JUDICIAL REFORM AND INSTITUTIONAL STRENGTHENING (JURIST) PROJECT

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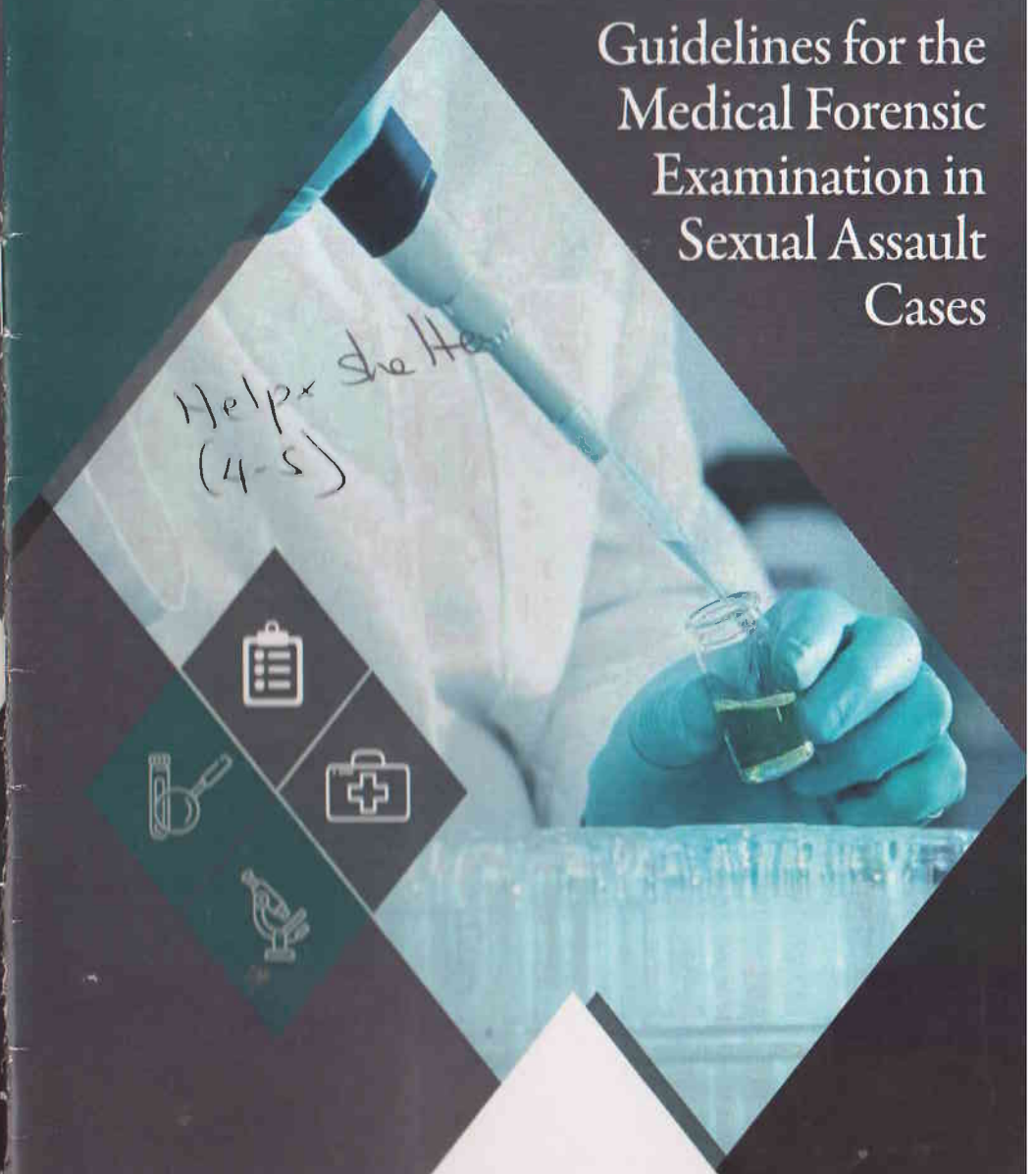
Guidelines for the Medical Forensic Examination in Sexual Assault Cases



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INTAKE GUIDELINES

1. A sexual assault complainant should be considered by a physician to be a priority complainant, regardless of whether additional physical injuries are evident.

