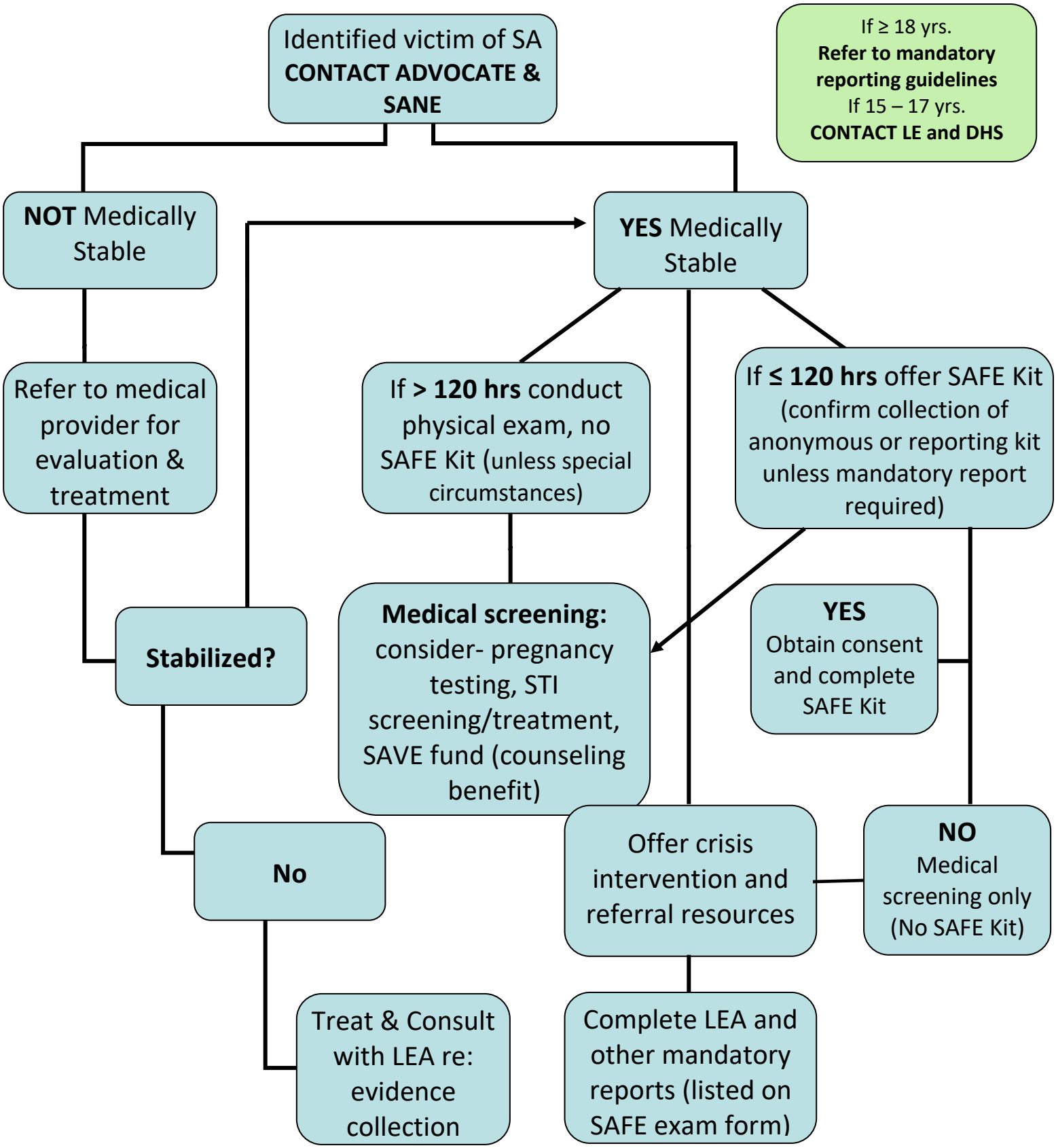
Sexual Assault (SA) Triage Algorithm for Patients 15 Years and Above



State of Oregon Medical Guidelines for Sexual Assault Evaluation†

ADOLESCENT (≥ 15 years)/ADULT

Overview

- This guideline represents the basic standards in the medical care of the sexual assault patient.
- The purpose of this guideline is to:
  - Provide direction for medical professionals in the care of the older adolescent or adult sexual assault patient;
  - Ensure that compassionate and sensitive services and care are provided in a non-judgmental manner; and to
  - Ensure that the physical and psychological well being of the sexual assault patient is given precedence over forensic needs.
- The guideline is based on current Oregon law, Centers for Disease Control and Prevention (CDC), and American College of Emergency Physicians (ACEP) recommendations for the prophylaxis of sexually transmitted infection and pregnancy, and "best practice" in the care of the sexual assault patient.

Age Considerations

- This guideline is for the care of the adolescent (age 15 years and older) and adult with a history or concern of sexual abuse or assault.
- For care of children age 14 years and younger, see the *Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents*, found at https://www.doj.state.or.us/wp-content/uploads/2017/06/ormedicalguidelines.pdf.
- **Acute triage assessment should include assessment of the specific aspects of physical and cognitive development of the individual adolescent patient to determine whether the Child or Adult Guideline should be used.**

Key Points

- The guideline is not intended to include all the triage issues, medical evaluations, tests, and follow-up that may be necessary for appropriate care for an individual patient.
- The timing of the exam, as well as the extent of the exam, depends on the detail and clarity of the history, as well as physical signs and symptoms. Not all the steps outlined in this guideline will be appropriate for every patient.
- **Best practice recommendation by the Attorney General's Sexual Assault Task Force is to have a sexual assault evaluation conducted by a SANE/SAE (Sexual Assault Nurse Examiner/Sexual Assault Examiner).**

State of Oregon Medical Guidelines for Sexual Assault Evaluation‡

ADOLESCENT (≥ 15 years)/ADULT

Table of Contents

I. GENERAL INFORMATION

Purpose of Exam	
Medical/Forensic	1. Identify and treat injuries 2. Evaluate and treat medical conditions 3. Assess risk of pregnancy and sexually transmitted infections 4. Provide prophylaxis for sexually transmitted infections and emergency contraception, when indicated 5. Document history of assault 6. Document medical findings 7. Collect forensic evidence
Social/Psychological	1. Respond to patient's immediate mental health needs 2. Access to advocacy services 3. Assess patient safety 4. Respond to patient's support person's immediate emotional needs and concerns 5. Explain reporting process, Crime Victims Compensation, Sexual Assault Victims' Emergency (SAVE) Fund and resources for advocacy and counseling, including campus support resources if patient is a college student
Report/Refer	1. Refer for follow-up medical care 2. Refer for advocacy or counseling 3. In the case of minors report to Oregon Department of Human Services (DHS) and/or law enforcement agency (LEA) ASAP 4. If report is mandated, report to LEA in the jurisdiction where the crime occurred (See section "Mandated Reporting" below) 5. If patient is a college student, discuss option of patient reporting assault to college student conduct office if perpetrator/s are also students

II. TRIAGE DECISIONS

Initial Triage

Medical assessment is indicated for ALL patients, regardless of reporting status, at any time following sexual assault.

