Colorado Evidence Collection Protocol

COLORADO COALITION AGAINST SEXUAL ASSAULT

&

COLORADO BUREAU OF INVESTIGATION

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COLORADO EVIDENCE COLLECTION PROTOCOL

Recommendations for healthcare, legal, law enforcement, advocacy and forensic science professionals on the identification, collection and preservation of physical evidence and minimization of physical and psychological trauma to adult and child survivors of sexual assault.

The arenas of forensics, healthcare, medicine and law are rapidly changing. As knowledge is expanded by research, experience and practice, changes in investigation, treatment, analysis and application do occur. The contributors to this protocol referred to sources believed to be reliable in their efforts to provide accurate and complete information, and in accordance with current acceptable standards. In view of the potential for human error or changes in practice, the contributors to this protocol do not warrant that the information contained in this publication is in every respect complete or accurate. Readers are encouraged to confirm the information contained in this publication with reliable resources relative to the field of expertise.

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Many thanks to all those who contributed their time, resources & expertise to this project.

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Preface

Few other criminal offenses require as extensive and intrusive an examination and collection of evidence *from a living person* as sexual assault. In view of this, it is not difficult to imagine that relaying the details of a traumatic assault, having blood and saliva samples taken and violated orifices probed with cotton swabs by a complete stranger can be a devastating experience.

We are aware that the physical, emotional and psychological impact of this crime on its survivors is formidable, and that many victims do not ever report the occurrence of sexual assault. Most importantly, we know that the first response of law enforcement, healthcare and advocacy professionals to a victim of sexual assault is often what shapes the whole of his or her experience. Since many victims report to or are taken to hospital emergency departments and trauma centers, the care and emotional support they receive, as well as the process of evidence collection will impact their well-being, recovery and perhaps their ability to participate in resulting criminal proceedings.

Considering the prevalence of rape in Colorado and in our society as a whole, the need for communities to develop a comprehensive response to victims of sexual assault cannot be overlooked.

The primary purpose of this document is to assist healthcare, law enforcement and advocacy professionals to accurately collect and preserve evidence for use in the criminal justice system, while minimizing physical and psychological trauma to sexual assault survivors.

The sensitivity, commitment and compassionate approach of those involved in this work will ensure improved services for all victims of sexual assault.

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Introduction

What is sexual assault?

Sexual assault includes many acts in addition to those traditionally thought of as "rape." Sexual assault includes forced vaginal, oral, or anal intercourse. Digital penetration, penetration of the vagina or anus with an object or body part all fall under the definitions of sexual assault in Colorado statutes. In addition to the use of force, the use of threats or coercion may also qualify as sexual assault. Many times an attempt to sexually assault someone may leave collectible, physical evidence. Sexual assault is defined as: **Any act of sexual contact, penetration or intrusion performed by an actor upon a victim without consent, or without the ability to give consent due to age or mental or physical incapacity.**

Who are the victims?

Victims can be any age. The contributors of this protocol have encountered victims from a few weeks to 94 years of age. Victims are both male and female, adults and children. A recent study conducted in Colorado found that the lifetime prevalence for sexual assault or attempted sexual assault was 1 in 4 for women and 1 in 17 for men. On a per year basis, the study found that 1 in 150 women and 1 in 830 men had experienced a completed or attempted sexual assault over the past 12 months (Colorado Sexual Assault Prevention and Colorado Coalition Against Sexual Assault, 1999).

A 1992 nationwide survey indicates that approximately 16% of those who experienced a completed sexual assault reported it to law enforcement. The reporting rates differ for stranger (higher) versus partner, ex-partner or acquaintance (lower) perpetrators. Many more victims tell a friend or significant other. An adult victim may report to an emergency department, but can decline to make an official report to law enforcement officers. In that situation, the survivor/patient should be informed that the financial responsibility for a medical exam will rest with him/her.

Only 12% of sexual assaults are committed by strangers. Eighty four percent of all sexual assaults are committed by an acquaintance of the victim (Kilpatrick et al, 1992).

What is the goal of this protocol?

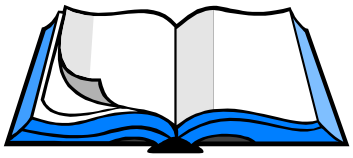
The goal for all who contact a sexual assault victim is to make the examination and collection of evidence from that person as thorough, timely and humane as possible. A sexual assault victim will literally be gone over with a fine tooth comb, have his or her hair plucked, fingernails scraped and every involved orifice swabbed and examined - those orifices which have just been violated.

In no other case will physical evidence be more important to police, social workers, prosecutors, judges and juries. Trace bits of evidence such as hair, dried saliva or a tiny scratch may be the difference between a case that moves forward in the justice system or one that languishes due to a lack of evidence. The way in which a survivor of sexual assault is treated can make the difference in whether or not the victim/survivor remains involved in the criminal justice system. At the same time a holistic, sensitive response may influence the survivor's ability to regain health and a sense of well-being in a timely manner.

A long-term goal of this protocol is to assist police, healthcare and justice systems in becoming more approachable to those impacted by sexual assault.

The primary purposes of this protocol are to:

- minimize physical and psychological trauma to the victim/survivor who has experienced sexual assault.
- maximize the probability of prosecution through appropriate examination, collection, and preservation of physical evidence.



Chapter 1: Adult

Chapter

1

Adult Sexual Assault Forensic Examination & Evidence Collection

Care and Treatment of the Adult Sexual Assault Survivor

Reports of sexual assaults have continued to increase throughout the past decade. It is unknown how many assaults actually take place yearly. Survivors still often choose not to report because of embarrassment and fear. There can be both substantial fear of the sexual assault exam and lack of faith in the follow-up treatment, investigative and prosecutorial systems.

The successful prosecution of sexual assault cases has proven difficult. The survivor is often the only witness to the crime. This makes the collection of evidence and documentation of medical trauma especially necessary to strengthen a case for effective prosecution.

Evidence from the perpetrator and the crime scene may often be found on the body and clothing of the survivor. In view of this, immediate medical attention and evidence collection is imperative. This increases the chance that some type of physical evidence will be found. Conversely, the chances of finding such evidence decrease in direct proportion to the length of time that elapses between the assault and the examination.

By necessity, the job of collecting physical evidence in sexual assault cases has fallen to physicians and nurses in hospital emergency rooms. This is obviously not the ideal situation, however their role in this process is often the key to successful prosecution, and recovery for the survivor.

The treatment of the sexual assault victim/survivor should be considered a medical emergency.

Initial Law Enforcement Response

Many adult survivors of sexual assault will have their first real contact with a law enforcement officer following the assault. The primary responsibilities of the responding officer are to ensure the immediate safety and security of the survivor, to obtain all the physical evidence that would be taken at any crime scene, and to advise the survivor of the availability and importance of seeking an immediate medical examination.

If the victim/survivor does report the sexual assault, the law enforcement jurisdiction investigating the case is responsible for payment of the forensic examination.

The sexual assault survivor has four immediate needs. They are physical safety, medical treatment and collection of evidence, emotional/psychological support and criminal investigation. **These needs should be addressed in the above order.** Ideally, all community support services should be coordinated to meet these needs.

Forensic Medical History

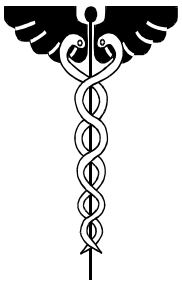
The purpose of the medical history is to obtain **only** the information necessary to conduct a proper medical examination and possible collection of physical, forensic evidence. **The medical history is not a forensic interview.** Law enforcement personnel should conduct a thorough investigative history and forensic interview prior to evidence collection. Law enforcement and other support services should provide the survivor with all the information needed to make an informed decision to prosecute.

The survivor should be interviewed in a room that allows visual and sound (conversational) privacy. The interview should be free from interruptions. It should be conducted, away from parents, spouses, romantic partners, friends and/or siblings. Survivors are often inhibited by the presence of these people, and may not be able to relay sensitive and private information. This is especially important if any of these people are suspected perpetrators. The presence of an advocate is discretionary with the investigator and healthcare professional; however, consideration should be given to the possible need or request by the survivor for an advocate in the room.

As with any history, questions should proceed from general to specific. Initial questions should be simple, non-threatening and appropriate for that person's developmental age. The healthcare professional should ask only what is needed to conduct the forensic medical examination. The medical history obtained should be documented in quotes, using the exact statements and words that the survivor has used.

The Forensic and Medical Examination

Any life and/or limb threatening injury should take precedence over forensic evidence collection!



A physical examination should be performed in all cases of sexual assault, regardless of the length of time that may have elapsed between the time of the assault and the examination. If the assault occurred within the 72 hours prior to the examination, then an evidence collection kit should be used. The timeline of 72 hours is not absolute. It is a guideline. Medical and law enforcement personnel should evaluate each case after that time individually.

If it is determined that the assault took place more that 72 hours prior to the examination, the use of an evidence collection kit may not be necessary. However, evidence may still be gathered by documenting any findings obtained during the medical examination (bruises, lacerations), and statements about the assault made by the survivor.

Informed Consent

Obtaining a survivor's written consent prior to conducting a medical examination or administering treatment is standard medical practice. However, informed consent should be a continuing process that involves more than obtaining a signature on a form.

When under stress, many survivors may not always understand or remember the reason for or significance of unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained as much as possible, so that the survivor can understand what the attending medical personnel are doing and why.

When written consent is obtained, it should not be interpreted as a 'blank check' for performing tests or pursuing questions. If a survivor expresses resistance or declines a step in the normal procedure, the healthcare personnel should discontinue that portion of the process and consider going back to it at a later time in the examination, if the survivor then agrees. All specimens in the sexual assault kit are important and any one may be pivotal in the investigation and prosecution of sexual assault. Consideration should be given to collecting specimens from all orifices, without inflicting additional trauma. **In any event, the survivor has the**

right to decline one or more tests or to decline to answer any question. Regaining a sense of control is an important part of the healing process for survivors, especially at the early stages of examination and initial interviewing.

It is important to remember that consent to have a support person or advocate present must be given by the survivor/patient prior to the introduction of the person. In addition, at any time throughout the treatment and evidence collection process, the survivor should be able to decline further interaction with the designated support person and/or request that the support person leaves.

Head-to-Toe Assessment

A systematic process for initial assessment of any traumatized patient is essential for recognizing life-threatening conditions, identifying injuries, and for determining priorities of care. This is no less important in the sexual assault survivor. A complete head-to-toe assessment must take place prior to evidence collection. Information from this assessment is collected primarily through inspection, auscultation, and palpation, while systematically moving from the patient's head to the lower extremities.

Note the patient's body position, posture, and any guarding or self-protection movements. Note and document odors that may be characteristic of the presence of alcohol, gasoline, chemicals, vomitus, urine, or feces.

Inspect the head and face for any soft tissue injuries, lacerations, abrasions, ecchymosis, edema and areas of tenderness. Observe for asymmetry of facial expressions. Inspect for periorbital ecchymosis, and assess pupils for size, shape, equality, and reactivity to light. Inspect the eyes, ears and nose for any unusual swelling, redness or drainage. Inspect the neck for surface trauma and ligature marks. Palpate neck area for signs of subcutaneous emphysema and/or areas of tenderness.

Observe breathing for rate, depth, degree of effort required, and use of accessory muscles. Inspect the anterior and lateral chest walls, including the axillae for lacerations, abrasions, contusions, ecchymosis, edema and scars. Document any birthmarks and tattoos. Auscultate heart sounds for the presence of murmurs, friction rubs, and/or muffled sounds. Palpate for signs of subcutaneous emphysema. Auscultate the lung fields for rales, rhonchi, wheezing and areas of decreased air exchange.

Inspect the abdomen and flanks for lacerations, abrasions, contusions, ecchymosis, edema and scars. Observe for distension. Auscultate for the presence or absence of bowel sounds. Gently palpate for rigidity, guarding, and areas of tenderness.

Inspect the pelvis and perineum for lacerations, abrasions, contusions, ecchymosis, edema and scars. Palpate for tenderness over the iliac crests and symphysis pubis.

Inspect the extremities for color, skin temperature, bleeding, lacerations, abrasions, contusions, ecchymosis, edema, angulations or deformities. Palpate for any areas of tenderness. Palpate pulses for strength.

Inspect the back, flanks and buttocks for lacerations, abrasions, contusions, ecchymosis or edema. Again, document any scars, tattoos and birthmarks along with documenting injuries noted.

Recommended Equipment

The recommended kit for evidence collection in Colorado is COL 100 manufactured by Sirchie Finger Print Laboratories Inc. (1-800-356-7311).

In the event that a sexual assault kit is not readily available, the following equipment is needed for a complete exam:

- Tape--silk or evidence tape
- White, unused envelopes
- Five frosted-end glass slides with unused slide holders
- 1 glass slide cover
- 30 sterile cotton swabs
- 1 small narrow tooth comb
- Disposable nail file or 2 toothpicks
- Vaginal speculum (sm., med., lg.)
- 1 large manila envelope--to enclose smaller envelopes/slides
- Forms for documenting history, injuries, steps completed
- After-care instructions for the patient/survivor
- Large and small paper bags--at least 2 large and 5 small
- Marking pens
- Ruler--with cm. measurements
- Disposable gloves
- Sharpened lead pencil
- White table paper
- Colposcope or magnifying device
- Blood tubes--1 lavender and 1 yellow (EDTA & ACD preservatives)
- Tourniquet and Band-Aid
- Betadine wipes

In order to prevent the loss of hairs, fibers, or other trace evidence, clothing and other evidence specimens must be sealed in paper or cardboard containers. If the containers are plastic, moisture remaining in the evidence items will be sealed in, making it possible for bacteria to quickly destroy biological fluid evidence.

Unlike plastic, paper 'breathes', and allows moisture to escape. Therefore, **biological evidence should never be packed in plastic.** However, this does not

mean that evidence may be packaged **wet** in paper. All items should be air dried before packaging, or given to the officers wet and informed of the need for drying at the evidence site.

Every item submitted to the forensic lab for analysis must be labeled as to site (vaginal, oral, rectal, penile, etc.), name of survivor, date, time and examiner's initials.

Attending Personnel

The only people who should be with the adult survivor in the examination room are the examining healthcare personnel, any translator needed and, if necessary, an advocate trained to meet the needs of the sexual assault survivor. Every effort should be made to limit the number of people in attendance during the examination. Every person in the room can be considered a witness to the procedure and therefore called to testify in court.

It is not necessary for a law enforcement representative to observe evidence collection procedures to maintain the chain of evidence or custody. This is the function of the attending, licensed healthcare personnel.

Preserving the Integrity of Evidence

The custody of any evidence collection kit and specimens it contains must be accounted for from the moment of collection until the moment it is introduced in court as evidence. This is necessary in order to maintain the legally necessary "chain of custody". Therefore, the number of people handling the evidence should be kept to a bare minimum. Ideally, the healthcare personnel collecting the evidence should hand it over to the officer responsible for the case as soon as it is sealed. Each item of evidence in the evidence collection kit must be sealed and initialed and the outside kit envelope must also be sealed and initialed prior to providing the evidence to law enforcement. If a law enforcement officer is not immediately available to secure custody of the evidence, it is the responsibility of the licensed healthcare professional to secure the evidence in locked, refrigerated storage. Law enforcement should forward the kit to the appropriate office of the Colorado Bureau of Investigation as soon as possible.

Details in Forensic Evidence Collection

The following information is intended to provide additional details specific to collection of forensic evidence. Exact collection procedures for adult victims and suspects should be followed as reviewed in this chapter under 'Collection Procedure.'

