SEXUAL ASSAULT:

A HOSPITAL/COMMUNITY PROTOCOL FOR FORENSIC AND MEDICAL EXAMINATION

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Contents

Introduction

Rape is a universal crime affecting all people, regardless of age, race or economic status. Women and children are most often the victims of rape. Rape is a sexual attack on a person against the person's will through threat or the use of force. Even though rape involves the use and violation of sexual organs, it is not a crime of sexual passion; rather, it is a crime arising from hate, hostility, power and violence.

Because of the mental and physical trauma a rape victim experiences, a variety of medical, legal and psychological help is needed by the victim. The manual is designed to assist physicians, nurses, social workers and other health care professionals in providing help to the victims of sexual assault. It was developed through the cooperative efforts of health care professionals, law enforcement personnel and others who are working to prevent the crime of rape and to improve services for all victims of sexual assault.

ADULT PROTOCOL

Sensitivity to Victims' Needs

Some sexual assault victims suffer severe physical injuries, contract a sexually transmitted or other communicable disease, or become pregnant as a result of the attack; many others do not. In each situation, however, victims will experience varying degrees of psychological trauma, although the effects of this trauma may be more difficult to recognize than physical trauma. An individual's perceptions of how sexual assault victims should look, dress or act and the way those perceptions are conveyed can have a major effect upon the victim's recovery process in the weeks and months following the crime. Each person has his or her own method of coping with sudden stress. When severely traumatized, victims can appear to be calm, indifferent, submissive, jocular, angry, or even uncooperative and hostile toward those who are trying to help. All of these responses are within the normal range of anticipated reactions. An inappropriate response to information concerning the circumstances surrounding the assault or a misinterpretation of a victim's reaction to the assault may lead to further traumatization and hinder the interview or evidence-gathering process.

For some victims the problems of poverty and discrimination already have resulted in a high incidence of victimization, as well as inadequate access to quality hospital treatment. There may be a mistrust of medical and law enforcement personnel who play a vital role in the aftermath of sexual assault, particularly if there has been a history of unpleasant or disappointing experiences with these professionals.

It is recommended, therefore, that hospitals serving specific populations seek the assistance of reliable community consultants to help develop procedures and counseling resources which will reflect the special needs of those populations.

For example, in certain cultures the loss of virginity is an issue of paramount importance which may render the victim unacceptable for an honorable marriage; in other cultures the loss of virginity may not be as great an issue as that of the assault itself. Also, religious doctrines may prohibit a female from being disrobed in the presence of a male who is not her husband, or forbid a genital examination by a male physician. Such practices are considered a further violation. In such instances, a female physician should be made available for patients who request them.

Age is an important factor to consider when responding to any victim of a sexual assault and when determining the proper method of administering an interview, conducting a medical examination, and providing psychological support.

The Elderly Victim

As with most other victims, the elderly victim experiences extreme humiliation, shock, disbelief and denial. However, the full emotional impact of the assault may not be felt until after initial contact with physicians, police, legal, and advocacy groups, or later, when the victim is alone. It is at this time that older victims must deal with having been violated and

possibly diseased and become aware of their physical vulnerability, reduced resilience and mortality. Fear, anger or depression can be especially severe in older victims, who many times are isolated, have no confidant and live on meager incomes.

In general, the elderly are physically more fragile than the young, and injuries from an assault are more likely to be life threatening. In addition to possible pelvic injury and sexually transmitted diseases, the older victim may be more at risk for other tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities. The recovery process for elderly victims also tends to be far more lengthy than for younger victims.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often render the elderly patient unable to make his or her needs known, which may result in prolonged or inappropriate treatment. It also is not unusual for responders to mistake this confusion and distress for senility.

Medical and social follow-up services must be made easily accessible to older victims, or they may not be willing or able to seek or receive assistance. Without encouragement and assistance in locating services, many older victims may be reluctant to proceed with the prosecution of their offenders.

The Disabled Victim

Criminal and sexual acts committed against the disabled (physically, mentally or communicatively) generally are unreported and seldom are successfully prosecuted. Offenders often are family members, caretakers, or friends who repeat their abuse because their victims are not able to report the crimes against them.

The difficulty of providing adequate responses to the sexual assault victim are compounded when the victim is disabled. Some have limited mobility, cognitive defects which impair perceptual abilities, impaired and/or reduced mental capacity to comprehend questions or limited language/communication skills to tell what happened. They may be confused or frightened, unsure of what has occurred, or they may not even understand that they have been exploited and are victims of a crime.

Disabled victims and their families should be given the highest priority. Additional time should be allotted for evaluation, medical examination and the collection of evidence. The physically disabled victim may be more vulnerable to a brutalizing assault and need special assistance to assume the positions necessary for a complete examination and collection of evidence. Improvisation from normal protocol may be indicated in some instances.

In sexual assault cases involving the communicatively disabled victim, the use of anatomically-correct dolls has proved to be a successful method of communication. Furthermore, under Section 504 of the Federal Rehabilitation Act of 1973, any agency (including hospitals and police departments) that directly receives federal assistance or indirectly 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, which must be provided at no cost to the patient, also includes an

arrangement to provide interpreters who can accurately and fluently communicate information in sign language.

Finally, referrals to specialized support services and reports to law enforcement agencies are particularly necessary for the developmentally and physically disabled who may need protection, physical assistance, and transportation for follow-up treatment and counseling.

The Male Victim

It is believed that the number of adult male victims of sexual assault who report the crime or seek medical care or counseling represents only a very small percentage of those actually victimized. Although many adult males do not seek medical care unless they also have been seriously injured, male child victims are now being seen at hospitals in increasing numbers, in large measure as a direct result of public education and more stringent child abuse reporting laws throughout the nation.

There has been significant progress in educating the public toward understanding the concept of sexual assault of both sexes as being an act of violence; however, there still remains a great reluctance on the part of most male victims to report a sexual assault. Present societal and cultural values can make the trauma of the reporting experience by the male victim at least equal to that of the female victim.

The male victim may have serious problems concerning his inability to resist the assault or confusion about the nature of his role as victim/participant because of a possible involuntary physiological response to the assault, such as stimulation to ejaculation. It is just as important for males as it is for females to be reassured that they were victims of a violent crime which was not their fault, and that other sexually assaulted males survive to function normally in every way.

Referral to available therapists or advocacy groups with expertise in the area of sexual assault of males are vital to assist in the recovery process.

Initial Law Enforcement Response

Many adult victims of sexual assault will have their first contact following the assault with a law enforcement officer.

The primary responsibilities of this officer are to ensure the immediate safety and security of the victim, to obtain some basic information about the assault in order to apprehend the assailant, and to transport the victim to a designated facility for examination and treatment.

The responding officer should convey the following information to the sexual assault victim:

1. The importance of seeking an immediate medical examination since injuries can go unnoticed or appear at a later time.

2. The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the victim that such evidence can inadvertently be destroyed by activities such as washing/showering, brushing teeth/using a mouthwash, and douching.

3. The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault as well as on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought along to the hospital in the event clothing is collected for evidentiary purposes.

Although intimate details of the sexual assault itself are not needed at this point in the investigation, a preliminary interview with the victim is necessary so that the responding officer can relay information that may be vital to the apprehension of the assailant. The preliminary interview should include the following:

1. The extent of injuries, if any, to the victim
2. A brief description of what happened
3. Where the assault took place
4. The identity or description of the assailant(s), if known
5. Where the assailant(s) lives and/or works, if known
6. The direction in which the assailant(s) left and by what means
7. Whether or not a weapon was involved

At the treatment facility the responding officer should provide the hospital staff with any available information about the assault which may assist in the examination and evidence collection procedures.

TREATMENT PLAN

Facility

It is advantageous for all victims of sexual assault to seek both medical treatment and evidence collection from a hospital facility. Physicians who work primarily in private office-based facilities usually do not have evidence collection kits on hand and may not be as familiar as hospital-based physicians with the specific medical and evidence collection procedures relevant to sexual assault victims. Additionally, many private medical offices are not open on a 24-hour basis and may not have equipment available to make the necessary cultures.

Adults should be treated in an emergency room. Children should be treated in a hospital pediatrics unit, if available, because staff in these units are specially trained to treat them. NOTE: At this time, Arkansas Children's Hospital will not treat a child who has begun menstruation.

The victim should be told that a police report must be filled out before the Office of the Prosecutor Coordinator may reimburse the treating facility.

Arkansas Law

Any publicly owned or tax supported medical facility in Arkansas shall adhere to the provisions in Arkansas Code Annotated §§ 12-12-402 and 20-9-303 when a person presents for treatment as a victim of rape, attempted rape, or any other type of sexual assault or incest. The provisions dictate that medical-legal examinations shall be performed.

Adult Victims. Any adult victim presenting for medical treatment shall make the decision of whether or not the incident will be reported to a law enforcement agency. The adult victim shall not be required to report the incident in order to receive treatment. Evidence will be collected only with permission of the victim. However, permission shall not be required in instances where the victim is unconscious, mentally incapable of consent, or intoxicated. Should the victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility.

Minor Victims. The reporting medical facility should follow the procedures set forth in A.C.A. § 12-12-507 regarding the reporting of injuries to victims under eighteen (18) years of age. A medical-legal examination shall be performed and specimens shall be collected for evidence. The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

In all cases the victim shall be treated as a regular emergency room patient and any injuries requiring medical attention will be treated in the standard manner.

Reimbursement for the medical-legal examinations shall be available to the medical facilities through the Office of the Prosecutor Coordinator as provided in A.C.A. § 12-12-404.

For complete copies of the laws cited above refer to Arkansas Law in the Appendix.

Hospitals designated to provide sexual assault treatment should have a 24-hour emergency room facility with a staff trained in sexual assault examinations. The ideal situation would also include the on-call availability of a specially trained obstetrician and/or gynecologist for consultation, the services of a local sexual assault victim advocate, and contingency plans for cases requiring photographs and bite-mark impressions.

Transfer

In the rare instance when a victim of sexual assault arrives at a hospital that is not equipped to provide a sexual assault examination, arrangements should be made to transfer the victim to the nearest designated treatment facility. However, if there are acute medical or psychological injuries which must be treated immediately, this should be done at the initial receiving facility. A copy of all records, including any X-rays, should be transported with the victim to the designated treatment hospital.

The Consolidated Omnibus Reconciliation Act of 1985 requires that a "medical screening examination" be provided to all patients who present to a hospital emergency department. It also sets forth a number of conditions that must be met before patients may be transferred to a different facility. Every patient must be examined to determine whether he or she is suffering from an emergency medical condition or is in active labor. All persons who present to an emergency department must be treated alike: the law makes no distinction between Medicare and non-Medicare recipients (see Appendix).

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community, and the list of designated hospitals should then be provided to all local law enforcement agencies and victim advocacy organizations. This action will greatly reduce the amount of confusion and additional trauma incurred by those victims who are initially taken or referred to a non-treatment facility, as well as reduce the loss of valuable evidence.

Intake

The treatment of victims of sexual assault should be considered a medical emergency. Although many victims may not have visible signs of physical injury, they will, at the very least, be suffering from emotional trauma. A private location within the hospital should be utilized, if at all possible, for the preliminary consultation with the victim. This could be a room adjacent to the emergency department or a private office located nearby. In order to prevent others from hearing the conversation, it is recommended that this same type of facility be provided for the follow-up law enforcement interview at the conclusion of the examination.

Over the past several years, many hospitals have developed code plans, such as 'Code R' or 'SA' which they use when referring to sexual assault cases. This eliminates the needless embarrassment to victims and/or their families of being identified in the public emergency or examining room setting as the 'rape' or 'sexual assault' victim.

Other methods can be devised to avoid inappropriate references to sexual assault cases, and hospitals are encouraged to develop their own code plans to ensure privacy.

While the victim is being treated at the hospital, the responding officer should wait in the prescribed waiting area. In some jurisdictions, police protocols call for the officer who accompanies the victim to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is complete before making arrangements to conduct the more in-depth interview with the victim.

Reporting

Adults. The adult victim may make the decision as to reporting the incident to law enforcement. Should the adult victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility. (See A.C.A. §§ 12-12-402 and 20-9-303 in the Appendix.)

Minors. Mandatory Reporting. (See A.C.A. § 12-12-504 in the Appendix.) When any physician, surgeon, coroner, dentist, osteopath, resident intern, registered nurse, hospital personnel who may be engaged in admission, examination, care, or treatment of persons, teacher, school official, social service worker, day care center worker or any other child or foster care worker, mental health professional, peace officer, or law enforcement official has reasonable cause to suspect that a child has been subjected to abuse, sexual abuse, or neglect or observes the child being subjected to conditions or circumstances which would reasonably result in abuse, he shall immediately report or cause a report to be made to the Department of Human Services. Whenever that person is required to report under this subchapter in his capacity as a member of the staff of a medical or public or private institution, school, facility, or other agency or his designated agent, who shall then become responsible for making a report or cause a report to be made.

Contents And Other Requirements. (See A.C.A. § 12-12-507 in the Appendix.) Reports of child abuse, sexual abuse, and neglect made pursuant to § 12-12-507 shall be made immediately by telephone and shall be followed by a written report within forty-eight (48) hours if so requested by the Department of Human Services. The Department of Human Services shall immediately prepare and forward a written report to the statewide central registry on forms supplied by the registry within twenty-four (24) hours after the initial report except weekends and holidays. The investigation of each report of suspected abuse or neglect shall begin with seventy-two (72) hours or within twenty-four (24) hours after the initial report of child abuse, sexual abuse, or neglect required by this section which involves sexual abuse, or serious physical abuse involving death, bone fractures, internal injuries, head injuries, burns, immersions or suffocations, severe bruises, or abandonment, the Department of Human Services shall notify and initiate an investigation in cooperation with law enforcement agencies and the prosecuting attorney.

Support Personnel

The importance of having a support person available to sexual assault victims cannot be overemphasized. Whenever possible, one person should be assigned to stay with the victim throughout the entire emergency department visit.

Well-trained support persons can provide the crisis intervention necessary when victims first enter the hospital for treatment, assist hospital emergency room staff in explaining the necessity of medical and evidence collection procedures, and counsel family members or friends of the victim who may be at the hospital. A support person also can help provide counseling referrals and other information such as the existence and availability of victim compensation programs or other types of assistance, emphasize the importance of follow-up testing for possible venereal disease or other medical problems, and answer additional questions victims may have following their medical and evidence collection examination.

Some hospitals are fortunate enough to have in-house staff who are specially trained to treat victim trauma and provide crisis intervention for sexual assault victims and their families. Many of these staff members also are qualified to provide follow-up counseling to victims on a short- or long-term basis.

Increasing numbers of hospitals have entered into working agreements with victim advocate organizations. These organizations may provide immediate crisis intervention to victims who have arrived at the hospital seeking treatment, as well as follow-up counseling and referrals. In some instances, they also are able to provide support for the victim throughout the entire criminal justice process.

Victim/Patient Consent

Obtaining a patient's written consent prior to conducting a medical examination or administering treatment is standard hospital practice. With the advent of evidence collection requirements and crisis intervention services, sexual assault victims are expected to make a decision about consent to these procedures as well.

Informed consent should be a continuing process that involves more than obtaining a signature on a form. When under stress, many victims 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 victim/patient can understand what the attending physician and nurse are doing and why.

Although much of the examination and evidence collection process can be explained by the hospital support person or victim advocate, this function is ultimately the responsibility of hospital personnel.

When written consent is obtained, it should not be interpreted as a 'blank check' for performing tests or pursuing questions. If a patient expresses resistance or non-cooperation, the physician should immediately discontinue that portion of the process and consider going back to it at a later time in the examination if the patient then agrees. In either event, the patient should have the right to refuse one or more tests or to refuse to answer any question. Having a sense of control is an important part of the healing process for victims, especially in the early stages of examination and initial interviewing.

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

REIMBURSABLE ITEMS AND SERVICES

The Office of the Prosecutor Coordinator, a state agency, is responsible for reimbursing medical facilities for the costs incurred in conducting the sexual assault examinations. Assistance is requested in keeping all charges to a minimum and within customary charging practices. Reimbursement funds are limited and must be utilized statewide. The state will reimburse the following:

1. Physician's Fee

    a. History
    b. Physical examination
    c. Conducting the sexual assault examination

2. Emergency Room

    a. Room charge
    b. Pelvic tray

3. Medical Facility Laboratory

    a. Gonorrhea culture
    b. Blood test for VDRL
    c. Pregnancy testing (blood test or urinalysis)
    d. Wet prep for motile sperm
    e. Fixed smear for sperm

NON-REIMBURSABLE ITEMS AND SERVICES

The following are *non-reimbursable* items and services by the Office of the Prosecutor Coordinator:

1. Sex crime (rape) kits. *FREE*. Sexual assault evidence collection kits are available from the Arkansas State Crime Laboratory free of charge. (To obtain kits, call 227-5747.)

