exam site.

◦ Examples of institutional settings include prisons, jails, immigration detention centers, juvenile detention centers, jails, nursing homes, assisted living programs and rehabilitation programs and inpatient treatment centers.

2. Facilities

Recommendations at a glance for jurisdictions to build the capacity of health care facilities to respond to sexual assault cases:

- Recognize the obligation of health care facilities to serve sexual assault patients.
- Ensure that exams are conducted at sites served by examiners with advanced education and clinical experience.
- Communities should explore what is best for them regarding locations of exam sites.
- Communities may wish to consider developing basic requirements for designated exam sites.
- Promote public awareness about designated exam sites, ensuring information is disseminated to appropriate agencies and community members. Encourage first responders to work together to assist victims in using these sites.
- If a transfer from one health care facility to a designated exam site is necessary, use a protocol that minimizes time delays and loss of evidence and addresses patients' needs. However, avoid transferring these patients where possible.

Recognize the obligation of health care facilities to serve sexual assault patients.¹¹¹ It is essential that all sexual assault patients who present to health care facilities be thoroughly evaluated. Treating injuries alone is not sufficient in these cases. Staff who examine these patients must be educated and clinically prepared to collect evidence and document findings while maintaining the chain of custody. They should be able to coordinate crisis intervention and support for patients, as well as provide STI evaluation and care, pregnancy assessment, and discuss treatment options, including reproductive health services. They must be aware of and follow jurisdictional reporting policies, and be able to provide court testimony if necessary.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)¹¹² requires emergency and ambulatory care facilities to have established policies for identifying and assessing possible victims of rape and other sexual molestation. It also requires staff to be trained on these policies. As part of the assessment process, JCAHO requires these facilities to define their responsibilities related to the collection and preservation of evidentiary materials.¹¹³ Sexual assault examiner programs are helping many health care facilities to carry out these requirements. Facilities should also familiarize themselves with the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), which has provisions pertaining to the ability of hospitals to turn away patients with emergency medical conditions.¹¹⁴

Conduct exams at sites served by specially educated and clinically prepared examiners. Some jurisdictions designate specific facilities as exam locations because they employ or have ready access to specially educated and clinically prepared examiners, as well as the necessary space, equipment, supplies, and policies to facilitate the exam process. Jurisdictions may rely on examiner programs to serve multiple exam sites within a specific area.¹¹⁵ Communities can benefit from designated exam facilities and examiner programs that use specially educated and clinically prepared examiners to conduct the exam because they:

- Increase the likelihood of a state-of-the-art examination;
- Enhance a coordinated team approach;

¹¹¹ This and the next paragraph were drawn from L. Ledray, *Evidence Collection and Care of the Sexual Assault Survivor: The SANESART Response*, 2001, p. 1.

¹¹² JCAHO standards for accreditation address a health care organization's level of performance in specific areas—not just what the organization is capable of doing, but what it actually does. The standards set forth maximum achievable performance expectations for activities that affect the quality of care. These standards are developed in consultation with health care experts, providers, measurement experts, purchasers, and consumers, and usually are updated every 2 years. (Drawn from www.jcaho.org/pms/index.htm. See www.jcaho.org for more information on JCAHO.)

¹¹³ Information on these requirements was drawn from www.sasafefamily.com.

¹¹⁴ 42 U.S.C. § 1395dd. See <http://www.emtala.com> for more information about EMTALA.

¹¹⁵ A mobile examiner program may be based in a health care facility—in addition to providing services at that facility, it also may contract with other exam sites to provide services as requested. Such a program may also be independent, with administrative offices only, and solely contract with exam sites to provide examiner services.

- Encourage quality control (e.g., through use of competent and dedicated examiners, established procedures for evidence collection, and standards for medical care); and
- Increase the quality of care for patients and attention to their needs.

