A. KITTITAS COUNTY
CHILD SEXUAL ABUSE INVESTIGATION PROTOCOLS

UPDATED
2004

PARTICIPATING AGENCIES:

Abuse Support and Prevention Education Now
Program Coordinator, Cheryl Cathcart _____;
Date

Central Washington Comprehensive Mental Health
Director, Harry Kramer _____;
Date

Central Washington University Police Department
Chief, Steve Rittereiser _____;
Date

Child Protective Services/DSHS, Ellensburg Branch
Area Supervisor, Lynnette Hynden _____;
Date

Cle Elum Police Department
Chief, Brennen Milloy _____;
Date

Cle Elum/Roslyn School District
Superintendent, Evelyn Nelson _____;
Date

Cle Elum Urgent Care Center
Nurse Manager, Linda Graves _____;
Date

Damman School District
Superintendent, Marsha Smith _____;
Date

Easton School District 28
Superintendent, Sue Ellen White _____;
Date

Ellensburg School District 401
Superintendent, Gretta Merwin _____;
Date

Ellensburg Police Department
Chief, Bob Richey _____;
Date

Kittitas County Department of Health
Director, Nancy Goodloe _____;
Date

Kittitas County Prosecuting Attorney's Office
Prosecuting Attorney, Greg Zempel_____;
Date

Kittitas County Sheriff's Office
Sheriff, Gene Dana_____;

Date

Kittitas County Sexual Assault Interagency Coalition
Chair, Lisa Larrabee _____;

Date

Kittitas Police Department
Chief, Steve Dunnagan _____;

Date

Kittitas School District 403
Superintendent, Jerry Harding _____;

Date

Kittitas Valley Community Hospital
Administrator, Eric Jensen _____;

Date

Kittitas Valley Community Hospital Emergency Department
Director, J. Horsley, M.D _____;

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Planned Parenthood of Central Washington
Medical Director, Sara Cate, M.D._____;

Date

Thorp School District 400
Superintendent, Virginia Erion, PhD. _____

Date

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B. INTRODUCTION

These protocols are designed to assist agencies responsible for the investigation and intervention surrounding complaints of child sexual abuse, to improve the reliability and integrity of investigations, and to protect the interests of victims, suspects, and our community.

They are guidelines to assist agencies in coordinating their differing roles/responsibilities, and to direct attention upon issues that may arise during such investigations. They form the basis for interagency cooperation and interaction in Kittitas County when dealing with investigations of Child Sexual Abuse.

The individuals and agencies that worked together to produce this document, while having independent functions to perform, share the goals of protecting child victims, holding offenders accountable, and seeking justice as defined by each individual case.

These goals must be accomplished with limited resources and thus these protocols are intended to assist in limiting conflict, duplication, and repetition.

If you have any questions about these protocols, or to obtain an additional copy, please contact Gregory L. Zempel, Kittitas County Prosecuting Attorney at:

Room 213
Kittitas County Courthouse
205 West 5th
Ellensburg, WA 98926
(509) 962-7520

C. LEGAL STANDING

- These protocols do not create legal authority for the admissibility or non-admissibility of evidence developed in the course of an investigation.
- These protocols do not create legal authority for the dismissal of any charges or complaints arising from a report of child sexual abuse.
- These protocols are intended solely for the guidance of agencies involved in the investigation and intervention surrounding complaints of child sexual abuse in Kittitas County. They are not intended to, do not and may not be relied upon to create a right or benefit, substantive or procedural, enforceable at law by any party in litigation with the state or Kittitas County or individual investigators or others who are a party to these protocols.

There is no single definition of a perfect investigation or interview. Each case, each victim, and each family involved creates a new and unique set of circumstances for the investigator. For these reasons it is essential that investigators and clinicians have the freedom to exercise judgment in each individual case.

Where deviations from these protocols occur, consideration should be given to the extenuating circumstances giving rise to such deviation. Such deviations are acceptable, and investigators can, and will be expected, to present their rationale for such deviation.

D. PROTOCOL CONTENTS

I. MISSION STATEMENT

The purpose of these protocols is to provide a clear framework for an interagency response to child sexual assault investigations, which is thorough, objective, and complete. These protocols promote collaboration among agencies involved in child sexual assault cases and recognition of and respect for, role distinctions between agencies. They serve to strengthen the reliability of investigations and safeguard the integrity of child victims, suspects, and our community.

This purpose is accomplished by:

Providing clear guidelines for inter and intra-agency child sexual assault investigation practices;
Encouraging understanding and respect for the different goals and responsibilities of participants, and managing —conflicts that may interfere with the efficiency, timeliness, and reliability of the investigation;
Increasing requisite skills through training, coordination, and critical review of actions taken;
Minimizing the number of investigative interviews conducted with victims, when possible;
Minimizing the trauma of all persons who are interviewed during abuse investigations; and
Maintaining routine coordination and communication among investigating agencies to ensure information is shared in a thorough and timely manner;
Recognizing the needs of special populations.

II. AGENCY ROLES AND RESPONSIBILITIES

The agencies and/or professionals that investigate child sexual abuse cases have different roles and responsibilities. It is important that professionals recognize and respect the knowledge, training, and responsibilities of other participants and refrain from engaging in activities outside the scope of their function or which interfere with the duties of other participants.

1. ROLE OF CHILD INTERVIEWER

The main objective of the Child Interviewer is to obtain legally sufficient statements from victims that will withstand scrutiny in a court of law in order to facilitate convictions of perpetrators. Interviews will be conducted with sensitivity to the child's developmental level and emotional well-being.

The Child Interviewer will:

- Conduct interviews of all victims of sexual abuse in Kittitas County under the age of 18;
- Be available, at the request of Law Enforcement or CPS, to conduct interviews of witnesses of sexual assault and adult victims of sexual assault with special needs;
- Be available to conduct courtesy interviews of child victims/witnesses or special-needs victims/witnesses of other crimes for CPS or Law Enforcement at the discretion of the Prosecuting Attorney;
- Obtain background information from the Investigating Officer and assigned CPS Social Worker;
- Inform ASPEN advocate of scheduled interviews;
- Conduct interviews in the child interview room at DSHS whenever possible;
- Conduct interviews at the child's school when necessary;
- Conduct interviews while the Investigating Officer observes. A deputy prosecuting attorney and CPS Social Worker (if sharing the case) should also observe when possible;

- Digitally record interview onto DVD disc (if the interview must be conducted somewhere other than the DHSH interview room, the interview shall be audio-taped);
- When the interview is completed, the Child Interviewer checks with observers regarding any requests for further questioning. When appropriate, the Child Interviewer will return to pose these additional questions to the child;
- Make a DVD copy of the interview for the Prosecutor's Office;
- Give original DVD, and any original drawings done by the victim during the interview pertaining to the sexual abuse disclosure, to investigating officer to keep in evidence;
- In cases where the interview has been audio-taped only, and sexual abuse has been disclosed, transcribe the taped interview and forward the signed transcript to the appropriate agencies;
- Type a summary of non-disclosure audio-taped interviews and forward signed summary to appropriate agencies;
- Return the original tape of interview, whether transcript or summary done, to investigating officer for keeping in evidence;
- Forward any original drawings done by the victim during the interview pertaining to the sexual abuse disclosure, with the audio transcript or summary to investigating officer for keeping in evidence;
- Be available to testify in court;
- Participate in multidisciplinary sexual assault case review meetings as needed;
- Attend ongoing training related to child sexual assault interviewing and investigation;
- Train mandatory reporters regarding their role with suspected child victims of sexual abuse on an on-going basis, training shall be conducted in conjunction with Law Enforcement and CPS whenever possible;
- Work with ASPEN in the implementation of prevention education programs in Kittitas County;
- Be available to present community talks related to child sexual abuse, forensic interviewing, or child abuse investigation.

The Child Interviewer also serves as the chairperson for the Kittitas County Sexual Assault Interagency Coalition. (See "Role of SAIC" page 15) The Child Interviewer will distribute relevant sexual assault information to interagency members. The Child Interviewer

will also conduct, arrange or announce periodic training on sexual assault topics.

2. ROLE OF LAW ENFORCEMENT INVESTIGATORS

Upon receipt of a child sexual abuse referral, Law Enforcement will assign an Investigating Officer as soon as possible. The time limits are dictated by the situation, but generally these reports will be responded to within 24 hours. The Investigating Officer will:

- Ensure all referrals are routed to the proper law enforcement jurisdiction and Child Protective Services Agency;
- Notify CPS in the following cases (within 24 hours if emergent, 72 hours in all other cases; phone or fax notice as appropriate)
  - abuse where the alleged offender is a member of the household of the victim,
  - the offender has continuing access to the child,
  - alleged abuse occurred in licensed facilities,
  - offender is under age of 8,
  - parent of child victim is not protective of victim;
- If child is in immediate danger of being further abused, or when a parent or guardian is failing to protect child from further abuse, law enforcement may elect to take child into temporary protective custody;
- Law enforcement officials taking a child into temporary custody for cases of physical or sexual assault will be responsible for initiating any required medical treatment. This is usually done in conjunction with CPS;
- Law enforcement will contact ASPEN to request coordination of exam with sexual assault nurse examiner;
- Once the forensic evidence is collected, it will be law enforcement's responsibility to secure the evidence and transport it to an evidence facility consistent with the law enforcement agency's established practices and policies. Evidence requiring crime lab processing will be submitted by law enforcement to the lab as deemed necessary or as requested by the prosecuting attorney's office;
- Investigate all cases of alleged sexual abuse in which the alleged perpetrator is eight years of age or older. If the alleged perpetrator is under eight years of age, the information shall be forwarded to the Prosecutor's office

to determine need for a Sexually Aggressive Youth (SAY) investigation;

- Complete an offense report and assign a case number;
- Conduct a complete and detailed interview of any person to whom the initial report of sexual abuse was made;
- Contact Child Interviewer as soon as possible to schedule an investigative interview with the child;
- Within two weeks of receiving the report, notify child's family of time set for child interview unless notification would jeopardize the integrity of the investigation;
- Notify CPS of scheduled interview;
- Provide relevant background information to the Child Interviewer including, if possible, the initial police report. This information should include: age of child, what the child reported and to whom, any special considerations regarding the child's capacity to be interviewed (e.g., hyperactivity, shyness, disability, etc.);
- Observe the child's interview and provide feedback;
- Debrief child's family directly following the interview when practical;
- Conduct all other witness interviews or request that Child Interviewer assist with witness interviews. Law Enforcement shall not conduct second interviews with alleged child sexual abuse victims unless requested by or coordinated through the Prosecutor's Office;
- Always attempt to interview all witnesses within one month of receiving a report;
- Always attempt to interview suspect/s within two months of receiving a report;
- Schedule suspect exam with Kittitas Valley Community Hospital Emergency Department Supervisor or local SANE when law enforcement personnel is not available to conduct suspect exam (see Appendices Q and R for exam guidelines);
- Once the suspect forensic evidence is collected, it will be law enforcement's responsibility to secure the evidence and transport it to an evidence facility consistent with the law enforcement agency's established practices and policies. Evidence requiring crime lab processing will be submitted by law enforcement to the lab as deemed necessary or as requested by the prosecuting attorney's office;
- Forward all reports included in the completed investigations to the prosecutor's office, as per RCW 26.44.030, within three months of receiving a report;

- Participate in multidisciplinary case review meetings as needed;
- Retain the victim's interview DVD or audio-tape in evidence;
- Inform victim's family, CPS Social Worker (if applicable), and Child Interviewer of case status in all cases not forwarded to the Prosecutor's Office within three months of receiving a report;
- Provide additional investigation and documentation of investigation, in writing, to the Prosecuting Attorney;
- Be available to testify in court;
- Law Enforcement Officers who are consistently involved in child sexual abuse investigation will attend ongoing training related to the investigation of child sexual abuse cases;
- The assigned law enforcement officer shall make a decision as to whether or not a case should be identified as a complex case within 48 hours of referral or within 48 hours of discovery of facts or issues that would make the case a complex case;
- When a decision is made that a complex case is presented by the facts of a given case, the referral shall be made immediately to the Prosecuting Attorney, and the processes for convening the team shall be set in motion;

❖ (SEE COMPLEX CASE SECTIONS, PAGE 28 AND APPENDIX I, FOR COMPLETE GUIDELINES)

- Law Enforcement shall not interview victims of sexual assault under the age of 18, except to obtain basic information to determine if the victim is at risk, or in exceptional circumstances. If there is CPS involvement, CPS will be contacted to coordinate joint emergency interview;
- Law Enforcement Officers primarily involved with child sexual abuse investigations should provide training in coordination with the Child Interviewer and Child Protective Services to school personnel regarding the mandatory reporter's role in child sexual abuse investigations.

3. ROLE OF PROSECUTING ATTORNEY'S OFFICE

The Prosecutor will assign a deputy at the time the case is received from law enforcement. The assigned Deputy Prosecutor, or his or her designee, will:

- Act as the contact for the victim, investigating officer, ASPEN advocate, etc., from that time forward;
- Decide whether or not charges will be filed or if additional information is necessary to make such a decision within
- thirty days of receipt of a report from Law Enforcement.
- In every case, the prosecutor will follow the filing and decline guidelines set forth in RCW 9.94A.411 and any additional guidelines that may have been adopted by the Kittitas County Prosecuting Attorney.
- The thirty days charging decision requirement may be extended in order to facilitate further inquiry and investigation of a case referred to the Prosecutor. All follow-up investigation should be conducted by law enforcement detectives or officers with training and experience in child abuse cases.
- The Prosecutor shall communicate requests for follow-up investigation work clearly and in writing, and have a discussion with the assigned law enforcement officer as to the parameters of the requested investigation.
- The assigned prosecutor and assigned law enforcement officer shall develop a time frame so that the case progress can continue to be monitored within the time frames set forth in these protocols;
- **In an Emergency situation**: The case will be filed earlier (immediately) if necessary to keep an alleged offender in custody, or a warrant issued on the offender, if probable cause exists for such detention;
- Seek a "no contact" order between the victim and alleged offender in all cases where charges are filed. "No contact" includes any supervised contact. Violations should be reported to the Prosecutor's Office for revocation of bond proceedings. In general, in the case of conflicting or overlapping court orders, the most restrictive order about contact should be followed;
- Contact ASPEN advocate to inform of all scheduled hearings, court proceedings and victim contact;

- Once a charging decision has been made, the prosecutor's office will, whenever possible, notify the victim, or appropriate parent or guardian or other person the victim requests, the local office of D.S.H.S (when applicable), the submitting law enforcement agency, and the sexual assault interviewer of the decision to charge or to decline to charge a crime within five days of making the decision (RCW 26.44.030);
- "Statutory Referral Only" cases will be returned by the Prosecutor to the proper law enforcement agency;
- Notify the victim and Law Enforcement of all scheduled hearings and any changes in scheduling. The victim and Law Enforcement shall have the opportunity to speak at sentencing, and will be informed of any plea bargains prior to the offer going to the defense;
- The Prosecutor should provide routine status updates of case progress to the victim or their representatives as appropriate, including apprising them of decisions affecting the case throughout the process, and may utilize advocates to enhance communication. Other participating agencies shall also be provided such status updates;
- Complete a Sexually Aggressive Youth referral to CPS in any case where the alleged offender is under age 12 and cannot be prosecuted for the alleged sexual offense because the child is incapable of committing a crime as provided in RCW 9A.04.050, (Appendix E). Such referrals shall only be made where the Prosecutor believes that probable cause exists to believe that the child engaged in acts that would constitute a sex offense;
- Enter protective orders for DVD interview tapes that are requested by the defense under RCW 10.97.130 and CrR4.7;
- Participate in multidisciplinary sexual assault case review meetings as needed;

❖ In the event that a dispute arises among the agencies during an investigation, the Law Enforcement Investigator, CPS social worker, Child Interviewer, and ASPEN advocate shall convene a multi-disciplinary team meeting through the Prosecutor's Office to resolve such dispute.

4. ROLE OF SCHOOL PERSONNEL

All school personnel are mandated by law to report suspected child sexual abuse. This extends to all professional school personnel: registered or licensed nurses; social service counselors; psychologists; certified child-care providers or their employees and includes child-care centers.

A school employee who has reasonable cause to believe that a student has been a victim of sexual misconduct by another school employee, shall report such misconduct to the appropriate school administrator, as mandated by RCW 28A.400.317. The school administrator shall cause a report to be made to the proper law enforcement agency pursuant to RCW 26.44.030.

If a professional school employee has reasonable cause to believe a child has been sexually abused, by anyone other than another school employee, the employee will:

- Make a report to the jurisdictional law enforcement agency, and/or CPS at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe that a child has suffered abuse (RCW 26.44.040, Appendix C) (failure to report is a gross misdemeanor that is punishable under RCW 26.44.080);
- School personnel should not pre-interview the child or call in school mental health practitioners to try to determine if the report is credible or if a report should be made;
- If the child makes a disclosure directly to school personnel, school personnel should document the disclosure and contact law enforcement who will follow up with a formal interview regarding the allegation;
- School personnel should continue to provide reassurance to the child as needed during the investigation, but refrain from asking questions about the abuse;
- School personnel should not notify parents, guardians or other school staff members that a report has been made. The agencies of primary statutory responsibility for investigating the allegation are responsible for informing families;
- Complete the Child Abuse Report Form (Appendix F) as per the Cooperative Agreement between Kittitas County

Public School Districts, Child Protective Services, and Law Enforcement as quickly as possible. One copy shall be sent directly to CPS and law enforcement, and the other shall be kept in a secured and confidential file apart from the regular student records;

- Each school shall abide by the Cooperative Agreement between Kittitas County Public Schools, CPS, and Law Enforcement regarding mandatory reporting of child sexual abuse;
- Work cooperatively with CPS and Law Enforcement. Allow them to access all relevant records;
- Participate in multidisciplinary sexual assault case review meetings as needed;
- Each school shall ensure that all mandatory reporters are trained on the statutes and Kittitas County Child Sexual Assault Protocols regarding mandatory reporting.

In the event that the child interview is conducted at the school, the interview will be conducted in an available private space and be audio-taped. Law Enforcement and CPS may be present for the interview along with the Child Interviewer. At the request of the child, school personnel may be asked to observe the interview.

5. ROLE OF CHILD PROTECTIVE SERVICES (CPS)

Upon receipt of a referral of alleged child sexual abuse, CPS will:

- Notify the proper law enforcement agency within 24 hours (as dictated by accreditation standards). If initial contact is made by telephone, a written report shall follow within five days. It is not the responsibility of CPS to determine whether or not the alleged abuse is a chargeable crime before reporting to the proper law enforcement agency;
- Make every reasonable effort to determine proper jurisdiction prior to forwarding referrals to Law Enforcement;
- Notify ASPEN Advocate of child sexual abuse referral;
- Assign an investigative social worker if the referral falls within the legal definition of abuse and neglect. Referrals assessed at a low level of risk might not be assigned for investigation;

- Begin all abuse/neglect investigations and make face-to-face contact with the child victim within 24 hours (as dictated by accreditation standards). CPS and law enforcement agencies have different investigative responsibilities. Law enforcement has the exclusive responsibility for investigation that may lead to the filing of criminal charges. CPS has the exclusive responsibility to investigate the risk factors involved with a child's parental/living situation. Though the criminal and civil investigations differ in focus, they are not mutually exclusive. The needs and constraints of both law enforcement and CPS require a high degree of cooperation and communication beginning with the initial referral. A lack of coordination between the respective investigative agencies can be detrimental to both investigations, and the desired outcomes of protecting children and prosecuting those that harm children;
- The investigating Social Worker will observe the child interview that is conducted by the Child Sexual Assault Interviewer as appropriate;
- Interview the alleged victim within ten working days only in cases in which coordination with Law Enforcement and Child Interviewer has not been possible;
- Share information with investigating law enforcement agency as directed in this protocol;
- Remain involved as long as is necessary (within Department policy guidelines) to complete the investigation and ensure the safety of children;
- Participate in multidisciplinary sexual assault case review meetings as needed;
- Investigate any referrals that allege that a child is a Sexually Aggressive Youth (RCW 74.13.075,Appendix G) in order to determine whether the youth has been abused or neglected as per statute (RCW 26.44.160,Appendix H);
- CPS Social Workers who are consistently involved in child sexual abuse investigation will attend ongoing training related to the topic of child sexual abuse.

CPS will participate in annual training of mandated reporters upon request. This training will be conducted in conjunction with Law Enforcement and Child Interviewer whenever possible.

6. ROLE OF THE ABUSE SUPPORT AND PREVENTION EDUCATION NOW (ASPEN) PROGRAM

- All ASPEN personnel are mandated by law (RCW 26.44.040, Appendix C) to report suspected child sexual abuse. A report to law enforcement and/or CPS should be made at the first reasonable opportunity, and in no case, longer than 48 hours after there is reasonable cause to believe that a child has suffered abuse;
- ASPEN will provide advocacy to child victims and their families. A child victim and his/her family have the right to be accompanied by an advocate at all phases of the investigation. This includes all contact with Law Enforcement, Child Protective Services, the Child Interviewer, the Prosecutor's Office, medical providers, or the criminal defense attorney;

- Unless the child and/or parent request otherwise, ASPEN will:
- Contact SANE to conduct forensic exam when requested by law enforcement;
- Provide ongoing support;
- Provide information and referrals;
- Provide access to relevant sexual assault information including books, pamphlets, videos, etc. available in the ASPEN library;
- Provide access to legal, medical and social service agencies;
- Provide access to sexual assault therapy;
- Provide advocacy and support through the legal, medical and social service systems (See "Medical Evaluation, Evidence, and Treatment", page 20, for medical referral triage decisions);
- Participate in multidisciplinary sexual assault case review meetings as needed;

7. ROLE OF MENTAL HEALTH PROFESSIONALS

- The staff, employees, and volunteers of agencies providing mental health services are mandatory reporters;
- Any time a mental health provider has a reasonable cause to believe that a child has been a victim of sexual abuse, the provider shall notify law enforcement and/or CPS at the earliest opportunity, which shall not exceed 48 hours. (RCW 26.44.030, Appendix C) The obligation to report extends to previously unknown or unreported abuse;
- The mental health professional will limit his/her discussion of specific events of sexual assault with child until an investigative forensic interview has been conducted, unless further discussion is deemed clinically necessary to address protection and health issues;

    ❖ The investigative forensic interview will be arranged as quickly as possible through law enforcement.

8. ROLE OF THE SEXUAL ASSAULT INTERAGENCY COALITION (SAIC)

The following are the responsibilities of the SAIC that pertain to child sexual assault investigations:

- Develop, review, and revise child sexual assault investigation protocols;
- Track and monitor outcomes of child sexual assault cases;
- Hold regularly schedules meetings;
- Collect county wide data on child sexual assault statistics
- Promote the development of community wide multidisciplinary coordinating bodies that respond to child sexual assault issues;
- Develop and/or provide multidisciplinary sexual assault investigation training;
- Develop and/or promote sexual assault prevention education programs;
- Coordinate public awareness campaigns;
- Perform periodic evaluations of community response to child sexual assault(i.e.: compliance with these protocols).

9. ROLE OF THE MULTIDISCIPLINARY INVESTIGATIVE TEAM (MDIT)

(also see “Multidisciplinary Investigative Teams and Complex Cases/Teams” page 27)

- Collaborate as a team to coordinate investigative practices, and/or review of, specific child sexual assault cases presented for consideration;
- Hold case review meetings not less than quarterly;
- Cooperatively exchange information about cases under review and about investigative and prosecution practices in general;
- Assist agencies in fulfilling their individual professional responsibilities while considering and respecting the roles and responsibilities of other team members;
- Regularly evaluate the effectiveness of the MDIT’s practices;
- Comply with the agreed upon MDIT guidelines and practices as set forth in the county SAIC Protocols (under development at time of adoption of these protocol revisions).

10. ROLE OF MEDICAL COMMUNITY

A specialized medical exam by an expert is recommended for all children where there is a report of a sexual contact offense. The potential benefits of a specialized exam include the opportunity to obtain a medical history from the child as well as a physical exam. Both of these may yield pertinent information and can assist in the overall case evaluation, as well as provide reassurance for the child and family about the child’s physical well being.

A medical exam is appropriate whether or not the contact included “penetration”, and at times may be appropriate even when the contact is reported to have been over clothing.