2. Treatment provided for:

   a. A pre-existing injury
   b. Physical injury directly resulting from the assault
   c. Any other condition not related to the assault

3. Follow-up examination visits

4. Sedatives, anti-depressants or tranquilizers

5. Social work services

6. Tetanus vaccine shots

7. Charges in excess of customary rates

8. Charges for persons falsely claiming to be victims. (The prosecuting attorney's office will assist in the collection of bills for individuals making fraudulent claims.)

9. Duplicitous charges

The Crime Victims Reparations Board, located at the Attorney General's Office, may reimburse medical facilities or victims for items which the Prosecutor Coordinator's Office cannot pay. This includes treatment for injuries incurred as a result of the assault, counseling, tranquilizers, etc. See Appendix.

REIMBURSEMENT PROCEDURES

Medical facilities must meet certain requirements to receive reimbursment from the Prosecutor Coordinator's Office for the sexual assault examination.

1. The adult victim must receive medical treatment within forty-eight (48) hours of the attack. For minors there is no time limitation if the examination is required in the opinion of the examining physician. (*NOTE*: The Crime Victims Reparations Board may pay for an examination that is performed after 48 hours from the time of the attack.)

2. Law enforcement personnel must be notified of the assault prior to or at the same time the examination is conducted.

3. A copy of the Sexual Assault Reimbursement Form must be completed, with copies of itemized bills attached. If the medical facility does not have a reimbursement form available, a letter from the medical facility may be used if it contains the following information:

   a. Name, address and phone number of medical facility
   b. Contact person at the medical facility
   c. Victim's name and address
   d. Date and time of the assault
   e. Date and time treatment was sought
   f. Which law enforcement agency was notified
   g. Copy of the itemized bills (attached to the letter)

4. The medical facility must send the reimbursement form (or letter), with the attached itemized bills, to the prosecuting attorney's office in the county where the assault occured.

The prosecuting attorney's office will verify the claim and forward the form or letter to the Office of the Prosecutor Coordinator in Little Rock, Arkansas, where it will be reviewed. Processing of payments for reimbursable items and services should take approximately six weeks to two months.

The Office of the Prosecutor Coordinator does not supply multiple copies of the reimbursement form. The medical facility may make copies of the form provided in the Appendix, or they may call the Prosecutor Coordinator's Office at 682-3671.

THE EVIDENTIARY AND MEDICAL EXAMINATION

A physical examination should be performed in all cases of sexual assault, *regardless of the length of time which may have elapsed between the time of the assault and the examination.*

Some victims may ignore symptoms which would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness which will later develop into bruises but which are not apparent at the time of initial examination.

If the assault occurred *within the 72 hours prior to the examination,* a medical/legal examination utilizing an evidence collection kit should be performed.

If it is determined that the assault took place *more than 72 hours prior to the examination,* the use of an evidence collection kit is generally not necessary. It is unlikely that trace evidence would still be present on the victim. However, evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises or lacerations), photographs and bite-mark impressions (if appropriate), and statements about the assault made by the victim.

When a forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times. This coordination of medical and forensic procedures is crucial to the successful examination of sexual assault patients.

For example, in order to minimize patient trauma, blood drawn for medical purposes (testing for syphilis) should be done at the same time as blood drawn for evidence collection purposes. Also, when evidence specimens are collected from oral, vaginal, or rectal orifices, cultures for sexually transmitted disease should be taken immediately following these collection procedures.

Attending Personnel

The only people who should be with the adult victim in the examining room are the examining physician, attending nurse and, with the consent of the victim, a trained support person. Although every effort should be made to limit the number of people in attendance during the examination, there may be instances when a victim requests the presence of a close friend or family member. If at all possible, these requests should be honored. *There is no medical or legal reason for a law enforcement representative, male or female, to observe these procedures.*

Evidence Collection (Rape) Kits

The Arkansas State Crime Laboratory will provide sexual assault evidence collection kits to medical facilities free of charge. To obtain kits, the medical facility must send a written request on medical facility letterhead to: Arkansas State Crime Laboratory, Forensic Serology Section, P.O. Box 5274, Little Rock, AR 72215. Should any questions arise during the utilization of the kit, contact the Crime Laboratory at 227-5747, Ext. 232.

Evidence Collection Documentation

NOTE: Many of the evidence collection issues apply equally to adult and child victims of sexual assault/abuse and are discussed in the following sections. However, particular issues, including the interviewing and medical examination needs of children, can be found beginning on page 34.

Packaging

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 any unstable biological fluid evidence. Unlike plastic, paper 'breathes' and allows moisture to escape.

Chain of Custody

The purpose of establishing a chain of custody is to guarantee that the items admitted into evidence at trial are authentic, i.e., that they are the same items and in substantially the same condition as those taken from the victim in question.

The custody of any evidence collection kit and the specimens it contains must be accounted for from the moment of collection until the moment it is introduced in court as evidence. Therefore, anyone who handles evidence items should label them with their initials, the date, and the source of the specimen.

Evidentiary Value of Semen and Spermatozoa

Semen is composed of cells and fluid known as spermatozoa and seminal plasma. Historically, medical and law enforcement personnel have placed significant emphasis on the presence of spermatozoa in or on the body or clothing of a sexual assault victim as the most positive indicator of sexual assault. Conversely, when no spermatozoa were found, a shadow of doubt was sometimes cast upon the victim's allegation of sexual assault, contributing to the misconception that the absence of spermatozoa meant that no sexual assault occurred.

The finding of spermatozoa is useful for two reasons:

1. It is positive indication that ejaculation occurred and that semen is present.

2. When spermatozoa are motile, it can be an indicator of the length of time since ejaculation. Although the survival of time of spermatozoa in the vaginal, oral, and rectal orifices following ejaculation varies considerably in scientific studies, there is fairly wide consensus that they may remain for up to 72 hours or longer in the vagina (persisting longer in the cervical mucosa), and up to several hours or more in the rectal cavity, particularly if the victim has not defecated since the assault.

Seminal plasma is also useful for two purposes:

1. In the absence of spermatozoa, seminal plasma components (P30 and acid phosphatase) can be used to identify semen. P30 is a prostatic antigen known to exist in the semen of humans, and its presence is regarded as a conclusive indication of semen. Acid phosphatase is present in high levels in seminal samples but is considered only a presumptive test for the presence of semen because it also appears in samples that are not seminal in origin.

2. Most of the genetic markers detected in semen, which are used to identify the possible donor, are located in seminal plasma. However, DNA material is located *on* the sperm cells.

In the past few years there has been a dramatic increase in the number of vasectomies. In as much as seminal plasma is produced in the ejaculates of all males, vasectomized or not, the forensic examiner is especially interested in the presence of seminal plasma. It is primarily the seminal plasma, not the spermatozoa, that gives evidence of the ABO blood type of secretors and the genetic markers of the donor of the specimen.

NOTE: The ABO blood group is the most commonly known of all blood groups to the general population and divides the population into four types: A, B, O and AB. Although ABO factors are found in everyone's blood, approximately 75-80% of the population also demonstrate ABO factors in their other body fluids such as semen, saliva, and vaginal secretions. Such persons are called ABO secretors. The remaining 20-25% are called non-secretors because they lack ABO factors in their other body fluids.

Many sexual assault offenders are sexually dysfunctional and do not ejaculate during the assault. Additionally, offenders may use a prophylactic, have a low sperm count (frequent with heavy drug or alcohol use), ejaculate somewhere other than in an orifice or on the victim's clothes or body, or fail to ejaculate if the assault is interrupted. *Therefore, a lack of spermatozoa is not conclusive evidence that an assault did not occur; it only means that spermatozoa may have been destroyed after being deposited or that they may never have been present.*

Furthermore, the absence of semen means only that no ejaculation occurred, for the reasons described above, or that various other factors contributed to the absence of detectable amounts of semen in the specimen. For example, there could have been a significant time delay between the assault and the collection of specimens, penetration of the victim could have been made by an object other than the penis, the victim could have inadvertently cleaned or washed away the semen, or the specimens could have been collected improperly.

Therefore, although the finding of semen, with or without the presence of spermatozoa, may corroborate the fact that sexual contact did take place and make a stronger case for the prosecution, its presence is not a necessity for the successful prosecution of a sexual assault case.

Analysis of Specimens

Crime laboratories generally have sophisticated equipment, specialized training and ultra-sensitive techniques which enable them to detect even minute traces of semen and spermatozoa. They are able to conduct a genetic marker analysis of semen. It is not uncommon for crime laboratories to detect traces of semen despite reports from the hospital of negative test results for spermatozoa and seminal acid phosphatase. The forensic analyst will then explain in court the apparent contradiction with the hospital laboratory findings. Therefore, hospitals do not have to conduct a wet mount for the presence of spermatozoa.

Sexual Assault Forensic Laboratory Report Form

Many hospitals have been encouraged to include a copy of the patient's medical report form with any evidence that was collected to provide information needed by the forensic examiner to assist in the analysis of specimens submitted.

Certain written information needs to be included with evidence submitted to the criminalistics laboratory. However, hospital medical report forms by nature contain some confidential information which is not relevant for forensic purposes, such as:

1. Information concerning gynecological history, e.g., miscarriages, abortions, past or current pregnancy, hysterectomy and tubal ligation.

2. Information on the patient's emotional status, drug allergies, or past medical problems, e.g., cancer.

The following information should be included on the form:

1. *Date and Time of Collection/Date and Time of Assault*

It is essential to know the period of time which has elapsed between the assault and the collection of evidence. The presence or absence of semen may correspond with the interval since the assault.

2. *Sex and Number of Offenders*

Forensic serologists seek evidence of cross-transfer of trace materials among the victim, assailant(s) and scene of the crime. These trace materials include foreign hairs and the deposit of body fluids from the assailant(s) on the victim. The gender of the assailant may determine the type of foreign body fluids which might be found on the victim's body and clothing. Therefore, the serologist should be informed whether to search for foreign semen or vaginal fluid and to focus the analysis on the relevant stains.

3. *Actions of Victim Since Assault*

The quality of evidence is critically affected both physically and chemically by actions taken by the victim and by the passage of time. For example, the length of time which

elapses between the assault and the collection of evidence, as well as self-cleansing efforts of the victim, can affect the rate of drainage of semen from the vagina or rectum. Trace evidence such as foreign hairs, fibers, plant material or other microscopic debris deposited on the victim by the assailant or transferred to the victim at the crime scene also can be lost.

It is important for the analyst to know what, if any, activities were performed prior to the examination, including bathing, urination, brushing teeth, and changing of clothes, any of which could help explain the absence of secretions or other foreign materials. For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina. Failure to explain the circumstances under which semen could have been destroyed might jeopardize criminal prosecution if apparent contradictions cannot be accounted for in court.

4. *Contraceptive/Menstruation Information*

Certain contraceptive preparations can interfere with accurate interpretation of the preliminary chemical test frequently used by crime laboratories in the analysis of potential seminal stains. In addition, contraception foams or creams can destroy spermatozoa. Lubricants of any kind, including oil or grease, are trace evidence and may be compared with potential sources left at the crime scene or recovered from the body of the assailant. Knowing whether or not a condom was used also may be helpful in explaining the absence of semen.

Tampons and sanitary napkins can absorb all of the assailant's semen, as well as any menstrual blood present. Additionally, the presence of blood on the vaginal swab could either be from trauma or as a result of menstruation.

5. *History of Assault*

An accurate but brief description of the assault is crucial to the proper collection, detection and analysis of physical evidence. This includes the discovery of oral, rectal and vaginal penetration of the victim, oral contact by the offender, ejaculation (if known by the victim) and penetration digitally or with foreign object(s). Analytical findings of the crime laboratory which corroborate the victim's account may support the victim's testimony in court.

6. *Physical Examination Details*

In the search for cross-transfer of trace evidence it is essential to know the location and extent of the injuries sustained by the victim. For instance, blood from the victim's injuries could be found on the body or clothing of the assailant or at the crime scene; or if the victim did not bleed at all, the blood located on his/her clothing could be from the assailant.

Sometimes saliva and semen stains are more easily visualized under ultraviolet light. The use of a hand held UV lamp (Woods Lamp) will assist in locating the presence of such stains on the body of the victim during the medical examination.

If the victim was bitten, there is a possibility that saliva was deposited on the victim's body or clothing. However, in order to effectively search the clothing for saliva stains, the crime laboratory must know precisely where the bite occurred.

Clothing Evidence

Often clothing contains important evidence in a case of sexual assault. The reasons for this are twofold:

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. While foreign matter can be washed off or work off the body of the victim, the same substances often can be found intact on clothing for a considerable length of time following the assault.

2. 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 victim with trace evidence collected from the suspect and/or the crime scene.

Prior to the full examination, the attending physician or nurse must determine if the patient is wearing the same clothing he or she wore during or immediately following the assault. If so, great care should be taken to see that the clothing is examined for any apparent foreign material, stains or damage. When the determination has been made that items may contain possible evidence related to the assault, with patient consent, those items should be collected.

If it is determined that the patient is not wearing the same clothing, the attending physician or nurse should inquire as to the location of the original clothing, such as at the victim's home or at the laundry for cleaning. This information should then be given to the investigating officer so that he/she can make arrangements to retrieve the clothing before any potential evidence is destroyed.

The most common items of clothing collected from victims and submitted to crime laboratories for analysis are underwear, hosiery, blouses, shirts, slacks, and even infant diapers. There also are instances when coats and even shoes must be collected.

In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. For example, if semen in the female victim's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear contradictory to the victim's own testimony in court of exactly what events occurred in the assault. *Therefore, each garment should be placed separately in its own paper bag to prevent cross-contamination from occurring.*

Collection Procedures

To minimize loss of evidence, the patient should disrobe over a white cloth or sheet of paper. If patients cannot undress on their own, or due to their condition it is necessary to cut off items of clothing, be sure *not to cut through* existing rips, tears, or stains.

Any foreign materials found should be collected and put into a small paper envelope, properly labeled, and sealed with cellophane tape. If the patient consents, the clothing should then be collected and packaged in accordance with the following procedures:

After air drying the underpants, place in them in the paper bag marked 'UNDERWEAR' provided in the sexual assault evidence collection kit. Other clothing items should be placed in separate *paper bags* obtained from hospital stock. Label all bags with the patient's name, the date and the collector's name.

Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain so that the stains are not in contact with the bag or other parts of the clothing.

If after air drying as much as possible moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed clothing bags should be placed inside a larger plastic bag *with the top of the plastic bag left open.* In these instances, a label should be affixed to the outside of the plastic bag, *which will alert the crime laboratory that wet evidence is present inside the plastic bag.* This will enable the laboratory to remove the clothing and avoid loss of evidence due to putrefaction.

Swabs and Smears

The purpose of making smears is to allow the forensic analyst to microscopically test for the presence of spermatozoa. If no spermatozoa are present, the analyst will then proceed to use the swabs to identify the seminal plasma components to confirm the presence of semen.

Depending on the type of sexual assault, semen may be detected in the mouth, vagina, and rectum. However, embarrassment, trauma, or lack of understanding the nature of the assault may cause a victim to be vague or mistaken about the type of sexual contact which actually occurred. For these reasons, and for the reason that there can be leakage of semen from the vagina or penis onto the anus even without rectal penetration, it is recommended that the patient be encouraged to allow examination of all three orifices and specimens collected from them.

In cases where a victim insists that contact or penetration involved only one or two orifices (or, in some cases, no orifices at all), it is important for the victim to be able to refuse these additional tests.

This 'right of refusal' also will serve to reinforce a primary therapeutic principle—that of returning control to the victim.

When taking swabs, the examiner should take special care not to contaminate the individual collections with secretions or matter from other areas, such as vaginal to rectal, or penile to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

If victims must use bathroom facilities prior to the collection of these specimens, they should be cautioned that semen or other evidence may be present in their pubic, genital and rectal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.

A pencil should be used when labeling frosted-end slides to lessen the chance that the labeling information will become smudged.

Oral Collection Procedures

The oral swab can be as important as the vaginal or rectal swabs by recovering seminal fluid from recesses in the oral cavity where traces of semen could survive. *This procedure should be performed first so that the patient can rinse out his or her mouth as soon as possible. Such a practice will reduce a significant source of unnecessary patient distress.*

Use *two cotton swabs together* and swab the mouth. Attention should be paid to those areas of the mouth where seminal material might remain for the longest amount of time, such as between the upper/lower lip and gum.

When the oral swabs have air dried, they should be inserted in the paper envelope marked 'ORAL SWABS'. The envelope should be sealed and the label completed.