Clothing

Clothing frequently contains the most important evidence in a case of sexual assault. The reasons for this are as follows:

1) Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs and fibers as well as debris from the crime scene. This foreign matter may be found on clothing for a considerable length of time.
2) Drainage of ejaculate from the vaginal or anal cavities may collect on the panties/underwear. Bacterial action and breakdown does occur although it happens at a slower rate than in the body cavities. After a considerable length of time, undergarments worn after an assault may contain the best semen evidence.
3) Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the survivor with trace evidence collected from the suspect and/or the crime scene.

Any item of clothing worn during the assault or prior to the examination may need to be collected. Each garment should be placed separately in its own paper bag to prevent cross-contamination from occurring.

Any briefs, trunks, sanitary napkins, panty liners, or tampons worn by the survivor for the period of up to 24 hours after the assault should be obtained as they may contain semen or other evidence. If possible, these should be air dried prior to packaging.

To minimize loss of evidence, the survivor should disrobe over a white cloth or a sheet of paper. Any foreign material found on the survivor's body should be collected and put into a small paper envelope, labeled and sealed with tape. The cloth or drape which the survivor stands on to disrobe, must be labeled, folded to contain any debris which fell on it, secured with tape, labeled and included in the completed evidence collection kit.

Blood Specimens

Any semen found on the clothing or in the body cavities of the survivor is likely to be mixed with her/his body fluid. Therefore, a blood sample must be collected from the survivor to determine the contribution of her/his genetic markers to the mixture.

This step should be done early as indicated, to permit a serum pregnancy test in women of childbearing age.

Dried Fluids

Semen and blood are the most common secretions deposited on the survivor by the assailant. There are also other secretions, such as saliva, which can be analyzed by the laboratories to aid in the identification of the perpetrator.

It is important that healthcare personnel examine the survivor's body for evidence of foreign matter, and that **two swabs be taken for each secretion.**
This material should be collected by moistening 2 swabs (held together) slightly with **sterile water** and swabbing the indicated area. The swabs used in the collection should be air dried, placed in an envelope, and labeled with the location on the survivor's body from which the secretion was collected.

Swabs and Smears

The number of tests which crime laboratories can perform is limited by the quantity of semen or other fluids collected; therefore, **four swabs should be used** when collecting specimens from body orifices. These swabs should be cotton and **used together** when collecting the sample. Then smear the sample from all four swabs still held together onto one slide. Air dry all swabs and place them in the designated envelope for inclusion in the kit. A pencil should be used when labeling frosted-end slides to lessen the chance that the labeling information will become smudged. Ink or permanent marker should **not** be used. When it is necessary to slightly moisten swabs--for the comfort of the survivor--sterile water is preferable, when that is not available saline is acceptable. It should then be noted on the label that saline was used.

Oral evidence collection can be as important as the vaginal or rectal smears. The purpose of this sample is to recover sperm/seminal fluid from recesses in the oral cavity where traces of sperm could survive. **This specimen should be collected early as indicated,** so that the survivor can rinse out his/her mouth as soon as possible.

The oral smear is prepared by using four cotton swabs and swabbing the mouth. Attention should be paid to the areas between the upper and lower lip, gum and along the gingiva where seminal material might remain for the longest amount of time.

The material from the swabs should be gently rubbed onto a glass slide, which has been labeled in pencil and contains the word "oral" to indicate the source of the specimen. The slide can then be placed in a cardboard mailer and air-dried before sealing. The swabs are then air-dried, placed in a labeled envelope and sealed with tape.

Hair

During an assault, hairs may be transferred from one individual to the person or clothing of the other or to the crime scene. Also during an assault hairs may be transferred by friction or other means of forcible removal. These hairs can be microscopically compared to known hair samples from both individuals to determine the origin. Hair characteristics are affected by many factors including stress, diet and hair care products. Time delay in the collection of hair samples of the survivor may adversely affect future comparisons.

When there is evidence of semen or other matted material on pubic or head hair, it may be collected by clipping around the matted area and placing the sample in a separate white envelope and labeled "possible secretion sample from head/pubic hair." If the sample cannot be cut, it may be collected in the same manner as other dried fluid.

Combings

A comb is used to collect any foreign hair or fibers from the pubic area. A piece of paper is placed under the patient's lower buttocks and thighs. The pubic hair is then combed through being careful to collect any loose hairs and debris on the paper. The pubic hair combings and the comb are folded into the paper and placed into an envelope labeled "pubic hair combings."

Pulled Standards

Evidence should never be taken from the survivor without her/his consent. Care should be taken prior to collecting pulled hair to inform the survivor of the procedures which will be used and why it is being done. If the survivor consents to the procedure, a standard sample of 25 head hair must be pulled, close to the scalp, from various areas of the head. These hairs are then placed in the envelope, labeled and sealed.

A standard sample of 25 pubic hair must be pulled from various areas of the pubic region. To minimize discomfort, several pubic hairs should be plucked at one time, using the thumb and forefinger. This collection procedure may be performed by the survivor if she/he desires.

There must be 25 hair pulled to include root for a complete and accurate comparison. If the individual shaves her/his head or pubic hair, these steps should be omitted, documenting the reason for the omission. The hair should never be pulled with tweezers or forceps. **The absence of pubic or head hairs should be documented.**

Anal/Rectal Swabs

The rectal smear is collected prior to the vaginal/cervical smears. This is because secretions could flow down into the rectum from the vagina while in the supine

position. Collecting these specimens first helps to insure that cross-contamination has not occurred.

The rectal smear is collected by holding 4 cotton swabs together and swabbing the rectum, being sure that these swabs only come into contact with the rectum. Prepare the slide as previously instructed, air dry both slides and swabs, and seal them in a labeled cardboard mailer and envelope.

Vaginal and Cervical Swabs

Speculums inserted for the vaginal/cervical exam **should not** be lubricated with any type of lubricating agent such as K-Y jelly, as this will disrupt the specimen collection. Sterile water or tap water can be used to lubricate the vaginal speculum prior to insertion.

Vaginal specimens are collected on four cotton swabs held together. The vaginal slide is made using the same process as previously described. This slide is air-dried and put into a labeled mailer, the swabs are air-dried and put into a labeled envelope and sealed.

Cervical contents should be obtained using four swabs **around** the cervical button and across the face of the cervix. **Do not** penetrate the cervical os!

Penile Swabs (for victims or perpetrators)

For the male assault survivor or the male perpetrator, the presence of saliva on the penis could indicate that oral-genital contact was made. Feces or lubricants might be found if rectal penetration occurred.

The proper method of collecting penile swabs is to use two cotton swabs to thoroughly swab the **external** surface of the penile shaft and glans, avoiding the urethra. All outer areas of the penis and scrotum where contact is suspected should be swabbed.

These swabs are <u>not for use</u> in the medical diagnosis of a sexually transmitted disease; therefore, they should not be used to swab inside the penile opening.

Bitemark Swabs

Bitemarks may be found on survivors as a result of sexual assault and other violent crimes and should not be overlooked as important evidence. Bitemark impressions can be compared to the teeth of a suspect and sometimes become as important as fingerprint evidence for identification purposes. At a minimum, bitemarks should always be photographed and swabbed for the presence of saliva.

Saliva is collected from the bitemark area by slightly moistening two swabs with distilled water and swabbing **gently** around the inside and outside of the bitemark. Dry and package the swabs as instructed for other fluids. **Do not clean the area of the bitemark until swabs have been collected and the bite injury has been photographed.** The bitemark should be measured and the measurement should be documented in the chart. Photograph the bite mark with and without a measuring device, using a 35mm camera if possible. Inform the investigating officer of bitemark evidence and contact a forensic odontologist if possible for plaster impressions of distinct bite patterns.

Fingernail Scrapings

The purpose of collecting fingernail scrapings is to collect potentially useful evidence of transfer. During the course of a physical crime, the survivor will be in contact with the environment as well as with the assailant. Trace materials, such as skin, blood, hairs, soil and fibers, can collect under the fingernails of the survivor. This is an especially important step if the survivor reports scratching the assailant.

The nails are scraped, one hand at a time, using the pick provided. The hands are held over a piece of paper to catch any scrapings. The paper and the pick should be folded up, placed in an envelope and labeled.

Buccal Swabs

The purpose of collecting buccal swabs is to obtain cells (DNA) from the victim. It is important that this specimen not be contaminated by outside elements. **The survivor should not smoke or have anything to eat or drink for at least 15 minutes** prior to this procedure. Hold 4 swabs together, swab both inner cheeks. When the swabs are completely dry they should be placed in a labeled envelope and sealed.

Sexual assault examination and forensic report form

The following information should be included on any sexual assault documentation form:

1) Date and time of collection and date and time of assault. It is essential to know the period of time that has elapsed between the assault and the collection of evidence. The presence or absence of semen may correspond to the interval since the assault.

2) Action of the survivor before and since the assault. The quality of evidence is critically affected both physically and chemically by actions taken by the survivor and by the passage of time. It is important for the analyst to know what, if any, activities were performed prior to the examination, including bathing, urination, defecation, brushing teeth, and changing clothes.

Forensic scientists may find evidence of multiple DNA types indicating that the survivor may have had multiple assailants or had intercourse with his/her partner sometime before the assault. Information about the most recent, consensual intercourse can explain any discrepancies.
3) Contraceptive/Menstruation information. Knowing whether a condom was used may be helpful in explaining the absence of semen. Tampons, sponges and sanitary napkins can absorb the assailant's semen as well as any menstrual blood present. Knowing the date of the last menstrual cycle will help to determine if the presence of blood in the vaginal swab is from trauma or a result of menstruation.

SEXUAL ASSAULT EXAMINATION ADULT VICTIM COLLECTION PROCEDURE

Complete and separate procedures for male and female victims are provided in the Colorado SIRCHIE kit # COL 100. **NOTE** differences to Steps 8 and 9 for male and female victims.

Step 1. **CLOTHING**

Unfold 2 drapes; lay one on top of the other. Have the patient disrobe on the top drape. Place each garment in a SEPARATE PAPER BAG; make sure any blood or semen stains are dry before packaging. Seal and label bags. Refold top drape to contain collected debris, secure with tape, label and return to kit. Discard bottom drape. Sanitary napkins and/or tampons should be *air-dried*; place in a paper bag or envelope; seal and label.

NOTE: If any damage to clothing is noted or caused by healthcare personnel, document and advise law enforcement. Also, indicate if clothing collected was worn at time of assault.

Step 2.**TRACE EVIDENCE**

Place in bindle any extraneous hairs, fibers, plant material, soil, glass, paint, etc. when found on the victim, or left on the examination table in bindle. Fold bindle to contain trace evidence; place bindle in envelope; seal envelope and complete label. Collect and package evidence from each area separately. Note location(s) of recovery.

Step 3. **BLOOD**

Withdraw 1 yellow-top (ACD) tube; withdraw 1 purple-top (EDTA) tube; label each tube and place in mailer. Seal mailer and complete label. These samples ARE NOT suitable for blood alcohol & drug testing.

Additional blood should be obtained and processed per hospital procedure. This includes pregnancy testing and blood alcohol testing of victim. These

samples must be kept separate from forensic samples. **Do not include or forward hospital samples with the kit.**

Step 4. **ORAL EVIDENCE COLLECTION** (for oral intercourse)

With 4 cotton-tipped swabs held together, rub around gum line and buccal area. Prepare smear slide; label as "oral" and air dry. Place in oral slide holder and complete label. Air-dry swabs and place in envelope. Seal envelope and complete label. Patient should rinse mouth after this step. Wait 15 minutes to collect Step 12.

Step 5. **PUBIC HAIR COMBINGS**

Open bindle and place under pubic area. Using clean and unused comb, comb pubic region for foreign material; fold paper to contain any debris collected and comb. Place bindle in envelope. Seal envelope and complete label.

Step 6. **PUBIC HAIR CONTROL**

Pull (using fingers) 25 pubic hairs from various areas of the pubic region. Place hairs in paper bindle; fold bindle to contain hairs; place bindle in envelope. Seal envelope and complete label.

Step 7. **ANAL CONTENTS** (for anal intercourse)

Sample anal crypt with 4 cotton-tipped swabs HELD TOGETHER. Swabs may be dampened with sterile water to minimize discomfort. Prepare smear slide; label as "anal" and air dry. Place in anal slide holder; seal holder and complete label. Air-dry swabs, place in envelope, seal envelope and complete label.

Step 8. **VAGINAL CONTENTS/PENILE SWABBINGS**

Female victim -- Sample vaginal vault with 4 cotton-tipped swabs HELD TOGETHER. Prepare smear slide; label as "vaginal" and air-dry. Place in vaginal slide holder, seal and complete label. Prepare a wet-mount slide and examine immediately for motile sperm. Label as "vaginal motility"; air-dry slide, place in vaginal motility slide holder, seal holder and complete label. Air-dry all swabs, place in envelope, seal envelope and complete label.

Male victim -- Use 2 cotton-tipped swabs HELD TOGETHER dampened with sterile water to swab the exterior of the penis and scrotum. AVOID URETHRAL OPENING. Air-dry swabs; place in envelope, seal envelope and complete label.

Step 9. **CERVICAL CONTENTS**

Female victim -- Swab the cervix with 4 cotton-tipped swabs HELD TOGETHER. Prepare a smear slide; label as "cervical" and air-dry. Place

in cervical slide holder, seal holder and complete label. Air-dry all swabs, place in envelope, seal envelope and complete label.

Male victim -- NOT USED

Step 10. **FOREIGN STAINS ON BODY**

Use 2 cotton-tipped swabs HELD TOGETHER dampened with sterile water to remove possible semen, saliva, urine, etc. deposited on the victim's body by the assailant. Check for bite marks. Air-dry swabs, place in envelope, seal envelope and complete label. Swab and package each area separately.

Step 11. **FINGERNAIL SCRAPINGS**

Scrape under nails of each hand with clean toothpick; place scrapings and toothpick in bindle to contain debris; return bindle to envelope. Seal envelope and complete label.

Step 12. **BUCCAL SWABS**

Rinse patient's mouth and allow nothing in mouth for 15 minutes prior to collecting this sample. Holding 4 swabs together, swab both inner cheeks. Air-dry swabs and place in envelope. Seal envelope and complete label.

Step 13. **HEAD HAIR CONTROL**

Pull (using fingers) 25 head hairs from various areas of the head. Place hairs in paper bindle; fold bindle to contain hairs; place bindle in envelope. Seal envelope and complete label.

Step 14. **ADDITIONAL ENVELOPE**

One additional envelope is included in the Colorado SIRCHIE kit. This envelope is for the collection of other samples as needed. Each sample must be packaged separately. Seal the envelope and complete the label when used. Indicate type of sample and its location on victim.

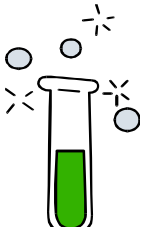
Procedures for storage and release of evidence to law enforcement:

- Medical and forensic specimens collected must be kept separate, both in collection and processing.

♦ All evidence specimens should be sealed and placed in kit.

♦ All paperwork should be completed, appropriate copies placed in kit, and the kit sealed.

♦ All sealed kits should be released to law enforcement immediately, or stored in a locked refrigerator until the time law enforcement can take custody. Clothing, if not immediately released to law enforcement, must also be stored in a locked area.



♦ Under no circumstances should a victim handle evidence after it has been collected.