A. GENERAL PRACTITIONERS

Professional medical providers are mandated reporters of child sexual abuse. (RCW 26.44.030, 26.44.040, Appendix C) If child sexual abuse is suspected, a medical provider shall:

- Make an immediate oral report to the jurisdictional law enforcement agency and/or CPS followed by a written report within five days;
- If a physician has reasonable cause to believe that permitting a child to remain in the care or custody of the adult that is legally responsible for the child will place the child in imminent danger, the physician may detain the child, whether or not medical attention is required, without the consent of the legally responsible adult (RCW 26.44.056, Appendix D);
- Contact ASPEN (509-925-9384)to inform of report and get assistance with referrals to a child sexual assault examination expert(Appendix M);
- Inform child's family of report as appropriate (i.e.: suspect is not guardian of child at time report is made);
- If there is concern that acute trauma or an emergency medical condition exists, perform an initial medical evaluation or refer child to hospital emergency room for immediate medical evaluation;
- If patient must urinate prior to exam, collect urine sample in clean glass jar with a lid;
- Collect evidence as needed if initial evaluation is deemed necessary;

FOR MORE DETAILED INFORMATION, REFER TO "MEDICAL EVALUATIONS, EVIDENCE AND TREATMENT", PAGE 20; AND APPENDICES N THROUGH P)

- Process and store evidence until it is released to law enforcement. It will be law enforcement's responsibility to secure the evidence and transport it to an evidence facility;
- Provide a copy of the exam form to law enforcement immediately after exam or as soon as is practical;
- Maintain communication with investigating agencies, and examination provider;

- Participate in multidisciplinary sexual assault case review meetings as needed;
- The medical provider who performs the sexual assault exam shall inform the child's Primary Care Provider of the procedure when follow up care by the primary care provider is needed or when the primary care provider was the initial medical referrer. This notification will take place within 48 hours of conducting the exam and shall be in writing. Written authorization for the release of this information will be obtained from the patient or legally responsible adult in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

B. SEXUAL ASSAULT NURSE EXAMINER (SANE) OR CHILD SEXUAL ASSAULT EXAMINATION EXPERT:

FOR COMPLETE GUIDELINES ON THE RESPONSIBILITIES OF THE SANE, REFER TO APPENDICES O AND P

The following is an overview of some of the sexual assault examiner's responsibilities:

- Conduct complete victim forensic examination as appropriate, and/or at request of law enforcement;
- Conduct complete suspect forensic exam at request of law enforcement;
- Document all findings utilizing standard exam forms (Appendices N and Q);
- Collect evidence and be responsible for processing and storing evidence until it is released to law enforcement;
- Provide a copy of the exam form to law enforcement immediately after exam or as soon as is practical;
- Maintain contact with investigating agencies;
- Be available to testify in court;
- Respond to victim's needs and provide referrals as needed
- Perform medical triage as necessary;
- Identify acute injuries and refer for treatment and medical clearance to the Emergency Department at Kittitas Valley Community Hospital;
- Participate in multidisciplinary sexual assault case review meetings as needed.

C.KITTITAS VALLEY COMMUNITY HOSPITAL EMERGENCY DEPARTMENT

PLEASE REFER TO N THROUGH R FOR DETAILS ON EXAM AND EVIDENCE COLLECTION

If a victim of sexual assault is presented at the Kittitas Valley Community Hospital Emergency Department:

1. Identify acute trauma, treat and stabilize patient.
2. Identify when the assault occurred.

IF ASSAULT OCCURRED WITHIN THE PAST 96 HOURS:

- Advise patient it is best not to eat or drink anything, or urinate before the examination;
- Collect urine specimen for forensic evidence if patient cannot hold their urine until the examiner arrives;
- Collect blood sample if sexual assault exam provider will not be able to within 24 hours of the assault;
- Advise patient it is best not to wash hands or any other parts of her/his body before the examination;
- If ASPEN has not been contacted, contact ASPEN immediately (509-925-9384);
- Contact law enforcement (if they are not already involved);
- ASPEN will contact sexual assault nurse examiner;
- If expert in sexual assault examinations is not available, conduct complete forensic exam, as appropriate, following the SANE protocols for such cases (see Appendices N, O, and P);
- Collect and be responsible for processing and storing forensic evidence until it is released to law enforcement;
- Provide a copy of the exam form to law enforcement immediately after exam or as soon as is practical;
- Maintain contact with investigating agencies;
- Participate in multidisciplinary sexual assault case review meetings as needed.

IF SEXUAL ASSAULT OCCURRED MORE THAN 96 HOURS PRIOR:

- Contact ASPEN who will assist patient with all necessary community referrals.

If law enforcement has scheduled to have a suspect forensic exam conducted by hospital staff:

- Conduct complete suspect forensic exam utilizing "Suspect Forensic Exam Form" and "Suspect Forensic Exam Guidelines" (Appendices Q and R);
- Provide a copy of the exam form to law enforcement immediately after exam or as soon as is practical;

III. MEDICAL EVALUATION, EVIDENCE, AND TREATMENT

1. TRIAGE DECISIONS FOR CHILDREN UNDER 13 YEARS:

Examination within 24 hours is recommended when:

- There is a clear report of, or witnessed sexual abuse that occurred within the previous; 72 hours; (exception: child to child contact with no apparent injury)
- Active vaginal or rectal bleeding of unknown etiology and concern for abuse;
- High risk situation such as abduction.

Advise family (and or victim)that the victim:

- Should not bathe before exam;
- Should bring in clothes worn at time of abuse (if not already collected by law enforcement), and bring change of clothing;
- Should collect urine sample in clean glass jar with a lid, if patient must urinate prior to exam;
- Could experience wait time for the exam.

Examination within the next 1 to 10 days, depending on circumstances, is recommended when:

- There is a clear report by child, or witnessed sexual contact which occurred more than 72 hours prior.

A <u>scheduled exam</u> (with a sexual assault exam expert or other qualified medical provider when expert is not available) is appropriate when:

- Child has concerning symptoms, such as pain with urination, vaginal discharge, or signs such as vulvar redness, and no clear report or witnessed abuse;
- Visible vaginal or anal abnormality with no definite abuse event;
- A young child has made vague statements which might have a variety interpretations;
- The medical provider may request consultation with a child sexual abuse specialist.

2. TRIAGE DECISIONS FOR ADOLESCENTS (13 TO 17 years):

Refer child for an <u>emergent (immediate) exam</u> with a sexual assault nurse examiner (SANE) or a physician trained in forensic sexual assault examinations whenever possible, or to the hospital emergency room when an expert is not available when:

- The reported abuse or assault occurred within the prior 96 hours;
- Advise: do not bathe before exam;
- Advise: bring clothes worn at time of assault (if not already collected by law enforcement) and a change of clothes;
- Advise: if patient must urinate prior to exam, collect urine sample in clean glass jar with a lid;
- Advise: Wait time and exam may last several hours.

A <u>scheduled exam</u> (with a sexual assault exam expert or other qualified medical provider when an expert is not available) is appropriate when:

- The reported abuse or assault occurred more than 96 hours prior. Forensic documentation may or may not be appropriate, depending on the case circumstances.

3. CONSENT FOR CARE- CHILDREN UNDER THE AGE OF EIGHTEEN:

In general, in the state of Washington, the parent or legal guardian must sign consent for care for patients under 18 years of age. There are some legal exceptions to this that may apply to medical care after sexual assault.

These exceptions may include, but are not limited to:

- A person of any age may obtain confidential care for pregnancy or birth control (RCW 9.02.100; State v. Koome)
- A person age 14 or older may obtain confidential care for sexually transmitted diseases (RCW 70.24.110)
- If a minor is legally emancipated, by court decree, the minor has the same rights as an adult regarding consent for medical care.
- When a minor is married to a person of full age, the minor shall be deemed and taken to be of full age (RCW 26.28.020)
- Emergency care at a hospital emergency department pursuant to United States Code (USC) 42, Chapter 7, XVIII, 1395dd
- As provided by RCW 18.71.220, relating to immunity of licensed physicians and hospitals in rendering emergency care
- Search warrant from the court

In circumstances where there is significant concern of sexual abuse within the previous 72 hours, and the parent or guardian is unavailable or unwilling to sign for medical care, call the police to place child into protective custody.

If a physician has reasonable cause to believe that permitting a child to remain in the care or custody of the adult that is legally responsible for the child will place the child in imminent danger, the physician may detain the child, whether or not medical attention is required, without the consent of the legally responsible adult. (RCW 26.44.056, Appendix D)

Mandatory reporting to law enforcement or CPS is still required for persons under 18 years of age. The teen should be advised that if CPS or law enforcement is

notified, it is possible that their parents will be informed about the event by those agencies.

4. EVIDENCE:

SEE APPENDICES O, P, AND R FOR DETAILED EVIDENCE HANDLING INFORMATION

After the initial child interview, important medical information to collect includes: active medical problems, current medications, recent ingestion of prescription drugs, illegal substances, or alcohol, ob-gyn history, last menstrual period (if applicable), last intercourse prior to sexual assault, if within past 96 hours,(if applicable), current vaccinations, and any allergies.

Once the forensic evidence is collected, it will be law enforcement's responsibility to secure the evidence and transport it to an evidence facility consistent with the law enforcement agency's established practices and policies. Evidence requiring crime lab processing will be submitted by law enforcement to the lab as deemed necessary or as requested by the prosecuting attorney's office.

The medical provider who performs the sexual assault exam shall inform the child's Primary Care Provider of the procedure when follow up care by the primary care provider is needed or when the primary care provider was the initial medical referrer. This notification will take place within 48 hours of conducting the exam and shall be in writing. Written authorization for the release of this information will be obtained from the patient or legally responsible adult in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. A copy of the exam form should be provided to law enforcement immediately after the exam or as soon as is practical.

It is important to keep in mind that it is possible for a sexually assaulted child to have a normal physical exam. This should not deter a complete and thorough investigation of the incident by law enforcement.

IV. SUSPECT AND WITNESS INTERVIEWS

Law enforcement shall always attempt to interview all witnesses within one month, and all suspects within two months of receiving a report. A complete and detailed interview shall be conducted with any person to whom the initial report of sexual abuse was made to determine facts relevant to the investigation. In cases where CPS is involved and required to interview a parent or guardian who is also a suspect, CPS and law enforcement shall coordinate this interview in a manner which does not interfere with the criminal investigation, but allows both agencies to meet their statutory and policy requirements.

Law enforcement should use appropriate investigative tools at the earliest possible point in the investigation in order to preserve essential evidence. Investigative tools may include but are not limited to the following:

- Search warrants;
- Documentation and processing of crime scenes and other evidence;
- Trace evidence;
- Biological evidence;
- Forensic suspect exam;
- Interview of corroborative and alibi witnesses; and/or
- Single party consent warrants (telephone recordings).

The interview of the person to whom the initial report of sexual abuse was made should cover the following:

- The circumstances under which the report occurred;
- What precipitated the report;
- What each party said;
- The demeanor of the child and/or witness; and
- Who was present during the report.

1. INTERVIEW OF SUSPECT:

If practical, prior to interviewing the suspect, Law Enforcement should assess whether the suspect has discussed the incident(s) with other agent(s) of the state. Law Enforcement shall have the sole responsibility for suspect

interviews in criminal cases. Other state agents should refrain from making any inquiries of the suspect or advising the suspect regarding the possible or pending involvement of Law Enforcement, and shall report the content and context of any communication with the suspect to Law Enforcement.

The suspect should be interviewed as soon as reasonably practical after Law Enforcement has obtained sufficient information for a meaningful interview while considering the safety of the victim, the timing of the victim's disclosure, the likelihood that the suspect will flee, and the integrity of the investigation. Whenever possible, these interviews should be conducted within two months of receiving a report.

Suspects should be offered the opportunity to make a recorded statement. The conduct and results of the interview shall be documented in a report, which should incorporate or reference notes taken by law enforcement during the interview.

2. INTERVIEW OF WITNESS:

All persons with information pertinent to the case should be interviewed to assist in gathering and collecting evidence, and to corroborate details from the victim interview and from the suspect interview. Witnesses should include non-offending household members, siblings, or collateral witnesses, and should be interviewed in an age appropriate manner. Special care should be taken to determine the basis of the witness's information or knowledge.

Law Enforcement may request the assistance of the Child Interviewer for witnesses under the age of 18.

Whenever possible, all witness interviews should be conducted within one month of receiving a report.

The conduct and results of the interview along with the identity of the witness (full name and date of birth) and contact information (address and phone number) shall be documented in a report which should incorporate or reference notes taken by Law Enforcement during the interview.

V. CHILD INTERVIEWS

The Child Interviewer will conduct all interviews of victims of sexual assault under the age of 18 whenever possible. If, in an emergent case situation, the Child Interviewer is unavailable to conduct the investigative interview, the interview should be conducted by a trained Law Enforcement Investigator in conjunction with CPS Social Worker whenever possible. In the event that there are no persons trained in accordance with RCW 43.101.224 and 74.14B.010 (Appendix A), a commissioned Law Enforcement Officer may conduct a preliminary interview to establish the welfare of the child, basic disclosure, assess need to remove child from environment, or need to effect an immediate arrest.

The Child Interviewer shall make every effort to conduct a developmental assessment of the child victim or witness to assess the child's developmental level. A child's special needs will be considered in the investigative interview.

Child interviews will preferably take place in the child interview room at the Ellensburg DSHS office. But when the needs of the investigation or child determine otherwise, the interview may be conducted in an alternate location.

If the interview is conducted in an alternate location, the interview shall be audio-taped.

Investigative interviews of a victim shall be digitally recorded onto a DVD disc when child's consent is obtained. The original DVD disc shall be given to the investigative officer for keeping in evidence.

A copy of the original DVD shall be made for the prosecutor's office.

Audio-taped interviews in which a victim discloses being sexually assaulted shall be transcribed in a near verbatim manner.

Audio-taped interviews in which no disclosure of sexual assault is made shall be summarized in writing.

VI. MULTIDISCIPLINARY INVESTIGATIVE TEAMS AND COMPLEX CASES/TEAMS

1. MULTIDISCIPLINARY INVESTIGATIVE TEAMS (MDITS)

The primary function of the MDIT is participation in sexual assault case review meetings. The purpose of case review meetings is to allow team members to coordinate their work on specific cases to produce thorough, planned investigations (from the initial report to the final disposition). Anytime that a particular case is identified as a "complex case" by law enforcement (see criteria below), an MDIT shall convene as quickly as possible.

The MDIT may also convene to review cases that are at any stage in the investigative process, are inactive, or have been closed in order to evaluate the past effectiveness of the interagency investigative response.

MDIT meetings held for other than reviewing a "complex case" may be arranged by any of the participating member agencies. These meetings shall be held on a semi regular basis, and not less than quarterly. The Prosecuting Attorney's Office shall be responsible for ensuring a quarterly meeting occurs.

The members on an MDIT shall consist of, at a minimum: the officer/detective investigating the case; the child sexual assault interviewer; and the prosecutor assigned to the case.

Other members may include:
CPS caseworker assigned to the case; medical provider who conducted the sexual assault exam; ASPEN advocate; line officers/deputies involved in the case; mental health professional; school personnel; and/or victim/witness assistant.

The team members may vary from one case review to another. One's participation will be determined by his/her investigative involvement in each case.

The coordinated efforts among team members will be guided by written agreement, and as outlined in the SAIC Protocols. (currently under development at time of protocol revisions adoption)

2. COMPLEX CASES

A. Criteria for defining and identifying a complex case for the purposes of criminal investigation and prosecution:

One or any combination of the following factors may indicate a complex case. However, this list is non-exclusive and any case in which the Law Enforcement Investigator determines that additional review and input should be sought is also appropriate for referral to the team.

Multiple Jurisdictions;

- Victim out of county/state/country
- Perpetrator out of county/state/country
- Offenses occurring out of county/state/country with victim in county;
- Offenses occurring in multiple jurisdictions, here and out of county/state/country
- Diplomatic Immunity Cases and the Vienna Convention issues;

Multiple victims;

Multiple perpetrators;

Extreme youth of victim(s);

Age eight (8) is a chronological benchmark, but not exclusive of other factors, such as maturity, capacity, and development

Victim(s) or perpetrator(s) out of county/state/country;

Special circumstances such as developmental disabilities, language barriers, mental health issues, assault involving drug enhancement, or gang-related activity, etc.;

Conflict of interest cases;

Suspect is somehow related to agency/agencies responsible for investigation/prosecution/ intervention.

The assigned law enforcement officer shall make a decision as to whether or not a case should be identified as a complex case **within 48 hours** of referral or within 48 hours of discovery of facts or issues that would make the case a complex case.

When a decision is made that a complex case is presented by the facts of a given case, the referral shall be made immediately to the Prosecuting Attorney, and the processes for convening the team shall be set in motion.

B. <u>Procedures for convening the complex case investigative team:</u>

All referrals of a complex case shall be made to the Prosecuting Attorney.

ii. A referral of a Complex Case must be made with a Complex Case Referral Form (Appendix I), copies of all reports existing at that point in time, and follow-up personal contact in any fashion by the assigned officer referring the case.

The Prosecuting Attorney or his/her designee shall be the party responsible for convening the Complex Case Investigative Team.

Upon referral the Prosecuting Attorney shall convene a meeting of the Complex Case Investigative Team as soon as necessary and practical, but no later than a week from referral.

The Prosecuting Attorney shall convene a meeting of all identified team members as per the below-listed membership as well as any other persons that are deemed necessary to be involved.

Assigned Complex Case Investigative Team members shall be expected to attend any such meeting convened by the Prosecuting Attorney. If their personal attendance is not possible, they shall send a designee who:

- Is familiar with these protocols for complex cases;
- Has decision making authority for investigations; and
- Has been provided with all information available about the particular case.

C. Core members of any complex cases investigative team shall include the following:

Law Enforcement(including tribal, military, federal agencies when appropriate):

Assigned Law Enforcement Officer/Agency, and any Law Enforcement Officer/Agency that may have jurisdiction or involvement with the case; and

The Prosecuting Attorney and/or his/her designee or prosecutor assigned to the case; and

The county child sexual assault interviewer; and

The Supervisor of Child Protective Services(CPS) and/or his/her designee or assigned CPS Case Worker; and

The Director of ASPEN or his/her designee and/or advocate assigned to the victim.

When appropriate, under the circumstances of a specific case, other agencies/professionals/entities involved in the case are to be included in the complex cases investigative team, for example, non-profit organizations, child-care, school, or medical personnel.

D. Outside Agency Contacts:

Agencies in other jurisdictions that have qualified people who are trained and experienced in the investigation of child sexual assault cases and are willing to assist in investigating complex cases are listed as contacts in Appendix B.

Those parties identified in Appendix B shall be verified on a yearly basis, and appropriate changes shall be made to reflect actual resources available.

E. Responsibilities of Complex Cases Investigative Team:

Once the complex case investigative team is convened, the members shall carefully plan and coordinate the investigation. The team should use the Complex Case Investigation Team Checklist, (Appendix J), to plan and coordinate interviews and investigations.

VII. INFORMATION SHARING

1. MANDATORY REPORTERS

Chapter 26.44 (Appendix C) requires certain professionals to report any reasonable belief of child abuse or neglect to law enforcement and/or the Department of Social and Health Services. In Kittitas County this can most easily be done by contacting either the appropriate law enforcement agency (Kittitas County Sheriff; Kittitas, Cle Elum, Ellensburg, or Roslyn Police Department) or the Child Protective Services Unit of the Department of Social and Health Services. Such report shall be made at the earliest convenience, which shall in no event exceed forty-eight hours.

Among the mandatory reporters are school professionals, social service counselors, such as mental health providers, domestic violence programs and social services providers, psychologists, pharmacists, daycare providers, medical providers, law enforcement officers, juvenile probation counselors, department of corrections probation officers, and others. Those defined as mandatory reporters satisfy their legal obligations by making a report to either law enforcement or the Department of Social and Health Services. One purpose of this protocol will be to provide for further information sharing between law enforcement agencies and units of the Department of Social and Health Services such that those who report possible abuse or neglect can feel confident that even if the agency they contact turns out to be an agency that would not be involved in that particular case, that the information they pass along will be shared with the appropriate agencies and therefore, an appropriate response and investigation will be initiated. Child Protective Services is primarily responsible for investigating cases in which a parent, guardian, or other person responsible for the care of a child is suspected of abuse or neglect. Often the Department is not involved in cases of third party abuse where there will be no need to provide services for the home where the child resides. The Department of Licensing (DLR) is responsible for investigating situations where a licensed child-care provider is potentially abusing or neglecting a child.

2. PERMISSIVE REPORTERS

Chapter 26.44 (Appendix C) provides that other persons may report suspected abuse or neglect to law enforcement or the Department of Social and Health Services and, so long as they are acting in good faith, shall be defended and indemnified by the State. These "permissive" reporters include clergy members and any other person who has reasonable cause to believe that a child has suffered abuse or neglect.

3. DEPARTMENT OF SOCIAL AND HEALTH SERVICES REPORTS TO LAW ENFORCEMENT

Whenever the Department of Social and Health Services receives a report of an incident of alleged abuse or neglect the department shall report such incident to the proper law enforcement agency. Such notice shall occur within twenty-four hours after the report is received by the department. (as dictated by accreditation standards) An oral report may be made, provided that, where an oral report is made a written report shall occur within five days thereafter.

Because time may be of the essence in child abuse cases, when CPS receives an initial report of suspected child abuse or neglect, CPS will ordinarily contact a local law enforcement agency for the jurisdiction wherein the alleged incident occurred. Such report will ordinarily be made immediately and by telephone in any situation wherein the information suggests that the child is in immediate risk or that criminal abuse or neglect has occurred, is occurring, or is likely to occur in the near future. Child Protective Services shall be provided with contact information for Duty Sergeants and/or Sergeants in charge of Detectives to ensure that such cases can quickly be referred to an appropriate detective. In addition to making a telephone referral, CPS will ordinarily send a copy of the initial report to the appropriate law enforcement agency by fax or courier the same day it is received.

In cases where factors supporting immediate notice to law enforcement are not indicated, the report to law enforcement will ordinarily be sent by fax, courier, or mailing on the next business day.

4. LAW ENFORCEMENT REPORTS TO DSHS

By statute, in emergency cases, where the child's welfare is endangered, such notice shall occur within twenty-four hours. In all other cases, notice shall be provided within seventy-two hours.

The statute provides the minimum standards. However, time is of the essence in emergency situations and therefore, when the information received by law enforcement suggests a need for immediate CPS involvement, CPS shall ordinarily be contacted directly by phone. It is expected that such contact shall normally occur within one hour. In other cases, where the immediate involvement of CPS is not indicated, the report may be made by telephone, fax, courier delivery, or mailing by the next business day. In either event, the law enforcement agency shall send copies of the incident report to the local office as soon as possible.

5. LAW ENFORCEMENT REPORTS TO KITTITAS COUNTY PROSECUTOR

When a law enforcement agency believes it has fully investigated a case, and there is sufficient evidence to believe that a sex crime has been committed, the case shall be referred to the prosecutor’s office for a charging decision. (RCW 26.44.030)

This does not necessarily mean that the investigation has been completed. Law enforcement may continue to investigate, and it does not prevent the prosecutor from requesting specific follow-up work.

6. KITTITAS COUNTY PROSECUTOR'S REPORTING OBLIGATIONS

The Kittitas County Prosecutor shall notify the victim, any persons the victim requests, the local CPS office, the child sexual assault interviewer, and the appropriate law enforcement agency of its decisions regarding each case referred for review. The prosecutor's office shall, within thirty days of the receipt of a report of a completed investigation by law enforcement, make a charging determination. Within five days of making such a determination, the office shall notify the above individuals and organizations of its decision. Thus, the prosecutor's office has a maximum of thirty five days from the time it

receives a report, to notify the above individuals and agencies of its decision. The decision made may include the possibility that more investigation is required before a final charging decision can be rendered (see pages 8 and 9 for details).

VIII. METHODS OF PROTECTING CHILDREN DURING INVESTIGATIONS AND PROSECUTION

1. INVESTIGATIONS

The safety and wellbeing of the child must be the first priority during any investigation and prosecution of sexual abuse. All reasonable steps should be taken to prevent unnecessary trauma to the child during an investigation and prosecution. This would include but not be limited to minimizing the number of interviews for the child, seeking the least disruptive protective placement options, consistent with RCW 13.34.060, and sensitivity to the child's needs during the trial process.