Vaginal Collection Procedures

When collecting the vaginal specimens, *it is important not to aspirate the vaginal vault or to dilute the secretions in any way.*

For purposes of DNA analysis, use *two cotton swabs together* and swab the vaginal vault. Using two additional swabs, repeat the swabbing procedure. For the additional swabs, prepare one smear on glass slide provided. The material from the swabs should be gently rubbed onto a glass slide which has been labeled in pencil and contains the word 'vaginal' to indicate the source of specimen. After the glass slide has been placed back into the mailer, it should be air dried before sealing. *The slide should not be fixed or stained.* After the label has been filled out, the mailer should then be sealed all around with tape.

After cotton swabs have air dried, they should be returned to their individual original paper sleeves. The sleeve of the first two swabs collected should be marked 'DNA'. Then all swabs and the smear should be returned to the paper envelope marked 'VAGINAL SWABS AND SMEAR'.

Immediately following this procedure, the pelvic examination should be performed and medical cultures taken for pregnancy and sexually transmitted diseases.

Penile Collection Procedures

For the male victim (both adult and child) the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice; and feces or lubricants might be found if rectal penetration occurred.

The proper method of collecting a penile smear is to *very slightly* moisten two cotton swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. All outer areas of the penis and scrotum where contact is suspected should be swabbed.

These swabs are not, however, for use in the medical diagnosis of a sexually transmitted disease; *consequently, they should not be used to swab inside the penile opening at this time.*

The swabs should be gently rolled over one of the glass slides which is then placed in a mailer. *Again, the examiner should not fix or stain the slide.* When labeling and sealing the slide mailer, the instructions given for the vaginal smears should be followed.

When the penile swabs are air dried, they should be placed in the envelope marked 'VAGINAL SWABS AND SMEAR'. Mark through 'VAGINAL' and write in 'PENILE'.

It is at this time that swabs should be made for detection of possible sexually transmitted disease.

Rectal Collection Procedures

Use two cotton swabs at the same time and swab the rectum. To minimize discomfort for the patient, these swabs should be moistened *very slightly* with distilled water.

After the rectal swabs have air dried, they should be placed in the envelope marked 'RECTAL SWABS' and sealed and labeled in the same manner as the oral, vaginal and penile swabs.

At this time, any additional examinations or tests involving the rectum should be conducted.

Other Dried Fluids Collection Procedures

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

It is important that the medical team examine the victim's body for evidence of foreign matter.

If secretions, such as dried blood or seminal fluid, are observed on other parts of the patient's body during the examination, the material should be collected by taking a swab. A different swab should be used for every secretion collected from each location on the body.

Dried secretions are collected by moistening the swab *very slightly* with distilled water and swabbing the indicated area.

The swabs should be placed in separate envelopes from hospital stock. The examiner should be sure to indicate on the envelope the location on the patient's body from which the evidence was collected.

Bite-mark Evidence

Bite marks may be found on patients as a result of sexual assault and other violent crimes and should not be overlooked as important evidence. Bite-mark impressions can be compared with the teeth of a suspect and can sometimes become as important for identification purposes as fingerprint evidence. The collection of saliva and the taking of a photograph of the affected area are the minimum procedures which should be followed in cases where a bite mark is present.

Saliva, like semen, demonstrates blood group factors characteristic of their donor. Therefore, the collection of saliva from the bite mark should be made prior to the cleansing or dressing of any wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva.

It is important that photographs of bite marks be taken properly. It is recommended that a representative of the local law enforcement agency be contacted when the hospital protocol is developed to provide the proper instructions on how to take photographs of bite-mark evidence.

In many bite-mark cases it is also vital to have a three-dimensional cast made. Whenever possible, a dentist or a forensic odontologist should be called in to examine the bite mark, make the cast and further document findings. Hospitals should either contact their nearest crime laboratory for a listing of qualified forensic odontologists who can assist in this process, or the American Board of Forensic Odontology, Inc., which can furnish a list of their members.

Collection Procedures

Saliva is collected from the bite mark area by moistening a swab *very slightly* with distilled water and *gently swabbing* the affected area, following the same procedures as instructed for other dried fluids.

To demonstrate the size of the bite mark, a ruler should be placed adjacent to but not covering the bite mark and then photographed. The camera should be perpendicular to the bite mark.

Hair Evidence

Hairs occur in three growth stages: anagen (actively growing), catagen (resting stage), and telogen (ready to be shed). There are subtle morphological differences which can be detected by a trained microscopist as the growth stages progress.

During an assault, the hairs most likely to be transferred from suspect to victim or victim to suspect tend to be telogen. Other hairs transferred during an assault are pulled out by friction or other means of forcible removal. Most of these hairs tend to be anagen or catagen.

Pubic hairs should be collected by the combing method only; they should not be cut. Standards should be pulled at a later date only if a suspect is apprehended, the prosecution requests these samples, and the victim consents to the procedure.

A comb should be used to collect any loose hairs or fibers from the pubic area over a piece of paper or paper towel. Patients may prefer to do the combing themselves to reduce embarrassment and increase their sense of control. The pubic hair combings *and the comb* are placed in the envelope marked 'PUBIC HAIR COMBINGS'. After the labeling information is completed the envelope should be sealed with tape.

Where there is evidence of semen or other matted material on pubic or head hair, it may be collected in the same manner as other dried fluids. The swab should then be placed in a small paper envelope from hospital stock and labeled 'possible debris sample from head (pubic) hair'. Although this specimen also can be collected by cutting off the matted material, *it is important to obtain the patient's permission prior to cutting any significant amount of hair.*

Pulled Standards (Not Taken at Initial Exam)

If a suspect is apprehended and the prosecution requests that head and pubic hair standards be obtained from the victim for comparison purposes, the following procedures should be followed after obtaining the victim's consent:

A standard sample of *no less than 15 head hairs* should be collected, consisting of hairs pulled from each of the following areas: back, top, front, left side, right side. To minimize patient discomfort, the attending physician or nurse can pull the hairs, 2 or 3 at a time, using the thumb and forefinger. *Forceps should not be used.* The pulled head hairs should be placed in an envelope, then labeled and sealed with tape.

A standard sample of *no less than 15 pubic hairs* should be collected from various areas of the pubic region. The hairs should be pulled 2 or 3 at a time with thumb and forefinger. The absence of pubic hair should be noted. The patient may wish to perform this procedure themselves; however, the procedure must be witnessed by medical or law enforcement personnel.

Fingernail Scrapings

The purpose of collecting fingernail scrapings is to collect potentially useful evidence of cross-transfer. During the course of a physical crime, the victim will be in contact with the environment as well as with the assailant. Trace materials such as skin, blood, hairs, soil and fibers (from upholstering, carpeting, blankets, etc.) can occasionally collect under the fingernails of the victim.

Collection Procedures

Patients should be asked whether or not they scratched the assailant's face, body or clothing. If fibers or other materials are observed under the patient's fingernails, the *nails should be scraped, one hand at a time, using an orange stick.*

This is a function that patients may want to perform themselves, and they should be encouraged to do so. It is important that scrapings be made for each hand over a separate piece of paper. The paper should then be folded and placed in small, individual envelopes from hospital stock.

The examiner should complete the labeling information for each envelope, *making certain to differentiate between 'left' and 'right' hand on the labels*. The flaps should then be sealed with tape.

Whole Blood Specimen

In many cases of sexual assault, blood will be found on the offender, the offender's clothes and/or at the crime scene. Blood may also be found on the victim or the victim's clothing. The purpose of collecting whole blood is to determine the victim's blood group (inherited factors appearing in blood and certain body fluids, also known as genetic markers).

In view of the additional *medical requirement to collect blood* to test for sexually transmitted disease, only one *tube should be used for evidence collection purposes.*

Collection Procedures

For adults, 7 milliliters of blood should be collected in a lavender blood tube. Place the tube in the envelope marked 'KNOWN BLOOD SAMPLE', seal and label.

In order to minimize patient discomfort, *blood needed for the VDRL should also be collected at this time*. However, any additional blood or other specimens collected to determine possible sexually transmitted disease are to remain at the hospital for processing.

It is important that collected whole blood samples be refrigerated, but not frozen.

Saliva Specimens

In the ABO analysis of secretion mixtures such as semen and vaginal secretions, the ABO type of the victim must be identified in order to properly evaluate the blood type of the other contributor. A dried sample of known saliva and the known liquid blood sample are used to determine the ABO secretor status of the victim.

Collection Procedures

It is important that this specimen not be contaminated by outside elements. Therefore, the victim should not smoke or have anything to eat or drink for at least 30 minutes prior to this procedure.

The examiner should collect a saliva sample by using a *filter paper disc* which is already packaged in a small pre-sealed envelope. The patient should place the inner circle on the paper disc in his or her mouth, saturating it with saliva. Labeling information on the envelope is then to be completed.

Patients should be reminded not to chew the disc; moistening it for a few seconds usually is sufficient. Patients should also be instructed to remove the disc with their own fingers. *The disc must not be removed by anyone other than the patient unless a hemostat is used,* because the slightest contamination from another person's secretions may be detected by the forensic analyst.

When dry, the disc should be completely inserted back in the envelope and the envelope sealed with tape.

MEDICAL EXAMINATION DOCUMENTATION

Body Diagrams/Photographs

Photographs of sexual assault victims *should not be taken on a routine basis.* Instead, drawings of the human figure should be used to show the location and size of the injury, as well as a written description of the trauma. Drawings should consist of both adult and child figures and contain genitalia for males and females.

Photographs of extremely brutal injuries and of bite marks can prove quite beneficial in court; however, many times injuries such as bruises will become apparent only after several days. There is no guarantee that photographs will develop to show the actual severity of the injury. Once taken, photographs can be subpoenaed into evidence and may hurt the case if actual injuries appear minimal or cannot be seen.

Therefore, any photographs which are taken *should be limited to those instances where there is an opportunity to produce clear pictorial evidence of injury,* such as bruises or lacerations. Also, if photographs are taken, they should be done only with the specific consent of the patient.

Further, *photographs should not be taken of the genital areas* unless the victim specifically requests this procedure because of added trauma to the victim during the examination as well as probable and unnecessary embarrassment in court. Again, drawings accompanied by accurate written descriptions can be as effective in court as photographs.

Finally, it is vital that all photographs be taken by a competent photographer, preferably of the same sex as the patient, and that a ruler and color chart be used to indicate the size and nature of each injury.

Terminology

Findings from the physical examination should be documented as completely as possible on the medical record. Sexual assault prosecution may not always require the presence or testimony of the attending physician or nurse; however, there will be times when it is necessary. If testimony is needed, *a thoroughly completed and legible medical record and accompanying body diagram* will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical and evidentiary examination, the attending physician must be careful not to include any subjective opinions or conclusions as to whether or not a crime occurred. The indiscriminate use of the term 'rape' or 'sexual assault' on a medical document is a conclusion that may prejudice future legal proceedings. Instead, the medical chart should reflect that a sexual assault examination was conducted and should include any pertinent medical findings.

An important distinction must be made between information gathered for the purpose of providing medical treatment and that which is gathered for the follow-up investigation and potential prosecution. Hospital personnel should not be expected to further expand their role to act as an 'investigator' for law enforcement. They should not ask for details *beyond*

those necessary to perform the medical and evidence collection tasks; it is the responsibility of the follow-up investigator to ask the more detailed questions.

Date of Last Voluntary Coitus

When analyzing semen specimens in sex-related crimes, forensic analysts sometimes find genetic markers which are inconsistent with a mixture from only the victim and the defendant. A mixture of semen from a defendant and the victim's previous sexual partner could lead to blood grouping results which, if unexplained, could conflict with the victim's own account of the assault.

Victims should be asked if they have engaged in voluntary sexual intercourse within several days prior to the assault. If so, victims should then be asked the date of the contact in order to help determine the possible significance of semen remaining from the prior sexual contact. It is not necessary to obtain the name of the sex partner at the time of the initial examination.

Toxicology Blood-Urine Screen

Great care should be exercised to ensure that toxicology screens do not become routine for victims of sexual assault.

Blood/urine samples for the purpose of toxicology screening should only be done in the following situations in cases of sexual assault:

1. If the victim or accompanying person (such as a family member, friend or police officer) states that the victim was drugged by the assailant(s).

AND/OR

2. If, in the opinion of the attending physician, the victim's medical condition appears to warrant toxicology screening for optimal patient care.

Medical Report Form For Sexual Assault Examination

Throughout the evaluation and medical examination, the attending physician should explain to the patient why questions are being asked, why certain medical and evidentiary tests may need to be performed and what treatment, if any, may be necessary.

1. Vital signs and other initial information such as the date and time of *both* the examination and the assault should be recorded.

2. A brief description of the medical details of the assault should be recorded. This description should include any oral, rectal, or vaginal penetration, whether the assailant penetrated the victim with finger(s) or foreign object(s), whether any oral contact occurred, and whether ejaculation occurred (if known).

3. Information regarding the physical location of the assault should be recorded (e.g., car, rug, grass, alley). This information will assist the physician with an indication of

where to look for evidence and what evidence to collect, such as hairs, fibers, or other trace material.

4. Significant medical history of the patient should be recorded. This would include any allergies, current medication, acute or chronic illness, surgery and any post-assault symptoms such as bleeding, pain, loss of consciousness, nausea, vomiting, or diarrhea.

5. Gynecological history information, including menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy), and contraceptive history should be evaluated and recorded. In patients at risk for pregnancy, a urine pregnancy test should be done to establish a baseline for possible *pre-existing* pregnancy. (The urine sample can also be examined for trichomonas.)

6. During the general physical examination, record all details of trauma such as bruises, abrasions, lacerations, bite marks, blood or other secretions, with particular attention paid to the genital and rectal areas of both male and female patients. Common sites and types of injury, even if not yet visible, include the breasts, the upper portion of the inner thighs, grab or restraining marks on the arms, wrists, or legs, and injuries or soreness to the scalp area, back, or buttocks as a result of being thrown against an object or on the ground.

NOTE: Information concerning sexually transmitted diseases can be found beginning on page 54. However, it is recommended that if penicillin is to be given as prophylaxis, it should not be delayed until the very end of the patient's hospital examination. Because some patients may be allergic to penicillin but unaware of their allergy, it is recommended that this treatment, if provided, be administered in time to allow for at least 30 minutes of patient observation.

PROCEDURES FOR RELEASE OF EVIDENCE

All medical and forensic specimens collected during the sexual assault examination must be kept separate, both in terms of collection and processing. Those required only for medical purposes should be kept and processed at the examining hospital, and those required strictly for forensic analysis should be transferred with the evidence collection kit to the criminalistics laboratory for interpretation.

Preliminary Procedures

When all evidence specimens have been collected, they should be placed back into the kit, making certain that everything is properly labeled and sealed. *Any unused kit components or medical specimens collected for non-evidentiary purposes should not be included in the kit.*

The original copy of the *Forensic Laboratory Report Form* is to be included in the completed kit and the second copy retained for the hospital records.

All required information should then be filled out on the top of the kit just prior to sealing it with red or orange evidence tape at the indicated area. The completed kit and clothing bags should be kept together and stored in a safe area.

Release of Evidence

Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult patient, or an authorized third party acting on the patient's behalf if the patient is unable to understand or execute the release. An *Authorization for Release of Information and Evidence Form* should be completed, making certain that all items being transferred are checked off. In addition to obtaining the signature of the patient or authorized third party on this form, signatures must be obtained from the hospital staff person turning over the evidence as well as the law enforcement representative who picks up the evidence.

One copy of the release form should be kept at the hospital and the other copy given to the law enforcement representative. This representative should also print and sign his or her name on the cover of the collection kit and bags of clothing and fill in the time of transfer.

POST-EXAMINATION INFORMATION

Patient Information Form

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault victims. Before the patient leaves the hospital, a Patient Information Form should be completed. The type and dosage of any medication prescribed or administered should be recorded on the first portion of this form.

Many hospitals report that the majority of sexual assault victims *do not return* to the facility for these follow-up tests. Denial of the assault or of the need for follow-up testing, especially if no unusual symptoms are experienced, and inadequate information provided by many hospitals concerning the necessity for follow-up treatment are common reasons for a failure to return.

Patients should be encouraged to obtain follow-up tests for possible pregnancy, sexually transmitted disease, and urinary tract or other infections *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 if the patient does not wish to return to the treating hospital. Victim advocates can be quite helpful in explaining the need for a return visit and what types of tests should be performed.

The second portion of the Patient Information Form should be used to record follow-up counseling information. While the patient should be encouraged to seek follow-up counseling, the decision to do so must be voluntary. Some victims may be reluctant to talk with a counselor; however, they are more likely to participate if counseling has been coordinated with the examination process. An appointment with a trained hospital counselor should be recommended and scheduled. A referral to a victim advocate, social worker, or psychologist in the community who is known to provide quality service could also be made.

The original copy of the Patient Information Form should be given to the patient and the second copy retained for the hospital's records.

Follow-up Contact

Any further contact with sexual assault victims must be carried out in a very discreet manner. In an effort to avoid any breech of confidentiality or unnecessary embarrassment, it is recommended that victims be asked prior to leaving the hospital whether or not they can be contacted about follow-up services. If so, they should be asked to provide an appropriate mailing address and/or telephone number where they can be reached.