2. Whenever practicable, provide a private area, such as a private treatment room, in which the complainant can await both intake and treatment.

3. Consent should be obtained from the complainant prior to the beginning of the exam and the appropriate consent forms signed. Where the complainant is a child, consent should be obtained from and signed by the parent or legal guardian of the child. If the parent is not available or unwilling to provide consent, then the legal authority authorized to provide such consent must give consent and sign the consent form. Normally, the police will have obtained the requisite consent and will have had the form signed prior to coming to the hospital but the medical examiner should still ensure consent is provided.

4. If the complainant is not escorted by a police officer but comes to the hospital alone or accompanied by others, mandatory reporting must be done as required by law.

5. There must be explanation as to who will be allowed to be in the examination room and who will have to wait in the private waiting area. For adult complainants, only the examiner and other medical assistance, police personnel, or advocate if required to be present, may be allowed into the examination area. For a child and other vulnerable persons, only the examiner and medical support staff, the police or child services representative, the parent or other support person that the child wants inside the room should be present.

INTAKE GUIDELINES (CONTINUED)

6. Avoid exposing the complainant to places and situations which may cause further emotional stress. Keep in mind the fears and disorientation which the complainant may be experiencing.

7. Use only the appropriate medico-legal or other medical examination form as shall be required to be submitted in court proceedings. Ensure that the examiner has experience of the medical exam process and has the requisite expertise to complete the form.

8. Exercise discretion and sensitivity when discussing a sexual assault complainant or the family with other personnel (e.g., when summoning specialized personnel or when transporting materials collected as evidence to an examination room).

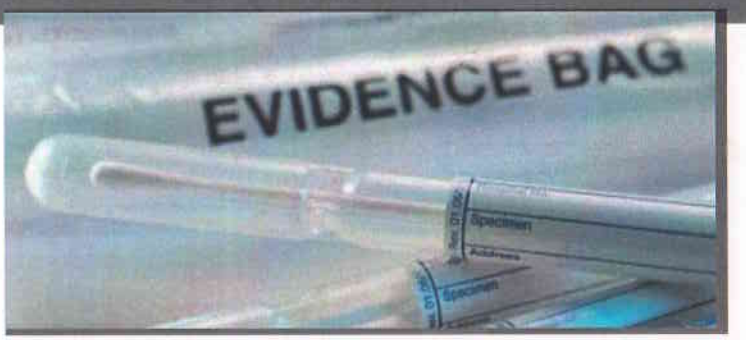
9. Explain to the complainant that urinating, rinsing of the mouth, showering, etc. may destroy evidence prior to collection. If a complainant must go to the bathroom, there must be a warning that semen or other evidence may be present in pubic, genital, and rectal areas, and not to wash or wipe away those secretions until after the examination.

10. If a complainant's clothes will be collected as part of the evidence collection, notify the support person, who may be able to provide clothing for the complainant to wear upon discharge.

11. Keep in mind that the evidence collection exam is likely to be the first significant physical contact with others that a complainant will have following an assault.

12. Treat the complainant with dignity and respect. Introduce yourself, acknowledge the trauma, and explain the exam process.

INTAKE GUIDELINES (CONTINUED)



13. Ask the complainant for permission before touching her/him in any way.

14. Give the complainant time to respond; try not to rush her/him.

15. Use open-ended questions such as, *"what, how, where, tell me..., describe..."* It is best to avoid *"why"* questions.

16. Avoid judgmental responses and facial expressions.

17. Avoid use of the word *"alleged"* as it tends to create the impression that you are doubtful about the complainant's truthfulness. Instead of recording *"alleged sexual assault"* as the chief complaint, simply record *"sexual assault."* Instead of recording, e.g., *"complainant alleges"* or *"complainant claims,"* indicate that the *"complainant states..."*

18. Allow the complainant to regain control and to make her/his own decisions.

19. Please remember that although caring for sexual assault complainants may be a routine procedure for medical personnel, it is a traumatic event for the survivor.