Laboratory Data

Alcohol and toxicology screens **are not routine forensic protocol** for victim/survivors of sexual assault. Blood and/or laboratory screening for determining toxicology in cases of sexual assault should only be done in the following situations:

- ♦ the victim/survivor or an accompanying person (such as a family member, friend or police officer) states that the victim was involuntarily drugged by the assailant/perpetrator.

  And/or

- ♦ if in the opinion of the attending healthcare personnel, the patient's medical condition or history of events appears to warrant toxicology screening for optimal care and forensic considerations.

Alcohol and toxicology screens requested by the reporting or referring law enforcement agency should be considered part of evidence collection, significant in the investigation of the crime and reimbursed by the requesting police agency.
Collected blood or urine samples for toxicology should not be included with the sex assault evidence kit.

Treatment & Referral Plan

All survivors should be given information about the possibility of contracting sexually transmitted diseases from the assault. Only follow-up testing at a later time will confirm any transmission. Prophylactic treatment for sexually transmitted diseases should be offered routinely at the time of the initial exam. If the patient is at risk for pregnancy, prophylactic treatment for pregnancy should be discussed and offered.

Any medications for STD's and pregnancy prophylaxis can only be given after a pregnancy test in child-bearing women has returned a negative result.

Post-examination information

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault survivors. Before leaving the hospital, the survivor should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted disease, and other infections. These tests should take place within four to six weeks after the initial hospital visit. It is vital that both written and verbal information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up. The patient should

be encouraged to seek follow-up counseling, however the decision to do so must be voluntary. Survivors are more likely to participate if counseling has been coordinated with the examination process. Again, it is vital that both written and verbal information be provided for follow-up services.

Many survivors would like to wash after the examination and evidence collection process. If possible, the healthcare facility should provide the basics, such as mouth rinse, soap and a towel and washcloth. If garments have been collected for evidentiary purposes, the survivor should be provided with suitable clothing. Friends or family can be asked to return with clothes or often, volunteer community organizations can supply some necessary items.

Care should be taken to insure that the survivor has a safe place to return to following the examination. Community referrals may need to be made regarding a safe house or facilities to accommodate survivors and their children if necessary.

The Elderly Survivor

As with other victims, the elderly male or female sexual assault survivor may experience extreme humiliation, shock, disbelief and denial. The full emotional impact of the trauma however, may not be felt until after the initial contact with health care providers, law enforcement, legal and advocacy groups or later when the victim/survivor is alone. The elderly survivor may then be faced with the realization of violation, exposure to disease, physical vulnerability, reduced resilience and mortality. Fear, anger or depression can be especially severe in the older population, who often are isolated, less confident and impacted by limited income.

In general, the elderly are physically more fragile than the young, and injuries sustained from assault are potentially more life threatening. Besides possible pelvic and genital injuries and sexually transmitted diseases, the older survivor may be at higher risk for tissue or skeletal damage and exacerbation of existing illness or injury. The recovery process for the elderly tends to be more lengthy than for those who are younger.

Physical conditions such as hearing impairment, diminished eyesight or memory loss, may make it difficult for an elderly victim of crime to relay a history of the assault, or make his or her needs known. Law enforcement, advocacy and healthcare responders must be careful not to confuse distress and fear with senility.

Healthcare, counseling and social services follow up must be made easily accessible to older survivors, or they may be unable or unwilling to seek or receive assistance. Without encouragement and assistance in locating services, elderly victims may be reluctant to proceed with the prosecution of offenders.

Special Needs Survivor

The difficulty of providing adequate responses to the sexual assault survivor can be compounded when the person is differently abled. Some special needs survivors have limited mobility and cognitive defects which impair perceptual abilities. Some are affected by impaired and/or reduced mental capacity to comprehend questions or limited language/communication skills which may impact their ability to relay what happened in the event of a sexual assault. Special needs survivors may be confused or frightened, unsure of what has occurred, or they may not understand that they have been exploited and are victims of a crime.

Criminal acts committed against the differently abled (physically, mentally or communicatively) often are unreported and seldom are successfully prosecuted. Offenders are often family members, caretakers, or friends who repeat the abuse in part due to the inability of the survivor to report the crimes against them.

Special needs survivors and their families should be given the highest priority. Additional time should be allotted for assessment, examination and collection of evidence.

Under Section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and law enforcement) that directly receives federal assistance or indirect benefits from such assistance, must be prepared to offer a full variety of communication options in order to ensure that hearing impaired persons are provided effective health care services. This variety of options must be provided at no cost to the patient, and include an arrangement to provide interpreters who can accurately and fluently communicate information in sign language.

Referrals to specialized support services and reports to law enforcement agencies are particularly needed for the developmentally and physically challenged who may need protection, physical assistance and transportation for follow up treatment and counseling.

Special Populations

Special populations of victims present with special needs. The survivor of sexual assault may be pregnant, male, gay or lesbian, transgendered, bilingual, non-English speaking or adolescent victims of either sex. The forensic examiner should strive to provide the examination and collection of evidence in as safe an environment as possible. Most healthcare settings have access to certified translators for non-English speaking patients or a certified translator is available 24 hours a day through the AT & T Language line at 1-800-528-5888. Developmental and culturally appropriate communications improve the accuracy of the history and ultimately the care of the survivor and the investigation of the sexual assault (Girardin, Faugno et al, 1997).

Each victim brings to the insult of sexual assault, all of their resources and strengths as well as vulnerabilities. Being cognizant of special needs or concerns at different times in a person's life can facilitate the delivery of compassionate care. Regardless of gender, sexual orientation or the cultural influences of any victim, the forensic examiner should aim to understand as much as possible about related issues, dynamics, and physical injuries in order to enhance the delivery of culturally competent healthcare and forensic evaluation (Crowley, 1999).

Suspect/Perpetrator Evidence Collection

During the investigation of sexual assault, a potential suspect may be identified. The investigating law enforcement agency may request that evidence be collected from the suspect or perpetrator. Healthcare professionals have a responsibility to appropriately collect evidence from those identified as potential suspects or perpetrators of sexual assault.

The recommended kit for suspect evidence collection is CMS 100 manufactured by Sirchie Fingerprint Laboratories, Inc. 1-800-356-7311

Like the victim of sexual assault, the suspect should have the benefit of a cursory head to toe assessment prior to the collection of forensic evidence. The examination of an alleged suspect of a sexual assault may provide useful corroborative information to the investigation. Likewise, evidence collected may be valuable in exonerating an alleged suspect.

The assessment should focus on the presence or absence of trauma and injuries such as bite marks, abrasions, lacerations or the presence of trace evidence on the clothing or body surface. Documentation, following assessment and evidence collection should address any injuries noted as well as the specific evidence collected.

MALE SUSPECT EVIDENCE COLLECTION PROCEDURE

(Do Not Use For Victims)

Collection of all steps is recommended when the incident occurred within 72 hours of this examination. If the incident is known to have occurred more than 72 hours ago, Steps 5, 9, 10 and 11 are the requested minimum collection. Other steps may be collected as case facts direct.

DO NOT COLLECT ANY SAMPLES WHICH WILL VIOLATE A COURT ORDER, THE SUSPECT'S CONSENT, OR THE EXIGENT CIRCUMSTANCE.

Step 1. **Clothing:** Unfold both drapes; lay one on top of the other. Have suspect disrobe on the top drape. Place each garment in SEPARATE PAPER

BAGS; make sure any blood or semen stains are dry before packaging. Seal and label each bag. Refold top drape to contain collected debris; seal and label. Return sealed drape to kit. Discard bottom drape.

Step 2. **Trace Evidence:** (if needed) Remove bindle from envelope; place any extraneous hairs, fibers, plant material, soil, glass, paint, etc. found on the suspect or left on the examination table in bindle. Fold bindle to contain trace evidence; return bindle to envelope; seal envelope and complete label. **Collect and package evidence from each area separately (see Step 12).** Note location(s) of recovery.

Step 3. **Digit Swabs:** (if digital penetration indicated) Use 2 cotton-tipped swabs dampened with sterile water, HELD TOGETHER, to swab the fingers to remove possible vaginal fluid, etc. deposited by the victim. Air-dry swabs; place swabs in envelope; seal envelope and complete label.

Step 4. **Pubic Hair Combing:** Open bindle provided and place under pubic area. Using comb provided, comb pubic region for foreign material; fold paper to contain any debris collected and comb. Place in envelope, seal envelope and complete label.

Step 5. **Pubic Hair Standard:** Pull (using fingers) 25 pubic hairs from various areas of the pubic region. Place hairs in paper bindle; fold bindle to contain hairs; place bindle in envelope. Seal envelope and complete label.

Step 6. **Penile Swabs:** Use 2 cotton-tipped swabs dampened with sterile water, HELD TOGETHER, to swab the exterior of the penis and scrotum. AVOID URETHRAL OPENING. Air-dry swabs; place swabs in envelope; seal envelope and complete label.

Step 7. **Foreign Stains on Body:** Use 2 cotton-tipped swabs dampened with sterile water, HELD TOGETHER, to remove possible semen, vaginal fluid, saliva, urine, etc. deposited on suspect by victim. (Check for bite marks; photograph; swab inside and outside the bite mark.) Air-dry swabs; place in envelope; seal envelope and complete label. **Collect and package evidence from each area separately (see Step 12). Note location of recovery.**

Step 8. **Fingernail Scrapings:** Scrape under nails of each hand with clean toothpick; place scrapings and toothpick in bindle; fold bindle to contain debris; return bindle to envelope. Seal envelope and complete label.

Step 9. **Buccal Swabs:** (Suspect should have rinsed mouth and had nothing in mouth for 15 minutes prior to collection of this sample.) Holding 4 swabs

together, swab inside the cheeks. Air-dry swabs; place in envelope; seal envelope and complete label.

Step 10. **Head Hair Standard:** Pull (using fingers) 25 head hairs from various areas of the head. Place hairs in paper bindle; fold bindle to contain hairs; place bindle in envelope. Seal envelope and complete label.

Step 11. **Blood Standards:** (CHECK EXPIRATION DATE OF EACH TUBE BEFORE USE.) Withdraw 1 yellow-top tube (ACD); withdraw 1 purple-top tube (EDTA); label each tube and place in mailer. Seal mailer and complete label. These samples ARE NOT suitable for blood alcohol.

Step 12. **One additional envelope is included for collection of other samples as needed.** Each sample must be packaged separately. Use additional clean/unused envelopes from examiner's supply if needed.

Procedures for storage and release of forensic evidence collected from suspects should follow the same recommendations indicated for release of evidence to law enforcement in adult victim collection.

Chapter 2: Child

Chapter 2

Child Sexual Abuse Forensic Exam & Evidence Collection

Care & Treatment of the Child Sexual Assault Survivor

Introduction

What is child sexual abuse?

Child sexual abuse is the abuse of a child with sexual intent. The perpetrator may be an adult or a juvenile and can be anyone from a close family member to a stranger. The child could be an infant or, depending on the statute involved, a child up to eighteen years old. For purposes of this protocol, we will focus on a child being touched or touching the perpetrator on intimate body parts.

What is the prevalence of child sexual abuse?

The exact incidence and prevalence of child sexual abuse is difficult to determine. It is estimated that one quarter to one third of all children have one or more sexual experiences with an adult before they reach the age of 13. Various studies of adults in the United States have found that 25% of women and 10%-16% of men were victims of sexual abuse as children (Elliott & Peterson, 1993).

What is the goal of the investigation of child sexual abuse?
The goal in every case of child sexual abuse is to have one forensic interview and one forensic medical examination.

What are the legal definitions involved in child sexual abuse?

1) Child sexual assault occurs when a person, who is four years older subjects a child (age 14 and younger) to any sexual contact.
2) Child sexual assault also occurs when a person in a position of trust subjects a child (age 17 and younger) to any sexual contact.
3) Sexual assault occurs to children age 15 or 16, if the actor is at least 10 years older.
4) Incest and aggravated incest include sexual contact with a natural child, stepchild, child by adoption, brother or sister of the whole or half blood, aunt or uncle, nephew or niece or ancestor or descendant (Colorado District Attorney's Council, 1999).

"Sexual contact" is the knowing touching of the victim's intimate parts by an actor or the actor's intimate parts by the victim if the contact is for the purpose of sexual gratification, arousal or abuse. Sexual contact necessarily includes sexual penetration (oral, anal and vaginal intercourse) and sexual intrusion (intrusion with objects). Sexual contact includes touching of the clothing over the intimate parts.

"Intimate parts" include external genitalia, perineum, anus, buttocks, pubic region and breasts.

Persons in a "position of trust" include babysitters, school personnel, clergy, scout leaders, and anyone charged with the health, education, welfare or supervision of a child, no matter how brief (C.R.S.§ 18-3-400 et seq.). Note that the majority of children delay reporting sexual abuse and for that reason, the statute of limitations is ten years for all sexual assault crimes.

What consents for examination should you obtain before examining a child for sexual abuse?
Hospital protocols for emergent and urgent care should be followed.

As in reports of adult sexual assault, the referring or requesting agency investigating the case of child sexual abuse is responsible for the cost of evidence collection.

C.R.S. § 13-22-106. Minors-consent-sexual assault. (1) Any physician licensed to practice in this state, upon consultation by a minor as a patient who indicates that he or she was the victim of sexual assault, with the consent of such minor patient may perform customary and necessary examinations to obtain evidence of

the sexual assault and may prescribe for and treat the patient for any immediate condition caused by the sexual assault.
(2)(a) Prior to examining or treating a minor pursuant to subsection 1 of this section, a physician shall make a reasonable attempt to notify the parent, parents, legal guardian, or any other person having custody of such minor of the sexual assault.

(b) So long as the minor has consented, the physician may examine and treat the minor as provided for in subsection (1) of this section whether or not the physician has been able to make the notification provided for in paragraph (a) of this subsection (2) and whether or not those notified have given consent, but, if the person having custody objects to treatment, then the physician shall proceed under the provisions of part 3 of article 3 of title 19, C.R.S.

(c) Nothing in this section shall be deemed to relieve any person from the requirements of the provisions of part 3 of article 3 of title 19, C.R.S., concerning child abuse [mandatory reporting statutes].

(3) If a minor is unable to give the consent required by this section by reason of age or mental or physical condition and it appears that the minor has been the victim of a sexual assault, the physician shall not examine or treat the victim as provided in subsection (1) of this section, but shall proceed under the provisions of part 3 of article 3 of title 19, C.R.S.

(4) A physician shall incur no civil or criminal liability by reason of having examined or treated a minor pursuant to subsection (1) of this section, but this immunity shall not apply to any negligent acts or omissions by the physician.

What is your duty to report suspected child physical or sexual abuse?
After a child's physical safety needs are secured, your next concern is your duty to report. The following persons are mandatory reporters of child abuse (physical, sexual & neglect). [See C.R.S. § 19-3-304].

a) Physician or surgeon, including a physician in training;
b) Child Health Associate;
c) Medical examiner or coroner;
d) Dentist;
e) Osteopath;
f) Optometrist;
g) Chiropractor;
h) Chiropodist or podiatrist;
i) Registered nurse or licensed practical nurse;
j) Hospital personnel engaged in the admission, care or treatment of patients;
k) Christian science practitioner;
l) Public or private school official or employee;
m) Social worker or worker in a family care home, employer sponsored on-site child care center, or child care center as defined in section 26-6-102, C.R.S.;
n) Mental health professional;
o) Dental health hygienist;

p) Psychologist;
q) Physical therapist;
r) Veterinarian;
s) Peace officer as defined in section 18-1-901(3)(1), C.R.S.;
t) Pharmacist;
u) Commercial film and photographic print processor

To whom should you report?