Explore possibilities for optimal site locations. SARTs (or involved agencies) should determine where exams should be conducted. Some factors to consider when identifying sites include safety and security for patients and staff, physical and psychological comfort for patients, capacity to accommodate victims with disabilities,¹¹⁶ availability of examiners with advanced education and clinical experience, access to a pharmacy for medication, access to medical support services for care of injuries, access to lab services, and access to the supplies and equipment needed to complete an exam.¹¹⁷ Decisions about site location should reflect the needs of victims (e.g., for accessible care close to their home and local referrals), what is most efficient for the multidisciplinary response team, and the need to maintain the neutrality and objectivity of examiners. Designated facilities may be in hospitals, health clinics, mobile health units, or other alternative sites, including family justice centers.¹¹⁸ ¹¹⁹The majority of medical forensic exams are conducted in hospital emergency departments. This location typically offers some level of security, is open 24 hours a day, and provides access to a wide array of medical and support services. Clinical staff often have the experience and expertise to perform the exam and collaborate with appropriate disciplines. Some jurisdictions have or are developing specialized hospital or community-based examiner programs.¹²⁰

SARTs may need to decide whether a local, regional, or State/Territorial system of designated facilities best serves community needs. Some issues that might impact this decision include community demographics and geography; the need for and availability of specialized services; availability of local health care facilities; local capacity to secure competent examiners and necessary space, equipment, and supplies; willingness of involved disciplines to coordinate with a local facility or examiner program; distance to/from regional or State/Territorial facilities; and service capacity of regional or State/Territorial facilities. Communities are encouraged to first consider using local designated exam sites. However, some may ultimately opt for regional- or State/Territorial-level facilities. For example, a small State or sparsely populated region may establish one or more designated facilities to serve all of its localities.

Exam facilities and examiners that serve at the local level may benefit from networking with examiners in other facilities or areas for support for peer review of medical forensic reports, quality assurance, and information sharing (e.g., on training opportunities, practices, and referrals for patients).

Communities may wish to consider basic requirements for designated exam sites, such as:¹²¹

- The site will be within a reasonable distance from any point in the area it serves (“reasonable” is locally defined);
- The site will promptly alert the SART, if one exists, when sexual assault patients arrive;
- Urgent or emergent physical injuries will be treated immediately;
- Responding examiners will be competent in their knowledge and skills;
- The site will arrange for certified interpretation as needed in patients’ preferred languages and/or obtain devices that facilitate communication for individuals with communication disabilities.

¹¹⁶ Title II and Title III of the Americans with Disabilities Act explains requirements for facilities in accommodating persons with disabilities (which may vary depending on the type of facility). Title II prohibits discrimination against persons with disabilities in all programs, activities, and services of public entities. Title III requires places of public accommodation to make reasonable modification in their policies, practices, and procedures in order to accommodate individuals with disabilities. See www.usdoj.gov/crt/ada for related information and resources.

¹¹⁷ Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 35–36.

¹¹⁸ Particularly on tribal land that is devoid of or a significant distance from a hospital, Indian Health Service (IHS) facilities should consider securing and maintaining examiners and necessary space, equipment, and supplies to conduct these exams. Ideally, all IHS facilities should have examiners and a minimum standard for examiner training.

¹¹⁹ For more information on the President’s Family Justice Center Initiative, see <http://www.ojp.usdoj.gov/vawo>.

¹²⁰ The pros and cons of developing hospital versus community-based examiner programs are discussed in more detail in L. Ledray’s *SANE Development and Operation Guide*, 1998, p. 35–9; L. Ledray’s *Sexual Assault: Clinical Issues, SANE Program Pros and Cons*, *Journal of Emergency Nursing*, 23(2), p. 183; and in K. Littel’s *SANE Programs: Improving the Community Response to Sexual Assault Victims*, pp. 10–1.

¹²¹ Adapted from Pennsylvania’s *SART Guidelines*, 2002, p. 21.

- Patients will be provided with a comprehensive medical forensic exam and resources to address their immediate emotional and psychological needs;
- The site will provide a private, secure, and quiet waiting area for patients and for personal support persons accompanying them;
- The site will provide a private and secure setting for the investigative interview;
- The site will provide a private exam room and other measures to assure patients' privacy;
- The site will have a bathroom (preferably with shower facilities) available for patients' use following completion of the exam;
- The site or examiner program that serves the site will have/provide proper equipment and supplies to facilitate a comprehensive exam ("proper equipment and supplies" are locally defined);
- The site or examiner program that serves the site will have a mechanism to ensure evidence collection kits are up to date;
- Patients will be offered medications for possible exposure to sexually transmitted infections;
- Patients will be offered information about how exams are paid for in their jurisdiction and reimbursement sources (if they exist) for related expenses that are their responsibility; and
- Site billing departments will adhere to proper coding and billing practices for sexual assault cases, as determined by the facility and informed by jurisdictional policy.