GUIDELINES FOR CONDUCTING THE EXAMINATION

1. The medical forensic exam may consist of four components:
   a. Alternate light source examination (if available) – look from head to toe for bruising and stains (likely semen if using light > 400 nm and patterned). Some bruises are in deep tissue and may only appear with light for first 24-36 hours (deep bruising). Swabs of stains may be taken for evidence at this time.
   b. Ambient light exam – repeat examination from head to toe using both inspection for injuries as well as palpation (applying gentle pressure) looking for tenderness and deformities/breaks.
   c. Genital examination – includes obtaining external swabs for DNA/semen and application of toluidine blue dye to highlight the subtle injuries typically found. An internal examination is then conducted on females with a speculum to obtain vaginal wall swabs and cervical swabs for DNA and look for internal injuries. Some teams also perform STI baseline testing at this time. An anal swab for DNA/semen and application of toluidine to the anal area is then typically performed if necessary.
   d. Blood/urine testing – blood is obtained for baseline DNA reference testing on FTA card and samples are also sent to local laboratories for sexually transmitted infection (STI) testing. Blood and urine may also be obtained for toxicology if drug facilitated assaults are likely.

2. However, the facilities and tools for alternate and ambient light testing may not be readily available so the procedures below will cover guidelines for the general examination and include blood and urine testing. Guidelines will also be provided for genital examination and use of the rape kit.

CONDUCTING THE EXAMINATION (CONTINUED)

General examination

1. The clothing must be examined and any abnormality documented if the patient has not changed. Clothing (if it has tears or stains) may be useful to prove that force was used, as a source of DNA as well as corroboration of the patient's story. If possible, clothing should be collected for forensic evidence. Stains on clothing can be swabbed, or cut out of the clothing with consent from the patient.

2. The general appearance and emotional status/behavior (e.g. controlled, fearful, listless, tense, sobbing etc.) of the patient should be observed during the examination and documented.

3. Examine the patient from head to toe including genito-urinary system. It may be necessary to start with a portion of the body that does not appear to be injured to gain trust or start with injuries on the hand.

4. Document presence of extra genital injuries (hands, wrist, arms, mouth, throat, head, face, neck, breasts, chest, abdomen, buttocks, thighs and legs) looking for the number, size, shape, color, contents, depth, classification and location of injuries, bite and scratch marks, bruises. Diagrams should be used to accurately portray the physical condition or photographs can be taken if the patient consents.

5. Also document the following information about injuries: - The age of the injury - How (mechanism by which) the injury was produced - The amount of force required to produce such an injury - The circumstances in which the injury was sustained - The consequences of the injury.

6. Swabs of the oropharynx and mouth should be taken routinely if oral penetration (tongue or penis) is reported to have occurred.

CONDUCTING THE EXAMINATION (CONTINUED)

7. Ensure collection of forensic (biological and trace) evidence from the body simultaneously with the examination.

8. Collect samples for toxicology screening as appropriate, if the complainant indicates that drugs were administered or if during the examination, the complainant appears intoxicated, drugged or otherwise impaired.

9. Detailed invasive examination should be conducted only if warranted.

Female genital examination and anal exam

Adults and children over the age of 14 years

1. Patients should be in lithotomy position for genital and anal examination. If necessary, the left lateral position can be used.

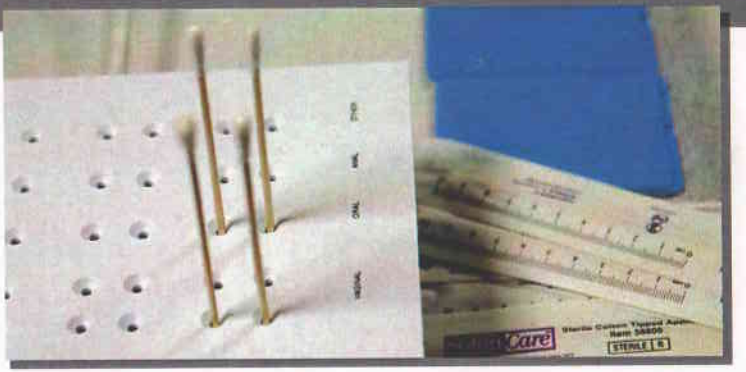
2. The process should be explained and at the initiation of each step, the patient should be told what will be done next and consent obtained.