1. The county department of human services where the child lives and /or
2. The police/sheriff department where the suspected abuse occurred.

A report to either of theses agencies will cover your duty to report. A good rule of thumb is: if the report concerns someone who lives in the child's home, make the report to human services; if the report concerns an acquaintance or a stranger, make the report to the police or sheriff.

Who should report?

Every person on this list has an independent duty to report. For example, many hospitals have a protocol regarding which healthcare professional or member of the clinical team should report abuse however, if your protocol states that the physician should report, that does not relieve the nurse or hospital social worker from reporting or verifying that the physician has reported.

When should you report?

There is a requirement that the reporting be done immediately. "Immediately" should be interpreted to mean, as soon as the child's immediate physical needs are met, while the child is in your facility.

What is meant by "knows or suspects?"

- the child states he or she has been hit or touched in a sexual (intimate) body part
- the caretaker states that the child told him/her that the child had complained of a touch on a sexual(intimate) body part
- any injury to genitalia, not otherwise explained
- any STD in a child

It is not the job of the mandatory reporter to determine if an allegation of sexual abuse or sexual assault is true; it is the statutory mandate of the Department of Human Services and/or the police to investigate and make a determination.

It is incorrect that abuse must be proven before a report is required; if a mandatory reporter has reason to suspect abuse, the reporter must report immediately.

Can healthcare professionals discuss their concerns with others?

Yes, discussion of child abuse concerns and consultation with other professionals is not a breach of confidentiality.

What is a mandatory reporter's liability for reporting suspected child abuse?
The law protects mandatory reporters for any report made in good faith. This would include any report for which you had an articulable basis for reporting. The duty to report is a continuing process and includes cooperation in the investigation as well as the medical and lab reports and documentation generated in conjunction with a child's hospital or clinic visit.

The myths surrounding child sexual abuse.

▪ It is a common myth in our society that child sexual assaults are mostly committed by strangers. The truth is that sexual abuse of children is most often perpetrated by persons known or well known to the child.

▪ It is a common myth in our society that child sexual assaults usually involve some sort of physical injury. The truth is that most child sexual abuse is perpetrated without physical force or violence. Children rarely resist the power exerted by those older and larger than themselves by fighting back.

▪ It is a common myth in our society that there are usually physical signs associated with child sexual abuse. The truth is that much child sexual abuse involves touching intimate parts without vaginal or anal penetration. It is important to note that penetration by a small object or body part or partial penetration of the genitalia may not cause significant injury or bleeding. It is also important to consider that injury to the genitalia of an infant or young, healthy child will heal in a relatively short span of time.

▪ It is a common myth in our society that many reports of child sexual abuse are false. The truth is that children rarely falsely report. There is a higher incidence of parents falsely or mistakenly reporting child sexual abuse, but it is still small. In fact, most children never report their abuse. It is very common that children under report the number or the severity of the events.

For these reasons, an accurate history and detailed physical examination, including genital evaluation is necessary whenever child sexual abuse is suspected or reported.

Many children are sexually abused over a period of years. Children are taught to keep secret their relationship with a perpetrator who may be a family member or acquaintance. Some children are threatened with harm to themselves, a family member or a pet.

When sexual abuse begins at a young age, a child may not understand or may not have been taught that the sexual nature of an activity is not appropriate. As a child victim of incest or sexual abuse grows older, and begins to understand the true

nature of the activity, he or she may choose not to report out of shame, fear or embarrassment. Many times the sexual abuse of a child starts gradually with fondling or gentle touching and may not escalate to digital penetration or intercourse.

A child who does report to a trusted adult often finds that the report is dismissed or denied as being inaccurate, making it even more difficult for the child to relay his or her story to someone else at a later time.

What is the response to child sexual abuse?
Because of the inability of children to secure medical treatment on their own, most children who are victims of sexual abuse, do not receive immediate medical attention. The request for healthcare intervention is often at the request of a third party. This may be a parent or caretaker who notices unusual genital soreness, or urinary problems, a teacher who observes sudden change in the child's behavior, a relative who observes physical injury or a healthcare provider, who suspects or confirms the presence of a sexually transmitted disease.

Ideally, each community should provide a clinical facility and an interdisciplinary team, available on an on-call basis for the examination and treatment of child sexual abuse. The team should consist of law enforcement officers, child protective services, healthcare providers and advocates. Each team member should be trained in the management and psychodynamics of the sexually abused child. Without such a specialized team, the minimum requirement should be a readily available physician or nurse, who is educated and experienced in meeting the forensic healthcare needs of the child impacted by sexual abuse.

Indicators of Child Sexual Abuse

Indications of child sexual abuse perpetrated by a family member, caretaker or other trusted individual are not always concrete. There is no stereotypical description of the sexually abused child, and sexual abuse is not determined by cultural, economic, or educational boundaries. Healthcare professionals and those involved in providing services to children should be alert for signals which may indicate sexual abuse. The following behaviors should be recognized as "red flags," however this list is not exhaustive. The diagnosis of child sexual abuse is most often based on **history** as opposed to physical findings.

Nonspecific indicators

- Regressive behavior (eg., encopresis or enuresis in a child that has been potty trained)
- Sleep disturbances (eg., nightmares and night terrors)
- Eating disorders
- History of genital pain or bleeding
- Suicidal ideation
- Aggression

- Social withdrawal
- Self-abusive behavior or lack of concern for personal safety
- Repetitive behavior (eg., hand washing, pacing, rocking, humming)
- Depression
- Problems in school

Specific indicators
- Abnormally sexualized behavior or sexual knowledge inappropriate for child's age
- Disclosure of sexual abuse

Forensic Medical History

Ideally, all children who are suspected of being sexually abused should have a comprehensive forensic exam by a health care professional, experienced in the evaluation of young children. This evaluation should include expertise in genital anatomy, photocolposcopy and recognition of sexually transmitted disease in the pediatric population. Decisions with respect to scheduling a forensic examination must be made considering the emotional health, physical health, needs and comfort of the individual child. In some cases of child sexual abuse, it is the medical history rather than the physical examination, which confirms the abuse.

Because children are not generally brutally raped, because they often know the perpetrator and because they often feel embarrassed, afraid or guilty, they often disclose abuse long after subtle physical findings have healed.

The medical history, provided by the child in his or her own words, including details of what he or she has learned from the sexual encounter, and how it made the child feel, generally provides the strongest evidence that abuse has occurred.

The forensic medical evaluation must be integrated with law enforcement and social services investigations and should address:

1) History
2) Detailed physical assessment, looking for trauma
3) Detailed genital assessment, looking for trauma
4) Photodocumentation and collection of forensic evidence and
5) Appropriate instructions for follow up and referral based on history and physical findings.

Medical History Interview

The purpose of the medical history is to obtain the information necessary to conduct a proper medical examination and possible collection of physical, forensic evidence**. The medical history is not a forensic interview.** Trained law enforcement and child protective agency personnel should conduct a thorough investigative history and forensic interview prior to the physical exam.

Medical History Interview Standards

The health care professional should establish a comfortable, private and trusting atmosphere for the child. This might include allowing the child to make choices and decisions about equipment used during the interview and the opportunity to become familiar with items in the examination room. Ideally, the medical history interview should be conducted separate from parents or caretakers. Children often will tell health professionals details and information they might not otherwise reveal to parents, family members or other adults.

Forensic Medical History, Child

The forensic medical history, obtained from the child by the physician, sexual assault nurse examiner or healthcare professional is used to determine diagnosis and treatment. This history, documented in the exact words used by the child, is valuable forensic evidence in the investigation of sexual abuse. If possible, the child should be interviewed alone in a child friendly room that allows privacy and safety. A child is often more likely to provide details of sexual assault in an atmosphere where they are not inhibited by the presence of a parent or family member. This is especially important if it is suspected that a parent or family member is the perpetrator. As with any history, questions should proceed from general to specific. Initial questions should be simple, non-threatening and appropriate for the child's age and stage of development. The history should be obtained **without** the use of leading questions or those that can be answered with a simple yes or no**. Ask only what is needed to conduct the forensic medical examination, using open-ended questions.**

- "Tell me why your mom brought you here to see me today."
- "Can you talk about what happened at Aunt Susie's house?"
- "What happened next?"

The medical history obtained from the child should be documented in quotes, using the exact statements and words the child offers**.**

Child sexual abuse is most often a diagnosis based on history, as opposed to physical findings.

Forensic Medical History, Parent

If possible, history obtained from a parent or primary caretaker should be in a place separate from the child, to allow the parent to speak freely. The examiner should obtain from the parent:

- A medical history and review of symptoms

- A behavioral assessment, including developmental issues, behavior changes or change in school performance

- A social history, including names of family members and living situation

- An account of the parent's understanding of what has happened related to the abuse

The parent should be asked about non-specific symptoms: fears, sadness, withdrawal & social isolation, sleep disturbances, behavioral changes, complaints of body pain, genital pain or bleeding, bowel or bladder accidents. In addition, the parent should be asked about specific symptoms: abnormally sexualized behavior, knowledge or sexually acting out, or a history of disclosure of sexual abuse by the child (Levitt, 1992).

An explanation of the nature and purpose of the forensic exam should be provided to the parents by the physician or sexual assault nurse examiner. Information about the forensic exam should address physical and genital assessment, use of the photocolposcope and possible laboratory testing for sexually transmitted disease.

Parents should be informed and reassured that the pediatric forensic exam is not invasive or painful and does not routinely include the use of internal instrumentation or speculum insertion.

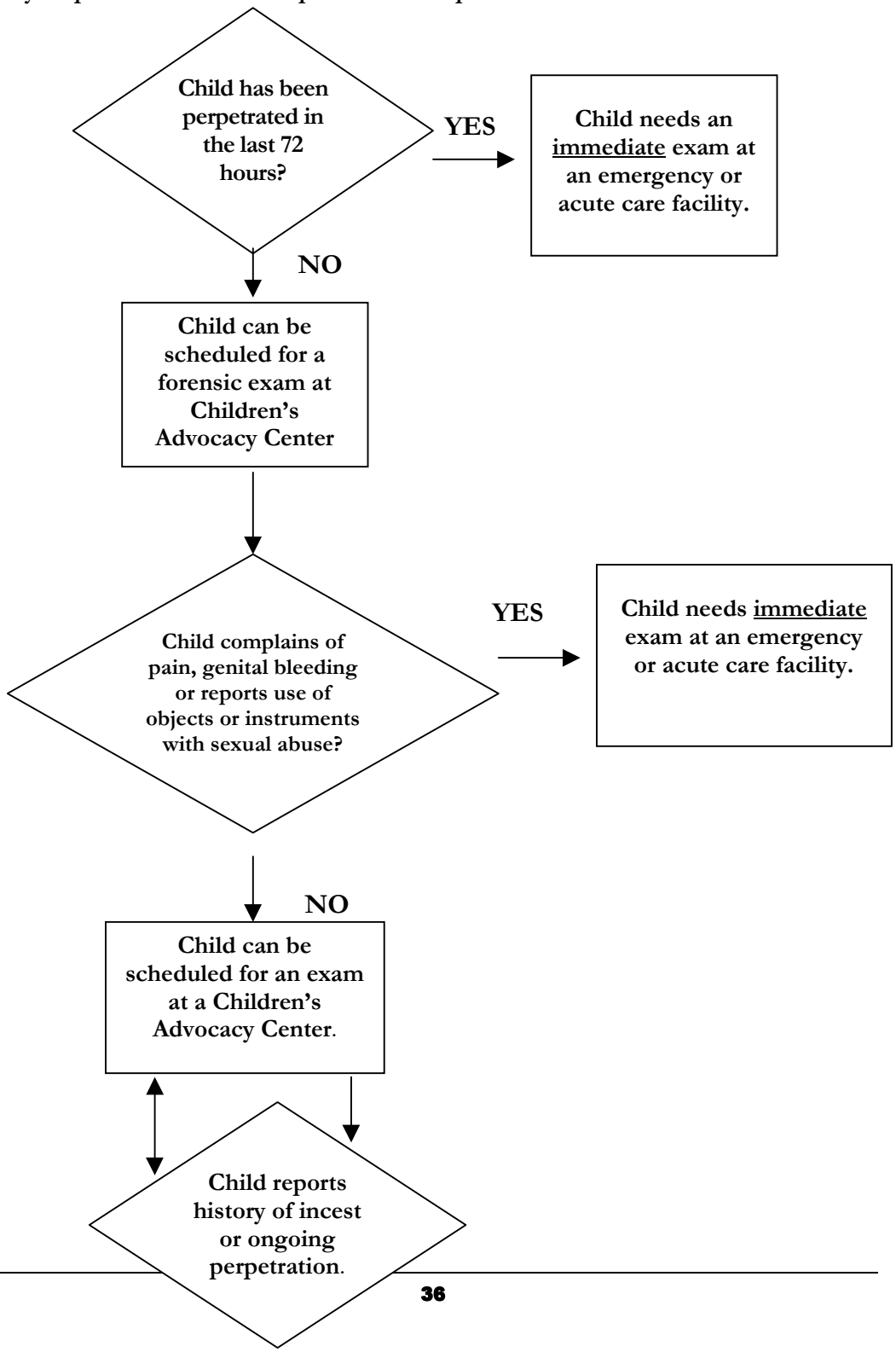
It is also important to inform the parents that a forensic exam does not provide definitive information about whether their child was or was not a victim of sexual abuse. A pediatric forensic exam allows the physician or sexual assault nurse examiner the opportunity to evaluate the child for the presence of acute or chronic genital injury and evidence of sexually transmitted disease.

The Pediatric Forensic and Medical Examination

Although many of the same principles and information involved in the examination and care of the adult sexual assault survivor apply to children, there are some important differences. Typically, children **are not traumatically injured when they are sexually abused**. More often, they are victims of incest or chronic abuse, reporting weeks, months or years after the abuse has occurred. Due to these reasons, the potential to collect perpetrator DNA from a child victim of sexual abuse is not significant and does not routinely require collection of evidence using the SIRCHIE Sexual Assault Forensic Evidence kit.

If the medical history interview determines the most recent sexual contact took place more than 72 hours prior to the medical visit, it is unlikely that any trace or biological evidence will still be present on the child's body or clothing.

Each case must be evaluated on an individual basis to determine which, if any, evidence collection procedures should be implemented. The following flow chart may help to determine exam priorities for reported sexual assault on a child.



ACUTE PEDIATRIC EVIDENCE COLLECTION

If it is established that the most recent sexual contact took place within 72 hours, or if the time frame could not be determined, then evidence procedures should be implemented according to the instructions given for adults, but with the following modifications:

- Diapers may contain biological and/or trace evidence. However, by their nature, they may be very wet. Take great care to dry these items.

- Drawing blood is rarely needed in young children, but if it is determined to be necessary for evidence collection, blood tubes from the sexual assault evidence kit may be replaced with the same type tubes, in the smaller pediatric volumes.

- If it is determined that simultaneous use of 4 swabs would be traumatic, use the minimum number of swabs deemed suitable. All swabs used to collect a specimen must still be collected simultaneously.

- If insertion of any swabs vaginally or rectally is not possible (even in the knee/chest position) without discomfort or injury to the child, consider swabbing the external genitalia with 2-4 swabs moistened with sterile water. Again, all swabs must be used simultaneously in collection of the specimen. A slide should be prepared from these swabs as well.