Law enforcement officers are empowered by RCW 26.44.050 (Appendix K) to take children into temporary custody when there are reasonable grounds to believe that the child is seriously endangered in his or her surroundings and immediate removal appears necessary to protect the child. The decision to place children in temporary custody rests solely with law enforcement officers, although consultation with CPS personnel can be valuable in making such decisions.

CPS personnel have the legal responsibility pursuant to RCW 26.44.105 to notify the parent if the child has been placed in protective custody using the current DSHS Temporary Custody Notification form. The notification process should be a joint process. To the extent possible, CPS personnel should be accompanied by law enforcement officers when making said notification. Law enforcement officers will be responsible for any criminal investigations.

There are circumstances that must be considered prior to any decisions to place a child in protective custody in such cases. **Lesser measures may suffice to protect the child.** This is a case-by-case decision that must be

carefully weighed. Protective measures that may be considered in lieu of temporary custody include:

Choice #1: In consultation with the protective parent/guardian, CPS and law enforcement shall arrange for the alleged perpetrator to be removed from the home and to have no further contact with the victim pending resolution of the matter. (Continued parent custody with non-offending parent in the family home.)

Choice #2: In consultation with the protective parent/guardian, CPS and Law Enforcement shall arrange for immediate correction of any other dangerous home conditions. CPS and other resource providers shall be utilized for the immediate provision of needed services such as advocacy through ASPEN, emergency shelter, and any other support. An agreement shall be made with the protective parent to continue needed services for the duration of the investigation and making sure the child's location is confidential. (Continued parent custody with non-offending parent out of the family home.)

Choice #3: In consultation with the protective parent/guardian, CPS and Law enforcement shall arrange for voluntary placement of the child with a responsible and mutually agreed upon relative or friend. The investigators must reasonably believe that such a third party can adequately protect the child and will make every effort to keep the child from being subjected to retaliation or coerced recantation. (Agreed custody with person other than parent.)

Choice #4: Use of appropriate shelter care placement pursuant to RCW 13.34.060
Any decisions made must be based on the potential for continuing risk to the child. Although prior history with the parents/guardians (if known) is certainly a major factor in the assessment, other factors may indicate that the potential for immediate risk has diminished. The use of appropriate protective/restraining orders should be considered in all cases.

2. PROSECUTION

Children need to be ensured that they have access to advocacy services per RCW 7.69A.030 (Appendix L: Rights of Child Victims and Witnesses). The Victim/Witness Unit of the office of the Prosecuting Attorney will establish a relationship between the child and the prosecutor handling his/her case.
The child will have the opportunity to become familiar with the courtroom by touring the courtroom prior to trial date. The Victim/Witness Unit will work with the child and the child's family to explain any and all court proceedings, provide a description of the different parties involved, and explain the roles of the primary persons present in the courtroom.

The office of the Kittitas County Prosecuting Attorney will provide child victims with a comfortable and private waiting area during the trial. This waiting area is separate from the defendant and other witnesses who may negatively impact the child. The child will have age-appropriate toys and materials available to him/her in the waiting area (coloring books, magazines, video player and television set, etc.).

The deputy prosecuting attorney or city attorney will seek to limit the scope of the child's testimony when appropriate. The prosecutor will also explore alternative means of testimony, i.e. in chambers with child advocate present; in absence of defendant; or by video via closed circuit TV. To prevent further trauma to the child, the office of the Prosecuting Attorney or City Attorney will oppose any and all continuances. At a minimum, the office of the Prosecuting Attorney or City Attorney will provide prompt notification to the child and his/her guardian of all continuances.

Additionally, when the child victim receives a medical examination, the results must be kept in confidence among the investigators. Said information shall not be released unless it becomes necessary in the course of the investigation.

Multiple interviews can contribute to additional confusion and/or trauma on the part of a child victim. The defense is entitled to conduct one interview of the child victim. The Office of the Prosecuting Attorney or City

Attorney shall object to any further interviews by the defense.

All parties involved, including the child, protective parent/guardian and perpetrator, must be apprised of the general status of the investigation and any pending legal proceedings.

IX. TRAINING AND QUALIFICATIONS OF INTERVIEWERS

The Kittitas County Sexual Assault Interagency Coalition shall establish a training committee as a standing sub-committee. The sub-committee shall not be restricted in membership, but shall at a minimum include a representative from:

1. A law enforcement agency;
2. The Prosecuting Attorney or his/her designee;
3. The director of the local CPS office or his/her designee;
4. The director of DV/SA or his/her designee; and
5. A representative from the school districts.

The training committee shall work to:

1. Develop training curriculum to address on-going training requirements at the local level;
2. Act as a clearing house for on-going trainings presented at the state and federal level;
3. Identify resources to address training and equipment needs; and
4. Address any other needs/issues relative to sexual assault investigation/prosecution training and education.

The various agencies shall attempt to meet the training requirements established by state law, and as recommended in these protocols, as follows.

1. LAW ENFORCEMENT TRAINING:

a. Every fully commissioned law enforcement officer within Kittitas County shall be trained on the Kittitas County Child Sexual Abuse Investigation Protocols;

b. Every fully commissioned law enforcement officer within Kittitas County, who will be called upon to interview a child sexual assault victim in circumstances surrounding an emergent case where no primary investigator with additional training is available, shall be trained on the basic investigative skills for an initial interview of such victims;
c. Every law enforcement officer within Kittitas County who has the primary responsibility for investigating cases of child sexual abuse shall have comprehensive on-going training on the requirements set forth in RCW 74.14B.010 and RCW 43.101.224 (Appendix A).

2. CHILD PROTECTIVE SERVICES TRAINING:

a. Every Child Protective Services(CPS) employee within Kittitas County shall be trained on the Kittitas County Child Sexual Abuse Investigation Protocols;
b. Every CPS employee within Kittitas County who will conduct any interview of any duration with a victim or reporting party shall receive on-going training on basic investigative skills for dealing with these victims/parties;
c. Every CPS employee within Kittitas County who has the primary responsibility for assisting in investigating child sex abuse cases shall have comprehensive on-going training on the requirements set forth in RCW 74.14B.010 and RCW 43.101.224 (Appendix A).

3. CHILD INTERVIEWER SPECIALIST TRAINING:

a. The Child Interviewer Specialist for Kittitas County shall have on-going training on the Kittitas County Child Sexual Abuse Investigation Protocols;
b. The Child Interviewer for Kittitas County shall, at a minimum, have comprehensive annual training on the requirements set forth in RCW 74.14B.010 and RCW 43.101.224 (Appendix A).
c. The Child Interviewer shall attend other trainings as deemed necessary and appropriate by the Prosecuting Attorney.

d. The Child Interviewer shall attend any and all trainings, consistent with available time and resources that shall enable that person to conduct local trainings consistent with the protocols outlined below.

4. PROSECUTING ATTORNEY'S OFFICE TRAINING:

a. Every attorney and the victim witness staff of the Office of the Prosecuting Attorney shall have training on the Kittitas County Child Sexual Abuse Investigation Protocols;
b. Every Deputy Prosecuting Attorney involved with the prosecution of cases of sexual assault upon children shall receive comprehensive on-going training on the requirements set forth in RCW 74.14B.010 and RCW 43.101.224 (Appendix A).
c. Any other employee of the Office of the Prosecuting Attorney's Office shall attend additional trainings as deemed appropriate by the Prosecuting Attorney.

5. SCHOOL DISTRICT EMPLOYEES TRAINING:

a. All School Professionals in every school district shall have training on the mandatory reporting laws and education on how to respond in accordance with the goals and objectives of these protocols in responding to a disclosure of possible sexual abuse (Appendix A).

6. VICTIM ADVOCATES TRAINING:

a. Every victim advocate within Kittitas County shall have annual training on the Kittitas County Child Sexual Abuse Investigation Protocols;
b. Every victim advocate within Kittitas County shall have annual training consistent with the goals and objectives of their advocacy role, and the purposes enumerated in RCW 74.14B.010 and RCW 43.101.224 (Appendix A).

7. MEDICAL PERSONNEL:

It is the goal of the Sexual Assault Interagency Coalition to make the Kittitas County Child Sexual Abuse Investigation Protocols available to every physician within Kittitas County. It is a further goal that training would be provided to every physician on these protocols.

8. AVAILABILITY OF TRAINING AND CERTIFICATION:

a. The Department of Social and Health Services, the Washington Association of Sheriff's and Police Chiefs, the Washington Association of Prosecuting Attorney's, and the Criminal Justice Training Commission, in conjunction with Harborview Medical Center will be conducting trainings consistent with the requirements set forth in RCW 74.14B.010 and RCW 43.101.224 (Appendix A).
b. The agencies within Kittitas County responsible for the investigation of child sexual assault cases shall conduct trainings in coordination with one another at the local level, consistent with the training requirements set forth in these protocols, RCW 74.14B.010 and RCW 43.101.224 (Appendix A).

9. RESPONSIBILITY FOR TRAINING AND DOCUMENTATION:

a. Every agency shall be responsible for identifying which members of their agencies shall have the level of training established by these protocols.
b. Every agency shall be responsible for documenting the training provided to their employees.

X. CASE CLOSURE

The culmination of any case comes with its closure. Due to the unique nature of Child Sexual Abuse cases and the necessary cooperation between agencies during their investigation it is essential that formal consistent case closure guidelines be used.

1. LAW ENFORCEMENT:

A law enforcement investigation is closed in one of three ways, consistent with the Uniform Crime Reports(UCR)categories. The time that elapses between the opening and closing of a case will be dictated by individual case circumstances. However, whenever possible, law enforcement will send a complete sexual assault report to the Prosecuting Attorney's Office within three months of opening a case. The victim and their representatives will be notified, via a letter, written by the investigating officer or designee, within two weeks of a closure decision. Copies of this letter will be sent to the child sexual assault interviewer for tracking purposes and to CPS when they are involved.

A. An incident may be closed **"Unfounded"** if through investigation it has been determined that the report was false or baseless or that no offense occurred nor was attempted.

B. An incident may be **"Cleared / Closed by Arrest"** when at least one person has been arrested, or charged with the commission of the offense and/or the information has been turned over to the Prosecutor's Office for a charging decision. No physical arrest is necessary to close a case in this manner. Arrest as used here includes physical arrest, case summary report, or summons.

C. An incident may be closed **"Exceptional"** when each of the following questions can be answered "yes".

- "Has the investigation definitely established the identity of the offender?"

- "Is there enough information to support an arrest, charge, and turning over to the court for prosecution?"
- "Is the exact location of the offender known so that the subject could be taken into custody now?"
- "Is there some reason outside law enforcement control that precludes arresting, charging, and prosecuting the offender?"

❖ Cases that cannot be specifically resolved in any of the three ways outlined above will be considered **"closed"**. Law enforcement agencies may use different terminology to describe this case outcome, such as "closed inactive", or "inactive pending new leads", etc. An example of this type of case would be a case in which the criminal act could be verified, but the suspect could not be identified.

2. PROSECUTOR'S OFFICE:

Once a referral has been received from law enforcement, the matter will remain in "pending" status until a charging decision is made. At the time the case is either declined or charges are filed and prosecution occurs, the referral is formally closed by the Kittitas County Prosecutor's Office.

A. INFORMAL CLOSURE:

The Kittitas County Prosecuting Attorney's Office has no mechanism by which a matter may be informally closed.

B. FORMAL CLOSURE:

In all cases in which a law enforcement investigation has concluded that a crime may have been committed, the case shall be deemed open and pending until such time as the law enforcement agency and the assigned prosecutor agree that the case should be closed.

Closure will normally occur only after criminal proceedings have ended. Closure may result from a final decision that charges will not be filed or from a final judgment rendered in the case.

The Prosecuting Attorney's case will be regarded as closed after any of the following events have occurred:

i. It has been determined that prosecution will be declined AND, where possible, the victim and/or victim's family OR a victim advocate has been advised of the decline and reasons for the decline; or

ii. One year has elapsed after the last adjudication of a case (either by plea or trial) AND no appeal has been filed; or

iii. One year has elapsed after the issuance of a mandate in cases where an appeal is filed.

C. CONSIDERATIONS CONCERNING IMPACTS OF CASE CLOSURE:

Before closing, the investigating agency and assigned prosecutor shall consider the potential impacts upon related cases; e.g., juvenile dependency actions. In situations in which other cases may be effected by closure, CPS and others should be contacted to ascertain the potential impact. In cases in which another proceeding may be impacted, closure can be delayed so long as no person or entity is unfairly prejudiced.

Whenever a decision is made to close an investigation, or move the investigation to inactive status, the victim shall be notified. In addition, any other appropriate party should be informed, such as CPS, the parents or guardians of the child(ren), the victim's advocate (when applicable), involved mental health professionals, and, upon request, other appropriate persons. Notice shall occur within two weeks of the decision. Law enforcement and the prosecutor's office shall be jointly responsible for ensuring the effected parties receive timely notice of the decision.

❖ There may be circumstances in which a case will remain open even though the prosecutor's office has declined to file charges. For example, where the Prosecutor's decision rests upon insufficient evidence and the investigating agency believes there is a reasonable possibility that additional evidence may be discovered, law enforcement may elect to continue the investigation. In special circumstances law enforcement may consider a case investigation to be open but inactive. Such a

situation may arise, for example, when a victim, suspect, or other necessary witness is unavailable.

❖ When a case of child sexual abuse has been open for six (6) months, the Prosecutor and responsible law enforcement officer SHALL notify the victim and the victim advocate, if any, of the status of the investigation, unless such notification would impair the investigation.

D. CLOSURE OF CASES PREVIOUSLY FILED:

The prosecutor shall notify the victim and other appropriate agencies of closure of cases that are filed.

E. ABILITY TO RE-OPEN CASES PREVIOUSLY CONSIDERED CLOSED:

A case that has been closed can be reopened at any time upon the discovery of new/additional evidence relevant to the allegation of sexual abuse, or upon other pertinent changes in the ability to prosecute the case. Such decisions will be governed by consideration of the statute of limitations and speedy trial issues.

3. CHILD PROTECTIVE SERVICES:

- A CPS investigation will be closed in accordance with the guidelines set out in the RCWs and the WACs and pursuant to the guidelines set forth in the DSHS Policies and Procedures Manual.

A CPS case/investigation may be closed when:

A. The problems resulting in the risk of abuse have been alleviated and no new factors have been discovered that would increase the risk of further abuse; the parents' rights have been terminated; or a continuing risk of abuse or neglect exists if further voluntary services are not available or accepted and there exists no plan to file a dependency petition.

B. A CPS case must not be closed for services while a dependency order or voluntary placement agreement is in effect or within six months of the time a child is returned to parental care as the result of a dependency order.

RCW 43.101.224 Training for persons investigating child sexual abuse.

(1) On-going specialized training shall be provided for persons responsible for investigating child sexual abuse. Training participants shall have the opportunity to practice interview skills and receive feedback from instructors.

(2) The commission, the department of social and health services, the Washington association of sheriffs and police chiefs, and the Washington association of prosecuting attorneys shall design and implement state-wide training that contains consistent elements for persons engaged in the interviewing of children for child sexual abuse cases, including law enforcement, prosecution, and child protective services.

(3) The training shall: (a) Be based on research-based practices and standards; (b) minimize the trauma of all persons who are interviewed during abuse investigations; (c) provide methods of reducing the number of investigative interviews necessary whenever possible; (d) assure, to the extent possible, that investigative interviews are thorough, objective, and complete; (e) recognize needs of special populations, such as persons with developmental disabilities; (f) recognize the nature and consequences of victimization; (g) require investigative interviews to be conducted in a manner most likely to permit the interviewed persons the maximum emotional comfort under the circumstances; (h) address record retention and retrieval; and (i) documentation of investigative interviews. [1999 c 389 § 2.]

RCW 74.14B.010 Children's services workers--Hiring and training.

(1) Caseworkers employed in children services shall meet minimum standards established by the department of social and health services. Comprehensive training for caseworkers shall be completed before such caseworkers are assigned to case-carrying responsibilities without direct supervision. Intermittent, part-time, and standby workers shall be subject to the same minimum standards and training.

(2) On-going specialized training shall be provided for persons responsible for investigating child sexual abuse. Training participants shall have the opportunity to practice interview skills and receive feedback from instructors.

(3) The department, the criminal justice training commission, the Washington association of sheriffs and police chiefs, and the Washington association of prosecuting attorneys shall design and implement state-wide training that contains consistent elements for persons engaged in the interviewing of children, including law enforcement, prosecution, and child protective services.

(4) The training shall: (a) Be based on research-based practices and standards; (b) minimize the trauma of all persons who are interviewed during abuse investigations; (c) provide methods of reducing the number of investigative interviews necessary whenever possible; (d) assure, to the extent possible, that investigative interviews are thorough, objective, and complete; (e) recognize needs of special populations, such as persons with developmental disabilities; (f) recognize the nature and consequences of victimization; (g) require investigative interviews to be conducted in a manner most likely to permit the interviewed persons the maximum emotional comfort under the circumstances; (h) address record retention and retrieval; and (i) documentation of investigative interviews.

[1999 c 389 § 5; 1987 c 503 § 8.]

Expert Resource List

Child Interviewers

Robyn Light
Child Interviewer
Room 329 Yakima County Courthouse
Yakima, WA 98901
Phone: (509) 574-1210
Fax: (509) 574-1211
RobynL@co.yakima.wa.us

Karen Winston; Tanya Morales
Child Interviewers
Casey Family Partners: Spokane South 6213 Washington Street
Spokane, WA 99204
Phone: (509) 473-4830
Fax: (509) 835-4840
Winstok@rockisland.com

Research Expert

Lucy Berliner
Research Director
Harborview Center for Sexual Assault and Traumatic Stress
325 9th Avenue
Seattle, WA 98104
Phone: (206) 521-1800
Fax: (206) 521-1814
lucyb@u.washington.edu

Law Enforcement

Robert Howard
Seattle Police Department
610 Third Avenue
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Phone: (206) 684-5495
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Appendix B

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Tim Scott, Detective
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Other Members

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Appendix C

Mandatory Reporting Requirements

RCW 26.44.030 Reports--Duty and authority to make--Duty of receiving agency--Duty to notify--Case planning and consultation--Penalty for unauthorized exchange of information--Filing dependency petitions--Interviews of children--Records--Risk assessment process--Reports to legislature.

(1)(a) When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement Agency or to the department as provided in RCW 26.44.040.

(b) The reporting requirement also applies to department of corrections personnel who, in the course of their employment, observe offenders or the children with whom the offenders are in contact. If, as a result of observations or information received in the course of his or her employment, any department of corrections personnel has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report the incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(c) The reporting requirement shall also apply to any adult who has reasonable cause to believe that a child who resides with them, has suffered severe abuse, and is able or capable of making a report. For the purposes of this subsection, "severe abuse" means any of the following: Any single act of abuse that causes physical trauma of sufficient severity that, if left untreated, could cause death; any single act of sexual abuse that causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.

(d) The report must be made at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe that the child has suffered abuse or neglect. The report must include the identity of the accused if known.

(2) The reporting requirement of subsection (1) of this section does not apply to the discovery of abuse or neglect that occurred during childhood if it is discovered after the child has become an adult. However, if there is reasonable cause to believe other children are or may be at risk of abuse or neglect by the accused, the reporting requirement of subsection (1) of this section does apply.

(3) Any other person who has reasonable cause to believe that a child has suffered abuse or neglect may report such incident to the proper law enforcement agency or to the department of social and health services as provided in RCW 26.44.040.

(4) The department, upon receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means or who has been subjected to alleged sexual abuse, shall report such incident to the proper law enforcement agency. In emergency cases, where the child's welfare is endangered, the department shall notify the proper law enforcement agency within twenty-four hours after a report is received by the department. In all other cases, the department shall notify the law enforcement agency within seventy-two hours after a report is received by the department. If the department makes an oral report, a written report must also be made to the proper law enforcement agency within five days thereafter.

(5) Any law enforcement agency receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, shall report such incident in writing as provided in RCW 26.44.040 to the proper county prosecutor or city attorney for appropriate action whenever the law enforcement agency's investigation reveals that a crime may have been committed. The law enforcement agency shall also notify the department of all reports received and the law enforcement agency's disposition of them. In emergency cases, where the child's welfare is endangered, the law enforcement agency shall notify the department within twenty-four hours. In all other cases, the law enforcement agency shall notify the department within seventy-two hours after a report is received by the law enforcement agency.

(6) Any county prosecutor or city attorney receiving a report under subsection (5) of this section shall notify the victim, any persons the victim requests, and the local office of the department, of the decision to charge or decline to charge a crime, within five days of making the decision.

(7) The department may conduct ongoing case planning and consultation with those persons or agencies required to report under this section, with consultants designated by the department, and with designated representatives of Washington Indian tribes if the client information exchanged is pertinent to cases currently receiving child protective services. Upon request, the department shall conduct such planning and consultation with those persons required to report under this section if the department determines it is in the best interests of the child. Information considered privileged by statute and not directly related to reports required by this section must not be divulged without a valid written waiver of the privilege.

(8) Any case referred to the department by a physician licensed under chapter 18.57 or 18.71 RCW on the basis of an expert medical opinion that child abuse, neglect, or sexual assault has occurred and that the child's safety will be seriously endangered if returned home, the department shall file a dependency petition unless a second licensed

physician of the parents' choice believes that such expert medical opinion is incorrect. If the parents fail to designate a second physician, the department may make the selection. If a physician finds that a child has suffered abuse or neglect but that such abuse or neglect does not constitute imminent danger to the child's health or safety, and the department agrees with the physician's assessment, the child may be left in the parents' home while the department proceeds with reasonable efforts to remedy parenting deficiencies.

(9) Persons or agencies exchanging information under subsection (7) of this section shall not further disseminate or release the information except as authorized by state or federal statute. Violation of this subsection is a misdemeanor.

(10) Upon receiving reports of alleged abuse or neglect, the department or law enforcement agency may interview children. The interviews may be conducted on school premises, at day-care facilities, at the child's home, or at other suitable locations outside of the presence of parents. Parental notification of the interview must occur at the earliest possible point in the investigation that will not jeopardize the safety or protection of the child or the course of the investigation. Prior to commencing the interview the department or law enforcement agency shall determine whether the child wishes a third party to be present for the interview and, if so, shall make reasonable efforts to accommodate the child's wishes. Unless the child objects, the department or law enforcement agency shall make reasonable efforts to include a third party in any interview so long as the presence of the third party will not jeopardize the course of the investigation.

(11) Upon receiving a report of alleged child abuse and neglect, the department or investigating law enforcement agency shall have access to all relevant records of the child in the possession of mandated reporters and their employees.

(12) The department shall maintain investigation records and conduct timely and periodic reviews of all cases constituting abuse and neglect. The department shall maintain a log of screened-out non-abusive cases.

(13) The department shall use a risk assessment process when investigating alleged child abuse and neglect referrals. The department shall present the risk factors at all hearings in which the placement of a dependent child is an issue. Substance abuse must be a risk factor. The department shall, within funds appropriated for this purpose, offer enhanced community-based services to persons who are determined not to require further state intervention.

The department shall provide annual reports to the legislature on the effectiveness of the risk assessment process.

(14) Upon receipt of a report of alleged abuse or neglect the law enforcement agency may arrange to interview the person making the report and any collateral sources to determine if any malice is involved in the reporting.

(15) The department shall make reasonable efforts to learn the name, address, and telephone number of each person making a report of

abuse or neglect under this section. The department shall provide assurances of appropriate confidentiality of the identification of persons reporting under this section. If the department is unable to learn the information required under this subsection, the department shall only investigate cases in which: (a) The department believes there is a serious threat of substantial harm to the child; (b) the report indicates conduct involving a criminal offense that has, or is about to occur, in which the child is the victim; or (c) the department has, after investigation, a report of abuse or neglect that has been founded with regard to a member of the household within three years of receipt of the referral.

RCW 26.44.040 Reports--Oral, Written—Contents

An immediate oral report must be made by telephone or otherwise to the proper law enforcement agency or the department of social and health services and, upon request, must be followed by a report in writing. Such reports must contain the following information, if known:

(1) The name, address, and age of the child;
(2) The name and address of the child's parents, stepparents, guardians, or other persons having custody of the child;
(3) The nature and extent of the alleged injury or injuries;
(4) The nature and extent of the alleged neglect;
(5) The nature and extent of the alleged sexual abuse;
(6) Any evidence of previous injuries, including their nature and extent; and
(7) Any other information that may be helpful in establishing the cause of the child's death, injury, or injuries and the identity of the alleged perpetrator or perpetrators.