3. Watch for trauma and avoid re-victimization of the patient with any inappropriate comments or facial expressions. If the patient becomes emotional, the support person present or the medical examiner should stop and use calming techniques such as deep breaths to stabilize and calm the patient before continuing.

4. Anal examination should be performed routinely prior to genital examination to avoid transfer of evidence during collection.

5. External anal and genitalia examination – take specimens simultaneously with the examination in the following order – anal, rectal, external genital, deep vaginal, cervical. Look for swelling, redness, bruises, lacerations, tenderness, bleeding and discharge.

CONDUCTING THE EXAMINATION (CONTINUED)



6. For the anal exam, the following should also be noted - bleeding, discharge, sphincter tone when indicated.

7. For the genital examination – collection of specimens should be performed at the same time when appropriate and it is useful to show both recent sexual contact and force; however, the absence of genital trauma does not indicate consent.

8. For the genital examination:
   a. Inspection of the perineum, labia majora, labia minora, clitoris, hymen or hymenal remnants, vaginal orifice, urethral orifice, frenulum, prepuce and swab all areas for injuries noting location, position, size, tenderness and consistency of all injuries.
   b. Speculum examination with the right-size speculum lubricated with warm water using good light source.
   c. Bimanual examination, cervix, uterus, adnexa (location, position, shape size, tenderness and consistency) should only be done if indicated (e.g. presence of STI/PID/pregnancy).
   d. Use photographs provided consent is obtained. Pictures of all injuries including genital injuries should be taken,

CONDUCTING THE EXAMINATION (CONTINUED)

labelled with the patient's name, date and time and a standardized measurement of instrument to indicate the size of the injury.

Children under the age of 14

1. Preparation of the child - Very young children or severely traumatized children should be given sedation or a general anesthetic before the examination. Gain the confidence of the child before the examination and accustom him or her to the instruments which are to be used.

2. Young children should be examined whilst sitting on (preferably) their mother's lap with their back to their mother and their legs held by their mother. Older children should be given the choice of this or sitting in a chair or lying on a bed in the lateral position. The anus can be examined in a lateral position.

3. A general examination of the child should be conducted to exclude signs of concomitant abuse or neglect and any childhood illnesses. The weight and height should be measured and recorded in the 'cases record' as well as on the 'medico-legal form'.

4. Genital examination of a female child should **NEVER** include digital or bimanual examination or the use of a speculum. Full vaginal penetration of a pre-pubertal girl causes severe damage and there is usually obvious trauma and bleeding. Children with such injuries are best examined under anesthetic.

5. If the abuse occurred within the previous five days, use the contents of the rape kit and follow the instructions.

CONDUCTING THE EXAMINATION (CONTINUED)

The Rape Kit

1. The rape kit has a checklist of all the evidence needed to be collected for forensic purposes as well as instructions which should be followed carefully.

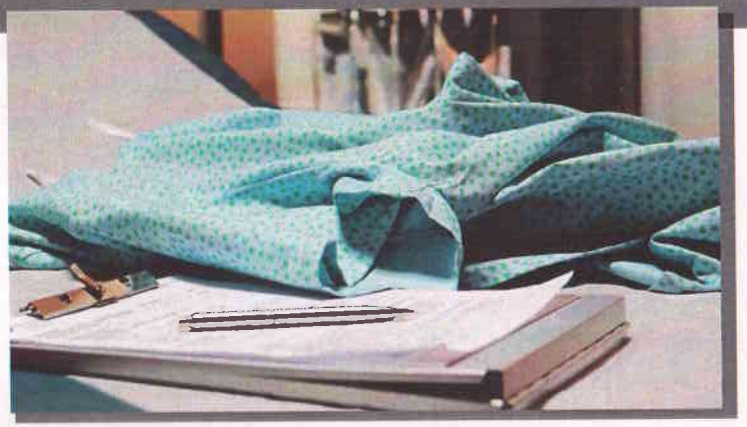
2. The collection of the forensic evidence needs to be carried out at the same time as the medical examination and while injuries are being noted, specimens should be collected for the rape kit. Forensic evidence is not just the biological samples collected from the person's body but also any trace evidence found on the body e.g. fibers, hairs, etc. The specimens that are collected are useless unless they are properly packaged and transferred. Even if there is lots of evidence that the person was sexually assaulted, improper storage and transfer may lead to the evidence being rejected in court.