- In prepubescent children it will not be possible to collect a pubic hair combing or control. There should still be attention paid to any hairs, or other trace evidence adhering in the pubic area.

When any deviation is made from the standard adult evidence collection protocols, these changes must be documented on the corresponding envelopes or slide holders in the kit (e.g., vaginal swabs, or pubic hairs not collected because the victim is prepubescent).

As with adult evidence collection, all labeling must be completed and all specimens sealed by the healthcare professional collecting the evidence. The sexual assault evidence kit or specimens collected should be kept refrigerated and submitted to the CBI laboratory as soon as possible by law enforcement.

NON-ACUTE PEDIATRIC EVIDENCE COLLECTION

Regardless of when the assault or last sexual contact in a child has occurred, valuable evidence may still be obtained through a history and forensic examination. Anytime a child reports abuse, an examination should be done by a physician or sexual assault nurse examiner, who has been educated and trained to provide appropriate forensic evaluation of the sexually abused child.

The forensic medical examination must not be traumatic to the child. Rather, reassure the child that he or she will have a check up and that he or she won't be hurt or have shots during the exam. Allow the child to decide who will be in the exam room. Taking time to explain each step of the exam also helps to reduce the child's anxiety.

Most children, even those who have been sexually abused, will have a normal genital examination. A normal exam does not rule out sexual abuse. Sexual abuse in a child is most often based on history.

If the reported sexual abuse occurred within 72 hours and involves possible injury or exchange of body fluids, the exam should be done immediately. Evidence collection appropriate for the event and physical development of the child is collected and given to law enforcement. More commonly, with children there is a delay in disclosure and an emergency examination is not necessary. Instead, a multidisciplinary evaluation including forensic medical examination may be scheduled.

Regardless of the timing of the exam, it should be part of a complete history and physical examination including brief assessment of development, behavior and emotional status and social history. If the exam must be performed emergently and the child is unable to cooperate, conscious sedation may be considered with standard safety monitoring.

For the genital portion of the examination in females, young girls can be instructed to lie in the supine frog leg position. Using gentle labial separation and traction, Tanner stage and genital anatomy should be noted including medial thighs, labia majora and minora, clitoris, urethra, hymen, fossa navicularis and posterior fourchette.

A speculum should not be used in pre-adolescent or early adolescent children.

In prepubertal females, care must be exercised not to touch the sensitive hymen, particularly during specimen collection if this is indicated. In mid to late adolescence, the redundant edge of the hymen is often better visualized using a cotton swab or other technique.

In males, the thighs, penis and scrotum are examined. In both sexes, the buttocks and anus can be visualized by having the child draw the knees toward the chest. Anal tone, bruises, tears or scars should be noted. Digital, rectal exam is usually not necessary, and rarely provides forensic information (American Academy of Pediatrics, 1999).

Post Examination Information & Referral

Information and referral instructions are equally as important for the child survivor of sexual assault as the adult. The child's parent or caregiver should be provided with instructions on the care of any injuries or prescription medications if applicable.

The provision of psychological services for children and their families is also needed. The Department of Human Services can arrange a referral to an appropriate agency or individual with approved credentials and training in the field of child sexual abuse. Coordination and communication of referrals to community support services is also encouraged.

After an acute assault, it is extremely important that children are seen for a follow up visit within one week to re-evaluate body surface or genital injuries and to perform follow up cultures if necessary. Ideally, the child should be re-examined by the physician or nurse who provided the initial forensic examination. Alternately, the child should be referred to their family pediatrician, primary care physician or local Child Advocacy Center.

Two resources that can provide pediatric forensic consultation and expertise:

Kempe Child Protection Team
Denver Children's Hospital
1825 Marion Street
Denver, Colorado 80218
(303) 861-6919

Pediatric Consultant in Child Abuse
Denver Health and Hospitals
Family Crisis Center

1290 King Street
Denver, Colorado 80204
(303) 572-4609
Crisis Hotline (720) 944-3000

Chapter 3:
Drugs

Chapter

3

Laboratory Testing and Drug Facilitated Sexual Assault

The last decade has provided a new marketplace of drugs that have been used to facilitate sexual assault. The media has given these drugs significant attention and often refers to them as the "date rape drugs." Unfortunately, these drugs can be given to a victim by someone they do not know or are not aware of, but someone who perhaps is targeting them. One drug, frequently used in these crimes and commonly used to facilitate sexual assault is ethanol (alcohol). When ethanol is used alone or in combination with other drugs, it increases the risk of sexual assault.

The availability and use of these drugs provides additional horror for the victim of sexual assault. Often the victim may delay in seeking medical treatment or reporting the crime, because he or she cannot remember sufficient details to know they have been sexually assaulted. In addition, accidental ingestion of these drugs may cause confusion and fogginess that may linger for several days, well after the chemical evidence in the body has metabolized.

ETHANOL (EtOH) can cause all phases of CNS depression from paradoxical disinhibition with increased sociability, to sedation, amnesia, and unconsciousness at higher doses. When used in combination with other CNS depressants, the effects of ethanol are exacerbated. Liquids like grain alcohol, which is relatively tasteless, may allow it to be administered to an unsuspecting victim without their knowledge (LeBeau, Andollo et al, 1999).

ROHYPNOL (Flunitrazepam) is a benzodiazepine. It is important to consider that benzodiazipines are the most widely and frequently prescribed sedative and

hypnotic drugs throughout the world and are therefore readily available. Rohypnol is tasteless and odorless, and as of January 2000, the manufacturer changed the pill to discolor and fizz in any liquid to which it is added. Unfortunately, this change needs to be approved in all countries in which Rohypnol is marketed, so this change may not be readily evident in the U.S. The drug is marketed in Europe and Latin America as a hypnotic sedative to decrease anxiety, treat sleep deprivation and cause musculoskeletal relaxation. It is also used for conscious sedation, and like Valium, produces amnesia. Therapeutic dosage is indicated to be 0.5-2.0 mg

GHB (Gamma Hydroxy Butyrate) is a naturally occurring substance in the mammalian central nervous system. GHB has been promoted in the past by some bodybuilders in an effort to stimulate the production of growth hormone. While GHB concoctions can be purchased in health food stores, it is believed the majority of circulating GHB is a "home brew" easily assembled with instructions and recipes found on the internet. It is a behavioral depressant, hypnotic and anesthetic with an unpleasant, salty taste. Primarily distributed as a liquid, GHB can be disguised in strong tasting, alcoholic beverages which potentiate its effect (LeBeau et al., 1999 & Crowley, 1999).

While ethanol, benzodiazipines and GHB compromise the majority of drugs used to facilitate sex crimes, other less popular drugs are also being used. These include ketamine, barbiturates, chloral hydrate, ethchlorvynol and antihistamines such as diphenhydramine (LeBeau et al., 1999).

KETAMINE is a non-barbiturate, rapid-acting disassociative anesthetic used primarily in emergency medicine, critical care and veterinary medicine. Recently the illicit use and abuse of Ketamine has grown and it has become popular as a "club drug." Available in the United States as an injectable prescription drug, Ketamine can also be made into a powder or tablet by evaporating the liquid. Low dose effects include impaired attention and memory functions. Higher doses may result in ataxia, dizziness, mental confusion and amnesia (Crowley, 1999).

Treatment of the sexual assault victim includes first and foremost management of physical injuries in accordance with standards of care, while attending to the patient's psychological needs. *Routine* drug screens and/or alcohol levels are not recommended; they may be obtained if <u>medically indicated</u> and if results will influence treatment.

The following information is intended to provide a source of referrals for toxicology testing in the event a drug-facilitated sexual assault is suspected. Testing for the presence of drugs like Ethanol, Rohypnol, GHB or Ketamine should be considered part of evidence collection, significant in the investigation of suspected sexual assault. **The referring or requesting law enforcement agency should be consulted regarding their department protocol for forensic laboratory testing.**

Specimen Collection

PROCESS:

1) Handle the specimen as you would any other forensic evidence.

2) Collect only blood or urine specimens if the victim exhibits signs of being drugged with one of the known "Date Rape" drugs. These specimens need to be collected as soon as possible. Blood specimens can be collected within 24 hours of suspected drug ingestion, urine can be collected within 72-96 hours.

3) Collect blood using a gray top tube or use the DUI Blood Alcohol collection tubes. When collecting urine use a sterile specimen cup (minimum of 25ml or 1oz of urine and up to 100 ml may be needed). If less than 25ml is collected, a targeted toxicology analysis may still be possible.

4) Immediately refrigerate the blood or freeze the urine specimen, in locked refrigerated storage, and document chain of custody. If a freezer is not available the urine can also be refrigerated.

5) Call the laboratory for shipping & packing instructions.

6) A specific protocol for forwarding specimens and analysis should be arranged with a laboratory in advance, by the requesting law enforcement agency.

Do not send specimens for drug toxicology to the Colorado Bureau of Investigation

Several of the listed laboratories are certified to test blood, urine and delayed breath for Colorado DUI and DUID Enforcement. These laboratories are certified annually by the Colorado Department of Health and Environment as authorized by the Colorado Board of Health Rules and Regulations 5 CCR 1005-2.

Currently there is no required state certification for toxicology testing related to drug-facilitated sexual assault.

All laboratories will hold a sufficient amount of the specimen aside for the defense. They will also hold the specimen for one year if it is positive.

All the labs have experts who can testify at future court proceedings. The cost of these experts varies.

The following labs are only suggestions that can be contacted for specimen analysis. Law enforcement and healthcare personnel are encouraged to confirm laboratory specifications and procedures.

Lab Referrals

►**ChemaTox Laboratory, Inc.**
5401 Western Ave.
Boulder, CO 80301
(303) 440-4500
(800) 334-1685

Expert*:* Dr. Dale Wingeleth

Cost: To Screen for Rohypnol $25
Confirmation of Rohypnol an additional $150
Confirmation of GHB $150
Blood will be analyzed for a toxicity level, which is an additional cost

►**Colorado Department of Public Health and Environment**
8100 Lowry Blvd.
Denver, CO 80220
(303) 692-3680
Fax (303) 344-9989

Expert: Currently there is no cost for expert testimony

Cost: Rohypnol and Ketamine $26.75 ea.
Ten panel drug screen $18.25
The CDPHE will analyze blood for alcohol only. They will analyze urine for alcohol and drugs.
There is an additional cost of $26.75 for a confirmation test

►**Colorado Forensics and Toxicology**
2150 West 6th Ave., Unit A-1
Broomfield, CO 80020
(303) 469-8042
Fax (303) 460-7502

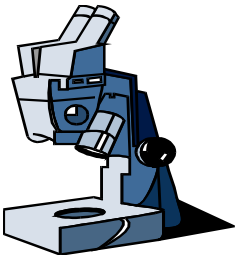
Expert: Dr. James Ruth, Board Certified Forensic Toxicologist

Cost: Rohypnol $150
GHB $150
Ten-panel screen for major drugs

►**Rocky Mountain Laboratories**
108 Coronado CT
Ft. Collins, CO 80525
(970) 266-8108
Fax (303) 530-1169

Expert: Dr. Robert Lantz and Dr. Patricia Sulik

Cost: Rohypnol $250
GHB $150
Ketamine $175
Screening for major drugs $45



Chapter 4:
STDs

Chapter 4

Sexually Transmitted Disease and Pregnancy Prophylaxis

The victim of sexual assault, regardless of gender or age, forced into an unprotected act of sexual intimacy, is at risk for acquiring a sexually transmitted infection. Prophylaxis for sexually transmitted diseases, following CDC guidelines should be offered to all sexual assault victims.

In the case of children, the presence of a sexually transmitted disease is a strong indication of sexual abuse, and the presence of certain STDs might prove useful in linking the offender to the crime. Although many infections can be transmitted to an infant at birth by an infected mother, all children beyond the first few months of infancy should be considered as having been sexually abused if an STD is present.

The routine testing of adult victims for gonorrhea, chlamydia, and syphilis during the initial sexual assault exam is **not recommended**. The reasons to consider deferring routine testing in adults are as follows:

- Individuals who are at risk for contracting gonorrhea or chlamydia as a result of sexual assault should be treated prophylactically.
- Testing is not necessary before prophylactic treatment is given.
- Testing for these organisms when prophylaxis will be given anyway is an unnecessary expense.
- Depending on the elapse of time between the occurrence of sexual

assault and medical care, testing may not reveal the acquisition of infection because of insufficient incubation periods.

- There is no evidence that initial baseline cultures at the time of the sexual assault exam are useful in court, and there is data demonstrating that positive cultures at the time of the exam are sometimes used in court to suggest sexual promiscuity.

Follow-up Testing for Sexually Transmitted Disease Prophylaxis
Subsequent tests-of-cure for gonorrhea and chlamydia are not recommended for patients who were treated prophylactically with the recommended regimens at the time of the initial sexual assault exam. The first-line medications recommended by the Centers for Disease Control are highly effective against these diseases. While resistant strains of *Neisseria gonorrhea* have been discovered worldwide, infections by these organisms are rare in the United States.

Sexually Transmitted Disease Prophylaxis in Adults Following Sexual Assault

The following recommendations are based on The Centers for Disease Control 1998 Guidelines for the Treatment of Sexually Transmitted Diseases.

This regimen covers gonorrhea, trichomonas, and chlamydia.

For gonorrhea: **Ceftriaxone 125 mg IM in a single dose**
Or **Cefixime 400 mg orally in a single dose**
Or **Ciprofloxacin 500 mg orally in a single dose**
Or **Ofloxacin 400 mg orally in a single dose**

plus

For chlamydia: **Azithromycin 1 g orally in a single dose**
Or **Doxycycline 100 mg orally twice a day for 7 days**

plus

For trichomonas: **Metronidazole 2 g orally in a single dose**

Treatment with Metronidazole (Flagyl) should include instructions to the patient regarding avoidance of alcohol and alcohol containing products during the medication regimen and for 24 hours after the last dose.

STD PROPHYLAXIS in PREGNANCY

Pregnant women should not be treated with quinolones or tetracyclines. Pregnant women who cannot tolerate a cephalosporin for prophylactic treatment of *N. gonorrhea* should be given **spectinomycin 2 g IM in a single dose**. Alternatives to azithromycin for pregnant women who cannot tolerate it are **erythromycin base (not estolate) 500 mg orally four times a day for 7 days** or **amoxicillin 500 mg orally three times a day for 7 days**. These regimens are less efficacious than azithromycin, and tests of cure for chlamydia and gonorrhea should be performed 3 weeks after completion of treatment.

HEPATITIS B

The incidence of hepatitis B contracted through sexual assault is not known. Persons at risk for acquiring this disease from a sexual assault are those who were exposed to the offender's body fluids. Inoculation with hepatitis B virus (HBV) can occur at mucosal membranes (vagina, rectum, mouth, conjunctiva) or through cutaneous abrasions. Blood and serous fluids harbor the highest concentrations of virus. Lower titers are found in other fluids such as saliva and semen.

Saliva can be a vehicle of transmission through bites; however, other types of exposure to saliva, including kissing, are unlikely modes of transmission. There appears to be no transmission of HBV via tears, sweat, urine, stool, or droplet nuclei.

Post-exposure hepatitis B vaccination (without HBIG) should adequately protect against acquiring the disease, especially if initiated within 14 days after the assault. Adult doses are given in the following table.