Appendix D

RCW 26.44.056 Protective detention or custody of abused child Reasonable cause -- Notice -- Time limits -- Monitoring plan -- Liability.

(1) An administrator of a hospital or similar institution or any physician, licensed pursuant to chapters 18.71 or 18.57 RCW, may detain a child without consent of a person legally responsible for the child whether or not medical treatment is required, if the circumstances or conditions of the child are such that the detaining individual has reasonable cause to believe that permitting the child to continue in his or her place of residence or in the care and custody of the parent, guardian, custodian or other person legally responsible for the child's care would present an imminent danger to that child's safety: PROVIDED, That such administrator or physician shall notify or cause to be notified the appropriate law enforcement agency or child protective services pursuant to RCW 26.44.040. Such notification shall be made as soon as possible and in no case longer than seventy-two hours. Such temporary protective custody by an administrator or doctor shall not be deemed an arrest. Child protective services may detain the child until the court assumes custody, but in no case longer than seventy-two hours, excluding Saturdays, Sundays, and holidays.

(2) Whenever an administrator or physician has reasonable cause to believe that a child would be in imminent danger if released to a parent, guardian, custodian, or other person or is in imminent danger if left in the custody of a parent, guardian, custodian, or other person, the administrator or physician may notify a law enforcement agency and the law enforcement agency shall take the child into custody or cause the child to be taken into custody. The law enforcement agency shall release the child to the custody of child protective services. Child protective services shall detain the child until the court assumes custody or upon a documented and substantiated record that in the professional judgment of the child protective services the child's safety will not be endangered if the child is returned. If the child is returned, the department shall establish a six-month plan to monitor and assure the continued safety of the child's life or health. The monitoring period may be extended for good cause.

(3) A child protective services employee, an administrator, doctor, or law enforcement officer shall not be held liable in any civil action for the decision for taking the child into custody, if done in good faith under this section.

Appendix E

RCW 9A.04.050 People capable of committing crimes- Capability of children.

Children under the age of eight years are incapable of committing crime. Children of eight and under twelve years of age are presumed to be incapable of committing crime, but this presumption may be removed by proof that they have sufficient capacity to understand the act or neglect, and to know that it was wrong. Whenever in legal proceedings it becomes necessary to determine the age of a child, he may be produced for inspection, to enable the court or jury to determine the age thereby; and the court may also direct his examination by one or more physicians, whose opinion shall be competent evidence upon the question of his age.

Appendix F

KITTITAS COUNTY PUBLIC SCHOOLS

Child Abuse Report Form

School District _____ Building _____

Name of Child _____ Date of Birth _____

Parents/Guardians _____ Phone _____
Address _____ City _____

Child Disclosure:
Date _____ Time _____A.M./P.M. To Whom _____
[ ] Confidential

CPS Notification:
Person making referral _____ Date of referral_____

[ ] By telephone [ ] Written Notice [ ] In Person
Intake Worker _____

Person(s) suspected of abuse or neglect
Name _____ Name _____
Relationship to Child _____ Relationship to Child _____
Date/Time of incident _____ Date/Time of incident_____
Location of incident _____ Location of incident _____

Nature and extent of reported abuse or neglect (mark all that applv)
[ ] Physical _____
[ ] Sexual _____
[ ] Emotional _____
[ ] Neglect _____

Evidence of Previous abuse or neglect
_____
_____
_____

Other Persons and/or Agencies Notified
___ School Counselor Date _____
___ School Psychologist Date _____
___ School Nurse Date _____
___ Superintendent Date _____
___ County Sheriff Date _____
___ Child Interviewer Date _____
___ Principal Date _____
___ Local Police Date _____
___ Juvenile Probation Date _____
___ ASPEN Date _____

Follow-up information:

Appendix G

RCW 74.13.075 Sexually aggressive youth--Defined-- Expenditure of treatment funds--Tribal jurisdiction.

(1) For the purposes of funds appropriated for the treatment of sexually aggressive youth, the term "sexually aggressive youth" means those juveniles who:
   (a) Have been abused and have committed a sexually aggressive act or other violent act that is sexual in nature; and
      (i) Are in the care and custody of the state or a federally recognized Indian tribe located within the state; or
      (ii) Are the subject of a proceeding under chapter 13.34 RCW or a child welfare proceeding held before a tribal court located within the state; or
   (b) Cannot be detained under the juvenile justice system due to being under age twelve and incompetent to stand trial for acts that could be prosecuted as sex offenses as defined by RCW 9.94A.030 if the juvenile was over twelve years of age, or competent to stand trial if under twelve years of age.

(2) In expending these funds, the department of social and health services shall establish in each region a case review committee to review all cases for which the funds are used. In determining whether to use these funds in a particular case, the committee shall consider:
   (a) The age of the juvenile;
   (b) The extent and type of abuse to which the juvenile has been subjected;
   (c) The juvenile's past conduct;
   (d) The benefits that can be expected from the treatment;
   (e) The cost of the treatment; and
   (f) The ability of the juvenile's parent or guardian to pay for the treatment.

(3) The department may provide funds, under this section, for youth in the care and custody of a tribe or through a tribal court, for the treatment of sexually aggressive youth only if:
   (a) The tribe uses the same or equivalent definitions and standards for determining which youth are sexually aggressive; and
   (b) The department seeks to recover any federal funds available for the treatment of youth.

[1994 c 169 § 1. Prior: 1993 c 402 § 3; 1993 c 146 § 1; 1990 c 3 § 305.]

Appendix H

RCW 26.44.160 Allegations that child under twelve committed sex offense--Investigation--Referral to prosecuting attorney--Referral to department--Referral for treatment.

(1) If a law enforcement agency receives a complaint that alleges that a child under age twelve has committed a sex offense as defined in RCW 9.94A.030, the agency shall investigate the complaint. If the investigation reveals that probable cause exists to believe that the youth may have committed a sex offense and the child is at least eight years of age, the agency shall refer the case to the proper county prosecuting attorney for appropriate action to determine whether the child may be prosecuted or is a sexually aggressive youth. If the child is less than eight years old, the law enforcement agency shall refer the case to the department.

(2) If the prosecutor or a judge determines the child cannot be prosecuted for the alleged sex offense because the child is incapable of committing a crime as provided in RCW 9A.04.050 and the prosecutor believes that probable cause exists to believe that the child engaged in acts that would constitute a sex offense, the prosecutor shall refer the child as a sexually aggressive youth to the department. The prosecutor shall provide the department with an affidavit stating that the prosecutor has determined that probable cause exists to believe that the juvenile has committed acts that could be prosecuted as a sex offense but the case is not being prosecuted because the juvenile is incapable of committing a crime as provided in RCW 9A.04.050.

(3) The department shall investigate any referrals that allege that a child is a sexually aggressive youth. The purpose of the investigation shall be to determine whether the child is abused or neglected, as defined in this chapter, and whether the child or the child's parents are in need of services or treatment. The department may offer appropriate available services and treatment to a sexually aggressive youth and his or her parents or legal guardians as provided in RCW 74.13.075 and may refer the child and his or her parents to appropriate treatment and services available within the community. If the parents refuse to accept or fail to obtain appropriate treatment or services under circumstances that indicate that the refusal or failure is child abuse or neglect, as defined in this chapter, the department may pursue a dependency action as provided in chapter 13.34 RCW.
(4) Nothing in this section shall affect the responsibility of a law enforcement agency to report incidents of abuse or neglect as required in RCW 26.44.030(5).

Appendix I

FOR PROSECUTOR'S REVIEW

Complex Case Referral Form (Child Sexual Abuse)

To be completed by referring Law Enforcement Investigator once the decision is made that a complex case is presented by the facts of a given case. Attach copies of all case reports to this form

Today's Date:_____

Investigator:_____**Agency:**_____

Victim:_____

(Additional Victims):_____

Alleged Offender(s):_____

(Non-offending) Parent:_____

(Complete as applicable)

CPS Social Worker:_____

ASPEN Advocate:_____

Other involved professional(s) (e.g. child's physician, counselor, school or daycare personnel):

_____

Date case received: _____

To be Completed by the Prosecuting Attorney:

Contacted the Investigating Officer

____ By Telephone **____ In Person**

Complex Case Investigative Team Members:

_____

_____

_____

Please describe the facts and circumstances of this case which indicate a Complex Case in the space below.

Date Set For:

_____

Appendix J

Complex Case Investigative Team Checklist

As the Complex Case Investigative Team meets to plan and coordinate child sexual abuse interviews and investigations, the following topics should be discussed and decided, among other pertinent topics.

Team Meeting

- Who will run the meeting?
- Identify what needs to be discussed at the meeting.
- When will the meeting end?
- When should periodic meetings be scheduled to analyze and review progress, update information, and debrief the investigation?
- Any special considerations if the alleged offender is an employee of an investigating agency?
- How do you close a case?

Investigation

- Who will take the lead in the investigation?
- How will the investigation be handled if children report details that may have bearing on other potential victims?
- Can this information be used without compromising the investigation or contaminating the other witnesses? If so, how can it be used?
- Will potential victims be kept from speaking with other potential victims and if so, how may that impact their well being?
- Who will contact and/or interview the suspects?
- Are there other agencies doing concurrent investigations, i.e., Division of Children and Family Services, Department of Licensed Resources? How can we work together?

Interviews

- Who will conduct the interviews of the children?
- What information should be provided to interviewers in advance of interview?
- Note how this case may be different from others in terms of sensitivity of information sharing.
- In the case of multiple victims, should interviewers work in teams? One approach is to maintain team but rotate interviewers/observers.
- Weigh the costs and benefits of having multiple interviewers (who may have less experience) vs. the most highly qualified interviewing conducting multiple interviews.

- All interviewers must be trained, and interviews must be consistent in approach and method.
- When will the interviews be conducted?
- Who will be present to observe the interview(s)?
- How will the interviews be documented?
- Who maintains the documentation?
- What steps will be taken to avoid contamination? For example, using multiple interviewers, provision of only limited case information to interviewers, assurance that interviews are conducted pursuant to accepted interviewing protocols or standards?
- If different procedures are followed than our standard protocols, how do we explain this variation?
- How will the interviews be documented?

External Communication

- Who will notify the victims' families? How will the notification be handled?
- How will parents/guardians of children who may have been at risk of victimization be notified?
- What information will be provided to them?
- Who will be identified as the person these individuals are to contact regarding the investigation?
- Which person will be designated to speak with the media?
- When does the media become involved?

Other

- Are other resources needed by the team or group members?
- Sharing of information: Do all team members get copies of all relevant reports, or just some, or does the team gather and share information and walk away? For example, a protected document in a Law Enforcement file may not be protected in CPS' possession. Need to identify what protections exist for CPS records and what procedures are necessary.

RCW 26.44.050 Abuse or neglect of child--Duty of law enforcement agency or department of social and health services--Taking child into custody without court order, when.

Upon the receipt of a report concerning the possible occurrence of abuse or neglect, the law enforcement agency or the department of social and health services must investigate and provide the protective services section with a report in accordance with chapter 74.13 RCW, and where necessary to refer such report to the court.

A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050. The law enforcement agency or the department of social and health services investigating such a report is hereby authorized to photograph such a child for the purpose of providing documentary evidence of the physical condition of the child.

Appendix L

RCW 7.69A.030 RIGHTS OF CHILD VICTIMS AND WITNESSES

In addition to the rights of victims and witnesses provided for in RCW 7.69.030, there shall be every reasonable effort made by law enforcement agencies, prosecutors, and judges to assure that child victims and witnesses are afforded the rights enumerated in this section. Except as provided in RCW 7.69A.050 regarding child victims or child witnesses of violent crimes, sex crimes, or child abuse, the enumeration of rights shall not be construed to create substantive rights and duties, and the application of an enumerated right in an individual case is subject to the discretion of the law enforcement agency, prosecutor, or judge. Child victims and witnesses have the following rights:

(1) To have explained in language easily understood by the child, all legal proceedings and/or police investigations in which the child may be involved.
(2) With respect to child victims of sex or violent crimes or child abuse, to have a crime victim advocate from a crime victim/witness program present at any prosecutorial or defense interviews with the child victim. This subsection applies if practical and if the presence of the crime victim advocate does not cause any unnecessary delay in the investigation or prosecution of the case. The role of the crime victim advocate is to provide emotional support to the child victim and to promote the child's feelings of security and safety.
(3) To be provided, whenever possible, a secure waiting area during court proceedings and to have an advocate or support person remain with the child prior to and during any court proceedings.
(4) To not have the names, addresses, nor photographs of the living child victim or witness disclosed by any law enforcement agency, prosecutor's office, or state agency without the permission of the child victim, child witness, parents, or legal guardians to anyone except another law enforcement agency, prosecutor, defense counsel, or private or governmental agency that provides services to the child victim or witness.
(5) To allow an advocate to make recommendations to the prosecuting attorney about the ability of the child to cooperate with prosecution and the potential effect of the proceedings on the child.

(6) To allow an advocate to provide information to the court concerning the child's ability to understand the nature of the proceedings.

(7) To be provided information or appropriate referrals to social service agencies to assist the child and/or the child's family with the emotional impact of the crime, the subsequent investigation, and judicial proceedings in which the child is involved.

(8) To allow an advocate to be present in court while the child testifies in order to provide emotional support to the child.

(9) To provide information to the court as to the need for the presence of other supportive persons at the court proceedings while the child testifies in order to promote the child's feelings of security and safety.

(10) To allow law enforcement agencies the opportunity to enlist the assistance of other professional personnel such as child protection services, victim advocates or prosecutorial staff trained in the interviewing of the child victim.

(11) With respect to child victims of violent or sex crimes or child abuse, to receive either directly or through the child's parent or guardian if appropriate, at the time of reporting the crime to law enforcement officials, a written statement of the rights of child victims as provided in this chapter. The written statement shall include the name, address, and telephone number of a county or local crime victim/witness program, if such a crime victim/witness program exists in the county.

Appendix M

Child Sexual Assault Forensic Examination Referral List

Kittitas Valley Community Hospital Emergency Department 603 South Chestnut Ellensburg, WA 98926 (509) 962-9841 Planned Parenthood of Central Washington Mary Reckard, ARNP 312 North Pine Ellensburg, WA 98926 (509) 969-0713 Roberta Buum, PA Primary Care Associates 611 S. Chestnut Suite A Ellensburg, WA 98926 (509) 962-8447 (home) Yakima Pediatrics 314-A South 11th Avenue Yakima, WA 98902 Tel: 509-575-0114 Moses Lake Clinic Marta Beaubien, M.D. 840 East Hill Ave. Moses Lake, WA 98837 (509) 765-0216	Central Washington Hospital Family Health Services 1215 Miller St. Wenatchee, WA 98801 Tel: 509-667-3350 Children's Hospital and Regional Medical Center 4800 Sandpoint Way NE Seattle, WA 98105 Tel: 206-987-2194 Harborview Center for Sexual Assault and Traumatic Stress 1401 E. 14th Avenue Seattle, WA 98122 Phone: (206) 521-1800 (weekdays), or (206) 731-3000 (24 hours in emergent cases) Children's Hospital Gynecology Clinic at CHRMC 4800 Sandpoint Way N.E. Seattle, WA 98105 (206)987-2049

KITTITAS COUNTY
SEXUAL ASSAULT NURSE EXAMINER (SANE)
Authorization Form

AUTHORIZATION FOR EXAM REQUESTED BY VICTIM / PATIENT / GUARDIAN
I hereby request a forensic examination for evidence of sexual assault/abuse and treatment for sexual assault care including emergency contraception and STD prophylaxis. I understand that collection of evidence may include photographing injuries and these photographs may include the genital area. I fully understand that the above requested forensic examination and information is to be used by Law Enforcement Officials in the investigation of a crime and hereby consent to the release of the Forensic Worksheet /Evidence to Law Enforcement and the Prosecuting Attorney's Office. I hereby authorize the Sexual Assault Nurse Examiner (SANE)/Medical Provider to request all past medical records that may be needed related to this present examination of abuse / assault. The SANE/Medical Provider has permission to use the prints / data for quality assurance and teaching purposes. Patient confidentiality will be maintained by the SANE/Medical Provider for all patient data. **Signature** of Victim /Parent /Guardian:_____ Date:_____Time:_____ See page 22 in Child Sexual Abuse Investigation Protocols **for "minor consent" guidelines**.

GENERAL INFORMATION				
Patient's Name: Acute ☐ Scheduled ☐ Follow-up ☐ Consult ☐				
Street Address Arrived Via: ❑ Police ❑ Friend ❑ Advocate ❑ Family Member				
City	State	Zip Code	County Pt. Resides	Time of Assault ☐AM ☐PM
Phone # with area code ( )			County Assault Occurred	
Admit Time	Discharge Time		Time of Examination AM PM	Date of Examination

ATTENDING EXAMINER AND LAW ENFORCEMENT OFFICIAL USE ONLY	
Examiner's Name Stamped:	Law Enforcement Agency:
Examiner's Signature:	Officer's Name:
SANE Examiner has been introduced to patient ☐	Rape Kit Complete: ☐ Yes ☐ No
SANE purpose of exam explained ☐	Was a Copy of SANE Report Sent with Rape Kit? ☐ Yes ☐ No
Dev – Assessment on Ped. Patient: N/A Concept real vs. pretend ☐ ☐	Law Enforcement Case #

COPIES OF FORENSIC CHART SENT TO		
FOR MEDICAL RECORD USE ONLY Prosecutor: County:	Date Sent:	Initials
Law Enforcement Agency:		
Other:		

FOR SANE USE ONLY					
	YES	NO		YES	NO
Colposcopy			Photographs (genital)		
			Photographs (Non-genital)		
Previous Medical Records REQUESTED ❑ Yes ❑ No	**Date:**	**By:**	**Reviewed Date:**	**By:**	
RECEIVED DATE:	**BY:**				

CVC / DISABILITY INFORMATION			
	YES	NO	
CVC Forms given to Patient			CVC Claim Number: N/A☐
Advocate Present			Name:
Parent / Guardian at Exam			Name:
Social Worker: (present/contacted)			Name:
CPS Worker: (present/contacted)			Name:
Law Enforcement Officer:			Name: Agency:

COMMENTS			
Pt. Alert and Oriented			
Sensory / Mental Disability			
Physical Disability			

Private M.D.	Phone #:	Referral Letter Sent Yes☐ No ☐N/A☐	Date:
Referral Letter Sent ❑ Yes	❑ No		

FOLLOW-UP EXAM				
	YES	NO	N/A	DATE
Exam Scheduled				

GENERAL PAST MEDICAL HISTORY

Serious illness / Injuries / Surgeries / Hospitalizations:

Prior Sexual Assault / Abuse Examination: ☐ Yes ☐No Where:

History of Previously Diagnosed STI(s): ☐ Yes ☐ No Diagnosis: When:

Immunization Status: Tetanus Status: Hep B Status: Current Meds:

Medication Allergies: Reaction Type:

Latex Allergy: Yes☐ No ☐Latex Sensitivity: Yes☐ No ☐ Describe Reaction: N/A ☐

PMH SECTION

None ☐ Abuse ☐ Cardio-Vasc Disease ☐ Smoking ☐ ____PPD CVA ☐ STD ☐

HTN☐ Asthma ☐ Pulmonary Disease ☐ Kidney Disease ☐ Diabetes ☐

Arthritis ☐ Headaches ☐ Seizure Disorder ☐ Mental Health ☐ Substance Abuse ☐

KITTITAS COUNTY **Patient Name:** _____ **DOB:** ___/___/___

WA Statutes require any public or private official who has reasonable cause to suspect a child may have been abused is to immediately report or cause a report to be made.				
	YES	NO	CASE WORKER/OFFICER/AGENCY	DATE
Prior report to Child Protective Services (CPS)				
SANE / SW Notification to CPS				
Prior Report made to law Enforcement				
Child Forensic interview referral needed				
Prior Child interview completed			Where:	

Referral Completed Yes ☐ No ☐ N/A ☐ Date: Place:

Telephone: FAX:

PEDIATRIC BEHAVIORS			
	YES	NO	If yes, briefly describe how long present and who answered the question
Concerning behaviors?			
Bedwetting or soiling / pooping pants?			
Toilet Trained?			
Nightmares / fears?			
Sexualized play / masturbation?			
Other changes in behavior?			
Developmental Delay?			

MENSTRUAL HISTORY – IF THE CHILD IS A FEMALE

When was the first time she had a menstrual period? _____ Tampons ☐ Pads ☐

What was the date of her last menstrual period? _____

Has she ever missed a period? Yes☐ No☐ Why? _____

WHAT WORDS DOES THE CHILD USE FOR PRIVATE PARTS?		WHAT WORDS DOES THE PARENT/GUARDIAN USE FOR PRIVATE PARTS?	
Buttocks/Bottom		Buttocks/Bottom	
Penis		Penis	
Vagina		Vagina	
Breasts		Breasts	

Briefly explain why child is here for an examination? (Examiner – use patient's, guardian's or parent's own words)

GENITAL EXAMINATON OF CHILD

	1	2	3	4	5		YES	NO		YES	NO
Tanner Stage						Was Colposcope Used?					

KITTITAS COUNTY **Patient Name:** _____ **DOB:** ___/___/___

SEXUAL ASSAULT HISTORY

DEMEANOR: (Please Circle all that apply) TEARFUL WITHDRAWN ANGRY QUIET AFRAID OTHER:

LOCATION WHERE ASSAULT OCCURRED

Address where assault / abuse occurred:

	Own Home		Other Home		Vehicle:		Public Outdoors		Public Indoors
	Workplace		Other		Unknown				

OFFENDER INFORMATON

Name of person providing history:

Alleged Offender(s) Name(s):

	RELATIONSHIP OF VICTIM TO ALLEGED OFFENDER			
		Parent/Guardian		Caregiver
		Other Relative		Stranger
		Acquaintance/Friend		Ex-partner
		Professional Service Provider		Partner
		Spouse		Other

Patient Description of Assault/ Abuse (below) ☐ See Police Report ❑

☐ See additional notes on next page

ACTS DESCRIBED BY VICTIM						
ACTS DESCRIBED BY VICTIM (Check Appropriate Box)	YES	NO	ATTEMPT	PATIENT UNSURE	NOT ASKED BY SANE	IF MORE THAN ONE ASSAILANT, IDENTIFY
Penetration of Vagina by: Penis						
Finger						
Foreign Object						
Describe Object Briefly: N/A						
Penetration of Rectum by: Penis						
Finger						
Foreign Object						
Describe Object Briefly: N/A						
Oral touching of genitals of victim by Assailant						
Of assailant by victim					Forced ❑	
Oral touching of anus of victim by Assailant						
Of assailant by victim					Forced ❑	
Masturbation Of victim by assailant						
Of assailant by victim					Forced ❑	
Describe masturbation: N/A						
Did Ejaculation Occur?						
Describe Ejaculation (describe in pt's. own words) (include sensory description: i.e. appearance, odor): N/A						
Did assailant exhibit sexual dysfunction? Yes ☐ No ☐ N/A ☐						

ACTS DESCRIBED BY VICTIM							
ACTS DESCRIBED BY VICTIM	YES	NO	ATTEMPT	NOT ASKED	DESCRIPTION LOCATION ON BODY	FORENSIC SWABS	
						YES	NO
KISSING							
LICKING							
FONDLING							
LUBRICANT							
FOAM							
JELLY							
CONDOM							
Positions used during Supine ☐ Prone ☐ Knee-chest ☐ Other ☐							
Other Acts (describe): N/A ☐							

PATIENT REPORTS					
CHECK APPROPRIATE BOX	**YES**	**NO**	**PATIENT UNSURE**	**NOT ASKED BY SANE**	**IF YES, DESCRIBE**
Lapse of Consciousness					
Vomited					
Pre-existing Physical Injuries					
Signs of Intoxication (subjective)					
Recent ingestion of prescription drugs, illegal substances or alcohol by assailant ❑ By victim ❑					
METHODS EMPLOYED BY ASSAILANT(S)					
CHECK APPROPRIATE BOX		NO	**PATIENT UNSURE**	**NOT ASKED BY SANE**	**IF YES, DESCRIBE LOCATION ON BODY**
Weapon Inflicted Injuries					
Type of Weapon (s) Describe:					☐ N/A
Physical blows by hands or feet					
Grabbing					
Scratches					:
Physical Restraints					
Types Used					☐ N/A
Bites to Assailant					:
Choking					
Burns (including cigarette chemical/toxic)					
Threats of Harm					Verbal Physical (Circle)
Describe Threats					N/A
Forced Drug Use					If yes, describe:
Forced ETOH Use					
Persistent badgering and harassment					
PHYSICAL INJURIES					
Physical injuries and / or pain described by victim:					
HEAD:					
NECK:					
BACK:					
ABDOMEN:					
EXTREMITIES:					
OTHER:					
EXAMINER'S STAMP / SIGNATURE:					

KITTITAS COUNTY **Patient Name:** _____ **DOB:** ___/___/___

Record Injuries and findings on diagrams: erythema, abrasions, bruises, (detail shape), contusions, indurations, fractures, bites, burns and stains / foreign materials on the body. Record size and appearance of injuries. Note swelling and areas of tenderness. Record positive Toluidine blue findings.