3. Oral swabs – Collect in the event of oro-genital contact. Carefully swab under the tongue, along the gum line of the teeth, the cheeks and the palate. Use only one swab for the whole of the mouth area. If post-exposure prophylaxis (PEP) for HIV is to be given give the first dose immediately but ensure that an oral swab has first been taken. This can be done at the

CONDUCTING THE EXAMINATION (CONTINUED)

beginning of the interview whilst informing the patient of the procedures to be performed and obtaining consent.

4. Evidence on patient's body - Certain samples are provided for in the rape kit, but additional samples may be taken by the health care worker if they so desire.
   a. Fingernails - If the patient says that, she/he may have scratched the assailant, then they should take samples from under the patient's finger nails with a swab.
   b. Saliva on skin - The examiner should ask the patient if the assailant had sucked/licked/kissed/bit her, and take a swab of that area. Visible bite marks should be similarly swabbed.
   c. Semen or other stains on body – Moisten swab and swab those areas.
   d. Head hair – Must be combed through over the catch sheet and a sample of reference hair from the patient provided: specifically, 20 hairs, five from all different areas should be pulled out.
   e. Pubic hair – Comb the pubic hair downwards on to the catch paper that is placed under the patient's buttocks. Take a reference sample of cut pubic hair.
   f. The kit also contains 'evidence catch papers' for other foreign debris on the body, e.g. soil, leaves, hairs, fibers, matted hair (cut out) and submit the piece of paper for forensic analysis.



CONDUCTING THE EXAMINATION (CONTINUED)

5. Throughout this examination, the patient should be dressed in a clinic gown not naked during the lengthy process.
   a. Genital specimens - Minimum of 3 swabs.
   b. External genital swab – Thoroughly swab the external and internal surfaces of the labia majora and minora, the clitoral area, around the urethra, and introitus with the same swab. Collect tampon if in place.
   c. Deep vaginal swabs – Before any internal examination takes place, swab the vaginal fornix.
   d. Cervical swabs – Swab the cervix, usually under speculum examination but should be done only where indicated. See instructions above under general examination.

6. Additional investigations for children:
   a. Screening for STIs - STIs may be diagnostic of sexual abuse and so investigations are needed. The following should be taken:
      i. A vaginal swab for microscopy, culture and sensitivity (mcs) – wet the swab in the culture media first to decrease pain and irritation
      ii. Blood for syphilis, Hepatitis B and HIV (1 EDTA tube).

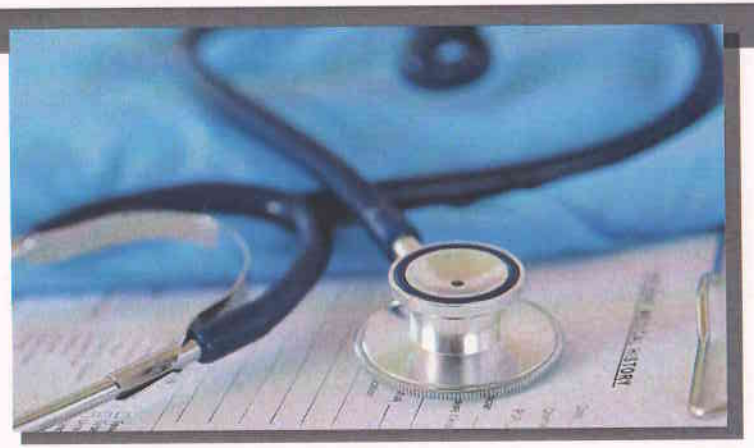
TREATMENT

1. Physical injuries – For minor injuries, conservative treatment may be sufficient. Management of severe injuries which may require surgical repair should take precedence over all other aspects of treatment. Treatment should also be provided for drugs administered ingested by the complainant during the assault.

2. Tetanus prophylaxis if there is a break in the skin or mucosa contaminated by external debris.

3. STIs and STDs must be tested for and treatment regimen provided.

4. Information should be provided about rape trauma counseling and other appropriate follow up as set out below should be provided.