1. Patients may be evaluated at the ED, PCP, or other clinical setting by a Licensed Independent Provider for a Medical Screening Exam prior to discharge from the facility.

Medical stabilization always precedes forensic examination

1. The following history or conditions should be evaluated medically *prior* to the sexual assault exam:
   - History of loss of consciousness
   - Head injury
   - Altered consciousness or mental status
   - Significant facial injury
   - Possible fractures
   - Blunt injury to abdomen or back
   - Active bleeding
   - Strangulation
   - Risk or concern for any life or limb threatening injury
   - Abdominal pain
2. Psychiatric illness
   - If apparent psychiatric illness complicates assessment of alleged sexual assault, both psychiatric assessment and medical forensic exam generally will be necessary. Proceed according to patient tolerance and needs

Forensic Exam

Acute:
If assault within prior 120 hours

Medical/forensic exam is appropriate on an urgent basis

1. Advise patient, if possible:
   - Do not bathe before exam
   - Bring in clothes worn at time of assault and immediately after assault, especially undergarments
   - Bring change of clothing
   - Come to hospital or clinic with support person, if possible

Non-Acute:
If assault >120 hours prior

Forensic exam is generally not indicated on emergency basis

1. Crime lab generally does not recommend evidence collected more than 120 hours after an assault
2. Individual case circumstances may warrant urgent evidence collection beyond 120 hours after assault (i.e., multiple assailants, patient was unconscious for a period of time) or when requested by LEA

SANE/SAE consultation should still be considered to assist with:

1. Medical screening and physical examination
2. Consideration of pregnancy testing, STI screening and treatment
3. Collaboration with advocacy for safety planning and social/psychological support
4. Assistance with SAVE fund application process (≤ 168 hours, counseling benefit)

Advocacy

Per SB 795 (Chapter 349), medical staff will dispatch an advocate, per their local Sexual Assault Response Team (SART) protocol.

1. Medical staff will dispatch an advocate from their local program as soon as a patient presents for sexual assault-specific care.
2. Medical staff should inform the patient that an advocate is on their way per protocol and that the advocate will explain their role fully, at which point the patient may accept or decline the advocate's involvement. Medical staff should understand that advocates are the best people to explain the advocacy role and avoid giving patients incorrect or incomplete information about advocacy services.

3. Once the advocate arrives, inform the patient that the advocate is present and offer the patient the opportunity to speak with the advocate one-on-one. Patients may then have the option to decline advocacy services. If the patient does not feel comfortable meeting the advocate in person, then medical staff should give the patient any informational materials delivered by the advocate. Advocate should only be allowed in the patient's room with patient consent.

Mandated Reporting

Serious Physical Injury/Injury from weapons
ORS 146.710 to 146.780; ORS 161.015

1. Serious physical injury or injury caused by any weapon must be reported to the appropriate law enforcement agency irrespective of reporting the sexual assault
2. Consult with provider (MD, DO, ND, NP, PA)
3. Mandated oral report of injury by telephone or otherwise, and followed soon thereafter by a written report to appropriate law enforcement agency
4. A serious physical injury, inflicted upon a person other than by accidental means

Minors < 18 years
ORS 419B.005 to 419B.045

1. Nursing and medical providers are mandated to report to police and DHS when they have a reasonable suspicion of child abuse
2. A report to police and DHS is mandatory if patient is under 18 years of age
3. Mandatory reporting applies even when minor has signed for own care
4. Mandated within 24 hours

Adults ≥18 years

If the patient is an adult age 18 years or older and is not disabled, mentally ill or ≥ 65 years of age, notification of law enforcement is done only if the patient gives consent to report the sexual assault.

Disabled
ORS 430.735 to 430.765
Mentally Ill
ORS 430.735 to 430.765
Vulnerable Adult
Adults ≥65 years of Age
ORS 124.050 to 124.095

1. If the patient is age 18 years or older and is disabled or mentally ill; or 65 years and over: a report to police and to county Adult Protective Services or State Residential Care Services is mandatory
2. Mandated within 24 hours

Consent

Minors ≥ 15 years
ORS 109.640

Informed consent for all procedures, evidence collection and treatments is obtained in all cases

1. Minors ages 15 and older may consent to hospital care, medical or surgical diagnosis or treatment by a licensed physician without the consent of an adult or guardian
2. Information regarding the components of a medical- forensic exam must be discussed in detail and the patient may withdraw consent for any portion of the exam at any time
3. If the patient is unable to consent to a medical-forensic examination efforts should be made to ascertain if the patient will have the capacity to consent in a timely fashion (e.g. intoxication/impairment) or if another individual should be contacted to consent on their behalf (e.g. POA, next of kin, DHS)

Release of Information

The patient must first be informed of the reasons for the release and written consent obtained before the release of medical information or sexual assault documentation is completed.

Cost of Evidence Collection

Please refer to the SAVE Fund Application for restrictions to the following: Within certain timeframes, patients assaulted in Oregon or outside of the U.S. are not charged for the cost of the medical examination, collection of forensic evidence, or other costs associated with the sexual assault incurred at the initial medical visit. These costs are paid for by the Department of Justice through its Sexual Assault Victims' Emergency Medical Response Fund. Patients are not required report to police to access these funds or to have a SAFE Kit collected.

Patients assaulted in other states must access that state's fund, which may have different restrictions.