Informational Brochures

Many victim advocacy agencies and individual hospitals have developed informational brochures about sexual assault and its aftermath. These brochures can be helpful in explaining to patients some of the common problems they may encounter, such as disturbances in sleeping or eating patterns, flashbacks of the attack, and post-trauma stress

syndrome. They also can provide reassurance to the patient that sexual assault victims are not responsible for the assault.

In addition, brochures should contain information about local or state resources, such as victim compensation programs, counseling services, AIDS, and information on home security and personal safety. If at all possible, arrangements should be made to provide a copy of such publications to sexual assault patients and their families when they leave the hospital.

Clean-up/Change of Clothing

Many patients would like to wash after the examination and evidence collection process. If possible, the hospital should provide the basics required, such as mouth rinse, soap and a towel.

If garments have been collected for evidence purposes and no additional clothing is available, arrangements should be made to ensure that no victim has to leave the hospital in an examining gown. In those instances where police officers transport victims from their homes to the hospital, officers should be instructed to advise victims to bring an additional set of clothing with them in the event any garments are collected. Some patients may wish to have a family member or friend contacted to provide substitute clothing. When the victim has no available personal clothing, necessary items could be supplied by hospital volunteer organizations and/or local victim assistance agencies.

Hospitals can address this issue by developing a community plan with local law enforcement agencies and victim assistance organizations.

LAW ENFORCEMENT INVESTIGATIVE INTERVIEW

Many police departments, especially within large metropolitan areas, have investigators or detectives whose duties include sexual assault investigations. These officers do not answer the initial call but rather enter the case after the responding officer has written his/her initial report. Upon arrival at the hospital, the investigator should talk with the responding officer and/or attending hospital staff to obtain information about the assault and the condition of the victim.

In most cases, the investigator will conduct the follow-up interview after the victim already has been interviewed by the responding officer and the hospital staff. *Therefore, it is very important that the need for this third interview be explained to the victim, especially the reason why more detailed questions must be asked.* Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information that the investigator must have in order to get an accurate picture of the circumstances surrounding the case and to prepare a report for the prosecutor.

General guidelines for this interview include the following:

1. The interview should be conducted *after the medical examination and evidence collection procedures have been completed.* In some cases, it may be necessary to delay this interview for several hours or even the next day. Often, delays at hospitals are caused by the length of time necessary for the medical examination and determination by emergency room staff as to the victim's 'readiness' for such an interview. The follow-up investigator needs to understand the role of hospital staff and the functions and priorities of the emergency room in coping with these delays.

2. If the follow-up interview is conducted at the hospital, it must be held in a private setting free of outside interruptions. If a suitable arrangement cannot be made, the investigator should schedule the interview at a later time and place.

3. With the consent of the victim, a support person who was present during the medical and evidence collection examination may also be present during this interview.

4. The interviewer should be sympathetic and understanding of the victim's trauma while at the same time effective in collecting all necessary information about the case.

5. The interviewer should establish him/herself as an ally of the victim and try to cushion the victim from pressures by family, friends and other workers, as well as from possible threats made by the attacker.

6. The victim should be allowed to tell his/her story without interruption by the interviewer. This will afford the victim an opportunity to ventilate pent-up feelings in describing the assault. A special note should be made to record anything the attacker might have said in order to help establish the modus operandi or crime pattern.

7. The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear.

Transportation

Finally, transportation should be arranged when the patient is ready to leave the hospital. In some cases this will be provided by a family member, friend or victim advocate who may have been called to the hospital for support. In other cases, transportation can be provided by the local police department as a community service.

CHILD PROTOCOL

Sexual abuse of children is a subject that society is beginning to acknowledge, and sexually abused children are appearing in physicians' offices more frequently. In Arkansas, the number of children identified as sexually abused after investigation increased tenfold during the 10-year period from 1977 to 1986. Most cases are unreported, however, and the incidence of sexual abuse may be much higher than that of physical abuse of children. Thus, physicians who provide medical care for children are likely to have patients who have been sexually abuse.

Sexual abuse may be defined as the involvement of children in sexual activities they do not fully understand, to which they are unable to give informed consent, or that violate social taboos of family roles. It includes such sexual activities as attempted intercourse, fondling, and exhibitionism. The perpetrator is usually a relative or caretaker of the child. The sexual abuse is commonly committed secretly, without force, often over a period of months or years. Verbal threats of dire consequences should the child tell are often made by the perpetrator. Sometimes, the child has told a parent and has not been believed. Psychological consequences for the incest victim and the non-perpetrator parent are commonly severe.

Evaluation and management of the sexually abused child is unique in health care. The physician must not only meet the medical needs of the child but also obtain and document legal evidence, provide emotional support for the child and family, and initiate social and legal management by reporting the abuse, as mandated under the Arkansas Child Abuse Reporting Act. Other professionals likely to be involved include case workers of the Arkansas Department of Human Services, Division of Children and Family Services, law enforcement officers, prosecuting and defense attorneys, judges, psychologists, public health nurses, and others. Physicians in most areas of Arkansas potentially have both the means and the professional support to evaluate and manage these children well, and medical care in the home community is almost always preferable for the sexually abused child.

Sexual abuse of children falls into three major categories:

1. *Sexual abuse of a child by a stranger, many times involving kidnaping and/or the use of a weapon.* These assaults usually occur on a random basis, are more likely to result in severe physical injuries to the child, and account for a growing number of sex-related deaths of children.

2. *Sexual abuse of a child through the use of pornographic materials and exploitation,* many involving runaway or 'throwaway' children who are dependent upon the exploiters for physical survival and even affection.

3. *Sexual abuse of a child by a family member or other person known to the child whom the child trusts to some degree.*

The abuser in *intra-familial child sexual abuse* is related to the child victim through blood, marriage, adoption or common living arrangement, and generally involves the following relationships:

1. The abuser is legally related and a member of the child victim's immediate family (natural or adoptive parent, sibling).

2. The abuser is a member of the child victim's extended family (e.g., grandparent, aunt/uncle, cousin).

3. The abuser is not legally related but is seen by the child as part of the immediate family because the abuser lives or has daily contact with the family (stepparent, guardian/foster parent, male or female friend of parent who is commonly viewed as the 'psychological parent').

The abuser in *extra-familial child sexual abuse* is not considered a part of the child's family; however, this person usually has an opportunity for frequent contact with the child and/or represents an authority figure which the child may believe to be synonymous with trustworthiness. These relationships include but are not limited to *neighbor, day care/school employee, clergy, scout leader, friend of family or babysitter.*

Many children are sexually abused in some way over a period of years. Long-term abuse in intra-familial situations may begin when the child is three or four years of age or younger and continue well into adolescence or even after the child leaves home.

Until recently, there has been little opportunity for many young children to learn what constitutes appropriate and inappropriate physical contact with an adult or older child. Secrecy associated with the sexual activity, or threats of personal harm to the child or to the child's family, may cause the child to sense that something is wrong. However, unless educated about proper and improper touching and the importance of telling someone when inappropriate behavior occurs, many children do not understand that they should report the incident(s) or are afraid to do so. The situation is made even more complicated when the offender is someone whom the child loves and/or trusts, such as a parent or other close family member.

In some instances, intra-familial abuse may be restricted to fondling or gentle touching; other instances may begin this way and escalate to manual penetration or full intercourse usually after an extended period of time. The family member is usually viewed as an authority who 'must know what is best,' which often allows the perpetrator to be able to convince the child that these types of sexual contacts are normal and take place in other families.

Some children become adolescents before realizing, through normal discussions with friends about family life and events, that the sexual contact they have experienced is wrong and does not usually occur in most households. By this time, however, the child may have assumed a great amount of guilt about the sexual activities and will be even more reluctant to reveal the situation to an adult or other family member.

When an attempt is made to talk to someone about the abuse many children are unable to communicate what is happening. Even when the child is quite verbal, the listener may dismiss the story as 'make believe' or accuse the child of lying. When no action is taken to protect the child from further abuse, the child may decline to initiate the subject again.

TREATMENT PLAN

Facility

Because of the inability of most children to secure medical treatment on their own, the majority of sexually abused children do not receive immediate medical attention. When medical attention is received, it is usually at the request of a third party. This request is frequently made by a parent who notices unusual genital soreness, discharge or urinary problems, by a teacher who sees a sudden change in the child's behavior, by a relative who suspects physical abuse, or by a physician who discovers gonorrhea from a vaginal, urethral or throat culture.

Ideally, each hospital designated to treat adult victims of sexual assault will also have a multi-disciplinary team available on an on-call basis for the evaluation and examination of child sexual abuse cases. This team should consist of a pediatrician for the physical examination and a social worker and/or nurse to provide patient support and coordination with the law enforcement and child protection agencies. An obstetrician/gynecologist should also be available on an on-call basis to provide consultation and follow-up when necessary. Each team member must be trained in the management and psychodynamics of the sexually abused child.

In the absence of such a specialized team, the minimum requirements should be a readily available physician and nurse, both of whom are trained in the medical and psychodynamic aspects of child sexual abuse.

Intake

Children are often brought to the hospital by a police officer and/or parents who are seeking examination and treatment. When the child is accompanied by an officer, the officer should be directed immediately to the emergency/pediatric department so that a brief history of the assault can be provided to the attending medical staff.

If the child's parent or guardian is present, he or she should be asked if there is any additional information about the event which should be shared with the physician. In cases involving young children, the parent/guardian also should be asked to provide the physician with the child's medical history.

Since children many times will tell health professionals things they may not tell in the presence of parents or other adults, *adolescents and older children should be encouraged to provide much of their own medical history, as appropriate.* This interview should be conducted in a private area, and information regarding sexual history (of both males and females), menstrual history, and use of birth control should be recorded.

The child's parents/guardians should be informed about and prepared for the physical examination by the nurse or the physician. They should also be told what specific lab tests will be done, the purpose of each test, and when the results will be available.

Reporting

See Arkansas Law (Children) in the Appendix.

Support Personnel

Under no circumstances should the child be left alone. Arrangements must be made to provide a support person who can establish a good rapport with the child.

As with adults, an important first step in intervention is to help children regain a sense of control over their bodies. For adolescents, this many times can be accomplished by allowing them a choice of the support person to be present during the physical examination. This support person could be a trained hospital social worker or nurse, a trained victim advocate, or a family member.

A support person of the same sex as the child can be quite reassuring and, in fact, may be required by many institutions for staff purposes.

Consent

Consent to conduct a medical examination and collect physical evidence should be obtained from parents/guardians of all children under *the age of 18.*

Fortunately, there are few situations where the parent/guardian refuses consent to these procedures. However, if consent cannot be obtained from the parent or guardian of the child, and if the child is in danger from his or her surroundings and requires immediate attention, the attending physician can take the child into custody at the hospital for a specific amount of time. This will allow the medical staff to provide diagnosis and treatment, the child protective and law enforcement agencies to investigate the abuse and, at least on a short-term basis, protection of the child from further abuse.

Arkansas Code Annotated § 12-12-509 (1987) states:

(a) A police officer, a law enforcement official, or a designated employee of the city or county department of social services may take a child into protective custody, or any person in charge of a hospital or similar institution or any physician treating a child may keep that child in his custody without the consent of the parent or the guardian, whether or not additional medical treatment is required, if the circumstances or conditions of the child are such that continuing in his place of residence or in the care and custody of the parent, guardian, custodian, or other person responsible for the child's care presents an imminent danger to that child's life or health. However, such custody may not exceed seventy-two (72) hours, and the juvenile court and the department must be notified immediately in order that child protective proceedings may be initiated.

(b) The director of the local social services or health agency may give effective consent for medical, dental, health, and hospital services for any abused child under the age of eighteen (18) years.

CHILD INTERVIEWS

Many sexually abused children who are brought to a hospital for examination and treatment have not yet been interviewed by law enforcement or child protective service workers. Therefore, it is likely that the examining physician will be the first person to interview the child about the event(s). The following guidelines will assist in this process.

Interviewing children about abuse of any kind—physical or sexual—requires special skills. It can often be difficult to get the child to talk or to understand what the child says. Many professionals are not really comfortable with children and may be unaware of techniques for establishing a rapport with children.

When children are asked about their sexual activities with adults or other children, many times their inability or reluctance to answer these types of questions is due to embarrassment, shyness, a fear of being thought of as a 'tattletale' or disloyal, or simply due to a lack of understanding of the question itself.

With children, to a much greater extent than with adults, interviewers must be aware of the long-term ramifications of their questions. While the immediate goal is to elicit the clearest possible information from the child, the interviewer should be aware of his/her own feelings about child sexual abuse and not communicate any attitudes which might create or increase the child's trauma. This is especially important in cases of sexual abuse with a family member where, *in the child's mind*, the action may have been viewed as one of affection.

Prior to the interview, it is important to determine what reactions the child has been exposed to following the disclosure of the abuse. For instance, the medical professional should try to ascertain if the child's family has been supportive, panicked, ambivalent, disbelieving, angry or blaming. Also, parents and others who have regular contact with the child should be questioned, whenever possible, about any behavioral changes they have observed.

Indicators of child sexual abuse perpetrated by a family member or other trusted individual, however are not always concrete. Therefore, hospital staff should be alert for signals from the parent/guardian which may indicate sexual abuse, including but not limited to the following:

1. The child stays inside the house more frequently
2. The child does not want to go to school
3. The child cries without provocation
4. The child bathes excessively
5. The child exhibits a sudden onset of bed-wetting

An assessment of the child's emotional state is a vital part of the interview process. This is an age-dependent interpretation, such as how the child relates, his or her body posture, and the language used. It is also important to assess the child's verbal skills level and to use terms that are understandable to the child. This assessment can many times be accomplished by asking topical questions about family, school, television and everyday events. After a degree of rapport has been established, the child can then be asked to describe what happened.

Key Interviewing Techniques

The interviewer should be supportive and sensitive through tone of voice, body expression, and the maintenance of eye contact. The interviewer should also sit at eye-level with the child so that the child is not intimidated and the interviewer is perceived as genuinely interested. The child must be allowed to tell the story with as few interruptions as possible and to use his/her own words in describing what happened.

It is absolutely vital that the child be believed at all times, especially in cases of disputed accounts by adults. The child's story should be taken at face value. Value judgments and expressions of shock or surprise should be avoided.

It must be made very clear to the child, as often as needed throughout the interview, *that the child was not at fault for what happened* and that medical staff are there to help and protect him/her.

Statements made by the child should be recorded accurately. The child should not be led in such a manner that he or she answers questions to 'please' the interviewer. Younger children often have problems with times and dates. In order to establish a time frame in which the abuse occurred, it can help to discuss favorite events or activities. These could include asking about television shows, a vacation or trip to see a relative, going to the zoo, or shopping. Younger children also are somewhat concrete and have a short span of attention. Therefore, the interviewer should avoid long and open-ended questions and provide short rest periods at appropriate intervals during the interview. The use of interview aids is extremely helpful. Drawings, pictures and anatomically-correct dolls are particularly effective.

It may be necessary for the interviewer to follow up the child's description with clarifying questions in order to learn exactly what happened. For instance, in situations where penetration did not occur but where there was other sexual contact, the child may not at first differentiate between oral and manual stimulation.

Finally, it is important for all interviewers to be aware that many times it is necessary to conduct more than one interview over a period of days in order to ascertain the circumstances of the abuse.

Medical History Interview

The most experienced professional medical staff person available should conduct a *preliminary medical history interview* of the child. The purpose of this interview is to ob-

tain the information necessary to conduct a proper medical examination and possible collection of physical evidence. *A more thorough, detailed investigative history will be obtained by law enforcement and child protective agency personnel at a later time.*

If the interview is held in the emergency or pediatrics department, it must be in a private setting free of interruptions. The interviewer should explain his/her need to know what happened and what procedures will be done. He/she should also use simple terms, including the child's vocabulary for body parts, acts, and people.

Attending Personnel

As few persons as possible should be present during the medical interview/evaluation or examination/evidence collection process. Attending personnel should consist of the examining physician, an authorized support person and/or nurse. *Those persons involved in the investigation, such as law enforcement or child protective agency representatives, should not be in attendance during these procedures.*

Presence of Parent/Guardian

In all cases of known or suspected child sexual abuse, the medical person in charge must decide whether or not the presence of a parent or guardian is desirable during the evaluation or medical examination.

Many times it is not preferable to have a family member present during the medical history interview or physical examination of the child in order to minimize confusion and additional trauma to the child, as well as for the purpose of obtaining information that might otherwise be censored. Some parents may be so emotionally distraught or disbelieving upon hearing the child's narrative that their presence has a negative impact on the child and the interview/examination process. When these situations occur, the parent/guardian should be taken to a private area and provided with support and comfort. However, if the child expresses a need for support from a parent/guardian and that parent/guardian is *not* suspected of perpetrating the abuse, their presence may be appropriate *if they are supportive to the child.*

Under no circumstances, however, should the interview/evaluation be held in the presence of a parent/guardian who is suspected of perpetrating the abuse.