Persons previously vaccinated with the complete hepatitis B vaccine series should be sufficiently protected, and do not usually need a booster. Vaccine-induced antibody levels do decline with time, but immune memory remains intact for > 13 years following immunization. Both adults and children who have been previously vaccinated but have declining antibody levels are still protected against significant HBV infection. Further exposure to HBV results in an anamnestic anti-HBs response that prevents clinically significant HBV infection in the previously vaccinated population. Chronic HBV infection has only rarely been documented among vaccine responders.
However, under certain conditions, a booster may be warranted for previously vaccinated persons:

- immunocompromise
- receiving hemodialysis
- previous vaccinations were given in the buttocks instead of the deltoid in adults
- age > 40 years at time of vaccine series initiation
- concomitant chronic illnesses

▪ possibility of incomplete series (less than 3 shots) given

Other host factors which have been independently associated with nonresponse to hepatitis B vaccine are male gender, obesity and smoking.

Pre-vaccination serologic testing for existing immunity to hepatitis B may be cost-effective in groups with a high prevalence of HBV infection, such as male homosexuals, injection drug users, Alaskan natives, Pacific Islanders, and children of immigrants from endemic countries, if the serologic testing can be completed at the time of the sexual assault exam. Because a high proportion of sexual assault victims fail to access follow-up care, many victims who might subsequently prove to be non-immune may go unprotected if the serologic testing is delayed.

No information is available about the safety of the vaccine in pregnant women. However, because the vaccine contains only particles that do not cause HBV infection, there should be no risk. In contrast, if a pregnant woman acquires HBV infection, it may cause severe disease in the mother and chronic infection in the baby. Therefore, pregnant women who are otherwise eligible can be given the hepatitis B vaccine.

Postexposure hepatitis B vaccination should be administered to all at-risk sexual assault victims at the time of the initial examination. The deltoid muscle is the recommended site for injection in adults and adolescents. Follow-up doses of the vaccine should be again administered 1 month and 6 months after the initial dose.

Recommended Doses of Hepatitis B Vaccines in Adults and Adolescents

AGE GROUP	VACCINE	
	Recombivax HB Dose(ml)	Energix-B Dose(ml)
Adolescents 11-19 years	0.05 mg(0.5 ml)	0.1 mg(1.0 ml)
Adults ≥ 20 years	0.1 mg (1.0 ml)	0.2 mg (1.0 ml)
Dialysis patients and other immunocompromised persons	0.4 mg (1.0 ml)*	0.4 mg (2.0 ml)**

*special formulation for dialysis patients **two 1.0-ml doses given at one site in a four-dose schedule at 0, 1, 2, and 6 months.

HIV

The risk of contracting HIV from a single sexual encounter is unknown but believed to be rare. Victims of sexual assault should be counseled concerning HIV testing and the need for repeat testing every 3 months.

The Emergency Department is not an appropriate setting for HIV testing due to the need for extensive pre and post test counseling.

Adult and child victims of sexual assault should be referred to centers where HIV testing and post exposure counseling is readily available. At the present time, the Centers for Disease Control (CDC) have not developed protocol for HIV prophylaxis related to sexual exposure. The consideration of offering postexposure therapy should be evaluated in view of the likelihood of HIV exposure, risk and benefits of retroviral therapy, interval between exposure and therapy, local epidemiology of HIV/AIDS, the nature of the assault and risk factors associated with the victim or assailant. Victims of sexual assault need to be informed of the risks, benefits, side effects and cost associated with antiretroviral therapy. Referrals for counseling, testing and prophylaxis should be made to the local public health department. In the event that a victim makes an informed decision to start postexposure therapy, the guidelines for occupational mucous membrane exposure should be followed (Feldhaus, 1999).

Sexually Transmitted Disease in Children

The presence of a sexually transmitted organism in a child can be an indication of prior sexual contact and confirmation of this organism has forensic as well as medical significance. Because of the implications of the presence of a sexually transmitted organism in a child or non-consensual, sexually active, adolescent the most specific and sensitive test available for the organism and or disease must be used, regardless of cost.

Routine STD screening tests, used for adults such as direct fluorescent antibody (DFA), enzyme immunoassay (EIA) techniques or DNA probes <u>should not</u> be used in children or adolescents.

The reasons these non-culture methods should not be used in the pediatric and adolescent population include:

1) The use of non-specific and non-sensitive tests in a low prevalence population creates an increased likelihood that a positive test will be a false positive and true positives will be missed.
2) Most of the current non-culture screening tests for STDs have been developed and approved for genital sites in the adult population. Existing organisms in the genital tract of children may interfere with these tests, causing false positive results.
3) Sampling techniques must be specific for the age and pubertal status of the child. The site of a genital infection with Gonorrhea or Chlamydia in prepubertal girls is not well documented, but generally involves a vaginal or urethral infection. Appropriate culturing of these organisms involves vaginal and urethral cultures, rather than cervical cultures.
4) The medicolegal significance of a sexually transmitted organism in a child is often a critical piece of forensic evidence, and the isolation of the organism will require reconfirmation of the specific subtype and additional analysis through biotyping. (Stewart, 1992).

Because the prevalence of STDs in sexually abused children is low, routine prophylaxis for STDs in children is not indicated unless routine follow-up is not obtainable. In contrast, the acutely assaulted adolescent should be provided post assault prophylaxis for sexually transmitted organisms. The Center for Disease Control(CDC) guidelines should be utilized for current recommendations and antibiotic regimens in children (Stewart, 1992).

Treatment of Non-Sexually Transmitted Diseases in Adult Victims of Sexual Assault

HEPATITIS A

Persons at risk for acquiring Hepatitis A through sexual assault are those who were subjected to contact (either orally or on hands/fingers) with fecal material from the offender. To prevent hepatitis A in at-risk individuals, give immunoglobulin (IG) intramuscularly at a dose of 0.02 ml/kg in a single dose as soon as possible after the exposure, but not greater than 2 weeks after exposure. IG is not necessary for individuals who were previously vaccinated with at least one dose of Hepatitis A vaccine at least one month prior to the assault, or who have had a documented case of the disease.

TETANUS

Tetanus toxoid vaccine administration should be considered in any victim who received abrasions or puncture wounds during the assault, especially if the assault took place on the ground.

BACTERIAL VAGINOSIS

Not considered a sexually transmitted disease, this shift in vaginal microbial flora can sometimes occur after sexual intercourse or antibiotic use. Any woman with concerns about a possible vaginal infection days or weeks post-assault should see her health care provider.

CANDIDA VAGINITIS

Some women may acquire a secondary vaginal yeast infection, especially if treated with prophylactic antibiotics. The signs and symptoms of this infection should be discussed with the patient, and she should visit her health care provider for any concerns. In women who have had a predictable history of candida vaginitis following antibiotic use, the health care professional may wish to provide the woman with a prescription for an anti-fungal (intravaginal cream or oral) to be filled if needed (Centers for Disease Control, 1998 and American College of Emergency Physicians, 1999).

Emergency Contraception for Pregnancy Prophylaxis

Emergency contraception is used to prevent pregnancy by utilizing commonly used birth control pills or devices soon after unprotected intercourse. The Federal Drug Administration in February 1997 concluded that the use of oral contraceptives, or birth control pills, for emergency contraception (EC) is safe and highly effective in preventing pregnancy. Two main types of birth control pills are used for emergency contraception: the progestin-only pills (also called the "mini-pill") and combination pills (estrogen plus a progestin) pills. For emergency contraception, the progestin-only regimen has proved to be even more effective than the combination oral contraceptive pills (the latter is also known as the Yuzpe regimen).

Even more effective for postcoital pregnancy prevention is the insertion of a Copper-T 380 intrauterine device (IUD). The IUD can be inserted for emergency contraception up to 5 days after unprotected intercourse, and is very effective. A review of 8,400 postcoital IUD insertions found a pregnancy rate of not more than 0.1 percent. If inserted prior to ovulation, the IUD most likely works by inhibiting sperm transport. If inserted after ovulation, the IUD most likely works by preventing implantation. The IUD is not recommended for women who are at increased risk for sexually transmitted diseases (STDs), because the morbidity associated with pelvic inflammatory disease (PID) is greater in IUD users. The risk of a woman who has been sexually assaulted for developing subsequent PID needs to be evaluated individually. Women should be appropriately counseled and allowed to make informed choices. A woman could receive emergency contraceptive pills in the Emergency Department and make a follow-up appointment with her reproductive health clinician to discuss postcoital IUD insertion, as one option (American College of Obstetrics & Gynecology, 1996).

EMERGENCY CONTRACEPTIVE PILLS (ECPs)

How do they work? The manner in which oral contraceptives prevent pregnancy when used as prophylaxis is not clearly understood. When given before ovulation, ECPs disrupt normal follicular development and maturation, resulting in anovulation or delayed ovulation with deficient luteal function. If given after ovulation, it is thought that ECPs may work by inhibiting ova or sperm transport, and may also alter the endometrium, preventing implantation, although this effect is thought to be limited. **ECPs do not interrupt or harm an existing pregnancy** (American College of Obstetrics & Gynecology, 1996).

When can they be given? The first dose should be administered as soon as practical after unprotected intercourse and the second dose given 12 hours later. Original studies also looked at the first 72 hours after intercourse and found a low rate of conception. Some authors have suggested that emergency contraception can be effective up to 120 hours (five days) after unprotected coitus.

What is the dosage? **Progestin-only emergency contraceptive pills:** Levonorgestrel 0.75 mg (equivalent to 20 Ovrette pills or one tablet of "Plan B") in one dose, and repeated 12 hours later (American College of Obstetrics & Gynecology, 1996). **Combination emergency contraceptive pills:** A variety of brands of birth control pills have been approved for emergency contraception. Combination oral contraceptive pills are usually packaged with a week on non-hormone containing "spacer" pills at the end. The spacer pills have a different color than the hormone containing pills. Only the hormone containing pills can be used for emergency contraception, so the user must be advised about what color of pills to take. **(See following table for dosage summary).**

Are ECPs safe? No studies have indicated any contraindications to ECP use, but studies are continuing. No serious or long term complications have been linked to ECP use in Europe, where emergency contraceptive pills have been widely used for many years. Based on studies involving inadvertent use of oral contraceptives during pregnancy, there is no evidence that ECPs will adversely affect an established pregnancy. Numerous studies on the teratologic risk of conception during regular use of oral contraceptives (including the use of higher dose preparations) have found no increase in birth defects. However, menarchal females should be screened for pregnancy prior to receiving emergency contraception.

Because ECPs are used for a short time period, clotting factors are not significantly affected. Increased risk of vascular problems is unlikely, even in women with traditional contraindications to combination oral contraceptives (e.g., older than age 35 who smoke). Research on ECP effectiveness has not suggested any increase in the risk of ectopic pregnancy. The hormones in ECPs are excreted into the breast milk in small amounts. No adverse effects from this transient change in milk composition has been found.

How effective are ECPs? For women using no birth control, the risk of pregnancy is virtually zero during the first three days of the menstrual cycle (day one of the cycle is the first day of bleeding). The risk rises steadily thereafter, reaching 9% on or about day 13, then slowly declines, reaching 1% on day 25 through the onset of the next cycle. It is important to note that these are statistics and an individual woman's risk may be higher or lower. The most important point is that almost any act of unprotected intercourse entails some risk of pregnancy and emergency contraception can substantially reduce the risk.

One study of emergency contraception showed that without regard to timing of intercourse in a women's cycle, 8 of every 100 women of reproductive age will conceive after a single act of unprotected coitus. Use of combination oral contraceptive pills reduce that number to 2 out of 100, a risk reduction of 75%. Use of the progestin only pills (Ovrette or Plan B) for emergency contraception is even more effective, resulting in 1 pregnancy out of 100 acts of unprotected coitus, a risk reduction of 87.5%. Following emergency insertion of a copper IUD, the risk of pregnancy is reduced by more than 99% (American College of Obstetrics & Gynecology, 1996).

What Are The Side Effects?: **Nausea/Vomiting:** The progestin-only oral contraceptive regimen generally is well tolerated, and anti-emetics may not be necessary. Premedicating with an antiemetic one hour prior to each EC dose is advised when using the combination pill EC regimen. About one-half of women taking the combination EC pills experience nausea. One-fifth will vomit after the first or second dose. If vomiting occurs an hour or more after the dose, as a result of nausea from the combination EC pills, it is likely that sufficient quantities of the hormones were absorbed. Repeating the EC dose in this case is probably unnecessary. If vomiting occurs soon after the ingestion of the EC dose because of an inability to keep the pills down, a replacement dose may be warranted.

Menstrual Irregularities: EC pills use can cause the woman's next menstrual period to begin a few days earlier or later than expected. A pregnancy test should be obtained if no menses occurs by three weeks.
Other: Some women may experience temporary fatigue, dizziness, and breast tenderness.

Are There Drug Interactions?: The effect on EC pills by drugs which theoretically reduce the effectiveness of oral contraceptives, such as anticonvulsants, Rifampin, and Griseofulvin, is unknown. The clinician could consider doubling the EC dose. No significant interaction between EC and broad-spectrum antibiotics has been found. Potential interactions with other drugs should be evaluated on a case-by-case basis.

Consent: A sample consent form is provided at the end of this section.

What Follow-Up Care Is Needed After ECP Use?: If the woman does not have a menstrual period within 3 weeks after ECP treatment, she should obtain a pregnancy test.

What If The Patient Is Unsure About Wanting to Use ECPs? During the sexual assault exam, some women may be undecided about ECP initiation. These women should be counseled that emergency contraception can be obtained later at a variety of sites, including pharmacies (a prescription is needed in Colorado) and public and private health clinics. Women need to remember the recommended time frame for use (within 72 hours, but possibly up to 120 hours) in making their decision (American College of Obstetrics & Gynecology, 1996).

This material is for informational purposes only and should not serve as the sole source for prescribing information or clinical decision making.

SUGGESTIONS FOR ANTIEMETICS

Prescription Medications

Meclizine hydrochloride (Antivert)
Dose: one or two 25 mg tablets
Take one hour before ECP dose; repeat if needed in 24 hours

Trimethobenzamide hydrochloride (Tigan)
Dose: one 250 mg tablet or one 200 mg suppository
Take one hour before ECP dose; repeat as needed every 4-6 hours

Promethazine hydrochloride (Phenergan)
Dose: one 25 mg tablet or one 25 mg suppository
Take 30 minutes to one hour before first ECP dose; repeat as needed every 8-12 hours

Non-Prescription Medications

Meclizine hydrochloride (Dramamine II, Bonine)
Dose: one or two 25 mg tablets
Take one hour before ECP dose; repeat if needed in 24 hours

Diphenhydramine hydrochloride (Benadryl)
Dose: one or two 25 mg tablets
Take one hour before first ECP dose; repeat as needed every 4-6 hours

Dimenhydrinate (Dramamine)
Dose: one or two 50 mg tablets or 4-8 teaspoons Dramamine liquid
Take 30 minutes to one hour before first ECP dose; repeat as needed every 4-6 hours

Cyclizine hydrochloride (Marezine)
Dose: One 50 mg tablet
Take 30 minutes before first ECP dose; repeat as needed every 4-6 hours

ORAL CONTRACEPTIVES USED FOR EMERGENCY CONTRACEPTION

CONTRACEPTIVE PILL INGREDIENTS	BRAND NAMES	TABLETS PER DOSE
Levonorgestrel 0.75 mg	Plan B	1 (white)
Norgestrel 0.075 mg	Ovrette	20 (white)

Levonorgestrel 0.25 mg + Ethinyl estradiol 0.05 mg	Preven	2 (blue)
Norgestrel 0.50 mg + Ethinyl estradiol 0.05 mg	Ovral or Ogestrel	2 (white)
Norgestrel 0.30 mg + Ethinyl estradiol 0.03 mg	Lo/Ovral or Levora or Low-Ogestrel	4 (white)
Levonorgestrel 0.15 mg + Ethinyl estradiol 0.03 mg	Levelen or Nordette	4 (light-orange)
Levonorgestrel 0.125 mg + Ethinyl estradiol 0.03 mg	Triphasil or Tri-Levelen	4 (yellow)
Levonorgestrel 0.125 mg + Ethinyl estradiol 0.03 mg	Trivora	4 (pink)
Levonorgestrel 0.125 mg + Ethinyl estradiol 0.02 mg	Alesse or Levlite	5 (pink)

EMERGENCY CONTRACEPTION: SAMPLE PATIENT INFORMATION

What Is Emergency Contraception?