If designated facilities or sites served by examiner programs are selected, their success depends on getting information about them to victims and agencies that provide immediate response or refer victims for treatment and evidence collection. At a minimum, the list of designated exam sites should be provided to all local hospitals, law enforcement agencies, emergency medical services, sexual assault victim advocacy programs, and protective services. Promoting community public awareness about these sites is also important given that victims may first disclose an assault to family members, friends, teachers, faith-based leaders, employers, coworkers, and others. In addition, success will depend on interagency cooperation in explaining facility options to victims and transporting them to designated exam sites (with their permission). Law enforcement representatives and advocates may need guidance on how to recommend an exam location to victims without mandating that they go to a specific site.

If transferring the patient from one health care facility to a designated site is necessary, use an established protocol that minimizes time delays and loss of evidence while addressing patients' needs.¹²² Avoid transferring sexual assault patients where possible. Every transfer can destroy evidence and cause patients further stress. However, if a sexually assaulted individual arrives at a health care facility that, for some reason, is not able to provide a medical forensic exam, interagency transfer procedures must be in place to transfer that individual to the nearest designated exam site. Evidence should be preserved when examining, treating, or transferring patients. If there are acute medical or psychological injuries that must be treated immediately, treatment should be provided at the initial receiving facility. It may be helpful to offer patients support and advocacy from advocates at both the receiving facility and exam site. A copy of all records, including any X-rays taken, should be transported with patients to the exam facility. (However, it may not be necessary to send all medical records if patients' medical needs are met before they are transferred to a nonmedical exam site for evidence collection.) All health care facilities receiving Federal funds, including Medicare and Medicaid payments, are required to screen patients medically before transferring them to another health care facility.¹²³

Patients have a right to decline a transfer. They should be aware, however, of the impact of refusing transfer, as it may negatively affect the quality of care, the usefulness of evidence collection (if it is collected at all), and, ultimately, any criminal investigation and/or prosecution. They should understand that declining a transfer might also be used to discredit them in court.

¹²² This section was drawn from the *North Dakota Sexual Assault Evidence Collection Protocol*, 2001, p. 12, and the *Texas Evidence Collection Protocol*, 1998, p. 14.

¹²³ Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.

3. Equipment and Supplies

Recommendations at a glance for jurisdictions and responders to ensure proper equipment and supplies are available for exams:

- Consider what equipment and supplies are necessary to conduct a medical forensic exam.
 - Address cost barriers to obtaining necessary equipment and supplies.
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Examiners should know how to use all equipment and supplies (including medications) properly during the exam. It is important that examiners and other responders involved in sexual assault cases stay abreast of the latest research on the use of equipment and supplies used in caring for sexual assault patients and/or collecting evidence from them.

Plan to have the following equipment and supplies readily available for the exam, according to jurisdictional policies: ¹²⁴

- A copy of the most current exam protocol used by the jurisdiction.
- Standard exam room equipment and supplies for a physical assessment and evidentiary pelvic exam. The needs of patients with physical disabilities should be taken into account.¹²⁵
- Comfort supplies for patients, even if minimal. Suggested items: clean and ideally new replacement clothing, toiletries, food and drink, and a phone or at least easy access to a phone in as private a location as possible. It is also important during the exam process to help patients obtain items they request related to their spiritual healing.¹²⁶ It may be useful for facilities to have items on hand that are commonly requested in that jurisdiction (e.g., things that are used for local tribal traditional healing practices) and policies for their use in the facility.¹²⁷
- Sexual assault evidence collection kits and related supplies. (See *B.4. Sexual Assault Evidence Collection Kit* for information on minimal kit contents.) Related supplies might include tweezers, tape, nail clippers and scrapers, scissors, dental floss, collection paper, saline solution or distilled water, extra swabs, slides, containers, envelopes, paper bags, and pens/pencils.
- A method or device to dry evidence. Drying evidence is critical to preventing the growth of mold and bacteria that can destroy an evidentiary sample. With any drying method or device used, ensure minimal contamination of evidence, and maintain the chain of custody. The kit's design can also aid in the drying process (e.g., by providing clear instructions and supplies to allow drying to occur).
- A camera and related supplies (using the most up-to-date technology possible) for forensic photography during initial and followup examinations. Related supplies might include film, batteries, a flash, and an inch scale or ruler for size reference. (Also see *C.5. Photography.*)
- Testing and treatment supplies needed to evaluate and care for patients medically (follow exam facility policies). Also, testing supplies may be needed for forensic purposes that are not included in the evidence collection kit. For example, supplies for toxicology testing are often not in the kit.
- An alternate light source (using the most up-to-date technology possible) can aid in examining patients' bodies, hair, and clothing. It is used to scan for evidence, such as dried or moist secretions, fluorescent

¹²⁴ All the equipment and supplies discussed will not be needed in every exam. What is appropriate in each case will depend on the circumstances of the assault and medical and forensic attention called for, patients' needs, and patients' consent to utilize equipment and supplies. Jurisdictional and/or facility policies will also influence what equipment and supplies are used.