THE EVIDENTIARY AND MEDICAL EXAMINATION

In preparation for the examination, the child should be undressed (except for underwear) and wearing an examination gown. Help with this process can be provided by the attending nurse, support person, and/or parent or guardian if present. Special considerations which will increase the child's sense of well-being include the following:

1. Throughout the examination, great care must be taken to minimize additional trauma to the child. For instance, many children have never before been in a hospital environment. Factors such as the presence of unfamiliar equipment, most of which can be quite 'scary' in appearance, and the necessity of darkening the examination room in order to conduct the Woods Lamp procedure properly can be extremely disconcerting and frightening to a child. *Therefore, each step in the examination process should be explained to the child prior to its being performed.*

2. It is important for the examiner to be aware that children interpret statements literally. For example, statements such as, "I'm doing cultures to see if there are bugs in there," should be avoided. Children may think this means they are dirty or have something 'alive' inside them.

3. The examiner should reinforce the idea that the child is not 'damaged goods' or irrevocably marked in some obvious way.

4. The child should not be restrained in order to do the examination and/or to gather evidence. If the child is visibly upset, the physician should determine what measures are to be taken to reduce his/her anxiety.

Some cases may require the use of sedation; *however, it is recommended that general anesthesia not be administered except in the most extreme cases, such as in a life-threatening situation or when the removal of a foreign object would cause undue pain and trauma to the child.* Careful explanation of any sedation or anesthetic should be provided to both the family *and to the child.*

Evidence Collection*

The purposes of the examination are to check for injury, infection, and evidence to support the suspicion of sexual abuse. However, only about one-third to one-half of sexually abused children have evidence of physical injury, and the physician usually is unable to confirm by physical findings alone that sexual abuse occurred.

The parents of sexually abused children usually are under considerable emotional stress at the time of the visit, and they may have preexisting psychological problems related to their own childhood sexual abuse. As a result, they may misinterpret examination procedures. We recommend that a nurse chaperon the examination and note in the medical record that she did, regardless of the sex of the physician and patient.

General — Describe the condition of the patient and torn or bloody clothing. A complete physical examination should be performed, providing an opportunity for the physician to obtain the child's trust. Height and weight should be recorded. Each parameter of sexual development (breasts/pubic hair or pubic hair/testes/penis) should be indicated according to the Tanner scales in the Appendix.

Skin — Describe bruises and lacerations, and make photographs is possible. Bruises may not be visible for 1 to 2 days, so the physician may want to recheck the child later. The skin should be scanned with a Wood's lamp to identify seminal stains and petroleum jelly, which fluoresce.

Mouth — Examine for evidence of semen, trauma, and sexually transmitted diseases.

External Genitalia — Examination of the genital area *should be performed without restraint* if possible, since restraint reproduces the loss of control experienced by the child during the sexual abuse. Thus, preparation of the child for examination, which may take longer than the examination itself, is essential. Explaining the procedure will give the child a sense of control, and expressing support and concern will differentiate the examination from forced sexual assault. Having female staff present when a male physician is performing the examination may also alleviate anxiety. Genital examination of a preschool child frequently can be performed with the child held on the mother's lap. The young child's legs usually should be in a frog-leg position. Children on an examining table often are less afraid when the head of the table is elevated. Gynecological stirrups are seldom needed, even for older children.

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* Jones, M.D., Jerry G., Yamauchi, M.D., Terry, and Lawson, R.N.P., Louanne: *Physicians' Guide to the Evaluation and Management of Sexually Abused Children*, 2d Ed., 1987. Adapted by permission.

It is acceptable to use brief restraint. However, some children will require *sedation* to prevent even partial examination or vaginal washing from being as frightening as the sexual abuse.

Wear gloves for the genital examination. Many sexually abused children have sexually transmitted diseases.

We recommend that genital (and rectal) examinations be performed utilizing *magnification*. An optical visor with a 2X magnification and a focal length of 10 inches is ideal for this purpose. Optical visors may be obtained at photographic and art supply stores for less than $50. Greater magnification may be obtained by use of a colposcope or surgical loupe; however, the significance of minute findings seen with higher magnification is unclear. An otoscope will also provide magnification (1.5X), but it has the disadvantage of lack of binocular vision and the need to hold it in the hand.

For adequate exposure of the genital area of a female, spread the majora laterally and dorsally with some pressure against the perineum. Most genital injuries of females involve the labia majora, posterior fourchette, perihymenal area, or hymen. The labia should be spread apart very carefully during the examination in order to avoid producing an iatrogenic tear in the posterior fourchette. However, when a small fissure develops in spite of careful separation of the labia, increased friability may be present. Application of toluidine blue dye can increase the detection rate of recent posterior fourchette lacerations. Severe perineal and vaginal injuries fortunately are uncommon. Vesicles, discharges, and warts suggest sexually transmitted diseases.

Recurrent sexual abuse is suggested by hypopigmentation or hyperpigmentation of the young child's vulva. Scars due to repeated abrasions may be present in the perihymenal area. Look especially carefully for scar tissue, manifested as a white area, on the hymen or posterior fourchette. However, a flat white midline streak across the posterior vestibule is sometimes seen in unabused children. Bridges of scar tissue (synechiae) may deform the hymenal orifice by binding the hymen to the posterior fourchette, vagina, or labia minora. Scarring may also be present at the site of a healed laceration. Neovascularization and thickening, the results of repeated minor trauma, may be present with or without scars. A healed laceration of the hymen may be present, which frequently can be distinguished from a congenital hymenal cleft or a fimbriated hymen by extension of the laceration's scar to the periphery of they hymenal ring or by the presence of scarring and neovascularization. These changes are easily seen with magnification.

The hymen, consisting of a small rim of tissue, is called attenuated. Gaping of the vaginal orifice may be present due to gaping of a healed, unapproximated laceration or repeated stretching. Gaping of the orifice, instead of constriction, may occur with digital stimulation; whether this indicates prior recurrent penetration is controversial. Labial fusion also suggests the possibility of recurrent trauma, as well as inflammation. Its presence in a female beyond infancy warrants careful genital and anal examinations and a disclosure interview seeking supportive evidence of sexual abuse.

The incidence of various genital findings in females is reported in only one study, that of Emens et al. The authors found that sexually molested girls were more likely than asymptomatic control females to have increased friability of the posterior fourchette, scars, synechiae from the hymen to the vagina, attenuation of the hymen, and bumps occurring on the lower half of the hymenal ring. However, a group of females who presented with genital complaints and no history of sexual abuse had a similar incidence of each of these findings. Whether their genital findings were a result of unreported sexual abuse or repeated inflammation was unknown. The occurrence of abrasions, hymenal tears, and intra-vaginal synechiae did not reach statistical significance, but they were found exclusively among abused children in the study. The authors conclude "... the need to collect further data is clear."

The size of the normal hymenal orifice has received some research attention. Cantwell found that 80% of females less than thirteen years of age, whose vaginal openings were greater than four millimeters in the horizontal diameter, provided a history of sexual abuse. White et al. reported that a vaginal introital diameter of more than four millimeters was highly associated with a history of sexual contact (94%) compared with a group with no history of sexual contact but at risk to be sexually abused (5%) and a control group (0%). Emans et al., in their previously described study, found that the differences in hymenal measurements in sexually abused females and asymptomatic control females were statistically significant, but the ranges overlapped and "the small differences measured in millimeters are unlikely to be clinically useful unless the hymen is dilated beyond the range of normal" (which was 6 x 7 millimeters in their three- to six-year-old females). Females who presented with genital complaints and no history of sexual abuse also had larger hymenal dimensions than those in the control group. A vaginal introital diameter of 4 millimeters or less does not negate a child's history of sexual abuse, since approximately one-half of children with such a history in the study by White et al., had a diameter of 4 millimeters or less.

The diameter should always be measured. The procedure is best performed with the patient in a frog-leg position, pausing after gently spreading the labia so the orifice can dilate maximally as the child relaxes. The size should be determined before inserting any object, such as a culture swab.

Measurement of the diameter of the hymenal orifice with a linear tape measure can be difficult due to the small size of the hymen and the encroachment of adjacent structure. Paper strips are much more useful. These strips can be moistened with normal saline without a preservative, if desired.

The size of the vaginal orifice can be a guide as to the possibility or likelihood of vaginal penetration, as can injuries of the hymen or vagina. The relationship of the current diameter of the opening to the diameter of a recently or remotely penetrating object, such as a penis or finger, apparently has not been studied.

The location of an injury can suggest the cause. Genital injuries produced by attempted penile penetration of girls usually are located posteriorly at the 5, 6 and 7 o'clock positions, since stretching and tearing of the tissue anteriorly is restricted by the pubis.

Evidence of trauma located anteriorly is usually caused by digital manipulation or accidental straddle injuries. Autostimulation does not produce injuries. Behavior of the child which would cause injuries, such as putting pencils in the vagina, should be suspected to have been modeled by previous sexual abuse.

Pelvic Examination

1. Omit the pelvic examination in a young female if the hymen is intact, vaginal bleeding is absent, and the vulva shows no evidence of major trauma. A true pelvic exam usually is unnecessary in the young child, and when needed frequently requires general anesthesia. However, vaginal washings usually can be obtained. If the size of the hymenal orifice permits, the vagina and cervix should be examined.

2. Look for signs of semen or trauma. Bruising of the vaginal wall, especially anteriorly, frequently occurs when a penis enters the vagina of a young child. Observe for evidence of penetration into the rectum or abdomen.

3. Vaginal full penetration on many occasions by a penile-like object is indicated by a hymenal opening that will allow penetration by at least two examining fingers into a roomy vagina long enough for the fingers to enter to their full length. However, partial penetration, either acutely or recurrently, may have occurred without producing these signs.

Toluidine Blue Dye Test

The posterior fourchette is a common site of lacerations in sexually abused females. The identification of lacerations in this location provides a physical clue to the presence of child abuse. McCauley et al. consider posterior fourchette lacerations in children ten years of age or younger to be "strongly suggestive" of sexual abuse.

Application of toluidine blue to the posterior fourchette of females with recent genital sexual abuse can increase the detection rate of posterior fourchette lacerations as well as confirm questionable ones. In the study reported by McCauley et al., the direction rate in sexually abused females increased from 16.5% to 33%.

The toluidine blue dye test is performed as follows:

1. Apply a 1% aqueous solution of toluidine blue to the posterior fourchette using a cotton tip applicator. Avoid entry of dye and lubricating jelly into the vagina to prevent interference with subsequent forensic tests, since both agents are spermicidal.

2. Let dry a few minutes.

3. Wipe gently with a cotton tip applicator moistened with lubricating jelly; repeat until no further recovery of dye occurs.

4. Use finer stroking with a dry cotton tip applicator to differentiate lacerations from dye trapped in crevices.

5. Dye retained within a laceration highlights the injury.

This objective evidence, like many of the physical findings of sexually abused children, must be interpreted in the context of all available medical, social and psychological information regarding the child and family.

Anal and Rectal Examination

This examination usually should be performed on both males and females.

1. Inspection. The buttocks should be gently separated, which typically produces a reflex tightening of the anal sphincter. In children who are accustomed to repeated anal penetration, reflex tightening of anal sphincter may not occur. Gaping of the anus may result. This finding is suggestive, but not diagnostic, of recurrent sodomy. Inspect the anal verge, the area of slightly darker skin in folds fanning toward the periphery. It is thin and loose, predisposing to traumatic tearing of blood vessels and overlying tissue with resultant formation of hematomas and anal fissures. Thus forceful sodomization may produce the anal injuries. The anus may be swollen for up to 3 or 4 days. Fissures of the anal verge may heal with scarring or hypopigmentation, most easily visualized with magnification, and a skin tag may result. Unfortunately, one cannot distinguish by the appearance of recent or healed anal fissures and skin tags whether they resulted from sodomy.

2. Digital rectal examination. The anal sphincter may be flaccid immediately after traumatic sodomy. If the sodomy was relatively atraumatic, the anal tone is likely to be normal soon afterward. However, 3 or 4 hours after the sodomy, the physician may be unable to insert a finger into the anus because of spasm of the sphincter. Thus the physician may want to repeat the digital rectal examination in about 4 hours if sodomy is suspected for the supporting evidence of sodomy that spasm of the anal sphincter provides. Repeated long-term sodomy will result in decreased elasticity of the anal sphincter thus permitting the easy insertion of three or more examining fingers and decreasing its ability to contract around the examining fingers. If both are present and the anal verge skin is thick with decreased folds, an assessment of recurrent sodomy may be made on the basis of physical examination. Their absence, however, does not rule out recurrent sodomy.

3. Anoscopy. Anoscopy, using a proctoscope or a lubricated 10cc test tube in which the lighted end of an otoscope is inserted, should be considered if evidence of external perianal trauma is present or digital rectal examination reveals blood. Signs of recent or healed injuries, such as a fissure that extends into the anal canal, may be found.

4. Photograph any injuries found, if possible. The basic Polaroid camera usually will not record genital and rectal injuries very clearly. However, photographs of good quality can be made with a modified Polaroid CU-5 camera, with an attachment for 2X magnification. The magnification has the advantage of greater detail and duplication of the 2X magnification of the optical visor. The camera has the disadvantage of cost, which is more than $1,000. A 35mm camera, with appropriate attachments, can be utilized if security of the photographs during processing can be established. Photographs also can be taken through a colposcope.

LABORATORY STUDIES

1. *Cultures for Neisseria gonorrhea*. Cultures of the vagina (urethra in males), rectum, and/or mouth should be taken. All three sites should be cultured when a reliable history of the sexual activity cannot be obtained, such as in the young child, in the child with a history of unconsciousness, and in the case of drug or alcohol ingestion. Vaginal specimens should be taken from the posterior fornix or from vaginal washings. The hymenal orifice should be cultured even if the hymen is intact (moistening the swab with sterile normal saline, without preservatives, may lessen the discomfort to the child. Oral cultures should consist of a swabbing of the posterior pharynx

2. *Test for Chlamydia antigen*. Chlamydia may be the most common agent resulting in sexually transmitted disease in adults. Although unproven, intuitively one would suspect its importance in sexually abused children, and some authorities recommend testing for Chlamydia.

Vaginal specimens to be tested for fluorescent antibody for Chlamydia antigen should be collected as follows: (NOTE: Culturing for Chlamydia is unnecessary if the test for Chlamydia antigen is positive.)

a. In the child in whom a pelvic examination is possible, a sterile *wire or plastic* (not wood) swab with a Dacron (not cotton) tip should be introduced into the cervical canal and rotated with slight pressure in order to obtain cellular material. When a pelvic examination is not possible, the swab should be rotated at the vaginal orifice or within the vagina. *Do not culture a discharge* because Chlamydia is likely to be obtained only from cellular material that is abraded onto the swab.

b. Streak the material onto the slide provided, being certain that the material gets into the wells in the slide. Allow to dry for about a minute.

c. Break the ampule of acetone and drop onto the slide. Allow to dry briefly.

d. Return the slide to the cardboard container.

3. *Vaginal culture for Chlamydia trachomatous:*

a. Collect the specimen as described above.

b. Immediately transfer the swab to a tube of Chlamydia-specific transport medium making certain that the portion with the fabric attached drops down into the medium.

c. Put the tube of transport medium in a cup of ice.

d. Chlamydia cultures may be transported on wet ice within a 24-hour period after they are taken. If it is necessary to hold them longer, they should be frozen at an ultra-low (70 degrees Celsius) temperature and transported on dry ice. They may be sent to the Virology Laboratory, Arkansas Children's Hospital, 800 Marshall St., Little Rock, AR 72202 (phone 370-1300); this laboratory will provide transport media on request.

4. *Microscopic examination (wet preparation) for spermatozoa.* Examine vaginal washings, vaginal or rectal fluid suspected to be semen, or oral fluid obtained by swabbing of the posterior pharynx, behind the teeth, and under the tongue. Put a drop of fluid on a slide with a coverslip and use a 40X lens. Sperm are easily identified.

Motile sperm in a vaginal specimen suggests that they were probably deposited within the previous 24 hours. However, one should be cautious about such time estimates in children because they have little research support and sperm in the cervices of adults may be motile for up to five days. Sperm in the mouth and rectum generally do not remain motile as long as sperm in the vagina.

5. *Serologic test for syphilis.* After suspected oral, rectal, or labial penetration (even if the hymen is intact), request this test to rule out pre-existing antibodies.

6. *Human Immunodeficiency Virus (HIV) antibody titer.* Childhood AIDS acquired by sexual abuse apparently has not been reported, but the potential for its transmission to sexually abused children is apparent. The indications for AIDS screening of these children is unclear. Currently, we obtain HIV titers only on boys subjected to anal intercourse by male perpetrators. We repeat the antibody titers in two months (when the test for syphilis is repeated). If there is great cause for concern, the test also may be repeated six months from the time of the sexual abuse.