III. HISTORY AND INITIAL EVALUATION

Discussion with Patient

1. Discuss each step of the medical and forensic procedures
2. Discuss patient reporting and non-reporting to law enforcement
3. Discuss mandatory DHS and LEA report
4. Let patient know that written information and educational literature will be provided

Patient Demographic

Document the following information if it is available and pertinent

1. Routine data: patient name, gender, age, birth date, hospital/clinic number or medical records number, home address, phone number; telephone number for parent or guardian if different
2. Date and time of arrival
3. Who accompanied patient, and their relationship
4. If an advocate was called/present
5. Interpreter name, if used, and language
6. Name of LEA assigned officer
7. Name of DHS caseworker if patient is less than 18 years old or adult protective caseworker if adult is disabled
8. LEA case number, if available

History of Assault

Obtain patient history and document the following:
Facts about assault

1. Source of information (patient, police, or other person)
2. Nature of concern
3. Time, place of assault, and jurisdiction/location if known
4. Hours since assault
5. Number of assailants and sexual assailants, identity if known
6. Identity and relationship of alleged offender, if known
7. Record narrative history of assault

Nature of force used

1. Patient had impaired consciousness
2. Known or suspected drug or alcohol ingestion
3. Verbal threats
4. Use of physical force
5. Use of weapon
6. Use of coercion

Physical facts of sexual assault

1. Which orifices assaulted
2. By what (finger, penis, mouth, foreign object)
3. Whether condom was used
4. Whether ejaculation was noted, and where
5. Physical injuries
6. Whether bleeding or pain was reported

Post assault activity of patient

1. Showered or bathed
2. Douched, rinsed mouth, urinated, or defecated
3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to emergency department/clinic

Risk factors of assailant regarding hepatitis B/C, syphilis, and HIV, if known

1. Known or suspected IV drug use
2. From a high risk community

3. STI history or history of multiple sexual partners
4. Blood or mucous membrane exposure

Past Medical History

1. Significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental, cognitive, mental health and/or physical disabilities
2. Current medications
3. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and alcohol
4. Allergies
5. Ob-gyn history
6. Birth control method (IUD, tubal, OCP, etc.)
7. Last menstrual period
8. Last consensual intercourse: when and what kind
9. Patient's history of hepatitis B vaccine or illness

IV. PHYSICAL EXAM & EVIDENCE COLLECTION

Forensic Evidence Collection

1. Clean swab drying box with antimicrobial cleaning solution per institution protocol.
2. Standard Sexual Assault Forensic Evidence (SAFE) Kit, provided by Oregon State Police Crime Lab, is used for evidence collection in both reported cases and non-reported cases
3. Complete Oregon State Police Sexual Assault Forensic Lab information form
4. The evidence collection exam is done by a qualified registered nurse or LIP currently licensed in Oregon.
5. Examiner should have a system to record where each swab was collected from and why to ensure accurate packaging

Chain of Custody of Forensic Specimens

One staff member must be responsible for maintaining chain of evidence at all times. That staff member

1. Observes specimens OR
2. Designates another staff member to watch specimens (documenting this in chain of custody) OR
3. Secures specimens in freezer, refrigerator, cabinet, or specific area

General Information

1. All patients should receive a complete head-to-toe physical examination
2. It is the patient's right to consent or refuse any aspect of the exam and evidence collection
3. The patient may have a support person (relative, friend, or advocate) present during the exam, see ORS 147.425 for restrictions
4. If suspected or known oral sodomy, it is preferable that the patient does not eat or drink before the exam, but the patient's comfort should not be compromised to achieve this
   - Oral swabs, for example, should be obtained immediately if patient is thirsty or wishes to rinse mouth
5. Use powder free gloves and change gloves frequently during exam and evidence collection
6. General exam findings:
   - Document developmental level, emotional status, mental status and general appearance
   - Document objective observations: "patient avoids eye contact and is teary-eyed" is preferable to "patient is sad"
   - Vital signs, height and weight

Medical Chaperones

1. Offer patient a medical chaperone for all breast, genital, and rectal examinations
2. Document that a medical chaperone was offered and whether the patient accepted or declined their presence

Exam Procedures

1. Because a patient may not initially report all aspects of the assault, collect evidence routinely from the mouth and vagina. Collect swabs from the rectum if there is any possibility that evidence may be found there.
2. If the patient has bathed or showered, specific steps of evidence collection should be omitted. These steps are indicated in the following sections
3. The following sections outline the steps for the medical exam and the collection of evidence. The order of these steps may vary by examiner preference or patient need

Clothing, Trace Evidence, and Skin Exam

Clothing Collection

If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important. Do not collect the clothes if the patient is wearing clothing other than what was worn during or immediately after the assault. Wet clothing should be dried in a secure room or area, or transferred to law enforcement ASAP. Do not cut through any existing holes, rips, or stains. Do not shake out patient's clothing or trace evidence may be lost

1. Place each item of clothing in a separate paper bag
2. Place kit number, case number, and contents on each bag. IF the patient is reporting to LEA, put name on bag. Tape bag closed, and sign and date over tape.
3. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed

If applicable to patient history, consider photo documentation (see below) on all 4 sides of the body and the patient's hands prior to being undressed.

Underpants

Collect patient's underpants routinely, even if changed after assault

1. Pooled secretions may leak onto underwear
2. Package patient's underpants in a small paper bag. Label bag with contents, SAFE kit number, and patient label (if reporting). Seal with evidence tape; sign, date, and time across tape. Do not place in SAFE kit

Trace Evidence Collection

To collect foreign material which may fall when patient undresses. Omit if patient has bathed or changed clothes since assault

1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper
2. Unfold and place evidence collection paper sheet over the bottom sheet
3. Instruct patient to stand in the center of paper and remove clothing
4. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) where patient stood, retaining any foreign material
5. Label bag with contents, SAFE kit number, and patient label (if reporting). Seal with evidence tape; sign, date, and time across tape. Do not place in SAFE kit

Photo Documentation

General

1. Photographs should be obtained in addition to, rather than in place of, bodygram documentation and injury logs.
2. Facilities should ensure that protocols and policies are in place regarding obtaining, storing, and releasing all photography in a secure manner that protects patient privacy and dignity
3. Please refer to the Oregon Sexual Assault Task Force's Medical Forensic Subcommittee position paper on forensic photography for more details
4. Care should be taken during the photography process to prioritize patient comfort, dignity, and privacy at all times
5. Techniques utilized during photography should include bookending with patient labels, beginning with an overall patient photograph, photographing from multiple distances to establish body landmarks, photographing with and without measuring devices, and ensuring

accuracy of photographs in regards to lighting and injury depiction
6. Do not delete any digital photographs, regardless of quality. Do not dispose of any film prints or negatives.

Ano-Genital Photographs
1. It is the recommendation of the Medical Forensic Subcommittee of the Oregon Sexual Assault Task Force that ano-genital photos not be taken except in rare circumstances, due to their sensitive nature and their limited usefulness in criminal justice settings.
2. Should ano-genital photos be taken, due to the extremely sensitive nature of these photographs, they are to be kept with the medical record. They are released only in response to a subpoena and are then released directly to the medical expert who is reviewing them.