Emergency contraception is a way to reduce the risk of pregnancy for women who were sexually assaulted or have had unprotected intercourse. There are two types of emergency contraception: birth control pills and the intrauterine device (IUD).

Emergency contraceptive pills (ECPs) are birth control pills which, if taken within 72 hours (three days) of intercourse, can prevent pregnancy. Some studies suggest that ECPs may be effective for even 120 hours, or five days, after unprotected intercourse. The way in which ECPs work is not completely understood. It is believed that if taken before the woman has ovulated, they work by preventing ovulation and therefore prevent fertilization. If taken after a woman has ovulated, they are thought to work in one of two ways. They slow down the movement of egg and sperm, preventing fertilization, and/or they change the lining of the uterus, preventing a fertilized egg from implanting. Emergency contraceptive pills are between 75% and 87.5% effective for preventing pregnancy.

The copper IUD is 99% effective at preventing pregnancy and can be put in up to 5 days after unprotected sex. A woman interested in using an IUD for emergency contraception should discuss this option with her primary care physician or nurse

practitioner. She can still receive an IUD if she has already taken emergency contraceptive pills.

Are There Side Effects With ECP Use?

Emergency contraceptive pills will not hurt or stop a pregnancy, which was there before the woman had unprotected intercourse or was sexually assaulted. There is no evidence that ECPs cause birth defects. Side effects for the woman may include nausea, vomiting, fatigue, breast tenderness, dizziness, or an early or late menstrual period. There are no known serious or long-term risks associated with ECPs. Some drugs may interfere with ECP use, so tell your healthcare provider if you're taking any medications.

How Do I Take ECPs?

Take the first dose as soon as practical after unprotected intercourse, and the second dose 12 hours later. The number of pills that needs to be taken with each dose will vary depending on the brand of birth control pills used for EC. For some brands of ECPs, taking medicine an hour before each ECP dose is advised to prevent nausea. If a woman does vomit within an hour of taking an EC dose, she may need to repeat the dose and should call her healthcare provider.

For your information, your healthcare provider will fill in the spaces below:

Brand of ECPs given: _____

Number of pills and their color to take with each dose:

_____

Date ECPs were first taken:_____

Time of first anti-nausea pills (if needed):_____

Time of first dose of ECPs:_____

Time of second anti-nausea pills (if needed):_____

Time of second dose of ECPs:_____(12 hours after first dose)

Take a pregnancy test if your period has not started by three weeks from now.
For more information about emergency contraception, contact your regular healthcare provider, Planned Parenthood, the national EC hotline at 1-888-NOT-2LAT or the EC websites at http://www.path.org, or http://www.NOT-2-LATE

SAMPLE PATIENT CONSENT FORM FOR EMERGENCY CONTRACEPTION

I have received and read the Patient Information Sheet on Emergency Contraception. I have discussed any questions with my healthcare provider at this time. I understand that:

- Emergency contraception is not 100% effective for everyone.
- Emergency contraception has no known serious side effects.
- If my menstrual period has not started within 3 weeks after taking Emergency Contraception I should take a pregnancy test.

Check one:

_____ I decline Emergency Contraception at this time.

_____ I accept Emergency Contraception at this time.

Signature of patient:_____

Signature of witness: _____

Date:_____

Chapter 5: Advocacy

Chapter

5

Advocacy

The anti-rape movement, which began in the United States in the 1970s started a revolution. Survivors and those who supported them were choosing to share their experiences, bringing the issue out of the personal realm and into the public and political realm. At this time, it was obvious to individuals concerned with the issue of sexual violence that there was a lack of acceptance, services, and support for rape victims. This recognition led to the grassroots formation of rape crisis centers, places that aimed to offer safe, confidential, and non-judgmental support to survivors of sexual violence.

When we consider the self-blame, humiliation, confusion and fear that rape victims are likely to feel, it is understandable that sexual assault victims benefit from having a supportive and knowledgeable person guide them through the process of accessing appropriate services and seeking justice. Victim advocates are individuals who take on this role of pleading the cause of the victim. Within the sexual assault movement, that role also includes the feminist philosophy of empowering a victim to make their own decisions, whether those decisions are around healing or taking action within systems.

It is important to realize that sexual assault victim advocates who operate out of rape crisis centers or similar organizations have a different role than victim advocates who work within the criminal justice system. The primary difference, which can significantly affect a victim, deals with the issue of confidentiality. While victim advocates through rape crisis centers are legally protected from being examined as to any communication with the victim, system-based victim advocates cannot keep information about the victim confidential (see statute below). Rape crisis center victim advocates therefore can ensure confidentiality, an important part of offering open, safe and non-judgmental advocacy. System-based victim

advocates have their own unique role, helping victims navigate through the criminal justice process. They are essentially experts within the system, while rape crisis advocates are experts in the field who work outside the system. With a coordinated response, sexual assault victims, families and communities can benefit from the support that is available from different advocates with different perspectives and expertise.

C.R.S. 13-90-107
(k) (I) A victim's advocate shall not be examined as to any communication made to such victim's advocate by a victim of domestic violence, as defined in section 18-6-800.3 (1), C.R.S., or a victim of sexual assault, as described in sections 18-3-401 to 18-3-405.5, 18-6-301, and 18-6-302, C.R.S., in person or through the media of written records or reports without the consent of the victim.
(II) For purposes of this paragraph (k), a "victim's advocate" means a person at a battered women's shelter or rape crisis organization or a comparable community-based advocacy program for victims of domestic violence or sexual assault and does not include an advocate employed by any law enforcement agency:
(A) Whose primary function is to render advice, counsel, or assist victims of domestic or family violence or sexual assault; and
(B) Who has undergone not less than fifteen hours of training as a victim's advocate or, with respect to an advocate who assists victims of sexual assault, not less than thirty hours of training as a sexual assault victim's advocate; and
(C) Who supervises employees of the program, administers the program, or works under the direction of a supervisor of the program (Colorado District Attorney's Council, 1999).

Victim Compensation

The State of Colorado provides Crime Victim Compensation to any person who is victimized by violent crime in Colorado. Colorado residents who are victimized in a state or country that does not have a victim compensation program, or residents who are victims of terrorism, may also apply for victim compensation in the judicial district where they reside.

Victims may receive up to $20,000 for out of pocket expenses not covered by insurance or other collateral resources, or up to $1,000 for emergency awards. Funds to pay crime victim compensation claims do not come from taxpayers; instead these funds are collected through fines from criminals convicted of felony, misdemeanor, and some traffic offenses. In Colorado, each judicial district has a victim compensation program. Victims are required to apply in the district where the crime occurred.

A victim of crime can apply for victim compensation if they:
- Are the victim of a violent crime in Colorado (or are a victim of a terrorist act)
- Are the victim of a compensable crime that occurred on or after July 1, 1982 which resulted in a loss

▪Report the crime to law enforcement within 72 hours
▪Cooperate with law enforcement
▪File an application within 1 year, 6 months for property damage
▪Are not substantially responsible for your own victimization
Note: The victim compensation board in each district may waive some of these requirements.

Compensable Losses
Losses directly related to the compensable crime are eligible for reimbursement and include:
▪Medical expenses
▪Mental health expenses
▪Lost wages
▪Loss of support to dependants
▪Funeral expenses
▪Residential property damage, including security doors

Note: Please refer to Colorado Revised Statutes and the Victim Compensation program administrator in the district where the crime occurred for a comprehensive list of compensable losses.

How to File a Claim
The victim is required to complete an application and submit itemized bills directly related to the crime in the district where the crime occurred. The processing time is different for each district however, it generally takes 30-45 days to be notified of the program's decision. Contact the victim compensation administrator in the district where the crime occurred for an application and more information.

Note: If a victim's compensation claim is denied or the award reduced, the victim has a right to appeal the board's decision. The victim should be notified of the right to appeal in writing (Colorado Division of Criminal Justice, http:internet source).

Victim Bill of Rights

The original Victim Rights Act became effective in January, 1993 after the law was signed by Governor Roy Romer. The Victim Rights Act was amended in 1995 and again in 1997. The Victim Rights Act provides victims an active role in the criminal justice process in an attempt to balance the scales of justice. The following is a summary of the rights guaranteed by the Victim Rights Act. (For a complete listing of victim rights, please refer to Colorado Revised Statutes § 24-4.1-101 through § 24-4.1-304.)

- To be treated with fairness, respect and dignity;
- To be informed of and present for all "critical stages" of the criminal justice process,

- To be free from intimidation, harassment, or abuse, and the right to be informed about what steps can be taken if there is any intimidation or harassment by a person accused or convicted of the crime or anyone acting on the person's behalf;
- To be present and heard regarding bond reduction, continuances, acceptance of plea negotiations, case disposition, or sentencing,
- To consult with the district attorney prior to any disposition of the case or before the case goes to trial and to be informed of the final disposition of the case,
- To be informed of the status of the case and any scheduling changes or cancellations, if known in advance,
- To prepare a Victim Impact Statement and to be present and/or heard at sentencing,
- To have restitution ordered and to be informed of the right to pursue a civil judgment against the person convicted of the crime,
- To a prompt return of the victim's property when no longer needed as evidence,
- To be informed of the availability of financial assistance and community services,
- To be given appropriate employer intercession services regarding court appearances and meetings with criminal justice officials,
- To be assured that in any criminal proceeding the court, the prosecutor, and other law enforcement officials will take appropriate action to achieve a swift and fair resolution of the proceedings,
- Whenever practicable, to have a safe, secure waiting area during court proceedings,
- Upon request, to be informed when a person accused or convicted of the crime is released from custody, is paroled, escapes or absconds from probation or parole,
- Upon written request, to be informed of and heard at any reconsideration of sentence, parole hearing, or commutation of sentence,
- Upon written request, to be informed when a person convicted of a crime against the victim is placed in or transferred to a less secure correctional facility or program or is permanently or conditionally transferred or released from any state hospital,
- To be informed of any rights which the victim has pursuant to the constitution of the United States or the State of Colorado,
- To be informed of the process for enforcing compliance with the Victim Rights Act (Colorado Division of Criminal Justice, http:internet source).

Additional rights and services are provided to child victims or witnesses. Law enforcement, prosecutors, and judges are encouraged to designate one or more

individuals to try to assure the child and their family understand the legal proceedings and have support and assistance to deal with the emotional impact of the crime and the subsequent criminal proceedings.

Appendix

Colorado Bureau of Investigation Laboratory sites:

Denver
690 Kipling, Suite # 4000
Denver, CO 80215
(303) 239-4303

Montrose
301 South Nevada Ave.
Montrose, CO 81401
(970) 249-0242

Pueblo
3416 North Elizabeth St.
Pueblo, CO 31008
(719) 542-1133

Recommended sexual assault evidence collection kits:
SIRCHIE Fingerprint Laboratories, Inc.
100 Hunter Place
Youngsville, N.C. 27596
(919) 554-2244 (800) 356-7311
Victim Kit COL 100
Suspect Kit CMS 100

Colorado Local Health Departments Which Offer STD/HIV Testing
(Alphabetical listing by name of city)

- Community Health Services, Inc. 0405 Castle Creek Road, Suite 6, **Aspen** 81611. (970) 920-5420/5427. Site performs anonymous testing. Hours of operation are Monday - Thursday from 9:00 a.m. to 3:00 p.m. By appointment only. HIV testing cost is $30; $10 for high school students
- Boulder County Health Department, 3450 Broadway, **Boulder** 80302. (303) 413-7500. Site performs anonymous testing. Hours of operation are Monday and Tuesday from 9:00 a.m. to 11:30 a.m. and from 4:00 p.m. to 6:05 p.m.; Wednesdays from 9:00 a.m. to 11:30 a.m; Thursdays from 9:00 a.m. to 11:30 a.m., 12:30 p.m. to 3:00 p.m. and from 4:00 p.m. to 6:05 p.m.; Fridays from 9:00 a.m. to 11:30 a.m. By appointment only. HIV testing cost is $20

- Saguache County Public Health Department, 220 Worth Street, **Center** 81125. (719) 754-2773, Site does not perform anonymous testing. Hours of operation are Monday through Friday from 8:30 a.m. to 4:00 p.m. By appointment only. HIV testing cost is up to $10
- El Paso County Health Department, 301 South Union Boulevard, **Colorado Springs** 80910. (719) 578-3148. Site does not perform anonymous testing. Hours of operation are Monday through Friday from 8:00 a.m. to 4:00 p.m. By appointment only. HIV testing cost is $15
- Montezuma Health Department, 106 West North, **Cortez** 81506. (970) 565-3056. Site does not perform anonymous testing. *Testing will be available in April 1999 (or shortly thereafter)*. By appointment only
- Denver Health and Hospitals, 605 Bannock Street, **Denver** 80204. (303) 436-7221. Site does perform anonymous testing. Hours of operation are Monday (by appointment only) from 10:00 a.m. to 5:00 p.m.; Tuesday through Friday from 8:00 a.m. to 3:00 p.m. (for walk-ins). HIV testing cost is free
- San Juan Basin Health Unit, 281 Sawyer Drive, Room 300, **Durango** 81301. (970) 247-5702. Site does perform anonymous testing. Hours of operation are Monday and Tuesday from 1:00 p.m. to 3:00 p.m. and every other Friday from 9:00 a.m. to 11:00 a.m. By appointment only. HIV testing cost is $20
- Northern Colorado AIDS Project (NCAP), 147 West Oak Street, **Fort Collins** 80524. (970) 484-4469. Site does perform anonymous testing. Hours of operation are Wednesdays from 8:00 a.m. to 5:00 p.m.; Thursdays from 1:00 p.m. to 8:00 p.m. and Saturday from 10:00 a.m. to 3:00 p.m. By appointment only (or walk-in if time slot is available). HIV testing cost is up to $15
- Weld County Health Department, 1555 North 17th Avenue, **Greeley** 80634. (970) 304-6240. Site does perform anonymous testing. Hours of operation are Monday and Wednesday from 1:00 p.m. to 4:00 p.m. By appointment only. HIV testing cost is $13
- Jefferson County Health Department, 260 S. Kipling, **Lakewood** 80226. (303) 239-7036. Site does not perform anonymous testing. Hours of operation are Monday, Tuesday, Wednesday and Friday (by appointment only); Thursday from 4:30 p.m. to 7:00 p.m. (walk-ins only). HIV testing cost is $25
- Pueblo City/County Health Department, 151 Central Main, **Pueblo** 81003. (719) 583-4300. Site does perform anonymous testing. Hours of operation are Monday through Friday from 8:00 a.m. to 11:00 a.m. and from 1:00 p.m. to 4:00 p.m. Appointments given priority over walk-ins. HIV testing cost is $20
- Northeast Colorado Health Department, 700 Columbine Street, **Sterling** 80751. (970) 522-3741. Site does not provide anonymous testing. Hours of operation are Monday through Friday from 8:00 a.m. to 4:30 p.m. By appointment only. HIV testing cost is $20
- Las Animas/Huerfano County Health District, 412 Benedicta **Trinidad** 81082. (719) 846-2213. Site does not perform anonymous testing. Hours of operation are Monday through Friday from 8:00 a.m. to 4:00 p.m. By appointment only. HIV testing cost is $10

- Las Animas/Huerfano County Health District, 119 East 5th Street, **Walsenburg** 81089. (719) 738-2650. Site does perform anonymous testing. Hours of operation are Monday through Friday from 8:30 a.m. to 4:30 p.m. By appointment only. HIV testing cost is $10
- **Colorado Department of Public Health & Environment, Denver** contact numbers for information on HIV exposure and medication prophylaxis: *303-692-2692, or the 24 hour a day hotline staffed by infectious disease physicians at San Francisco General * 1-888-HIV-4911.