7. *Pregnancy test.* This is done in post-pubertal children to rule out pre-existing pregnancy.

Hospitalization

1. Hospitalization may be necessary to protect the child from further sexual abuse, to treat injuries, obtain consultations, observe the interaction of parent and child, or to establish the trust of the child in order to obtain a more complete history of the sexual abuse.

2. A physician may hospitalize a child for up to 72 hours without consent of the parent or guardian if he/she believes there to be "imminent danger to that child's life or health...." The Department of Human Services, Division of Children and Family Services and the juvenile court must be notified immediately so that an investigation and perhaps an emergency court hearing to determine appropriate custody of the child can proceed.

Medications

1. *Venereal disease prophylaxis.* Some authorities recommend giving antibiotic prophylaxis after suspected oral, rectal, or labial penetration, even if the hymen is intact; however, most do not.

2. At Arkansas Children's Hospital, in a 12-month period (1980-81), 20% of female children who presented acutely following sexual abuse, with a history of penile-vaginal contact, had positive vaginal cultures for *N. gonorrhea*. In another 12-month period (1982-83), approximately half of our children with evidence of sexual abuse, upon genital examination, had positive vaginal cultures for *N. gonorrhea*. Thus, when we strongly suspect that a

patient has been sexually abused, with attempted vaginal intercourse, especially if we find supporting evidence upon examination of the genitalia, we sometimes treat prophylactically for gonorrhea.

ANTIBIOTICS FOR PREVENTION OR TREATMENT OF SEXUALLY TRANSMITTED DISEASES

Gonorrhea

1. Vaginal or urethral exposure or infection. If the child is over age 8 and compliance is certain, give tetracycline. When a child is age 8 or younger, or compliance is uncertain, give a single dose each of amoxicillin and probenecid. If the child is allergic to penicillin, spectinomycin is the drug of choice.

2. Pharyngeal exposure or infection. If the child is over age 8 and compliance is certain, give tetracycline. When the child is age 8 or younger, or compliance is uncertain, give a single dose each of procaine penicillin and probenecid.

3. Rectal exposure or infection. Give a single dose each of Procaine penicillin and probenecid. If the child is allergic to penicillin, give spectinomycin.

4. Vaginal/urethral, pharyngeal, and rectal exposure or infection. If coverage of all these sites is required, procaine penicillin with probenecid is the preferred treatment.

Chlamydia genital infection

1. If the child is over age 8, give tetracycline for 7 days. (NOTE: Tetracycline is listed first for prophylaxis and treatment of vaginal and pharyngeal gonorrhea in the child over age 7 who is likely to comply with therapy, because up to 45% of adults with gonorrhea also have Chlamydia infections.)

2. If the child is age 8 or younger, give erythromycin for at least 7 days.

Syphilis

Patients with incubating syphilis are likely to be cured by all the above regimens except procaine penicillin G and spectinomycin. Therefore, the serologic test for syphilis should be repeated two months after either of these two antibiotics has been given or if no antibiotics are administered.

Trichomoniasis

Metronidazole (Flagyl), the medication of choice for infected children of all ages, should not be given for prophylaxis.

Pregnancy prevention (included for completeness; not appropriate in the premenarchal child)

1. Diethylstilbestrol (DES) should be considered in post-pubertal female victims who have been assaulted during mid-cycle. However, if menstruation has been irregular, the physician cannot rely on the estimated day of the cycle.

2. DES is indicated only within the first 72 hours post-coitus, is only about 75% effective and carries certain risks, all of which the victim must understand. She must know that, should pregnancy result, an abortion may be recommended. The physician should carefully document in the medical records that these warnings were provided to the child and parents, and perhaps they should give written consent. Before giving DES, the physician must perform a careful history and a bimanual vaginal examination to detect an early pregnancy or gynecological abnormality. A definitive pregnancy test (not slide) must be performed and results documented prior to utilization of DES. Although commonly used as a post-coital contraceptive, DES is approved the FDA for use only in the case of rape.

3. The dosage of DES is 25mg twice daily for 5 days. Antiemetics can be prescribed to counteract the marked nausea and vomiting that commonly occur.

4. Repeat the pregnancy test in two weeks.

Non-Authorization to Release Evidence

Although there have been instances where a parent or guardian acting on behalf of the child has refused to authorize the release of evidence to law enforcement, the actual incidence of this has been very low.

If this does happen, the examining physician may be able to sign for the release in the best interests of the child. If the local child protective service or law enforcement agency are not already involved in the case, they should be contacted for assistance by hospital personnel. Each individual hospital should ascertain policy in their particular legal jurisdiction.

POST-EXAMINATION INFORMATION

Patient Information Form

A patient information form should be filled out, providing the same information as is given to the adult patient. The patient's parent or guardian should sign the form at the bottom and be given the original copy.

The provision of psychological services for children and their parents or guardian is just as important as for adults. If this service is not available through the hospital, a referral should be made to an appropriate agency or individual with approved credentials and training in the field of child sexual abuse.

It is extremely important that children return for a follow-up visit within one week to re-evaluate any genital or other injuries, and to perform follow-up cultures if necessary.

This visit will also provide the examining team an opportunity to assess how well the child and/or family are handling the stress and whether or not counseling has been received or is necessary.

Law Enforcement Interview

It is the responsibility of the investigating officer to ascertain the most supportive environment for the child during the follow-up law enforcement interview.

The goal of the juvenile officer's/investigator's interview with the child victim of sexual abuse, whether the abuse was committed by a stranger, family member or other trusted adult, is twofold:

1. To obtain accurate information needed for case investigation

2. To avoid further trauma to the child

Ideally, the law enforcement interview would include the presence of a child protective services representative so that the trauma of multiple interviews is curtailed. It also can be helpful to have a support person present who established a good rapport with the child during the medical examination/interview. This type of 'joint response team' effort has proven effective in many areas of the country. To avoid confusion, however, *it is important that only one person be the primary interviewer.* In all cases, the people present during the interview must be there for a specific purpose and must be psychologically supportive to the child.

Depending upon the circumstances surrounding the case, some child victims will be interviewed by law enforcement and/or child protective service representatives at a location away from the hospital, such as the child's home, school, or an agency facility. However, space adjacent to the emergency room or pediatrics unit of the examining hospital should always be provided for those situations where the interview must be held immediately after the medical examination. Privacy is, of course, crucial to the success of this interview.

Great care should be taken by the juvenile officer/investigator to minimize visibility of weapons and standard equipment (such as handcuffs and nightsticks) carried during the interview so that the child is not further intimidated or traumatized.

When the interview is concluded, it is important for the interviewer to thank the child for his or her cooperation and, with older children, to give them a telephone number where the interviewer can be reached if they have any further problems or questions.

If a parent or guardian is present, the purpose of the interview should be explained in a straightforward manner, and cooperation should be elicited to reassure the child that it is 'safe' to talk with the interviewer. The parent/guardian should also be told that any facial expressions of shock, disbelief or disapproval, or any verbal or physical signals to the child could impede the investigation.

Although some children are more relaxed and informative without a parent/guardian present, others, particularly very young children, may not be willing to cooperate in an interview without such support. Also, parents or relatives may be the only adults to whom the child will talk. When this happens, questions can be directed to the child through these family members, *but only after initial efforts of the interviewer to directly talk with the child are unsuccessful.*

IMPORTANT: As with the medical history interview, if it is suspected that the parent/guardian is the perpetrator, then under no circumstances should the interview of the child be held in his/her presence.

Sexually Transmitted Diseases (STD)

The risk of contracting a sexually transmitted disease as a consequence of sexual assault is not known; however, *a baseline for STD should always be established at the initial hospital examination.*

It could be helpful to the prosecution to have information on the presence or absence of STDs at the time of initial examination so an informed decision could be made as to whether to order additional tests of both the victim and the offender at some future date. If tests are initially negative but at the follow-up examination the results are positive, the presumption is that the disease was contracted from the assailant. Although every effort should be made to ascertain whether or not the assailant is infected, few suspects are apprehended by the time the victim receives initial hospital examination and testing. Therefore, some adult patients will request immediate treatment as a precautionary measure, and unless contraindicated, prophylaxis can be given at that time.

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 in some way link the offender to the crime. Although many infections, including gonorrhea and herpes simplex, 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. Therefore, all cases of sexually transmitted disease in children should be reported to the appropriate law enforcement and child protective services as well as to the local department of health.

Due to continuing research and discussion of the most effective treatment of sexually transmitted diseases specific to sexual assault victims, treatment regimens have not been included in this report. Instead it is suggested that the reader consult the latest publication of the U.S. Department of Health and Human Services, Centers for Disease Control, for their latest treatment recommendations: "Sexually Transmitted Diseases Treatment Guidelines", 1985.

Traditionally, tests for sexually transmitted disease in sexual assault and abuse patients have been focused on screening tests for syphilis and gonorrhea. There are many types of sexually transmitted diseases; however, the following represents a brief overview of those most likely to be seen in the sexually abuse patient.

Chlamydia

In the past few years the incidence of chlamydia trachomatous has escalated dramatically within the general population and has become the most prevalent cause of sexually transmitted disease in the United States.

Chlamydial organisms are unusual in that they are completely dependent upon their host cell for energy and therefore are only able to survive outside of their host environment for the briefest period of time. Transmission of organisms, except in the newborn who can acquire chlamydial conjunctivitis and/or pneumonitis during passage through the birth canal, is almost always through sexual contact.

In adults chlamydial infections may be asymptomatic but are more frequently manifested in a wide variety of symptoms ranging from nonspecific urethritis to PID, orchitis, epididymitis, perihepatitis and proctitis.

In children the exact incidence of this problem is unclear, but infection with this organism has been shown to be significantly more frequent than was previously recognized. Moreover, children appear to be asymptomatically infected more often than adults, especially when the infection is oral or rectal.

When symptomatic, common clinical manifestations in females, other than those in pelvic inflammatory disease, are vaginal irritation, itching and discharge. In males a whitish urethral discharge, with or without painful urination, is a most common clinical picture.

In the past, hospitals were reluctant to routinely test for chlamydia because the method for detection was expensive and time consuming. Recently, inexpensive fluorescent antibody tests have become available and, although not as sensitive as chlamydial cultures, are adequate for screening.

Unlike many other STDs, tests are available to detect circulating antibodies to chlamydia. The presence of these specific antibodies can provide corroborating evidence of a chlamydial infection.

Due to the prevalence and severity of the infection, it is recommended that this test be included in hospital protocols for detection of sexually transmitted disease.

Gonococcal Infections

Gonococcal infections are caused by Neisseria gonorrhea. Although newborns may acquire gonococcal infections during passage through the birth canal, older children and adults almost always become infected with this organism through sexual contact. Clinical symptoms are myriad and include but are not limited to newborn conjunctivitis, pelvic inflammatory disease, orchitis epididymitis, urethritis, perihepatitis, proctitis, pharyngitis, vaginitis and disseminated gonococcaemia.

The diagnosis of gonorrhea in the male can tentatively be made with a gram stain. However, a definitive diagnosis of gonorrhea in both males and females is dependent on a positive culture using Thayer Martin media and a differential sugar fermentation test.

Asymptomatic infections are not uncommon and should be treated. It is important to recognize that chlamydial infections commonly occur in conjunction with gonorrheal infections.

Syphilis

Syphilis is caused by Treponema pallidum and is transmitted by sexual contact except in cases of congenital syphilis and in those individuals infected by blood products or contaminated needles. Clinical signs and symptoms are dependent upon which of the four stages are manifested in the patient: primary, secondary, latent, or tertiary. The diagnosis

of syphilis, especially in the tertiary and latent stages, requires a high level of suspicion. Most hospitals utilize serologic tests (either an RPR or VDRL) for the initial screening of patients suspected to have syphilis.

Genital Herpes Simplex Virus Infection (HSV)

Genital herpes is the result of an infection with HSV type 1 or 2. This infection can be either symptomatic or asymptomatic and can reflect a primary, latent, or recurrent process. Over 90% of genital herpes infections are due to type 2, with the remaining 10% due to type 1.

Symptoms may be limited to several localized and painful vesicles, or they can be systemic and associated with fever, malaise, and swollen lymph nodes in addition to the local herpetic vesicles.

Transmission of the virus occurs during both its active and latent phases. The diagnosis of genital herpes is usually obvious from the clinical picture, but immunofluorescent and serologic tests, as well as cultures, can be used to confirm the diagnosis. It is important to recognize that the presence of HSV 2 is almost always acquired through sexual contact and that HSV 1, when present in the genital area, should also arouse suspicion of sexual activity.

Trichomonas Vaginalis

Trichomonads are protozoans which can infect the genito-urinary tract of both males and females. The presence of these organisms, except in newborns, who can become infected during passage through the birth canal, should be considered as indicators of sexual activity.

These organisms are easily identified by microscopically examining a fresh sample of urine or vaginal/urethral discharge. Trichomonads are approximately the size of white blood cells and are easily recognized by their unusual means of motility.

Symptoms of trichomonas are usually localized to the site of the infection and consist of pruritus, pain on urination, urethral discharge in males, and vaginal and/or urethral discharge in females.

Genital and Anal Warts (Condyloma Acuminatum)

These warts are due to infection with human papilloma virus (HPV) and, except for newborns, who can become infected during passage through the birth canal, transmission is almost always through sexual contact.

Condyloma acuminatum may occur as single or multiple lesions and are most often located on the glans area of the penis and on the labia, vagina and/or cervix. They can also be found in the anal canal and occasionally in the mouth, on the lips, or on the breast nipples.

Condyloma usually look like polyps, with irregular bright-red surfaces. They produce few acute clinical manifestations other than obstruction (blockage of the urethra or the cervi-

cal outlet). The chronic presence of these lesions has been associated with malignant transformation. A diagnosis is usually made from the clinical appearance and location, but a tissue biopsy may occasionally be needed to differentiate these from other warts.

Autoinoculation rarely has been identified and should be a diagnosis of exclusion.

Nonspecific Vaginitis

This is probably the most common form of vaginal infection in post-pubescent sexually active females and represents the complex interaction of several organisms.

Gardnerells vaginalis is the organism most frequently identified in women with nonspecific vaginitis and is often accompanied by anaerobes, Mycoplasma hominis, and Ureaplasma urealyticum.

Infections may be either asymptomatic or associated with local vaginal/urethral discharge, pruritus and burning on urination. The vaginal discharge is usually whitish gray and is striking because of its 'fish-like odor', especially when hydrogen peroxide is added to it.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Although there is no test for AIDS, there is a readily available antibody (blood) test for Human Immunodeficiency Virus (HIV), which is the cause of opportunistic infections or malignancies that indicate an underlying immune deficiency or central nervous system disorder.

Human Immunodeficiency Virus kills the white blood cells that produce antibodies for fighting disease. Less than 35% of persons infected with the virus will develop AIDS in five years; another 25% will develop AIDS-Related Complex (ARC), which causes prolonged flu-like symptoms. Approximately 40% of those infected will not exhibit the symptoms, yet they will be able to infect others. Once a person is infected, they remain infected.

What is the HIV antibody test?

The HIV antibody test detects the presence of antibodies produced by the human immunodeficiency virus. It determines whether a person has been exposed to the virus. A positive test does not mean a person has or will develop AIDS.

How is the virus spread?

HIV is found in the body fluids (blood, semen, vaginal fluid, tears, saliva and excretions) of infected persons. The virus is spread when there is an exchange of body fluids during sexual contact (including active or passive, oral, anal, or vaginal sex), through sharing needles/syringes, and from an infected pregnant woman to her fetus. Although the virus has been found in saliva, tears and sweat, there is no evidence that the virus is spread by an exchange of these fluids. Semen, vaginal fluid, and blood are the most probable modes by which the virus is spread.

What are the symptoms?

The majority of persons infected with HIV will not exhibit symptoms, yet they can infect others. Some infected persons will develop neurological symptoms, such as confusion and forgetfulness; others will develop AIDS-Related Complex. Symptoms of AIDS-Related Complex include *prolonged:*

- unexplained weight loss
- fever or night sweats
- extreme fatigue
- recurring diarrhea
- loss of appetite
- swollen lymph nodes in the neck, underarm or groin area
- recurring yeast infections

If these symptoms continue for longer than two weeks, the person should see his/her physician.

The most common symptoms are pneumonia-like symptoms or skin cancer lesions.

What does a positive test result mean?

A positive test result means a blood sample has been tested more than once and has shown antibodies to HIV. It does not mean that the infected person will develop AIDS or ARC. It does mean the infected person can pass the virus to others.

What does a negative test result mean?

A negative test result means either a person has not been infected with HIV or, at the time of the test, the virus was in the incubation period so no antibodies were being produced. If you are in a risk group or have had unsafe sex with someone in a risk group within twelve weeks prior to the test, you may want to retake the test in three to six months.