¹²⁵ For example, it would be ideal to have an exam table with a hydraulic lift for persons with mobility impairments. If this exam table is not available, health care personnel must be aware of how to assist patients with physical disabilities onto standard exam tables. If it is determined that a patient can only be examined on an exam table with a hydraulic lift, procedures should be in place to get the patient to a site with such a table with as little loss of evidence as possible.

¹²⁶ Along with these items, patients may want the opportunity to speak with a trusted religious or spiritual leader, such as a medicine man/woman, a rabbi, a priest, or a pastor, before, during, or after the exam.

¹²⁷ Involved responders/facilities should be aware of local traditional healing practices and support American Indian and Alaska Native patients if they wish to use such practices at some point before, during, or after the exam. Keep in mind that each tribe has its own traditional practices to promote healing, but not all Native people follow traditional spiritual paths. Rather, spiritual values and belief systems among Native people are as widely diverse as they are among the general population.

fibers not visible in ambient light, and subtle injury.¹²⁸ While the exam can be done without a light source, it is a relatively inexpensive piece of equipment that is commonly used during exams.¹²⁹ (Also see C.6. *Exam and Evidence Collection Procedures*.)

- An anoscope may be used in cases involving anal/rectal trauma.¹³⁰ This instrument can help in visualizing an anal injury, obtaining reliable rectal swabs (if there is a concern about contamination), and identifying and collecting trace evidence. Many health care facilities have anosscopes available. (Also see C.6. *Exam and Evidence Collection Procedures*.)
- Written materials for patients. (For details on this topic, see A.2. *Victim-Centered Care*.)

In addition:

- A colposcope with photographic capability is strongly suggested. Although injuries can be detected visually by examiners without the colposcope, the colposcope is an important asset in the identification of microscopic trauma. Photographic equipment, both still and video, can be attached for forensic documentation. (Also see C.6. *Exam and Evidence Collection Procedures*.)
- A microscope. In some jurisdictions, examiners are required to wet mount and immediately examine vaginal/cervical secretions for motile and nonmotile sperm.¹³¹ In these cases, an optically staining microscope is used to highlight cellular material and facilitate the search for sperm.¹³² (Also see C.6. *Exam and Evidence Collection Procedures*.)
- Toluidine blue dye. In some jurisdictions, the dye is used to assist in identifying recent genital and perianal injuries. (Also see C.6. *Exam and Evidence Collection Procedures*.)

(See C. *The Examination Process* for more discussion on use of equipment and supplies during the exam.)

Note that some jurisdictions, particularly those in rural and remote areas, are beginning to utilize advanced technology (equipment and methods) such as real-time video consultation, store and forward video consultation, and interactive video consultation to support examiners conducting exams. Using this type of technology, examiners can eliminate the barriers of geography and consult with offsite medical “experts.” (This use of such technology in medicine is sometimes called telemedicine.) Equipment needed to facilitate use of telemedicine may include, but is not limited to, computers, software programs, and the Internet.¹³³

Consider ways to overcome cost barriers. Obtaining equipment and supplies that can increase the quality and quantity of evidence collected can have a significant impact on case outcomes. However, the costs of equipment and training on equipment use can be prohibitive for some jurisdictions and examiner programs. Some ideas to address cost barriers:

- Seek used or donated equipment or alternative, less-expensive equipment where it exists;
- Apply for grant or foundation funding for equipment where eligible;¹³⁴

¹²⁸ Drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 37.

¹²⁹ A Wood’s Lamp is perhaps the most commonly used type of light source in sexual assault exams. Examiners should be aware of what the light sources they use will detect and their limitations. For example, many examiners find the Wood’s Lamp useful in helping to detect secretions, stains, and fibers on patients. However, one research study questioned its utility as a screening device for the detection of semen. (K. Santucci, D. Nelson, K. McQuillen, S. Duffy, and J. Linakis, “Wood’s Lamp Utility in the Identification of Semen,” *Pediatrics*, 104(6), 1999.) Continued research is needed (and being conducted) on the utility of this and other light sources in evidence collection. Ongoing refinement of these instruments is encouraged.