Head Hair

Collect standard head hair samples on all patients.
1. Pre-fold blank sheet of paper in thirds, both horizontally and vertically
2. With gloved hand run fingers through hair to collect any loose hair and place on paper
3. 24 head hairs are required. Ask patient if he/she would like to pull hair or would rather the provider do it
4. Bindle paper and place in envelope
5. Seal envelope with patient labels or tape (do not lick) to ensure no contents can fall out
6. Label envelope with contents

Skin Exam: **Document**

Bruises, petechiae, abrasions, lacerations, and bite marks, and suction ecchymoses, tenderness
1. Measure and describe traumatic lesions and mark on traumagram
2. Ask patient how each injury occurred and document patient's statements
3. Confirm that photos have been taken and a drawing completed of acute traumatic skin lesions (see photo documentation section)
4. Using an alternate light source with room lights dimmed: scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, and thighs
5. Semen may fluoresce
6. Document presence/absence and location of fluorescence

Fingernail Debris/Swabbing

Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched offender
1. Use one moistened swab under all five fingernails of one hand, then swab the same five fingers with a dry swab. Do the same procedure with the other hand. Dry swabs
2. Patient may be able to do this with direct supervision
3. Package all swabs from one hand in one envelope and all swabs from other hand in a separate envelope
4. Seal envelopes with patient labels or tape (do not lick) to ensure no contents can fall out
5. Label envelopes with contents

Skin and Hair Debris

Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to assault. Collect grass, fibers, paint flecks, etc., which may adhere to patient's skin. Omit this step if patient bathed or if no debris visible
1. Place small paper sheet on flat surface
2. Collect any foreign debris (dirt, leaves, fiber, hair, etc.), place in center of paper
3. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) to retain debris

4. Place each folded sheet in an envelope and label with site
5. Seal envelope with patient labels or tape (do not lick) to ensure no contents can fall out
6. Label envelope with contents

Forensic Swabs

Collect when assault occurred within last 120 hours:

1. Patient reports alleged assailant's blood, semen, or saliva may be deposited on skin or
2. Assailant's blood or dried secretions are visible or
3. Assailant's bite marks or suction ecchymosis are visible or
4. Alternate light source scan is positive

Swab Technique

1. Use 4 cotton swabs for moist mucous membranes, 2 cotton swabs (moist to dry) on non-mucous membranes
2. Lightly moisten one swab with tap water if secretions are dried
3. Swab areas of possible dried secretions, follow moist swabbing with one dry swab
4. Package swabs from each separate location in separate envelopes
5. Seal envelopes with patient labels or tape (do not lick) to ensure no contents can fall out
6. Label envelopes with contents

Oral Exam

Document

Lacerations, abrasions, petechiae, and bruises. Check mucosa, palate, upper/lower frenula, tongue, and lingual frenulum

Forensic Swabs

Collect four swabs when

1. Abuse/assault occurred within prior 24 hours or
2. Visible oral injury or
3. History of oral/genital contact in prior 24 hours

Reference Swabs

Collect reference oral standard swabs to establish patient DNA

1. Use 4 swabs on mucous membranes,
2. Vigorously swab inside of cheek of the mouth
3. Process as forensic swab (page 15)

Pubic Hair Combing, Plucking and Cutting

If pubic hair is present comb onto a paper and bindle

CONSIDER plucking pubic hairs when one or more of the following conditions apply:

1. Stranger or unknown assailant or multiple assailants
2. Foreign pubic hair is collected in the pubic combing
3. Assailant is an acquaintance that has not previously been in the environment where the assault(s) occurred
4. Matted pubic hair should be cut in addition to plucking.

If plucking is necessary ASK THE PATIENT IF THEY WANT TO PLUCK THEIR OWN. Collect 24 hairs from all around the pubic area via combing, plucking, or shed hairs

Genital Exam – Female

Document

Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, and discharge; Tanner Stage

Forensic Swabs

Use 4 cotton swabs on moist mucous membranes, 2 cotton swabs (one moist then one dry) on non-mucous membranes

Collect when

1. Assault occurred within prior 120 hours and
2. History of penile-genital or oral-genital contact or
3. Report of contact to genitalia, perineum, or anus by any part of assailant's body or
4. Ejaculation occurred near anogenital area or

5. Visible acute genital or anal injury or
6. Alternate light source scan is positive

External Genital Area Swabs

Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body.

1. For non-mucous membranes, lightly moisten one swab with tap water if secretions are dried
2. Swab labial folds, clitoral hood, fossa navicularis, and posterior fourchette using wet swab, followed by dry swab
3. Consider swabbing mons pubis, perineum, inner thighs, and/or inguinal folds using wet swab, followed by dry swab

Internal Genital Area Swabs

Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body. For young adolescents who have not had a prior pelvic exam, or post-menopausal adults, or any other patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina

1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising
2. Rinse speculum in warm water for patient's comfort.
3. If lubricant is needed use minimum amount, water based and document type used.
4. Sites to consider swabbing include:

1. Vagina (particularly posterior vaginal pool)
2. Endocervix
3. Cervical os

5. Use 4 swabs total including the vagina, endocervix, and cervical os
6. Use 1 or 2 swabs at a time. Do not moisten swabs for areas that are moist

Genital Exam – Male

Document

Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, and discharge; Tanner Stage

Forensic Swabs

Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body.

1. For non-mucous membranes, lightly moisten one swab with tap water if secretions are dried
2. Swab external surface of glans/penis, under foreskin if applicable, scrotum using wet swab, followed by dry swab
3. Consider swabbing mons pubis, perineum, inner thighs, and/or inguinal folds using wet swab, followed by dry swab

Perianal and Anal Exam- Male and Female

Document

Perianal bruising, petechiae, edema, discharge, bleeding, tenderness, abrasions, lacerations, erythema, inflammation, and visible anal laxity

Exam Technique

1. Use good light source
2. Use magnification with otoscope, visor, or colposcope
3. Separate anal folds to visualize injuries
4. Digital exam is not indicated, except if concern for foreign body retention
5. Anoscopy is indicated as an option if there is patient report of rectal penetration, active rectal bleeding, or rectal pain
6. Lubricant should be used for anoscopy. To avoid contamination by lubricant, perform anoscopy only AFTER FORENSIC SWAB COLLECTION. When applicable, document the type of lubricant used during the exam
7. If used, apply Toluidine blue to identify abrasions on skin surface only AFTER FORENSIC SWAB COLLECTION

Forensic Swabs

Collect when

1. Assault occurred within prior 120 hours and
2. History of penile-genital or penile-anal contact or
3. Report of contact to genitalia, perineum, or anus with any parts of assailant's body or
4. Visible acute anal trauma or
5. Alternate light source scan is positive

External Anal/Perianal Swabs

1. Sites to consider swabbing
   - Perianal area (external to anal sphincter)
   - Anus
   - Gluteal cleft
2. Lightly moisten one swab with tap water before using
3. Use moist swab to swab external anal rugal area. Repeat with second swabs
4. Process as forensic swab

Rectal Swabs

Consider collecting rectal swabs with reported penetration and ejaculation when indicated by patient history.