SEXUAL ASSAULT FORENSIC EXAMINATION

(Normal Exam Does Not Preclude the Possibility of Sexual Assault / Abuse)

FEMALE	WNL	ABN	DESCRIBE	MALE	WNL	ABN	DESCRIBE
Labia Majora				Penis			
Labia Minora				Urethral Meatus			❑ Yes ❑ No
Clitoris				Scrotum			❑ Yes ❑ No
Periurethral tissue Urethral Meatus				Testes			❑ Yes ❑ No
Hymen				Circumcised			❑ Yes ❑ No
Posterior Fourchette				**FEMALE / MALE ANAL EXAM**			
Fossa Navicularis				Buttocks	WNL	ABN	

	YES	NO	Describe	Perianal Skin			
Visualized Vagina				AnalVerge/Folds Rugae			
Vaginal Injury				Tone			
Visualized Cervix					YES	NO	
Cervical Injury				Toludine Blue			
Foley Catheter				Anal Spasm			
Speculum Used Circle One: Small Med				Anal Laxity			
Toludine Blue Dye				Note Presence of Stool in Rectal Ampulla			

EXAM POSITION USED				Method of Exam for Anal Tone: (Discretion of Examiner): ☐Observation☐ Digital Exam			
	Frog Leg Supine		Inspection	**EXAM POSITION FOR ANAL EXAM**			
	Knee / Chest		Separation		Frog Leg Supine		Lithotomy
	Lithotomy		Retraction		Side Lying Right or Left (Circle)		Knee / Chest

EXAM INFORMATION

Genital Exam Done With:	YES	NO	N/A	EXAMINER'S STAMP/SIGNATURE
Direct Visualization				
Colposcope				
Anoscope				

KITTITAS COUNTY **Patient Name: _____ _____ DOB: ___/___/___**

PHYSICAL EXAMINATION		
TEMP:	HEAD:	CHEST:
PULSE:	EYES::	ABD:
RESP:	NECK:	BACK:
BP:	FACE:	EXTEMITIES:
WT:	ORAL CAVITY:	OTHER:

PERTINENT MEDICAL HISTORY

Last Menstrual Period (List Date): Contraceptive Method:

Any recent (90 days) anal/genital injuries, surgeries, diagnostic procedures? Yes ☐ No ☐

Describe:

LAST PREVIOUS CONSENSUAL INTERCOURSE (If within past 96 hours)

DATE	VAGINAL	ORAL	ANAL	WITH WHOM?

EXAMINER MARK BOX OF HYMEN TYPE ON FEMALE PATIENTS

ANNULAR HYMEN	SEPTATE HYMEN	CRIBIFORM HYMEN	REDUNDENT HYMEN	IMPERFORATE HYMEN	N/A MALE EXAM
❑	❑	❑	❑	❑	❑

IMPRESSIONS (CHECK ALL THAT APPLY)

	History of Sexual Abuse per Patient or Referral Source (Please Circle)		GU Skin Infections
	Non-Specific Findings		Genital / Anal Trauma
	No Physical / Genital Findings of Trauma		Other Medical Issues
	Clear Evidence of Penetrating Injury Anus or Hymen (Please Circle)		Healed Genital / Anal Injury
	Genital Vestibule Penetration Per History		STD Cultures Pending
	Normal Genital /Anal Variants		Other:

KITTITAS COUNTY **Patient Name:** _____ **DOB:** ___/___/___

HYGIENE ACTS DESCRIBED BY VICTIM					
	Yes	No	During Assault	After Assault	COMMENTS
Defecated / Urinated					
Genital Wipe / Wash					
Bath / Shower					
Douche					
Remove/Insert tampon/sponge/diaphragm					
Brushed Teeth					
Oral Gargle / Swish					
Changed Clothes					

LABORATORY

ETOH Level _____ ☐ Not Done

TOX Screen (Acute Only) ☐ Not Done ☐ Hospital ☐ Outside TOX Screen Sample with Officer _____

Hospital Admission ☐ Yes ☐ No

Exam Location ☐ Clinic ☐ ER

ER Physician Required: ☐ Yes ☐ No Given Orders: ☐ Yes ☐ No ☐ Verbal ☐ Telephone

☐ Urine HCG Results _____ ☐ Serum HCG Results _____

☐ Gonorrhea ☐ Chlamydia ☐ VDRL ☐ CBC ☐ ETOH OTHER:

MEDICATIONS

	MEDICATION GIVEN		INSTRUCTION GIVEN		COMMENTS
	YES	NO	YES	NO	
Plan B					
Zithromax 1 gm po					
Flagyl 2 gm po					
Cefixime 400 mg po					
Phenergan 25 mg po					
Other					

SANE EXAMINER STAMP / SIGNATURE:

Appendix O

RECOMMENDED GUIDELINES

Sexual Assault Emergency Medical Evaluation

ADOLESCENT (13 TO 17 YEARS)

The following are guidelines for conducting the medical-legal examination and collecting forensic evidence for adolescent male and female patients when there is a report or concern of sexual assault. These guidelines are not intended to include all the medical evaluations and tests which may be necessary for appropriate care for an individual patient. Likewise, not all the steps outlined here will be appropriate for every patient.

General

Purpose of Exam

Medical

- Identify injuries and refer for treatment and medical clearance to the emergency department of Kittitas Valley Community Hospital
- Assess risk of pregnancy and sexually transmitted diseases
- Provide prophylaxis for sexually transmitted diseases and emergency contraception, when indicated.

Social/Psychological

- Respond to patient's immediate emotional needs and concerns
- Assess patient safety and assist with interventions
- Provide information about typical reactions and fear-reduction coping strategies
- Explain reporting process, Crime Victims compensation, and resources for advocacy and counseling

Legal

- Document history
- Document medical findings
- Collect forensic evidence, maintain chain of custody and transfer to law enforcement

Refer/report

- Refer for follow up medical care
- Refer for advocacy or counseling
- Report to law enforcement as requested by patient, or in the case of minors to Child Protective Services (CPS) or law enforcement

TELEPHONE TRIAGE BY SEXUAL ASSAULT RESPONDERS

If assault within past 96 hours

- Medical/forensic exam is appropriate on an urgent basis
- Advise patient:
    - Do not bathe before exam
    - Bring in clothes worn at time of assault and bring change of clothing
    - Come to hospital with support person (family, friend, advocate), if possible.

If Assault more than 96 hours

- Medical/forensic exam generally not indicted on emergency basis
    1. Individual case circumstance may warrant urgent exam beyond 96 hours after assault, e.g. multiple assailants or patient was unconscious for a period of time
- Refer to primary care provider or clinic for medical care
- Refer to rape crisis center, advocacy organization or mental health counselor for psychological support
- Advise or assist patient in making police or CPS report

MEDICAL TRIAGE BY SEXUAL ASSAULT RESPONDERS

Medical stabilization always precedes forensic examination

- The following history or conditions should be evaluated medically prior to the sexual assault exam
  - History of loss of consciousness
  - Altered consciousness or mental status
  - Head injury
  - Significant facial injury
  - Possible fractures
  - Blunt injury to abdomen or back
  - Active bleeding
  - History of choking
  - Age > 60 years
  - Psychiatric illness
  - If apparent psychiatric illness complicates assessment of reported sexual assault, both psychiatric assaults, both psychiatric assessment and medical forensics exam generally will be necessary. Proceed according to patient tolerance and needs.

Billing

- By law, the initial medical forensic exam for exam for assault must be billed only to Washington State Crime Victim's Compensation (CVC)
- Crime Victims Compensation application does not need to be completed for this coverage to be in effect.
- Treatment of injury (e.g. broken arm sustained during the assault) is billed to the patient's insurance, with CVC as secondary insurer.

Consent for Care

Adults

- The forensic exam is not a medical emergency, and consent must be obtained for the exam.
- The patient may refuse any part of the exam; for example, may consent to the physical exam but not forensic collection.
- If the patient is not capable of informed consent due to a longer than transitory condition (e.g. intoxication), the sexual assault exam should be delayed until the patient is capable of consent.
  - If the patient is not capable of consent due to longer term medical or psychiatric condition, consent must be obtained from the surrogate decision maker (next of kin).
  - If surrogate decision maker is not available, a court order must be obtained.
- If the patient is not capable of consent and clothing is removed for medical care, the clothing should be packaged in forensically appropriate manner.

Children Under the Age of Eighteen

- In general, in the state of Washington, the parent or legal guardian must sign consent for care for patients under 18 years of age. There are some legal exceptions to this that may apply to medical care after sexual assault.

- These exceptions may include, but are not limited to:

  - A person of any age may obtain confidential care for pregnancy or birth control (RCW 9.02.100; State v. Koome)
  - A person age 14 or older may obtain confidential care for sexually transmitted diseases (RCW 70.24.110)
  - If a minor is legally emancipated, by court decree, the minor has the same rights as an adult regarding consent for medical care.
  - When a minor is married to a person of full age, the minor shall be deemed and taken to be of full age (RCW 26.28.020)
  - Emergency care at a hospital emergency department pursuant to United States Code (USC) 42, Chapter 7, XVIII, 1395dd

- As provided by RCW 18.71.220, relating to immunity of licensed physicians and hospitals in rendering emergency care
- Search warrant from the court

In circumstances where there is significant concern of sexual abuse within the previous 72 hours, and the parent or guardian is unavailable or unwilling to sign for medical care, call the police to place child into protective custody. After child is in protective custody, CPS is authorized to approve treatment.

If a physician has reasonable cause to believe that permitting a child to remain in the care or custody of the adult that is legally responsible for the child will place the child in imminent danger, the physician may detain the child, whether or not medical attention is required, without the consent of the legally responsible adult. (RCW 26.44.056, Appendix D)

Mandatory reporting to law enforcement or CPS is still required for persons under 18 years of age. The teen should be advised that if CPS or law enforcement is notified, it is possible that their parents will be informed about the event by those agencies.

Law Enforcement Report

- Reporting to law enforcement is the patient's choice, unless the patient is under 18 or a dependent adult (see below)
- Medical staff must obtain patient consent before discussing the case with the law enforcement (exception for minors or dependent adults, see below)

Mandated Reporting

Minors

- A report to police or CPS is mandatory if victim is under 18 years of age.

Crimes against minors

Sexual activity involving minors must be reported when there is a specified age difference between the two parties. This is defined as:

When the victim is less than 12 years old, and the offender is 24 months or more older
When the victim is 12 to 13 years old, and the offender is 36 or more months older
When the victim is 14 to 15 years old, and the offender is 48 or more months older

Mandatory reporting applies even when a minor has signed for own care

Vulnerable Adults

- If the victim is a vulnerable adult, a report to law enforcement and the Department of Social and Health Services (DSHS) is mandatory. If the adult is in state licensed care, the report should be made to DSHS, Residential Care Services. If the adult is not in state licensed care, the report should be made to DSHS, Adult Protective Services.

Diagnosis

a. Rape is a legal term, not a medical diagnosis. Rape is defined as sexual intercourse (penetration of bodily orifice)
b. By forcible compulsion (or)
c. When the victim is incapable of consent because victim is physically helpless or mentally incapacitated (or)
d. When the victim does not consent and clearly express lack of consent by words or conduct.
e. Assessment throughout the chart should be "History of sexual assault"

Documentation

- Medical chart is likely to be legal evidence
  - Use black ink, print legibly
  - Use only standard abbreviations
- On each page of the report:

- Clearly indicate patient's number.
- Print name of staff member who completed the page
- Sign and date

HISTORY AND INITIAL EVALUTION

Patient Information

In addition to routine registration data, document

- Person who accompanied patient and relationship to patient
- Police report if filed: police department and case number and officer name.

History of Assault

Obtain history from patient and document facts about assault

- Source of information (patient, police, or accompanying person)
- Time and place of assault
- Hours since assault
- Number of assailants and sexual assailants, relationship to victim and identity if known
- Brief narrative history of assault.

Nature of force used

- Patient and impaired consciousness
- Known or suspected drug or alcohol ingestion
- Verbal threats
- Perceived life threat
- Use of physical force
- Use of weapon
- Badgering or harassment (verbal or physical) until victim submits

Post assault activity – if patient

- Showered, bathed
- Douched, rinsed mouth urinated or defecated.
- Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to ER.

Risk factors

- Known or suspected IV drug use
- Man who has sex with men
- Assailant from an endemic country

Medical history

- Active medical problems
- Current medications
- Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances and alcohol
- Ob-gyn history, history of STD's, use of contraception and risk of pregnancy
- Last menstrual period, last consensual intercourse
- Patient's history of hepatitis B vaccine or illness
- Allergies to medication

Discussion with Patient

- Discuss medical and forensic procedures
- Offer clear explanation for all procedures
- Discuss reporting to law enforcement (CPS ifS minor)
- Clarity that it is the patient's right to decline any aspect of the exam or evidence collection
- For minors, discuss mandatory CPS or police report

- Discuss advocacy, community resources for support.

FORENSIC EVIDENCE PROCESSING AND STORAGE

Processing Forensic Specimens

- Forensic specimens are not processed at the clinic, but stored separately and transferred to law enforcement
- Evidence may later be tested by the Washington State Patrol Crime Lab, but all evidence is not necessarily processed.

Chain of Custody Forensic Specimens

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

- Maintains continuous physical possession of specimen and items of evidence or
- Designates another staff member to maintain possession of evidence, or
- Locks specimens in locked evidence cabinet

Evidence Kit

- A commercially produced sexual assault evidence kit shall be used which contains the necessary components to collect the evidence in the guidelines
- All reference to "Evidence Kit" in these guidelines refers to material components for evidence collection.

Evidence Storage

Temperature

- Dry or dried evidence may be kept at room temperature. However, dry evidence must not be frozen and then thawed
- Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer.

Evidence Kit

- All evidence placed in the evidence kit must be dry or dried before packaging
- Store sealed Evidence Kit in locked cabinet until transfer to law enforcement.

Clothing

- Store clothing in locked room or cabinet until transfer to law enforcement
- Wet clothing must transferred to law enforcement within 3 hours, and should be triple bagged in paper.

Urine and Blood

- Urine and blood tube specimens (except for reference blood specimen of FTA paper) should not be placed in the evidence kit, but should be refrigerated or frozen until transfer.

Trace Evidence (small fragmentary evidence such as hair, fingernail clippings, dirt particles, etc.)

- Collect on piece of plain paper
- Refold paper "bindle fashion" to retain evidence before placing in envelope
- Place patient label on envelope. Write contents on outside of envelope.
- Seal envelope using tape, adhesive seal, and patient ID label. Never lick envelope seal.
- Sign over seal

Swabs

- Use sterile cotton swabs
- To obtain swabs from dry areas (e.g., skin, fingertips, rectum) lightly moisten swabs with sterile water or saline (soaking in water will prolong drying time)

- To obtain swabs from wet area, e.g., mouth, vagina) use dry swabs

Drying swabs

- Swabs maybe dried in locked cabinet or drying box.
- Air-dry swabs for 1.5 hours before packing
- Maintain chain of custody while drying
- Do not use heat to dry swabs
- If drying box is used, place swabs from only one patient at a time in drying box. If necessary, lock specimens from 2nd patient in cupboard until drying box is empty.
- Clean drying box with 20% bleach between each use.

Labeling and Packaging Swabs

- Swabs must be labeled with site of collection
- Write on a label site of specimen, (e.g. "Skin – right upper leg", or "oral", "endocervical", "vulvar", "rectal"
- Affix label to wooden shaft of swabs, 1 label 2 swabs from same site.
- OR
- Affix label to cardboard box in which dried swabs are packaged.
- If cardboard boxes are used, place 2 swabs from same site in one box
- Place dried swabs in envelope. Place swabs from only 1 site each envelope (oral, vaginal, endocervical, rectal, skin)
- Place patient label on envelope. Write contents on outside of envelope.
- Seal envelopes using tape, adhesive seal, or patient ID label. Never lick envelope to seal.
- Sign over seal, and place in Evidence Kit.

Foreign Objects (items which may contain forensic evidence, such as sanitary pads, condom, or tampon)

- Place item in plastic bio-hazard bag or sterile urine cup.
- Place patient label over seal, sign over seal.
- If item is wet or damp, transfer to law enforcement immediately, or store in locked refrigerator or freeze until transfer.
- Do notplace these items in Evidence Kit.

Medical Photography

If visible injuries are present, photograph with 35mm, Polaroid, digital, or video camera.

- Sexual Assault Nurse Examiner may either take the photos or assist law enforcement in obtaining photos.

Technique

- Filter flash with gauze or tissue taped over flash (this is necessary for photographing bruises).
- First photo is of patient standing or sitting, include face and body if possible, dressed in own clothing prior to exam.
- Photograph each injury site, with and without measuring tool. Photography may be done as needed.
- Include a ruler or coin in photos of injuries to document size of lesions.
- Bite marks should be photographed, but police should be notified for police photographer to obtain technically optimum photos.

Storage

- Photos will be turned over to police as evidence.
- For Polaroids place patient label on each photo, sign and date each photo.
- Place Polaroids in envelope, place patient label on envelope and secure in locked storage area.
- Document type of photos, parts of body in photos and name of photographer in case documentation
- Careful documentation with drawings is advised, even when photo-documentation is done.

INITIAL LAB TESTS

Pregnancy Test

- Obtain urine or serum pregnancy test on all females ages 12-50 as appropriate

Toxicology Tests

Obtain when:

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

Alcohol Levels

- If needed for patient care, obtain blood alcohol level.

Storage

- Do not seal urine or blood tubes in Evidence Kit Box
- Place in locked refrigerator (blood and urine) outside Evidence Kit Box
- Transfer with evidence to law enforcement

Forensic Toxicology

Obtain when:

- Patient is concerned she may have been drugged, reports blackout, memory lapse, or partial or total amnesia, or if clinical symptoms do no match know history.
- Clarify with patient that these tests will only be run if patient makes a police report and if investigator requests the tests are run.
- Specimen collection: Use state Toxicology Laboratory Kit, if available.
- If 24 hours, collect 2 gray top blood tubes and 50 ml urine.
- If >24 hours, collect 50 ml urine only.
- Seal specimen container with tape or adhesive seal, place patient ID label on container
- Sign over seal

Independent lab toxicology

- If patient is concerned about surreptitious drug administration, and wishes option for independent lab
  tests, and exam is within 72 hours of possible drug ingestion
- Collect extra 50cc urine
- Freeze or refrigerate until transfer to independent lab.

MEDICAL EXAMINIATION AND FORENSIC COLLECTION

General Information

- It is the patient's right to consent to or refuse any aspect of the exam and evidence collection.
- By law, the patient may have a support person (relative, friend, or advocate) present during the exam. Offer clear explanations of the reasons for each procedures, offer patient some control over the exam process
- It is preferable that the patient does not eat or drink before the exam, but the patient's comfort should not be compromised to achieve this.
- Oral swabs, for example, should be obtained immediately if the patient is thirsty or wishes to rinse mouth.
- Urine specimens may be collected before initiating the exam.

Exam procedures

- Examiner should use powder-free gloves, and change gloves frequently during exam and evidence collection.

- Because a patient may not recall or may be embarrassed to report all aspects of the assault, the exam should be complete, with routine evidence collection from all orifices (mouth, vagina, and anus).
- If the patient has bathes or showered, specific steps of evidence collection should be omitted. These steps are indicated in the following sections.
- The following are the steps for the medical exam itself. The order of these steps may vary by hospital or examiner preference.

Trace Evidence Collection
To collect foreign material which may fall when patient undressed
Omit if patient has bathed or changed clothes since assault.

- Place large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper.
- Unfold and place evidence collection paper sheet over the bottom sheet.
- Instruct patient to stand in center and remove clothing
- Refold paper where patient stood, retaining any foreign material, and place in paper envelope.
- Seal, label, initial over seal and place in Evidence kit

Clothing Collection

Outer Clothing: **Omit if patient changed clothing after assault.**
If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important.

- Place each item of clothing in a separate paper bag.
- Place patient label on each bag. Tape each bag closed, and sign over tape
- Place smaller clothing bags in one large paper bag. Tape bag closed. Label, seal and sign over seal.
- Maintain chain of evidence for clothing bags. Lock in secured area when not directly observed.

Note: Wet clothing should be dried in a locked room or area, or transferred to law enforcement within 3 hours.
Do not cut through any existing holes, rip or stains. Do not shake out patient clothing or trace evidence may be lost.

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

- Pooled secretions may leak on to underwear.
- Package patient's underpants in small paper bag Seal, label, and place in the Evidence Kit before sealing the kit

Oral Exam
Document:

- Lacerations, abrasions, petechiae, bruises
- Check mucosa, plate, frenulum and tongue

Oral Swabs
Collect routinely

- Use 4 cotton swabs total.
- Using 2 dry swabs at a time, swab around buccal mucosa, under tongue, and tonsillar pillars, with special attention to in inferior (dependent) areas of the mouth.

Fingernail Cuttings or scrapings
Obtain when visible debris or blood under nails broken during assault

- Place small paper sheet labeled "left hand" on flat surface.
- Using disposable plastic scraper or clean, disposable blunt metal scissors, scrape under all five fingernails of left hand, allowing any debris to fall onto paper.
- Alternatively, with patient's permission, cut fingernails.
- Refold paper inward to retain debris and scraper.

- Repeat procedure for right hand using sheet of paper marked “right hand”.
- Fold scraper in paper, fold each separately
- Place in envelope, label and seal envelope, sign over seal.

Finger Swabs

To collect secretions which may be on patient’s fingers

Collect routinely

Omit this step is patient has bathed, showered, or washed hands

- Moisten 1 swab with sterile water or saline
- Swab fingertips, including area under nails on right hand
- Moisten 2 swab, swab fingertips on left hand
- Attach patient ID label to each swab, labeled “fingertips, right” and “fingertips, left”
- Air dry swabs thoroughly.
- Label swabs or cardboard boxes, place in envelope, and sign over seal

Head Hair Combing

To collect foreign hairs and debris.

Omit this step if patient washed hair after assault.

- Place paper sheet on exam table or tray.
- With patient standing, sitting, or lying on exam table, comb or fluff hair over sheet
- Re-fold paper, enclosing both comb and hair
- Place in envelope. Label and seal envelope, sign over seal.

Skin Exam

Document

a. Visible skin injuries, bruises, abrasions, lacerations, erythema.
b. Note bite marks and suction ecchymoses.
c. Ask patient of injury is from assault or another event and document.

Skin Swabs

Omit if patient bathed or showered after assault.

- Ask patient if assailant’s mouth touched her, or if she noted ejaculation on skin.
- Swab areas of possible assailant saliva or semen.
- Document sites of swabs in documentation.

Skin Swab technique

- Use 1 cotton swab at a time.
- Moisten first swab with sterile water or saline.
- Swab area of possible dried secretions.
- Swab same area with second, dry swab.
- Repeat for each with second, dry swab.
- Air-dry thoroughly at least 1 hour.
- Affix patient label to shaft of swabs or to cardboard boxes.
- Write on label site of collection (e.g., rt shoulder, lower abdomen).
- Place both swabs from a single site in same cardboard box.
- Place in envelope, label envelope, seal, and sign over seal.

Debris on Skin

To collect grass, fibers, paint flecks, etc., which may adhere to patient’s skin.

Omit this step if patient bathed or showered after assault.

- Unfold paper and place on tray.
- Using either end of cotton swab, lift off debris from skin.
- Place on paper. Fold paper inward to retain debris.
- Place in envelope. Label and seal envelope, and sign over seal.

Pubic Hair Combing

To collect foreign hairs and debris.

Omit this step if patient bathed or showered after assault.