¹³⁰ The examiner must use discretion in determining whether a case warrants the use of the anoscope for medical and/or forensic purposes, as well as obtain patients’ informed consent for anoscopy. The discomfort this invasive procedure may cause the patient should be weighed against its potential medical or forensic uses.

¹³¹ Wet-mount evaluation of vaginal secretions for infection (e.g., yeast infection and STIs) may be conducted if medically or forensically indicated, whether or not wet-mount evaluation for sperm is done. Hospital lab personnel rather than examiners usually analyze these samples rather than examiners.

¹³² The most commonly used optically staining instrument by hospital labs is the phase contrast microscope. In jurisdictions that require examiners do wet-mount evaluations for sperm, an optically staining microscope should be readily available to them at all times. Ideally, due to chain-of-custody issues and the fact that the slide will dry in 5 to 10 minutes, examiners should not have to leave the exam room to evaluate the slide.

¹³³ Keep in mind that telemedicine in sexual assault cases is in its infancy—further research and debate is needed to address concerns related to logistics of use, patients’ consent, confidentiality, and impact; legal implications; affordability; and accessibility.

¹³⁴ Funding under the STOP Violence Against Women Formula Grant Program and the STOP Violence Against Indian Women Discretionary Grant Program may be used to cover costs of some equipment. For more information, see www.ojp.usdoj.gov/vawo.

- Ask for help from community groups in raising funds for one-time equipment or ongoing supply costs;
- Consider sharing costs and equipment with other departments in an exam facility or among other nearby local health care facilities;
- Consider the benefits of a mobile examiner program where costs of equipment, examiner education and clinical preparation, and on-call costs may be shared by multiple exam sites; and
- Since the information gathered in the exam is used to investigate and prosecute the offense, ask for assistance from local law enforcement and prosecutor's offices in obtaining equipment and supplies used specifically for forensic evidence collection.

4. Sexual Assault Evidence Collection Kit

Recommendations at a glance for jurisdictions and responders when developing/customizing kits:

- Use kits that meet or exceed minimum guidelines for contents.
- Work to standardize kits within a jurisdiction. Make them readily available for use at any facility that conducts sexual assault medical forensic exams.
- Those involved in kit development and distribution should periodically review the kit's efficiency and usefulness and make changes as needed.

Use kits that meet or exceed minimum guidelines for contents. Many jurisdictions have developed their own sexual assault evidence collection kits (for evidence from victims) or have purchased premade kits through commercial vendors. Kits may vary from one another in types of samples collected, collection techniques, materials used for collection, and terms used to describe categories of evidence. Despite variations, however, it is critical that every kit meets or exceeds the recommended minimum guidelines for contents.¹³⁵

- A kit container. It is suggested that this container have a label with blanks for identifying information and documenting the chain of custody. Most items gathered during evidence collection are placed into the container, after being dried, packaged, labeled, and sealed according to jurisdictional policy. Bags are typically provided for more bulky items that will not fit in the container (e.g., clothing). Some jurisdictions provide large paper bags to hold the container and additional evidence bags.
- An instruction sheet or checklist that guides examiners in collecting evidence and maintaining the chain of custody.
- Forms that facilitate evidence collection and analysis, including patients' authorization for collection and release of evidence and information to the law enforcement agency; the medical forensic history; and anatomical diagrams.
- Materials for collecting and preserving the following evidence, according to jurisdictional policy:¹³⁶
 - Patients' clothing and underwear and foreign material dislodged from clothing;
 - Foreign materials on patients' bodies, including blood, dried secretions, fibers, loose hairs, vegetation, soil/debris, fingernail scrapings and/or cuttings, matted hair cuttings, material dislodged from mouth using dental floss,¹³⁷ and swabs of suspected semen, saliva, and/or areas highlighted by alternate light sources;¹³⁸
 - Hair evidence (including head and pubic hair samples and combings);¹³⁹
 - Vaginal/cervical swabs and smears;
 - Penile swabs and smears;
 - Anal/perianal swabs and smears;

¹³⁵ The following resources were helpful in developing this list: the *Sexual Assault Evidence Collection Kit, VEC100*, by Sirchie Finger Print Laboratories, the *Texas Customized Sexual Assault Evidence Collect Kit* by Tri-Tech, Inc., the Commonwealth of Virginia's *Physical Evidence Recovery Kit*, the State of California's *Medical Forensic Report: Adult/Adolescent Sexual Assault Examination, Less than 72 Hours (OCJP 923)*, the *Ohio Department of Health's Sexual Assault/Abuse Evidence Collection Kit* (as found in their protocol), *Detailed Instructions; Connecticut's Sexual Assault Evidence Collection Kit* (as found in their protocol), and the American College of Emergency Physicians' *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, pp. 101–107.