If you need more information about additional testing sites (ie: STD Clinics or Rocky Mountain Planned Parenthood Offices), please call (303) 692-2740. Please note that scheduled hours for each site and the cost of testing is subject to change.

Rocky Mountain Planned Parenthood Clinics

Alamosa
719-589-4906
1560 12th St.

Arvada
303-425-6624
7853 No.Wadsworth Blvd.

Aurora
303-671-7526
1150 So. Abilene St.

Boulder
303-447-1040
2434 Arapahoe

Canon City
719-275-1537
2405 North 9th St.

Colorado Springs, Eastside
719-573-8880
3958 No.Academy Blvd.

Colorado Springs
719-475-7162
1330 West Colorado Ave.

Colorado Springs, Security
719-390-5411
3029 So. Academy Blvd

Denver, Central
303-832-5069
921 East 14th Avenue

Denver, Southeast
303-320-1630
6310 East Exposition

Fort Collins
970-493-0281
1217 East Elizabeth

Glenwood Springs
970-945-8631
1517 Blake

Granby
970-887-2454
236 Agate

Greeley
970-352-4762
3487-B W. 10th St.

LaJunta
719-384-4496
112 Santa Fe

Lakewood
303-988-3821
1400 So. Wadsworth

Lamar
719-336-5418
108 W. Olive

Littleton
303-798-0963
7987 So. Broadway

Longmont
303-772-3600
195 So. Main

Pueblo
955 West Highway 50
719-545-0246

Steamboat
970-879-2212
1104 B 11th St.

Trinidad
719-846-6000
328 Bonaventure

Resources for information on Emergency Contraception

Program for Appropriate Technology in Health (PATH). 1997. Emergency Contraception: A Resource Manual for Providers. More information is available at, 4 Nickerson St., Seattle, WA, 98109, (206) 285-3500, http://www. info@path.org.

Gynetics, Inc. is a pharmaceutical company that markets a prescription-only emergency contraceptive kit called Preven Emergency Contraceptive Kit. The kit contains sufficient ECPs (0.25 mg levonorgestrel and 0.05 mg ethinyl estradiol) and a pregnancy test.

Planned Parenthood Federation of America has information packets available regarding emergency contraception. For information contact 1-800-669-0156; FAX 1-212-261-4352; Marketing Department, PPFA, 810 Seventh Avenue, New York, NY, 10019

Women's Capital Corporation markets the progestin-only EC called "Plan B". To order Plan B, call 1-800-330-1271, or write WCC, P.O.Box 5026, Bellevue, WA 98009-5026.

A national hotline number for EC information is 1-888-NOT-2LAT. Information along with locations of clinics which provide EC is available on the Internet at www.NOT-2-LATE.com.

Colorado Child Advocacy Centers

Pueblo Child Advocacy Center
301 West 13th Street
Pueblo, CO 81003
(719) 583-6332
(719) 583-4545 Fax

Larimer County Child Advocacy Center
404 West Myrtle
Ft. Collins, CO 80521
(970) 407-9739
(970) 407-9743 Fax

Four Corners Child Advocacy Center
140 North Linden
Cortez, CO 81321
(970) 565-8155
(970) 565-8279 Fax

Office of the DA 5th Judicial District
(Clear Creek, Summit, Lake, Eagle Counties)
PO Box 2000
Georgetown, CO 80444
(303) 569-2567
(303) 569-2757 Fax

Children's Advocacy Center
(Sites in Lakewood and Arvada)
PO Box 27355
Lakewood, CO 80227
(303) 987-4885
(303) 987-4863 Fax

Adams County Child Advocacy Project
1825 Marion St., Suite 100
Denver, CO 80218
(303) 864-5271
(303) 254-6696 Fax

Denver Children's Advocacy Center
1271 Elati Street
Denver, CO 80204
(303) 825-3850
(303) 825-6087 Fax

Child and Family Advocacy Program
Blue Sky Bridge
PO Box 805
Niwot, CO 80544
(303) 652-0744
(303) 652-0285 Fax

Western Slope Center for Children
PO Box 3978
Grand Junction, CO 81502
(970) 245-3788
(970) 245-7550 Fax

Children's Advocacy & Family Resource Center "Sungate"
PO Box 24225
Denver, CO 80224
(303) 368-1065
(303) 368-1089 Fax

Children's Advocacy Center for the Pikes Peak Region
423 South Cascade Ave
Colorado Springs, CO 80903
(719) 636-2460
(719) 636-1912 Fax

A Kid's Place
814 9th Street
Greeley, CO 80631
(970) 353-5970
(970) 353-4738 Fax

Resources

* indicates rape crisis hotline services

Advocate Safehouse Project
PO Box 2036
Glenwood Springs
Phone(970)945-2632
Fax (970) 928-9026
Email/Website advocate@aspn.net

Advocates - Crisis Support Services
PO Box 1050
Craig
Phone (970) 824-9709
Fax (970) 824-5848

Advocates - Victim Assistance Team
PO Box 155
Hot Sulphur Springs
Phone(970)725-3442
Fax (970) 725-3983

Advocates Against Battering & Abuse
PO Box 774742
Steamboat Springs
Phone(970) 879-2034
Fax (970) 879-4339
Email/Website www.advocatesaba.org

Advocates for Victims of Assault, Inc.
PO Box 1859
Frisco
Phone(970) 389-0090
Fax (970) 262-5926
Email/Website advocates@rkymtn.com

Alliance Against Domestic Abuse
PO Box 173, 120 East First
Salida
Phone (719) 539-7347
Fax (719) 539-2005

Alternatives to Family Violence
PO Box 385
Commerce City
Phone (303) 428-9611
Fax (303) 657-4754

Arkansas Valley Resource Center
PO Box 716
La Junta
Phone (719) 384-7764
Fax (719) 384-1938
Email/Website www.ruralnet.net/~avrc/avrcmain.html

Assault Survivors Advocacy Program
University of Northern Colorado, Cassidy Hall
Greeley
Phone (970) 351-1490
Fax (970) 351-1485
Email/Website www.unco.edu/ASAP/

Boulder County Rape Crisis Team*
2885 East Aurora, Suites 9 & 10
Boulder
Phone (303) 443-0400
Fax (303) 443-0187
Email/Website www.rapecrisisteam.org

Boulder County Safehouse
835 North Street
Boulder
Phone (303) 449-8623
Fax (303) 449-0169
Email/Website http://bcn.boulder.co.us/safehouse

Cadet Counseling & Leadership Development Center
HQ USAFA/DFBL, 2348 Sijan Dr, Suite 2A13
USAFA
Phone (719) 333-2107
Fax (719) 333-3095
Email/Website tracy.neal-walden@usafa.af.mil

Center for Prevention of Domestic Violence
PO Box 2662
Colorado Springs
Phone (719) 633-1462
Fax (719) 632-2342

Clear Creek County Advocates
P.O. Box 21
Georgetown
Phone (303) 569-3251
Fax (303) 679-2447
Email/Website jbrown@sheriff.co.clear-creek.co.us

Counseling & Career Center
Adams State College
Alamosa
Phone (719) 587-7746
Fax (719) 587-7522
Email/Website www.adams.edu/campus_ life/services/services7.html

Colorado State University - Women's Programs & Studies
112 Student Services Bldg
Ft Collins
Phone (970) 491-6384
Fax (970) 491-4922
Email/Website www.colostate.edu

Denver Victim Service Center
PO Box 18975
Denver
Phone (303) 860-0660
Fax (303) 831-7282
Email/Website www.denvervictims.org

Domestic Safety Resource Center
PO Box 953
Lamar
Phone (719) 336-4358
Fax (719) 336-2929

High Plains Sexual Assault Center*
PO Box 106
Sterling
Phone (970) 522-8329
Fax (970) 522-5874
Email/Website www.hpdc.com/hpsac

Larimer Center for Mental Health*
315 West Oak Street Suite 514
Ft. Collins
Phone (970) 472-4204
Fax (970) 472-4203
Email/Website www.fortnet.org/sava

Latimer House Counseling and Advocacy
1003 Main Street
Grand Junction
Phone (970) 241-0324
Fax (970) 245-6632
Email/Website www.hilltop.org

Rape Assistance and Awareness Program*
PO Box 18951
Denver
Phone (303) 329-9922
Fax (303) 329-9964
Email/Website www.raap.org

Rape Intervention Team*
PO Box 2723
Durango
Phone (970) 259-3074
Fax (970) 385-0300

Renew, Inc.
PO Box 169
Cortez
Phone (970) 565-4886
Fax (970) 564-0988

Resource Center of Eagle County
PO Box 2558
Avon
Phone (970) 949-7097
Fax (970) 949-7087
Email/Website www.geocites.com/resourceeagle

Response
PO Box 1340
Aspen
Phone (970) 920-5357
Fax (970) 920-9523

San Miguel Resource Center
PO Box 3243
Telluride
Phone (970) 728-5842
Fax (970) 728-4894

Sexual Assault Survivors, Inc.*
PO Box 5135
Greeley
Phone (970) 506-2738
Fax (970) 506-2739
Email/Website Survivorinfo.org

The Advocates of Lake County, Inc.
PO Box 325
Leadville
Phone (719) 486-3530
Fax (719) 486-2889

Tri-County Resource Center
PO Box 3509
Montrose
Phone (970) 249-8345
Fax (970) 240-4066

Tu Casa
PO Box 473
Alamosa
Phone (719) 589-5291
Fax (719) 589-1465

University of Colorado at Boulder
Campus Box 119
Boulder
Phone (303) 492-8855
Fax (303) 492-1747

Victim/Witness Services
PO Box 883
Lamar
Phone (719) 336-7303
Fax (719) 336-9893

SANE Programs

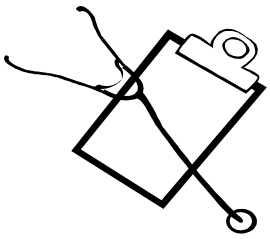
A Sexual Assault Nurse Examiner (SANE) is a licensed, registered nurse who has received specialized forensic education in providing comprehensive care to adult and child survivors of sexual assault. A SANE demonstrates clinical competence in the collection of forensic evidence, in addition to the care, treatment and referral of those impacted by interpersonal violence.

Colorado SANE programs are nurse based practice models that work in collaboration with law enforcement, advocacy, criminal justice and other healthcare professionals. SANE programs have been providing forensic services in Colorado since 1995. The first SANE program in the state was developed at Memorial Hospital in Colorado Springs.

The mission of the Colorado SANE program is:
To avoid further trauma to all sexual assault survivors in the healthcare environment. This mission is accomplished by •providing a compassionate and sensitive approach •providing a timely medical/forensic examination with standardized forensic evidence collection •providing a consistent healthcare provider throughout the exam •providing referral for follow up care and counseling and •responding to the criminal justice system to provide objective testimony in a court of law.

Numerous communities through out the state have collaborated to develop Sexual Assault Nurse Examiner programs. Most SANE programs are affiliated with local hospital facilities. SANEs are also providing forensic evaluations to victims of domestic violence, children and adolescents in Child Advocacy Centers and evidence collection from suspects in hospital or correctional facilities.

To find out more about the development of a Sexual Assault Nurse Examiner program in your community or to access the nearest SANE program, call the Colorado Coalition Against Sexual Assault, 303-861-7033.



References

Adams, J., Harper, K., Knudson, S., & Revilla, J., (1994). Examination findings in legally confirmed child sexual abuse: It's normal to be normal. Pediatrics, 94 (3), 310-317.

American Academy of Pediatrics Committee on Child Abuse and Neglect (1999). Guidelines for the evaluation of sexual abuse of children. Pediatrics, 103, 186-191.

American College of Emergency Physicians (1999). Evaluation and management of the sexually assaulted or sexually abused patient. Washington, D.C: Author.

American College of Obstetricians and Gynecologists (1996). ACOG practice patterns, emergency oral contraception. (No. 3): Washington, D.C: Author.

American Psychological Association (1994). Publication manual (4th ed.) Washington D.C.: Author

Centers for Disease Control and Prevention. 1998 Guidelines for treatment of sexually transmitted diseases MMWR 1998; 47 (No.RR-1): [pp. 55-64]. Washington, D.C: U.S. Government Printing Office.

Colorado Coalition Against Sexual Assault (1992). Colorado sexual assault forensic examination protocol. Denver, Colorado: Author.

Colorado District Attorney's Council (1999). Colorado revised statutes pertaining to criminal law. Denver, Colorado: Author.

Colorado Division of Criminal Justice (2000). State of Colorado crime victim compensation program [On-line].Available:http://cdpsweb.state.co.us/ovp/comp.htm

Colorado Sexual Assault Prevention & Colorado Coalition Against Sexual Assault (1999). Sexual assault in Colorado: Results of a 1998 statewide survey. Denver, Colorado: Author.

Crowley, S. (1999). Sexual assault: The medical-legal examination (pp.23-30, 117-121). Stamford, CT: Appleton & Lange.

Elliott, A., & Peterson, L. (1993). Maternal sexual abuse of male children. Postgraduate Medicine, 94 (1), 169-180.

Girardin, B., Faugno, D., Seneski, P., Slaughter, L., & Whelan, M. (1997). Color atlas of sexual assault. (p.90). St. Louis: Mosby.

Feldhaus, K. (1999). Female and male sexual assault. In J. Tintinalli (Ed.), Emergency medicine: A comprehensive study guide (pp. 1952-1956). New York: McGraw-Hill.

Kilpatrick, D., Edmunds, C., & Seymour, A.. (1992). Rape in America. A report to the nation. Arlington, VA: National Victim Center and Charleston, S.C.: Crime Victims Research and Treatment Center.

LeBeau, M., Andollo,W., Hearn, W.L., Baeslt, R., Cone, E., Finkle, B., Fraser, D., Jenkins, A., Mayer, J., Negrusz, A., Poklis, A., Walls, H.C., Raymon, L., Robertson, M., & Saady, J. (1999). Recommendations for toxicological investigations of drug-facilitated sexual assaults. Journal of Forensic Science, 44 (1), 227-230.

Levitt, C. (1992). The medical interview. In A. Heger & S. J. Emans (Eds.), Evaluation of the sexually abused child: A medical textbook and photographic atlas (pp. 31-38). New York: Oxford Press.

Stewart, D. (1992). Sexually transmitted diseases. In A. Heger & S. J. Emans (Eds.), Evaluation of the sexually abused child: A medical textbook and photographic atlas (pp. 145-169). New York: Oxford Press.

The Office of the State of Texas Attorney General. (1998). Texas evidence collection protocol (2nd ed.). Austin: Author.

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