AFTER THE EXAMINATION

1. Wherever possible provide facility for showering and change of clothing. The patient may be afraid to return home alone. An attempt should be made to call the police if the patient came in directly to the health care facility without referral from or escort by the police (if she/he reports the case). For children, mandatory reports must be made to the police and all requisite mandatory reporting requirements must be followed.

2. It may also be necessary to a friend and or relative to accompany the patient home or to a place of safety.

3. After the examination, the patient should be given some feedback about the results of the examination and the opportunity to ask any questions. This is particularly important for children.

4. Appropriate documentation and chain of custody procedures as set out below must be followed.

REFERRAL

The patient should be given information about appropriate local support services. Written referrals should be provided if the patient requests this. These services may include:

a. NGOs supporting survivors of sexual assaults.
b. Rape crisis centers.
c. Shelters or safe houses.
d. Legal aid.
e. Support groups.
f. Social services.

FOLLOW UP

On discharging the patient ensure that proper follow-up arrangements are in place. Clinical follow-up should be at 3 days, 6 weeks and 3 months. At the clinical follow-up examinations check the following:

1. Counselling and HIV test for those that did not take the test initially, ARV treatment may also be provided.
2. Assessment of general physical state, and healing of injuries.
3. Assess completion of medications.
4. Assessment of emotional state.
5. Look for post-traumatic stress disorder.
6. Contraception counselling if appropriate.

DOCUMENTATION

1. Documentation of evidence is a very important part of adequate medical care as well as the medico-legal examination. Sexual assault health care providers should document completely and precisely the physical and genital injuries, other forms of evidence and medical treatment.

2. Full details of the case should be retained in the case notes for further medical management of the patient.

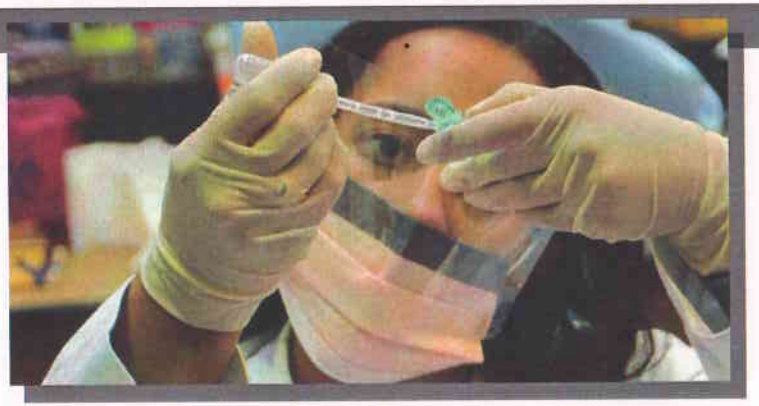
3. The case record and medico-legal form should be completed accurately and with attention to detail in the health care provider's hand writing. Accurate reporting will ensure physical and genital injuries, and other forms of evidence are competently interpreted and this in turn will ensure professional presentation of evidence in court.

4. Where possible, a brief conclusion should be made on completion of the general examination as well as genital examination. It should be consistent with the medical findings.

An example may be, "Injuries consistent with history given". If no physical injuries are observed please do not write "no evidence of abuse", simply write perhaps "no obvious physical injuries observed".

5. Case record - This document will provide a checklist for the health care provider to facilitate complete and comprehensive care of patients and avoid omissions. The report may be part of the legal record and can be submitted as evidence if the case goes to court.

6. It is advisable to keep a copy of the completed medico-legal form with the hospital records in case of docket loss by the police.



MAINTAINING CHAIN OF EVIDENCE WHEN REPORTING TO THE POLICE

1. Until a trial takes place, access to the privileged confidential information contained in the medico-legal form is restricted legally to the investigating officer and D.P.P. office.

2. The medico-legal form and the sexual assault kit are to be given only to the investigating officer who must sign a register and the medico-legal form or other appropriate form to acknowledge receipt.

3. If the police are not present at the time of the exam, the medical examiner must keep the forms and the kit under lock and key in a dedicated cupboard, by a specific person-in-charge and this should be clearly documented in the patient's notes or protocol form and a register kept in the cupboard. These should be turned over as soon as practicable to the police.