¹³⁶ Some samples that historically have been collected are no longer recommended in many jurisdictions, unless the medical forensic history and physical exam indicate otherwise (e.g., a vaginal wash).

¹³⁷ Although in some instances flossing could help dislodge evidence that may be between the patient's teeth, flossing for evidence is not routinely done across jurisdictions. Any related safety risks to patients (e.g., potential increased risk of HIV exposure if there is semen in the mouth and flossing causes gums to bleed) should be considered before flossing for evidence.

¹³⁸ It is acknowledged that approaches to categorizing evidence vary. For example, one kit may collect external genital swabs when gathering foreign materials, while in another kit, collection of genital swabs may be a separate category of evidence.

¹³⁹ Some jurisdictions collect pubic and head hair combings, others collect only pubic combings. Some also collect pubic and/or head hair reference samples. Materials should be included in the kit to collect and preserve hair evidence required by jurisdictional policy.

- Oral swabs and smears;
- Body swabs;¹⁴⁰ and
- Known blood, saliva sample, or buccal swab for DNA analysis and comparison.

(See *C.6. Exam and Evidence Collection Procedures* for specifics about evidence collection techniques.)

Extra copies of forms should be available to examiners for cases when the kit is not used, but documentation of the medical forensic history and the exam is done. All forms included in the kit should be designed to facilitate optimal forensic evidence collection, analysis, and examiner testimony.

Separate from the kit, materials and forms for collecting toxicology samples should be available to examiners (and to responding law enforcement officers and emergency medical technicians, according to jurisdictional policy).

Work to standardize sexual assault evidence collection kits within a jurisdiction and preferably across a State or Territory, or for Federal cases.¹⁴¹ A designated agency in the jurisdiction should be responsible for oversight of kit development and distribution.¹⁴² It should:

- Ensure that any facility that conducts sexual assault medical forensic exams is involved in kit development and supplied with kits;¹⁴³
- Work with relevant agencies (e.g., crime labs, law enforcement agencies, exam facilities and examiner programs, advocacy programs, and prosecutors' offices) to keep abreast of related changes in technology, scientific advances, and cutting-edge practice;
- Review periodically (e.g., every 2 to 3 years) kit efficiency and usefulness;
- Make adjustments to the kit as necessary; and
- Establish mechanisms to ensure that kits at exam facilities are kept up to date (e.g., if a new evidence collection procedure is added, facilities need to know what additional supplies should be readily available).

(See *B.6. Evidence Integrity* for handling and storage of kits.)

¹⁴⁰ Some jurisdictions use the medical forensic history, the examination, and patients' consent to determine whether and where to collect swabs, while others collect swabs from all orifices and from the surface of the body (with patients' consent). In particular, some do not collect anal swabs unless indicated.

¹⁴¹ It may be useful to consider developing a standardized kit across all communities, States, and Territories, and for Federal cases. Further analysis is needed to assess the benefits and disadvantages of such a kit and the feasibility of development and implementation. Some challenges could include building consensus across communities regarding best practices and obtaining buy-in from involved agencies.

¹⁴² It is important to consider costs to the State/Territory/Tribe/Federal agencies and local community, and ability of local communities to cover costs. In some States, one State agency (e.g., the crime laboratory) assumes the costs. In others, the costs are passed onto local criminal justice agencies.

¹⁴³ As a backup to having kits readily available at exam sites or with examiner programs, jurisdictions may also want to discuss the feasibility of storing a few kits at local law enforcement agencies or in law enforcement patrol cars. Before storing kits in patrol cars, however, make sure that the temperatures the kit will be exposed to will not affect kit contents.

5. Timing Considerations for Collecting Evidence

Recommendations at a glance for health care providers and other responders to maximize evidence collection:

- Whether or not evidence is collected for the sexual assault evidence collection kit, examiners should obtain the medical forensic history, examine patients, and document findings (with patients' consent). Patients' demeanor and statements related to the assault should also be documented.
- Examine patients promptly to minimize loss of evidence and identify medical needs and concerns.
- Make decisions about whether to collect evidence and what to collect on a case-by-case basis, guided by knowledge that outside time limits for obtaining evidence vary.
- Responders should seek education and resources to aid them in making well-informed decisions about evidence collection.

Recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence. Examiners should obtain the medical forensic history as appropriate, examine patients, and document findings when patients are willing, whether or not evidence is gathered for the sexual assault evidence collection kit. The history and documentation of exam findings can help in determining if and where there may be evidence to collect and in addressing patients' medical needs. In addition, they can be invaluable in and of themselves to an investigation and prosecution if a report is made. It is also important to document patients' demeanor during the exam process (e.g., crying, shaking, or showing signs of upset) and their statements made related to the assault because if the case is reported, this information could be admitted as evidence at trial.

Examine patients promptly to minimize the loss of evidence. Evidence can be lost from the body and clothing through a number of mechanisms. For example, degradation of some seminal fluid components can occur within body orifices, semen can drain from the vagina or wash from the mouth, sperm can lose motility, bodily fluids can get washed away, and dried secretions and foreign materials can fall from the body and clothing.¹⁴⁴ Prompt examination also helps to quickly identify patients' medical needs and concerns.

Recognize that evidence may be available beyond 72 hours after the assault. In recent history, 72 hours after a sexual assault has been considered a guideline to use as an outside limit for obtaining evidence for the evidence collection kit. Research and evidence analyses indicate that some evidence may be available beyond this time period. For instance, sperm might be found inside the cervix after 72 hours and urine may reveal traces of certain drugs up to 96 hours after ingestion. Some examples of situations where evidence may be found even after considerable periods of time include when patients complain of pain or bleeding, have visible injuries, or have not washed themselves since the assault, or where there is a history of significant trauma from the assault. Some jurisdictions have extended their standard cutoff time beyond 72 hours (e.g., to 5 days or 1 week).

Due to the stability of DNA and sensitivity of tests, advancing DNA technologies also continue to extend time limits. These technologies are even enabling forensic scientists to analyze stored evidence from crimes that occurred years before.¹⁴⁵ Such breakthroughs demonstrate the importance of collecting all possible evidence.

Make decisions about whether to collect evidence on a case-by-case basis, guided by the knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected. Examiners and law enforcement representatives, in particular, should be aware of the standard cutoff time for evidence collection in their jurisdictions, which is typically indicated in instructions in evidence collection kits. But it is important to remember that evidence collection beyond the cutoff point is conceivable and may be warranted in particular cases. In any case where the utility

Child Sexual Abuse Victims, 2001, p. 29.

¹⁴⁵ When the evidence was initially collected after the assault, it was not of adequate quality to allow crime lab analysis using existing technologies.

of evidence collection is in question, encourage dialogue between law enforcement representatives (if involved), examiners, and forensic scientists regarding potential benefits or limitations.

Involved responders should avoid basing decisions about whether to collect evidence on how they think patients' characteristics or circumstances will affect the investigation and prosecution. For example, the fact that an adolescent may have lied to her parents about where she was going the night of the assault should in no way influence the decision of the examiner and/or the law enforcement representative to collect evidence.

Responders should seek education and resources to aid them in making well-informed decisions about evidence collection. Examiners and law enforcement representatives require training and resources to allow them to make informed decisions about whether to collect evidence and what to collect in each case. They also need local policies and kit instructions that encourage them to make informed decisions in each case, rather than applying a limiting general standard to all.¹⁴⁶ First responders also need instructions on collecting a urine sample if there is any suspicion of drug-facilitated sexual assault and victims cannot wait to urinate until their arrival at the exam site.

¹⁴⁶ For many communities, moving away from the 72-hour cutoff time represents a major shift in policy. Training and policies should discourage decision making about evidence collection that is based on extraneous factors, such as reluctance of a criminal justice agency to pay for sexual assault evidence collection in general.

6. Evidence Integrity

Recommendations at a glance for health care providers and other responders to maintain evidence integrity:

- Follow jurisdictional policies for drying, packaging, labeling, and sealing evidence.
- Follow jurisdictional policies for consistent evidence management and distribution. A duly authorized agent should transfer evidence from the exam site to an appropriate crime laboratory or other designated storage site.
- Develop storage procedures that maximize evidence preservation. Ensure that storage areas are secure and the proper temperature for evidence.
- Make sure that jurisdictional policies are in place to address storage of evidence in cases where patients are undecided about reporting.
- Maintain the chain of custody for the evidence. Educate all those involved in handling, documenting, transferring, and storing evidence regarding the specifics of properly preserving evidence and maintaining the chain of custody.