- Omit if pubic hair is not present or has been shaved. This finding should be documented.
- Either patient or examiner may do actual combing (if patient, examiner must observe)
- Patient should be sitting or lying in dorsal lithotomy position.
- Place paper sheet under victim's buttocks.
- Using disposable comb, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper.
- Refold paper to retain both comb and any evidence present.
- Place in envelope. Label and seal envelope, and sign over seal.

Genital Exam – Female

Document:

Genital lacerations, abrasions, bruises, petechiae, erythema, and inflammation.

- Use both labia separation and traction to examine vulva and introitus.

Perineal/ vulvar swabs

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

Omit if patient bathed or showered after assault.

- Use 4 cotton swabs total.
- Using 2 swabs at a time, lightly moisten swabs with sterile water or saline.
- Swab genital folds and perineum.
- Air-dry thoroughly at least 1 hour.
- Label swabs or cardboard boxes. Write on label site of collection (perineal/vulvar)
- Place both swabs from a single site in same cardboard box.
- Place in envelope. Label and seal envelope, and sign over seal.

Vaginal / Cervical exam and swabs

Insert speculum and examine vagina and cervix for trauma and lesions.

Do not use lubricant (e.g., surgilube) for speculum. Rinse speculum in warm water for patient's comfort.

- Use 4 swabs total.
- Use 1 swab at a time. Do not moisten swabs.
- Swab endocervix with 1 swab, repeat with second swab.
- Swab fornices and vaginal pool with next 2 swabs.
- Air dry thoroughly for at least 1 hour.
    - Write on label sire of collection (cervix/vagina)
- Place 2 swabs each in 2 cardboard boxes.
- Place in envelope. Label and seal envelope, and sign over seal.

NOTE: For prepubertal girls, vaginal speculum exam is not necessary and is contraindicated, except under anesthesia.

For young adolescents who have not had a prior pelvic exam, postmenopausal women, or any patient who cannot tolerate a speculum exam, forensic swabs may be collected by means of vaginal swabs alone.

Alternative method

- If speculum is not used, use 1 (dry or slightly moistened) cotton swab at a time.
- Insert 2"-3" into vaginal canal.
- Swab posterior vaginal pool.
- Repeat with 3 more swabs -one a time.

- Air dry thoroughly for at least 1 hour.
    - Write on label site of collections (vaginal)
- Place 2 swabs each in 2 cardboard boxes.
- Place in envelope. Label envelope and seal, sign over seal.

Genital Exam – Male
Document:
Penile or scrotal abrasions, bruises, lacerations, erythema and inflammation.

- Exam inner thighs, all sides of penile shaft, corona, and glans.
- Examine scrotum, including anterior, posterior aspect.
  If uncircumcised, retract foreskin to examine glans penis.

Outer Penile Swabs
Collect if report of assailant saliva or secretions on patient's penis.
Omit this step if patient has bathed or showered.

- Swab surface of penis with 2 swabs moistened with saline or sterile water.
- Repeat with 2 dry swabs.
- Air dry thoroughly.
- Label and package as forensic evidence.

Anal Exam- Male and Female
Document
Perinal bruising, petechiae, abrasions, lacerations, or visible anal laxity

- Separate anal folds to visualize lacerations
- Digital exam is not indicated, except if concern for foreign body retention
- Referral to M.D. is indicated if there is anal bleeding or rectal pain. May be indicated if history of anal penetration or visible perianal injury.

Anal Swabs
Collect routinely when patient reports contact to vagina, perineum, or anus by any part of assailant's body:

- Use 4 cotton swabs total.
- Moisten swabs lightly with sterile water or saline.
- First 2 swabs: Using 1 swab at a time, swab within anal folds.
  Repeat with second swab.
- Second 2 swabs: Slowly insert 1 swab part anal sphincter (approximately 2 cm).
  Slowly withdraw swab. Repeat with second swab.
- Air dry thoroughly.
- Label and package as forensic evidence.

Toluidine Blue
Toluidine blue may be used to delineate small areas of abrasion on non-mucosal skin.
Use only after perineal / vulvar and anal swabs are obtained. Use before speculum insertion.

- Apply toluidine blue 1% with cotton swab, wipe off dye with water, petroleum jelly, or dilute solution (2.5%) acetic acid. Abrasions will be stained blue.

Reference Blood Sample
Explain to patient that this blood can be used to compare assailants with patient's DNA.

- Obtain drop of patient's blood with sterile lancet, or use drop from needle drawn sample.
- Fill all circles on FTA paper.
- Allow to air dry.
- Place in envelope, place patient label on envelope, and package with forensic evidence in Evidence Kit.
- Sign over seal.

The following tests and procedures are not recommended for forensic purposes, but may be done for patient care.

Optional Tests

Vaginal wet mount

- Not recommended to examine for sperm, due to lack of reproducibility and standardization.
- May not be used to assess vaginitis if signs or symptoms are present.
- Use standard methods for diagnosis.

STD tests (Chlamydia, gonorrhea, syphilis)

- Not generally useful for forensic purposes in the non-sexually active patient.
- Patient consent for these tests should be obtained. Inform patient that these tests are related to health issues, and not forensic tests.
    - Use to assess pre-existing infection. Highly sensitive tests such as PCR/LCR may also indicate infection in assailant.
    - For females, STD tests may include gonorrhea and Chlamydia tests.
    - For males with prior risk of infection, appropriate test for urethral, rectal and oropharyngeal gonorrhea and Chlamydia infection may be offered.
    - Syphilis baseline test may be offered with knowledge of community epidemiology.
- Follow up for lab results must be arranged.

HIV testing

- Baseline HIV testing may be performed up to 2 weeks after assault, and may be performed in follow-up visit.
    - If patient wishes HIV serology testing, pre-test counseling must be done and post-test counseling arranged.
    - Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but relates to possible exposure 2 months or more prior.
- If testing is done, arrangements must be made for follow-up visit to discuss results.

TREATMENT

Emergency Contraception

Offer emergency contraception when:

- Patient is at risk for pregnancy and
    - ❖ Patient is not using a highly reliable method of contraception such as oral contraceptives (no pills missed in current cycle) Depo Provera® or IUD and/or
    - ❖ Patient feels any pregnancy conceived in the last five days would be undesirable to continue and
    - ❖ Pregnancy test is negative

- Since the emergency contraception is most effective if given soon after unprotected intercourse, if possible patient should obtain medications prior to discharge, and take first dose prior to discharge or as soon as possible.

STD Prophylaxis

Offer Antibiotic prophylaxis for gonorrhea and chlamydia when:

- Patient is anxious about the possibility of contracting an STD or
- Alleged assailant is known to have an STD or high risk behavior or
- Patient reports multiple assailants or
- Patient desires treatment

Hepatitis B Vaccine
Offer when:

- Patient has not been previously fully immunized for Hepatitis B, and
- Patient has a negative history for Hepatitis B, and
- Secretion mucosal contact occurred during assault, and
- Patient signs consent for immunization
- Inform patient that repeat vaccine doses are necessary at one month and six months after initial vaccine.

Tetanus Prophylaxis
Offer when:

- Skin wounds occurred during the assault and
- Patients not up to date for tetanus immunization (no immunization in past five years)

Tetanus toxiod, 0.5ml IM

HIV Prophylaxis
For women:
HIV prophylaxis is generally not recommended because the risk of acquiring HIV from an unknown male in Washington is extremely low.
Higher risk circumstances are:

- Assailant is known to be HIV positive
- Assault by a man who is from an endemic country
- Secretion / mucosal exposure by four or more males

For men who are assaulted by men:

- The risk of HIV acquisition is somewhat higher, although calculated to be still less that 1%
- Discuss options for HIV prophylaxis with patient.

Refer to guidelines "HIV Prophylaxis after Sexual Assault" for full discussion and recommendation.
Discharge

- Explain to patient what tests were obtained
- Explain follow up for test results
- Explain that if police report was made, detective will contact patient within several days
- Assess support systems, refer for supportive care
- Offer patient education materials
- Give written discharge instructions
- Confirm plans for follow up

FOLLOW UP MEDICAL VISIT

Timing of Follow Up
Recommend within two weeks of the initial exam. May be done with patient PCP.
Records to be sent to PCP when PCP was the initial medical referrer, or as is authorized by the patient or patient's legal guardian.

Billing
Crime Victim's Compensation (CVC) does not routinely cover the follow up visit.
Application to CVC may be made, and if approved, CVC may be the secondary insurer.

Review with Patient

- Exam results
- Lab results
- Current physical symptoms
- Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks)

- Concerns for safety
- Concerns regarding STDs and HIV
- Assess social support (family, friends)
- Review legal issues

Medical Exam
Depending on history and symptoms

- Check for resolution of injury
- Evaluate and new symptoms

Laboratory Tests
Depending on risk and patients concern

- Obtain urine pregnancy test
- Culture for gonorrhea and Chlamydia if single dose prophylaxis was not given in emergency department
- Saline wet mount and KOH prep to evaluate vaginitis symptoms
- HIV: pre-test and post-test counseling required after exposure
  - Baseline
  - Three months
  - Six months
- Hepatitis B serology if particular concerns
- Syphilis serology if particular concerns

Treatment
Hepatitis B vaccine

- Prophylaxis with vaccine may be initiated up to 14 days post assault
- Indicated if there has been secretion to mucosal contact, and if patient has not been fully immunized, and has no history of Hepatitis B infection.
- Initiate, continue or refer for completion of series (initial, one month, six months)
- Assess and treat other medical conditions, as needed.

Referral

- Refer to medical, advocacy, mental health and social service

Recommended Guidelines
Sexual Assault Medical Evaluation
Child 12 years and under

The following are guidelines for conducting the medical-legal examination and collecting forensic evidence for male and female child patients when there is a report or concern of sexual assault. These guidelines are not intended to include all the medical evaluations and tests which may be necessary for appropriate care for an individual patient. Likewise, not all the steps outlined here will be appropriate for every patient.

This outline is for pre-pubertal children, usually up to and through age 12 years. For care for adolescents, see "Recommended Guidelines for Sexual Assault Medical Exam, Children 13 to 17", Appendix O.

GENERAL

PURPOSE OF EXAM

MEDICAL

- Identify injuries and refer for treatment and medical clearance to the emergency department of Kittitas valley Community Hospital
- Diagnose and treat other medical conditions
- Assess risk of sexually transmitted diseases
- Inform patient and family regarding physical findings, permanent injury, and disease risk

SOCIAL/ PSYCHOLOGICAL

- Respond to patient's and family's immediate emotional needs and concerns
- Provide crisis intervention and stabilization
- Assess safety and assist with interventions
- Explain mandatory reporting process
- Explain Crime Victims Compensation: give brochure or application (for materials call 1-800-762-3716)

LEGAL

- Document history
- Document medical findings
- Collect forensic evidence when appropriate, maintain chain of custody, and transfer to law enforcement

REPORT /REFER

- Report to law enforcement and/or Child Protective Services when the medical provider has a reasonable suspicion of child abuse (see Appendices C and D)
- Refer for follow-up medical care if indicated
- Refer for advocacy or counseling

BACKGROUND

A sexual abuse medical exam is indicated when a child reports a contact sexual offense, or when a witness (including the offender) observes such an offense

- A decision to obtain a medical exam should not depend on report of "penetration"- this definition is difficult to ascertain

Children may minimize the extent of contact

- Children may present with a combination of concerns: parent's perception of a risky situation, non-specific physical complaints such as redness or discomfort, and child's statements
- The child's statements are often the most critical aspect of the medical evaluation for child sexual abuse
- However, a young child's statements may be difficult to interpret.

In sexually abused children, physical findings are most often normal or non-specific
A normal or non-specific exam does not rule out prior sexual abuse

- Physical injuries to the genital or anal regions usually heal within a few days
- The medical provider should consider differential diagnosis or alternative explanations for physical signs and symptoms
- Symptoms or signs such as redness, dysuria, vaginal discharge or bleeding may have many causes, which may or may not be associated with sexual abuse
-

Forensic evidence

- Studies which use the most current DNA forensic techniques are not available. It is not known

what historical and physical exam factors are positive predictors of DNA findings

- It is impossible to tell from the initial history what the outcome of any case will be. The child's comfort must be balanced against the knowledge that specimen collection will not be possible at a later date
- Clothing, especially underwear, is an excellent source of evidentiary DNA
- Scene investigation, including collection of linens and clothing should be done early. Evidence from the home is more likely to be positive than evidence from the patient's body

TRIAGE

Examination within 24 hours is recommended when

- Clear report by child, or witnessed sexual contact which occurred within the previous 72 hours (exception: child to child contact with no apparent injury)
- Active vaginal or rectal bleeding of unknown etiology and concern for abuse
- High risk situation, such as abduction
- Advise family:
  - Do not bathe child before exam
  - Bring in clothes worn at time of incident, if possible, and bring change of clothing
  - Come to office, clinic, or hospital with support person (family, friend, advocate)

The setting for this exam will vary by community. The examiner must be capable of performing an adequate, comfortable exam, with documentation of injury and forensic evidence collection

Examination within the next 1 to 10 days, depending on circumstances, is recommended when

- Clear report by child, or witnessed sexual contact which occurred more than 72 hours prior

Examination by a primary medical provider is indicated when

- Child has concerning symptoms, such as pain with urination, vaginal discharge, or signs such as vulvar redness, and no clear report or witnessed abuse

Visible vaginal or anal abnormality with no definite abuse event

A young child has made vague statements which might have a variety of interpretations

The primary provider may request consult with child sexual abuse specialist

ED TRIAGE

Concern of child sexual abuse is often a psychosocial emergency for the family, and should be triaged for urgent support and assistance

- Details of reason for concern should be obtained outside of the child's hearing
- Depending on circumstances, the ED exam may be a limited screening exam, with or without evidence collection. The child may then be referred for a more complete evaluation by a specialist

REGISTRATION/BILLING

By law, the initial medical forensic exam for sexual abuse or assault must be billed only to Washington State Crime Victim's Compensation

- A Crime Victims Compensation application does not need to be completed for this coverage to be in effect

Treatment of injury or illness (e.g., x rays, or treatment for urinary tract infection) is billed to the patient's insurance, with CVC as secondary insurer

Consent for Care	In general, in the state of Washington, the parent or legal guardian must sign consent for care for patients under 18 years of age. There are some legal exceptions to this that may apply to medical care after sexual assault. These exceptions may include, but are not limited to: • A person of any age may obtain confidential care for pregnancy or birth control (RCW 9.02.100; State v. Koome) • If a minor is legally emancipated, by court decree, the minor has the same rights as an adult regarding consent for medical care. • When a minor is married to a person of full age, the minor shall be deemed and taken to be of full age (RCW 26.28.020) • Emergency care at a hospital emergency department pursuant to United States Code (USC) 42, Chapter 7, XVIII, 1395dd • As provided by RCW 18.71.220, relating to immunity of licensed physicians and hospitals in rendering emergency care • Search warrant from the court • In circumstances where there is significant concern of sexual abuse within the previous 72 hours, and the parent or guardian is unavailable or unwilling to sign for medical care, call the police to place child into protective custody. After child is placed in protective custody, CPS is authorized to approve treatment. ❖ If a physician has reasonable cause to believe that permitting a child to remain in the care or custody of the adult that is legally responsible for the child will place the child in imminent danger, the physician may detain the child, whether or not medical attention is required, without the consent of the legally responsible adult. (RCW 26.44.056, Appendix D) ✓ Mandatory reporting to law enforcement or CPS is still required when a victim is under 18 years of age. The child should be advised that if CPS or law enforcement is notified, it is possible that their parents will be informed about the event by those agencies.
MANDATED REPORTING MINORS	**A report to law enforcement or CPS is mandatory <u>if the medical providers have a reasonable suspicion of child abuse</u>** (RCW 24.44.030, see Appendix C) Non-consensual or coercive sexual acts must be reported to police <u>and/or</u> CPS as a crime against a child. The age of the alleged assailant is not relevant Police should be informed as soon as possible if forensic evidence is collected CPS must be informed if there is any concern for safety of patient or other children
CRIMES AGAINST MINORS	**Sexual activity must involving a minor must be reported :** When the victim is less than 12 years old, and the offender is 24 months or more older **Mandatory reporting applies even when a minor has signed for own care**
PROFESSIONAL QUALIFICATIONS	**The examiner should be familiar with normal pre-pubertal genital anatomy, basics of child development, means to maintain child's comfort, and non-intrusive methods of examination and specimen collection** ▪ Sexual assault nurse examiners should obtain specific training in exams of children before conducting these exams ▪ Pediatric exams require differential diagnosis. Exams which include photo documentation should be reviewed by an independent practitioner with expertise in child sexual abuse (MD, PA-C, or ARNP)

PEER REVIEW AND EXPERT REVIEW

Peer review or formal consultation is strongly recommended when the evaluator considers an exam concerning or abnormal

This review is best done by reviewing photographs or videos

ASSESSMENT, DIAGNOSIS AND CONCLUSIONS

- "Rape" and "molestation" are legal terms, not medical diagnoses
- Assessment should delineate history and physical findings
  - Useful terms are "history of sexual abuse", "report of sexual abuse"(if the child made clear report or sexual abuse was witnessed) or "concern of sexual abuse" if there is no clear statement or witness

DOCUMENTATION

- The medical chart is likely to be legal evidence
  - Use ink, print legibly or type
  - Use only standard abbreviations
- On each page of the report
  - Clearly indicate patient name and hospital number
  - Print name of staff member who completed the page
  - Sign and date

HISTORY

PATIENT INFORMATION

In addition to routine registration data, document

- Person who accompanied patient and relationship to patient
- Police report if filed: police department and case number if available
- CPS report if filed, and name of office

HISTORY OF EVENT OR CONCERN

The history is obtained from the parent or guardian and/or law enforcement

This information may be obtained by the health care provider or a designated member of the team.

- The history may be more focused in the emergency setting, and more extensive in the clinic setting

DOCUMENT

- Who referred patient
- Source of information: document all sources of information, including telephone contacts
- Reason for concern for sexual abuse
- What information caregiver obtained from the child
- What specific questions the parent or guardian asked to elicit information
- Time (hours or days) since last probable contact

Physical symptoms or signs noted by parent or guardian: itching, bleeding, discharge, constipation, diarrhea
Behavioral changes

- If the patient has
  - Showered, bathed, cleaned genital-anal area, rinsed mouth, eaten, drank, urinated or defecated since the alleged abuse
  - Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to medical setting

RISK FACTORS

Assailant risk regarding Hepatitis B, Syphilis, and HIV if known

- Multiple assailants
- Man who has had sex with men
- Recent residence in an endemic country
- Known or suspected IV drug use

MEDICAL HISTORY

Active medical problems, significant past medical problems
Current medications
Developmental status (known speech or cognitive delays, special education)
Past medical history, including immunizations
Patient's history of hepatitis B vaccine or illness
Allergies to medications
Antibiotic use in past 2 weeks

History of past genital injury, surgery, or instrumentation especially urinary catheterization

SOCIAL HISTORY

Home setting: family members and others in home
School, daycare, other caregivers
Other possible child victims or witnesses

INTERVIEW WITH PATIENT

The medical interview is for the purpose of medical diagnosis and treatment, and is distinguished from the forensic interview
Medical interview may be done by medical provider, nurse, or social worker
When possible, the interview should be done with family members or other emotionally involved persons out of the room
The interviewer must identify self and clarify the medical role to the patient
Information provided by the patient in the medical interview may be used in court as "medical exception to the hearsay rule"

INTERVIEW TECHNIQUES

The medical interview does not require special training, but the interviewer should adhere to certain basic rules of non-leading questioning
Establish rapport by initiating neutral conversation
Assess patient's development, especially in speech pattern, articulation, and sense of time
Ask non-leading questions ("why did your parent bring you here today?" or "is there a problem?", "has someone been bothering you?")
Allow child to fully answer each question before asking another
Encourage free narrative
Avoid yes or no questions, and multiple choice questions
Do not introduce new information, such as actions ("did he do …?") in questions. Referring to prior statements by the child is acceptable ("you told me he did …")
After asking a narrow question ("where did that happen?") next question should be open-ended. ("tell me everything about that")
It is <u>not</u> necessary for the medical provider to obtain all the details of the event
If the child is unwilling or unable to participate in an open-ended medical interview, do not persist in attempting to interview. The medical evaluation is only one part of an investigation

DOCUMENT INTERVIEW

Document persons present during talk with child
Document near verbatim questions asked and child's statements regarding abuse, assault, or injury

- Document child's demeanor during interview

DISCUSSION WITH PATIENT AND FAMILY

Discuss medical procedures. Provide clear age appropriate explanations
Discuss with the family the extent of the exam, the plan for photo-documentation and evidence collection, if needed
Discuss CPS or police report, if needed. Assist parent in making a report, if appropriate
Refer to community resources for support (see attached list)

Medical examination

The exam should be done in a manner which is least disturbing to the child. Techniques to increase comfort include

EXAM PROCESS

- Assure the child that there are no shots given during the exam
- Offer clear age appropriate explanations for the reasons for each procedure, offer patient some control over the exam process
- Offer that a person of child's choice can be present for the entire exam. Have that support person positioned near the child's head
- Use drapes to protect privacy, if the child wishes
- Use distracters: These can be:

The parent singing, reading a book or telling a story to the child
A music box or bubbles
A Viewmaster or visual distraction

The child should not be held down or restrained for the exam, it is not possible to do an adequate exam under these conditions
If is necessary to restrain the child for a detailed exam, then either the exam should be deferred or the child should be sedated

SEDATION

- Although anxious parents or patients may request sedation for the exam, sedation is very rarely indicated for the sexual assault exam
- One clear indication for a sedated exam is active vaginal or rectal bleeding where the exam is needed for medical assessment
- In cases where the child refuses the evidentiary exam, the following evaluation should occur

Is the parent increasing the child's anxiety?
- If so, the medical provider should take the parent aside and listen to their concerns. If necessary, and if the parent is in agreement, the parent should remain outside the room during the exam

Is the child non-specifically distressed?
- Offer conversation, reassurance, food, distraction

Is the child distressed about the genital exam per se?
- Listen to child's concerns, emphasize privacy

Recognize that clothing and household linens may be the best source for DNA evidence

- If an exam is not immediately required for medical issues, and if deemed appropriate to collect evidence, offer to trade child's underpants for a new pair, and place child's underpants in evidence.
- If the child resists the genital exam, swabs from the abdomen and umbilicus may be a source for DNA evidence as well

PHYSICAL EXAM

A complete head to toe physical exam, with particular attention to findings of trauma or neglect, should be documented in every case

ORAL EXAM

Document

Lacerations, abrasions, petechiae, bruises

- Check mucosa, palate, frenulum, tongue
- Dental caries or infection

SKIN EXAM

Document

- Visible skin injuries, bruises, abrasions, lacerations, erythema, scars
- Note bite marks and suction ecchymoses
- Ask patient if each injury is from assault or another event and document

GENITAL EXAM - FEMALE

Document
- Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, vaginal discharge, scars, and hymenal transections
- Use both labial separation and traction to examine vulva and introitus
- Prone knee chest position is usually not necessary in the acute setting, but may be a useful adjunct to assess for healed injury
- Gentle irrigation with warm water may assist with assessment of the hymenal anatomy

For prepubertal or early pubertal girls, the vaginal speculum exam is not necessary and is contraindicated, except for exam under anesthesia

GENITAL EXAM – MALE

Document
- Penile or scrotal abrasions, bruises, lacerations, erythema, and inflammation
- Examine inner thighs, all sides of the penile shaft, corona, glans, under foreskin.
- Examine scrotum, including anterior, posterior aspect

ANAL EXAM- MALE AND FEMALE

Document
- Perianal bruising, petechiae, abrasions, lacerations, or visible anal laxity
- Separate anal folds to visualize lacerations
- Digital exam is contra- indicated, except if concern for foreign body retention

- Anoscopy may be used if there is anal bleeding or rectal pain following reported anal penetration, or if there is visible perianal injury
- Lubricant should be used for anoscopy. To avoid contamination, perform anoscopy after forensic swab collection

Medical Photography

INDICATIONS

Injuries which are judged concerning for abuse should be documented as thoroughly as possible, including careful drawings and photo-documentation

- Trained personnel may either take the photos or assist law enforcement in obtaining photos
- Careful documentation with drawings is advised, even when photo-documentation is done
- 35 mm, video, and digital photography are all acceptable methods. Polaroid photography is generally poor quality
- Photography may be done as needed throughout the physical exam