1. Use 4 cotton swabs total
2. Ensure that the rectum can be seen (past the dentate line, approximately 2 cm into the anal canal), either in conjunction with an anoscope exam performed by a provider or by placing the patient in prone knee-chest position and allowing the internal sphincter to relax
3. Use 1 or 2 swabs at a time
4. Process as forensic swab (page 15)

Other Items

Collect items which may contain forensic evidence, such as tampon or pad, and condom. These should be collected on a case-by-case basis

1. Place in plastic bag and freeze or refrigerate until pick-up by LEA.
2. If freezer/refrigerator is not available, air dry the item if possible. If unable to air dry, package the item in a non-air tight container, such as a urine cup with holes in the lid to allow the item to dry. Contact LEA for transport ASAP.
3. Label bag with contents, SAFE kit number, and patient label (if reporting). Seal with evidence tape; sign, date, and time across tape. Do not place in SAFE kit

V. EVIDENCE PACKAGING & STORAGE

Evidence Collection & Storage

Processing Forensic Swabs

Obtain forensic swabs (saliva, seminal fluid & perspiration)

1. Use sterile cotton swabs
2. To obtain swabs from dry areas (e.g., skin, fingertips, anus, and any areas that fluoresce) lightly moisten one swab with one or two drops of tap water (soaking in water will prolong drying time and increase likelihood of specimen molding) and follow with a dry swab
3. To obtain swabs from wet areas (e.g., mouth, rectum, vagina) use four dry swabs

As each swab is obtained

4. Maintain a notation system to remember what site each swab was collected from and why it was collected
5. Place swabs in drying rack or drying box in secure area if available. Alternative drying methods, such as upside-down cups, may also be used as long as care is taken to preserve them from contamination
6. Allow swabs to dry fully

When swabs are dry

7. Place all swabs from same site in one envelope (i.e., only one site per envelope)
8. Label envelope with specimen site (e.g., "oral," "vaginal," "skin")
9. Label envelope with reason collected (e.g., "saliva," "semen,"

"aggressive handling")
10. Seal envelope with tape or patient label, ensuring that contents cannot fall out of any openings. Do NOT lick envelope to seal, as this introduces moisture and your DNA
11. Store securely in Evidence Kit

Note on Forensic Slides

Slides are no longer obtained as of 2016.

Processing Evidence Collection Kit

1. Once all evidence has been placed inside the kit
2. Complete the Forensic Laboratory Information Form found inside the kit and include white and blue copies in the kit
3. Include copy of chart in kit per hospital policy
4. Complete the information requested on the front of the kit, replacing patient name with "Anonymous" if non-reporting
5. Place evidence tape over the envelope, seal, and sign over tape with initials, date, and time
6. Give the kit to the LEA representative along with the yellow copy of the Forensic Laboratory Information Form if reporting, and have them sign the Evidence Receipt to be placed on the patient's chart
7. If no LEA representative is available, store the kit in a secure area, then contact LEA immediately and give them the location of the completed kit so LEA can pick it up ASAP

Drying Box

8. Clean drying box with antimicrobial cleaning solution per institution protocol

<u>Evidence Storage</u>

Temperature

1. Dry or dried evidence may be kept at room temperature
2. Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer to avoid molding

Clothing

1. Dry clothing should be placed in paper bags with each item of clothing in a separate bag
2. Label each bag with contents, SAFE kit number, and patient label (if reporting). Seal with evidence tape; sign, date, and time across tape. Do not place in SAFE kit
3. Clothing should be stored in a secure area until transfer to law enforcement
4. Wet clothing must either be dried in a secure area, refrigerated or frozen and transferred ASAP to law enforcement
5. In order to maintain chain of custody of wet clothing you may double or triple paper bag wet clothing, utilizing evidence tape as described in step 1 prior to handing to LEA. Notify LEA representative that clothing will need to be dried.

Photo documentation

1. Photographs are part of the medical record and are subject to the same protection and confidentiality.
2. Photos may be stored outside of the medical records department. (just as x-rays films may be stored in the radiology department.)
3. Photos can be stored on a hard drive with limited access or on CD-R (non-rewritable).
4. No alterations should ever be made to the original downloaded image. Copies can be enhanced (contrast, brightness, size, rotation and color temperature only). Document any enhancements made to the copies.
5. Compact flash cards are reused once the patient data is deleted from it.
6. If photos are stored only on disk, two copies should be made and kept in two separate locations.
7. Photos, negatives, or CDs should be stored in an area protected from temperature extremes, with limited access, and which can be locked when not in use.

Release

1. Ensure HIPAA compliance when releasing photographs.
2. If copies are made or released, document the date, time and person receiving the items.

The documentation released should be specific to the dates indicated on the request. Do not copy or release non-related medical information.

To process as Forensic Evidence/Evidence Kit

1. Place all evidence in paper bag, kit, or envelope
2. All evidence in the Evidence Kit should be dry
3. Evidence besides swabs, hairs, and debris should be packaged in paper bags separate from the Evidence Kit
4. Store entire, sealed Evidence Kit in room temperature secure area, refrigerator, or freezer until transfer to law enforcement
5. Blood tubes and urine samples should be packaged in a separate biohazard bag, outside of kit. Label and seal as you would per step 2.
6. Biological specimens (swabs, slides) should be labeled with site obtained from
7. Swabs should be dried in a secure drying box or area before transfer or freezing
8. Biologic specimens should be placed in a secure area until transfer to law enforcement

Processing Non-Reporting/Anonymous Kits

To process a non-reporting/anonymous exam:

1. Note: These kits will be held by law enforcement for 60 years.
2. Patient signs consent for a non-reporting/anonymous exam
3. Label all evidence (minus the patient's name) and package as instructed to do above. The envelope should be sealed the same as for a reporting exam. When the kit is sealed; in place of the patients' name, you may use the kit number or 'Anonymous'. No patient name or label should be on the outside of the kit.
4. Clothing is packaged as previously described, but double bag all clothing. Bag#1 will have patients name on it and then placed inside of Bag#2, then sealed and the nurses name through the tape. Bag#2 is identified by the kit and case number, date, time, contents, facility where collected and nurses name.
5. The laboratory information form should not be separated but rather left complete and inserted into the kit prior to sealing.
6. The patient is provided the kit #, case # if available, name of the hospital and date kit will be held until.
7. After the patient leaves the appropriate LEA is called to pick up kit.