Follow jurisdictional policies for drying,¹⁴⁷ packaging, labeling, and sealing the evidence. Involved responders should be educated regarding these policies. It is critical to air-dry wet evidence at room temperature in a clean, sterile environment and quick manner that prevents contamination.¹⁴⁸ A drying box or other device may be used to facilitate the drying process. Jurisdictions should have policies for handling evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, sanitary napkins, tissues, diaphragms, and condoms), as well as for liquid evidence such as urine and drawn blood samples. When packaging dry evidence, use paper containers rather than plastic, because plastic containers retain moisture and promote degradation of biological evidence. Following proper drying and packaging procedures is vital to prevent the growth of mold and bacteria that can destroy an evidentiary sample.

Keep in mind that evidentiary materials include exam documentation. Follow jurisdictional policies for documenting exam findings and the medical forensic history, and packaging, labeling, and sealing such documentation. Properly recording and preserving this information is critical for its admissibility during a trial.

Make sure transfer policies maximize evidence preservation. Minimize transit time between collection of evidence and storage of kits. To avoid potential degradation of evidence, it is important to transport kits containing liquid samples and other wet evidence in a timely fashion. Only a law enforcement official or duly authorized agent should transfer evidence from the exam site to the appropriate crime laboratory or other designated storage site (e.g., a law enforcement property facility). Jurisdictional procedures for evidence management and distribution must be in place and followed. Those involved in evidence management and distribution should be educated on the specifics of these procedures and their responsibilities.

Make sure storage policies maximize evidence preservation. Secure storage sites should be designated and storage requirements should be consistent across a jurisdiction. Storage requirements depend on what types of specimens are being collected and on jurisdictional policy. For example, kits without drawn blood or other wet evidence generally do not need to be refrigerated. Follow jurisdictional policy for refrigeration of drawn blood samples and other wet evidence. Dried blood samples on blood collection cards do not require refrigerated storage.¹⁴⁹ Urine should be refrigerated or frozen when stored. Those involved in storing evidence should be educated regarding storage requirements.

Make sure jurisdictional policies are in place to address evidence storage in cases where patients are undecided about reporting. Finding adequate storage space for these kits is a challenge for many facilities and agencies (e.g., community-based or hospital examiner programs may lack the capacity for secure long-term storage of kits at their facilities). Local responders, particularly examiners, law enforcement

¹⁴⁷ Dry evidence unless indicated otherwise (e.g., freezing).

¹⁴⁸ With the ever-increasing sensitivity of DNA analysis, there is a greater chance that accidental contamination and dilution by foreign DNA can be detected. Every precaution should be taken to reduce outside contamination and dilution of evidence.

¹⁴⁹ The National Institute of Standards and Technology is conducting a 10-year project on DNA storage. Thus far, it confirms that refrigeration of dried DNA is generally unnecessary.

representatives, and crime lab staff, should discuss and address these and related challenges and develop procedures that allow for the secure storage of these kits without revealing patients' identity. Storing the evidence as long as necessary is the ideal (e.g., until the patient decides whether to report or until the jurisdiction's statute of limitations for retaining evidence expires). However, due to lack of storage space, kits in some jurisdictions are stored for a limited period of time (e.g., 30, 60, or 90 days) and then destroyed if no report is made. If such a policy is implemented, it is important that patients are informed regarding the amount of time they have to decide to report and procedures for reporting. It is also critical that the period of time given to patients to decide allows them the chance to consider their decision thoroughly; 24 to 48 hours is not sufficient to make such a decision.

Document the handling, transfer, and storage of evidence. Examiners must maintain control of evidence during the exam, while evidence is being dried, and until it is in the kit container and sealed (and then follow jurisdictional procedures for storing evidence securely or handing it over to a duly authorized agent for transfer to a storage site). Documentation should continue with each transfer of the evidence to law enforcement, the crime laboratory, and others involved in the investigative process.¹⁵⁰ Patients, advocates, family members, and other support persons should not handle the evidence. Documentation of the chain-of-custody information is vital to ensuring that there has been no loss or alteration of evidence prior to trial. Educate all those involved in handling, transferring, and storing evidence regarding the specifics of maintaining the chain of custody.

Sexual Abuse Victims, 2001, p. 34.

¹⁵⁰ Adapted from the *California Medical Protocol for Examination of Sexual Assault and Child*