GENERAL BODY INJURY

- If using date function, verify that date on camera is correct
- First photo is of patient's face for identification
- Include a ruler or coin in photos of injuries to document size of lesions
- Photograph each injury site 3 times
  - At 3 to 4 foot distance (to document injury in context)
  - Close up (between 12 and 24 inches) with ruler or coin
  - Close up without ruler or coin
- Bite marks should be measured and photographed, and police should be notified for police photographer to obtain technically optimal photos

COLPOSCOPY

- Magnified photographs (colposcopy), if available, are recommended for documentation of acute injury, healed injury and other findings, and has definite value for comparing one examination with a later exam, second opinion and peer review, as well as evidentiary value
- Photocolposcopy can be video, macro 35 mm, digital camera, or a colposcope with attached photographic device
- Use of a photocolposcope requires special training, equipment and technical expertise, and this may not always be available in the emergency setting
- Magnified photographs are equivalent to photocolposcopy

PHOTO STORAGE

There must be a clear protocol detailing storage, copying, and release. See Sample Protocol for Medical Photography for Child Abuse

- Photos may be released to police as evidence or kept in hospital records

Forensic Evidence Collection, Packaging, and Storage

INDICATIONS FOR EVIDENCE COLLECTION

- Clear report or witnessed contact offense within prior 72 hours (even if patient has bathed) when alleged assailant is over 11 years of age
- High risk situation, for example, abduction
- Perineal injury and clinician suspects abuse

BACKGROUND

If evidence is collected, that evidence should not be limited to the areas which the patient reports contact

- Patients may be embarrassed, or may forget aspects of the abuse/assault
- Specimen collection is not only for possible semen, but also for DNA analysis of possible foreign saliva and hair
- History of bathing does not rule out obtaining skin or surface swabs, as DNA may be obtained even in this circumstance
- Evidence collection is not an all-or-nothing process and may be limited by patient or family tolerance
- If evidence is collected, the priorities are:
  - Underpants, even if changed
  - Clothing worn at the time of the abuse
  - Fingertip, skin, oral, vulvar, penile, peri-anal and rectal swabs
  - Collection of foreign material (fibers, hairs, etc)

- In cases involving abduction or assault by strangers, collection of trace evidence, debris, and hair combing is more significant than in cases where abuse is alleged to have occurred in the family home
- Notify police to collect evidence from the scene: this is positive more often than evidence collected from the patient's body

Forensic specimens are not processed within the medical facility, but stored separately and transferred to law enforcement

Evidence may later be tested by the Washington State Patrol Crime Lab, but all evidence is not necessarily processed

EXAMS OF BOYS

- Use standard evidence collection
- Attention to swabs from penile shaft and glans penis

USING MANUFACTURED KIT

- A commercially produced sexual assault evidence kit may be used, but is not mandated
- Tri-tech kit REWA-1 corresponds to these guidelines
- Do not discard unused envelopes in kit
- All references to "Evidence Kit" in these guidelines refer to material components for evidence collection

If using TriTech RE-WA1 kit, do not use envelopes labeled "Pubic hair combings", "Pubic hair cuttings", "Vaginal swabs" unless patient is Tanner 3 or above, or post-menarchal

EXAM PROCEDURES

- Examiner should use powder-free gloves, and change gloves frequently during exam and evidence collection
- Moisten swab with one drop of distilled water (included in kit), or with tap water or sterile saline when moistened swabs are required

EVIDENCE COLLECTION STEPS WHEN CLEAR REPORT, WITNESS OR HIGH RISK SITUATION WITHIN 72 HOURS

Site	Patient Selection	Technique
Trace debris	If abuse occurred out of home or outdoors, and patient has not changed clothes	▪ Place clean bedsheet (or paper sheet) on floor ▪ Place clean paper sheet (at least 2' x 2 ') on top ▪ Have child undress while standing on paper ▪ Fold paper to retain debris ▪ Place in envelope, seal, sign and date over tape
Outer clothing	If wearing (or brought in) clothing worn at time of abuse If event occurred out of doors or clothing was stained or damaged collection is particularly important	▪ Place each item of clothing in a separate paper grocery-type bag ▪ Place patient label on each bag ▪ Tape each bag closed with clear packing tape, and sign over tape ▪ Place smaller clothing bags in one large paper grocery type bag ▪ Tape this bag closed with clear packing tape. Label with patient ID, and with permanent marker sign and date over tape ▪ Maintain chain of evidence. Lock in secured area when not directly observed *Do not cut through any existing holes, rips, or stains. Do not shake out patient's clothing or trace evidence may be lost* *Wet items – place in double paper bag, place in open plastic container or in open plastic bag. Label "WET" and transfer to law enforcement within 3 hours*
Underpants or diaper	All, even if changed after event (exception: if police have collected at scene)	▪ Package in a small paper bag ▪ Seal, label, and place in the Evidence Kit *Note: Do not attempt to dry a wet diaper. Either transfer to law enforcement within 3 hours, or place in double paper bag, seal, place in open plastic container(basin) or open plastic bag. Label "WET" and refrigerate or freeze until transfer*
Oral swabs	All	▪ Use 4 cotton swabs total. Do not moisten ▪ Using 2 swabs at a time, swab around gingival border, at margins of teeth, under tongue, and gingival gutters ▪ Repeat with remaining 2 swabs
Finger swabs	All	▪ Use 2 swabs total - one swab for each hand, moisten with 1 drop water ▪ Swab fingertips, area under nails, and web spaces of right hand ▪ Repeat with second swab on left hand
Debris on skin	If alleged assault was out of home and debris visible (e.g., threads, dirt)	▪ Use 1 swab, moisten with 1 drop water ▪ Lift off debris, place in clean paper ▪ Fold and place in envelope
Umbilicus	All - even if patient bathed after event	▪ Use 2 swabs total. Moisten 1 swab with 1 drop of water ▪ Gently swab umbilicus ▪ Repeat with second, dry swab
Skin	If patient reports saliva or semen deposition on skin, or visible dried secretions on skin. Obtain even if patient bathed after event	▪ Ask patient if assailant's mouth touched him/her or patient noted wetness. Note areas of possible dried secretions ▪ Use 2 swabs total for each site - Moisten 1 swab with 1 drop of water - Swab area of suspected foreign secretions - Repeat with second, dry swab ▪ Repeat 2 swab wet/dry technique for each suspect area

Evidence Collection Steps (cont.)

Vulvar/perineal	All girls	▪ Use 4 cotton swabs total ▪ Moisten 2 swabs with 1 drop of water on each - Swab external genital folds and perineum ▪ Repeat with 2 dry swabs *Intravaginal swabs are difficult to obtain because of the extreme sensitivity of this area in prepubertal girls* *These swabs are NOT necessary, external swabs are adequate*
Penile shaft	All boys	▪ Use 4 cotton swabs total ▪ Moisten 2 swabs with 1 drop of water on each - Swab surface of penis and glans ▪ Repeat with 2 dry swabs
Anal/Perianal	All	▪ Perianal: Use 2 swabs total - Moisten 1 swab with 1 drop water - Swab peri-anal folds - Repeat with dry swab ▪ Anal: Use 2 swabs total - Moisten each with 1 drop of water - Insert 1 swab 1-2 cm into anus ▪ - Repeat with second moistened swab
Reference DNA swab	To obtain patients DNA	▪ Use 1 dry swab - Swab vigorously inner surface of cheek and near gum line ▪ Place on designated filter (FTA) paper
Reference hair	To obtain patient's hair for comparison with possible foreign hair. Not useful if allegation is regarding someone with legitimate close contact (family member, babysitter).	▪ Pluck 10 hairs from scalp ▪ Place on clean paper (alt., place on sticky side of clean Post-it note) ▪ Fold and place in envelope
Toxicology	If patient reports blackout, or clinical signs of intoxication	▪ For medical care, obtain blood alcohol and stat urine toxicology screen in hospital ▪ For forensics, if < 24 hours, 2 grey top blood tubs + 50 ml urine if >24 hours, 50 ml. urine only ▪ Place in biohazard bag ▪ Do NOT package in kit. Transfer separately to law enforcement

FORENSIC EVIDENCE PACKAGING AND STORAGE

CHAIN OF CUSTODY FORENSIC SPECIMENS

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

- Maintains continuous physical possession of specimens and items of evidence, or
- Designates another staff member to maintain possession of evidence, or
- Locks specimens in closed area (room, cabinet, refrigerator or freezer)

GUIDELINES FOR EVIDENCE PACKAGING

- ***Swabs must be thoroughly dried before packaging***
- ***Those specimens which cannot be dried (soaked clothing or diaper, for example) should be refrigerated or frozen until transfer to law enforcement***
- Seal envelopes using tape, adhesive seal, or patient ID label
- Never lick envelope to seal
- Place patient label on envelope. Write contents on outside of envelope
- Sign over seal, and place in Evidence Kit

SWABS

Drying swabs

- Swabs may be dried in a locked in room, cabinet or drying box
- Air dry swabs for at least 1 hour before packaging. Do not use heat to dry swabs
- Maintain chain of custody while drying
- If drying box is used, place swabs from only one patient at a time in drying box. If necessary, lock specimens from 2nd patient in cupboard until drying box is empty
- Clean drying box with 20% bleach between each use

Labeling and packaging swabs

- Either affix patient label to each swab, or place patient label on each swab box
- On each label, write site of collection. e.g., "Skin - right upper leg," "oral," "vulvar/perineal," "rectal"
- Place 2 swabs from same site in one cardboard swab box
- Place dried swabs in cardboard box in envelope. Place swabs from only 1 site in each envelope (oral, vaginal, rectal, skin)

UNUSED ENVELOPES

Do not discard

- Place patient label on each envelope
- Indicate reason on envelope why specimen not collected
- Place back into evidence kit box

EVIDENCE STORAGE

Temperature

- Dry or dried evidence may be kept at room temperature or frozen. However, dry evidence must not be frozen and then thawed
- Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer

Evidence Kit

- Store sealed Evidence Kit in locked cabinet, refrigerator, or freezer until transfer to law enforcement

Clothing

- Store clothing in locked room or cabinet until transfer to law enforcement
- Wet clothing must either be dried in a locked area or transferred within 3 hours to law enforcement

PREGNANCY, STD, AND TOXICOLOGY TESTING

PREGNANCY TEST

- Should be done on girls 12 years and older, and on any girl who has either had any menstrual periods or who has breast or pubic hair (Tanner stage 3 or above)

STD TESTS

- Positive STDs are highly significant in evaluation of child abuse.
- However, the positive predictive value of a positive test in a low prevalence population is low
- Therefore, all positive non-culture tests should be confirmed with culture or another test, e.g., confirm PCR with LCR, or with culture
- Tests are unlikely to be positive in hours or first days after a single episode of abuse: in these cases may be best to defer testing to a follow-up visit

INDICATIONS FOR STD TESTING

- Routine testing for all STDs in children has a very low yield
- Testing is recommended when
- Clear report of genital to genital or genital to anal contact with a teen or adult or
- Signs of disease, specifically vaginal or urethral discharge, or genital ulcers
- or
- Positive diagnosis of another sexually transmitted disease
- Follow-up for lab results must be arranged

GONORRHEA

- In prepubertal girls, GC is a vaginal, not cervical infection. Cervical specimens DO NOT need to be obtained in children
- Infection is very unlikely in the absence of vaginal discharge in girls
- Swab of the vaginal discharge, or in boys of the meatal discharge, suffices for culture. Intravaginal swabs rarely need to be obtained
- Anal GC: anal infection is very rare in the absence of vaginal infection in girls However, for boys or girls who report anal penetration, anal culture is recommended (rapid tests are not approved)
- Pharyngeal GC: culture if report of penile-oral contact
- If an initial non-culture test is positive, culture is preferred as confirmatory test

CHLAMYDIA

- Vertical infection (perinatal) infection may persist for at least 3 years, and possibly longer
- Infection may be asymptomatic

If non- culture methods are used, then confirmation of positives by another method should be obtained before diagnosis is made. This confirmation may be by a different non-culture technique (PCR, LCR) or by culture

HUMAN PAPILLOMA VIRUS GENITAL WARTS

Assessment of the probability that HPV has been sexual transmission should depend on: age at onset, child's statements regarding abuse, maternal history, and other risk factors

- Genital warts may be vertically (prenatal or transmitted). These are usually evident by 3 years of age
- Ask child's biological mother about any personal history of genital warts or abnormal pap smear at any time in the past
- Vertical transmission is possible even if the mother has no history of warts (infection may be asymptomatic)

- Diagnosis is by visual inspection: referral to a specialist in child abuse or dermatology may be necessary

HEPATITIS B

- If immunizations incomplete or history of vaccine uncertain, consider Hepatitis B vaccine
- Hepatitis B vaccine may prevent acquisition of Hep B from infected contact if given within 2 weeks of contact
- Hepatitis B serology may be obtained at the acute or follow-up visit
- HBIG not generally recommended

SYPHILIS

- Serologic testing not generally recommended in low prevalence geographic areas
- If special concerns, best done 6 – 12 weeks after last contact

HIV

- If there is a history of semen to mucosal contact, especially with a high risk assailant, the clinician may recommend HIV testing
  - Tests should be done at baseline, 6 weeks, 3 months and 6 months after abuse or assault

Parent or guardian must sign consent for testing. For children in state dependency, DSHS must sign consent

Toxicology tests

Obtain when

- Patient appears impaired, intoxicated, or has altered mental status
- Patient reports blackout, memory lapse, or partial or total amnesia for event
- Patient or parent is concerned that he or she may have been drugged

When toxicology tests are indicated, both stat hospital test (for immediate information) and forensic toxicology specimens (for legal purposes and testing for some drugs which require special methods) should be obtained

Forensic toxicology specimens

- Specimen collection: Use State Toxicology Laboratory Kit, if available
- If <24 hours, collect 2 gray top blood tubes and 50 ml urine
- If >24 hours, collect 50 ml urine only
- Seal specimen container with tape or adhesive seal, place patient ID label on container

Storage for transfer to law enforcement

- Do not seal urine or blood tubes in Evidence Kit box
- Place in locked refrigerator (blood and urine) or freezer (urine only) outside Evidence Kit box
- Transfer with other evidence to law enforcement

Treatment, Discharge, and Follow-up

STD PROPHYLAXIS

Prophylactic treatment of STDs should not be given to children, as it may compromise investigation and conclusions about abuse or assault

Treatment should be initiated only after confirmation of infection: see STD testing above

- For recommended treatment regimens, see CDC Sexually Transmitted Diseases Treatment Guidelines, or the American Academy of Pediatrics Red Book

EMERGENCY CONTRACEPTION

By law, hospitals providing emergency care to victims of sexual assault must provide information about emergency contraception, and, unless medically contraindicated, provide emergency contraception. (RCW 70-41.350)

- Emergency contraception should be offered when
  - There may have been semen to vulvar or vaginal contact within the previous 5 days AND
  - The patient is post-menarchal, or is a girl Tanner stage III or above
- At times the history may be incomplete. Consider that emergency contraception is extremely safe and has very few side effects and may be highly desired by patient and family
- Emergency contraception (levonorgestrel) decreases the risk of pregnancy by approximately 85%. It does not cause abortion
- Both patient (if 12 or older) and parent should sign consent for EC, with understanding of the risks and benefits of treatment and non-treatment.
- If the patient is not able to give informed consent, consent must be obtained from parents, guardian, or surrogate decision-maker
- Since emergency contraception may be more effective if taken soon after unprotected intercourse, patient should be given medication while still in the medical center
- Advise patient and family that withdrawal bleeding similar to a menstrual period may occur within a few days or weeks of emergency contraception

Discharge instructions

- Prescribe: Plan B
- Levonorgestrel 1 tab (0.75 mg) po immediately and 1 tab 12 hours later
- Alternative: 2 tabs immediately
- Anti-nausea medication is not required with this medication

- Discuss medical findings
- Explain tests, if any, which were obtained
- Explain follow-up for medical test results
- Explain if CPS or law enforcement will be contacted by medical provider, as required by law
- Assess support systems and immediate safety of child
- Offer patient education materials
- Give written discharge instructions
- Arrange referral to community resources for case management, legal advocacy, and psychosocial care

Follow Up Medical Visit

Recommended when

- The initial visit has been a limited evaluation or
- There is need for medical re-evaluation, photo-documentation, assessment of healing, or STD evaluation

Billing

- Crime Victim's Compensation (CVC) does not routinely cover the follow up visit
- Application to CVC may be made, and if approved, CVC may be the secondary insurer

Appendix Q

FORENSIC SUSPECT EXAMINATION

If a suspect is detained in custody and has either consented to evidence collection or a search warrant has been issued, the following evidence collection procedure is recommended for use by law enforcement officers conducting such examinations, or by a medical professional conducting the suspect forensic examination at the request of law enforcement. If performed by a medical professional without a warrant, the law enforcement officer should also obtain a release of medical information form from the suspect.

2. **PURPOSE FOR FORENSIC SUSPECT EXAMINATION:** To document physical findings, and collect biological and other trace evidence which may be related to a particular crime;
   a. To collect reference samples from the suspect.
   b. These guidelines are applicable to male suspects, and will have to be modified for female suspects, but can provide a general reference point for such examinations.

3. TIME FRAMES:
   f. Examinations of suspects will yield more useful information if conducted within hours of the alleged assault.
   g. In most circumstances, a general guideline for conducting suspect exams is within 72 hours of the assault. Injuries such as lacerations, bruises, and bites, however, can be observed after a longer period of time.
   h. The longevity of most evidence is dependent upon activities of the suspect after the assault such as bathing, changing clothes, etc.
   i. For these reasons, 72 hours should not be viewed as a rigid cut-off. Professional judgment should be used.
   j. The 72 hours is most specifically geared to the collection of trace evidence (evidence of the crime scene or contact with victim, etc), as well as evidence of injuries from such assaults. The reference samples are not affected by the 72 hours and should be collected from suspects regardless of the passage of time.

4. WARRANTS AND CONSENT:
   a. A warrant or signed consent is necessary before collecting evidence from the suspect’s body.
   b. A warrant, although it takes more time to obtain, is a more definite method than consent, as the suspect may withdraw or argue the validity of the consent.
   c. If conducted with consent, and conducted by a medical professional at the request of law enforcement, then law enforcement should also have the suspect complete an authorization for release of medical information as well to

avoid any arguments as to the application of HIPAA or other laws governing the release of medical information.

5. WHO CONDUCTS THE EXAMINATION

a. The exam and evidence collection should be performed by a trained medical provider (nurse, doctor, physician's assistant, or technician) or a trained law enforcement officer.

b. A hospital that routinely sees sexual assault victims may or may not be able to provide exams for suspects. Such arrangement must be made in advance, especially regarding billing and security. In addition, law enforcement should make arrangements for the paying of all bills related to such examinations as they most likely will not be covered by Crime Victims Compensation through the medical facility.

c. Law enforcement or the forensic examiner may respond directly to the hospital if the suspect is injured, but will require permission and assistance from the hospital to conduct examinations at that location.

d. A forensic examiner should not be left alone with the suspect - law enforcement personnel should be present during all phases of the collection of evidence, if possible. If the officer is of the opposite sex of the suspect, they should not remain in the room for the examination, and another officer shall be called in to observe the examination and assist with evidence collection by the forensic examiner. If the examination is conducted by law enforcement, there should be a minimum of two officers present, and they should be of the same sex as the suspect.

e. Injured suspects and victims SHOULD not be taken to the same medical facility for treatment. If that is not possible, they should be separated by the largest possible distance within the facility, and law enforcement should assure that no contact or observation is allowed by either victim or suspect.

5. WHAT SUSPECTS SHALL BE EXAMINED:

Law enforcement should examine or request examination of all suspects, adult or juvenile. If the suspect is under the age of 18, and a warrant has not been obtained, law enforcement should obtain consent from a responsible parent for the juvenile prior to the examination (another reason to obtain a warrant).

6. EQUIPMENT NEEDED TO CONDUCT EXAMINATION:

a. 20 packages (2 each) of sterile cotton swabs.
b. Distilled or sterile water or saline.
c. 2 plastic combs.
d. 10 clean sheets of paper.
e. 15 envelopes.
f. Clean (never used before, or soaked in 20% bleach solution) nail clippers or scissors.
g. Brown paper bags for clothing.

h. If using the Tri-Tech **RE-1WA** kit, the following envelopes will be used for evidence collection within 24 hours: Step 1A, 1B, 1C, 3, 4, 5, 6, 8, 9, 10, 11, 14, and 15;
i. Digital Camera.
j. 35 mm Camera.

7. INFORMATION TO BE OBTAINED PRIOR TO THE EXAMINATION:

a. Information about the alleged assault from the law enforcement officer who has full information concerning the facts of the assault – This should be recorded on a separate worksheet/document;
b. This information is necessary to direct the examiner to look for injury and evidence not readily visible.
c. Ask the law enforcement officers questions regarding:
   i. Date and time of alleged assault;
   ii. Alleged acts;
   iii. Any potential injuries that may have been inflicted by the victim upon the assailant;
   iv. Location and physical surroundings of the assault; and
   v. Any physical identifying information provided by the victim, such as scars, tattoos, etc.
d. Accept and record the suspect's statements, if they are volunteered.

8. EVIDENCE - GENERALLY:

d. The forensic examiner shall collect evidence and/or specimens using sexual assault evidence kits, if appropriate.
e. To the extent it can be controlled, the suspect should not wash hands, urinate, shower, or bathe before the examination;
f. Examiner's gloves should be changed frequently during the exam and evidence collection;
g. The forensic examiner shall be responsible for collecting and properly securing/storing the forensic evidence until released to the law enforcement officer;
h. Refer to the "Sexual Assault Suspect Examination" form (Appendix R)for recommendations on specific evidence collection procedures.

9. TRACE EVIDENCE:

a. Place large paper sheet or bed sheet on floor.
b. Place 2nd paper sheet (approx 24" x 24") on top of first sheet.
c. Suspect undresses while standing on clean large paper sheet.
d. Fold top sheet inwards to retain debris.
e. Place in clean envelope.

10. CLOTHING:

a. Collect all clothing worn at the time of apprehension (and any other clothes that are identified as having been worn at the time of the assault).

b. Underpants should be collected separately and placed in a small paper bag.
c. Each additional article of clothing should be packaged in a separate bag, and then all the bags should be placed in one larger paper bag and sealed.

11. HEAD HAIR/FACIAL HAIR:

a. Comb hair over a clean sheet of paper.
b. If combing is not possible, fluff hair over collection sheet.
c. After combing, place comb in middle of sheet, fold sheet carefully to package comb and any foreign hairs, and place in envelope.
d. If suspect has a beard or moustache: comb facial hair over a clean sheet of paper.
e. After combing, place comb in middle of sheet, fold sheet carefully to package comb and any foreign hairs, and place in envelope.

12. PUBIC HAIR:

a. Comb hair over a clean sheet of paper. This is to collect any foreign hairs.
b. After combing, place comb in middle of sheet, fold sheet carefully to package comb and any foreign hairs, and place in envelope.
c. Fold in a clean paper sheet and place in envelope.

13. FINGERNAIL CLIPPINGS:

a. Hold fingertips of one hand over clean sheet of paper.
b. With clean (not used before or soaked in bleach) metal clippers or scissors, clip off each fingernail on one hand.
c. Fold paper to hold in clippings.
d. Label indicating right or left hand and seal.
e. Repeat with other hand.
f. Place both folded sheets of paper in an envelope, fold and seal.

14. FINGER AND HAND SWABS:

a. Use 1 swab for each hand, lightly moisten with tap or distilled water.
b. Swab all fingers, front and back, fingertips, palms, web spaces with one swab.
c. Place in appropriate evidence container and label indicating right or left hand and seal.
d. Repeat with another swab for other hand

15. SKIN SWABS:

a. Collect dried and moist secretions, stains (including semen, blood stains, and saliva from bites), and foreign materials from the body.

b. Scan the entire body with a Wood's Lamp (Long wavelength ultraviolet light), or other alternate light source, if available and indicated. Note fluorescent area(s) on the diagram and record.
c. Swab moist secretions with a dry swab to avoid dilution. Label and air dry before packaging.
d. Swab dried stains and/or Wood's Lamp positive area(s) with a swab (or multiple swabs for large stains) moistened with sterile, dionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
e. Swab areas which may be bite marks or fingernail marks to obtain victim's DNA.
f. Moisten one swab with one drop sterile, dionized, or distilled water.
g. Swab each area with one moist swab – repeat with one dry swab.
h. Repeat for each suspected bite mark or scratched area.
i. Collect foreign materials such as fibers, sand, hair, grass soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
j. Record all findings on the diagrams and record the locations of swab collection sites and control swabs.