The Centers for Disease Control estimates that, on average, six to twelve weeks elapse between an individual's infection with HIV and the appearance in the blood of detectable antibodies to the virus. However, there have been isolated reports of lag times of up to six months, and recent data suggests even longer delays in the appearance of antibodies is not unusual. Furthermore, there is new evidence that the virus can occasionally go into a latent period, during which it is still present (and the person is still infectious) but the antibodies are undetectable by available tests.

RECOMMENDATIONS FOR PERSONS WHO TEST POSITIVE

– Avoid infecting others by practicing safe sex. Any exchange of body fluids should be avoided. Use condoms to help prevent fluid exchange.

– Inform your sex partner(s) about your test results. Discuss the importance of the HIV antibody test to them. If you feel unable to do this, assistance is provided through the Health Department in a confidential manner.

– Obtain a complete medical evaluation, which might include a medical, sexual and social history, a physical exam and additional laboratory tests. Notify the medical staff of your test results.

– Obtain a tuberculosis (TB) skin test on a regular basis. If the skin test is positive, notify the medical staff that you are infected with HIV. The TB skin test is provided by health departments or by your physician.

– Consult your physician regarding immunizations for flu and pneumococcal pneumonia.

– DO NOT donate blood, plasma, sperm, body organs, or other tissue.

– Avoid using alcohol, marijuana, and street drugs – they are dangerous to the immune system.

– Practice good health habits: get eight hours of sleep a night, exercise regularly and eat well-balanced meals.

SERVICES AVAILABLE

Hotlines:

– The Arkansas Department of Health operates Monday through Friday, 8:00-4:30, with a trained operator on duty. 1-800-445-7720.

– Operation Switchboard operates daily from 6:30 p.m. to 10:30 p.m., with a trained operator on duty. 501-666-3340

– The Washington County Task Force AIDS Information Line operates from 7:00 p.m. to 7:00 a.m. daily, with a trained operator on duty. 501-443-AIDS.

– The National AIDS network operates 24 hours a day. 1-800-342-7514, trained operator on line; 1-800-342-AIDS, recorded message; 1-800-314-SIDA, Spanish-speaking operator.

Support Groups:

– The Fayetteville support group for people with AIDS/ARC meets every other Tuesday. Call 443-4278 for more information.

– Information about the El Dorado support group can be obtained by calling Mr. Winn at 501-862-7921.

– Information about the Fort Smith support group can be obtained by calling Dr. Acklin at 501-785-2431.

Cash Grant:

Financial assistance for people with AIDS is available from Helping People with AIDS. Call 501-666-6900 for more information.

Services Sponsored by the Arkansas AIDS Foundation:

– Information Line. Every evening from 6:30 p.m. to 10:30 p.m. a trained volunteer answers questions about AIDS and refers callers to sources of help in the community. Call 501-666-3340.

– Referral for Testing. Persons considering being tested for exposure to the AIDS virus are referred to selected physicians where they can be assured of anonymous, inexpensive and respectful HIV antibody testing. Call 501-663-7833.

– "Living with Positive Results", an information packet for persons who test positive for HIV, contains information on maintaining health and dealing with the stress of HIV infection.

– Referral to Professionals. The Foundation maintains a list of medical, legal, mental health and dental professionals who are especially well qualified to deal with AIDS-related concerns. Call 501-663-7833 or 501-666-3340.

– Civil Rights Advocacy. Persons who believe they have been discriminated against for reasons related to AIDS may contact the Foundation for information concerning their civil rights in housing, employment, access to health care, etc. Call 501-663-7833.

– AIDS Support Group. This group serves persons with AIDS, ARC and HIV infection and their families and friends. A licensed psychologist leads the weekly discussion of members' thoughts, feelings, and needs. The group meets every Monday at 6:30 p.m., at 210 Pulaski Street in Little Rock. For more information call Dr. Ralph Hyman at 501-374-3605 or 501-663-7833.

– Caregivers Support Group. This group serves individuals providing care to persons with AIDS, ARC and HIV infection. This group is composed of nurses, social workers and individuals in a professional care setting for mutual support and the dissemination of information as it relates to treatments and services. This group meets at 7:00 p.m. on the third Thursday of each month. Call 501-663-7833 for more information.

– Buddy Program. Buddies are trained volunteers who assist people with AIDS (either at home or in the hospital) with daily activities and provide support and companionship. For assignment of a buddy, call Randy Jones at 501-376-2220 or 501-663-7833.

APPENDIX

TANNER SCALES

	GIRLS	BOYS/GIRLS	BOYS	BOYS
STAGE	BREAST GROWTH	PUBIC HAIR GROWTH	TESTES GROWTH	PENIS GROWTH
1	Preadolescent	None	Preadolescent	Preadolescent
2	Breast budding; Areolar hyperplasia with small amount of breast tissue	Long, downy pubic hair near the labia, straight or slightly curled	Enlargement of testes; increased stippling and pigmentation of scrotal sac	Minimal or no enlargement
3	Further enlargement of breast tissue and areola, with no separation of their contours	Increase in amount and pigmentation of hair, coarser and more curled	Further enlargement	Significant enlargement, especially in length
4	Separation of contour; areola and nipple form secondary mound above level of breast	Adult in type but covers smaller area than in adult	Further enlargement; scrotal skin darkens	Further enlargement, especially in diameter
5	Larger breast with single contour (areola not elevated)	Adult in distribution	Adult in size	Adult in size

RAPE TRAUMA SYNDROME

All victims of rape go through stages of crisis and recovery from their assault. This process is called Rape Trauma Syndrome (RTS). If you have been raped, it is important to realize that no matter how you deal with the trauma, it is your rape and you may react in your own way. Everyone is unique and has different ways of coping and handling stress. It is important to deal with this trauma instead of trying to "forget" it. Only through the healing process will you become whole and happy again.

Stages of Rape Trauma Syndrome

It is helpful to know the signs and symptoms of the three stages of RTS in order to know what to expect during your recovery. You are not alone. One in four females will be sexually abused in her lifetime; one in ten males will be sexually abused in his lifetime. These common factors link rape victims together.

IMPACT STAGE (first few days)
Possible Psychological Reactions: Controlled: feelings are masked or hidden. You appear quite calm and in control. Expressed: you let your feelings out. You cry, talk, show nervousness, shakiness and other outward behavior. You may want to avoid talking or thinking about the rape, or you may constantly go over the attack in an attempt to rationalize it. Both reactions are normal.

ACUTE STAGE (up to six weeks)
Possible Physical Reactions: soreness, bruising, irritated throat, tension headaches, fatigue, sleep disturbances, jumpiness, stomach problems, nausea, vaginal discharge, itching, burning, rectal bleeding and pain.
Possible Psychological Reactions: The most significant feeling you may have now is fear of being hurt again or being killed. It is fine to take more precautions now, but it helps to try to get back into a normal routine again. You may also feel a degree of self-blame, guilt or embarrassment. Other rape victims have these feelings too. You may find yourself asking why this happened to you. No matter what you did, please know that you did not provoke the rape. Try to be "in tune" with your feelings; let yourself express them by talking with a sympathetic friend or counselor — then move on.

LONG-TERM REORGANIZATION STAGE (eight weeks or more)
Possible Physical Reactions: Most of your physical problems should be better by now, but some victims continue to have stomach or menstrual problems for a while after the rape. Generally, your emotional healing will affect the way your body heals. Don't be afraid of your feelings. All of these reactions to the rape are a normal part of your body's healing process.
Possible Psychological Reactions: While this is the time when you are most likely beginning to regain control over your life again, several psychological problems may persist. You may have some upsetting dreams and nightmares about the attack. You may also be afraid of certain people or things which remind you of your rape. You may be scared to be home alone or to be outside. You may have a fear of crowds or sex. Remember, these are normal reactions to the trauma you have been through. You may feel the need to move to a different home, take a vacation, change your telephone number, or visit family and friends more frequently. It will help your recovery to have a network of family and friends to support you now.

ARKANSAS RAPE CRISIS CENTERS

The following is a list of addresses and phone numbers where you may reach rape crisis personnel who will assist you with counseling and various other support services in your community.

Rape Crisis, Inc.
920 West 2nd, Suite 102
Little Rock, AR 72201
501-375-1395
Hotline: 501-375-5181

CASA Women's Shelter
Rape Crisis Program
P.O. Box 6705
Pine Bluff, AR 71611
501-535-0287

Battered Women's Shelter
Crisis Center for the Sexually Assaulted
P.O. Box 712
Texarkana, AR/TX 75504
Hotline: 214-793-4357

Northwest Arkansas Rape Crisis
P.O. Box 1824
Fayetteville, AR 72702
Hotline: 501-443-2000

Abused Women and Children
P.O. Box 924
Arkadelphia, AR 71923
501-246-2587

Garland County Rape Task Force
705 Malvern Avenue
Hot Springs, AR 71901
501-623-4048

Sanctuary, Inc.
P.O. Box 762
Harrison, AR 71601
Hotline: 501-741-2121

Rape Crisis Service
c/o Western Arkansas Counseling &
Guidance Center
3111 S. 70th Street
P.O. Box 2887
Fort Smith, AR 72903
Hotline: 501-452-6650

Delta Rape Task Force
Delta Counseling & Guidance
c/o Warren Service Center
Drawer A
Monticello, AR 71655
501-367-2461

CRIME VICTIMS REPARATIONS BOARD

In 1987 the Arkansas Legislature passed Act 817, known as the "Arkansas Crime Victims Reparations Act." This legislation provides a method of compensating and assisting persons who have suffered bodily injury as the result of violent crime, including DWI. Funds awarded to victims come from assessments placed on people found guilty or pleading guilty or "no contest" to both misdemeanor and felony offenses, including DWIs.

Injured victims of violent crimes or dependents of deceased victims, including those victims of DWI, may be eligible to receive up to $10,000 from the Arkansas Crime Victims Reparations Board for medical expenses, loss of income, replacement services loss and funeral expenses resulting from the crime. The law does not cover loss of property, nor pain and suffering.

You May Qualify For Benefits If:

The crime-related injury or death occurred in Arkansas on or after July 1, 1988.

The crime was reported to law enforcement officials within 72 hours of the incident.

A claim for compensation is filed within one year of the date of the incident.

You are not the offender or accomplice.

Compensation would not benefit the offender or accomplice.

You cooperate fully with the investigation of the incident.

You did not contribute in any way to the injury or death.

All victims of violent crime are eligible as long as the previously mentioned criteria are met. Victims are not required to demonstrate financial need for reimbursement. There does not have to be an arrest or conviction of the assailant before compensation will be paid.

The Arkansas Crime Victims Reparations Board makes all decisions on claims. The claimant will be notified of the date his/her claim will be considered by the Board and will have the opportunity to attend the meeting.

For further information or claim forms call toll free 1-800-482-8982 or 501-682-5028, or write:

The Arkansas Crime Victims Reparations Board
c/o Attorney General's Office
323 Center, Suite 400
Little Rock, AR 72201

Or contact your local Sheriff's Office or Prosecuting Attorney's Office.

ARKANSAS LAW

» ARKANSAS CODE ANNOTATED § 20-9-303. **MEDICAL TREATMENT OF SEXUAL ASSAULT VICTIMS.**

(a) All publicly owned or tax-supported medical facilities in Arkansas shall adhere to the following procedures in the event that a person presents himself or is presented at the medical facility for treatment as a victim of rape, attempted rape, or any other type of sexual assault, or incest:

(1) **Adult Victims.** (A) Any adult victim presented for medical treatment shall make the decision of whether or not the incident will be reported to a law enforcement agency.

(i) No medical facility may require an adult victim to report the incident in order to receive medical treatment.

(ii) The victim shall be examined and treated as a regular emergency room patient. Any injuries requiring medical attention will be treated in the standard manner.

(iii) Evidence will be collected only with the permission of the victim. However, the permission shall not be required in instances where the victim is unconscious, mentally incapable of consent, or intoxicated.

(B) Should an adult victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility.

(i) The victim shall be examined and treated as a regular emergency room patient; any injuries requiring medical attention will be treated in the standard manner; a medical/legal examination shall be conducted, and specimens shall be collected for evidence.

(ii) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

(2) **Minor Victims.** (A) The reporting medical facility should follow the procedures set forth in §§ 12-12-502 and 12-12-507 regarding the reporting of injuries to victims under eighteen (18) years of age.

(B) Any victim under eighteen (18) years of age shall be examined and treated as a regular emergency room patient; any injuries requiring medical attention will be treated in the standard manner.

(i) A medical/legal examination shall be performed and specimens shall be collected for evidence.

(ii) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

(b) Reimbursement for the medical/legal examinations shall be available to the medical facilities pursuant to the provisions of §§ 12-12-401, 12-12-403 and 12-12-404.

» ARKANSAS CODE ANNOTATED § 12-12-401. **DEFINITIONS.**

As used in this subchapter, unless the context otherwise requires:

(1) "Victim" means any person who has been a victim of any sexual assault or incest as defined by §§ 5-14-101, 5-14-112, 5-14-122, and 5-26-202;

(2) "Appropriate emergency medical-legal examinations" means health care delivered to outpatients, with emphasis on the collection of evidence for the purpose of prosecution.

(A) It shall include but not be limited to:

(i) Appropriate stains and cultures to determine the presence or absence of venereal disease; and

(ii) All components contained in an evidence collection kit for sexual assault examination deemed appropriate by the Serology Division of the State Crime Laboratory.

(B) "Appropriate emergency medical-legal examinations" shall not include the treatment of emotional trauma or ambulance services.

(3) "Medical facility" means any health care provider.

» ARKANSAS CODE ANNOTATED § 12-12-402. **PROCEDURES GOVERNING MEDICAL TREATMENT.**

(a) All publicly owned or tax-supported medical facilities in Arkansas shall adhere to the procedures set forth below in the event that a person presents himself or is presented at the medical facility for treatment as a victim of rape, attempted rape, any other type of sexual assault, or incest.

(b)(1)(A) Any adult victim presented for medical treatment shall make the decision of whether or not the incident will be reported to a law enforcement agency.

(B) No medical facility may require an adult victim to report the incident in order to receive medical treatment.

(C) The victim shall be examined and treated as a regular emergency room patient, and any injuries requiring medical attention will be treated in the standard manner.

(D) Evidence will be collected only with the permission of the victim. However, permission shall not be required in instances where the victim is unconscious, mentally incapable of consent, or intoxicated.

(2)(A) Should an adult victim wish to report the incident to a law enforcement agency, the appropriate law enforcement agencies shall be contacted by the medical facility.

(B) The victim shall be examined and treated as a regular emergency room patient, any injuries requiring medical attention will be treated in the standard manner, a medical-legal examination shall be conducted, and specimens shall be collected for evidence.

(C) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

(c)(1) The reporting medical facility should follow the procedures set forth in § 12-12-507 regarding the reporting of injuries to victims under eighteen (18) years of age.

(2)(A) Any victim under eighteen (18) years of age shall be examined and treated as a regular emergency room patient, and any injuries requiring medical attention will be treated in the standard manner.

(B) A medical-legal examination shall be performed and specimens shall be collected for evidence.

(C) The evidence shall be turned over to the law enforcement officers when they arrive to assume responsibility for investigation of the incident.

(d) Reimbursement for the medical-legal examinations shall be available to the medical facilities pursuant to the provisions of § 12-12-404.

» ARKANSAS CODE ANNOTATED § 12-12-403. **UNIVERSITY OF ARKANSAS MEDICAL SCIENCES CAMPUS - EXAMINATIONS AND TREATMENT - PAYMENT.**

(a) The University of Arkansas Medical Sciences Campus shall provide prompt, appropriate emergency medical-legal examinations for sexual assault victims.

(b) All victims seeking treatment shall be exempted from the payment of expenses incurred as a result of the treatment provided the following conditions are met:

(1) The assault must be reported to a law enforcement agency; and

(2) The victim must seek treatment within forty-eight (48) hours of the attack.

(c)(1) It is the express intent of this section and §§ 12-12-401 and 12-12-404 that the victim shall be liable for any medical treatment of a pre-existing injury, physical injury resulting from the assault and any treatment sought or rendered more than forty-eight (48) hours after the attack.

(2) However, in the event the victim is a minor, the forty-eight (48) hour time limitation may be waived if, in the opinion of the examining physician, evidence of sexual activity could be found.

» ARKANSAS CODE ANNOTATED § 12-12-404. **REIMBURSEMENT OF MEDICAL FACILITY - RULES AND REGULATIONS.**

(a) The Office of the Prosecutor Coordinator may reimburse any medical facility that provides the services outlined in this subchapter for the reasonable cost incurred for such services.

(b) The Prosecution Coordination Commission is empowered to prescribe minimum standards, rules and regulations necessary to implement this subchapter. These shall include, but not be limited to, a cost ceiling for each claim and the determination of reasonable cost.