SAMS Track

1. Initiate SAFE Kit tracking process on SAMS- Track webpage https://sams.osp.oregon.gov/Account/Login
2. Provide patient written information on how they can track their kit using the website https://trackit.osp.oregon.gov/

VI. INITIAL LAB TESTS

Pregnancy Test

Obtain urine or serum pregnancy test on all patients at risk of pregnancy.

Toxicology Tests

Obtain toxicology and/or alcohol level when:

1. Patient appears impaired, intoxicated, or has altered mental status
2. Patient reports blackout, memory lapse, or partial or total amnesia for event, or has baseline memory impairment
3. Patient or other is concerned that he or she may have been drugged
4. Separate consents for toxicology specimens need not be obtained, but patient should be informed that specimens are obtained

Hospital/clinic toxicology

1. If toxicology and/or alcohol results are needed for patient care, stat hospital/clinic toxicology tests must be done

Forensic lab toxicology

1. Drug and alcohol testing may be done for legal purposes; legal specimens follow a chain of custody and generally are given to LEA (not processed through hospital/clinic lab).
2. In some circumstances examiner may order tests to be run at "any detectible level," rather than the standard cut off. Talk with the lab toxicologist to determine how to order.
3. When it is deemed necessary to collect samples for toxicology purposes, collect blood for alcohol testing *and* urine for drug testing. Urine must be obtained as soon as possible.
4. Refer to Section V "Evidence Packaging & Storage: Evidence Storage" to process as forensic evidence. *Do not* place blood or urine samples in SAFE kit. Package separately.

VII DIAGNOSTIC TESTS FOR MEDICAL TREATMENT

The costs of the following tests will be covered by the Sexual Assault Victims' Emergency Fund when done as part of a sexual assault medical-forensic exam, following the restrictions as listed on the application. Patients should be informed that these tests will not detect very recent infection or pregnancy. Negative tests should not preclude the patient from receiving prophylactic medications.

Laws in all 50 states limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STIs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment also is enforced in most states.

Decision to perform testing should be made on an individual basis

1. STI testing, if done at time of acute assault, should be repeated at follow-up visit in 1 to 2 weeks if patient not completely treated during the initial examination and at again at 4 to 6 weeks, HIV should also be repeated at 3 to 6 months
2. Specimens for STI testing go to hospital/clinic lab NOT to crime lab
3. Inform patient that these tests are related to health issues and are not exclusively for forensic purposes

Pregnancy Test

Obtain urine or serum pregnancy test on all patients at risk of pregnancy

Toxicology Tests

Hospital/clinic toxicology

1. If toxicology and/or alcohol results are needed for patient care, stat hospital/clinic toxicology tests must be done

Vaginal Wet Mount

1. Not recommended to examine for sperm, due to lack of reproducibility and standardization
2. POC or wet mount with measurement of vaginal pH and KOH application for the whiff test from vaginal secretions may be performed for evidence of BV and candidiasis, especially if vaginal discharge, malodor, or itching is present

STI Tests for Gonorrhea and Chlamydia	1. Positive tests may indicate pre-existing infection. Highly sensitive tests such as Nucleic Acid Amplification Test (NAAT) may also indicate infection in assailant 2. For vaginal or penile infection: Urine NAAT test or vaginal or penile culture for gonorrhea and chlamydia 3. For anal infection: Culture for gonorrhea and chlamydia NAAT test cannot be done 4. For pharyngeal infection: Culture for gonorrhea Do not culture for chlamydia
STI Tests for Syphilis and Syphilis Serology	1. Syphilis baseline test may be offered 2. Serologic tests for syphilis should be repeated 6 and 12 weeks after the assault if initial test results were negative and these infections are likely to be present in the assailant. 3. Prophylactic treatment for gonorrhea may prevent incubating syphilis from becoming clinical
HIV Testing	1. Baseline HIV testing is recommended prior to initiating HIV nPEP (see HIV nPEP guidelines), and should be considered on an individual basis, repeat at 6 weeks and 3 months 2. Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but related to possible exposure 2 weeks or more prior 3. If testing is done, arrangements must be made for follow-up contact to discuss results and provide counseling
Hepatitis B/C Serology	1. Indicated if patient is unsure of hepatitis B immune status 2. Hepatitis B/C serology is best done 3 months after last exposure 3. Baseline hepatitis B and hepatitis C testing recommended when initiating HIV nPEP

VIII TREATMENT

Pregnancy Prevention **Emergency Contraception: Oregon Administrative Rules (OAR) 333-505-0120**	1. A hospital providing care to individuals with female reproductive organs reporting a sexual assault shall: (a) Promptly provide the victim with unbiased, medically and factually accurate written and oral information about emergency contraception; (b) Promptly orally inform the victim of their option to be provided emergency contraception at the hospital; and (c) If requested by the victim and not medically contraindicated, provide the victim of any childbearing age with emergency contraception immediately at the hospital, notwithstanding ORS 147.397 (defining the availability of the Sexual Assault Victims' Emergency Medical Response fund "SAVE Fund"). (d) For purposes of this rule, "emergency contraception" means the use of a drug or device that is approved by the United States Food and Drug Administration to prevent pregnancy after sexual intercourse 2. A hospital shall post a written notice, approved by the Division, to inform victims of their right to be provided emergency contraception at the hospital 3. Pursuant to ORS 109.640, anyone under the age of 18 has the right to consent to birth control information and services, including emergency contraception

4. A hospital shall document in writing that the information required to be given to a victim of sexual assault in section (1) of this rule, was provided. Failure to have such documentation may result in the issuance of a civil penalty

Since the effectiveness of emergency contraception is time dependent, if possible, the patient should obtain medications prior to discharge or as soon as possible

Medications for patients who have a negative pregnancy test and are at risk for conception may be given as follows:

Levonorgestrel (Plan B) 1.5mg tab by mouth, take one tablet
Progestin-only pill
May not work well for patients with a BMI >25 and may not work at all in patients with a BMI >30
Works best to prevent pregnancy if given within 72 hours of assault, can work up to 5 days

-OR-

Ulipristal acetate (ella) 30mg by mouth, take one tablet
Most highly effective EC pill
May prevent pregnancy for up to 120 hours post assault
Works better for patients with a BMI >30 and may not work at all in patients with a BMI >35
Might make hormonal birth control methods less effective right after taking it, a backup birth control method should be used until next period starts

Do not administer different EC pills within 5 days of each other

For patients with a BMI >35
Oral emergency contraceptives may not be effective in preventing pregnancy
Patient should be given information on use of **Copper-T IUD (Paragard)** for EC
The most effective form of EC, reducing the risk of pregnancy by 99% when inserted within 5 days of assault
Works regardless of a person's weight
Not readily available in the emergency department
Patient will require bimanual examination, cervical inspection and STI screening by provider inserting IUD prior to use

STI Prophylaxis

Every patient will be offered prophylactic treatment for sexually transmitted infections per CDC STI Treatment Guidelines, 2021

Gonorrhea Prophylaxis

Ceftriaxone (Rocephin) 500 mg IM in a single dose
For patients weighing ≥150 kg, 1g of ceftriaxone should be administered
If ceftriaxone cannot be used (cephalosporin allergy)
Azithromycin 2 g orally in a single dose **PLUS** Gentamicin 240 mg IM in a single dose

Chlamydia Prophylaxis

Doxycycline 100 mg orally twice a day for 7 days
If concerns for compliance or pregnancy
Azithromycin 1 g orally in a single dose
Alternative regimen
Amoxicillin 500 mg orally 3 times a day for 7 days

Bacterial Vaginosis/Trichomoniasis	**Metronidazole** (Flagyl) 500 mg orally twice a day for 7 days If concerns for compliance Metronidazole (Flagyl) 2g orally in a single dose
Hepatitis B Vaccine and Immunoglobulin	1. If patient has been previously immunized for Hepatitis B but did not receive post vaccination testing, give a single vaccine booster dose 2. If hepatitis status of assailant/s is unknown and patient has not been previously vaccinated, administer first Hepatitis B vaccine dose 3. If assailant/s are known to be HBsAg-positive and patient has not been previously vaccinated, administer first Hepatitis B vaccine dose and also give HBIG 4. Follow-up doses of Hepatitis vaccine are given 1-2 months after initial dose and 4-6 months after first dose
Tetanus Prophylaxis	**Offer when** 1. Skin wounds occurred during assault and 2. Patient not up to date for tetanus immunization (no immunization in past five years) 3. Patient signs consent for immunization
HPV Vaccine	1. Offer HPV vaccination for female and male survivors aged 9–26 years who have not been vaccinated or are incompletely vaccinated 2. The vaccine should be administered to sexual assault survivors at the time of the initial examination, and follow-up doses should be administered at 1–2 months and 6 months after the first dose
Anti-Emetic Medications	1. Consider premedicating patients with antiemetics 15 to 30 minutes prior to administration of EC, STI, or HIV prophylaxis 2. Offer food and water prior to medication administration when appropriate
HIV Prophylaxis **Assistance with PEP-related decisions can be obtained by calling the National Clinician's Post Exposure Prophylaxis Hotline (PEP Line) (telephone: 888-448-4911)**	**CDC Recommendations for Postexposure HIV Risk Assessment of Adolescents and Adults <72 Hours After Sexual Assault, 2021** Health care providers should do the following: Assess risk for HIV infection in the assailant, and test that person for HIV whenever possible If the survivor appears to be at risk for acquiring HIV from the assault, discuss PEP, including benefits and risks If the survivor chooses to start PEP, provide an initial course of 3–7 days of medication (i.e., a starter pack) with a plan in place for the individual to obtain remaining medications necessary to complete a 28-day course **OR** provide patient full course of medication or prescription for full course per facility protocol If the survivor chooses to start PEP provide counseling regarding medication assistance programs If PEP is started, obtain serum creatinine, AST, and alanine aminotransferase at baseline Perform an HIV antibody test at original assessment; repeat at 6 weeks and 3 months Counsel the survivor regarding ongoing risk for HIV acquisition and about HIV PrEP, and provide referrals to a PrEP provider See HIV Postexposure Prophylaxis (PEP) after Sexual Assault Guidelines and algorithm on the Attorney General's Sexual Assault Task Force website

IX. DISCHARGE AND FOLLOW UP MEDICAL VISIT

Discharge

1. Discuss safety issues/plan. Do not write down safety plans in any document that will be scanned into the medical record due to the possibility of compromising the patient's safety
2. Appropriate medical follow up will be identified for the patient with respect to the evaluation of possible sexually transmitted diseases, pregnancy and any physical injuries sustained during the assault
3. Explain follow-up for test results
4. Offer patient education materials
5. Confirm plans for medical and counseling follow-up
6. Give phone numbers for sexual assault victim advocate and other support services, including campus resources if the survivor is a college student
7. Follow up counseling information will be provided to the patient by the sexual assault advocate or the forensic examiner
8. Give written discharge instructions for all treatment and follow up
9. Provide printed information on how to track their SAFE kit using SAMS-Track
10. Information on area resources concerning: medical follow up, crisis intervention phone numbers, sexual assault crisis centers, shelters, DHS Child Welfare, Crime Victims Compensation Program, law enforcement and the district attorney's office will be given to the patient at the time of discharge
11. Per community protocol, refer minor patients to local child abuse intervention center for medical and forensic follow-up

Follow Up

Recommended within two weeks of the initial exam

Medical Visit

Review with patient or guardian

1. Emergency department/clinic record
2. Lab results
3. Current physical symptoms
4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
5. Concerns for safety
6. Concerns regarding STIs and HIV
7. Assess social support (family, friends)
8. Additional history or any new information regarding the assault
9. If patient is a minor or a disabled, mentally ill, or elderly adult, report any new allegations to LEA and appropriate protective services agency. Developmentally disabled patients may benefit from access to services at the local Child Advocacy Center

Physical Exam

Depending on history and symptoms

1. Evaluate for resolution and healing of injury
2. Evaluate current symptoms
3. Re-photograph any areas that were photographed on initial exam

Laboratory Tests

Depending on risk and patient concerns

1. Obtain urine pregnancy test. Let patient know that this is only a screening test and should be repeated if patient does not have a regular menstrual period
2. Nucleic Acid Amplification Test (NAAT) or culture for gonorrhea and chlamydia if single dose prophylaxis was not given in hospital/clinic
3. HIV: pre-test and post-test counseling required after exposure
   - Baseline, if not already done
   - Six weeks
   - Three months
4. Hepatitis B/C serology--three months after exposure
5. Syphilis serology—6 weeks and 3 months after exposure

Treatment	1. Prophylaxis with Hepatitis B vaccine may be initiated up to 14 days post assault; indicated if there has been secretion-to-mucosal contact and if patient has not been fully immunized; counsel regarding completion of series.
Referral	**Refer for further medical follow-up, mental health and social services**

Oregon State Police Forensic Laboratory

Adult Sexual Assault Forensic Evidence (SAFE) Kit Collection Instructions

Updated 03/15/2021

GENERAL COLLECTION GUIDELINES

Gloves and a mask should always be worn when collecting or handling the contents of a SAFE kit.