16. GENITAL EXAMINATION:

a. Examine the inner thighs, external genitalia, and perineal area for injury, foreign materials, and other findings. Document findings.
    i. Use a colposcope, if available, or employ other means of magnification;
    ii. Record size and appearance of injuries, foreign materials, and other findings. Note swelling and areas of tenderness and induration.
    iii. Record findings relevant to identification, e.g., tattoos, scars, body piercing, chronic skin lesions, etc.
    iv. Record whether circumcised or not
    v. Collect dried and moist secretions identified in the fashion set forth above.
b. Collect two (2) penile swabs, if indicated by the assault history.
    Hold the swabs together as a unit and swab the glans, shaft, and base of the penis with a rotating motion to ensure uniform sampling. Avoid swabbing the urethral meatus. Use swabs moistened with sterile, deionized, or distilled water for these swabbings. Air dry, package, label, and seal.
c. Collect two (2) scrotal swabs, if indicated by the assault history.

Collection of scrotal swabs is recommended because secretions from the victim may also be transferred to this area.

Hold the swabs together as a unit and swab the scrotum in a rotating motion, focusing on the area that is in closest proximity to the penis. Use swabs moistened with sterile, deionized, or distilled water. Air dry, package, label, and seal.

d. Record other findings per history.

17. HEAD, NECK AND ORAL EXAMINATION:

a. Examine the face, head, hair, scalp, and neck for injury and foreign materials.
   i. Give special focus to the lips, perioral region, and nares in the examination.
   ii. Record injuries and other findings.
   iii. A colposcope may be used.

b. Collect dried and moist secretions, stains and foreign materials from the face, head, hair, scalp, and neck in a similar fashion as indicated under skin swabs, including use of alternate lights sources and control swabs when possible.
   i. Collect foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
   ii. Cut matted head or facial hairs bearing crusted material and place in a bindle. Package, label, and seal.
   iii. Record the locations of swab collection sites and control swabs.

c. Examine the oral cavity for injury and foreign materials (if indicated by the assault history, e.g., ejaculation by a male victim).
   i. Give special focus to frenulums, buccal surfaces, gums, and soft palate.
   ii. Record injuries, foreign materials, and other findings.
   iii. A colposcope may be used.
   iv. Collect foreign materials found in the oral cavity, e.g. hair. Package label, and seal.

d. Collect two (2) swabs from the oral cavity for seminal fluid up to 12 hours post assault and prepare one dry mount slide from one of the swabs (if indicated by the assault history, e.g., ejaculation by a male victim).
   i. Swab the gum to the tonsillar fossae, the upper first and second molars, behind the incisors, and the fold of the cheek (buccal space).
   ii. Label and air dry swabs and slide. Code the swab to enable the crime laboratory to determine which swab was used to make the slide. Package, label, and seal.

18. DRYING SWABS:

a. Swabs may be dried in a locked room, cabinet or drying box.
b. Air dry swabs for 1 hour before packaging. Do not use heat to dry swabs.
c. Maintain chain of custody while drying.
d. If drying box is used, place swabs from only one patient at a time in drying box. If necessary, lock specimens from 2nd patient in cupboard until drying box is empty.
e. Clean drying box with 20% bleach between each use

19. LABELING AND PACKAGING OF SWABS:

a. Affix label to wooden shaft of swabs, 1 label to 2 swabs from same site OR
b. Affix label to cardboard box or envelope in which dried swabs are packaged.
c. Place 2 swabs from same site in one envelope.
d. Seal envelopes using tape. Never lick envelope to seal.
e. Write on envelope time and date collected, and contents.
f. Sign over seal.

20. TOXICOLOGY SAMPLES:

a. Collect samples for blood alcohol/toxicology at the discretion of the examiner and/or law enforcement officer in accordance with policies for such collection.
b. Up to 96 hours after suspected ingestion of drugs, collect a urine specimen (100cc) in a clean container. It is important to collect the first available sample (even if it interrupts the flow of the examination).
c. Collect when suspect appears impaired, intoxicated, or has altered mental status.
d. Collect when suspect reports or victim report blackouts, memory lapses, or total or partial amnesia for event.
e. Use State Toxicology Laboratory Kit for collection.

21. REFERENCE SAMPLES:

If collected at the time of the forensic suspect examination, <u>ALWAYS</u> collect after the evidence samples.

a. HEAD HAIR:

i. Pluck total of 10 – 15 head hairs close to scalp from each of the following sites: left side, right side, front, back, top.
ii. Fold in a clean paper sheet and place in envelope.
iii. May use a clean “Post-It” note adhesive side up, to remove hairs from glove: fold inward and fold in clean paper sheet and place in envelope.
iv. Package, label, and seal.

b. FACIAL HAIR (SUSPECTS WITH BEARD OR MOUSTACHE/GOATEE):

i. Pluck 5 hairs close to skin from each of the following sites: moustache, left side of beard, right side of beard, neck.

ii. Package, label, and seal.

C. PUBIC HAIR:

i. Pluck 10 hairs from the pubic area (or have patient pull at your direction), from different areas.

ii. Package, label, and seal.

D. CHEST HAIR:

i. Pull (or have patient pull at your direction) 20-30 hairs representative of variations in length and color from different areas of the chest; OR cut the hairs close to the skin.

ii. Package, label and seal.

E. ORAL (BUCCAL – INNER CHEEK) SWABS:

i. With 1 sterile dry cotton swab, rub on inside of cheek and on gums in a rotating motion to ensure even sampling, especially at base of teeth.

ii. Use another swab to repeat on opposite side of mouth.

iii. Place on designated saliva DNA card.

iv. Air dry thoroughly, package, label and seal.

v. This is for reference DNA.

22. RECORD ALL EVIDENCE COLLECTED AND ALL EVIDENCE SUBMITTED TO THE CRIME LABORATORY – THERE MAY BE A DIFFERENCE:

a. Record all items of clothing collected.

b. Record all foreign materials collected and the name of the person who collected them.

c. Record information about the oral/genital samples.

i. Record the number of swabs and slides collected, the time collected, and the person who took the samples.

d. Record who makes/made the decision as to what evidence to send to the crime lab – they should do report on reasons for submission of evidence.

23. PHOTOGRAPHIC DOCUMENTATION:

a. Document photographic methods used and areas which were photographed. Documentation must clearly link the patient's identity to the specific photographs of injuries and/or findings. For example, include a picture of the patient identification on the roll if using film or on disk or use a databack camera, which can be programmed with the patient's identification number.

b. Use of a digital camera is the preferred method of collecting photographic evidence, PROVIDED that the examiner

has the ability to review the photos collected to assure that they are capturing what is being photographed.

c. A 35 mm camera should be available as a back-up to ascertain that those items photographed are captured.

d. If using a colposcope, it should have photographic capabilities.

e. Photograph all injuries and areas where samples are collected for all evidence collected.

24. RECORD ALL PERSONS PRESENT:

a. Who was responsible for the examination?

b. Where was the examination conducted?

c. Who was responsible for photographs?

d. Who was responsible for evidence collection?
   i. Who collected?
   ii. Who transported to evidence locker, if different.

e. Who will process the evidence?
   i. Into the evidence lockers
   ii. From the evidence lockers to the crime lab

f. Who is responsible for the packaging of evidence?
   i. Different from person obtaining/collecting?
   ii. Different from person transporting?
   iii. Different from person admitting to evidence locker?
   iv. Different from person sending to crime lab?

f. Who else was present – What did they do?

FORENSIC MEDICAL REPORT SEXUAL ASSAULT SUSPECT EXAMINATION

Confidential Document Patient Identification:

A. GENERAL INFORMATION (print or type) **Name of Medical Facility:**

1.Name of patient

2. Address City County State Telephone (W) (H)

3. Age DOB Gender Ethnicity Arrival Date Arrival Time Discharge Date Discharge Time

B. AUTHORIZATION **Jurisdiction (city county other):**

1. Name of Law Enforcement Officer: Agency ID Number Telephone

2. I request a forensic medical examination for suspected sexual assault at public expense.

Law enforcement officer signature **Date** **Time** **Case number**

C. Medical History

1. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? No___ Yes____
If yes, describe:

2. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings?
No____ Yes_____
If yes, describe:

3. Any pre-existing physical injuries? No____ Yes____
If yes, describe:

D. RECENT HYGIENE INFORMATION **Not applicable if over 72 hours**

	No	Yes		No	Yes
Urinated			Bath/shower/wash		
Defecated			Brushed teeth		
Genital or body wipes			Ate or drank		
If yes, describe:			Changed clothing		
Oral gargle/rinse			if yes, describe:		

E. GENERAL PHYSICAL EXAMINATION

1. Blood Pressure Pulse Respiration Temperature 2. Exam Started Date Time Exam Completed Date Time

3. Height Weight Hair color Eye color Right-handed____ Left-handed____

4. Describe general physical appearance

Original - Law Enforcement____ Copy within evidence kit - Crime Lab_____ Copy - Medical Facility Records_____

5. Describe general demeanor

6.Describe condition of clothing upon arrival.

7. Collect outer and under clothing, if indicated. Not indicated____

E. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system

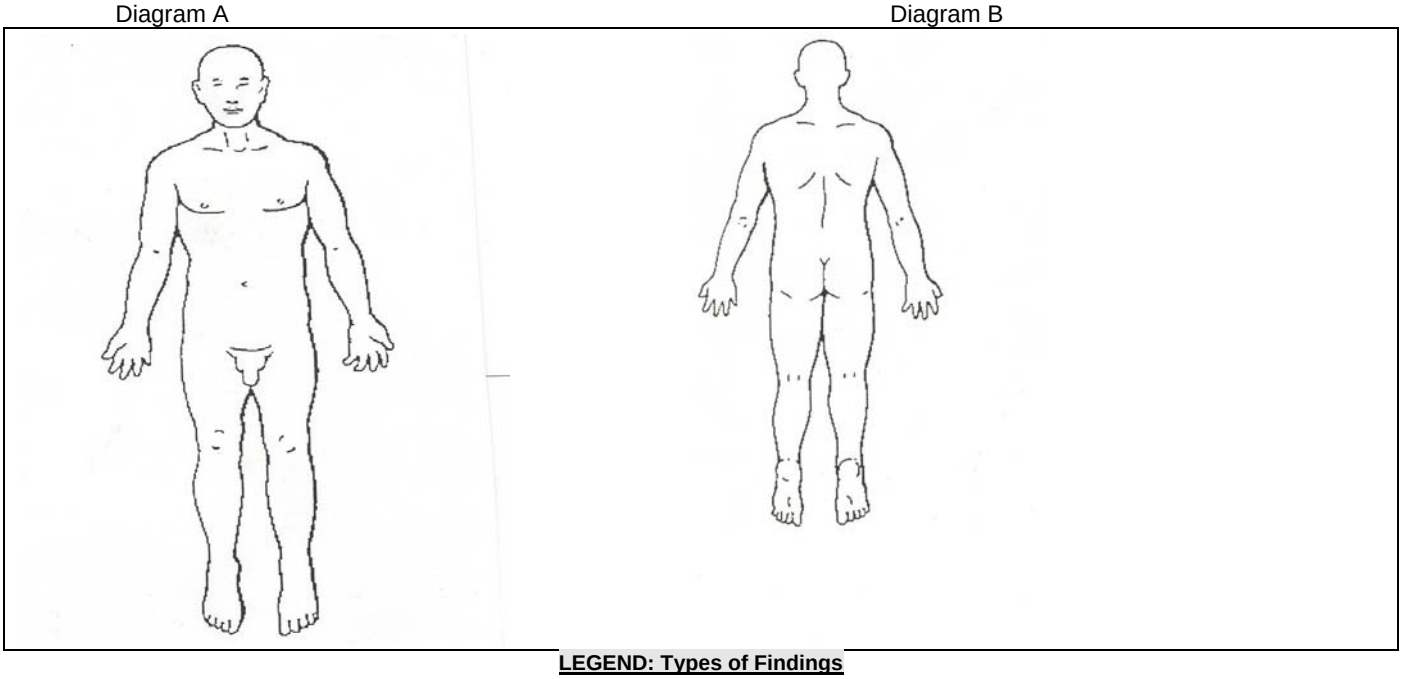
8. Conduct a physical examination. Record scars, tattoos, skin lesions, and distinguishing physical features. Findings____ No Findings___

9. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with a Wood's Lamp. Findings____ No Findings___

10. Collect fingernail scrapings or cuttings according to local policy.

11. Collect chest hair reference samples according to local policy. **Patient Identification:**

Diagram A Diagram B



LEGEND: Types of Findings

AB Abrasion **DE** Debris **F/H** Fiber/hair **OF** Other Foreign Materials **SC** Scars **TA** Tattoos
BI Bite **DF** Deformity **IN** Induration (describe) **SHX** Sample Per History **TB** Toluidine Blue.
BP Body Piercing **DS** Dry Secretion **IW** Incised Wound **OI** Other Injury (describe) **TE** Tenderness
BU Burn **EC** Ecchymosis (bruise) **LA** Laceration **PE** Petechiae **SI** Suction Injury **V/S** Vegetation/Soil
CS Control Swab **ER** Erythema (redness) **MS** Moist Secretion **PS** Potential Saliva **SW** Swelling **WL** Wood's Lamp.

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED IN SECTION "H"

F. HEAD, NECK, AND ORAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials. Findings_____ No Findings____

2. Collect dried and moist secretions, stains, and foreign materials from face, head, hair, scalp, and neck. Findings_____ No Findings_____

3. Examine the oral cavity for injury and foreign materials (if indicated by assault history). Collect foreign materials.

Exam done: Not applicable____ Yes Findings ____ No Findings____

4. Collect 2 swabs from the oral cavity up to 12 hours post assault and prepare one dry mount slide from one of the swabs.

5. Collect head and facial hair reference samples according to local policy. _____

Patient Identification

Diagram C

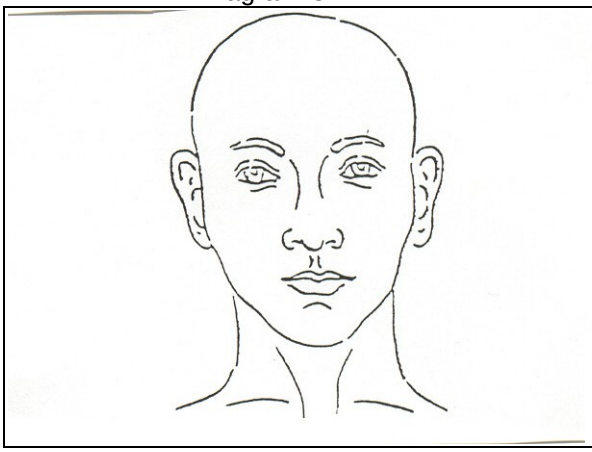


Diagram D

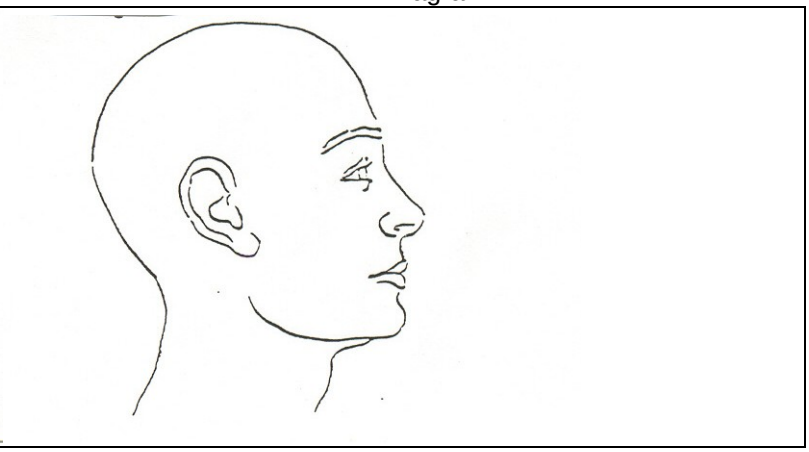


Diagram E

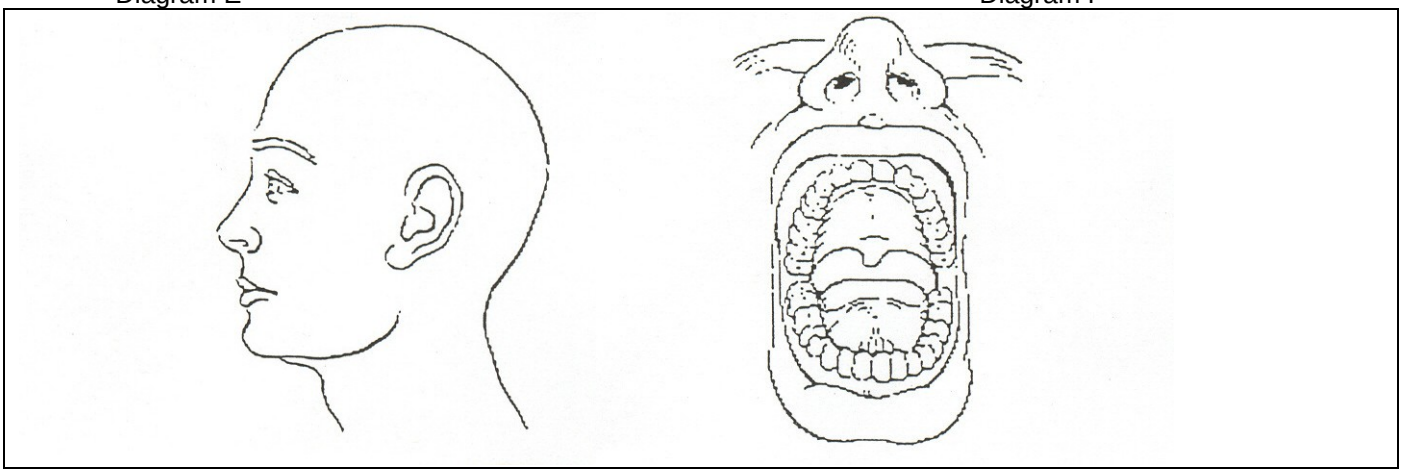


Diagram F

LEGEND: Types of Findings

AB Abrasion **BI** Bite **BP** Body Piercing **BU** Burn **CS** Control Swab **DE** Debris **DF** Deformity **DS** Dry Secretion **EC** Ecchymosis (bruise) **ER** Erythema (redness) **F/H** Fiber/hair **IN** Induration **IW** Incised Wound **LA** Laceration **MS** Moist Secretion **OF** Other Foreign Materials (describe) **OI** Other Injury (describe) **PE** Petechiae **PS** Potential Saliva **SC** Scars **SHX** Sample Per History **SI** Suction Injury **SW** Swelling **TA** Tattoos **TB** Toluidine Blue. **TE** Tenderness **V/S** Vegetation/Soil **WL** Wood's Lamp.

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED IN SECTION "H"

G. GENITAL EXAMINATION **Patient Identification:**_____

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings:

No Findings	☐				
Inner thighs	☐	Glans penis	☐	Scrotum	☐
Perineum	☐	Penile shaft	☐	Testes	☐
Foreskin	☐	Urethral meatus	☐		

2. Circumcised No_____ Yes____
3. Collect dried and moist secretions, stains, and foreign materials. Scan the area with a Wood's Lamp (if available and indicated). Findings____ No Findings_____
4. Collect pubic hair combing or brushing.
5. Collect pubic hair reference samples according to local policy.
6. Collect 2 penile swabs, if indicated by assault history. N/A___
7. Collect 2 scrotal swabs, if indicated by assault history. N/A___
8. Record other findings per history. No____ Yes____

If yes, describe:

Diagram G

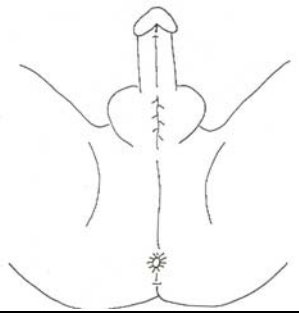


Diagram H

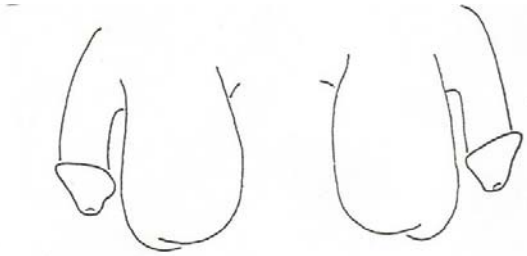


Diagram I

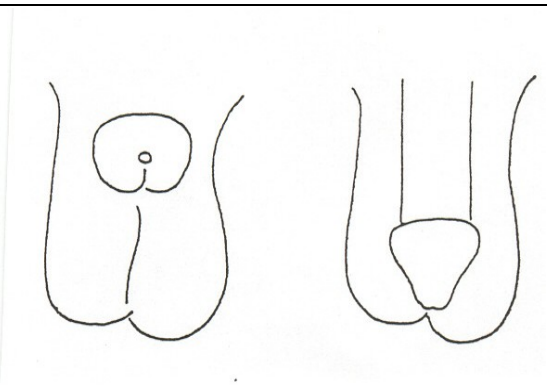
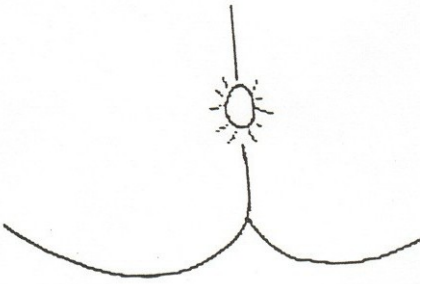


Diagram J



LEGEND: Types of Findings

AB Abrasion **ER** Erythema (redness) **PE** Petechiae **V/S** Vegetation/Soil
BI Bite **F/H** Fiber/hair **PS** Potential Saliva **WL** Wood's Lamp.
BP Body Piercing **IN** Induration **SC** Scars
BU Burn **IW** Incised Wound **SHX** Sample Per History
CS Control Swab **LA** Laceration **SI** Suction Injury
DE Debris **MS** Moist Secretion **SW** Swelling
DF Deformity **OF** Other Foreign **TA** Tattoos
DS Dry Secretion Materials(describe) **TB** Toluidine Blue.
EC Ecchymosis (bruise) **OI** Other Injury (describe) **TE** Tenderness

Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED IN SECTION "H"

H. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing placed in evidence kit Other clothing placed in bags Patient Identification:_____

_____
_____
_____
_____
_____
_____

L. RECORD EXAM METHODS

2.Foreign materials collected

	No	Yes	Collected by:
Swabs/suspected blood			
Dried secretions			
Fiber/loose hairs			
Vegetation			
Soil/debris			
Swabs/suspected semen			
Swabs/suspected saliva			
Swabs/Wood's Lamparea(s)			
Control swabs			
Fingernail scrapings/cuttings			
Matted hair cuttings			
Pubic hair combings/brushings			
Other types			

If yes, describe:

3. Oral/genital samples

	# Swabs	# Slides	Time collected	Collected by:
Oral				
Penile				
Scrotal				

	No	Yes
Direct visualization only		
Colposcopy		
Other magnifier		
Other		

If yes, describe

_____

M. RECORD EXAM FINDINGS_____

Physical findings___ No physical findings_____

N. SUMMARIZE FINDINGS_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)				
Urine toxicology				

J. REFERENCE SAMPLES

	No	Yes	Collected by:
Blood (lavender top tube)			
Blood (yellow top tube)			
Blood Card (optional)			
Buccal swabs (optional)			
Saliva swabs			
Chest hair			
Facial hair			
Pubic hair			
Head hair			

K. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope/ 35mm	Macrolens/ 35mm	Colposcope/ Videocamera	Other optics
Body						
Genitals						

Photographed by:

_____

O. PRINT NAMES OF PERSONNEL INVOLVED

History taken by: Telephone:_____

Exam performed by:_____

specimens labeled and sealed by:_____

Assisted by: _____ NA____

Signature of examiner:_____ License No.____

P. EVIDENCE DISTRIBUTION GIVEN TO:_____

Clothing (item(s) not placed in evidence kit)
Evidence Kit
Reference blood samples
Toxicology samples

Q. SIGNATURE OF FFICER RECEIVING EVIDENCE

Signature:_____
Print name and ID#:_____

Agency:_____

Date:_____ Time:_____