CHILDREN

» ARKANSAS CODE ANNOTATED § 12-12-502. **DEFINITIONS.**

As used in this subchapter, unless the context otherwise requires:

(1) "Child" means any person under eighteen (18) years of age;

(2) "Abuse" means any nonaccidental physical injury, mental injury, sexual abuse, or sexual exploitation inflicted on a child by anyone legally responsible for the care and maintenance of the child, or an injury which is at variance with the history given. The term encompasses both acts and omissions;

(3) "Neglect" means a failure to provide, by those legally responsible for the care and maintenance of the child, the proper or necessary support; education, as required by law; medical, surgical, or any other care necessary for his well-being; or any maltreatment of the child. The term includes both acts and omissions. However, nothing in this subchapter will be construed to imply that a child who is denied medical or surgical treatment and is instead furnished with treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof is for this reason alone a dependent, abused, or neglected child within the meaning of this subchapter.

(4) "Sexual abuse" includes solicitation or participation in sexual activity with a child by an adult or person responsible for the care and maintenance of the child. Sexual abuse also includes any offense relating to sexual activity, abuse, or exploitation, including rape and incest, as set out and defined in the Arkansas Criminal Code and amendments thereto;

(5) "Sexual activity" means any act of deviate sexual activity, sexual intercourse or contact as set out and defined in the Arkansas Criminal Code and amendments thereto;

(6) "Sexual exploitation" includes the allowing, permitting, or encouraging by a person responsible for the child's care and maintenance of engaging the child in prostitution, obscene photographing, filming, or depicting of a child for commercial purposes for any use or purpose;

(7) "Person legally responsible for the child's welfare" includes the child's parents, custodian, guardian, foster parent or any person who is entrusted with the child's care by a parent, custodian, guardian or foster parent, including, but not limited to, an agent or employee or a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the child's welfare;

(8) "Unfounded report" means any report made pursuant to this subchapter which is not supported by some credible evidence;

(9) "Department" means the county or state office of the Department of Human Services.

» ARKANSAS CODE ANNOTATED § 12-12-503. **PENALTY - CIVIL LIABILITY.**

(a)(1) Any person, official or institution required by this subchapter to investigate or report a case of suspected child abuse, sexual abuse, neglect or exploitation who willfully fails to do so shall be subject to a fine of one hundred dollars ($100) and up to five (5) days in jail.

(2) The department or prosecuting attorney is empowered to file petitions in the appropriate circuit court seeking imposition of penalty for violation of this section.

(b) Any person, official or institution required by this subchapter to report a case of suspected child abuse, sexual abuse, neglect or exploitation who willfully fails to do so shall be civilly liable for damages proximately caused by that failure.

» ARKANSAS CODE ANNOTATED § 12-12-504. **REPORTS OF SUSPECTED ABUSE OR NEGLECT.**

(a) When any physician, surgeon, coroner, dentist, osteopath, resident, intern, registered nurse, hospital personnel who may be engaged in admission, examination, care or treatment of persons, teacher, school official, social service worker, day care center worker or any other child or foster care worker, mental health professional, peace officer, or law enforcement official has reasonable cause to suspect that a child has been subjected to abuse, sexual abuse or neglect, or observes the child being subjected to conditions or circumstances which would reasonably result in abuse, he shall immediately report or cause a report to be made to the department.

(b) Whenever that person is required to report under this subchapter in his capacity as a member of the staff of a medical or public or private institution, school, facility or other agency, he shall immediately notify the person in charge of the institution, school, facility, or other agency or his designated agent, who shall then become responsible for making a report or cause a report to be made.

(c) In addition to those persons and officials required to report suspected child abuse, sexual abuse or neglect, any other person may make a report if such person has reasonable cause to suspect that a child has been abused or neglected.

» ARKANSAS CODE ANNOTATED § 12-12-505. **REPORTS OF DEATH.**

(a) Any person or official required to report cases of suspected child abuse, sexual abuse or neglect under § 12-12-504, including workers of the local child protective services, who has reasonable cause to suspect that a child has died as a result of child abuse, sexual abuse or neglect shall report that fact to the appropriate medical examiner or coroner.

(b) The medical examiner or coroner shall accept the report for investigation and shall report his findings to the police, the appropriate prosecuting attorney, the local child protective service agency and, if the institution making the report is a hospital, to the hospital.

» ARKANSAS CODE ANNOTATED § 12-12-506. **PHOTOGRAPHS AND X-RAYS.**

(a) Any person who is required to report cases of child abuse, sexual abuse, or neglect may take or cause to be taken, at public expense, color photographs of the areas of trauma visible on a child and, if medically indicated, cause to be performed radiological examinations of the child.

(b) Any photographs or X-rays taken shall be sent to the department as soon as possible.

(c) Whenever the person is required to report, under this subchapter, in his capacity as a member of the staff of a medical or other private or public institution, school, facility or agency, he shall immediately notify the person in charge of the institution, school, facility or agency or his designated delegate, who shall then take or cause to be taken, at public expense, color photographs of physical trauma and shall, if medically indicated, cause to be performed radiological examinations of the child.

» ARKANSAS CODE ANNOTATED § 12-12-507. **REPORTS - CONTENTS AND OTHER REQUIREMENTS - USE AS EVIDENCE.**

(a) Reports of child abuse, sexual abuse and neglect made pursuant to this subchapter shall be made immediately by telephone and shall be followed by a written report within forty-eight (48) hours if so requested by the receiving agency. The receiving agency shall immediately prepare and forward a written report to the statewide central registry, on forms supplied by the registry, within twenty-four (24) hours after the initial report, except weekends and holidays. The investigation of each report of suspected abuse or neglect shall begin within seventy-two (72) hours or within twenty-four (24) hours after the initial report of child abuse, sexual abuse or neglect required by this subchapter which involves sexual abuse or serious physical abuse involving death, bone fractures, internal injuries, head injuries, burns, immersions or suffocations, severe bruises or abandonment. The Department of Human Services shall notify and initiate an investigation in cooperation with law enforcement agencies and the prosecuting attorney.

(b) The reports shall include the following information:

(1) The names and addresses of the child and his parents or other persons responsible for his care, if known;

(2) The child's age, sex and race;

(3) The nature and extent of the child's injuries, sexual abuse or neglect, including any evidence of previous injuries, sexual abuse or neglect to the child or his siblings;

(4) The name and address of the person responsible for the injuries, sexual abuse or neglect, if known;

(5) Family composition;

(6) The source of the report;

(7) The person making the report, his occupation and where he can be reached; and

(8) The actions taken by the reporting source, including the taking of photographs and X-rays, removal or keeping of the child, or notifying the coroner, State Medical Examiner, and other information that the person making the report believes may be helpful in the furtherance of the purposes of this subchapter.

(c) A copy of the written report shall immediately be filed with the appropriate law enforcement agency and the prosecuting attorney's office. In the event the investigation is not conducted by the department or its agents, the investigator shall immediately file a copy of the report with the department.

(d) A written report from persons or officials required by this subchapter to report shall be admissible in evidence in any proceeding relating to child abuse, sexual abuse or neglect.

MEDICAL REPORT FORM FOR SEXUAL ASSAULT EXAMINATION

Patient Name_____ DOB_____ Sex_____

Address_____

Patient brought in by_____ Agency/relationship of escort_____

Date & Time of Assault_____ Date & Time of Exam_____

Patient Hospital Number_____

VITAL SIGNS: Time_____ B.P._____ Pulse_____ Resp._____ Temp_____

HISTORY OF ASSAULT: (Patient's description of pertinent medical details of assault – oral, rectal, vaginal penetration; digital penetration or use of foreign object; oral copulation; ejaculation).

SIGNIFICANT PAST MEDICAL HISTORY:

PHYSICAL EXAMINATION: (Include all details of trauma; abrasions, lacerations, bite marks, insertion of foreign objects; presence of blood or other secretions).

GENITAL EXAMINATION:

External Genitalia_____

Vagina_____

Hymen_____

Cervix_____Penis/Scrotum_____

Uterus_____Rectum_____

DIAGNOSTIC TESTS: (Do not include in evidence collection kit)

__Pregnancy Test: __Pos __Neg

__VDRL/FTA

__GC Cultures: __Oral __Vaginal __Urethral __Rectal

__Chlamydia Cultures: __Oral __Vaginal __Urethral __Rectal

TREATMENT:

Prophylaxis for STD: __Yes __No Medication_____ Dosage_____
Time_____RN_____

Other prescribed medication: Problem_____
Medication_____Dosage_____Time_____RN_____

Tetanus Toxoid given: __Yes __No

Surgical Procedures:_____

PATIENT FOLLOW-UP CARE/LEGAL CHECKLIST:

__GYN/Medical/STD follow-up appointment: __Yes __No

__Sexual assault counseling referral: __Yes __No

__Written and verbal information given to patient: __Yes __No

__Hospital received permission to contact patient: __by phone __by mail __permission denied

__Authorization for Release of Evidence to Law Enforcement Agency completed: __Yes __No

__Appropriate state law enforcement/child protective agency notified (if patient is child of age mandated for report by state statute): __Yes __No

_____

Examining Physician Signature Nurse Signature

_____

Physician Printed Name Nurse Printed Name

SEXUAL ASSAULT FORENSIC LABORATORY REPORT FORM

Patient Name _____

Date of Birth _____ Sex _____ Evidence Collection Kit Number_____

Date _____ Time of Collection _____Date of Assault _____ Time of Assault _____

Sex of Assailant _____ Number of Assailants _____

Prior to evidence collection, patient has:

___Douched ___Bathed ___Urinated ___Defecated ___Vomited ___Had food or drink ___Brushed teeth or used mouthwash ___Changed clothes ___None of the above

At the time of the assault:

Was contraceptive foam or spermicide present? ___Yes ___No ___Don't know

Was lubricant used by assailant? ___Yes ___No ___Don't know

Was condom used by assailant? ___Yes ___No ___Don't know

Was tampon present? ___Yes ___No ___Don't know

Was patient menstruating? ___Yes ___No ___Don't know

At the time of the examination, was tampon present? ___Yes ___No
Menstruating at time of exam? ____Yes ___No
Was patient bleeding from any wounds inflicted by assailant? ___Yes ___ No

HISTORY: (Pertinent details of assault: e.g., oral, rectal, vaginal penetration; assailant penetration of patient with fingers or with other foreign object; oral contact by assailant; oral contact by patient; ejaculation, if known by patient).

PHYSICAL EXAMINATION: (Include pertinent medical details of trauma, secretions on body and clothing, Wood's Lamp/black light examination, if available).

COMMUNICABLE DISEASES OF RISK TO LAB PERSONNEL: (e.g., hepatitis, TB, herpes, HTLV/III, etc., and/or presence of parasites, e.g., head, crab and body lice, mites, etc.).

EVIDENCE ITEMS COLLECTED AND INCLUDED IN KIT

__ Oral swabs	__ External penile swabs	__ Head hair combings & comb
__ Oral smears	__ External penile smears	__ Pubic hair combings & comb
__ Vaginal swabs	__ Saliva disc	__ Dried secretions
__ Vaginal smears	__ Blood tube	__ Dried blood stains
__ Rectal swabs	__ Blood disc	__ Foreign matter
__ Rectal smears	__ Fingernail scrapings	__ Other

EVIDENCE ITEMS COLLECTED BUT NOT PART OF KIT

__ Clothing __ Photographs __ X-rays __ Other Number of bags ____

WAS AUTHORIZATION FOR RELEASE OF INFORMATION AND EVIDENCE FORM COMPLETED? ___Yes ___No

Nurse _____ Physician _____
(Signature) (Signature)

_____ _____
(Nurse - Printed Name) (Physician - Printed Name)

Name of Hospital _____

City and State _____

Original in Kit / Copy to Hospital

PATIENT INFORMATION FORM

Patient Name _____
Hospital Name _____
Date of Examination _____
Examining Physician _____
Hospital Telephone No. _____

With your consent, a number of specimens were collected from you to provide evidence in court should your assailant be apprehended and the case prosecuted. Additional tests were conducted as follows:

1. A blood test for syphilis Yes ___ No ___
2. Smear and culture for:
   Gonorrhea Yes ___ No ___
   Chlamydia Yes ___ No ___
3. Pregnancy test to determine **pre-existing** pregnancy only Yes ___ No ___

☐ You were given an antibiotic to prevent gonorrhea. However, you must return in 4-6 weeks following this treatment for another test to be sure you do not have syphilis. You need to return for this test and possible treatment the week of _____.
Name of medication _____ Dosage _____

☐ You were not given treatment to prevent AIDS, gonorrhea, or any other venereal disease because

_____
_____
_____

If you want counseling, referrals, and/or follow-up testing and treatment for venereal disease from an agency other than this hospital, call one of the agencies listed below for assistance.

_____
_____
_____

☐ An appointment was made for you at this hospital for follow-up medical treatment on

_____

☐ No appointment was made for follow-up treatment.

☐ An appointment was made for you at this hospital for follow-up counseling on

_____

☐ I have received this Patient Information Form.

_____
(Patient/Parent/Guardian Signature)

☐ I do not wish to receive this Form.

_____
(Patient/Parent/Guardian Signature)

Original to Patient / Copy to Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION AND EVIDENCE TO LAW ENFORCEMENT AGENCY

Patient Name _____

Date of Birth _____ Hospital _____

I **DO**___ **DO NOT**___ hereby authorize _____ Hospital and/or Doctor _____ to conduct a medical examination of my person; to collect blood, hair, urine, tissue and other specimens deemed necessary; to make photographic records of physical trauma if deemed necessary to document findings; and to discuss or disclose medical reports, laboratory reports and photographs to appropriate law enforcement agencies, to the office of the prosecuting attorney having jurisdiction, and to the Prosecutor Coordinator's Office.

Date: _____ Person Examined: _____

Witness: _____ Parent or Guardian: _____

Address: _____

RECEIPT OF INFORMATION

I certify that I have received the following items (check those which apply):

One sealed evidence kit____ X-rays or copies of X-rays____ Photographs____

Sealed clothing bag(s) (if more than one sealed clothing bag, please note)_____

Other _____

Signature of person receiving information and/or articles: _____

Date & Time_____

ID #/Shield #/Star #/Title _____Precinct/Command/District_____

Person receiving article(s) is representative of _____

Name of person releasing articles_____

Original to Hospital / Copy to Law Enforcement Agency

(Please make copies of this form)

SEXUAL ASSAULT VICTIM REIMBURSEMENT FORM

Under Act 403 of 1983, the Prosecutor Coordinator's Office will reimburse a medical facility for costs incurred in performing a medical/legal examination and for tests for venereal disease on sexual assault victims. The Coordinator's Office cannot pay for any treatment other than the medical/legal exam and V.D. tests. Reimbursement will be made only on the following conditions:

1. Treatment is sought and rendered within 48 hours of the attack. (This may be waived if the victim is a minor.);
2. The incident was reported to a law enforcement agency prior to or during the sexual assault examination;
3. Treatment was not for a pre-existing injury, physical injury directly relating to the assault, or any other condition.

To be reimbursed, a medical facility should obtain the physician's certification, complete its section, attaching copies of bills for treatment and any other pertinent forms to substantiate the claim. The form, bill and substantiating documents must be forwarded to the prosecuting attorney in the county where the assault occurred. He verifies it and sends it to the Prosecutor Coordinator's Office, where the claim is then reviewed and processed for payment. Payment generally takes six weeks. For more information, please contact the Prosecutor Coordinator's Office, 323 Center - Suite 750, Little Rock, AR 72201; 682-3671.

MEDICAL FACILITY_____

ADDRESS_____

TELEPHONE NUMBER_____CONTACT PERSON_____

VICTIM'S NAME_____

VICTIM'S ADDRESS_____

DATE & TIME OF ASSAULT_____

DATE & TIME OF TREATMENT SOUGHT_____

WHAT LAW ENFORCEMENT AGENCY WAS NOTIFIED?_____

ATTENDING PHYSICIAN'S CERTIFICATION

I hereby certify that the above-named patient received a medical/legal examination, which included all laboratory tests needed by the State to collect evidence for prosecution. I further certify that none of the treatment for which reimbursement is sought was for a pre-existing condition, a physical injury directly resulting from the sexual assault, or for treatment sought 48 hours after the attack.

PHYSICIAN'S SIGNATURE:_____ DATE:_____

DESCRIPTION OF EXAMINATION, TREATMENT AND TESTS:

_____

_____

_____

** ATTACH COPIES OF BILLS AND OTHER SUPPORTING DOCUMENTS **

PROSECUTING ATTORNEY'S VERIFICATION

I hereby certify that the information contained in the application is true and correct to the best of my knowledge and belief. In my opinion, the alleged victim was sexually assaulted.

SIGNATURE_____

Subscribed and sworn to me this ____ day of _____19___.

_____Commission Expires _____
NOTARY PUBLIC

(Seal)

Revised 8/89