THE RECOMMENDED TIME FRAME FOR EVIDENCE COLLECTION IS UP TO 120 HOURS POST ASSAULT.

Oral swabs should always be collected, regardless of elapsed time, as they can be used as a DNA standard.

SWABS—should be collected from the appropriate areas, air-dried, and packaged in the corresponding envelopes. Swabs from dry or non-mucosal skin surfaces should be collected using the double swab technique, air-dried, and packaged in a clean envelope.

DOUBLE SWAB TECHNIQUE:

1. **Wet a single sterile swab with water.**
2. **Thoroughly swab, *with pressure*, the area of interest.**
3. **While area is still wet thoroughly re-swab, *with pressure*, the same area with a dry sterile swab.**

ENVELOPES—should be labeled and sealed with patient labels or evidence tape. Never seal an envelope by licking it. Each container of evidence collected in addition to the SAFE kit (exam paper, underwear or other clothing, etc.) should be packaged individually and labeled with the patient's name, description of the evidence, date collected, and your initials.

If additional supplies are needed, evidence can be collected using your own sterile cotton swabs and envelopes.

COLLECTION INSTRUCTIONS

Step 1: Collect four oral swabs.

- **Always collect a set of oral swabs because the laboratory will use these as a DNA standard.**
- **Swab the inside of the mouth with four sterile cotton swabs.**
- **Air-dry the swabs and place in the provided envelope.**
- **Mark the appropriate box on the envelope with purpose of collection (DNA standard or oral sodomy).**

Step 2: Have the patient disrobe while standing on a piece of exam paper.

- **Collect each piece of clothing and place in separate paper bags.**
- **Carefully fold the piece of exam paper so as to preserve any trace evidence and place the paper fold in a separate bag.**

Step 3: Note any bruising, soreness, and/or other injuries.

- **Use provided scale to measure visible injuries.**
- **Advise law enforcement agency of injuries because follow-up photography may be required.**

Step 4: Conduct alternate light source (ALS) examination.

- **Use an alternate light source (e.g., Blue Maxx) to examine the body and hair for possible biological fluids.**
- **If an area fluoresces, collect the sample using the double swab technique (see above).**
- **Air-dry the swabs and place in an envelope.**

- **Document on the envelope "fluorescence" and note the anatomical location.**

Step 5: Collect head hair standards.

- **Collect 24 pulled and shed hairs from various areas of the head.**
- **Place the hairs in the provided envelope.**

Step 6: Collect pubic hair combings.

- **Comb the pubic hair area collecting any loose hair(s) or other trace evidence.**
- **Place the trace evidence and the used comb in the provided envelope.**
- **If pubic hair combings are not collected, please document why (e.g., no pubic hair, patient declined).**

Step 7: Collect pubic hair standards. Consider collecting when one or more of the following situations are present:

1. **Stranger or unknown assailant or multiple assailants.**
2. **Pubic hair is collected in the pubic hair combings.**
3. **Assailant is an acquaintance that has not previously been in the environment where the assault(s) occurred.**

- **Collect 24 pulled and shed hairs from various areas of the pubic region.**
- **Place the hairs in the provided envelope.**
- **If pubic hair standards are not collected, please document why (e.g., no pubic hair, patient declined).**

Step 8: Collect four combined vaginal/cervical swabs.

- **Swab the cervix and posterior vaginal area with four sterile cotton swabs.**
- **Air-dry the swabs and place in the provided envelope.**
- **Alternatively, if no cervix is present or patient declines/cannot tolerate a speculum, "blind" vaginal swabs may be collected and noted on the collection envelope.**

Step 9: Collect any additional evidence.

- **Document on the swab envelope the collection location and purpose of collection (e.g., "hickey on left breast for saliva", "inner thigh swabs for skin-to-skin contact", "abdomen – semen").**
- **Rectal/anal swabs: If swabs are collected from the rectal/anal area, clearly document if sampling was external or internal.**
- **Use four swabs to collect evidence from internal body sites (e.g., rectum).**
- **Use two swabs to collect evidence from external body sites (e.g., external genitalia, breasts, neck).**
- **Air-dry the swabs and place in an envelope.**
- **Trace evidence: If loose hairs are observed in an unexpected location on the patient's body (e.g., hair in the labial fold of a patient with shaved pubic hair), they should be collected and placed in an envelope. Mark the envelope with the contents and location from where the evidence was collected.**

Step 10: Distribute forms and package evidence.

- **Write the SAFE kit number on the "SAMS-Track" business card, and give the card to the survivor.**
- **Fill out the *Forensic Laboratory Information Form* with as much information as is available. Give the "Law Enforcement Agency" copy of the form to the law enforcement officer or affix to the outside of the SAFE kit envelope.**
- **Place the remaining copies of the *Forensic Laboratory Information Form*, the Oregon Sexual Assault Medical Forensic Exam Form and evidence samples in the SAFE kit envelope. Seal with the provided red evidence tape and initial across the seal.**

Questions? Call the Oregon SANE Coordinator OR

During business hours call the Oregon State Police Forensic Laboratory for your area:
● Bend (541) 388-6150 ● Central Point (541) 776-6118
● Pendleton (541) 276-1816 ● Portland Metro (971) 673-8230 ● Springfield (541) 726-2590

After business hours call the on-call Oregon State Police Forensic Laboratory Supervisor:
OSP Dispatch ● Northern Oregon (503) 731-3030 ● Southern Oregon (541) 776-6111

3625 River Rd. N., Suite 275, Keizer OR 97303 | Phone: (503) 990-6541 | Fax: (503) 990-6547
Email: taskforce@oregonsatf.org | Web: www.oregonsatf.org

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